

The Long Road to Universal Health Coverage

A century of lessons for
development strategy

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A century of lessons for development strategy**

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I. Introduction

Universal health coverage (UHC) has risen to the forefront of the global health agenda in the past few years, as reflected by donor pledges, international declarations, and high-profile publications (BBC News 2009; Garrett, Chowdhury et al. 2009). The next *World Health Report* will focus on UHC, and other recent efforts have worked to identify sustainable financing for health systems strengthening. For instance, to coincide with the final report of the Taskforce on Innovative International Financing for Health Systems (TIIFHS)¹ in September of 2009, donors announced commitments and new financing strategies expected to generate US\$5.3 billion. At the same time, six developing countries announced policy reforms to increase access to health services, including the elimination of user fees, the provision of free care, and new insurance mechanisms (TIIFHS 2009).

Despite the apparent momentum behind UHC, there has yet to be a thorough discussion of the full parameters of this concept. The meanings and implications of UHC are unclear and the goals of UHC's proponents are unknown except in broad senses. Furthermore, it is not obvious what strategies could be used to promote UHC through development assistance channels, or even what past experiences could provide insights into the process or shed light on its prospects.

I seek to address these important issues and offer some guidance to the global debate by developing a conceptual framework for discussing UHC and developing a methodological framework for examining historical events to provide lessons for the present. Using a historical political economy perspective I tackle two large questions: First, does the history of UHC suggest ingredients important to implementing UHC in the future? I examine the development of important health institutions in Germany and the United Kingdom, where the first national health insurance scheme and the general taxation model of health system financing were developed, respectively. I also examine the history of early sickness funds in the United States, which might have led to German-style institutions, but did not. I study the historical context and political economy of each of these episodes to derive lessons for developing countries trying to move toward UHC. In particular, I focus on the conditions under which the social contract is renegotiated to include or expand health benefits to understand the context in which health institutions can be built.

Second, what has happened in past assistance strategies designed to foster UHC systems? I examine past efforts to promote UHC through development assistance. Today we are in the third such movement of the past century. Similar objectives have been advanced at the global level since the World War I era, first by the Rockefeller Foundation's International Health Division² and the League of Nations

¹ The TIIFHS was jointly chaired by the UK and the World Bank.

² The International Health Division of the Rockefeller Foundation operated under a series of different names: the International Health Commission (1913–1916), the International Health Board (1916–

Health Office in the 1920s and 1930s. Second, after World War II, the main institutions of the post-colonial international architecture have advanced the proposition of UHC, most visibly in the Alma-Ata Declaration of “Health for All” in 1978 (WHO 1978).

The prospect of an externally assisted transition to UHC raises many questions because so far all countries that have achieved UHC have done so through organic, domestic processes, which necessarily reflect local historical, cultural, and institutional legacies. Supporting the creation of UHC systems with financing and expertise provided through development assistance channels is a different process. What are the implications of this discrepancy? By examining these past episodes, I expose some of the main historical obstacles to UHC and draw lessons to inform current efforts.

I contend that past experiences of countries with UHC systems can provide lessons for countries moving toward UHC now. I invoke theoretical and empirical support for these arguments from the economics and political science literatures on the importance and persistence of institutions. Most of this discussion takes place within a path dependence framework. More generally, I argue that the study of broad social phenomena, such as UHC, should be undertaken with methodological rigor. These phenomena would be very difficult to randomize, which limits the applicability of quantitatively precise methods such as randomized controlled trials (RCTs) or natural experiments. These methods face external validity problems where they can be used, as well. In the absence of RCTs and its substitutes, it is common in policymaking to rely on a “best practices” approach of studying shared characteristics of successful cases. I attempt to improve on this practice by discussing how I apply lessons from one health system to another, and examining the evidence for doing so.

I begin with a discussion of definitions of UHC and a clarification of the stated issues and unmentioned assumptions. In Section III, I present a justification for applying evidence from the past to the present, and discuss the data used in this paper. In Section IV I discuss important episodes in the evolution of UHC financing schemes in Germany, the United Kingdom, and the United States. In Section V I analyze three episodes of efforts to implement UHC through international assistance, including the social medicine movement and the Bandoeng Conference of 1937, the Primary Health Care movement and the Alma-Ata Conference of 1978, and the Selective Primary Health Care movement of the 1980s. In Section VI I discuss health as a human right and examine recent attempts to legally enforce that right through litigation. In Section VII I assess the differences between past international attempts to foster UHC systems and those of the present.

1927), and the International Health Division (IHD)(1927–1951). See Farley, 2004, p. 9. For simplicity, IHD is used throughout this paper.

II. Methods, Data, and Limitations

Limitations of Two Common Methods

Broad historical and cultural patterns are extremely important to the creation of health systems, but are very difficult to analyze with the most quantitatively precise social scientific methodologies. In public health research, the most quantitatively precise results come from randomized controlled trials (RCTs). But all RCTs face challenges in establishing external validity, and the method cannot be applied to phenomena not subject to randomization. Many of the biggest questions in social science research concern issues that fall into this category. Examples include the effect of institutions, the impact of democracy, and the importance of culture. Natural experiments allow us to approach the precision of the RCT, but these do not present themselves as neatly or as frequently as would be required to answer the large questions I mentioned. As do RCTs, natural experiments produce results that are hard to generalize.

In the absence of RCTs conducted to inform a specific decision, it is common practice in public health policymaking to fall back on personal and published experiences, whether these are formal results from other settings or informal observations. The logic is that “successful” cases are examined to produce lessons that are then applied to other settings where similar outcomes are desired. Typically, this approach is invoked under names such as “best practices,” “lessons learned,” and “case study.” On some level, the “lessons learned” approach makes sense, even though there is little formal justification for extrapolating these lessons out of sample. On the international scale of global health policy, where there are many variables and very large stakes, this practice should be engaged with caution. Although case studies do allow the consideration of shared characteristics, establishing causality is challenging when the cases all have the same outcome and are selected based on the dependent variable (King, Keohane et al. 1994).

An Historical Political Economy Methodology

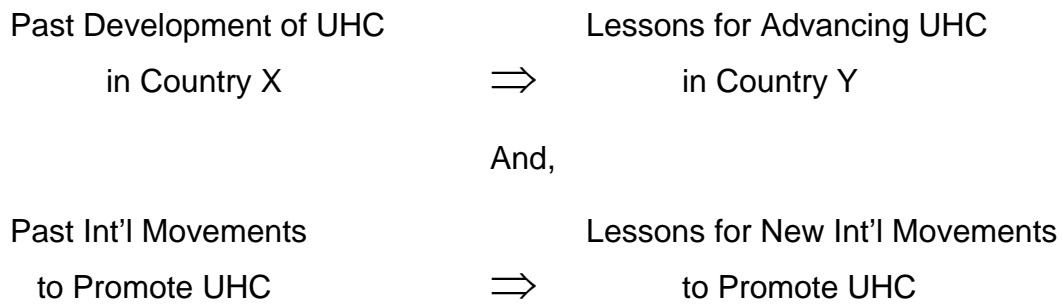
This discussion of methodology centers on inference issues and historical evidence. How can we move beyond “best practices,” where internal validity is questionable and external validity is opaque? What alternative methods are required to analyze rich historical evidence within a rigorous social science framework?

I propose to address these questions with an historical political economy methodology, which employs historical analysis as tool for generating social science hypotheses. As I lay out below, this method is grounded in established theoretical and empirical frameworks, careful case selection, and systematic examination of each case. This process allows us to examine internal validity with historical research, which is primarily an explanatory exercise. I do this within a social science framework to support a shift from explanation of what *has happened* to the development of hypotheses about what *might happen*, which is important to considering public health policies for guiding what *does happen*. In this method I use a political economy approach because it specifically recognizes the importance of

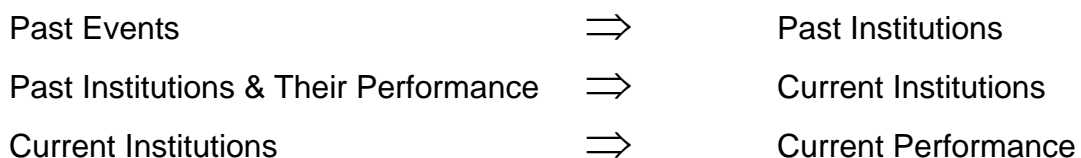
both political and economic factors in determining the distribution of resources for health.

I begin by explicating the logic of my inquiry to fully clarify the premises on which it rests. I then consider what evidence could support those premises. Doing so allows us to assess external validity by exposing the assumptions on which extrapolation rests. Once exposed, these assumptions can be considered, and we can better judge whether the proposed extrapolation is merited.

This inquiry proposes that an analysis of past national advancements toward UHC can uncover lessons relevant to current and future UHC transitions in other countries. (I discuss case selection below.) Similarly, I propose that an analysis of past strategies to encourage UHC through development assistance can provide lessons useful to current and future development strategies to promote UHC. Schematically, these two propositions can be represented as:



Because the past episodes I examine are deemed important in part because of where they have led in the present, the first step of logic is to say that the past affects the present. To make this obvious point more useful, I must propose that the past does affect the present, and because I want to extrapolate my results out of sample, I must propose that the past affects the present in a consistent pattern. Because this is a discussion of health systems and the progression toward UHC, I focus on institutions. Again proceeding schematically, the logic can be represented as:



Theoretical and Empirical Support

There is theoretical and empirical support to justify these propositions. Economist Paul David has characterized the development of path dependence theory as part of a “quest for *historical social science*,” and an attempt to formalize the general sense that “history matters” (emphasis original, p. 15) (David 2001). In his definition, “*Path-dependence*...refers to a dynamic property of allocative processes. It may be defined either with regard to the relationship between the process dynamics and the outcome(s) to which it converges, or the limiting probability distribution of the stochastic process under consideration” (p. 18). David applied this theory to explain how historical influences are persistent in the design and performance of institutions (David 1994).

The political science field of historical institutionalism has also advanced this concept and is similarly supportive of the contention that institutions of the past influence current behavior (Hall and Taylor 1996). Giliberto Capano’s review of theoretical frameworks for policy change concludes that although history is featured most prominently in path dependency frameworks, all frameworks must account for the historical contexts and processes that surround policies (Capano 2009).

Recent empirical work has exploited natural experiments to produce precise quantitative estimates of the impact of institutions in specific settings. MIT economist Melissa Dell examines the present day impact of an historical forced labor system, *mita* (1573–1812), under the Spanish Empire in some mining areas of Bolivia and Peru. Comparing *mita* areas to otherwise similar non-*mita* areas of Peru, Dell finds persistent impacts from this slavery institution nearly two centuries after it was formally abolished. In the Spanish colonial period, *mita* areas were required to send 1/7 of their adult male population to mine silver and mercury. Dell estimates that this conscription practice reduces household consumption by about 25%, and elevates child stunting rates six percentage points in former *mita* areas versus similar control areas. The institution of *mita* also continues to express its influence through effect on land tenure and public goods provision: residents are more likely to be subsistence farmers and road networks are less well developed in the former *mita* areas (Dell 2010).

Nathan Nunn has shown that historical institutions can have a broad and relatively consistent influence across much larger areas. Analyzing the patterns of slave extraction in Africa, Nunn demonstrates that the areas from which the most slaves were deracinated have the lowest current economic performance (Nunn 2008). Nunn also develops a path dependence model to show that highly extractive colonialism lowered the returns to productive behavior (making things) and rewarded unproductive behavior (taking things). With the erosion of property rights institutions, a society can become stuck in a stable, but unproductive equilibrium in which more and more agents focus on schemes to redistribute rather

than create as the risk of expropriation rises. Once established, this equilibrium persists beyond the period of colonialism because no property rights institutions exist to encourage productive activities (Nunn 2007).

Nunn's model is consistent with previous findings by Acemoglu, Johnson, and Robinson (2002), who examine institutions and long-run growth using urbanization and population density as a proxy for economic development in 1500AD. Acemoglu et al. find that prosperity in 1500 is negatively associated with prosperity today. They hypothesize that European colonialists established extractive regimes in these areas of then-wealth and built institutions to protect property rights and encourage production in areas that were then poor. This pattern caused what the authors term an "institutional reversal": areas with good institutions and relative wealth were saddled with extractive regimes that destroyed both and led to low current outcomes; areas with few inhabitants and few institutions were settled and encouraged to grow through the establishment of good institutions that have led to prosperous present-day outcomes (Acemoglu, Johnson et al. 2002).

Acemoglu et al. find in an earlier paper that current development (GDP/capita) in former colonies is also negatively correlated with European mortality rates of the pre-colonial and early-colonial periods. Building on Philip Curtin's work on European military death rates in the tropics, they argue that Europeans were more likely to establish extractive regimes and build few institutions to protect property rights in areas with higher mortality. In areas of lower mortality, Europeans tended to settle in greater numbers and build better institutions to encourage production. The quality of these institutions, they argue, is reflected in better institutions historically and higher GDP/capita today. Their results appear robust across a wide spectrum from settler colonies such as the United States and Australia to the extractive regimes common in the sub-Saharan (Acemoglu, Johnson et al. 2001).

Continuing the logical argument of this paper, I contest that GDP/capita and health are closely linked. This proposition has been well established in general (Preston 1975; Pritchett and Summers 1996; Deaton 2003), even though many details such as the direction of causality are much discussed (Bloom and Canning 2007). In a specific case, Dell's analysis of the *mita* system, we see an explicit accounting of the health impact of colonial institutions in the greater likelihood of stunting among children in the former conscription areas (Dell 2010). I draw on this evidence to support the connection between colonial institutions and current health status:

Past Events, \Rightarrow Current Health
through Past Institutions Outcomes

The final logic link I wish to expose is that past institutions impact current health in a reasonably predictable pattern. Again, I turn to the empirical investigations for support. Acemoglu et al. and Nunn all find strong evidence for a fairly consistent

relationship between current GDP/capita and the colonial and pre-colonial institutions they examine. This step is important because it suggests that “institutions” function in predictable ways regardless of place, which provides a justification for applying lessons of institution building in one country in the past to other countries in the present.

Using instrumental variables to evaluate the effect of “institutions” leaves “institutions” as a black-boxed concept. This approach does not detail the historical moment that gave rise to the institutions under study, and does not explore the political economy of their creation. What I have attempted to support is the contention that institutions of the past influence health outcomes in the present in a reasonably predictable pattern. This suggests that institutions should have similar effects if recreated in new settings—*provided that the historical context could be controlled for*. The problem of accounting for this context points to the importance of understanding the political economy that gave rise to institutions in countries with good health outcomes in the present and other institutions whose effects are different. Studying the political economy of generating health institutions serves as a mechanism to generate hypotheses about how successful health institutions are founded, and how development assistance strategies could be improved.

One major limitation of path dependence and historical institutionalism is that proponents have yet to clarify when these theories should apply. Beyond areas where empirical evidence has been found, there are no guidelines to suggest what will persist and what will not. In this sense, these theories remain incomplete. Although David uses path dependence to historicize social science, he cites no credible historical evidence to support the QWERTY keyboard example of his foundational article (David 1985). This problem reduces path dependence to an interesting idea; as a theory its internal and external validity is open to debate. I suggest that better case selection and more thorough historical research would provide the basis for better formalizing path dependence theory. That objective is beyond the scope of this paper. Nonetheless, in the more narrow area of health systems development, I hope to demonstrate the important role of careful historical research in social science hypothesis generation.

Case Selection

The cases considered in this study were selected on the following basis. Hsiao (2003) identifies five mechanisms of health system financing: general revenue, social health insurance, private insurance, community financing, and out-of-pocket expenditures. All developed countries, with one exception, rely on either general revenues or social health insurance to finance their health systems. The remaining developed country, the United States, relies primarily on private insurance (Hsiao 2003). Community financing could be the basis for a UHC system, but I am not aware of any national-scale implementations of this policy. Out-of-pocket expenditures can play some role in UHC, but cannot serve as the main financing mechanism because of UHC’s commitment to financial protection. Private insurance

is not considered for the same reason, except as incorporated in national UHC systems.

One country case was then chosen to represent each of the two remaining financing systems. Germany was selected because it was the first country to adopt a national social health insurance model. The United Kingdom was selected because it was the first country to adopt a general taxation model for financing the health system.

The United States was then chosen as the most similar country with an alternative outcome. The similarity appears in cultural heritage, contemporary and current income, and in historic institutions. Also, the US is only example of its kind—a developed country reliant primarily on private health insurance to finance its health system, and is the only developed country without some type of UHC system.

Whereas the time periods of interest in Germany and the UK are clear, it is not immediately obvious which time period in US history is most relevant. Since the US has never adopted a UHC system, there is no turning point similar to those of the other countries I examine. In fact, there have been several waves of interest in UHC 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 (Derickson 1994; Cunningham and Cunningham 1997; Rodgers 1998; Derickson 2005; Hennock 2007; Murray 2007).

I also selected cases for a review of attempts to advance UHC through development assistance. As above, this exercise was conducted within the bounds of some historical facts: The main international institutions concerned with development were founded only during or after WWII. These include the World Bank (1944), UNICEF (1946), and the World Health Organization (1948). Of the earlier

international health mechanisms, only the League of Nations Health Organization (1924) undertook activities in health and development on a global scale (Farley 2008).³ The Rockefeller Foundation was also added to this list of important actors because it was the most active force in what is now known as international or global health in the first half of the 20th century and did much to define the field. To my knowledge, historians have not identified any other comparable entity.

The history of these organizations was then reviewed to identify large-scale movements in support of UHC or an intermediate objective, which I defined to include building health systems. General sources covering the history of international health, such as Paul Basch's *Textbook of International Health*, were also reviewed. Episodes were selected for further investigation on the basis of scale, novelty, impact, and relevance to UHC or health systems support.

As a final step, this approach allows me to generate and refine hypotheses about how nations move toward UHC. My dependent variable is UHC, which I consider as some nationally defined end stage of movement along the spectra of government involvement with the health system, the population covered, the services included, and the financial protections provided. For a full discussion of the meaning of UHC, see below. Additional independent variables will be identified in the analyses of UHC definitions and historical episodes.

Data

Data were collected through a literature review and Internet searches. For the literature review, I began by consulting four databases: PubMed; CSA WorldWide Political Science Abstracts; and FirstSearch's History of Science, Technology, and Medicine and FRANCIS databases. Each database was queried with the term "universal health." This was chosen because it captured germane results such as "universal health insurance" and "universal health financing," which would have been excluded by searches for the full phrase "universal health coverage." The most papers were retrieved through PubMed, where the search generated 780 results. The same phrase retrieved 130 results in the CSA Worldwide Political Science Abstracts Database and 34 results in First Search's FRANCIS database. The terms were used as two keywords to search FirstSearch's History of Science, Technology, and Medicine database, which yielded 19 results. All citations and abstracts were reviewed. Those discussing UHC were retained. Some of the excluded results mentioned the company "Universal Health, Inc.," or mentioned a UHC system as the setting for a clinical inquiry. Following my review of these results, additional searches were conducted in the same databases using the names of important authors and subjects. I then searched the Internet using Google Scholar; Google Books; and the websites of important institutions, including the World Health Organization, the International Labour Organization, the United Nations, and the World Bank. In total, approximately 275 published papers, books, and reports were obtained. A list of all materials I collected is attached as Annex 2.

³ On a regional scale, the Pan-American Sanitary Bureau (1902) would also qualify.

The phrase “universal coverage” was used, also, but the results were not systematically reviewed because an initial sample found frequent uses of “universal coverage” in conjunction with a single intervention rather than a broader system. Where relevant results were obtained they were found to overlap with those detected with the phrase “universal health.”

Limitations

There are at least three important limitations in the approach I followed. First, key episodes may not have been identified by the literature search I conducted. Second, I was limited by my lack of access to primary sources. The materials I obtained offered interpretations by other scholars of how ideas have moved between nations 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, not all UHC systems are well described in English language sources, which dominate the databases I used.

III. Defining Universal Health Coverage

What is meant by UHC? In this section I review recent and historic definitions of UHC in an attempt to analyze what this idea implies. I then discuss the assumptions of UHC and identify areas of vagueness in the concept. My objective is to present a framework for understanding and discussing UHC.

A Framework for Discussing UHC

The term “universal health coverage” has become more common in recent years,⁴ but there appears to be little consensus on a precise definition. There are at least two very broad categories of meaning. Sometimes UHC has been used to mean everyone should have health insurance (IOM 2004). Others have used “universal coverage” to mean that all needed medical services should be available at low or no cost, or to refer to a system that provides or ensures these benefits (Shisana, Rehle et al. 1996; Puenpatom and Rosenman 2008; Garrett, Chowdhury et al. 2009). In this review I focus on the latter usage because it is broader.

In much of the recent literature, UHC has been used as a banner under which to discuss the design and implementation of health systems, rather than to clarify the underlying conceptual meaning. Rob Yates has stated that “coverage” should mean the use of services and facilities rather than the mere existence of infrastructure. He has argued that eliminating user fees is an important element in reducing financial barriers that limit “coverage,” in this sense (Yates 2009). Analyzing Ghana, Witter and Garshong define UHC quickly to “[mean] that all of the population has access to appropriate health care when needed, and at an affordable cost,” and then turn to a discussion of the trade-offs between financial sustainability and the range of provided services (Witter and Garshong 2009).⁵ Giedion and Uribe discuss UHC in terms of insurance coverage in Colombia and analyze the impact of two insurance schemes on access and use of health services (Giedion and Uribe 2009).

My interpretation of these examples is that UHC means a well functioning, accessible health system, with some financial protections and some basket of services.⁶ A thoughtful discussion of implementation issues is important, but insufficient to resolve the conceptual issues implied with this usage. Each component—accessibility, financial protection, needs, and services—is a central element in the

⁴ In the PubMed database, for instance, the exact phrase “universal health coverage” appears in the title or abstract of papers published in the 1980s three times, in the 1990s 16 times, and in the partially catalogued decade of the 2000s 56 times. (As of 1 February 2010.)

⁵ Quote is from the second page of the article; the electronic copy does not have page numbers for citation.

⁶ Defining a health system is also fraught with difficulty. For this I rely on W. C. Hsiao (2003): “it is most useful to conceptualize a health system as a set of relationships in which the structural components (means) and their interactions are associated and connected to the goals the system desires to achieve (ends)... *A health system is defined by those principal casual components that can explain the system’s outcomes. These components can be utilized as policy instruments to alter the outcomes.*” (Emphasis original, see pp. ii and 3.) Hsiao uses WHO’s definition of the boundary of a health system from the 2000 *World Health Report*: “all the activities whose primary purpose is to promote, restore, or maintain health.”

social contract and must be addressed as such from an ethical perspective. Because resources are always limited, the heart of each issue is a rationing problem. Important questions for countries considering UHC overlap greatly with those present in designing a health system:

- What are the goals of the system?
- What rights are guaranteed to whom?
- Who bears what responsibilities?
- How will “needs” be determined?
- How will limited resources be distributed across unlimited demand?
- Does “universal health coverage” refer to a goal, a process, a policy?
- What trade-offs exist between breadth (universality) and depth (services)?

Scholars writing on health from a human rights perspective have raised some of these questions (Ooms and Van Damme 2009). Similarly, rationing problems in health have been identified and considered by ethicists (Daniels 1994; Daniels 2008).

In this meaning of UHC—a well functioning, accessible health system, with some financial protections and some basket of services—there are at least three assumptions:

- The government must play a central role in health care
- A public commitment to collective responsibility and redistribution
- Public values in support of some health equity

These three assumptions and the previous seven questions delineate a framework for considering UHC in the abstract. These raise so many philosophical issues—moral and ethical—and so many practical matters—financial resources, human resources, infrastructure, and the mix of public and private roles—that it is nearly certain UHC would have different ingredients and meanings across nations.

“Universal Health Coverage” in Historical Usage

Because UHC appears to draw on older concepts of the right to health, I reviewed important historical and recent documents that offer definitions of UHC and similar concepts. A systematic review was envisioned, but this approach was abandoned because the first 14 definitions considered were all substantially similar and too vague to support an analysis of conceptual evolution. Sources included the Beveridge Report, the UN Universal Declaration of Human Rights, the Alma-Ata Declaration, the 2005 World Health Assembly Resolution 58.33 on Universal Coverage, and a 2007 social protection strategy document from the International Labour Organization (Beveridge 1942; UN 1948; WHO 1978; WHO 2005; ILO 2007). Relevant portions of all 14 definitions I collected are included in Annex 1.

The review revealed three basic components in common. Each statement involved “people,” “services,” and “needs,” where people should get free or affordable medical and health services according to their needs. In implementation, the definition of “people” is vigorously contested, often around lines of citizenship or residence. It is hard to distill a common meaning for either “services” or “needs” because the definitions do not specify what is meant by either of these terms, nor provide any rationale for doing so in a particular setting. As with “people,” these latter two areas are subject to intense debate at the implementation stage because how one defines these concept determines rights and responsibilities.

The questions and assumptions I identified above around current usage of the term UHC are unanswered in the documents I reviewed. To give one example, the UN Universal Declaration of Human Rights, Article 25, 1, establishes health as a right of “everyone,” but does not specify how needs or services will be determined or provided (and as a declaration carried no legal authority):

“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control” (UN 1948).

Defining “Universal Health Coverage” in This Report

In this report, I use UHC as I have distilled it above, and modified to articulate the concept’s basis in collective responsibility and redistribution: a well functioning, accessible government-facilitated health system, with some financial protections and some basket of services. I use the concept of “progress toward UHC” to refer to attempts to build any aspect of such a system. Although the philosophical and practical questions raised in this section are beyond the scope of this paper, each of them would have to be addressed to operationalize UHC—a challenge principally summarized as *who gets what, when, and who pays*.

These questions are all central to the social contract that defines most modern nations. To deepen the analysis of how UHC has evolved, I turn from this definition to historical analysis. Discovering how UHC has been discussed, proposed, and implemented can reveal its origins and illuminate the forces that have underlain important developments. An inquiry into the political economy of each episode can help us understand how the concepts around “people,” “services,” and “needs” have been reflected in historical and political contexts over the past 125 years.

IV. Important Episodes of Conceptual Advance Towards UHC

To discover how UHC has evolved, I examined important episodes in its history, selected as discussed in Section II, above. First I discuss three examples showing important advances toward the creation of UHC systems, one of which has not (yet?) led to a UHC system and two of which have. I begin with the first national health insurance scheme—a groundbreaking step toward UHC—established in Germany by 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 make progress toward universal coverage during the Progressive Era.

Second, I discuss several episodes from the history of international assistance to show how the idea of promoting broad improvements in health in developing countries has come and gone several times. I investigate the politics surrounding each episode to analyze why the periodic momentum for promoting UHC through health assistance has yet to translate from rhetoric and meetings into implementation and health systems. I discuss the role of the Rockefeller Foundation's International Health Division and the social medicine movement in spreading the idea of population-wide public health in the late 1920s and 1930s. The most internationally important event in spreading the idea of whole population health—as opposed to urban-only public health—was the well-attended conference on rural hygiene in 1937 in Bandoeng, Java. I then follow this concept of broader health through the founding of WHO and the postwar period, leading up to the Primary Health Care strategy and the Alma-Ata Declaration of 1978. I show how the philosophical commitments to “Health for All” and Primary Health Care were partially translated into action over the decade that followed.

Third, I turn to health as a right enforceable through court action. Focusing on Central and South America, where such cases have been most successful, I analyze how this legal argument has been crucial to establishing or extending UHC systems in countries such as Colombia and Brazil.

UHC System Models I

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 ask what was the SHI system and how did it lead toward UHC? Second, I investigate the historical political economic context in which this innovation emerged. Why did Bismarck 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.

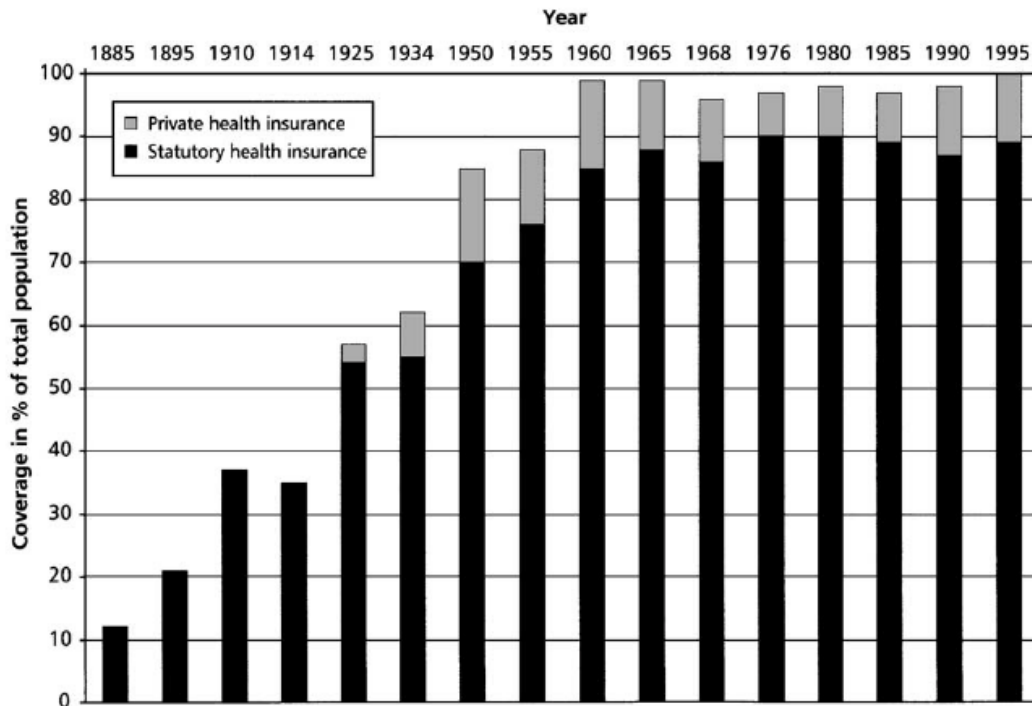
Bismarck's innovation in 1883 was to establish several so-called "sickness funds" that had mandatory enrollment and defined benefits. These funds covered members nationally, but only about 10% of the German population was eligible (required) to join one. Most of those included were industrial workers, 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 (Bärnighausen and Sauerborn 2002).

Under Bismarck's leadership, the German government took a fundamental step toward UHC. 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.

Over the course of roughly a century, this SHI system evolved to provide universal health coverage. Germany slowly expanded the system in two directions. Mandatory enrollment was extended piecemeal to include more and more employment categories. 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. For example, the minimum sick pay benefit was doubled from 13 to 26 weeks in 1901, midwifery and obstetric services were added in 1917–8, full coverage for all notifiable diseases was mandated in 1941, and in 1972 sick farmers gained support for the salaries of temporary replacement agricultural workers (Bärnighausen and Sauerborn 2002).

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 (Carrin and James 2005). Bärnighausen and Sauerborn have quantified this long-term progressive increase in the proportion of the German population covered by public and private insurance. Their graph is reproduced below as Figure 1:

Figure 1: German Population Enrolled in Health Insurance (%) 1885–1995



Source: Bärnighausen and Sauerborn, 2002.

If SHI is what Bismarck established, then the next question is, why did he do it? 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 (Sigerist 1943; Sigerist 1999). 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. 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 (Hennock 2007).

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 SHI to meet the primary demand of its supporters, which was for social protection (Sigerist 1943).

Further, Bismarck had socialist leanings in the sense that he 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, too. “The social insecurity of the worker is the real cause of their being a peril to the state,” he had said publicly in 1849 (Sigerist 1943). SHI would have also fit well with Bismarck’s strong Christian faith and its emphasis on charity, and was consistent with his pattern of using his own ill health as a political bargaining tool. A suspected hypochondriac, Bismarck may have identified personally with the workers’ demands for health care, as well (Pflanze 1972).

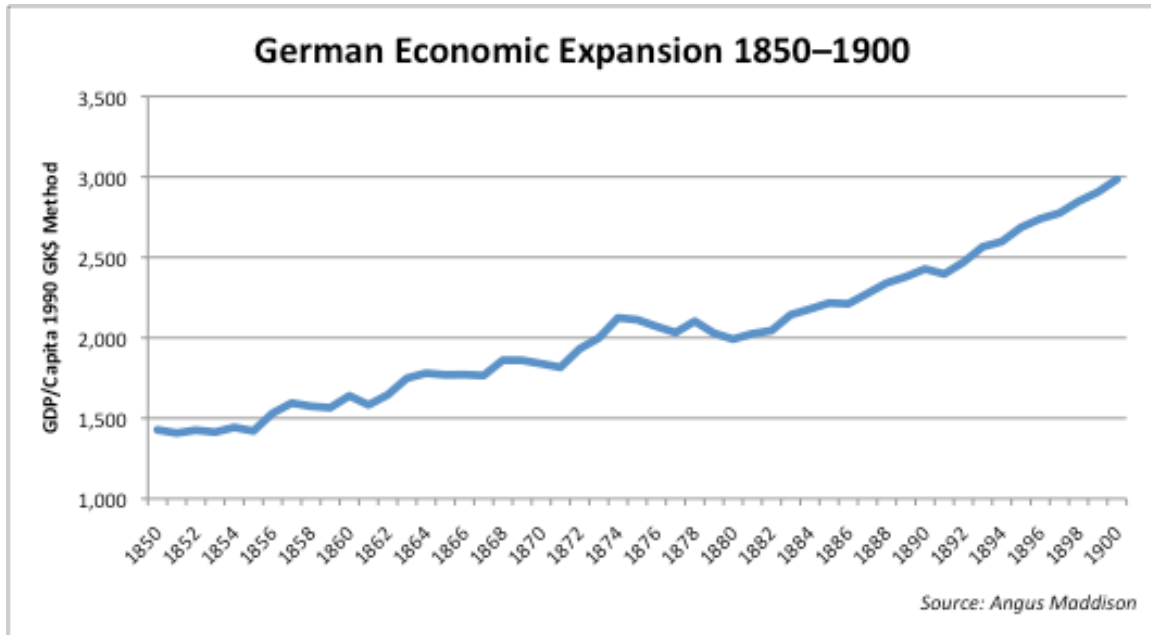
Bismarck’s SHI system drew heavily on concepts that had long existed in the territories that formed unified Germany. Roman law held that employers were liable for the compensation of workers injured in accidents, although the burden of proof was on the workers. In 1838 Prussia passed a law placing responsibility 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 (Sigerist 1943).

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 (Sigerist 1943; Bärnighausen and Sauerborn 2002).

Thus, all of the policies and mechanisms crucial to SHI pre-dated 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’s compromises with other political powers left the original structures essentially unchanged. For instance, benefit packages were not harmonized because sickness funds protested successfully to preserve their autonomy (Sigerist 1943; Bärnighausen and Sauerborn 2002).

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. Figure 2, below, shows Germany's economic expansion 1850–1900.

Figure 2. German Economic Expansion 1850–1900



UHC System Models II

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—predated the establishment of a national health system (Webster 1998). 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 may be the most famous early example, but even it was based on precedents that went back hundreds of years locally, which in turn drew on Roman, Greek, and Palestinian concepts from antiquity. The Statute of Laborers was actually a set of restrictions intended to cap wages and inflation, both of which had spiraled higher because of labor shortages following an epidemic of Black

Death. But the lasting importance of the Statute lay in the distinction of types of beggars that evolved from it. 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, which primarily meant whatever was given to beggars. Also, churches sometimes distributed resources to their poorer members (de Schweinitz 1961).

For several hundred years English conceptions of poor relief continued to hinge on this distinction between those who could work and therefore did not need charity and those who could not work and were therefore eligible. By the 1700s a system had evolved where relief for the deserving poor was funded through taxes assessed primarily on households. This system functioned throughout England but was thoroughly 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 based on geographic regions that were expected to fund their own needs. Poor areas could pay less in taxes and had greater needs. For the undeserving poor—those judged able to work—there were harsh punishments and workhouses designed to coerce their labor. Because of rapid migration to cities, many citizens were unknown to the regional authorities that might have provided them some modest protections. This meant that the poorer areas tended to have the fewest services and the greatest needs. These inequities caused deep-seated resentment among the lower working classes (de Schweinitz 1961; Szreter 2004).

By 1830 discontent among the working classes was sufficiently vocal to threaten political stability. Because so many migrants were living in makeshift, unrecognized accommodations outside their “home” parishes, the government’s first step was to initiate a national registry system that could keep track of mobile populations. Also in the 1830s, suspicion grew in the upper classes that welfare benefits were too generous and promoted idleness and laziness. A new Poor Law in 1834 slashed benefits and required all unemployed who could work to do so in workhouses, which entailed many hardships. Families were separated by gender, for instance, in a nod to Malthusian theory (Szreter 2004).

Essentially, the transformation in Poor Laws 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 (Szreter 2004). 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 (Ringen 1979).

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 (Hamlin 1995). In his 1842 *Report on the Sanitary Condition of the Labouring 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 (Rosen 1993). This was his attempt to patch the holes in the security system created by industrialization and the new Poor Laws using technological solutions (Szreter 2004).

The Public Health Act of 1848 followed from Chadwick's report, but it did not signal the start of a long career. Chadwick quickly lost support from one constituency after another as he tussled over the correct methods to construct sewers, usurped authority from physicians, and loudly criticized the business practices of water and sewer construction firms. In 1854 the Public Health Act and the first National Board of Health both expired for want of parliamentary renewal. Chadwick was out of office and did not return, even though the Act was reinstated four years later (Hamlin 1992; Rosen 1993).

With the Public Health Act the UK 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 (Szreter 2004).

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 practically impossible to navigate them all (Abel-Smith 1992; Webster 1998).

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 William Beveridge, an economist. Beveridge laid out broad principles of social protection and directly precipitated the establishment of the NHS (Abel-Smith 1992; Webster 1998).

The report had a star-crossed start. The Treasury had a minor report in mind, 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 the “pushy” Beveridge from his ministry. Beveridge knew he was being sidelined and took the position with great reluctance (Abel-Smith 1992).

After soliciting input and receiving next to none, Beveridge drafted the report himself. Although he feared the assignment as a career-ending wild-goose chase, 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 (Abel-Smith 1992).

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 (Abel-Smith 1992).

The war also played a key role in the creation of the NHS’ 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 (Webster 1998).

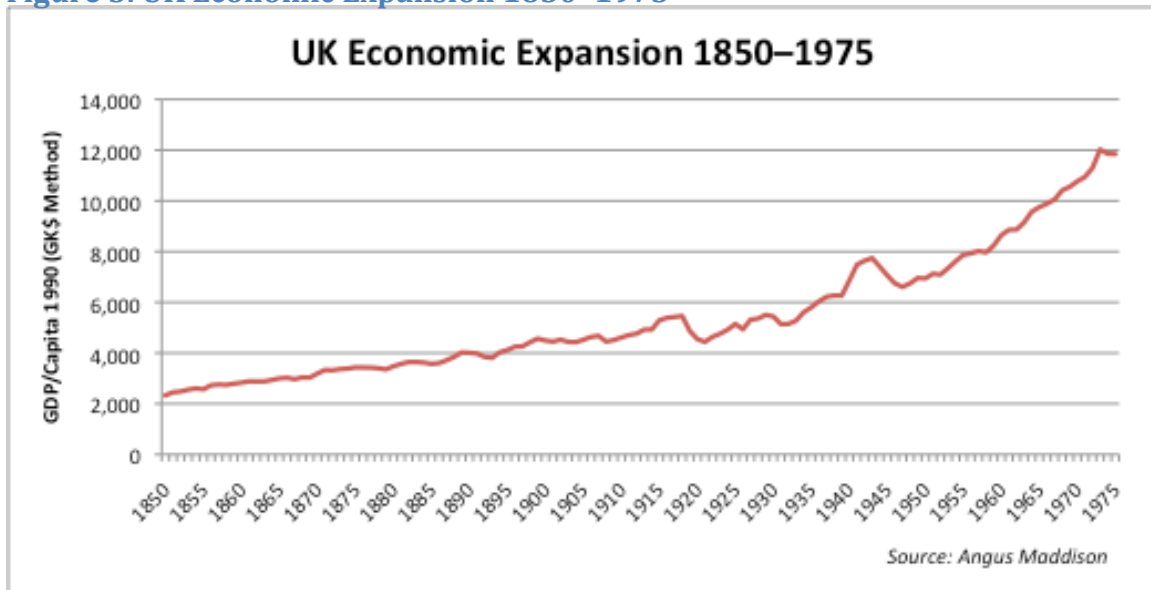
The rapidity with which the NHS was proposed and realized disguises some of the system’s heritage. As historian Charles Webster has explained, there had been calls for a unified and coordinated health system for decades before Beveridge, there were proposals similar to Beveridge’s in circulation, and contemporary surveys showed high popular approval for the ideas Beveridge used. By 1939, some of the richer municipalities had come close to achieving most of the goals later identified

in the report. But the report was eloquently stated and well timed. Political factors unique to the war gave crucial impetus to making a national system through a new administrative structure and a reorganization of pieces primarily already in place (Webster 1998). As Dan Fox has argued, the NHS must 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 (Fox 1985).

As distinct from the German model, the UK standardized benefits across the population, controlled almost all delivery infrastructure through direct ownership or coordinating authority, and maintained equity in financing by supporting the system with general taxation revenues. This model has since been adapted by Italy and Spain, among many other countries (Webster 1998).

Industrialization created the demand for increased social protections and also provided the economic resources to support Beveridge's plan. As in Germany, the basic political and economic factors leading to an expanded government role in health were largely driven by industrialization. Figure 3, below, shows the UK's economic growth over the period under discussion.

Figure 3. UK Economic Expansion 1850–1975



Social Protections and Industrialization in the US Progressive Era

Many of the same forces that shaped government social protections 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 protections 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 protections 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 recently 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 (Murray 2007).

The American Association for Labor Legislation (AALL) was the most important advocate for mandated health insurance. 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%). Those covered would include most workers, but not those who were poorly paid, whom the AALL thought would do better on charity alone. Benefits included the already common sickness pay, as well as new benefits for medical care for spouses and children. 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 (Murray 2007).

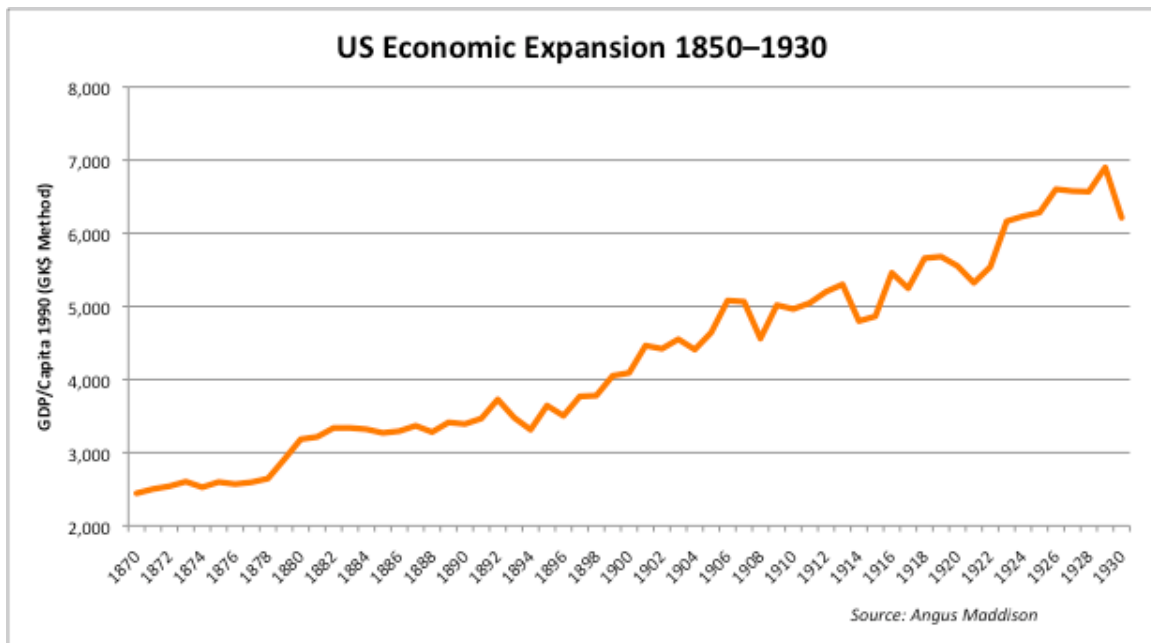
One obstacle was that the AALL had the support of only a tiny fraction of the nation's workers, even if "labor" was part of its name. Many workers were only interested in sick pay—a need already met by sickness funds—and were reluctant to pay for medical coverage, which they believed would be ineffective. 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. Voters were similarly dismissive and consistently rejected proposals for government health insurance. 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 (Murray 2007).

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. Commonly, those receiving benefits were subject to curfews, and prohibited from visiting saloons and other establishments that encouraged unhealthy behaviors. 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 (Murray 2007).

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. These criticisms had some merit, but the proposed remedy of government involvement promised to worsen moral hazard, raise premiums, and was unlikely to affect sickness rates. Funds defended themselves, of course, but the most meaningful evidence comes from workers themselves. 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. In a 1918 referendum on state health insurance, California voters rejected the measure by a margin of almost 3:1 (Murray 2007).

The American economy grew rapidly during the Progressive Era. 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 and points to the simple conclusion that industrial workers—the group at the center of the debate—were happier with the existing funds than the prospect of a government system. Figure 4, below, shows US Economic performance between 1850 and 1930.

Figure 4. US Economic Expansion 1850–1930



V. Supporting UHC Through Development Assistance

How can UHC be approached when a setting lacks the infrastructure to deliver health services? In the German example, Bismarck's innovation relied on existing human and institutional resources to deliver care; his crucial step toward UHC addressed directly only how care would be financed and what minimum care would be guaranteed. Similarly, England's boldest steps were in the general taxation model of financing. I now turn from finance to delivery.

Operational strategies for improving public health frequently employ the terms "vertical" and "horizontal" to describe differing approaches in developing countries. Broadly speaking, "vertical" means attacking one problem with one program. This narrow, focused approach is typified by WHO's Malaria Eradication Program, or its Smallpox Eradication Program. "Horizontal" refers to broad efforts aimed at raising health standards by addressing several problems simultaneously, and usually implies a commitment to building health system capacity. The Primary Health Care movement is a leading example. A benefit of the horizontal approach is the ability to address many issues simultaneously. However, compared to vertical programs, horizontal programs are much harder to implement, cost more, and take more time. The concept of UHC is closely aligned with the horizontal approach because it requires a health system and offers a wide range of services.

Part A: Selskar Gunn, Social Medicine, and the Bandoeng Conference, 1930s

In the first half of the 20th century, no single institution was more influential in international health than the Rockefeller Foundation's International Health Division (IHD). Operating from 1913 to 1951, the IHD worked in 80 countries in every region of the world and spent more than \$1.7 billion in 2009 dollars (Farley 2004).⁷ The IHD was important even early in its existence. "By 1920, the [IHD] was already playing a leading role in the planning and administration of public health programs, research, and education in dozens of locales around the globe, including virtually every Latin American country" (Birn 2006) (p. 2). Although the IHD usually employed vertical approaches to attack single diseases—malaria, most famously—one large initiative in China was oriented toward broad public health amelioration and helped establish the movement that foreshadowed Primary Health Care and the Alma-Ata Declaration of "Health For All" decades later (Litsios 2007).

The central figure in the IHD's foray into a broader vision of health and development is Selskar M. Gunn (1883–1944). Gunn studied sanitary engineering at MIT and graduated with a biology degree in 1906. Much of his early experience was on state and local boards of health, including a period as the first director of the Division of Hygiene at the Massachusetts Health Department. Reflecting this background, Gunn practiced public health from a pragmatic rather than clinical perspective (Opdycke 2000).

⁷ Spending figure given by Farley in 1990 dollars; adjusted to 2009 dollars using the Bureau of Labor Statistics' Consumer Price Index Inflation Calculator, available at <http://data.bls.gov/cgi-bin/cpicalc.pl>

Gunn's outlook and later work with the IHD also reflected larger themes in American public health. The discipline was born during the mid-nineteenth century as a response to the overcrowding, poor sanitation, and rampant disease brought by rapid industrialization and urbanization. At the time Gunn trained and began practicing half a century later, public health authority was expanding rapidly in scientific, geographic, and legal terms. The new science of bacteriology and the growing regulatory power of the state gave public health newfound authority (Melosi 2000). By the beginning of the 20th century, public health activities were beginning to extend beyond large urban centers such as Boston, New York, and New Orleans. The discipline of public health professionalized at the same time, and boards of health, sanitary codes, and enforcement authority were established in relatively small cities such as Orange, New Jersey, where Gunn served as Health Officer in one pre-IHD stint (Rosenkrantz 1974; Melosi 2000; Litsios 2007). Gunn's early papers reflected these circumstances when he wrote on the application of modern public health methods in small cities (Gunn 1911) and on the need for cooperation between public health boards and local police departments (Gunn 1915).

In philosophical terms, progressive ideals of the day fit well with the notion that public health benefits should be extended to all corners of a country. This same sense was reflected in the Rockefeller Foundation's charter in 1913, which in part specified its purpose as "to promote the well-being of mankind throughout the world" (Fosdick 1952)(p. vii).

The Rockefeller Foundation's work in China began in 1915 with the founding the Peking Union Medical College (PUMC), "the Johns Hopkins of China," as they called it. Through the PUMC and the China Medical Board (founded at the same time), the Foundation promoted the creation and dissemination of Western-style biomedical knowledge. This was similar to the Foundation's approach in other countries and was the basis for its activities in China through the 1920s (Ma 2002).

But when Selskar Gunn visited China in 1931 he brought his broader view of public health and his concern for spreading its benefits beyond an urban elite. Additionally, the Great Depression had heightened Gunn's awareness of the many connections between health and socio-economic development. He felt that the next frontier of IHD activities should be to unify public health with other social and natural science approaches to develop comprehensive welfare systems covering areas such as health, agriculture, and animal husbandry. Gunn spent 1929 and 1930 planning such a system in Yugoslavia, which was never implemented but became something of a template for China (Weindling 1993; Ma 2002; Litsios 2007).

Gunn's initial visit was followed by a longer stay from 1932 to 1934 during which he developed a plan for China that amounted to a radical rethinking of IHD's usual modus operandi in two ways. First, Gunn proposed that public health activities be tightly integrated in a comprehensive development package because its progress would depend on "progress in other fields of community activity, such as industry, agriculture, education,

and transportation,” he wrote.⁸ This approach contrasted sharply with IHD’s typical focus on single diseases. Second, Gunn pointed to the community as a primary level for assessing needs and delivering interventions. Further, he identified a large role for community members. These commitments represented a substantial departure from usual IHD practices, which tended to build national-level institutions, work with national governments, train elites, and prefer technical interventions that limited the need for citizen participation. The Foundation debated Gunn’s new direction and decided to approve his proposal, which was initiated in 1935. The ambitious program was only partially implemented in 1937 when it was effectively terminated by the Japanese invasion (Ma 2002; Litsios 2005; Litsios 2007).

However, the ideas Gunn developed in China meshed powerfully with the rise of social medicine to produce a widely disseminated vision of comprehensive development and health care strikingly similar to the Declaration of Alma-Ata 41 years later. The forum for this synergy was an important conference held by the League of Nations Health Organization (LNHO) on rural hygiene in Bandoeng, a city in present-day Indonesia. The conference’s focus on rural hygiene reflected the concerns of the social medicine movement, which had blossomed in the 1920s and 1930s and stressed the social determinants of disease (Borowy 2007). In Yugoslavia, Gunn had worked with one of the movement’s leaders and adopted many of its tenets (Litsios 2005; Litsios 2007). In contrast with the biomedical approach that applied bacteriological methods and focused narrowly on pathogens such as the malaria plasmodium and the tuberculosis bacillus, social medicine sought to confront ill health as the broad result of unfavorable structural factors, such as low economic development, inadequate housing, poor nutrition, and a lack of education (Borowy 2007).

Historians Theodore Brown and Elizabeth Fee have noted that the Bandoeng conference is increasingly regarded as a crucial precursor to Alma-Ata and the primary health care movement of the 1970s. The conference’s proceedings emphasized the importance of nutrition, identified public health as a key engine of development, called for a respect of local traditions, connected some modern technologies with the increased spread of disease, and stressed the responsibility of governments to deliver interventions for sick people (Brown and Fee 2008). These themes appeared prominently in the conference’s proceedings. As the author of the introduction, Gunn captured the essence of the moment (Litsios 2008):

“Governments realize more strongly than ever that that part of the population living on the land and producing the essential foodstuffs for all has been too often neglected. Governments are realizing more and more their obligations in this matter, and programs working toward the bettering of the social, economic, health and cultural conditions of the country-dwellers are becoming more general and more comprehensive...” (Bandoeng Proceedings 2008).

⁸ Quote from Gunn’s report taken from Litsios, 2007.

Part B: Wider Visions Abandoned

The Bandoeng conference was a high water mark for advocates of social medicine and integrated approaches to health and development, but not all delegates supported this view. Paul Russell, also of the Rockefeller Foundation, was one of the principal advocates for narrow, technical interventions targeted at weak points in the transmission cycles of specific diseases. Within the Foundation—a dominant force in international health—Russell’s view had the weight of history and experience on its side. Pre-dating the Foundation, the Rockefeller family had made its first philanthropic foray into health with a campaign against hookworm in the American South beginning in 1909. Initially, the campaign employed broad interventions coupling medical treatments with popular education about the worm’s transmission cycle, personal hygiene practices, and sanitary latrine construction. But after a few years the Foundation’s leadership became bored with the slow and routine activities of maintaining what amounted to a nascent health system. Much more agreeable was the other part of the hookworm program, which showed the dramatic progress available through drugs and offered the temptation of eradication through an intensive and short campaign (Ettling 1981). This style of operation was also much better suited to a private foundation with global ambitions because it depended very little on a knowledge of local culture, did not require a long-term presence, and could be managed by a small number of experts. It was these elements of the hookworm program that were adopted by the IHD when it was founded in 1913 (Ettling 1981; Farley 2004). With the exception of Gunn’s work, these were the predominant methods used by IHD in the period before WWII.

The Second World War thoroughly disrupted international efforts to promote development and health, and by the time activities resumed the landscape had changed. Technical innovations were widely credited for the Allied victory, which in health added to the momentum behind IHD’s usual strategy. A prime reason was DDT, an apparent miracle substance that could eliminate or control many insect-borne diseases, including malaria. Within a few years of the war’s end “development” became the new banner under which rich countries related to poor ones. Economic concerns—particularly the US’s fear of returning to the Great Depression—greatly increased the scale of health programming as donor and colonial governments sought to expand their influence and markets (Packard 1998). The postwar architecture of international health took shape with the 1948 establishment of the World Health Organization and the formal incorporation of health assistance as a US political strategy under Truman’s Point Four plan in 1949. Thus enmeshed in Cold War gamesmanship, international health debates were often flavored by larger disagreements over how societies should be organized and governed, and international health funding became an important channel through which wealthy nations attempted to promote good will and curry influence in developing countries. This upswing in international assistance by governments was an important factor in the Foundation’s decision to close the IHD in 1951 (Farley 2004; Birn 2006; Farley 2008).

As the IHD wound down, its staff decamped to other posts, spreading and amplifying the influence of its experiences and strategies. For instance, Frederick Soper’s pioneering work for the IHD eliminated yellow fever from Northeast Brazil through control of its vector

mosquito in the 1930s (Packard and Gadehla 1997). In 1947, Soper resigned from the IHD to become the first director of the Pan American Sanitary Bureau (now PAHO, the Pan American Health Organization) (Farley 2004). Paul Russell left IHD when it closed to assume a position at WHO in Geneva, where he played a dominant role in designing and shepherding the Malaria Eradication Program (MEP) through its launch in 1955 (Packard 1998). The United States, which also funded by far the largest share of the MEP, modeled its own considerable development efforts on the IHD precedent of narrow technical interventions for single diseases. As the IHD had done before, US development policymakers preferred to think in terms of eradication and limited local interaction. The primary engagement of international health was not with people, but with pathogens. This was the version of health assistance that dominated the first two postwar decades (Packard 1997a; Packard 1997b).

Part C: Primary Health Care and the Reappearance of Social Medicine

Widespread enthusiasm for malaria eradication using DDT did not translate to global success. The MEP succeeded in some places, including Italy, Cyprus, Greece, Guyana, and Venezuela. But after initially promising results, malaria rebounded strongly in many other countries, such as Afghanistan, Burma, India, Indonesia, Nepal, Pakistan, Sri Lanka, and Thailand. The “global” program’s implementation in the sub-Saharan was not attempted (Lancet Editorial 1975). Despite proofs of concept by the IHD in the 1940s in places such as Sardinia, the large global program was doomed by insect resistance to DDT, inconsistent application of the chemical, haphazard implementation of the program, and other factors (Lancet Editorial 1975; Brown 1986).

The colossal failure of the MEP raised questions about how to promote public health in developing countries. Even in settings where it had succeeded, economic benefits were not always realized, casting doubt on the ability of narrow programs to unlock broad growth. In this climate older ideas of social medicine began to reappear. Toward the end of the MEP’s first ten years it became clear to many WHO staff that even in the most vertical programs some host-country health infrastructure was essential (Litsios 2004). The success of the barefoot doctors program in Mao’s China provided a powerful contrast and stood against the main principles of the MEP. The barefoot doctors program used ordinary people instead of experts, employed rather than ignored indigenous healing systems, focused on people—especially the rural poor—instead of pathogens and vectors. Further, the barefoot doctors program seemed to be a resounding success, where the MEP was not (Basch 1999).

By the mid-1960s WHO had begun to draft plans for encouraging the development of basic health systems, partly because of a request from UNICEF. In 1967 WHO launched a new division, under which a project on health systems was initiated. This new project developed health strategies that incorporated ecological, behavioral, and epidemiological perspectives while employing statistical methods and simulation modeling. Another new project was soon charged with reassessing how WHO related to its member countries. In 1970, the head of this second program, Halfdan Mahler, was appointed Assistant Director-General of WHO, which gave him responsibility for the other, as well (Litsios 2004).

WHO's trend toward broader methods and a greater involvement with member governments advanced rapidly, as Socrates Litsios has shown. In 1972 a new division, Strengthening Health Services, was created under Mahler. One of the new division's early contributions was the conclusion that each country's health system would have to suit the unique circumstances, needs, and expectations of its population. Technologies used would have to be "appropriate" to the setting. When Mahler became Director-General in July of 1973, these were the principles he advanced. In the two years that followed, WHO became increasingly close to the Christian Medical Commission (CMC), which had developed a community-based approach to public health and medicine. The CMC was part of the World Council of Churches and had been formed in the 1960s to study ways of improving the medical services offered through member organizations, which included over 1,200 church-affiliated hospitals. The hospitals were often aging rapidly or already obsolete, and field investigations showed that 95% of patients were admitted for conditions that could have been prevented through public health interventions. The CMC recommended a community approach that neatly addressed many problems. First, preventative interventions were much less expensive. Second, working at the community level offered more evangelical opportunities and fit the Christian tradition of service. Third, close contact with communities would permit a much greater understanding of local problems and facilitate broad, long-term solutions, for instance by improving sanitation, agriculture, or personal habits. The CMC publicized these views through demonstration projects and magazine articles disseminated to its considerable membership (Litsios 2002; Litsios 2004).

The community approach espoused by CMC was a ready answer to some of WHO's most pressing questions, including how to deliver broader health care and how to interact with the populations of member states. Additionally, cooperation with the World Federation of Churches brought WHO into contact with the diverse and far-flung network of Christian nongovernmental organizations, which could supply some of the manpower needed to reach communities. Through joint commissions and statements this alliance was forged. It could not have hurt that Mahler, the son of a Baptist parson, had philosophical and ethical commitments to health and justice very much in line with those of CMC members (Litsios 2004).

WHO's Primary Health Care (PHC) strategy was formally launched in 1975 and embodied four objectives, as quoted by Litsios from Executive Board document EB55/9:

1. The development of a new tier of primary health care;
2. The rapid expansion of existing health services, with priority being given to primary health care;
3. The reorientation of existing health services so as to establish a unified approach to primary health care;
4. The maximum use of ongoing community activities, especially developmental ones, for the promotion of primary health care.

These principles were remarkably similar to those advanced at the Bandoeng conference, as Mahler noted in an article three years later (Mahler 1978).⁹

Part D: Alma-Ata and the Loss of Momentum

The Alma-Ata conference on primary health care in 1978 is one of the most famous episodes in international health. It was a “landmark,” and at the time the largest conference ever convened on a single theme (Basch 1999)(p. 211). Its goal and slogan “Health For All” remains a rallying cry for many in international health, and the conference’s 30th anniversary in 2008 motivated dozens of articles in high-profile journals, including the Lancet (Chan 2008; Fleck 2008; Lancet Editorial 2008; Lawn, Rohde et al. 2008; Mahler 2008; Walley, Lawn et al. 2008).

The Declaration of Alma-Ata was signed by the 143 attending countries and formally supported positions similar to those WHO had adopted with PHC. For example, the Declaration identified the goal as “Health For All” and specified the strategy as PHC. The primary intervention level would be the community; technologies would be appropriate; the approach to health would be comprehensive and involve all related sectors. The Declaration could not have been a more thorough rejection of the philosophy behind vertical programs such as the MEP, as shown in its definition of the PHC strategy as:

“...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” (WHO 1978).

The Declaration has been long lasting and widely cited, but it restated a position WHO and UNICEF had jointly espoused three years earlier and the conference that produced it was strongly opposed by Mahler. Mahler objected to the conference because it would be a centralized, “top down” process of decision making, which was exactly the opposite of his “bottom up” view of how communities should define issues and solutions. He may have wanted to avoid the politics, as well. Where the technological approach had been predominantly American, the health for all idea was most convincingly demonstrated in China and the conference was most staunchly supported within WHO by the Soviet delegation, which had been advocating for it since 1972. In the Soviet conception, health for

⁹ The connection to Bandoeng was discovered by Litsios, who was then a WHO staff member drafting Mahler’s article. See Litsios, 2008.

all was achieved through centralized planning, a key departure from the Mahler vision (Litsios 2002).

The friction between Mahler and the Soviet delegation came from opposing views of how PHC should be implemented and managed. Litsios has argued convincingly that the three years between PHC and Alma-Ata were wasted and proved very costly. At WHO headquarters much of the time was spent wrangling over how to define PHC in academic and philosophical terms instead of assisting its implementation by working with its own field staff, UNICEF, and the many NGO partners gained through the World Council of Churches alliance. The lost three years sapped much of the movement's momentum. The conference showed broad agreement over PHC, but that had existed anyway, and it left unaddressed field-level details crucial to the strategy's implementation and effectiveness (Litsios 2002). When WHO finally turned its attention to implementation, powerful forces had aligned in support of alternatives to PHC.

Part E: Primary Health Care Is Scaled Back

With the Alma-Ata conference concluded, questions soon arose over how to implement the Health for All vision. Despite the field presence brought by Christian organizations and UNICEF, there was no obvious method for creating full-fledged health systems all at once. As the implementation discussion continued into 1979, a monumental disease-specific victory was achieved through the Smallpox Eradication Program (certified in 1980)(Fenner, Henderson et al. 1988).

The victory over smallpox and concerns over the breadth, missing details, and short timeline of Health for All helped sway some observers to a middle path conceptualized as "selective primary health care" (SPHC). SPHC was advanced by the Rockefeller Foundation, USAID, the World Bank, and others, and was opposed by WHO (Cueto 2004). After a meeting at the Rockefeller's Bellagio facilities, the group articulated its reservations to the WHO-backed PHC stance: "The goal set at Alma-Ata is above reproach, yet its large and laudable scope makes it unattainable in terms of its prohibitive cost and the numbers of trained personnel required" (Walsh and Warren 1979).

The argument for SPHC was to maximize the effectiveness of limited resources by focusing on a few important diseases and a few cost-effective interventions. Progress against a few defined foes could be implemented, managed, and measured and would create the core of a full PHC system, which could be built over time. This proposition appealed to James Grant, who became the executive director of UNICEF in 1980. Unlike his predecessor at UNICEF who had joined and supported WHO in the PHC approach, Grant sided with World Bank president McNamara and the other advocates of SPHC. Although WHO remained in favor of PHC, the SPHC approach gained more proponents among the leadership of major international agencies and important bilateral donors (Litsios 2002; Cueto 2004).

By the time UNICEF formally launched SPHC in 1982, it had been defined as a package of four interventions and branded as GOBI, which stood for Growth monitoring, Oral rehydration, Breastfeeding, and Immunizations (UNICEF 1982).

The theory of SPHC was faithful to the broad vision of Alma-Ata and its commitment to building full health systems, but the ever narrowing, increasing verticality of its implementation ranks among the greater ironies of global health. In the first stage of GOBI, there were ostensibly four interventions, but in reality only oral rehydration and immunizations could be rolled out on a large scale. Growth monitoring was a nod to the huge proportion of childhood morbidity and mortality caused by poor nutrition. But unfortunately the only intervention was a steady supply of food, which could not be delivered by the global health institutions. Breastfeeding was included because it had important implications for child health, and also it fit the family-level, education-centered spirit of the day. But the intervention was never fully developed and implemented, in part because it was hard to define, hard to measure, and depended on large-scale societal change to make women more available to their children (Bump, Johnson et al. 2009).

GOBI was never formally renamed, but three more interventions—family spacing, female education, and food supplementation—appeared for the first time in UNICEF's 1985 State of the World's Children report, and afterward the approach was popularly referred to as GOBI-FFF (UNICEF 1985). Unfortunately, all of the "F" interventions faced problems similar to those that hampered breastfeeding and growth monitoring. Family spacing was a euphemism for birth control, and even though there were interventions, none were politically viable. Female education was long recognized as the bedrock of child health, but again, the idea was difficult to couple with an explicit implementable solution. Food supplementation remained highly desirable, but was no easier to implement than it had been years before (Bump, Johnson et al. 2009).

Apart from oral rehydration and immunization, the other five targets in GOBI-FFF all depended fundamentally on broad social change, which could not be implemented or even planned by UNICEF and other global health institutions. That was the vision of Alma-Ata, and even in the stripped-down version of SPHC, it was extremely challenging to implement (Bump, Johnson et al. 2009).

It was for these reasons that in 1986 oral rehydration and immunization were elevated to special status as the "twin engines" of UNICEF's Child Survival Revolution, even as GOBI-FFF continued (UNICEF 1986). Oral rehydration and immunization were by no means simple to implement, but they did exist within the usual space of products and services that UNICEF, WHO, and the US Agency for International Development had been delivering. What began at Alma-Ata as full PHC, and narrowed down to a few things under GOBI, ultimately boiled down to a pair of vertically implemented interventions (Bump, Johnson et al. 2009).

As had happened after the Bandoeng conference, the broad vision of Alma-Ata was abandoned in favor of limited interventions that could be implemented vertically and managed through the usual centralized bureaucracy of international aid organizations. In each case, an important commitment to something approaching a UHC strategy for developing countries had been made and then broken.

VI. Health as an Enforceable Human Right

Health and universal health coverage are sometimes discussed as a legal right, as in the UN Universal Declaration of Human Rights, for instance (UN 1948). But what does this right actually imply, and who or what is responsible for upholding it? Backman and colleagues have produced a comprehensive scorecard of the realization of the right to health in 194 countries, which reveals encouraging progress (Backman, Hunt et al. 2008). But there are many issues too complex to investigate in this report; I nonetheless discuss the concept of health as a right because the enforcement of that right is a potential pathway to UHC. The legal basis for the right to health extends at least two centuries into the past. I briefly explore this tradition to illuminate the recent strategy of litigation to force governments to provide essential medicines. I then discuss the implications of this approach for achieving UHC.

The concept of human rights dates to antiquity (Annas 1998). The idea that health is one such right dates at least to the European Enlightenment and appeared for the first time in legal documents created around the American and French revolutions. In the US Declaration of Independence this notion was expressed as a right to “life,” or, in Jefferson’s first draft, the right to the “preservation of life” (Jefferson 1776; Susser 1993). The connection between health and the concept of social justice is a little younger, dating to the middle of the 19th century. This was an integral part of the philosophy of public health as a discipline, which emerged at the same time with England’s Public Health Act of 1848 (Krieger and Birn 1998).

The modern framework for health as a human right dates to the 1948 UN Universal Declaration of Human Rights, a document conceived in the aftermath of WWII. Because that document was a declaration rather than a treaty, it implied no enforcement obligations. After almost two decades of negotiation the UN General Assembly adopted two treaties in 1966, which then went to member countries for ratification. These were the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social, and Cultural Rights (Annas 1998). At present, almost every country is a party or signatory to both treaties (UN Treaty Collection 2009a; UN Treaty Collection 2009b).¹⁰ Thus, almost everywhere in the world, governments have agreed to be bound by treaties that establish health as a human right.

¹⁰ Notably, the US and South Africa have not ratified the International Covenant on Economic, Social and Cultural Rights, and China and Pakistan have not ratified the International Covenant on Civil and Political Rights. See UN Treaty Collection 2009a, 2009b.

In the late 1980s Jonathan Mann took critical steps to reify this amorphous concept by incorporating the principles of human rights in an HIV/AIDS program he launched at WHO. This was the germinal episode of the current health and human rights movement (Mann 2006; Tarantola, Gruskin et al. 2006), although it employed arguments similar to many others used in the past, for example in the launch of English Poor Laws and sanitary reforms by Edwin Chadwick (Oppenheimer, Bayer et al. 2002). Over the last two decades citizens and activists have extended Mann's approach using judicial systems to attempt to enforce the right to health within the framework of the two UN treaties mentioned above or similar language incorporated in national constitutions.

Hans Hogerzeil and coauthors have examined 71 cases of litigation to obtain access to essential medicines in low- and middle-income countries, most in Central and South America. Of these, 59 were successful and 12 were lost. Although health is a right enshrined in many national constitutions and in international agreements, Hogerzeil et al. found that successful court cases seeking essential medicines in low- and middle-income countries dated only to 1992. The predominant logic of successful cases has been to link the right to life to a right to health, and then draw on constitutional provisions and international human rights treaties. Most commonly, the defendant has been a social security agency or the Ministry of Health (Hogerzeil, Samson et al. 2006). Many of the cases are internationally famous, probably none more than Brazil, where the constitution guarantees medical access with few restrictions, and where intellectual property rights have been weighed against the right to health (Biehl, Petryna et al. 2009). A summary of the cases reviewed in the Hogerzeil et al. paper is reproduced as Table 1 below:

Table 1: Litigation to Enforce Access to Essential Medicines

	Right to health enshrined in the constitution	International treaties enjoy constitutional rank	Successful cases claiming the right to health (cases referring to international treaties)		Unsuccessful cases claiming the right to health (cases referring to international treaties)	
			n	First case	n	First case
Argentina	No	Yes	8 (2)	1998	1 (1)	2003
Brazil*	Yes	No	3 (0)	2002		
Bolivia	Yes	Yes†	1 (0)	2003		
Colombia	Yes	Yes	28 (1)	1992	2 (0)	2001
Costa Rica	Yes	Yes	7 (5)	1994	3 (0)	1992
Ecuador	Yes	Yes	1 (1)	2004		
India	No	No	2 (0)	2000		
Nigeria	Yes	No			1 (1)	2001
Panama	Yes	No			2 (0)	1998
San Salvador	Yes	Yes	1 (1)	2001	1 (0)	2004
South Africa	Yes	Yes†	2 (1)	2002	2 (0)	1997
Venezuela	Yes	Yes	6 (3)	1997		
Total			59 (14)		12 (2)	

*Large number of new cases filed more recently. †Status not fully clear.

Source: Hogerzeil, Samson et al. 2006, p. 306.

It is important to qualify this discussion by noting that a favorable court judgment cannot be equated with the actual delivery and administration of medicines to needy patients. Where constitutions guarantee seemingly unlimited health rights, as in Brazil or Colombia, there is no parallel guarantee of unlimited financial resources or appropriately convenient delivery systems. It is therefore a government duty to decide what can be provided within the prevailing constraints. In this connection advocates and scholars have invoked the concept of progressive realization, meaning that nations are obligated to move toward the ultimate goal, but may do so in incremental and equitable steps (Rosa and Alberto 2004). Even in wealthy countries with UHC systems, services must be rationed. Social courts in Germany play a large role in adjudicating this issue of access and resource constraints, for instance (Jost 2002). Despite uncertainty about what final outcomes can be realized immediately, the judicial pursuit of health services has become an important tactic in Latin America (Yamin 2000).

Within the context of fostering UHC through development assistance, the logic of these cases may be useful. If citizens themselves can compel their governments to provide medical services, then that opens several points of intervention. These include support for organizations that help patients bring suits, pressuring governments with reference to the tactic, and promoting benefit packages to uphold

the right to health. I stress this example because it is recent and unique in the history of UHC systems and the progressive realization of the right to health through court action is unfolding rapidly in many countries in Central and South America.

VII. Implications

In this section I discuss some of the implications suggested by the historical analysis. I examined key portions of the development of two UHC systems (Germany and the UK) and a third comparator (the US). In each of the cases that led to UHC, important elements in the story included the long-term development of underlying legal and social concepts and the exact politics surrounding moments of critical government intervention. In Germany and in the UK there were centuries of legal precedents that proved useful in the establishment of UHC. In Germany, workers' protections had long existed as a matter of law, if not always practice, and local governments had had charity mechanisms, even if these were not always funded. Trade groups had organized their own insurance programs, which served as a model for Bismarck's legislation. In the UK, the state had recognized the category of deserving poor and organized a social protection scheme to help them through the church system, which was functioning well even in 1700. Through the 1800s the provision of public services in water and sanitation signaled a greater state involvement with population health and demonstrated the importance of labor supply in government decision making. As in Germany, labor groups were an important source of demand for greater social protections, including health.

The differences surrounding each national turning point suggest that demand for greater social protections can be expressed through a variety of political solutions. Bismarck expanded protections for only some labor groups, but he chose the groups that had the most political power. The Beveridge Report was written at the behest of labor groups, but it was released at a moment when there was great solidarity throughout the population. Politicians agreed to establish a nation-wide system only in response to this broad demand. In each case the first steps toward UHC brought protections to only a small portion of the population.

Although the road to UHC was extremely long in both of these cases, it is important to observe the uniqueness of the politics at play in the germinal moments. The larger context in each case was one of upheaval in which the government pursued UHC as a part of a new social contract with citizens. I have not systematically reviewed the evidence from other important national transitions, but this conclusion seems to be in keeping with experiences elsewhere, as in Brazil, Cambodia, and Rwanda.

In both Germany and the UK, the adopted systems used the basic delivery infrastructure already in existence. Health care professionals and public and private infrastructure were incorporated into the national programs. In the English case, some of the hospital infrastructure had been recently constructed to meet wartime

needs, but even so, it was not built as part of the UHC system. I stress this to underscore that even where some capacity was built quickly, existing resources and patterns were central in the larger progression toward UHC.

The two examples suggest that efforts to support UHC systems in developing countries should consider the following points:

- What historical legal or social concepts can be invoked to support UHC?
- Is there popular support for UHC? Can it be created or increased?
- Politics are central to the process. What mechanisms exist to capture and express popular concerns and those of medical or health professionals?
- When there is a window of political opportunity, it is important to strike quickly.
- What infrastructure can be incorporated into a larger UHC system?
- Is it appropriate to launch a system that covers only part of the population?

I also examined several episodes from the past century of international assistance efforts to move in the direction of UHC. This exercise suggests that there was significant support for moving toward UHC in the 1930s with the social medicine movement and in the 1970s with the PHC movement. In each case, this momentum was lost before international agencies could support widespread implementation—once because of a war and once because of a meeting. For advocates of UHC, this suggests that action is best taken quickly, before interest dissipates.

Without more data it is hard to speculate about a potential periodicity of interest in UHC promotion as a development assistance strategy. However, there was a period of about 35 years between the peak of the social medicine movement and the peak of the PHC movement. A similar length of time has elapsed since the PHC movement and the present, when there is again interest in promoting UHC internationally.

The historical examination of efforts to promote UHC through development assistance suggests the following points of similarity and discrepancy between the present and the past:

Similarities:

- Few practical details on what UHC means in most cases.
- Strategy designed by WHO.
- Health portrayed as a right.
- Disillusionment with large vertical programs, skepticism of the possibility and cost/benefit of eradication approach.

Differences:

- Communications technology, such as the Internet and cellular telephones, has vastly increased the international flows of information.
- Much more emphasis on financing mechanisms.

- More emphasis on delivery via the health systems strengthening movement.
- WHO has allies, including the International Labour Organization, Austria, France, Germany, Italy, Netherlands, Norway, UK, UN, and the World Bank.
- Many developing countries have already implemented versions of UHC and more are seemingly ready to move in that direction—for instance, Colombia, Brazil, Ghana, Thailand, Vietnam.
- No large Christian advocacy group.
- Recognition of the need for a progressive implementation strategy of incremental steps leading to the ultimate goal of UHC.
- Health portrayed as a right in legal language, with reference to legal frameworks, and precedent of court enforcement of that right in some national settings.
- No longer such intense skepticism of western technology in developing countries.

The historical investigation shows that many of the concepts and conflicts that now permeate the UHC discussion have long historical legacies. Who is eligible for benefits, for instance, has been debated for centuries. In the UK, this discussion has revolved around distinctions between the deserving and undeserving poor, and also around the meaning of “resident.” In Germany, the same debate tended to focus more on occupational groups. In both cases, there are historic discussions of what services should be afforded and under what circumstances—who can claim unemployment benefits and how long should support last, for instance.

What does this discussion suggest for policymakers and advocates? I offer four observations:

1. The processes involved in UHC can take a very long time. The national decision to pursue UHC and the actual implementation have both unfolded over the scale of centuries and decades. Policymakers should approach this issue with patience. Although it is possible to make much faster progress than in the cases reviewed, the value of incremental steps cannot be discounted. Rapid progress seems to occur at times of social upheaval. These may present windows of opportunity.
2. According to my review, cross-country policy learning is an significant international element present in the development of UHC systems. This suggests that international agencies can play an important role in sharing ideas and possible policy solutions.
3. The UHC systems now in existence have been produced primarily by domestic processes. UHC is a renegotiation of the social contract and changes who gets what and who bears the financial responsibility. As such, the transition to UHC is intensely political. International resources and assistance have not previously played a role in these discussions.

4. The possible role for external entities hoping to facilitate UHC in developing countries is unclear. It is an open question whether the provision of financing is essential or even necessary. The past century shows that many countries have moved toward UHC without assistance. If there is a broad secular trend in this direction, we need to think carefully about what potential supporting roles may be played by international actors.

VIII. Future Research

The historical evidence presented in this report justifies a further inquiry into the timing and context of national transitions to UHC systems. I propose two related research questions, which can be answered using social science theories and a regression analysis. First I ask how the idea of UHC spread. I do not know whether it spread from country to country via international learning or whether it emerged in more than one country independently in an example of intellectual convergence. I propose to test the idea that UHC spread via international learning by comparing the rate of UHC adoption with that predicted by the *Diffusion of Innovations* theory first articulated by Everett Rogers in 1964.

Rogers' theory says that innovations are adopted by members of a social system following an S-curve as the cumulative share of adopters rises from zero to 100%. In the beginning, the innovation is created and limited to a few "innovators." Subsequent adoption is slow and limited to "early adopters," then rises rapidly as the majority of members convert to the new innovation before slowing again as the last remaining "laggards" convert over a prolonged period mirroring that at the beginning. The number of members adopting the innovation per time follows a bell curve; cumulatively, the percentage of adopters rises over time following the S-curve (Rogers 2003).

Second, I propose to investigate the national-level transition to UHC. What ingredients are necessary to this transition? For this inquiry I design a theory based on the three elements of UCH gleaned from my historical research: "people," "services," and "needs." I begin by proposing that the necessary ingredients can be represented formally as:

$$\text{UHC Transition} = \text{Economic Expansion} + \text{Delivery System Capacity} + \text{Sufficient Funding} + \text{Popular Demand}$$

I propose to evaluate this theory qualitatively and quantitatively using the published and unpublished information on countries that have made the UHC transition; countries that used to have UHC, such as those of the former USSR; and the United States, which might be expected to have UHC based on income, but does not. I will include all countries for which data are available. I will test and adjust this

theory in a dialogue with our evidence, an approach informed by Anselm Strauss' *Grounded Theory* (Strauss and Corbin 1990).

Quantitatively, I propose to conduct a linear regression analysis to build on the work of Carrin and James.¹¹ Their investigation is based on a linear regression and asks a question similar to the one posed here. But I believe I can improve the model specifications. For instance, Carrin and James write that the degree of "solidarity" should be related to a country's willingness to adopt UHC. This is probably true, but Carrin and James use the income Gini as a proxy for "solidarity," arguing that more equality should be seen as willingness to cross-subsidize. I believe it would be much better to compare pre-tax and post-tax Ginis. This is because some countries have tax regimes that actually increase income inequality and therefore do not evidence "solidarity." Examining pre- vs. post-redistribution might also explain why there are UHC systems in Brazil and Colombia, both of which have very high income inequality, but which might have significant cross-subsidization nonetheless.

¹¹ Carrin, G. and C. James (2003). Determinants of achieving universal coverage of health care: An empirical analysis. *Le financement de la santé dans les pays d'Afrique et d'Asie à faible revenu*. M. Audibert, J. Mathonnat and E. de Roodenbeke. Paris, Karthala: 299-322.

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Annex 1: Universal Health Coverage Definitions

Beveridge Report (1942)

“The first principle is that any proposals for the future, while they should use to the full the experience gathered in the past, should not be restricted by consideration of sectional interests established in the obtaining of that experience. Now, when the war is abolishing landmarks of every kind, is the opportunity for using experience in a clear field. A revolutionary moment in the world’s history is a time for revolutions, not for patching.

“The second principle is that organisation of social insurance should be treated as one part only of a comprehensive policy of social progress. Social insurance fully developed may provide income security; it is an attack upon Want. But Want is one only of five giants on the road of reconstruction and in some ways the easiest to attack. The others are Disease, Ignorance, Squalor and Idleness.

“The third principle is that social security must be achieved by co-operation between the State and the individual. The State should offer security for service and contribution. The State in organising security should not stifle incentive, opportunity, responsibility; in establishing a national minimum, it should leave room and encouragement for voluntary action by each individual to provide more than that minimum for himself and his family.

“The Plan for Social Security set out in this Report is built upon these principles. It uses experience but is not tied by experience. It is put forward as a limited contribution to a wider social policy, though as something that could be achieved now without waiting for the whole of that policy. It is, first and foremost, a plan of insurance - of giving in return for contributions benefits up to subsistence level, as of right and without means test, so that individuals may build freely upon it.” From <http://www.sochealth.co.uk/history/beveridge.htm>

WHO Alma-Ata Declaration (1978):

“**Article I:** The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

“**Article 6:** Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and

economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

“Article 8: All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.”

WHO/World Health Assembly (2005)

“Universal coverage is defined as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access. The principle of financial-risk protection ensures that the cost of care does not put people at risk of financial catastrophe. A related objective of health-financing policy is equity in financing: households contribute to the health system on the basis of ability to pay. Universal coverage is consistent with WHO's concepts of health for all and primary health care.” From http://www.who.int/health_financing/documents/cov-wharesolution5833/en/index.html

WHA58.33 Sustainable health financing, universal coverage and social health Insurance (2005)

“1. URGES Member States:

- (1) to ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care;
- (2) to ensure adequate and equitable distribution of good-quality health care infrastructures and human resources for health so that the insurees will receive equitable and good-quality health services according to the benefits package;
- (3) to ensure that external funds for specific health programmes or activities are managed and organized in a way that contributes to the development of sustainable financing mechanisms for the health system as a whole;
- (4) to plan the transition to universal coverage of their citizens so as to contribute to meeting the needs of the population for health care and improving its quality, to reducing poverty, to attaining internationally agreed development goals, including those contained in the United Nations Millennium Declaration, and to achieving health for all;
- (5) to recognize that, when managing the transition to universal coverage, each option will need to be developed within the particular macroeconomic, sociocultural and political context of each country;
- (6) to take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organizations, under strong overall government stewardship;
- (7) to share experiences on different methods of health financing, including the

development of social health-insurance schemes, and private, public, and mixed schemes, with particular reference to the institutional mechanisms that are established to address the principal functions of the health-financing system.”

World Federation of Public Health Associations (2007)

“Universal coverage is defined as an access to key health interventions, to promote, prevent, cure, and rehabilitate all members of society, and to do so at an affordable cost.” WFPHA (2007). "Editorial: Challenging Developments in Universal Insurance Coverage." *Journal of Public Health Policy* 28(2): 281–289.

ILO (2007)

“The ILO’s ultimate objective in the field of social health protection is:

To achieve universal social health protection coverage defined as effective access to affordable health care of adequate quality and financial protection in case of sickness.

This definition of coverage refers to the extension of social health protection in respect of the size of the population that can access health services and the extent to which costs of the defined services are covered so that the amount of health-care cost borne out of pocket does not pose a barrier to access or lead to service of limited quality.

To be effective, *universal coverage* needs to ensure access to care for all residents of a country, regardless of the financing subsystem to which they belong. This does not exclude national health policies from focusing at least temporarily on priority groups such as women or the poor when setting up or extending social health protection.

Coverage relates to effective *access* to health services that medically match the morbidity structure of the covered population. Compared to legal coverage describing rights and formal entitlements, effective coverage refers to the physical, financial and geographical availability of services.

The ILO advocates that benefit packages (i.e. packages of health services that are made available to the covered population) should be defined with a view to maintaining, restoring or improving health, the ability to work and to meet personal health-care needs.

Key criteria for establishing benefit packages include the structure and volume of the burden of disease, the effectiveness of interventions, the demand and the capacity to pay.

Effective access thus includes both access to health services and financial protection.

Financial protection is crucial to avoid health-related impoverishment. Financial protection includes the avoidance of out-of-pocket payments that reduce the affordability of services.

Affordability or non-affordability of services refers to the non-existence or existence of financial barriers of access for individuals, groups of individuals and societies as a whole.”

International Encyclopedia of Public Health (2008)

“Universal coverage can be defined as the extension of health insurance that covers a basic list of core medical services to the entire population.” Ensor, T. and H. Kris

(2008). Universal Coverage in Developing Countries, Transition to. International Encyclopedia of Public Health. Oxford, Academic Press: 441-452.

Margaret Chan (2009)

“We will not be able to reach the health-related MDGs unless we return to the values, principles, and approaches of primary health care. A recent WHO report found striking inequities in health outcomes, access to care, and what people pay for care. Many health systems have lost their focus on fair access to care, their ability to invest resources wisely, and their capacity to meet people’s needs and expectations. To steer health systems toward better performance, the report called for a return to primary health care....This approach to health is people-centred, with prevention considered as important as cure. As part of this preventive approach, primary health care tackles the root causes of ill health, including in non-health sectors, and offers an upstream attack on threats to health.” **Note:** Does not use “universal health coverage”; advocates for primary health care, health systems strengthening. Chan, M. (2009). "Primary health care as a route to health security." The Lancet **373**(9675): 1586-1587.

Laurie Garrett et al. (2009)

“To assume that universal health coverage necessarily requires a single-payer government mechanism would be a mistake, and adherents to that position doom the people of the poorest nations to generations of medical deficiency. In classic terms, debates may be framed as the Bismarck model versus the Beveridge model, but this dichotomy is increasingly viewed as being as false as that which seeks to pit vertical schemes of health against horizontal. Whether a nation chooses a mixed economy model of coverage, single-payer mode, donor-issued voucher mechanism, or other innovative models of universal financing is not the issue; provision of universal health coverage is the issue facing the entire global health construct. Sadly, for most of the world’s populations universal health coverage remains a mirage, blurred further out of focus by the present world financial crisis.

“The 58th session of the World Health Assembly in May, 2005, endorsed a resolution urging its member countries to work towards sustainable health financing, defining universal health coverage as access for all to appropriate health services at an affordable cost. The World Health Assembly also urged countries to strive for achievement of universal health coverage by using, on the basis of their specific contexts, a mix of prepayment systems including tax-based financing and social health insurance.” Garrett, L., A. M. R. Chowdhury, et al. (2009). "All for universal health coverage." The Lancet **In Press, Corrected Proof**.

Julio Frenk (2009)

“Beyond immediate response to the crisis, health security must be grounded on truly universal package of guaranteed benefits or entitlements, comprising set of essential services applied to all in the world. Such a package would empower people by making them aware of their explicit rights, through what could be termed a ‘health social contract’ as key component of global citizenship. As has happened in

successful national experiences, explicit benefits at global level would offer template for long-term planning of efforts. It would also represent a major source of global security." Frenk, J. (2009). "Strengthening health systems to promote security." The Lancet **373**(9682): 2181-2182.

Guy Carrin/WHO Health Systems Financing Dept. (2009)

"Equity of access to health services of all types is key to universal coverage policy. High levels of out-of-pocket payments, including user fees, are still pervasive in many countries, limiting the ability of people to use services." **Note:** Seems to equate Alma-Ata definition of health for all with UHC. Carrin, G., K. Xu, et al. (2008).

"Exploring the features of universal coverage." Bulletin of the World Health Organization **86**(11): 818-818.

Rob Yates, DFID (2009)

"...scaling up some cost-effective health-care interventions would improve the health status of people in the developing world. However, this improvement can happen only when people actively use the services in question. To have services nominally available is not enough—they need to be used. In many low-income countries, the rate of use is very low...Therefore, if we are to reach the health-related Millennium Development Goals (MDGs), a concerted effort is needed to improve the coverage of health services. WHO has recognised this need, and in its World Health Assembly resolution WHA58.33 called on all member states to 'plan the transition to universal coverage of their citizens.' Of note, however, the case for universal coverage would be even stronger than it is now were there additional research evidence to prove conclusively that a rise in service use leads to improved health outcomes. Clearly, health financing will play a crucial part in the attainment of universal coverage." Yates, R. (2009). "Universal health care and the removal of user fees." The Lancet **373**(9680): 2078-2081.

The People's Charter for Health (People's Health Movement, 2009)

"Within the health sector, failure to implement the principles of primary health, care as set out in the Alma-Ata declaration, has significantly aggravated the global health crisis. Governments and the international community are fully responsible for this failure.

"It is now essential to build a concerted international effort to put the goal of Health for All in its rightful place on the development agenda. Genuine, people-centred initiatives must be strengthened to increase pressure on decision makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality." <http://www.phmovement.org/en/resources/charters/peopleshealth>

Tsounta, IMF Working Paper (2009)

Tsounta, E. (2009). Universal Health Care 101: Lessons for the Eastern Caribbean and Beyond. WP/09/61. Washington, DC, International Monetary Fund. Available from <http://www.imf.org/external/pubs/ft/wp/2009/wp0961.pdf>

"Universal health care has received considerable attention in recent years. In such a system, the population enjoys free of charge a specific list of health services, often

linked to a list of diseases. These services are typically financed by the government, via mandatory payroll/social security contributions, general taxation, or a combination of both. For example, general tax-based funding is used in the United Kingdom, Australia, Canada, Denmark, Sweden, Cuba, Italy and Brazil, while mandatory payroll/social security contributions finance universal health care in Germany, Japan, France, Singapore, and Costa Rica. In most Caribbean countries, budgetary allocations from the central government are the dominant source of health financing (Table 1). Many Caribbean countries are actively considering introducing universal health care. Examples include the Eastern Caribbean countries of St. Lucia and St. Kitts and Nevis, which are moving in that direction primarily to tackle high-out-of-pocket spending.” (Page 3.)

Annex 2: References Collected

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