

Social health insurance: Key factors affecting the transition towards universal coverage

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Several low- and middle-income countries are interested in extending their existing health insurance for specific groups to eventually cover their entire populations. For those countries interested in such an extension, it is important to understand the factors that affect the transition from incomplete to universal coverage. This paper analyses the experience of eight countries in the implementation of social health insurance. It highlights the importance of the socioeconomic and political context, particularly in relation to the level of income, structure of the economy, distribution of the population, ability to administer and level of solidarity within the country, but also stresses the important stewardship role government can play in facilitating the transition to universal coverage via social health insurance.

Social health insurance (SHI) is one of the principal methods of health financing. Twenty-seven countries have established the principle of universal coverage via this method.¹ Several low- and middle-income countries are currently interested in extending their existing health insurance for specific groups to eventually cover their entire populations. For those countries interested in such an extension, it is important to understand the factors that affect the transition from incomplete to universal coverage. Other authors have analysed key questions that need to be considered before a country embarks on the extension or establishment of SHI, along with implementation guidelines.² This paper adds to the literature by analysing the transition to universal coverage via SHI. For analysis of the performance of an SHI scheme during implementation, the reader is referred to Carrin and James (2004); for assessment of the performance of mature SHI schemes in western Europe, see Saltman et al. (forthcoming).

¹ Based on Carrin et al. (2004).

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² See Normand and Weber, 1994, *Icon*, 1993.

Social health insurance as an option for reaching universal coverage

A question that remains of paramount importance in a majority of the world's countries is how their health financing systems can provide sufficient financial risk protection to all of the population against the costs of healthcare. The latter objective is tantamount to the aim of *universal coverage*, which is to secure access to adequate healthcare for all at an affordable price. That is, universal coverage incorporates two different coverage dimensions: healthcare coverage (*adequate healthcare*) and population coverage (*healthcare for all*). A crucial concept in health financing policy towards universal coverage is that of *society risk pooling*, whereby all individuals and households share the financing of total healthcare costs. The larger the degree of risk pooling in a health financing system, the less people will have to bear the financial consequences of their own health risks, and the more they are likely to have access to the care they need.

There are essentially two main options for achieving universal coverage. One is a health financing system whereby *general tax revenue* is the main source of financing health services. These health services are usually provided by a network of public and contracted private providers, often referred to as a national health service. Second, there is *SHI*, which in principle involves compulsory membership among all of the population. Workers, self-employed, enterprises and government pay contributions into a social health insurance fund. The base for workers' and enterprises' contributions is usually the worker's salary. The contributions of self-employed persons are either flat-rate or based on estimated income. Government may provide contributions for those who otherwise would not be able to pay, such as unemployed people and low-income informal economy workers. SHI either owns its own provider networks, works with accredited public and private healthcare providers, or uses a combination of both. Within SHI, a number of functions (for example registration, collection of contributions, contracting and reimbursement of providers) may also be executed by parastatal or non-governmental institutions, often referred to as sickness funds.

We do see countries, however, which use a mix of the two main options. Thus, there are *mixed health financing* systems that have some part of the population partially covered via general tax revenue, and clearly specified population groups only covered by health insurance. This insurance can be provided by one or a number of parastatal health insurance schemes that function according to SHI principles. Alternatively, a system of private health insurers may also be in place, but one that is subject to government regulatory powers, especially ensuring a specified benefit package of care.

Note finally that *within* each of the options referred to above, private health insurance can also play a supplementary role.³ It typically covers extra healthcare services that are not covered in a basic package of care (of one of the three systems described above), arranges for a reduction in waiting time, or covers some of the cost of patient repayments. Indeed, in reality no health financing system is entirely financed by general taxation, SHI or the mixed health financing system described above. However, these options are useful for describing what is the principal method driving a health financing system towards universal coverage.

In this paper we focus on the development of SHI, especially in low- and middle-income countries, *given* that a choice is made in favour of this particular pathway. It will be supposed that the basic feasibility questions have been answered properly by the country that has made such a choice. This means that the country has analysed carefully the pros and cons of general taxation, SHI and a mix of the two as options for reaching universal coverage. The next section will address important facilitating factors that can speed up this transition period, based on the experience in a selection of countries with developed SHI schemes.

³ See Sekhri and Savedoff (2003).

Towards universal coverage via social health insurance: General factors that affect the speed of transition

One can appreciate that achieving universal coverage may not be an easy process. Many countries that currently have a universal coverage system often needed decades to implement it. But if the choice is to take the path of SHI, several factors may be slowing down the process towards universal coverage. These are discussed in the "Facilitating factors" section below.

In order to assess past experience on the transition to universal coverage via SHI, we use data about the evolution of the health insurance legislation in eight SHI countries for which sufficient information was readily available. These countries are Austria, Belgium, Costa Rica, Germany, Israel, Japan, Republic of Korea (ROK) and Luxembourg.⁴ We will pay attention thereby to the variety of organizational forms used during the transition period in those countries. In particular, the role of the voluntary character of sickness funds in the initial phases of SHI implementation will be highlighted.

The transition period was defined as the number of years between the first law related to health insurance and the final law voted to implement universal coverage. The numbers of years of transition are 79 (Austria), 118 (Belgium), 20 (Costa Rica), 127 (Germany), 84 (Israel), 36 (Japan), 26 (ROK) and 72 (Luxembourg). Note, though, that Costa Rica's final law introduced the *principle* of universal coverage via SHI rather than effectively providing universal insurance coverage subsequent to this law. In Japan, the 1958 law on compulsory health insurance was implemented three years later. Further, in Israel, the estimate of 84 years includes 37 years of social health insurance before Israel as a sovereign State was established.

It is not simply the total length of the transition period that is important, however. We also need to pay attention to evolution of the percentage of the population that becomes covered in this period. Furthermore, it should be home in mind that extending coverage to certain population groups is more difficult than extending to other groups (examples are casual workers and self-employed persons). In other words, increased coverage is not necessarily a simple linear increase. Moving from, for example, 25 to 50 per cent coverage might take less time than moving from 50 to 75 per cent.

From time series data on population coverage, we see that in Austria it took 40 years (from 1890 to 1930) to move from 7 to 60 per cent, but another 35-37 years (from 1930 to 1965-67) were needed to extend insurance to farmers and civil servants, reaching 96 per cent coverage. Likewise in Germany, coverage increased from 10 to 50 per cent in 47 years (from 1883 to 1930). But another 58 years were needed to extend coverage to 88 per cent, drawing in, among others, the self-employed workers to SHI. In Costa Rica, it took 20 years to reach a population coverage level of 17 per cent (in 1961). But then only five years were needed to double population coverage and thus arrive at a level of 34 per cent (in 1966). The latter increase was an immediate consequence of the law of 1961 introducing the principle of universality. More than ten years, however, were needed to again double population coverage: by 1978, it amounted to 74 per cent. Subsequently, a population coverage level of 83.4 per cent was obtained in 1991; thus, 13 years were required to add a further 10 per cent of the population. Also in Costa Rica, special efforts were needed to extend coverage to self-employed workers and those on low incomes, demanding ever longer periods to systematically enrol these population groups.

⁴ Most of the information is based on the country profiles collected by the European Observatory on Health Systems and Policies (2002). Additional sources are Curler (2002), Miranda (1994), Moon (1998) and Bärnighausen and Sauerborn (2002).

Experience with the transition period: Analysis of selected countries with developed SHI schemes

All of the eight countries mentioned above followed an incremental approach. Yet some took longer to develop their systems than others. Those with a fairly extensive transition period, above 40 years, are Germany, Austria, Belgium, Costa Rica, Israel and Luxembourg. Only Japan and ROK have known a transition period below 40 years. We now summarize the various stages that these countries experienced in the transition to universal coverage. These focus on important developments between the first law related to health insurance and the final law voted to implement universal coverage (as noted earlier, these laws mark the beginning and end of the transition period), although relevant stages preceding the first health insurance law are also described *where* information was readily available. In the "Facilitating factors" section we discuss a number of factors that have facilitated the transition in the selected countries.

Germany. Three stages of incremental developments⁵ prepared for Bismarck's introduction of *SHI* as a nationwide and comprehensive system in 1883. First, in the late eighteenth and early nineteenth centuries, laws were voted that set detailed rules on how voluntary sickness funds should be organized. These rules included provisions concerning contributions, the benefit package, entry conditions and fund management. In a second stage, in 1843, laws introduced the notion of compulsory membership. The right was given to local government to acknowledge existing voluntary funds and even to introduce compulsory membership in those funds. In 1849, it also became possible to make membership compulsory for specific employment groups. In a third stage, a number of laws became applicable at national level. The first compulsory health insurance law was that of 1854, when health insurance coverage became compulsory for all miners. It was a milestone in that it was the first law that covered the entire German territory for one occupational group, with miners being required to become a member of one of the regional miners' health insurance funds.

Then followed an important landmark in 1883 when Bismarck introduced SHI for a larger number of occupational groups. Initially the health insurance law of 1883 covered blue-collar workers in *selected* industries, craftspeople and other selected professionals.⁶ It is estimated that this law brought health insurance coverage up from 5 to 10 per cent of the total population. After 1883, the incremental approach to coverage continued by systematically bringing different socioprofessional groups into compulsory insurance. By 1910, population coverage had reached 37 per cent, attaining 50 per cent by 1930. In 1950, insurance coverage was 70 per cent of the population. One of the last laws enrolled artists and publicists into the SHI system in 1981.⁷ By 2000, 88 per cent of the German population was enrolled in the SHI system.⁸ Population coverage by SHI is not 100 per cent as, above a certain income level, one can opt out of the SHI system and insure on a private basis.⁹

⁵ Bärnighausen and Sauerborn (2002, p.1562).

⁶ We refer to persons employed by lawyers, notaries, bailiffs, industrial cooperatives and insurance funds.

⁷ For an overview of the years in which laws were voted to systematically cover the various professional groups and their dependants, see Bärnighausen and Sauerborn (2002, Table 1, pp. 1566-67).

⁸ European Observatory on Health Systems and Policies (2000, p.39).

⁹ Apart from the privately trained to per cent of the population), 2 per cent of ads population is covered via free government care (including police officers and soldiers), with 0.1 per cent uninsured.

Austria. A gradual approach as in Germany was adopted. A first Industrial Accident and Health Insurance scheme for enterprise workers was established in 1887-88. Leading up to this scheme were the early regulatory provisions in the early nineteenth century for employers to pay for hospital care and care of sick employees. In 1859, an Industrial Code came to regulate the creation of benevolent funds and cooperative health insurance funds. However, so far these provisions and regulations had been mostly ignored. Then came the 1867 Associations Act that authorized the creation of association-based funds. As a result, the associations for general workers' health and the invalidity relief funds were established in 1868 and 1873, respectively.

The initial 1887-88 scheme was further expanded in the early twentieth century, by systematically enrolling all categories of white-collar workers, blue-collar workers and agricultural workers. The final expansion of coverage came in 1965 and 1967 with the Farmers' Health Insurance Act and the Civil Servants' Health Insurance Act, respectively. By 1980, a population coverage level of 96 per cent had been achieved. Note that there were 79 years between the first law in 1888 and the last major law, the Civil Servants' Health Insurance Act of 1967.

Belgium. In 1851, a special law officially acknowledged the sickness funds, often referred to as mutual health funds. These were based on different occupational groups and were rather small-scale. Later on, in 1894, more extensive legislation provided the legal foundation of these funds for almost a century: a broader scope of activities was recognized, while they could henceforth benefit from government subsidies. Subsequently, mutual health funds from the same political or ideological background combined into national alliances or unions.

Until the early 1940s, membership in these mutual health funds had been voluntary. Towards the end of the Second World War, on 28 December 1944, a decree was adopted to make health insurance compulsory for all salaried workers. A National Fund for Sickness and Invalidity (embedded in a National Office of Social Security) would collect contributions and distribute them to the mutual health funds that would be in charge of administering compulsory health insurance. The next important steps were the laws of 1964, 1965, 1967, 1968 and 1969 that would expand compulsory health insurance coverage to self-employed workers (but for major health risks only), civil servants, people with physical disabilities, those with learning difficulties, and the remaining uninsured population, respectively. Thus, at the time of universal coverage, 118 years had elapsed since the 1851 law.

Luxembourg. In 1901, compulsory health insurance was established for manufacturing and industrial workers. It was also inspired by the earlier 1883 law in Germany. Health insurance developed and, by 1903, 73 sickness funds were operating. Later on, in 1925, legislation was introduced to regulate the health insurance sector, which had become increasingly complex. As in other European countries, SHI further developed after the Second World War. Retirees were the first new group to become covered. Then in 1952, health insurance became compulsory for civil servants and other public sector workers. In 1958, 1963 and 1964, compulsory insurance laws were introduced for the independent professions (businesspeople, craftspeople, etc.), farmers, and the independent intellectual professions (doctors, architects, lawyers, etc.), respectively. By 1973, the whole population was covered by SHI. Thus, the transition period had taken 72 years since the first law in 1901.

Israel. A first health insurance fund, the Kupat Lichen Clalit (General Sickness Fund), was founded in 1911 by agricultural workers in collective settlements (kibbutz).¹⁰ Later on, in 1920, this fund was taken over by the Histadrut (General Federation of Labour) and became one of its political power bases. Three other health

¹⁰ Information in this section from www-israel-mfa.gov.it/mfa/.

insurance funds were established as well. By the end of 1948, the year in which Israel gained statehood, 53 per cent of the population was covered, with the majority (80 per cent) being insured by the Kupat Holim Clalit. This high coverage and subsequent expansion were due largely to political commitment in covering all members of the Histadrut; by the inclusion of all recipients of government social assistance; and by automatically covering all new immigrants; even though health insurance was not compulsory for all. By 1995, 96 per cent of the population was insured. In that same year, the National Health Insurance Law was voted, confirming compulsory insurance and the duty of every resident to register as a member in one of the existing funds. The lapse of time since the first health insurance fund in 1911 was therefore 84 years.

Costa Rica. The country¹¹ initiated its SHI system via the establishment of the Social Insurance Fund of Costa Rica (CCSS)¹² in November 1941. At first, the urban population was targeted, as well as the population of certain coffee-producing zones such as the Valle Central, with membership in principle compulsory for these population groups. An important characteristic was that, initially, only the insured worker was the beneficiary of SHI. However, already in 1944, when extending SHI to other zones such as the Valle de Turrialba, there were pressures to have all family members covered. It was in 1956 that family coverage was introduced on a compulsory basis, including coverage for spouse or partner, children younger than 12 years old and parents if they were also dependants in the insured worker's family.

Another important event occurred in 1960 when a regulation more than doubled the maximum taxable earnings. So far, SHI had focused on the protection of low-income workers. However, the 1960 regulation permitted, among other things, an important increase in contributions and an extension of SHI benefits. In addition, in 1961, legislation was accepted with the intention to extend SHI to all of the population. Thus, there were 20 years between the establishment of the CCSS in 1941 and the 1961 law. The 1961 law meant that also self-employed workers and indigent persons were to be incorporated into the SHI scheme. In fact, the Costa Rican Parliament set a ten-year target for achieving nationwide coverage. This has so far not been reached, however. But note that by early 1990, 29 years after the law of 1961, 85 per cent of the population was effectively covered by SHI.

Japan. At the root of SHI is the very early development of voluntary community health insurance schemes in the nineteenth century. In 1835, a community health insurance scheme¹³ (having rice as prepaid contributions and basic care as the main benefit) was established in Fukuoka Prefecture. In later decades this type of mutual health association grew in importance. In the 1930s, government encouraged the replication of community health insurance on a national scale. In 1934-35, 12 models of community health insurance were already established in three prefectures. However, in 1938 a broader National Citizens' Health Insurance Law, based on community financing principles but with cash-based contributions, was proclaimed and implemented. This law was designed to meet the needs of poor people in underserved rural villages, the farmers and self-employed workers in rural communities, and small companies. It was also initially run on a voluntary basis. Still, this particular law contributed significantly to insurance coverage, increasing it from 2 to 51.2 per cent of the total population.¹⁴

As far as employees are concerned, a major law was voted in 1922, establishing compulsory insurance for selected groups of workers. This was the first law passed related to health insurance. Employee health insurance

¹¹ The information on Costa Rica is taken from Miranda (1994, ch.8).

¹² Caja Costarricense de Seguro Social.

¹³ Called *Jyorei* in Japanese.

¹⁴ Ogawa et al. (2003).

Social health insurance : Key factors affecting the transition towards universal coverage

together with National Citizens' Health Insurance covered 60 per cent of the whole nation by 1945.¹⁵ After the Second World War, these two types of insurance expanded to cover 90 per cent of the population. Legislation establishing compulsory insurance for all was finally adopted in 1958 and fully implemented by 1961. Hence, only 36 years had passed since the first law in 1922.

Table 1. Summary of the transition period for selected SHI countries

	Speed of transition	Important stages in the extension of social health insurance - legislative inside
Germany	1854-1988 (127 years)	1. Voluntary relief funds (early-mid-19th century) established
		2. Compulsory membership within health insurance funds (1843); for specific employment groups (1849). ^a
		3. First law passed at national level, making health insurance compulsory for all miners (1854).
		4. SHI becomes a nationwide, comprehensive system (1883), with systematic enrolment of different socioprofessional groups (until 1988).
Austria	1888-1967	1. Regulatory provisions for employer-based care (early-mid-19th century)
		2. Creation of association based funds enhanced (1867) a
		3. Industrial accident and health insurance scheme (1887-88), with systematic enrolment of different socioprofessional groups (until 1967).
Belgium	1851-1969 (118 years)	1. Mutual health funds for different occupational groups officially acknowledged (1851).
		2. Funds subsidized by government (1894), with national alliances as unions formed between funds.
		3. Health insurance made compulsory for all salaried workers (1944), with extension to remaining non-covered groups (1964-69).
Luxembourg	1901-73 (72 years)	1. Compulsory health insurance for manufacturing and industrial workers (1901).
		2. Extension to retired (post-Mil), civil servants/other public sector (1952), former socioprofessional groups (1958-64).
Israel	1911-95 (84 years)	1. Health insurance fund -Kupat Holim Clalif -for agricultural workers in collective settlements (1911).
		2. Three further health insurance funds established in this period.
Costa Rica	1941-61 (20 years)	1. Social insurance fund - CCSS - mainly for urban population and certain coffee-producing zones established (1941).
		2. Compulsory family coverage for insured (1956).
		3. Increased contributions and benefits (1960).
		4. Extension to remaining population accepted (1961), with intended systematic enrolment of these non-covered groups over 10-year period.
		5. Effective enrolment of 834 per cent by 1991.

¹⁵ Japan, Ministry of Health, Labour and Welfare (2003a).

Social health insurance : Key factors affecting the transition towards universal coverage

	Speed of transition	Important stages in the extension of social health insurance - legislative inside
Japan	1922-58 (36 years) ^b	<ol style="list-style-type: none"> 1. Voluntary community health insurance scheme, (CHIs) developed (36 years) (early 19th century).^a 2. Compulsory insurance-Employee Health Insurance-for selected groups d workers (1922). 3. CHI, replicated on national wale (1930s), mainly for poor in rural areas, farmers, self-employed and small companies, culminating in National Citizens' Health Insurance Law (1938). 4. Simultaneous expansion of both health insurance schemes (1944-58)
Republic of Korea	1963-89 (26 years)	<ol style="list-style-type: none"> 1. First Health Insurance Act passed (1963), with several voluntary health insurance schemes piloted (1963-77). 2. Compulsory for workers and their dependants firms with 500-plus employees (1977), firms with 100-plus employees (1981); firms with 16-plus employees (1983), 3. Extension to remaining population, such as self-employed (until 1989).

^a Stages proconsul flat health insurance law.

^b In Costa Rica, universal coverage not effectively implemented after 1961 law. In Japan, effective implementation of universal coverage via SHI in 1961.

Republic of Korea. In 1963, a Health Insurance Act was passed, triggering the move towards universal health insurance coverage. Health insurance remained voluntary until 1977, however. Several voluntary health insurance societies were organized on a pilot basis, covering at most 0.2 per cent of the population.

From 1977 on, compulsory insurance was established sequentially for the various occupational groups in the country. In that same year, employees' health insurance became compulsory for employees (in companies with 500 employees and above) and their dependants. Subsequently, coverage was systematically extended. In 1979, it became compulsory for workers (and their dependants) in firms with a minimum of 300 workers. Government officials and private school teachers were compulsorily insured in this year as well. In 1981, the coverage was extended to workers in firms employing at least 100 workers and, in 1983, 16 workers. Also in 1981, demonstration programmes for self-employed health insurance were set up in selected rural and urban areas. Finally, in 1988 and 1989, health insurance became compulsory nationwide for rural and urban self-employed workers, respectively. Thus, the transition period had lasted 26 years since the enactment of the initial 1963 Health Insurance Act.

Summary. In all the countries studied, the move towards full SHI coverage has been an incremental process, with systematic expansion over the transition period. The organizational arrangements introduced to achieve this expansion have been different, however. They ranged from the steady expansion of membership in multiple sickness funds, initially run on a voluntary basis, to extension of membership steered by a government-driven central health insurance organization. Also note that the speed of transition has varied from country to country.

Table 1 summarizes the main stages in the extension of SHI for these countries, based on key legislative changes, after which the analysis moves onto the factors that helped facilitate this transition.

*Facilitating factors
that speed up the transition to universal coverage*

An overview. We submit that a number of factors can in principle enhance the speed of achieving universal coverage via SHI.¹⁶ First, there is the general *level of income* and the rate of economic growth. A greater amount of income per capita is apt to increase the capacity of enterprises and citizens to prepay SHI contributions. In addition, tax revenues are likely to increase with income, facilitating the subsequent channelling of any government subsidies into SHI. Steady economic growth, therefore, is likely to enhance this capacity to prepay.¹⁷

Second, the *structure of the economy* also matters. What is most relevant here are the relative sizes of the formal sector and informal economy. Many developing countries do have important agricultural, manufacturing and service sectors where a notable part of employment is informal. Such countries then are likely to face administrative difficulties in assessing incomes and collecting contributions because so many workers do not receive a formal salary. This may hamper provision of health protection for the informal segment of the population, especially when an SHI scheme would *rely* significantly on household contributions.

Third, administrative costs may be influenced further by the *distribution of the population*¹⁸ that one intends to cover. The population in urban areas, where there is likely to be at least a minimum quality of infrastructure and communications, and high population density, is likely to be easier to serve with an SHI system than a widely dispersed rural population.

A fourth factor is the country's ability to *administer*. The establishment of an SHI scheme requires a sufficiently skilled labour force with capacities in bookkeeping, banking and information processing. Secondary and tertiary education should ideally respond to such training needs. Related markets, such as in financial services, other insurance businesses and even well-established community health insurance schemes, can also provide appropriately trained personnel. Their staff can also be called upon to be involved in the training and general capacity building of SHI staff. An SHI's administration is also reinforced when a social security system is in place, thanks to the availability of personnel skilled in functions common to all branches of social security.

The fifth factor is the level of solidarity within a society. A society with a higher level of solidarity is interpreted here as being one where individuals are more willing to support other individuals. A system of full financial protection requires a significant amount of cross-subsidization, both from rich to poor and from low risks to high risks. Each country needs to define what an appropriate level of solidarity to enable such cross-subsidization is. Policymakers can, at times, impose solidarity, but a sufficient degree of innate solidarity in society is needed in order to implement and sustain the cross-subsidization inherent within SHI.

Finally, the five facilitating factors discussed above may be present to a lesser or larger degree, but it will still take government's stewardship to launch and guide a process that leads to compulsory health insurance for all. Stewardship can be best understood as a function of a government that is responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry.¹⁹ One important element of governmental stewardship is therefore to allow the various stakeholders and the population at large to have a voice in social policymaking. Open political debate and availability of financial information help the population to gain trust in government and other agencies involved in SHI implementation. It is therefore warranted that the contributors to SHI, the providers and the population (for example through

¹⁶ This section is based on Carrin and James (20m).

¹⁷ Ensor (1999, p.875).

¹⁸ Ensor (1999, p.875).

¹⁹ Saltman and Ferroussier-Davis (2000, p. 735 ; WHO (2000, p. 119).

community and professional associations), interact with decision-makers on its design. We will refer to the relative importance of these factors for the eight SHI countries analysed in the discussion below.

Application to the experiences of the selected countries with developed SHI schemes. Level of income. It is interesting to note that health insurance in all eight countries started when they were lower-middle-income countries. In Germany, gross domestic product (GDP) per capita was US\$ 2,237 at the time of Bismarck's 1883 law. The Austrian GDP per capita was US\$ 2,420 when the 1887-88 Industrial Accident and Health Insurance scheme for workers was established. In Belgium, at the time of the official recognition of the mutual health funds in 1851, GDP per capita was US\$ 1,808. Even in Japan and ROK, where the transition period was considerably shorter, GDP per capita was at similar levels. In Japan, GDP per capita was US\$ 2,140 around the time the Health Insurance Law for workers was enacted in 1922. In ROK, while income level per capita was quite low at the passing of the first Health Insurance Law, namely US\$ 209 per capita, in 1977 when the "compulsory" period started, gross national product (GNP) per capita was US\$ 1,012.

Furthermore, economic growth was either high or at least steady for each of these countries during the transition period. In Belgium and Germany, GDP per capita had more than quintupled by 1970, whereas Austria's GDP per capita had quadrupled. These countries had therefore developed a substantial economic capacity since the mid-nineteenth century, facilitating the financial build-up of SHI. In Costa Rica, economic growth in the 1950s was quite high, pushing GDP growth rates up to 7 per cent. This is reported to have strengthened the initial development of SHI in the country.²⁰ Concerning Japan, its income growth was steady, though not spectacular, at about 2.9 per cent between 1920 and 1940. Between 1940 and 1961, GDP had continued to grow, though modestly, at an average rate of 1.75 per cent a year. Still, by 1961, GDP per capita had progressed to US\$ 5,150, more than double the amount 40 years earlier. The ROK annual growth rate was much higher, at 13.3 per cent. By 1989, when universal coverage was achieved, GNP per capita had more than quadrupled in 12 years to become US\$ 4,994.

Structure of the economy. It is evident that in the western European and Asian countries analysed, there were growing formal sectors during their transition periods. This enabled these countries to enhance the enrolment of workers in a systematic way, including those in mining and industry but also in the agricultural sector. For instance, in Germany, agricultural and forestry workers were already covered by 1911. And in ROK, it has been recognized that the high growth phenomenon rapidly changed the structure of the economy, and that the growing formal sector was instrumental in SHI development.²¹

Distribution of the population. The strengthening of the formal sector in the countries studied is also seen to be correlated with growing urbanization and increased population density. Administrative cost savings can be realized from this particular evolution, especially as a result of greater efficiency in identifying and registering SHI members and in the subsequent collection of contributions. Note for example that in ROK, the urban population was 36.6 per cent of the total in 1966 (three years after the introduction of voluntary health insurance). This climbed to 48.4 per cent in 1975 (two years before SHI became compulsory). And in 1980, the urban population was already 57.3 per cent of the total.²² We submit that this evolution has also contributed to the notable speed of transition to universal coverage in ROK.

²⁰ Miranda (1994, p. 119).

²¹ Moon (1998, p. 228).

²² ROK, National Bureau of Statistics (1980).

Ability to administer. In relation to Germany's experience, it is argued that the voluntary *relief* funds that preceded the initial compulsory health insurance laws "had served as an apprenticeship stage for the development of skills in the insurance administration and actuarial science at the level of the fund as well as in insurance regulation at the level of government".²³ A similar interpretation is likely to be valid for the other countries where voluntary funds were operating before the first official laws. In ROK, the availability of well-trained middle management workers was instrumental in expanding SHI.²⁴

Solidarity. Regarding the impact of *solidarity*, a similar argument can be made. The initial voluntary schemes in Germany can be interpreted as "learning models for solidarity" that facilitated the establishment of or participation in larger schemes, or that helped compliance with compulsory arrangements. It should also be said that the solidarity achieved was backed up by an important build-up of trust among insured members in the management of the voluntary schemes. In some cases, political or ideological affiliation also helped to achieve larger schemes. For instance, in Belgium, mutual *health* funds with the same political or ideological background merged into five national unions at the beginning of the twentieth century.

Stewardship. We submit that the capacity of governments to make health insurance compulsory is crucial for arriving at a mature SHI system. Strong *stewardship* on the part of governments is therefore needed. Governments have surely exemplified stewardship, although in perhaps different ways and in different periods. In Germany, Bismarck made a first move towards universal coverage with the 1883 Health Insurance Law, and built upon the experience of voluntary schemes in earlier decades. In Belgium, the government also stimulated the target of universal social protection by officially recognizing the mutual *health* funds in 1851. In 1894, the scope of the activities of mutual *health* funds was legally extended, by awarding them the right to claim government subsidies. Such positive governmental actions were not always spurred on solely by interest in population welfare, however. Politics have often played a role. For instance, it is recognized that Bismarck used this law to counteract the political weight of workers and trade unions so as to strengthen the German State.²⁵ Also in Austrian²⁶ and Japan,²⁷ the rise of the workers' movement at the beginning of the twentieth century pushed forward the extension of SHI.

Still, on the whole, it is accepted that, especially in the aftermath of the Second World War, significant improvements in health insurance were planned by governments having the public interest in mind. In Belgium, Germany and Austria, stewardship was built in a significant way on *consensus*, giving voice to concerned stakeholders and finding a balance between their interests.

The SHI history in Belgium has been characterized from the beginning by consensus building between employers and employees. For instance, in 1943 a draft Agreement on Social Solidarity was signed between employers and trade unions. This was the precursor of the decree of 28 December 1944 that established social security for workers. The latter also recognized the importance of the health insurance funds in the running of the system. Employers' organizations, trade unions and health insurance funds continue to have an important stake in its management. They are represented, and now joined by the organizations of self-employed workers, in the management board of Belgium's SHI agency.

In the case of Germany, it should be noted that statutory health insurance funds and provider organizations have historically been instrumental in SHI development. They are autonomous and "self-governing" institutions,

²³ Bärnighausen and Sauerborn (2002, p. 1560).

²⁴ Moon (1998, p. 228).

²⁵ Bärnighausen and Sauerborn (2002, p. 563).

²⁶ Hofmarcher, and Rack (2001, p. 7).

²⁷ Japan, Ministry of Health, Labour and Welfare (2003a).

though under the general supervision of the government. Over the past decades, these institutions with their regional base were gradually drawn into a more centralized process of decision making, through federal committees and negotiations. Germany's federal government in turn has enhanced its role in health policy; for instance, the federal Ministry of Health had an important impact on the establishment in 1993 of the risk equalization system.²⁸

Austria has had a similar experience to that of Germany, with health insurance funds being self-governing bodies that negotiate contracts, health service benefit packages and provider payments with professional provider bodies. However, the federal government maintains its responsibilities for legislation and implementation.²⁹

In Japan, social protection has been an explicit part of government policy. In fact, the postwar Constitution determined that the State "shall use its endeavours for the promotion and extension of social welfare and security, and of public health".³⁰ Thus, it provided the basis for the establishment of social security in postwar Japan. Still, this did not mean that governments intervened unilaterally in the field of health. Rather, health policy has been characterized by a pragmatic attitude on the part of government. One can refer to "the art of balance in health policy", whereby a balance is achieved between well-established interest groups,³¹ especially Japan's Ministry of Health, Labour and Welfare (with its interest in management of healthcare) and the Japan Medical Association (with its interest in professional autonomy).³²

In Israel, stewardship was shown by, among other actions, the government's commitment to extend coverage, following Israel's establishment in 1948, to all new immigrants. Although 96 per cent of the population was covered by 1990,³³ and this despite membership being voluntary for many, from the 1980s there appeared to be growing discontent with the system from both the population and providers (including complaints about long queues and under-the-table payments). In addition, the largest health insurance fund encountered severe financial problems, with smaller funds engaging in "cream skimming". The government then asked the Supreme Court to appoint a five-member state commission of inquiry into the Israeli healthcare system in June 1988. One of the most important recommendations in the commission's report (submitted in August 1990) was to introduce a National Health Insurance Law that would enrol every citizen and determine a legal framework for the financing and provision of healthcare. A National Health Insurance Institute would collect contributions and then distribute these via capitation payments to the various health insurance funds. This law was then passed in 1995 and served several key objectives. The first was to give the State the responsibility to provide health services for all residents; the second to be clear on the population's entitlements to care; the third to institute the obligation on each health fund to accept every insured person, whatever his or her risk of illness, so as to avoid cream skimming.³⁴ It also took important political skills on the part of the leaders of the Histadrut³⁵ to support a universal health insurance law that implied a delinking of the Kupat Holim Chalit sickness fund from the Labour Federation, and whereby unionized workers would be able to register in another health insurance fund.

²⁸ Barnighausen and Sauerborn (2002, p. 1577).

²⁹ Hofmarcher and Rack (2001, pp. 16-17).

³⁰ Japan, Ministry of Health, Labour and Welfare (2003b).

³¹ Ikegami and Campbell (1998, pp. 213-214).

³² Ikegami and Campbell (1998, p. 24).

³³ Chernichovsky (1991, p. 1).

³⁴ Chernichovsky (1991, p. 24).

³⁵ Chinitz (1995, p. 921).

Conclusions

Universal coverage, secure access to adequate healthcare for all at an affordable price, is the ultimate objective of SHI. Through analysis of the experience in eight countries with developed SHI schemes, this paper has shed light on what are important facilitating factors for the speed of the transition period. A number of factors were judged crucial in facilitating this transition: the level of income, the structure of the economy, the distribution of the population, the country's ability to administer SHI, and the level of solidarity within a society. It is essential that policymakers take these factors into account and try to use them as policy levers. Improving administrative capacity and fostering a sufficient level of solidarity are among those factors that can be impacted upon more directly via government stewardship.

Thus, while experience demonstrates that SHI development in a particular country to a large extent depends on that country's own specific socioeconomic and political context, experience also shows how the transition to universal coverage is dependent on the government's stewardship of the health system.

Bibliography

- Bärnighausen, T.; Sauerborn, R.** 2002. "One hundred and eighteen years of the German health insurance system: Are there any lessons for middle- and low-income countries?", in *Social Science and Medicine*, Vol. 54, No. 10.
- Carrin, G.; James, C.** 2003. "Determinants of achieving universal coverage of health care: An empirical analysis", in M. Audibert, J. Mathonnat and E. De Roodenbeke (eds.), *Financement de la santé dans les pays d'Afrique et d'Asie à faible revenu*. Paris, Karthala.
- Carrin, G.; James, C.** 2004. *Evaluating social health insurance: Key design features in the transition period* (Health Financing Policy Issue Paper). Geneva, World Health Organization, Department of Health System Financing, Expenditure and Resource Allocation (PER).
- Carrin, G.; Zeramdini, R.; Musgrove, P.; Pouillier, J.-P.; Valentine, N.; Xu, K.** 2004. "Impact of risk sharing on the attainment of health system goals", in A. Preker and G. Carrin (eds.), *Health financing for poor people: Resource mobilization and risk sharing* (chap. 12). Washington, DC, World Bank.
- Chernichovsky, D.** 1991. *Economic dimensions of the crisis in the Israeli health-care system: Key principles and proposals for reform* (research report). Jerusalem, JDC-Brookdale Institute of Gerontology.
- Chinitz, D.** 1995. "Israel's health policy breakthrough: The politics of reform and the reform of politics", in *Journal of Health Politics, Policy and Law*, Vol. 20, No. 4.
- Cutler, D. M.** 2002. "Equality, efficiency and market fundamentals: The dynamics of international medical-care reform", in *Journal of Economic Literature*, Vol. 40, No. 3.
- Ensor, T.** 1999. "Developing health insurance in transitional Asia", in *Social Science and Medicine*, Vol. 48, No. 7.
- European Observatory on Health Systems and Policies.** 2000. *Germany*. Copenhagen, World Health Organization.
- European Observatory on Health Systems and Policies.** 2002. *Country profiles*. Also available at <http://who.int/observatory/CtryInfo/CtryInfo> (visited on 18 October 2004). Copenhagen, World Health Organization.
- Hofmarcher, M. M.; Rack, H.** 2001. *Health care systems in transition: Austria*. Copenhagen, World Health Organization, European Observatory on Health Systems and Policies.
- Ikegami, N.; Campbell, J. C.** 1998. *The art of balance in health policy: Maintaining Japans low-cost, egalitarian system*. New York, Cambridge University Press.
- Japan. Ministry of Health, Labour and Welfare.** 2003a. *The social security system in the prewar days*. Also available at <http://www.mhlw.go.jp/english/index.html> (visited on 18 October 2004). Tokyo.
- Japan. Ministry of Health, Labour and Welfare.** 2003b. *Emergency relief and rebuilding of the foundation in the postwar days: 1945-1954*. Also available at <http://www.mhlw.go.jp/english/index.html> (visited on 18 October 2004). Tokyo.
- Miranda, G.** 1994. *La seguridad social y el desarratio en Costa Rica*. San Jose, Editorial Nacional de Salud y Seguridad Social (EDNASSS).
- Moon, Ok Ryun.** 1998. "The Korean health insurance programme", in S. Nitayarumphong and A. Mills, *Achieving universal coverage of health care* (chap. 8). Nontaburi, Thailand, Ministry of Public Health.
- Normand, C.; Weber, C.** 1994. *Social health insurance. A guidebook for planning*. Geneva, World Health Organization and international Labour Office.
- Ogawa, S.; Hasegawa, T.; Carrin, G.; Kawabata, K.** 2003. "Scaling up community health insurance: Japan's experience with the 19th century *Jyorei* scheme", in *Health Policy and Planning*, Vol. 18, No. 3.
- Republic of Korea. National Bureau of Statistics.** 1980. *Social indicators in Korea*. Seoul, Economic Planning Board.
- Ron, A.** 1993. *Planning and implementing health insurance in developing countries: Guidelines and studies* (Macroeconomic, Health and Development Series, No. 7). Geneva, World Health Organization, Division of Intensified Cooperation with Countries in Greatest Need (ICO).
- Saltman, R. B.; Busse, R.; Figueras, J. (eds.)** (forthcoming). *Understanding social health insurance systems: A comparative review of western Europe*. Copenhagen, World Health Organization, European Observatory on Health Systems and Policies.

Social health insurance : Key factors affecting the transition towards universal coverage

- Saltman, R. B.; Ferroussier-Davis, O.** 2000. "On the concept of stewardship in health policy", in *Bulletin of the World Health Organization*, Vol. 78, No. 6.
- Sekhri, N.; Savedoff, W. D.** 2003. *How can private health insurance serve the public interest?* (Health Financing Policy Issue Paper). Geneva, World Health Organization, Department of Health System Financing, Expenditure and Resource Allocation (PER).
- WHO.** 2000. *World Health Report – Health systems: Improving performance.* Geneva, World Health Organization.