

insurance funds showed a small decline in the relationship of benefit payments to premiums written between 1973 and 1974—from 73.4 percent to 71.7 percent. The four largest State funds—California, New York, Ohio, and Washington—dominate this sector, and all but Washington evidenced faster growth in premiums than in benefits in 1974, but the reason for this pattern is not evident. The average loss ratio for State funds, with those three States excluded, rose by two percentage points, a rate similar to that in the private insurance sector.

The loss ratios for private carriers and, to some extent, those for State funds do not take into account the premium income that is returned to employers in the form of dividends. Data secured from State insurance commissions reveal that dividends under private work injury policies in the 1960's amounted to 4-6 percent of premiums in the jurisdictions reporting this information. If the loss ratios mentioned above were adjusted to allow for dividends, they would be increased by about three percentage points.

Social Security Abroad

Foreign Health Programs: Changes in Population Covered*

An analysis of data available on national health programs throughout the world indicates that, in general, the percentage of population covered has increased significantly over the past 20 years. The developed countries, with few exceptions, already had national health programs of long standing at the beginning of this period, but in most cases large segments of the population were still excluded. In the intervening years, however, coverage has been extended to the point where the general pattern is now one of nearly universal coverage.

The term "national health program" here refers to a nationwide health care delivery system.

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with some degree of government participation, either in administration or financing. Basically, two types of programs can be distinguished: (a) national health insurance, where coverage is not necessarily universal and usually depends on payment of premiums and other preconditions for eligibility such as employment in certain work categories, and (b) national health service, under which comprehensive medical services, basically financed by general revenue, are made available usually to the whole population, some traces of an insurance approach may exist—the payment of a small premium, for example, but they are not central to the system. The term does not generally include public medical care programs that provide only limited services or reach only a portion of the total population in a given country.

Coverage in a large number of developing countries has also expanded considerably. Yet, since only a small portion of the population was generally covered initially, the number of people still excluded often remains large. In the developing countries that have become independent in the past 20 years coverage is especially low. In fact, very few have instituted national health programs although many provide limited care through public health facilities. In both the developing and the developed countries the agricultural worker has generally been among the last elements of the population to obtain coverage.

The accompanying table shows increases in coverage for a number of countries during the 15-year period from 1955 to 1970. The countries selected are representative of various geographical areas and different stages of economic development. For the sake of brevity, countries without any significant changes in coverage during this period have not been included. The table also excludes countries such as New Zealand, Sweden, the Soviet Union, and the United Kingdom where, during the entire period under review, virtually all of the population has been entitled to medical care and has usually been covered for such care under a national health service.

WESTERN EUROPE

Most European countries have evolved systems originally patterned after the pioneering national health insurance program established in Germany.

Percentage of population covered under national health programs, selected countries, 1955 and 1970¹

Country	Percent covered	
	1955	1970
Australia	45	90
Austria	70	92
Belgium	63	99
Canada	19	99
Chile	65	80
Costa Rica	13	48
Denmark	86	94
France	48	98
Germany, Federal Republic of	76	90
India	1	3
Italy	60	91
Japan	86	100
Mexico	5	23
Netherlands	64	76
Poland	56	99
Switzerland	63	89
Turkey	1	10
Venezuela	49	20
Yugoslavia	39	100

¹ Excludes countries—New Zealand, the Soviet Union, Sweden, and the United Kingdom, for example—where virtually the entire population has been entitled to medical care and covered for such care, usually under a national health service from at least 1955 on

² 100-percent coverage achieved in Australia in 1975, in Denmark in 1973

³ Data for 1972

⁴ Data for 1966

⁵ Estimate derived from Milton J. Roemer, *International Labor Review*, July 1973, pp. 1-23, and information from the Pan American Health Organization

⁶ Based on data from the Organization of American States

⁷ Data for 1957

Source: International Labor Organization, *The Cost of Social Security*, Geneva, 1972, pp. 388-87, United Nations *Statistical Yearbook*, 1958 edition, European Economic Community, *Exposé sur l'évolution de la situation sociale dans la Communauté en 1971*, Brussels, 1972, International Social Security Association, *Volume and Cost of Sickness Benefits in Kind and Cash (1967-1970)*, Part I, 1973

in 1883¹ In these systems coverage is not universal but is contingent on a connection with the labor force and involves the insurance principle of premium payments, usually in the form of payroll deductions. As they have moved toward universality of coverage, most systems have abandoned the once widespread practice of excluding workers with earnings above a certain ceiling, but the German system still employs this principle. Even there, however, considerable liberalization in this respect in recent years has been the major factor behind the increase in German coverage from 76 percent in 1955 to 90 percent in 1970. Most of the noncovered portion of the population is accounted for by people earning above the ceiling who chose not to enroll during a 3-week open season declared in 1971.

Growth in coverage in France has been particularly noteworthy, rising from 48 percent in 1955 to 98 percent in 1970. This growth has been due largely to the extension of eligibility to self-employed farmers in 1961 and to the nonagricul-

tural self-employed in 1966. In Italy, also, coverage increased substantially during this time with the inclusion of new groups, such as handicraft workers and certain independent professions (principally lawyers and journalists).

At the present time the Netherlands is an exception to the general pattern of nearly universal coverage for medical care in Western Europe, since only 76 percent of the population has access to health care under the general health program. The excluded categories are mainly those with earnings above a certain ceiling. Even this portion of the population has been covered, however, for catastrophic types of illness in a special, universal program inaugurated in 1967.

SOVIET UNION, EASTERN EUROPE, AND CHINA

Most Communist countries have established national health services to provide medical care that is basically funded by general revenue and is essentially free at the point of delivery. Nonetheless, there have been a number of departures from this general pattern over the years. The Soviet Union did not adopt the principle of financing exclusively by general revenue for its medical care until 1937. Before that time, funds were largely obtained from the same source as those for its overall social insurance system—wage-related premiums paid by the insured worker's employer.

Until recently, Poland and Yugoslavia did not adhere to the principle of universal coverage. Elements of the insurance approach persisted in both countries, with certain portions of the population excluded by restricting eligibility to certain categories of workers and their families. The modest coverage of the mid-fifties was subsequently increased considerably by including the farmer, who in these agriculturally oriented economies represented a large part of the total population. Yugoslavia extended coverage to its agricultural population in 1960, but it was not until 1972 that Poland took action to include the great bulk of the farming population.

Mainland China represents another departure from the traditional pattern in Communist countries. Throughout the fifties the country continued to rely on a national program, based mainly on employer liability, that extended limited medical

¹ See Joseph G. Simanis, *National Health Systems in Eight Countries*, Social Security Administration, Office of Research and Statistics, 1975

care to workers in manufacturing and their dependents. Over the years the number covered under this program has been gradually expanded and the services provided have been somewhat modified.

Of far more importance, however, has been the more recent development in that country of a parallel system of medical care in the countryside where approximately 80 percent of the population lives. Most rural inhabitants are now covered by this system begun after 1965, under which virtually all primary medical care is provided by an extensive network of lay practitioners known as "barefoot" doctors who have received rudimentary medical training. Serious cases are referred to centralized clinics with more highly trained personnel. The system is essentially self-supporting, financed by premiums from both the peasant and his commune and by various degrees of cost-sharing.

OTHER INDUSTRIALIZED COUNTRIES

The developed countries outside of Europe have, in general, also been moving toward universal coverage for medical care under government programs. Unlike the European countries, however, they have often had to develop programs where none existed before or to raise a generally low level of coverage.

During the last two decades, Canada, for example, instituted a new health system in two stages. The first, begun in 1958, was a program designed to provide hospital care on a universal basis. The second was begun about 10 years later and was aimed at providing physician services. As the table shows, approximately 19 percent of the population was covered in 1955 under programs that had been set up by a few of the Provinces. Coverage since then has been expanded through the nationwide arrangements mentioned above. By 1970 it had reached a virtually universal level.

Under Australia's program of government-subsidized private health insurance a considerable expansion also took place in coverage, which rose to the 90-percent level by 1970 from a relatively small base of 45 percent in 1955. The increase in membership, which has been completely voluntary, was most rapid at the outset of the

period when the system was only 1 year old. In recent years, most of the noncovered population was to be found among the poor, even though a program existed for subsidizing premiums on an income-tested basis. On July 1, 1975, universal coverage was introduced in conjunction with a new national health service that came into effect on that date.

Developments in Japan have followed a pattern closer to the European. From a fairly high base of 66 percent in 1955, coverage has become virtually universal. Nationwide coverage was actually attained by 1961, and the greatest period of expansion took place in the 3 years after 1958 when an act was passed that ordered all local authorities to establish by 1962, if they had not already done so, public medical insurance mechanisms. At the same time, membership was made compulsory for all persons not already insured. Large groups of the citizenry were affected—mainly farmers, the self-employed, and employees of small establishments.

Israel is usually considered a departure from the general pattern in developed countries since it has not yet adopted a government health program. It does, however, have a nationwide health care system administered by the trade unions that covers about 85 percent of the economically active population and their dependents. The United States, since July 1966, has provided government hospital and medical care insurance that now covers most persons aged 65 or over and some categories of disabled persons. These groups constitute about 10 percent of the overall population.

LATIN AMERICA

In Latin America as in Europe, most countries already had national health systems in 1955, and the few that did not, in general, have since instituted them. The trend in coverage has also been upward but, starting at a lower level than in Europe, it has remained substantially lower up to the present time. In Chile, however, coverage has been exceptionally high. It already had 55-percent coverage in 1956, and by 1970 it had raised the level to 80 percent, most of the remaining 20 percent of the population is entitled to receive free health care under government aus-

pices as medical indigents. When the Chilean system was first established in 1924, it followed the early European pattern in restricting coverage to relatively low-income blue-collar workers. Coverage was gradually extended to dependents and to workers with high incomes. In 1968 a particularly large increase occurred as white-collar workers became eligible for medical care under a separate program.

Coverage in Latin America has usually been limited to certain categories of employed persons, with agricultural workers the most notable exclusion. Mexico does not follow this pattern completely, the increase in coverage from 5 to 23 percent was achieved largely by extending eligibility to a significant number of rural laborers. Much of the population that is not yet covered is located in outlying rural areas that do not have access to adequate medical care resources. In most other Latin American countries, health systems have also been initially limited to a few heavily populated areas from which they are only gradually extended to the rest of the country. This has been the pattern in Venezuela and Costa Rica, for example.

Like Chile, a number of countries follow the early European practice of limiting coverage at least initially to workers with earnings below a set ceiling. Much of the increase in Costa Rica's coverage in recent years has been due to increases in the ceiling.

As in other developing areas, expansion of health care delivery in Latin America has taken place against a background of particularly rapid population growth. Thus the seemingly modest percentage figures and their growth rates reflect a somewhat greater investment of resources than might be apparent. It is also worth noting that in many of these countries part of the population has access to free medical care in Government-operated networks of clinics and hospitals wherever such facilities have been established.

OTHER DEVELOPING COUNTRIES

Trends in the developing countries that have been independent for at least 2 decades have in general been similar to those experienced by Latin America. Countries that had no programs in 1955 have established them in the interim. The number covered has also increased. Nevertheless, the population covered remains at an appreciably lower proportion than that in their Latin American counterparts as the data for Turkey and India indicate. In India, however, publicly provided medical care is not so limited as the data in the table suggest. If Government workers and others entitled to organized public medical care are added to those covered under social insurance, the total would be approximately 10 percent, instead of the 3 percent indicated.

The pattern in the newly dependent countries is one of even lower coverage. Few of these countries, in fact, have established national health systems. Data for the 60 countries that have achieved their independence since 1958, show that only about one-tenth have adopted nationwide health programs.² Some of these countries, however, like others in the developing world, provide health care to the populace in a limited number of publicly operated medical facilities. A number of countries have also established public programs seeking to provide rudimentary health care by more effectively organizing resources at the community level. On the assumption that such an approach is the most promising way—within existing limitations on available resources—to improve health care for the greatest number possible, the World Health Organization and other organizations involved in development assistance have been urging increased emphasis on this type of community-based medical care.

² Social Security Administration, Office of Research and Statistics, *Social Security Programs Throughout the World, 1973* (Research Report No. 44), 1974.