The Long Road To Universal Health Coverage: A century of lessons for development strategy

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Thanks for looking...

Thanks for looking at my slides. These were presented at the Center for Global Development on 2 March 2010. I thank Katie Stein and Heather Haines for their assistance. I thank Rachel Nugent, who invited me and moderated the event, and Bill Savedoff, who was an excellent commentator. I also thank Michael Clemens, who proposed the seminar. Thanks also to all who attended and participated.

This work is part of a larger project on the political economy of universal health coverage. Our team is led by Dai Hozumi at PATH and includes Laura Frost and Michael Reich. Their feedback has been very important to my research. We have been supported by a grant from the Rockefeller Foundation. All opinions and any errors in my presentation or in these slides are mine alone.

Historians usually do not present in this format because historical evidence is detailed, nuanced, complicated, and hard to fit into the limitations demanded by slides. For ease of presentation, I use simplified devices such as stakeholder tables, which are only a small part of the political economy I investigate.

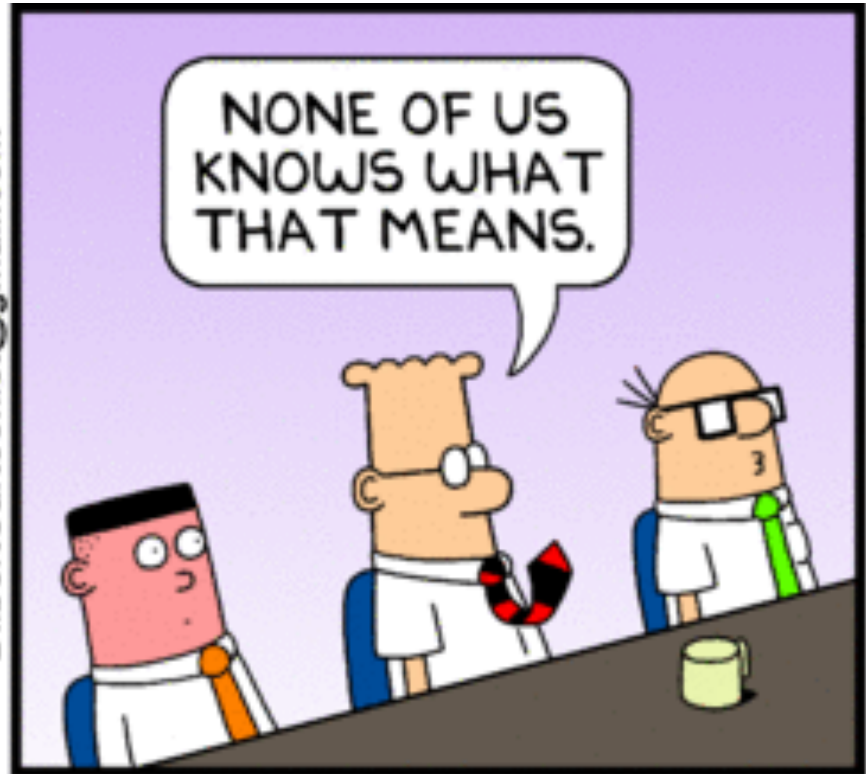
I welcome your comments. The paper on which these slides are based will be available soon. If you would like a copy, please send me an email: jbump@hsph.harvard.edu

Three Acts

- An Historical Political Economy Methodology
- Creating Government Health Systems
  - Germany, 1883
  - United Kingdom, 1947
  - United States, 1880s–1920s
- Conclusions and Next Steps

"Universal Health Coverage" is rising on the global health agenda:

- 2005 WHA Universal Coverage resolution
- 2009 Garret et al. "All for UHC," *Lancet*
- Next World Health Report is on UHC



Adapted from: http://www.dilbert.com/strips/comic/2010-02-14/

“Universal Health Coverage”

- Diversity of meanings
- Assumes a central governmental role
- Assumes a public commitment to collective responsibility and redistribution
- Ambiguity facilitates agreement
- Implementation requires details

The Parameters of “Universal Health Coverage”

My interpretation covering *some* ways “UHC” is now used:

> “A well functioning government health system, with some financial protections, some basket of services, and some standard of accessibility for everyone.”

Three Waves

1930s: The *Social Medicine* movement (RF and LNHO)

1970s: The *Primary Health Care* movement (WHO and WFC)

2000s: “UHC” and similar terms

An Historian's Question on the Development of UHC:

How does an historical analysis of past health systems development help us achieve UHC in developing countries now?

Methods for Historical Analysis of Health Systems

- Institutions are persistent and they matter
  - Path dependence theory
  - Historical institutionalism
- It is important to understand how they are created
- Particularly when considering how to build or export them

Part I
An Historical
Political Economy Methodology

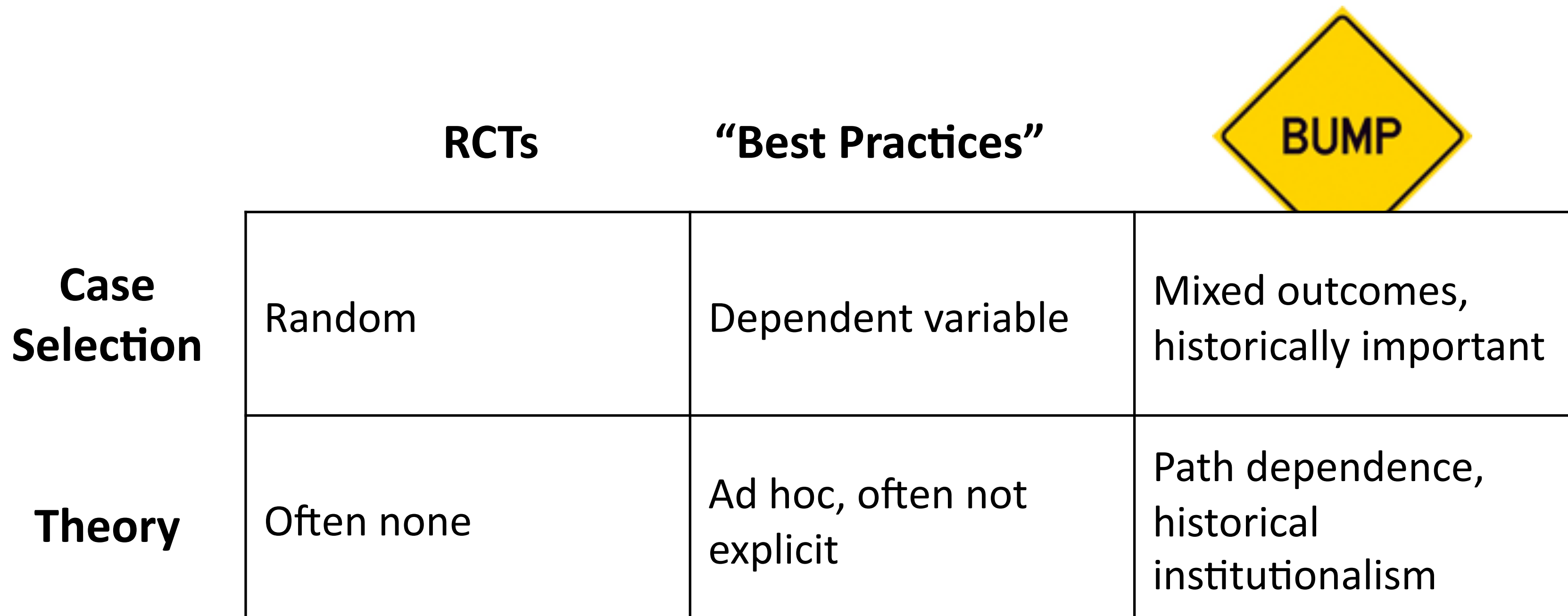
A Methodological Chasm in Policymaking (1)

- Quantitative precision through RCTs
- Many social phenomena cannot be randomized
- Natural experiments

A Methodological Chasm in Policymaking (2)

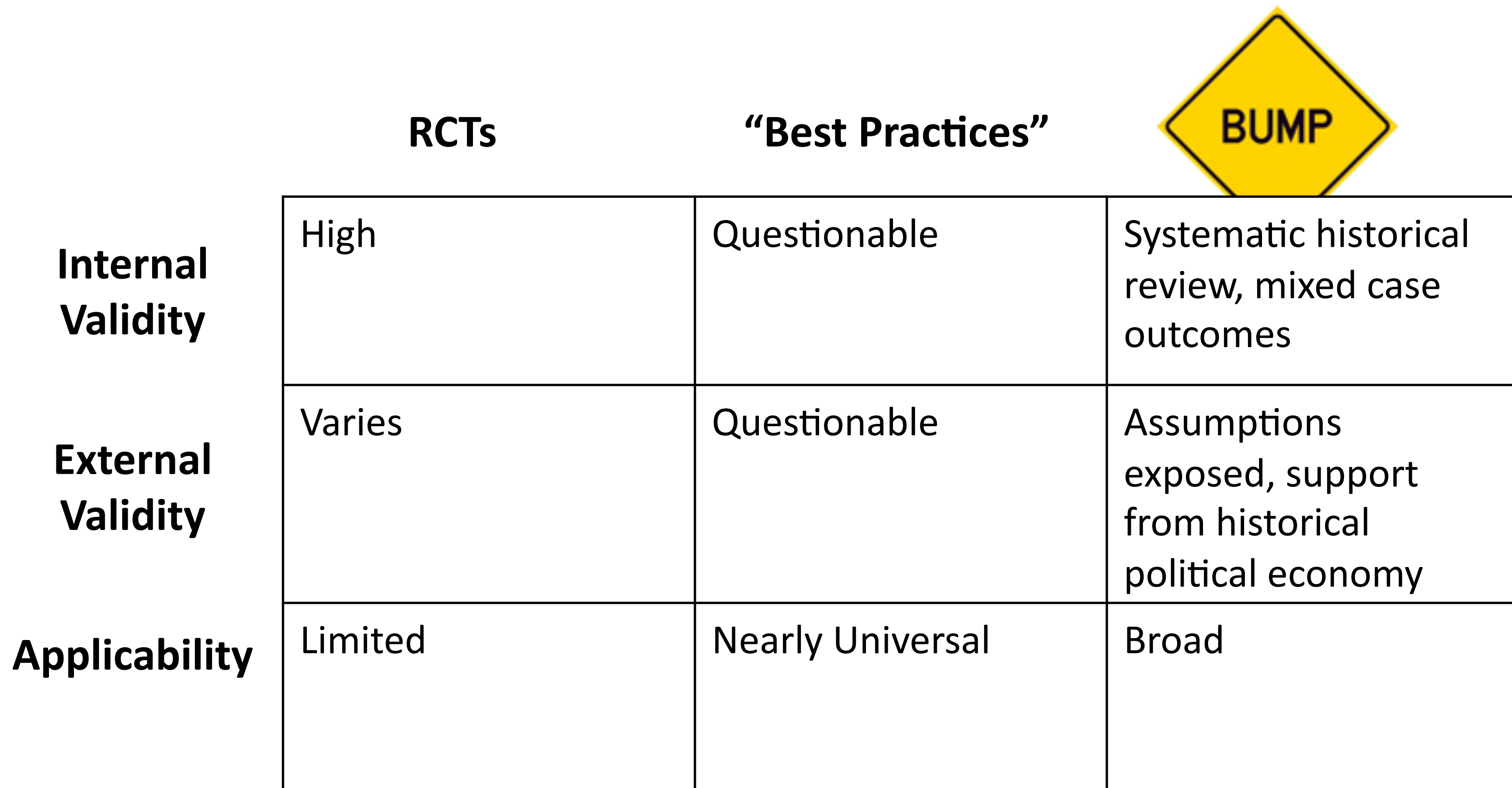
- In new realms, validity must be established
- Policymakers often rely on “best practices,” “lessons learned”

A Methodological Alternative: Historical Political Economy



	RCTs	"Best Practices"	BUMP
Case Selection	Random	Dependent variable	Mixed outcomes, historically important
Theory	Often none	Ad hoc, often not explicit	Path dependence, historical institutionalism

Validity and Applicability of Historical Political Economy



	RCTs	"Best Practices"	BUMP
Internal Validity	High	Questionable	Systematic historical review, mixed case outcomes
External Validity	Varies	Questionable	Assumptions exposed, support from historical political economy
Applicability	Limited	Nearly Universal	Broad

Cases for Analysis

Health system developments in
Germany, 1883
United Kingdom, 1948
United States, 1880s–1920

Lessons for improving health systems in developing countries

Support From The Literature For Explanation

Past events	$\Rightarrow$	Past Institutions
Past Institutions & their Performance	$\Rightarrow$	Current Institutions
Current Institutions	$\Rightarrow$	Current performance

And

Past Events, through Past Institutions	$\Rightarrow$	Current Health Outcomes

Deriving Policy Implications From Explanations

- Instrumental variables can quantify the impact of institutions
- Policy implications incomplete
  - in studied countries
  - for other places
- Generate hypotheses about the processes that create institutions

Part II
Three Cases of
Creating Government Health Systems

Germany, 1883
United Kingdom, 1947
United States, 1880s–1920s

Case Selection

- Hsiao (2003): Five financing models
- Two could support universal schemes
  - Social health insurance (Germany)
  - General Revenue (UK)
- Closest comparator with different outcome: USA

Data Collection

- Systematic search of major databases with terms "universal health" and "universal coverage"
  - PubMed
  - WorldWide Political Science Abstracts
  - FirstSearch's Hist-Sci-Med-Tech and FRANCIS databases
- Repeat searches for material on each historical episode
- Review internet resources such as Google Scholar and relevant websites, including WHO, World Bank, ILO
- Snowball strategy

A Framework for Historical Analysis

- Universal coverage outcome
- Political-Economic space of change
  - Historical context
  - Stakeholders

Germany: National Social Health Insurance, 1883

Outcomes:

- Sickness Insurance Act
- Existing institutions retained (SHI)
- Slow expansion by employment categories
- Eventually, virtually all Germans were enrolled

Germany: National Social Health Insurance, 1883

Historical Context:

- National Unification (1871)
- Industrialization
- Heritage of laborer's rights
- Over 5,000 sickness funds before law

Germany: National Social Health Insurance, 1883

Stakeholder Analysis

Players (all high power)	**Positions**
Bismarck	Consolidate leadership role, keep Germany unified under Kaiser
Social Democratic Party	Gain political power
Industrial Workers	Gain social protections via SDP
Sickness Funds	Keep autonomy

UK: National Health Service, 1948

Outcomes:

- Beveridge Report, National Health Service
- Existing institutions retained (GT)
- Whole population enrolled immediately

UK: National Health Service, 1948

Historical Context:

- Industrialization
- War and population solidarity
- War and infrastructure
- Centuries of poor laws, parish based charity
- Existing provision mechanisms

UK: National Health Service, 1948

Stakeholder Analysis

Players (all high power)	Positions
Beveridge	Advance socialist ideals
Labor groups	Demanded better, simpler benefits
Population	Strong solidarity, strong support for publicly provided health care
National Government	Churchill gov't distracted by war and unresponsive; Labor Party elected in 1945

United States: Industrial Sickness Funds, 1880s–1920s

Outcomes:

- German-style sickness funds
- Replaced by Blue Cross and Blue Shield
- Patchwork of private insurance; limited government role

United States: Industrial Sickness Funds, 1880s–1920s

Historical Context:

- Industrialization
- Progressive Era reforms
- Heritage of rights and protections
- Social protections: savings, co-workers, public charities
- …And voluntary private mechanisms
  - Mutual Benefit Societies
  - Sickness Insurance Funds

United States: Industrial Sickness Funds, 1880s–1920s

Stakeholder Analysis

Players (all high power)	Positions
Progressive Era Reformers	Social protection uncertain unless offered by government
Industrial Workers	Content with private options
Private Insurance Funds	Protective of market
State and Federal Government	Not engaged
Population	Low solidarity, many racial and ethnic divisions. Poorly mobilized
Providers	Not mobilized; strongly opposed later efforts to expand gov't role

Part III
Conclusions and Next Steps

Findings

1. Changes in government health systems *are* social contract renegotiation…

   And happened within a larger context of social contract renegotaiation

Findings

2. Historical context exerted great influence on health systems
   - Great heterogeneity in origins
   - Antecedents crucial
   - Organic processes
   - Delivery and financing mechanisms existed

Findings

3. The role of demand was crucial
   - Was expressed politically by labor groups (Germany, UK) and by the general population (UK) via solidarity

   - These groups in the US did not demand government intervention

An Historically Informed Hypothesis

Decision to Expand Government Health Institutions requires:

Delivery System Capacity +

Economic Expansion+

Solidarity and Demand+

Social Contract Renegotiation

Implications from this analysis for current debate on extending UHC

- Historical Political Economy is an analytic entry point
  - Generate hypotheses
  - Bridges explanatory and predictive realms
  - Guide quantitative research

    Probit regression analysis of the likelihood of UHC transition (joint with Michael Clemens)
- Guide development assistance strategies
- A basis for assessing climate for universal coverage

Implications from this analysis for current debate on extending UHC

DELIVERY SYSTEM CAPACITY	Technical and policy support
ECONOMIC EXPANSION	*Potential* role for long-term financing
SOLIDARITY AND DEMAND	Depends on actor
SOCIAL CONTRACT RENEGOTIATION	Act fast

Frameworks are essential; details must be settled locally

Supporting Health Systems Through Development Assistance

The Social Medicine Movement

- Rockefeller IHD dominant
- A European reaction to industrialization
  - living conditions, employment, poverty
  - integrate curative and preventative
- Czechoslovakia
- Selskar Gunn

Source: National Library of Medicine

The Social Medicine Movement (2)

- Gunn's rural health experiments in China
- Principles disseminated at a 1937 conference in Java
- Japanese invasion, WWII

Social Medicine and Rural Health Systems

Stakeholder Analysis

Players (all high power)	Positions
Gunn	Advance rural health in China with social medicine principles
Rockefeller Foundation	Focus on Western bio-medical concepts
National Government	Supportive of both
Chinese Population	?
Japan	Invade China

"Health for All"

- Malaria Eradication Program failed
- Primary Health Care
- WHO HQ focused on definitions
- By Alma-Ata, opposition had formed
- Large programs to develop health systems did not materialize
- Implementation, financing not emphasized

Health For All

Stakeholder Analysis

Players (all high power)	**Positions**
Mahler	Promote community-driven PHC
World Federation of Churches	Promote PHC, community PH
Soviet Delegation	Showcase communist triumph; centrally planned PHC
McNamara, RF, UNICEF, USAID	Focus on few high-benefit, low-cost interventions