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Universal health care

Universal health care (also called **universal health coverage**, **universal coverage**, or **universal care**) is a health care system in which all residents of a particular country or region are assured access to health care. It is generally organized around providing either all residents or only those who cannot afford on their own, with either health services or the means to acquire them, with the end goal of improving health outcomes.[1]

Some universal healthcare systems are government-funded, while others are based on a requirement that all citizens purchase private health insurance. Universal healthcare can be determined by three critical dimensions: who is covered, what services are covered, and how much of the cost is covered.[1] It is described by the World Health Organization as a situation where citizens can access health services without incurring financial hardship.[2] Then-Director General of the WHO Margaret Chan described universal health coverage as the "single most powerful concept that public health has to offer" since it unifies "services and delivers them in a comprehensive and integrated way".[3] One of the goals with universal healthcare is to create a system of protection which provides equality of opportunity for people to enjoy the highest possible level of health.[4] Critics say that universal healthcare leads to longer wait times and worse quality healthcare.[5]

As part of Sustainable Development Goals, United Nations member states have agreed to work toward worldwide universal health coverage by 2030.[6] Therefore, the inclusion of the universal health coverage (UHC) within the SDGs targets can be related to the reiterated endorsements operated by the WHO.[7]

History

Note: *Links in table are "Healthcare in COUNTRY".*

The first move towards a national health insurance system was launched in Germany in 1883, with the Sickness Insurance Law. Industrial employers were mandated to provide injury and illness insurance for their low-wage workers, and the system was funded and administered by employees and employers through "sick funds", which were drawn from deductions in workers' wages and from employers' contributions. This social health insurance model, named the Bismarck Model after Prussian Chancellor Otto von Bismarck, was the first form of universal care in modern times.[17] Other countries soon began to follow suit. In the United Kingdom, the National Insurance Act 1911 provided coverage for primary care (but not specialist or hospital care) for wage earners, covering about one-third of the population. The Russian Empire established a similar system in 1912, and other industrialized countries began following suit. By the 1930s, similar systems existed in virtually all of Western and Central Europe. Japan introduced an employee health insurance law in 1927, expanding further upon it in 1935 and 1940.

Following the Russian Revolution of 1917, the Bolsheviks established the world's first fully free and universal health care system was established in Soviet Russia in July 1918.[18][19] The system was highly centralized, and while nominally any person regardless of his status was covered, the actual coverage, especially in the more remote and impoverished areas was virtually non-existent.

In New Zealand, a universal health care system was created in a series of steps, from 1938 to 1941.[20][21] In Australia, the state of Queensland introduced a free public hospital system in 1946.

Following World War II, universal health care systems began to be set up around the world. On July 5, 1948, the United Kingdom launched its universal National Health Service. Universal health care was next introduced in the Nordic countries of Sweden (1955),[22] Iceland (1956),[23] Norway (1956),[24] Denmark (1961)[25] and Finland (1964).[26] Universal health insurance was introduced in Japan in 1961, and in Canada through stages, starting with the province of Saskatchewan in 1962, followed by the rest of Canada from 1968 to 1972.[20][27] A public healthcare system was introduced in Egypt following the Egyptian revolution of 1952. Centralized public healthcare systems were set up in the Eastern bloc countries. The Soviet Union extended universal health care to its rural residents in 1969.[20][28] Kuwait and Bahrain introduced their universal healthcare systems in 1950 and 1957 respectively (prior to independence).[29] Italy introduced its *Servizio Sanitario Nazionale* (National Health Service) in 1978. Universal health insurance was implemented in Australia in 1975 with the *Medibank*, which led to universal coverage under the current Medicare system from 1984.

From the 1970s to the 2000s, Western European countries began introducing universal coverage, most of them building upon previous health insurance programs to cover the whole population. For example, France built upon its 1928 national health insurance system, with subsequent legislation covering a larger and larger percentage of the population, until the remaining 1% of the population that was uninsured received coverage in 2000.[30][31] Single payer healthcare systems were introduced in Finland (1972), Portugal (1979), Cyprus (1980), Spain (1986) and Iceland (1990). Switzerland introduced a universal healthcare system based on an insurance mandate in 1994.[32][29] In addition, universal health coverage was introduced in some Asian countries, including Malaysia (1980s),[33] South Korea (1989), Taiwan (1995), Singapore (1993), Israel (1995) and Thailand (2001).

Following the collapse of the Soviet Union, Russia retained and reformed its universal health care system,[34] as did other now-independent former Soviet republics and Eastern bloc countries.

Beyond the 1990s, many countries in Latin America, the Caribbean, Africa and the Asia-Pacific region, including developing countries, took steps to bring their populations under universal health coverage, including China[35] and Brazil's SUS[36] which improved coverage up to 80% of the population.[37] Taiwan implemented its system in

Universal health care start date[8]

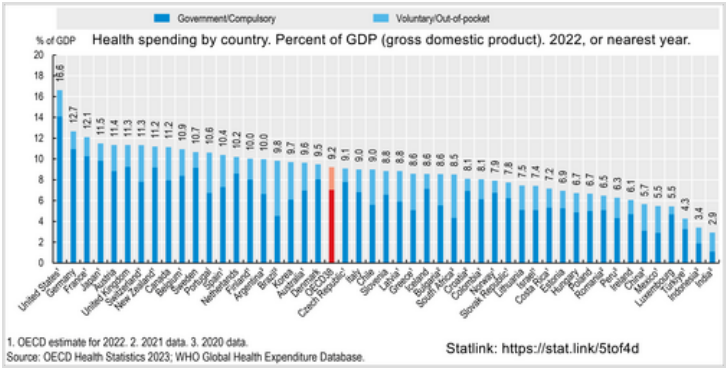
Country	Year
Algeria[9]	1975
Armenia[10]	2023
Australia	1975
Austria	1967
Bahrain	1957
Belgium	1945
Bhutan	1970
Brazil	1988
Brunei	1958
Canada	1966
China	2009
Cyprus	1980
Denmark	1973
Finland	1972
France	1974
Germany	1941
Greece	1983
Hong Kong	1993
Iceland	1990
Indonesia	2014
Ireland	1977
Israel	1995
Italy	1978
Japan	1961[11][12]
Kuwait	1950
Luxembourg	1973
Malaysia	1980s
Netherlands	1966
New Zealand	1938
Norway	1956[13]
Portugal	1979
Russian SFSR	1918[14][15]

1995.[38] India introduced a tax-payer funded decentralised universal healthcare system as well as comprehensive public and private health insurances that helped reduce mortality rates drastically and improved healthcare infrastructure across the country dramatically.[39] A 2012 study examined progress being made by these countries, focusing on nine in particular: Ghana, Rwanda, Nigeria, Mali, Kenya, Indonesia, the Philippines and Vietnam.[40][41]

Country	Year
Saudi Arabia	2019
Singapore	1993
Slovenia	1972
South Korea	1988
Spain	1986
Sweden	1955
Switzerland	1994
Taiwan	1995
Turkey[16]	2003
United Arab Emirates	1971
United Kingdom	1948

Currently, most industrialized countries and many developing countries operate some form of publicly funded health care with universal coverage as the goal. According to the National Academy of Medicine and others, the United States is the only wealthy, industrialized nation that does not provide universal health care. The only forms of government-provided healthcare available are Medicare (for elderly patients above age 65 as well as people with disabilities), Medicaid (for low-income people),[42][43] the Military Health System (active, reserve, and retired military personnel and dependants), and the Indian Health Service (members of federally recognized Native American tribes).

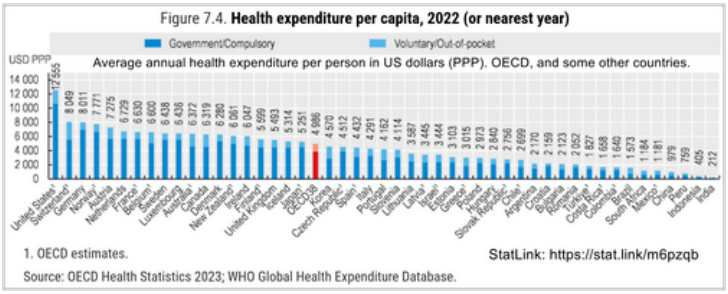
Funding models



Health spending by country. Percent of GDP (Gross domestic product). For example: 11.2% for Canada in 2022. 16.6% for the United States in 2022.[44]

Universal health care in most countries has been achieved by a mixed model of funding. General taxation revenue is the primary source of funding, but in many countries it is supplemented by specific charge (which may be charged to the individual or an employer) or with the option of private payments (by direct or optional insurance) for services beyond those covered by the public system. Almost all European systems are financed through a mix of public and private contributions.[45] Most universal health care systems are funded primarily by tax revenue (as in Portugal,[45] India, Spain, Denmark and Sweden). Some nations, such as Germany, France,[46] and Japan,[47] employ a multi-payer system in which health care is funded by private and public contributions. However, much of the non-government funding comes from contributions from employers and employees to regulated non-profit sickness funds. Contributions are compulsory and defined according to law. A distinction is also made between municipal and national healthcare funding. For example, one model is that the bulk of the healthcare is funded by the municipality, specialty healthcare is provided and possibly funded by a larger entity, such as a municipal co-operation board or the state, and medications are paid for by a state agency. A paper by Sherry A. Glied from Columbia University found that universal health care systems are modestly redistributive and that the progressivity of health care financing has limited implications for overall income inequality.[48]

Compulsory insurance



Total healthcare cost per person. Public and private spending. US dollars PPP. For example: $6,319 for Canada in 2022. $12,555 for the US in 2022.[44]

This is usually enforced via legislation requiring residents to purchase insurance, but sometimes the government provides the insurance. Sometimes there may be a choice of multiple public and private funds providing a standard service (as in Germany) or sometimes just a single public fund. Healthcare in Switzerland is based on compulsory insurance.[49][50]

In some European countries where private insurance and universal health care coexist, such as Germany, Belgium and the Netherlands, the problem of adverse selection is overcome by using a risk compensation pool to equalize, as far as possible, the risks between funds. Thus, a fund with a predominantly healthy, younger population has to pay into a compensation pool and a fund with an older and predominantly less healthy population would receive funds from the pool. In this way, sickness funds compete on price and there is no advantage in eliminating people with higher risks because they are compensated for by means of risk-adjusted capitation payments. Funds are not allowed to pick and choose their policyholders or deny coverage, but they compete mainly on price and service. In some countries, the basic coverage level is set by the government and cannot be modified.[51]

The Republic of Ireland at one time had a "community rating" system by VHI, effectively a single-payer or common risk pool. The government later opened VHI to competition, but without a compensation pool. That resulted in foreign insurance companies entering the Irish market and offering much less expensive health insurance to relatively healthy segments of the market, which then made higher profits at VHI's expense. The government later reintroduced community rating by a pooling arrangement and at least one main major insurance company, Bupa, withdrew from the Irish market.

In Poland, people are obliged to pay a percentage of the average monthly wage to the state, even if they are covered by private insurance.[52] People working under a employment contract pay a percentage of their wage, while entrepreneurs pay a fixed rate, based on the average national wage. Unemployed people are insured by the labor office.

Among the potential solutions posited by economists are single-payer systems as well as other methods of ensuring that health insurance is universal, such as by requiring all citizens to purchase insurance or by limiting the ability of insurance companies to deny insurance to individuals or vary price between individuals.[53][54]

Single-payer

Single-payer health care is a system in which the government, rather than private insurers, pays for all health care costs.[55] Single-payer systems may contract for healthcare services from private organizations, or own and employ healthcare resources and personnel (as was the case in England before the introduction of the Health and Social Care Act). In some instances, such as Italy and Spain, both these realities may exist at the same time.[17] "Single-payer" thus describes only the funding mechanism and refers to health care financed by a single public body from a single fund and does not specify the type of delivery or for whom doctors work. Although the fund holder is usually the state, some forms of single-payer use a mixed public-private system.

Tax-based financing

In tax-based financing, individuals contribute to the provision of health services through various taxes. These are typically pooled across the whole population unless local governments raise and retain tax revenues. Some countries (notably Spain, the United Kingdom, Ireland, New Zealand, Italy, Brazil, Portugal, India and the Nordic countries) choose to fund public health care directly from taxation alone. Other countries with insurance-based systems effectively meet the cost of insuring those unable to insure themselves via social security arrangements funded from taxation, either by directly paying their medical bills or by paying for insurance premiums for those affected.

Social health insurance

In a social health insurance system, contributions from workers, the self-employed, enterprises and governments are pooled into single or multiple funds on a compulsory basis. This is based on risk pooling.[56] The social health insurance model is also referred to as the **Bismarck Model**, after German Chancellor Otto von Bismarck, who introduced the first universal health care system in Germany in the 19th century.[57] The funds typically contract with a mix of public and private providers for the provision of a specified benefit package. Preventive and public health care may be provided by these funds or responsibility kept solely by the Ministry of Health. Within social health insurance, a number of functions may be executed by parastatal or non-governmental sickness funds, or in a few cases, by private health insurance companies. Social health insurance is used in a number of Western European countries and increasingly in Eastern Europe as well as in Israel and Japan.[58]

Private insurance

In private health insurance, premiums are paid directly from employers, associations, individuals and families to insurance companies, which pool risks across their membership base. Private insurance includes policies sold by commercial for-profit firms, non-profit companies and community health insurers. Generally, private insurance is voluntary in contrast to social insurance programs, which tend to be compulsory.[59]

In some countries with universal coverage, private insurance often excludes certain health conditions that are expensive and the state health care system can provide coverage. For example, in the United Kingdom, one of the largest private health care providers is Bupa, which has a long list of general exclusions even in its highest coverage policy,[60] most of which are routinely provided by the National Health Service. In the Netherlands, which has regulated competition for its main insurance system (but is subject to a budget cap), insurers must cover a basic package for all enrollees, but may choose which additional services they offer in supplementary plans; which most people possess .

The Planning Commission of India has also suggested that the country should embrace insurance to achieve universal health coverage.[61] General tax revenue is currently used to meet the essential health requirements of all people.

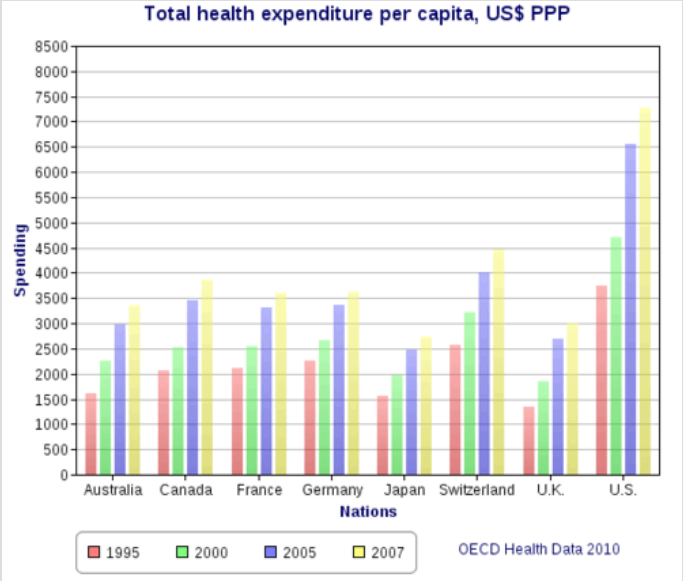
Community-based health insurance

A particular form of private health insurance that has often emerged, if financial risk protection mechanisms have only a limited impact, is community-based health insurance.[62] Individual members of a specific community pay to a collective health fund which they can draw from when they need medical care. Contributions are not risk-related and there is generally a high level of community involvement in the running

of these plans. Community-based health insurance generally only play a limited role in helping countries move towards universal health coverage. Challenges includes inequitable access by the poorest[63] that health service utilization of members generally increase after enrollment.[62]

Implementation and comparisons

Universal health care systems vary according to the degree of government involvement in providing care or health insurance. In some countries, such as Canada, the UK, Italy, Australia, and the Nordic countries, the government has a high degree of involvement in the commissioning or delivery of health care services and access is based on residence rights, not on the purchase of insurance. Others have a much more pluralistic delivery system, based on obligatory health with contributory insurance rates related to salaries or income and usually funded by employers and beneficiaries jointly.



Health spending per capita, in US$ purchasing power parity-adjusted, among various OECD countries. For later data see List of countries by total health expenditure per capita.

Sometimes, the health funds are derived from a mixture of insurance premiums, salary-related mandatory contributions by employees or employers to regulated sickness funds, and by government taxes. These insurance based systems tend to reimburse private or public medical providers, often at heavily regulated rates, through mutual or publicly owned medical insurers. A few countries, such as the Netherlands and Switzerland, operate via privately owned but heavily regulated private insurers, which are not allowed to make a profit from the mandatory element of insurance but can profit by selling supplemental insurance.

Universal health care is a broad concept that has been implemented in several ways. The common denominator for all such programs is some form of government action aimed at extending access to health care as widely as possible and setting minimum standards. Most implement universal health care through legislation, regulation, and taxation. Legislation and regulation direct what care must be provided, to whom, and on what basis. Usually, some costs are borne by the patient at the time of consumption, but the bulk of costs come from a combination of compulsory insurance and tax revenues. Some programs are paid for entirely out of tax revenues. In others, tax revenues are used either to fund insurance for the very poor or for those needing long-term chronic care.

A critical concept in the delivery of universal healthcare is that of population healthcare. This is a way of organizing the delivery, and allocating resources, of healthcare (and potentially social care) based on populations in a given geography with a common need (such as asthma, end of life, urgent care). Rather than focus on institutions such as hospitals, primary care, community care etc. the system focuses on the population

with a common as a whole. This includes people currently being treated, and those that are not being treated but should be (i.e. where there is health inequity). This approach encourages integrated care and a more effective use of resources.[64]

The United Kingdom National Audit Office in 2003 published an international comparison of ten different health care systems in ten developed countries, nine universal systems against one non-universal system (the United States), and their relative costs and key health outcomes.[65] A wider international comparison of 16 countries, each with universal health care, was published by the World Health Organization in 2004.[66] In some cases, government involvement also includes directly managing the health care system, but many countries use mixed public-private systems to deliver universal health care.

Overview of Health Coverage Reports

The 2023 report from the WHO and the World Bank indicates that the advancement towards Universal Health Coverage (UHC) by the year 2030 has not progressed since 2015. The UHC Service Coverage Index (SCI) has remained constant at a score of 68 from 2019 to 2021. It is reported that catastrophic out-of-pocket (OOP) health expenditures have impacted over 1 billion individuals globally. Additionally, in the year 2019, it was found that 2 billion people experienced financial difficulties due to health expenses, with ongoing, significant disparities in coverage. The report suggests several strategies to mitigate these challenges: it calls for the acceleration of essential health services, sustained attention to infectious disease management, improvement in health workforce and infrastructure, the elimination of financial barriers to care, an increase in pre-paid and pooled health financing, policy initiatives to curtail OOP expenses, a focus on primary healthcare to reinforce overall health systems, and the fortification of collaborative efforts to achieve UHC. These measures aim to increase health service coverage by an additional 477 million individuals by the year 2023 and to continue progress towards covering an extra billion people by the 2030 deadline.[67][68]

Criticism and support

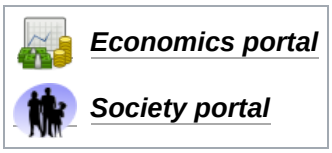
Critics of universal healthcare claim that it leads to longer wait times and a decrease in the quality of healthcare.[5] They claim that quality is lower due to budget constraints and overburdened medical staff. For example, many patients in Canada may go to the United States for medical care due to the long wait times.[69] Some believe that government-run healthcare systems are less efficient than private ones, leading to potential waste and mismanagement.[70] Other critics point out the potential of overuse and abuse leading to insolvency.[71] Relatedly, some also argue that universal health care can be extremely expensive for governments to maintain, leading to higher taxes and potential strain on public finances, such as those in the Nordic countries, Australia, and New Zealand.[72] For countries that do not currently have universal healthcare like the United States, they argue it would raise healthcare expenditures due to the high cost of implementation that the United States government supposedly cannot afford.[5]

However, most of the resistance to universal healthcare in the United States is rooted in ideology. For example, critics of implementing universal healthcare in the United States claim that it would require healthy people to pay for the medical care of unhealthy people, which goes against the American values of personal responsibility. Also, they argue it represents unnecessary government overreach into the lives of American citizens and

employers as it denies them individual choice. In other words, it may limit the choices available to patients, as the government may control which treatments and medications are covered. Lastly, it would unfairly limit the healthcare and health insurance industry.[5]

According to a 2020 study published in *The Lancet*, the proposed Medicare for All Act would save 68,000 lives and $450 billion in national healthcare expenditure annually.[73] A 2022 study published in the *PNAS* found that a single-payer universal healthcare system would have saved 212,000 lives and averted over $100 billion in medical costs during the COVID-19 pandemic in the United States in 2020 alone.[74] Given the high prevalence of uninsured and under-insured people in the United States, if implemented, universal health care would increase health care access for more than 25 million Americans.[75]

See also



- Health care
- Health care rationing
- Health economics
- Health promotion
- Health law
- Health insurance cooperative
- Health spending as a percent of GDP by country (gross domestic product)
- Healthcare reform debate in the United States
- Incremental cost-effectiveness ratio
- List of countries by health insurance coverage
- List of countries by total health expenditure per capita
- List of countries with universal health care
- National health insurance
- Primary healthcare
- Public health
- Publicly funded health care
- Right to health
- Single-payer healthcare
- Socialized medicine
- Two-tier healthcare
- Universal Health Coverage Day

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