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Trends in time: Identifying health care system introductions worldwide

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Abstract

The present research aims to identify the *timing* of health care system introductions in countries across the globe, an event which represents the state's assumption of substantial responsibility in the health (care) of its people. In doing so, we especially look for *trends in time*, which refers to the clustering of system introductions over a distinct period, whether marked by shared historical experiences or by simple virtue of their proximity in years. Our study is structured as follows: First, we set out to identify the introduction date of each country's system starting in 1883 with the creation of the first health care system in the world. We then proceed to map out introduction dates for the entire period of observation and all countries to explore whether *trends* emerge. Looking beyond domestic factors that are traditionally associated with the development of social policies, we explore the potential impact of transnational events as drivers of social policy change, such as de-colonization, membership in international organizations, and the introduction of a health care system in a neighboring country. While the present paper does not tease out the explanatory factors contributing to the rise of health care systems worldwide, by identifying trends in their timing, our study provides important clues as to the potential influences of transnational interdependencies in driving social policy, as well as points to future avenues for comparative research.

Zusammenfassung

Die Einführung eines Gesundheitssystems ist ein Ereignis, das die Übernahme wesentlicher Verantwortung des Staates für die Gesundheitsversorgung seiner Bevölkerung darstellt. Ziel der vorliegenden Untersuchung ist es, den Zeitpunkt dieses Ereignisses für Länder auf der ganzen Welt zu identifizieren sowie anhand ähnlicher historischer Erfahrungen oder zeitlicher Nähe nach Trends zu suchen, die sich auf die Häufung von Systemeinführungen über einen bestimmten Zeitraum beziehen. Die Studie ist wie folgt aufgebaut: Beginnend mit dem Jahr 1883, als das erste Gesundheitssystem der Welt entstand, werden zunächst die Einführungsdaten der Gesundheitssysteme in den einzelnen Ländern ermittelt. Anschließend werden die Einführungsdaten für den gesamten Beobachtungszeitraum und alle Länder beschrieben und abgebildet, um zu untersuchen, ob sich bestimmte Trends abzeichnen. Während inländische Faktoren traditionell mit der Entwicklung von Sozialpolitik in Verbindung gebracht werden, stehen darüber hinaus transnationale Ereignisse, wie z. B. Entkolonialisierung, die Mitgliedschaft in internationalen Organisationen und die Einführung eines Gesundheitssystems in einem Nachbarland, als Triebkräfte des sozialpolitischen Wandels im Vordergrund dieser Untersuchung. Wenngleich in der vorliegenden Arbeit keine erklärenden Faktoren, welche zum Aufstieg von Gesundheitssystemen weltweit beitragen, herausarbeitet werden, liefert die vorliegende Studie durch die Identifizierung von Trends im zeitlichen Verlauf wichtige Hinweise auf die potenziellen Einflüsse transnationaler Interdependenzen bei der Steuerung der Sozialpolitik und weist auf zukünftige Wege für die vergleichende Forschung hin.

Contents

1. Introduction

The aims of health care are both manifold and ambitious, spanning a wide range of activities to improve, maintain and prevent the deterioration of the health status of individuals, as well as to mitigate the consequences of ill-health through qualified health knowledge (de Carvalho & Fischer, 2020). Given the breadth of this mission and its bearing on people's lives, the emergence of the *health care system under public responsibility* (hereafter health care system) represents a groundbreaking event in social policy history in a country – one in which the state takes on responsibility for the financing, provision, and/or regulation of health care.

Of all social policies, health care is said to be the most controversial, constituting a "boundary issue" of the welfare state as it is not automatically accepted as part of the social protection package such as unemployment insurance and pension plans (Derthick, 1980; Immergut, 1992). According to Immergut (1992), the introduction of health policies represents the division between liberalism/free market and socialism/planned economy, and, therefore, is a highly politicized issue that involve numerous societal players. In analyzing the timing of health care system introductions worldwide, we may understand when political processes result in the extension of social rights across the globe, which advances our understanding about the politics of the welfare state in general, and when health care in included in the political agenda. Further, its timing reflects the moment in which the state no longer relegates the totality of risk associated with illness and injury to the individual, family, or societal actors. Put differently, the state finally 'steps up' in a fundamental area of social protection. While the degree of state involvement in health care may vary wildly over space and time, all system introductions share in the significance of this turning point at which the state's policy trajectory shifts to pursue a commitment – even if minimal – to the health of its people.

In the present study, we set out to identify this point in time for countries across the globe, asking the two-fold question: *When do health care systems emerge and can patterns be identified in the timing of system introductions?* To address the latter, we look beyond established domestic factors associated with welfare state developments, such as economic growth or the role of political parties, to explore the potential impact of major transnational events as drivers of social policy change, indicating possible causal explanations to be investigated in future research. More specifically, we examine whether the timing of health care system introductions worldwide clusters around one or several of the following events: (1) political independence following de-colonialization and leading to a period of nation building; (2) membership in an international organization (IO) concerned with health; and (3) the introduction of a health care system in a neighboring country. Crucially, by focusing on major transnational events we do not argue against the significance of domestic factors rather we expand our analytical horizon to include the space in which the domestic meets the regional or global and becomes transnational and interdependent.

In what follows, we begin by discussing the main tenets of classical welfare state and comparative social policy theories, before proceeding to more recent scholarship – the insights of which inform the present study: *global social policy theory* and the *transnational interdependencies' framework* (TIF) (CRC, 2018; Deacon, 2007; Kaasch, 2012; Obinger, et al. 2012; Nullmeier et al., 2021). We then describe our research design and methods, including our operationalization of key concepts. Following this, we present our findings under each major transnational event and discuss their importance for understanding the timing of system introductions. We conclude by reflecting on

the strength and limitations of our study, as well as with next steps for research.

2. Theoretical background: what drives health care system introductions?

To be able to understand what drives health care system introductions, it is first necessary to pause and consider what is meant by a health care system itself. Different definitions can be found in extant scholarship, as health care systems are a 'conceptual moving target' that reflect the researcher's goals, choices and interests (Frisina Doetter et al., 2021). The present study defines healthcare system as "the sum of all formal arrangements concerning financing, regulation and provision of qualified health services within a society dealing specifically with healthcare as an area of social protection" (de Carvalho & Fischer, 2020, p. 12). As concerns the definition of health care system *introductions*, here social scientific literature has not been as abundant (de Carvalho & Fischer, 2020). The complexity of developing a concept that can capture the beginning of a health care scheme lies in the fact that they are a sum of processes and practices, and different ways to measure their introduction can be adopted (Frisina Doetter et al., 2018). As previously mentioned, this research focuses on systems in which there is involvement of the state in health care. Further, the initial involvement of the *central* state is a necessary condition for the introduction of a system, as observing regional variation within states is beyond the scope of this research. However, this does not exclude non-state actors from having a role in the system. In line with de Carvalho and Fischer (2020), we hold three conditions as necessary to identify the introduction of a health care system. First, a first nation-wide legislation must be ratified. Second, entitlement to health care benefits must be enacted. And third and finally, the elements of the health care system must be integrated, i.e. the existence of a (set) of institution(s) mainly responsible for health care.

Existing literature on health care system introductions often concentrates on specific types of systems, such as social health insurance, or programs, such as vaccination and disease-related policies (e.g. Flora & Alber, 1982; Hu & Manning, 2010; Immergut, 1992; Köhler & Zacher, 1981). Scholarship dealing with the worldwide introduction of distinct and integrated health care systems for which there is substantial involvement by the state is lacking however. Further, literature that aims at explaining the emergence and ongoing reform of health care systems traditionally tends to look no farther than the boundaries of the nation-state. Health care, as all other areas of social policy, is viewed almost exclusively as a domestic policy issue, thus driven by developments from within. This line of thinking characterizes much classical welfare state and comparative social policy theories which put the onus of explanation on factors such as modernization (related to industrialization and urbanization) and *conflicts and power resources* in countries (e.g., Myles & Quadagno, 2002; Wilensky, 1975). As regards the former, modernization processes are said to represent a double-edged sword: on the hand, eroding traditional means of social protection through the family; on the other hand, affording the necessary economic growth for the establishment of health and other social protection programs.

The claims surrounding modernization as a driver of social policy expansion mainly rely on large sample quantitative studies. By way of example, research by Collier and Messick (1975) and Usui (1994) involving countries at varying stages of economic development point to the correlation between per-capita GDP and the early adoption of social protection schemes. In a similar vein, Schmitt et al. (2015) identify a positive effect of GDP on the adoption of health insurance in 177 territories and independent states over the

period of 1820 to 2013. Meanwhile, Kangas (2012) attribute higher levels of industrialization with the increased likelihood of health insurance introductions across 43 African nations. The impact of modernization as a driver of social policy would therefore appear robust. At closer examination, particularly involving smaller samples of cases or single case studies, however, this impact seems to wane. For instance, a look to the work of Cutler and Johnson (2004), which covers 20 OECD and Latin American countries, points to contradictory evidence: higher levels of GDP per capita are found to actually slow down the implementation of a national health insurance defined as compulsory coverage for a broad class of people. Based on such mixed results, it is therefore difficult to conclude as to whether or when modernization drives health care system introductions or rather hampers it.

Similar inconsistencies characterize a second strand of theory which looks to conflict and power resources within states as a source of explanation for social policy change. Such approaches emphasize the role of political regimes, particularly democratic representation and the power of left-wing parties and unions, as drivers of social protection (Korpi, 1983). Based on a sample of 76 cases, for example, Cutright (1965) finds that countries with more representative governments tend to introduce social security programs earlier than elsewhere. This evidence is contradicted, however, by the work of Flora and Alber (1982) and Mares and Carnes (2009) which points to monarchies or autocratic governments as early adopters of social policy. Within the context of the latter, early implementation of social policy is undertaken as a means to appease and control workers, to acquire output legitimacy and stabilize regimes with weak or without democratic legitimacy. Taken together, the competing claims found within this body of literature offer little clarity as to the precise role played by political regimes in contributing to health care system introductions.

Crucially, classical welfare state and comparative social policy theories are marked not only by mixed findings, but also by systematic shortsightedness. That is, scholarship tends to concentrate on high-income countries to the neglect of the Global South. Amongst other things, this means that the realities of social policy making and health care system developments in poorly resourced states go undetected (Deacon, 2007; Yeates, 2008). As examples, Blake and Adolino (2001), Immergut (1992), Köhler and Zacher (1981), Lin and Carroll (2006) study the introduction and evolution of social health insurance only in Western European countries. In recent decades, scholarship on health care systems of the Global South has expanded, however it still falls short in comparison to studies focusing on advanced economies (de Carvalho et al., 2020). Further, this growing literature mainly focuses on in-depth country analysis (e.g. Coleman, 2011; He & Wu, 2017; Tavecchi & Rebecchi, 2018), as well as regional comparisons of current systems (e.g. Azevedo, 2017; Balabanova et al., 2011; Mesa-Lago, 2007), resulting in a lack of systematic comparisons of health care system introductions worldwide. The limitations of such 'theoretical nationalism' do not only impact research on the Global South: social policy, including health care, in every country is said to now face similar challenges that may require solutions beyond the nation-state level (e.g., demographic changes, growing inequality, global socioeconomic crises) (Obinger et al., 2012; Kaasch, 2013).

Over the past few decades, newer strands of research coming from *global social policy* and, more recently, the TIF have emerged to address some of the theoretical and empirical shortcomings of classical approaches by introducing a new focus on the *transnational* context in which policy making unfolds (CRC, 2018; Deacon, 2007; Kaasch, 2012; Obinger et al., 2012; Yeates, 2008). The term 'transnational' is used here to capture the linkages between local, national, international, and/or supranational actors of

all stripes and colors across the boundaries of the national. In the case of global social policy theory, an analytical focus is decidedly placed more heavily on the side of international actors and processes – particularly in the form of aid and activities set in motion by international governmental and non-governmental organizations (see e.g. Kaasch, 2012; Yeates, 2008). The TIF, instead, follows a more balanced approach in seeing social policy as the result of *interdependencies* arising between and across all levels from the local and national to the regional and global (CRC, 2018; Obinger et al., 2012; Nullmeier et al., 2021). But what do interdependencies consist of and how can they come to affect health care system introductions?

2.1 Transnational interdependencies and health care system introduction

In attempting to explore the realm of the 'transnational' and its significance for health care system introductions, particularly with a view to the assumptions of the TIF (CRC, 2018), the role of interdependency between actors comes to the fore. That is, the acknowledgement that the actions of one actor may impact another and vice versa. This may involve the willful actions of actors such as the waging of a war. Or, it may involve involuntary actions and consequences – such as when the stock market crashes in one country causing ripple effects for other markets. When such relations between actors are systematic and cross-national borders, one can speak of a *transnational interdependencies*. It is important to note that interdependency does not necessarily imply symmetry, as actors may wield different amounts of influence in a relation (e.g., in the case of international aid, the donor organization can be said to wield more power than the receiving country that is dependent on financial assistance). But what types of actions and actors can be expected to play a role in driving health care system introductions?

To answer this question, we build on the assumptions of the TIF (CRC, 2018) and global health policy scholarship (Kaasch, 2012) by exploring the role of three transnational interdependencies: colonialism; membership in an international organization; and geographic proximity. More specifically, these interdependencies can be said to provide the context for specific *processes*[1] to emerge – whether with the onset of the interdependency, at some point during, or at its suspension – that capture a set of related happenings unfolding within a distinct period of time triggered by a major historical event: (1) post-colonial nation building processes following political independence and the conclusion of colonialism; (2) assimilation processes within a country following the event of joining an international organization concerned with health (i.e., the state of maintaining membership taken as a transnational interdependency); and (3) policy diffusion processes unfolding in countries that neighbor with a (regional) early adopter of a health care system (i.e., introduction of a health care system in a neighboring country is a major historical event). In what follows, we present the theoretical assumptions underlying each of these processes as they apply to health care system introductions.

Post-colonial nation building processes following political independence

The colonial legacy in health is most often associated with imperial public health measures to control contagious and parasitic

1 In line with discussion by Vayda et al. (1991), we use the term 'processes' to refer to a set of related events that occur within specific temporal parameters and which collectively lead to a given outcome. To establish the existence of a process entails going beyond loosely applied story telling but necessitates strong evidence of a relationship between events and between events and an outcome.

diseases in order to foster economic activity by keeping 'bodies' healthy enough to work (Lasker, 1977). This typically involved invasive means of behavioral control applied to indigenous populations, as well as the undermining of traditional healing practices. Colonial public health programs were often accompanied by a strong role for missionary hospitals, which eventually gave way to training centers for midwives and nurses and, in some instances, some of the earliest medical schools (Gros, 2016). In Africa, the basic infrastructure set up during the colonial period, especially by non-state actors, became the organizational bases for numerous post-colonial developments in health care. This also applied to epistemic communities: the British Medical Association, for example, had representation in Africa, while the political elite regularly received training in imperial institutions of higher education. Accordingly, the colonial period was marked by a great deal of exposure to Western understandings of the body, as well as the instrumentalization of that knowledge to keep labor supply abundant in the colonies.

With the advent of de-colonialization, political independence led to a period of nationalization, particularly in Africa, in which many newly formed governments took on health care and other social policy issues as a means of gaining legitimacy and forging a new national identity (Gros, 2016). Often, this translated to the government takeover of pre-existing colonial institutions in health. Thus, the policy and infrastructure that had been left behind by former imperial powers created a space for newly independent states to occupy as part of their nation building process. In the language of the TIF, this suggests that colonialization – a transnational interdependency – once disrupted by the event of political independence, may give way to a process of nation building that led to accelerated action in health and the introduction of a health care system in a country.

Assimilation processes following the joining of an international organization

With the development of new strands of scholarship in *global social policy* and *global health*, IOs have become one of the main protagonists in the study of social policies (Yeates, 2008; Kaasch, 2015). Beyond the obvious role of financing agents through aid and loans, these actors are also sources of ideas and normative standards, disseminators of models, promoters of policy exchange, as well as advocators of rights (Kaasch, 2013; de Carvalho et al., 2020). Considering health care, two IOs been especially active: The International Labor Organization (ILO) founded in 1919 and the World Health Organization (WHO) established in 1956 (Sirrs, 2020; Kaasch, 2021). Particularly for the countries of the Global South, where limited capacity in terms of economic and technical resource mobilization is a chronic issue, IOs play an important role in financing, providing services, and even regulating systems. These may result in an imbalance of power, making low-to-middle income countries more prone to international pressures and forces (Babb & Carruthers, 2008; Kaasch, 2013; de Carvalho et al., 2020). Accordingly, we assume that membership in an IO concerned with health policy quickens the introduction of a health care system in a country by triggering assimilation processes – whether shaped by normative changes through exposure to new policy ideas and learning or through more forceful means such as conditionality – in health care in the new member state. We anticipate that this will especially emerge in cases where dependency on international aid is high, as characterizes many countries in the Global South.

Policy diffusion processes following the introduction of a health care system in a geographically proximate country (regional neighborhood)

Geographic proximity has been found to play a role in social policy diffusion and transfer (Obinger et al., 2012). The main argument of this so-called *neighborhood effect* is that the closer the countries are located to each other, the more likely they are in contact, which may lead to the spread of ideas and normative standards, as well competition. Geographically close countries may influence each other as they have economic, cultural, and linguistic similarities (Beck et al., 2006). Further, spatial proximity intensifies communication between countries, as the exchange of information between neighbors is higher (Obinger et al., 2012). These shared ties may lead to the establishment of similar welfare state institutions (Maags, 2020). For instance, Schmitt and Obinger (2013) argue that policy examples from neighboring states are usually considered blueprints for domestic policies. In the present study, however, we add a temporal element to the neighborhood effect, assuming that countries belonging to the same region establish health care systems around the same period, thereby suggesting a process unfolding due to the major event of a system introduction within the area.

3. Methods

In order to identify trends in the timing of health care system introductions, this research descriptively shows when systems came into being over time. In doing so, we focus on systems in which there is substantial involvement of the state in health care. As previously state, systems under public responsibility are introduced when (a) the first nation-wide legislation is established; (b) entitlement to health care benefits is enacted; and (c) the elements of the health care system are integrated. The first condition reflects the scope of our research at the national level as the locus of legislative action. Thus, health care systems implemented only at the local level are excluded from the analysis, even when they precede nation-wide schemes[2]. The second condition refers to the establishment of statutory rights to medical care as opposed to voluntary benefits or sick pay. At last, the third condition allows us to distinguish health care systems from rudimentary and/or policies or programs.

We identify the introduction of health care systems under public responsibility through a five-step procedure: (1) the system must be introduced by legal act; (2) this legislation must be the first act of its kind ratified; (3) an institution or a set of institutions must be made explicitly responsible for health care; (4) the legal act must establish entitlements to health care; and (5) these entitlements must define the population group(s) that can access benefits/services. Table 1 summarizes our operationalization of system introduction. The practical approach to pinpoint system beginnings starts with expert- judgement, particularly found in extant scholarship, about when a healthcare system has been introduced in order to map potential starting dates. Second, we evaluate these possible introduction points against secondary literature, legal acts, and experts' validation and based on the aforementioned criteria for identifying health care system introductions. The earliest date at which all necessary conditions are met is taken as the introduction point. The introduction of the Uruguayan health care system illustrates our practical procedure (Table 2)[3].

To pinpoint introduction dates, we examine states with more than 500,000 inhabitants in 2017, resulting in a pool of 167 cas-

2 Even though we understand that the introduction of local systems may represent the first step towards establishing nation-wide schemes, for pragmatic purposes we limit our analysis to arrangements put in place by central governments, as legislations enacted by local governments are not easily found for 167 countries.

3 For a full account of the definition and operationalization employed in this research, see de Carvalho & Fischer, 2020.

Table 1.
Operationalization criteria for the introduction of health care systems under public responsibility

Conditions	Operationalization Criteria
Public responsibility	Introduced by nation-wide legislation
Entitlements to benefits	Definition of the population group for which is possible to receive benefits
Public responsibility AND entitlement to benefits	Entitlements must be established by legislation
Temporal criterion	First nation-wide legislation enacted
System integration	Existence of an institution or set of institutions explicitly responsible for health care

Source: de Carvalho & Fischer, 2020, p. 14.

Table 2.
Operationalization of health care system introductions – Practical procedure

Procedure	Potential Introduction Date I: 1910	Potential Introduction Date II: 1934
Expert judgement on system introduction	Government of Uruguay, 1913; Puñales, 2002; Ferrari, 2010	Muñoz et al., 2010; ISAGS, 2012; Government of Uruguay, 2020
Has it been introduced through nation-wide legislation?	Yes (Law No. 3724)	Yes (Law No. 9202)
Do entitlements define the population group of beneficiaries?	Yes (People suffering with diseases, homeless, disabled and elderly, pregnant women, and children)	Yes (residents of the country)
Are entitlements established by a legal act?	Yes (Law No.3724)	Yes (Law No. 9202)
Is there an institution, or set of institutions, responsible for healthcare?	Yes (Consejo de Salud Publica – Public Health Council)	Yes (Ministry of Public Health)
Is this the earliest date that meets the above criteria?	Yes	No
This is the beginning of the system?	Yes	No

Source: de Carvalho & Fischer, 2020, p.15.

es. Our period of observation starts in 1883 with the introduction of the first health care system in the world (Bärnighausen & Sauerborn, 2002; Busse et al., 2017; Light, 1985), and ends in 2015, when the last country established a system. Since the boundaries of states has changed over our period of observation, we also look for legislation in the sovereign states preceding those currently in existence. For nations which have been part of larger political unions or confederations and separated over the course of the observation period, as occurred particularly in Europe after the First World War and with the collapse of the Soviet Union, we trace back system beginnings to the first regulations effective in the respective territory. This means that, e.g., the Central Asian nations of Kazakhstan, Kyrgyzstan, Uzbekistan, Tajikistan, and Turkmenistan share the same introduction date, as the first health care system in these territories was implemented by legislation in the Soviet Union. Since our focus is on sovereign states legislations, we do not take into account the regulations of colonial administrations to identify the emergence of a healthcare system, as colonies were never fully integrated into the colonizing state, but an extra-territory where the rules applicable to the colonial power did not automatically apply. Thus, for former colonies, we only consider systems introduced *after independence* has been achieved[4].

Drawing from global social policy theory and the *TIF* framework, we observe whether

4 List with introduction dates and sources is available on Appendix C.

Table 3.
Operationalization criteria for the introduction of health care systems under public responsibility

Assumption	Operationalization
Political Independence	» The analyzed countries are former British, French, Portuguese, and Spanish colonies. We selected these colonial powers in line with Schmitt (2015, p. 332) as "all other colonial powers had either only a very few colonies or maintained their colonies for a much shorter duration". » When a country was colonized by more than one country, we consider it former colony of the last colonizer. » Independence year is set in accordance with the Correlates of War (CoW, 2021) » Countries that became independent before 1883 are excluded from the analysis, as health care systems did not exist at the time and, therefore, could not diffuse[5].
International Organizations	» ILO membership date[6]. » WHO membership date. » Countries of the Global South are operationalized according to the World Bank income group classification (World Bank 2021). We consider the Global South all countries that are not classified as high-income[7].
Neighborhood Effect	» We consider 'neighbors' countries belonging to the same region according to the UN geographical regions classification[8].

Source: own presentation.

the timing of system beginnings overlap with selected transnational events in order to indicate avenues for future explanatory research. As we assume that, given the complexity of the phenomena at hand, a considerable time-lag can arise between the event itself and the introduction of a health care system, we take a period of up to ten and/or 15 years as evidence of a *potential* relationship. The burden of proof for the latter, however, rests on future analysis. Bearing this mind, the present research is guided by the following three assumptions: [7][8]

a. Political Independence: Political independence leads to a period of nation building which accelerates the introduction of health care systems in former colonies.

b. IO Membership: Membership in an international organization concerned with health policy accelerates the introduction of a health care system in a country.

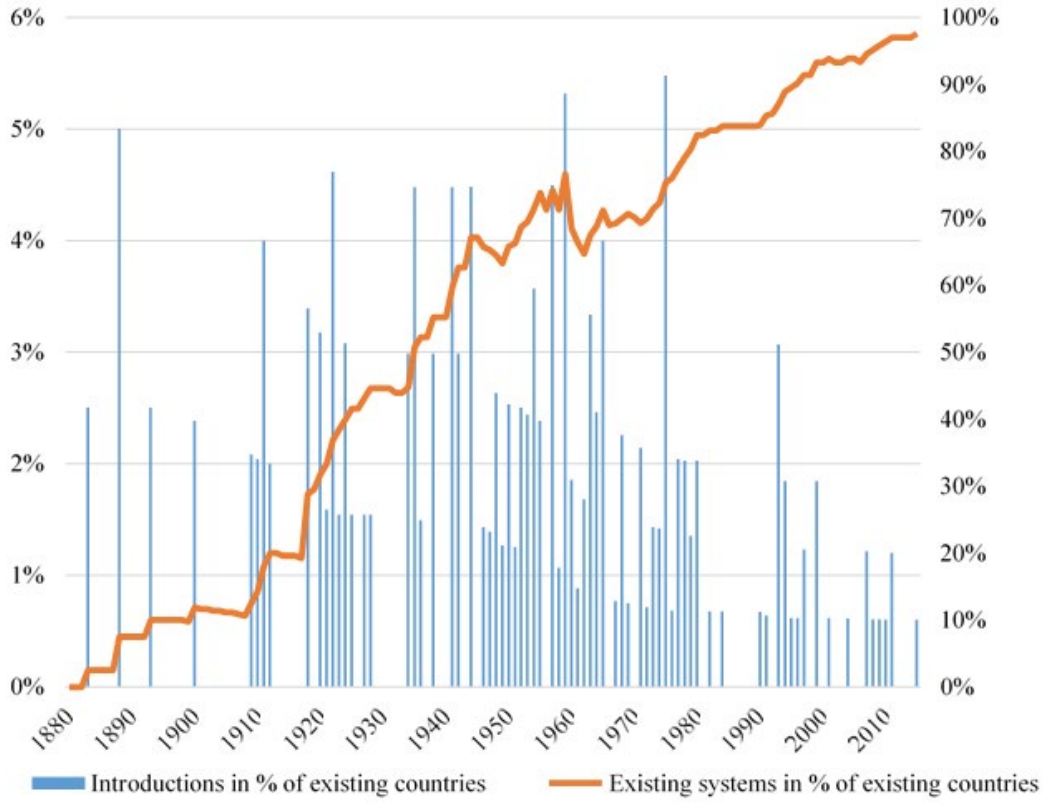
c. The Neighborhood Effect: The introduction of a health care system in a neighboring country accelerates the introduction of other systems within the region.

4. Results

This section presents the findings of our study. First, we elaborate on the temporal distribution of health care system introductions in order to identify potential clusters in time. Second, we examine whether the timing of system beginnings overlaps with political independence, membership in international organizations, and geographical proximity of a healthcare system introduction.

5 See Appendix B for independence dates and assigned colonizer.
6 See Appendix A for ILO and WHO membership dates.
7 See Appendix A for complete list of countries and World Bank income group classification.
8 See Appendix A for complete list of countries and UN geographical region classification.

Figure 1.
Temporal distribution of health care system introductions (health care system introductions as percentage of existing countries)



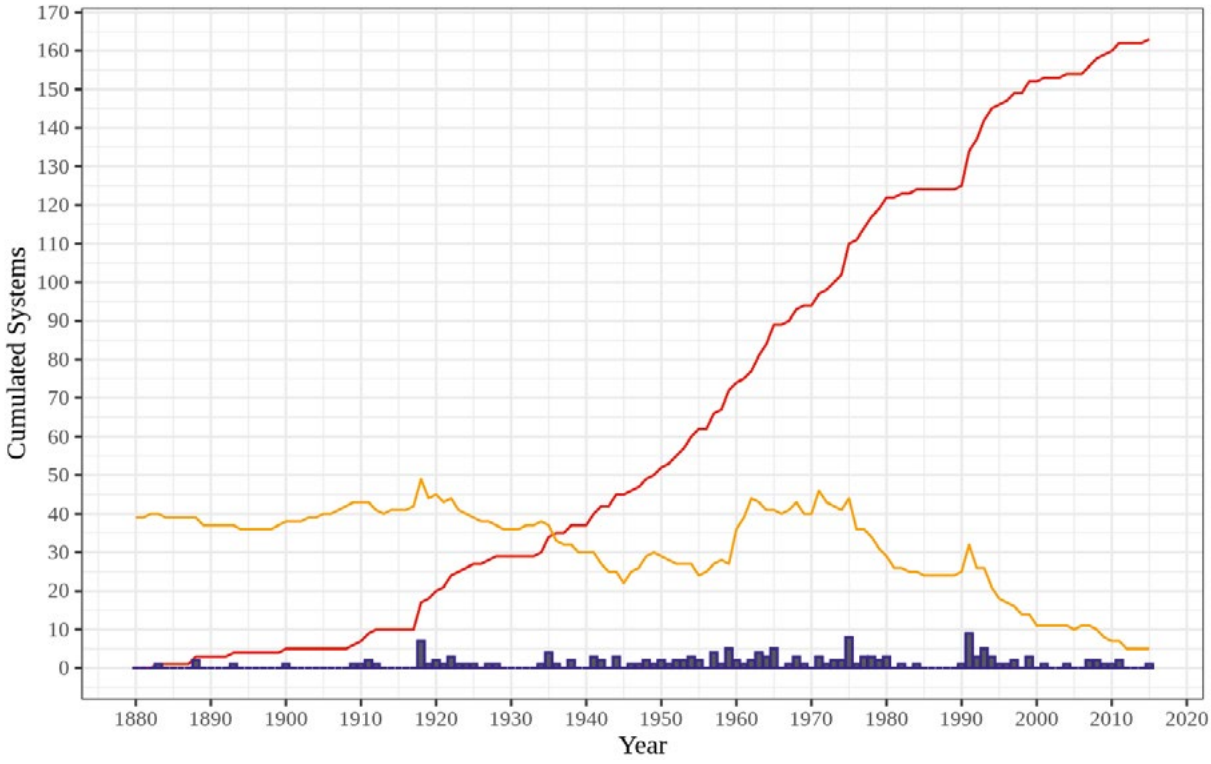
Source: own presentation.

Temporal distribution of health care system introductions

Our results suggest that 164 out of 167 countries currently have a health care system under public responsibility in place. Chad, Central African Republic, and Somalia are the only states with more than 500,000 inhabitants where the government does not have a substantial role in the field (by January 2021). The first health care system was established in 1883 in Germany, while the last country to adopt a system was Burkina Faso in 2015. Therefore, health care systems have been introduced over a span of 132 years.

Figure 1 displays the temporal distribution of health care system introductions as a percentage of existing countries. It is possible to observe several spikes in the graph, but 1888, 1959 and 1975 were the years in which the most countries adopted health care systems in relative terms. In 1888, Austria and Italy established systems, which represents 5% of all existing countries at the time of introduction. Egypt, Ethiopia, Honduras, Morocco, and Syria created schemes, accounting for 5.3% of the extant countries in 1959. At last, in 1975 Angola, Congo, Laos, Mali, Mauritius, Oman and Senegal put systems in place, making 1975 the year in which more countries adopted health care systems in both relative and absolute terms. Interestingly, the 1959 and the 1975 spikes represent developments mainly in countries of the Global South. Further, it is important to highlight that the Austrian empire and Russia created their systems in 1888 and 1912, respectively. In terms of current independent countries, these adoptions resulted in systems being put in place in Austria, Bosnia and Herzegovina, Croatia, Czech Republic,

Figure 2.
Absolute and cumulative number of health care system introductions by the number of adoption candidates



Source: own presentation.

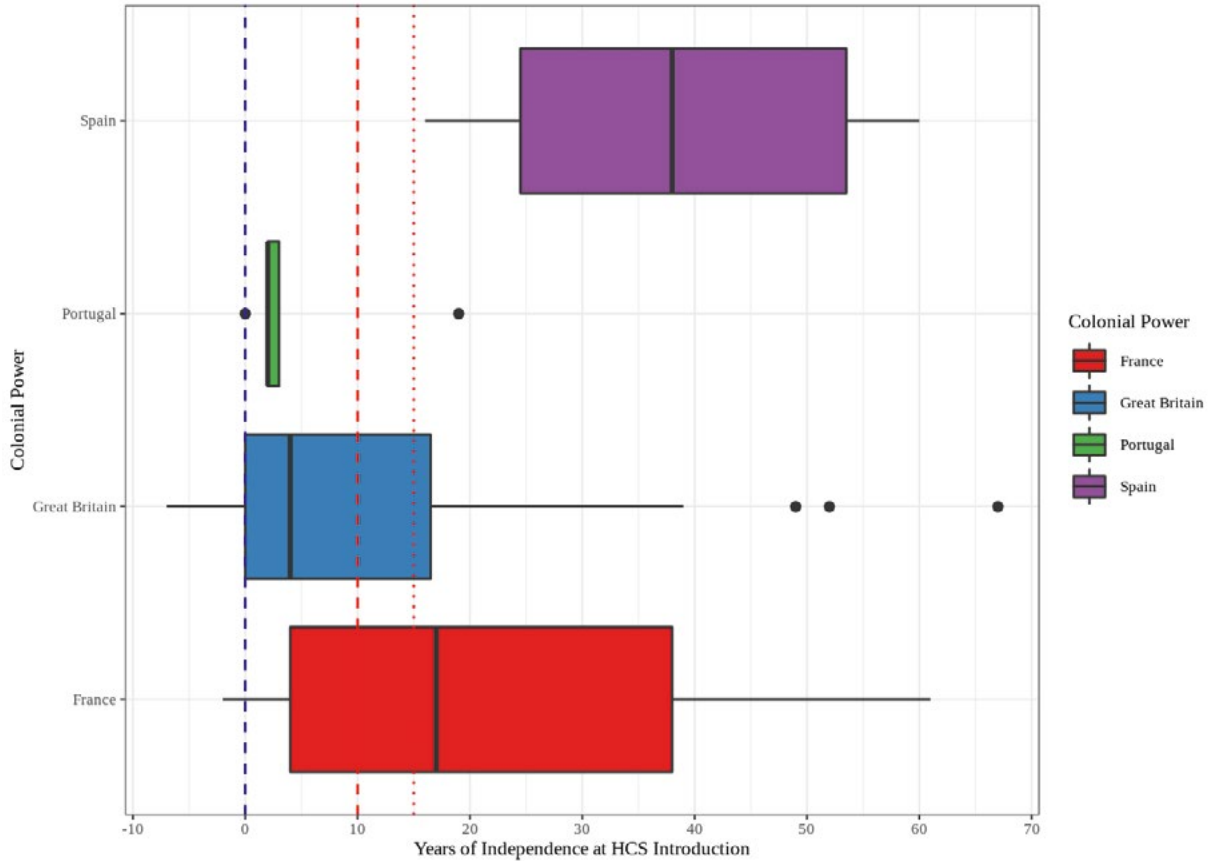
Slovakia, Slovenia, Armenia, Azerbaijan, Belarus, Estonia, Georgia, Latvia, Lithuania, Moldova and Ukraine.

The orange line, representing the cumulative number of health care system introductions in percentage of existing countries, shows consistent growth in the number of systems being introduced throughout the entire period of observation. Between 1918 and 1960 one can see a sharper increase in the development of arrangements, which seems logical as the number of extant countries almost doubles during the period, from 59 in 1918 to 108 in 1960. Even though there is a slight reduction in the number of system introductions around the early 1960s, from 1965 to 2015 there is a steady growth in the establishment of health care schemes, when almost all existing countries put a system in place.

Figure 2 illustrates the total number of health care system introductions by the number of candidates for adoption. The red line shows the cumulative number of health care systems, and the orange line represents the total number of extant countries without a health care system in place, or what we refer to as *adoption candidates*. For instance, 40 countries and one scheme existed in 1883; therefore, there are 39 countries that can establish a system at this point in time. The blue bars represent the number of systems introduced in a year. As expected, the number of health care system introductions and the number of adoption candidates move in tandem, showing a direct relationship between these variables: The number of introductions increase when the number of countries with no arrangement in place grows, and in the years in which less countries are at-risk of creating a system, there is a reduction in the number of systems being established.

We also attempt to verify the existence of temporal cluster, delimited periods when a great number of health care systems have been introduced. However, both figures

Figure 3.
Health care system introduction in former colonies



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seem to suggest that health care schemes have been introduced constantly and almost evenly distributed throughout the whole period of observation, with no clusters being identified. The period with most activity, however, is from 1934 to 1980, when more than half of all the existing health care systems were introduced (92 out of 164).

Transnational interdependencies: Assumptions for potential relationships of health care system introductions

This section examines the potential relevance of three transnational events, identified in the Global Social Policy and the TIF scholarship, for trends in the timing of health care system introductions observed above.

Assumption I: Political independence leads to a period of nation building which accelerates the introduction of health care systems in former colonies.

Figure 3 displays the introduction of health care systems in former British, French, Portuguese and Spanish colonies[9]. The X-axis shows the difference in years between the establishment of a system and the independence, with zero/blue line representing the year of independence. As previously stated, we consider all countries colonized by the former colonial powers that became independent after 1883, when the first health care system came into existence. Further, in this case, we are interested in cases in which the period between independence and the

9 Appendix D visually represents the relationship between political independence and health care system introduction by country.

establishment of a system is smaller, here indicated by the red lines. This may indicate that health care arrangements are part of the nation building process.

The boxplots show that the median difference between both events is lowest for former Portuguese colonies (2) and highest for former Spanish colonies (38). The median differences for former British and French colonies are 4 and 17, respectively. In former British colonies, 26 out of 46 cases adopted schemes within 10 years of political independence. Cyprus, Eswatini, Ghana, Malaysia, New Zealand, Qatar, Saudi Arabia, Singapore, South Sudan, Uganda, United Arab Emirates and Zambia introduced health care system in the same year of becoming independent. If we expand this period to 15-years, 67% of the cases created system in the aftermath of the independence. Considering former Portuguese countries, Angola, Cape Verde, East Timor and Mozambique introduced systems within 3 years of political independence. For instance, Angola became independent in November 11 of 1975, and created its system in December 10 of the same year (Hilhorst & Serrano, 2010; Tallio, 2017). Among the 26 former French colonies, 8 adopted a health care system legislation within 10 years, and 11 within 15 years, which represents 30% and 42% of the cases. On the other hand, for former Spanish colonies, political independence does not seem to be closely related to the introduction of health care systems. As Figure 3 clearly shows, none of the countries introduced during the first 15 years of independence and the median gap between introduction year and independence is by far the largest in this group.

The graph shows a potential relationship between political independence and the adoption of a health care system, as 38 out of 81 countries introduced a scheme within 10 years, and 46 in the first 15 years of political independence.

Assumption II: IO membership in an international organization concerned with health policy accelerates the introduction of a health care system in a country.

As previously discussed, at the core of the TIF and global social policy literature are IOs and their impact on domestic social policies. Based on this, we assume that becoming a member of an IO interested in the field of health quickens the introduction of a system due (but not limited) to recommendations, pressure and knowledge sharing. In this research, we highlight the ILO and WHO as key IOs in the field of health care. Additionally, we ask whether there is a triangular relationship between membership, income level, and health care system introductions, hypothesizing that low-to-middle income countries are more likely to be influenced by external pressures associated with IOs and foreign aid. Figures 4 to 7[10] display health care system introduction in Global North and Global South countries after membership in the ILO and WHO.

Figure 4 shows the timing of health care system beginnings related to the year of membership in the ILO for four income groups. The X-axis shows the difference in number of years between membership and health care system adoption. While negative values denote that systems have been introduced before becoming part of the organizations, positive values represent the number of years between ILO membership and health care system creation. The boxplots suggest that the median time difference between both events is lowest for high-income countries (-8) and highest in low-income countries (16). For both lower- and upper-middle-income countries the period is similar, 3 and 4 respectively. The great majority of high-income countries introduced their systems already before becoming affiliated with

10 Appendix E visually represents the relationship between ILO and WHO membership and health care system introduction by country.

Figure 4.
Health care system introductions in ILO country members by income groups

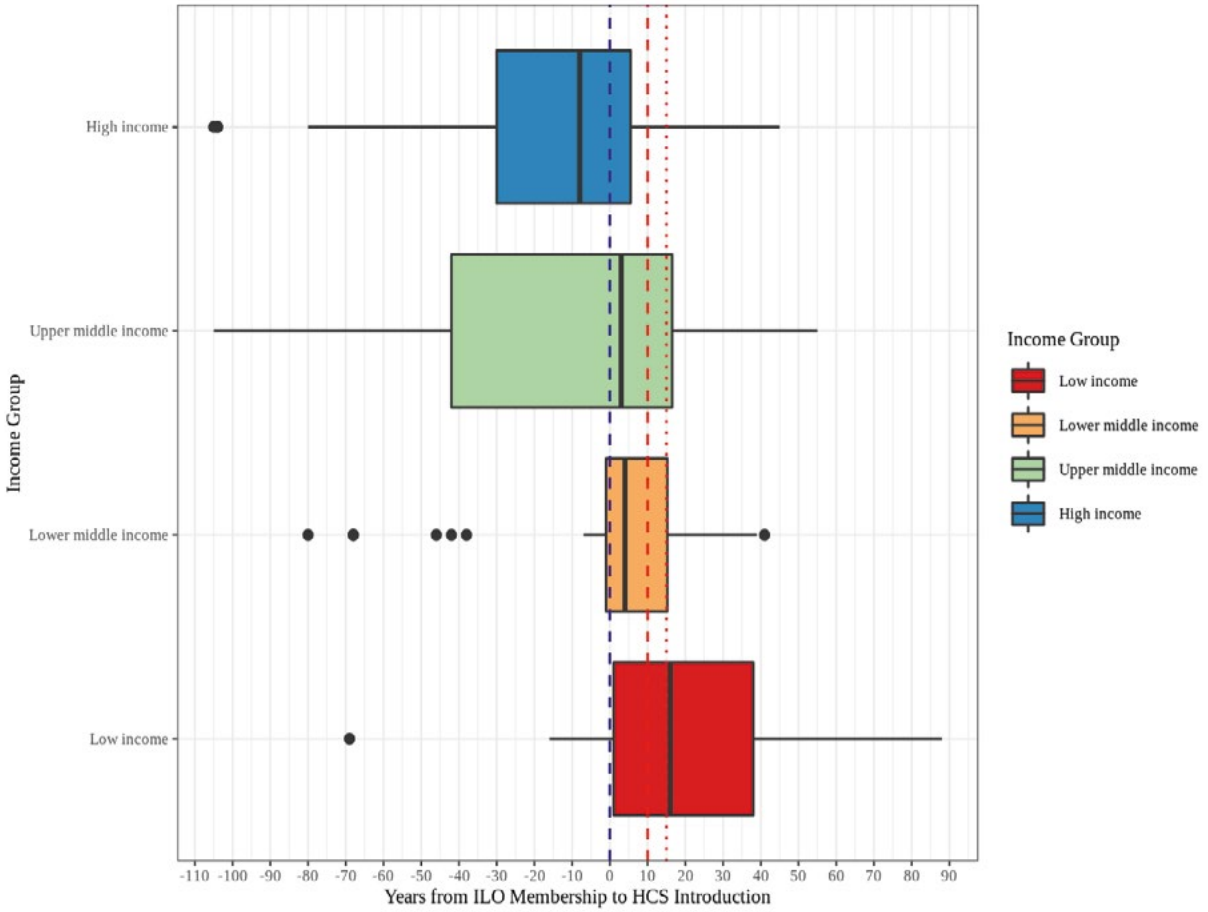

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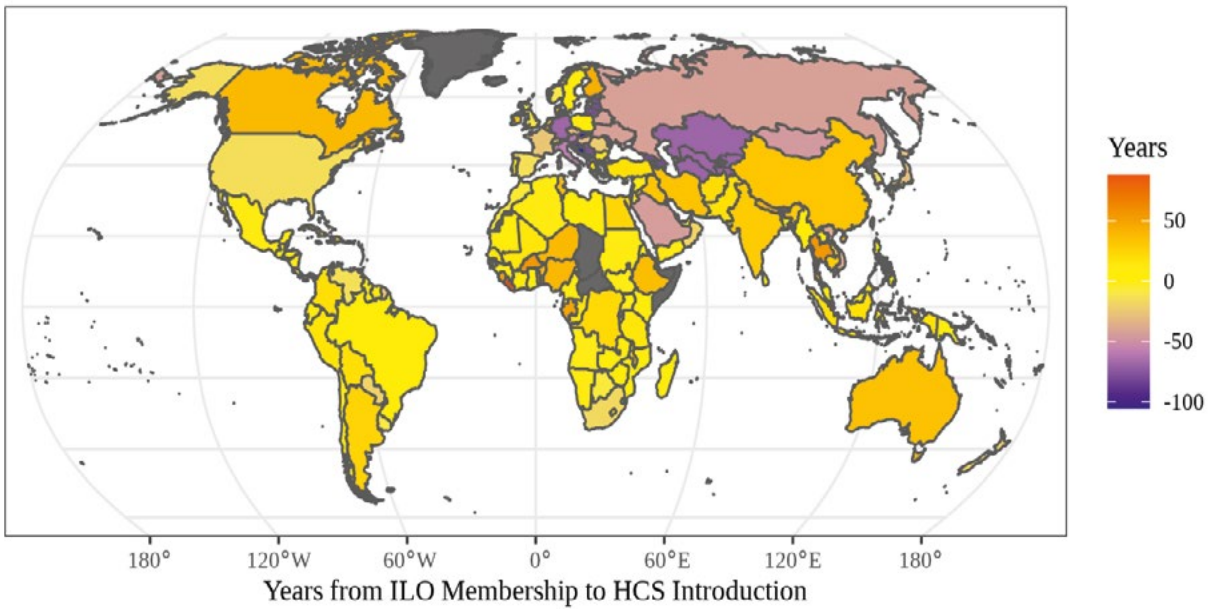
Figure 5.
Health care system introductions in ILO country members



Source: own presentation.

the ILO; therefore, the phenomenon under study is not associated with membership in this institution.

Differently, the great majority of the low-to-middle income countries introduced health care arrangements after becoming an ILO member, as only 35 out of 119 countries had a system before membership. If we split this larger group, we can observe that for low and lower-middle-income countries about 75% of the observations created health care systems following ILO membership. It is also worth noting that almost 50% of lower-middle-income countries introduced systems within 15 years after membership. If we only consider countries that are adoption candidates, out of the 33 lower-middle-income countries that are adoption candidates, around 64% adopted within 15 years of association. Timing of introduction in this income group seems to have the highest potential for being associated with ILO membership.

Figure 5 displays in a map the relationship between ILO membership and health care system introduction. Shades of yellow to red, i.e. positive values, indicate that system adoptions happened after membership. Countries in grey are not members of the institution or do not have a system in place. It is possible to observe that the great majority of countries adopted health care systems after becoming ILO member. In countries represented by different shades of yellow, the period between membership and health care system introduction is smaller. It is possible to observe that the interval between membership and the adoption of health care arrangements seems to be smaller in several African and Latin American nations, compared to Northern Asia and Europe, which introduced before their ILO membership, or large countries in south and south-east Asia and Oceania, which adopted afterwards.

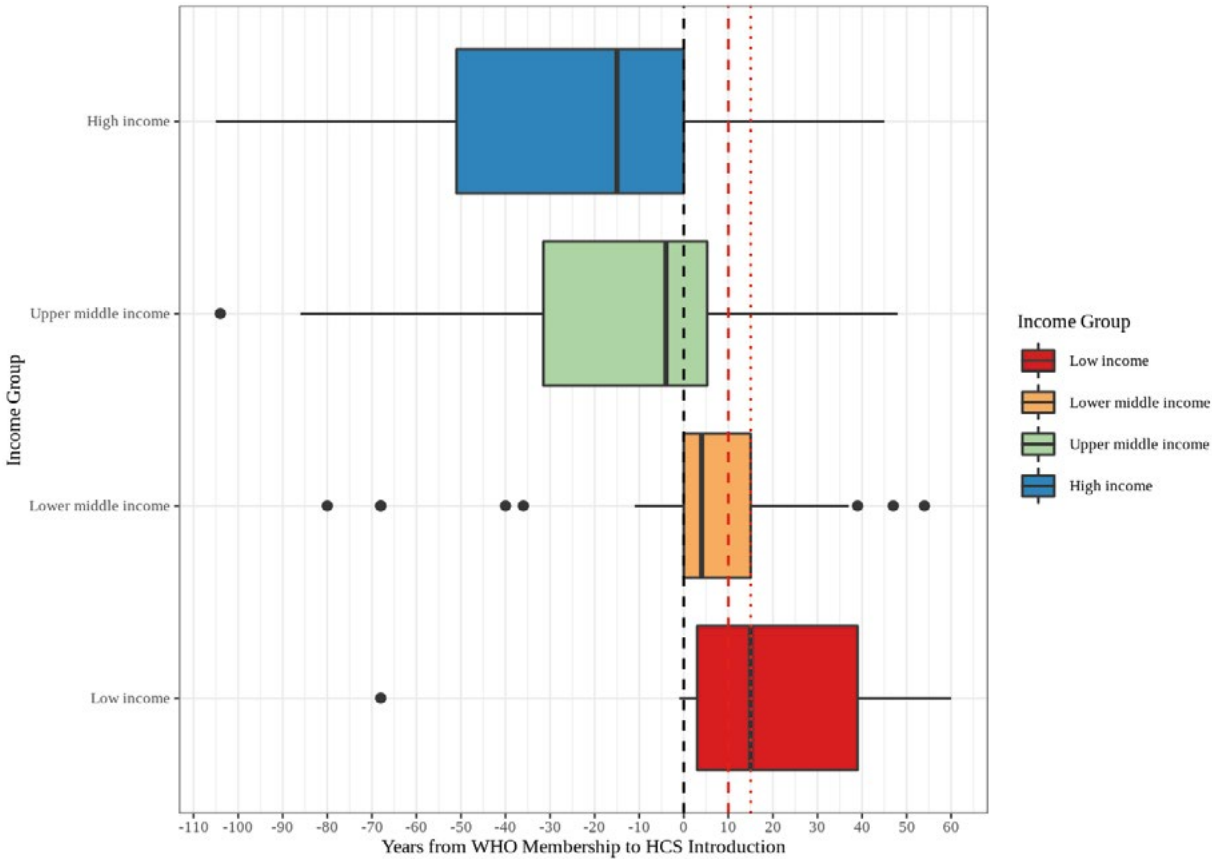
The relationship between WHO membership and the introduction of health care systems is displayed in *Figures 6* and *7*. *Figure 6* shows the median time difference between both events is lowest for high-incomers (-15) and highest in lower-incomers (15). The great majority of high-income countries (35) had health care arrangements in place before becoming a WHO member, as this institution was created only in 1948 (Kott, 2019). This also holds true fir upper-middle-income countries. For this income group, the median time difference between both events is -4. Therefore, health care system introductions in richer countries are not associated with WHO membership.

For low-middle- income and low-income countries the great majority introduced their health care systems after becoming WHO members, representing about 75% and more of the observations. The median time difference between events in low-middle-and low-income countries are 4 and 15, respectively. It is important to note that 55,3% of the lower-middle-income countries that are candidates for adoption create a system within 15 years. In summary, the figures show a possible relationship between IO membership and health care system introductions for low-middle and low-incomers.

Figure 7 shows the interval between ILO membership and health care system introduction throughout the globe. Like the previous map, shades of yellow and red indicate that system adoptions happened after membership, and shades of purple and blue before membership. Countries in grey are not members of the WHO or do not have a health care system in place. It is also possible to observe that most countries in Africa, south east Asia, and North America adopted health care systems after becoming WHO member, while most European, central and north Asian, as well as some south American countries adopted before.

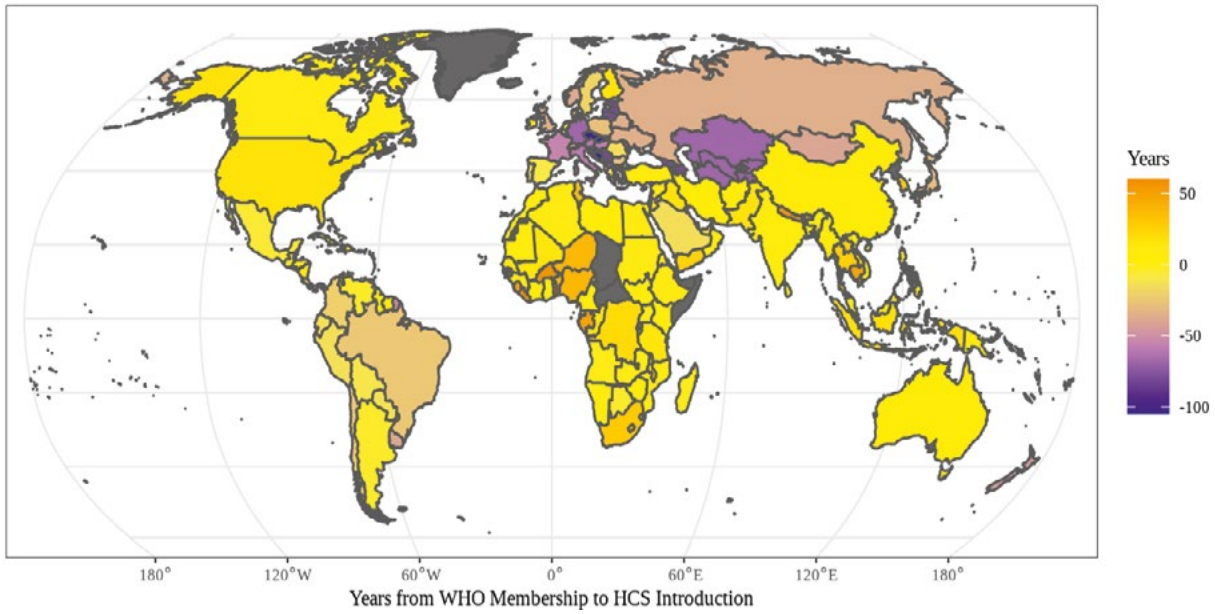
Comparing the relationship between ILO and the WHO memberships with health care system introductions, the boxplots presented in this study have similar shapes. In both cases, the majority of high-incomers had systems in place before membership, and the

Figure 6.
Health care system introductions in WHO country members by income group



Source: own presentation.

Figure 7.
Health care system introductions in WHO country members



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greatest part of low-middle- and low-incomers did not have any arrangement in place before becoming associated with these organizations. The great difference seems to be found in upper-middle-incomers, as the majority of the countries adopted systems after ILO and before WHO memberships. Therefore, it seems that membership and health care system creation have a stronger impact on poorer countries, both lower-middle and low-incomers.

Assumption III: The introduction of a health care system in a neighboring country accelerates the introduction of other systems within the region.

The neighborhood effect implies that geographical proximity is a driver of social policy diffusion and transfer. If this assumption holds true, countries belonging to the same geographic region adopt health care systems around the same period. *Figure 8* displays the total number health care system introductions throughout our entire period of observation within geographical regions according to the United Nations' classification[11]. In Africa, health care systems were introduced between 1957 and 2015. Ghana and Libya were the early- adopters, and Burkina-Faso the laggard. Africa was the last continent to start the introduction of the schemes, and is the only continent where we find countries without any arrangement (Chad, Central African Republic, and Somalia). In comparison to Europe, when Africa introduced its first system, all European states had a scheme in place except for Finland (1963). Considering all regions, Africa is the continent with the smallest difference between the first and the last adopter, even though this is spread over a 58 years-period. Considering African sub-regions[12], it is also difficult to notice temporal clusters. Northern Africa is the sub-region where we can find the smallest interval between first and last introduction (25 years).

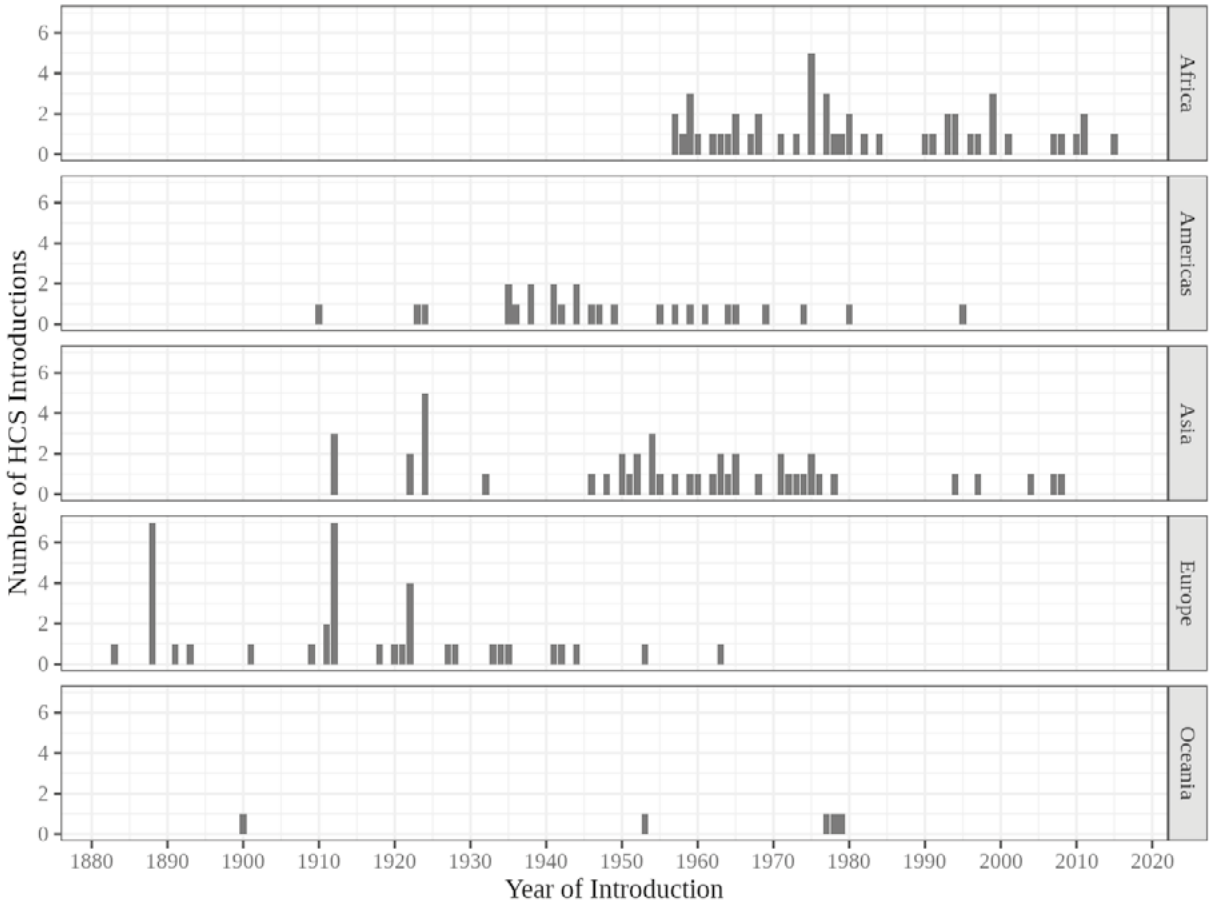
For the other regions, the interval between first and last adoption is even larger; however, it is possible to notice periods with more intense activity, particularly in Asia. In this continent, it is possible to notice some clusters of health care system introduction. In the 30- years-period, from 1948 and 1978, 30 systems were created, which may suggest a snow-balling effect. Japan and Mongolia were the first Asian countries to establish a health care system under public responsibility, and Bhutan the last. In the Americas, the period with most intense activity is from 1935 and 1980, but it is not possible to identify temporal clusters. However, accounting only for subregions, there is a shorter adoption interval in Central America, where all seven countries created systems within 14 years, and Northern America, as Canada and the US established systems in 1957 and 1965 respectively. In South America and the Caribbean, the number of introductions was more spread. Uruguay was the first country of this region to create a system: In 1910, the Uruguayan government provided medical care to vulnerable groups, such as homeless people, children, and pregnant women (Government of Uruguay, 1913). Haiti was the last country of the region to put a system in place only in 1995.

It is also difficult to identify clusters of health care system introductions in Europe, as countries adopted arrangements throughout an 80-years period. It is possible to notice, nonetheless, that Europe was the first region to start and to finish the implementation of health systems. At last, three out of five countries adopted schemes between 1977 and 1979 in Oceania (Papua New Guinea, Fiji and Solomon Island). Australia

11 North Korea and Kosovo are not part of the analysis as these countries are not classified in any region by the UN classification.

12 See Appendix A for sub-region division according to the UN classification (2021).

Figure 8.
Health care system introductions by geographical region



Source: own presentation.

passed a health care system legislation creating a system in 1953, and New Zealand was the first country outside Europe to put an arrangement in place yet in 1900. Based on these, the introduction of a health care scheme in a neighboring country does not seem to have a great impact on the adoption of such policy in countries belonging to the same region.

5. Discussion and conclusion

The main goals of the present study were to describe the timing of health care system introductions and to present the data collected within the research project *Global developments in health care systems and long-term care as a new social risk*, part of the *Collaborative Research Center 1342: Global Dynamics of Social Policy*, based at the University of Bremen, Germany. A secondary goal of this paper is to explore the relationship between the timing of health care system introductions and three events: political independence of a former colony, IO membership, and the introduction of a healthcare system in a neighboring country. Each event represents a punctuated moment in time underlined by a complex set of interdependencies both between countries and between countries and IOs.

Our study of healthcare system introductions led us to a number of important observations: By analyzing all countries with more than 500,000 inhabitants in 2017, we identified the existence of systems under public responsibility in 164 out of 167 countries. Health care systems have been introduced

over a 132-year span, Germany being the first adopter in 1883, and Burkina Faso the last adopter in 2015. Regarding trends, we observed that the establishment of systems was constant throughout the whole period of observation; however, it is possible to identify years 1934 to 1980 as the period in which the great majority of systems were adopted in both relative and absolute terms. We could also verify that the three largest spikes in our data (1888, 1959 and 1975) represent the creation of systems in countries with similar economic levels. In 1888, high-income countries introduced systems; and in 1959 and 1975, only countries of the Global South established arrangements. In terms of geographical distribution, we observed that European countries were the early adopters of health care systems, and Africa was the last region to start implementing arrangements.

As previously mentioned, the secondary goal of the study was to explore whether the introduction of health care schemes overlapped with transnational events selected in accordance with scholarship on global social policy and TIF. We reiterate that this paper does not intend to establish causal explanations, but to point to potential relationships between the establishment of health care systems and important historical events on the basis of their temporal proximity. With respect to political independence, our results point to a potential relationship between independence and the creation of health schemes, mainly in former British and Portuguese colonies, where approximately 67% of the countries adopted systems within 15 years of independence.

Our second assumption dealt with the potential relationship between membership in IOs concerned with health and health care system introductions, i.e. ILO and WHO. We observed that most high-income countries adopted systems before becoming members of both institutions. A possible explanation for this is that richer countries were early-adopters and these institutions were only created later. Considering low- and lower-middle-incomers, the great majority did not have health arrangements in place before membership in both the ILO and the WHO. Our findings show a potential stronger relationship between affiliation to the organizations and health care system introductions: In both cases, about 75% of the observations established health care systems following membership. In upper-middle-income countries, however, it seems that there is a potential relationship between WHO association and the creation of health care schemes, but this correlation cannot be observed when considering ILO membership. In summary, our observation suggests a potential relationship between ILO and WHO membership for low and lower-middle-incomers, and upper-middle-incomers in the case of the WHO. For high-income countries, the relationship seems to be inexistent. This confirms our assumption that membership in an IO quickens the introduction of a health care system in a country, especially in cases where dependency on international aid is high, as characterizes many countries in the Global South.

We also attempted to observe a possible connection between geographical proximity and health care system introductions. Based on the data presented in this research, geographical proximity added to temporal distribution did show regional differences in timing of introduction, Europe being an early adopter and Africa a laggard.

Despite a set of promising observations, the present study is not without limitations. With regard to health care system introductions' data, we identify possible introduction dates through experts' judgement only, mainly found in English-language secondary literature. This means that potential system introductions not represented in this literature were not included in our analysis. Second, as our understanding of a system begins with the enactment of the first health care legislation that meets our pre-established criteria, we may identify as starting points legislation

that is approved but not implemented, and/or may overlook fully functioning systems that do not have any legal basis. Third, we only consider countries having systems after independence, excluding any potential system implemented under, for instance, colonial rule.

Regarding the assumptions indicating potential relationships between event and health care system introductions, the main limitation in our study concerns the geographical proximity assumption. The UN-based regional division is artificial, and countries may be closer to other continents than nations within the same region. Additionally, for the assumption dealing with IO membership, we define countries of the Global South as low-to-upper-middle-income according to the World Bank. This classification is fairly recent, and we may categorize a nation as high-income/Global North that at the moment of introduction would be considered as part of the Global South.

To overcome many of the aforementioned limitations, further research that tests the strength of relationships between the timing of system introductions and major transnational events would be required. As a first step, such research could employ correlation and/or cluster analysis involving all cases or subsets of cases (e.g., by income group or region). Then, as second step and on the basis of statistical findings, qualitative case study research could be conducted on select cases to reconstruct causal narratives through process-tracing. This would allow researchers to explore the transnational interdependencies at play in driving health care system introductions in different countries. As the results of the present study suggest, the role of political independence and nation building processes following de-colonialization, as well as IO membership in lower-middle-income countries may provide good starting points for future comparative research. Such work stands to make important contributions to enriching the burgeoning body of scholarship on global social policy and the TIF.

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Appendix

Appendix A. Geographical division, income group, IOs membership, and heath care system introduction year

Country name	Abbreviation (CoW,2021)	Sub-Region	Region	Income Group	Date of ILO membership	Date of WHO membership	Year of Introduction
Afghanistan	AFG	Southern Asia	Asia	Low income	1934	1948	1955
Albania	ALB	Southern Europe	Europe	Upper middle income	1991	1947	1927
Algeria*	ALG	Northern Africa	Africa	Lower middle income	1962	1962	1973
Angola	ANG	Middle Africa	Africa	Lower middle income	1976	1976	1975
Argentina	ARG	South America	Americas	Upper middle income	1919	1948	1944
Armenia	ARM	Western Asia	Asia	Upper middle income	1992	1992	1912
Australia	AUL	Oceania	Oceania	High income	1919	1948	1953
Austria	AUS	Western Europe	Europe	High income	1947	1947	1888
Azerbaijan	AZE	Western Asia	Asia	Upper middle income	1992	1992	1912
Bahrain	BAH	Western Asia	Asia	High income	1977	1971	1973
Bangladesh	BNG	Southern Asia	Asia	Lower middle income	1972	1972	1972
Belarus	BLR	Eastern Europe	Europe	Upper middle income	1954	1948	1912
Belgium	BEL	Western Europe	Europe	High income	1919	1948	1944
Benin*	BEN	Western Africa	Africa	Lower middle income	1960	1960	1997
Bhutan	BHU	Southern Asia	Asia	Lower middle income	N/A	1982	2008
Bolivia	BOL	South America	Americas	Lower middle income	1919	1949	1938
Bosnia and Herzegovina	BOS	Southern Europe	Europe	Upper middle income	1993	1992	1888
Botswana	BOT	Southern Africa	Africa	Upper middle income	1978	1975	1971
Brazil	BRA	South America	Americas	Upper middle income	1919	1948	1923
Bulgaria	BUL	Eastern Europe	Europe	Upper middle income	1920	1948	1918
Burkina Faso*	BFO	Western Africa	Africa	Low income	1960	1960	2015
Burundi	BUI	Eastern Africa	Africa	Low income	1963	1962	1980
Cambodia	CAM	South-eastern Asia	Asia	Lower middle income	1969	1950	1997
Cameroon	CAO	Middle Africa	Africa	Lower middle income	1960	1960	1968
Canada	CAN	Northern America	Americas	High income	1919	1946	1957
Cape Verde	CAP	Western Africa	Africa	Lower middle income	1979	1976	1978

Central African Republic*	CEN	Middle Africa	Africa	Low income	1960	1960	N/A
Chad*	CHA	Middle Africa	Africa	Low income	1960	1961	N/A
Chile	CHL	South America	Americas	High income	1919	1948	1924
China	CHN	Eastern Asia	Asia	Upper middle income	1919	1946	1951
Colombia	COL	South America	Americas	Upper middle income	1919	1959	1938
Comoros	COM	Eastern Africa	Africa	Lower middle income	1978	1975	1994
Congo	CON	Middle Africa	Africa	Lower middle income	1960	1960	1975
Costa Rica	COS	Central America	Americas	Upper middle income	1944	1949	1941
Côte d'Ivoire	CDI	Western Africa	Africa	Lower middle income	1960	1960	1965
Croatia	CRO	Southern Europe	Europe	High income	1992	1992	1888
Cuba	CUB	Caribbean	Americas	Upper middle income	1919	1950	1961
Cyprus	CYP	Western Asia	Asia	High income	1960	1961	1960
Czech Republic	CZR	Eastern Europe	Europe	High income	1919	1993	1888
Democratic Republic of the Congo	DRC	Middle Africa	Africa	Low income	1960	1961	1982
Denmark	DEN	Northern Europe	Europe	High income	1919	1948	1921
Djibouti	DJI	Eastern Africa	Africa	Lower middle income	1978	1978	1999
Dominican Republic	DOM	Caribbean	Americas	Upper middle income	1924	1948	1947
East Timor	ETM	South-eastern Asia	Asia	Lower middle income	2003	2003	2004
Ecuador	ECU	South America	Americas	Upper middle income	1934	1949	1935
Egypt	EGY	Northern Africa	Africa	Lower middle income	1936	1947	1959
El Salvador	SAL	Central America	Americas	Lower middle income	1948	1948	1949
Equatorial Guinea	EQG	Middle Africa	Africa	Upper middle income	1981	1980	1984
Eritrea	ERI	Eastern Africa	Africa	Low income	1993	1993	1996
Estonia	EST	Northern Europe	Europe	High income	1992	1993	1912
Eswatini	ESW	Southern Africa	Africa	Lower middle income	1975	1973	1968
Ethiopia	ETH	Eastern Africa	Africa	Low income	1923	1947	1959
Fiji	FIJ	Oceania	Oceania	Upper middle income	1974	1972	1978
Finland	FIN	Northern Europe	Europe	High income	1920	1947	1963
France	FRN	Western Europe	Europe	High income	1919	1948	1893
Gabon*	GAB	Middle Africa	Africa	Upper middle income	1960	1960	2008

Gambia	GAM	Western Africa	Africa	Low income	1995	1971	1979
Georgia	GRG	Western Asia	Asia	Upper middle income	1993	1992	1912
Germany	GMY	Western Europe	Europe	High income	1951	1951	1883
Ghana	GHA	Western Africa	Africa	Lower middle income	1957	1957	1957
Greece	GRC	Southern Europe	Europe	High income	1919	1948	1934
Guatemala	GUA	Central America	Americas	Upper middle income	1945	1949	1946
Guinea-Bissau	GNB	Western Africa	Africa	Low income	1977	1974	1993
Guinea*	GUI	Western Africa	Africa	Low income	1959	1959	1958
Guyana	GUY	South America	Americas	Upper middle income	1966	1966	1969
Haiti	HAI	Caribbean	Americas	Low income	1919	1947	1995
Honduras	HON	Central America	Americas	Lower middle income	1955	1949	1959
Hungary	HUN	Eastern Europe	Europe	High income	1922	1948	1891
India	IND	Southern Asia	Asia	Lower middle income	1919	1948	1948
Indonesia	INS	South-eastern Asia	Asia	Upper middle income	1950	1950	1968
Iran	IRN	Southern Asia	Asia	Upper middle income	1919	1946	1952
Iraq	IRQ	Western Asia	Asia	Upper middle income	1932	1947	1964
Ireland	IRE	Northern Europe	Europe	High income	1923	1947	1953
Israel	ISR	Western Asia	Asia	High income	1949	1949	1994
Italy	IRA	Southern Europe	Europe	High income	1945	1947	1888
Jamaica	JAM	Caribbean	Americas	Upper middle income	1962	1963	1974
Japan	JPN	Eastern Asia	Asia	High income	1951	1951	1922
Jordan	JOR	Western Asia	Asia	Upper middle income	1956	1947	1963
Kazakhstan	KZK	Central Asia	Asia	Upper middle income	1993	1992	1924
Kenya	KEN	Eastern Africa	Africa	Lower middle income	1964	1964	1965
Kosovo	KOS			Upper middle income	N/A		1922
Kuwait	KUW	Western Asia	Asia	High income	1961	1960	1962
Kyrgyzstan	KYR	Central Asia	Asia	Lower middle income	1992	1992	1924
Laos	LAO	South-eastern Asia	Asia	Lower middle income	1964	1950	1975
Latvia	LAT	Northern Europe	Europe	High income	1991	1991	1912
Lebanon	LEB	Western Asia	Asia	Upper middle income	1948	1949	1963
Lesotho	LES	Southern Africa	Africa	Lower middle income	1980	1967	1993

Liberia	LBR	Western Africa	Africa	Low income	1919	1947	2007
Libya	LIB	Northern Africa	Africa	Upper middle income	1952	1952	1957
Lithuania	LIT	Northern Europe	Europe	High income	1991	1991	1912
Luxembourg	LUX	Western Europe	Europe	High income	1920	1948	1901
Madagascar*	MAC	Eastern Africa	Africa	Low income	1960	1961	1960
Malawi	MAG	Eastern Africa	Africa	Low income	1965	1965	1994
Malaysia	MAW	South-eastern Asia	Asia	Upper middle income	1957	1958	1957
Mali*	MAL	Western Africa	Africa	Low income	1960	1960	1975
Mauritania	MAA	Western Africa	Africa	Lower middle income	1961	1961	1963
Mauritius	MAS	Eastern Africa	Africa	High income	1969	1968	1975
Mexico	MEX	Central America	Americas	Upper middle income	1931	1948	1942
Moldova	MLD	Eastern Europe	Europe	Lower middle income	1992	1992	1912
Mongolia	MON	Eastern Asia	Asia	Lower middle income	1968	1962	1922
Montenegro	MNG	Southern Europe	Europe	Upper middle income	2006	2008	1922
Morocco*	MOR	Northern Africa	Africa	Lower middle income	1965	1956	1959
Mozambique	MZM	Eastern Africa	Africa	Low income	1976	1975	1977
Myanmar	MYA	South-eastern Asia	Asia	Lower middle income	1948	1948	1954
Namibia	NAM	Southern Africa	Africa	Upper middle income	1978	1990	1990
Nepal	NEP	Southern Asia	Asia	Lower middle income	1966	1953	2007
Netherlands	NTH	Western Europe	Europe	High income	1919	1947	1941
New Zealand	NEW	Oceania	Oceania	High income	1919	1946	1900
Nicaragua	NIC	Central America	Americas	Lower middle income	1957	1950	1955
Niger	NIR	Western Africa	Africa	Low income	1961	1960	1999
Nigeria	NIG	Western Africa	Africa	Lower middle income	1960	1960	1999
North Korea	PRK		Asia	Low income	N/A	N/A	1946
North Macedonia	MKD	Southern Europe	Europe	Upper middle income	1993	1996	1922
Norway	NOR	Northern Europe	Europe	High income	1919	1947	1909
Oman	OMA	Western Asia	Asia	High income	1994	1971	1975
Pakistan	PAK	Southern Asia	Asia	Lower middle income	1947	1948	1965
Panama	PAN	Central America	Americas	High income	1919	1951	1941
Papua New Guinea	PNG	Oceania	Oceania	Lower middle income	1976	1976	1977

Paraguay	PAR	South America	Americas	Upper middle income	1956	1949	1936
Peru	PER	South America	Americas	Upper middle income	1919	1949	1935
Philippines	PHI	South-eastern Asia	Asia	Lower middle income	1948	1948	1954
Poland	POL	Eastern Europe	Europe	High income	1919	1948	1920
Portugal	POR	Southern Europe	Europe	High income	1919	1948	1935
Qatar	QAT	Western Asia	Asia	High income	1972	1972	1971
Romania	ROM	Eastern Europe	Europe	High income	1956	1948	1933
Russia	RUS	Eastern Europe	Europe	Upper middle income	1954	1948	1912
Rwanda	RWA	Eastern Africa	Africa	Low income	1962	1962	2001
Saudi Arabia	SAU	Western Asia	Asia	High income	1976	1947	1932
Senegal	SEN	Western Africa	Africa	Lower middle income	1960	1960	1975
Serbia	YUG	Southern Europe	Europe	Upper middle income	2000	2002	1922
Sierra Leone	SIE	Western Africa	Africa	Low income	1961	1961	2010
Singapore	SIN	South-eastern Asia	Asia	High income	1965	1966	1965
Slovakia	SLO	Eastern Europe	Europe	High income	1993	1993	1888
Slovenia	SLV	Southern Europe	Europe	High income	1992	1992	1888
Solomon Islands	SOL	Oceania	Oceania	Lower middle income	1984	1983	1979
Somalia	SOM	Eastern Africa	Africa	Low income	1960	1961	N/A
South Africa	SAF	Southern Africa	Africa	Upper middle income	1994	1947	1977
South Korea	ROK	Eastern Asia	Asia	High income	1991	1949	1976
South Sudan	SSD	Eastern Africa	Africa	Low income	2012	2011	2011
Spain	SPN	Southern Europe	Europe	High income	1956	1951	1942
Sri Lanka	SRI	Southern Asia	Asia	Lower middle income	1948	1948	1952
Sudan	SUD	Northern Africa	Africa	Low income	1956	1956	1967
Suriname	SUR	South America	Americas	Upper middle income	1976	1976	1980
Sweden	SWD	Northern Europe	Europe	High income	1919	1947	1928
Switzerland	SWZ	Western Europe	Europe	High income	1919	1947	1911
Syria	SYR	Western Asia	Asia	Low income	1947	1946	1959
Taiwan	TAW	Eastern Asia	Asia	High income	N/A	N/A	1950
Tajikistan	TAJ	Central Asia	Asia	Low income	1993	1992	1924
Tanzania	TAZ	Eastern Africa	Africa	Lower middle income	1962	1962	1977
Thailand	THI	South-eastern Asia	Asia	Upper middle income	1919	1947	1974
Togo	TOG	Western Africa	Africa	Low income	1960	1960	2011

Trinidad and Tobago	TRI	Caribbean	Americas	High income	1963	1963	1964
Tunisia*	TUN	Northern Africa	Africa	Lower middle income	1956	1956	1991
Turkey	TUR	Western Asia	Asia	Upper middle income	1932	1948	1950
Turkmenistan	TKM	Central Asia	Asia	Upper middle income	1993	1992	1924
Uganda	UGA	Eastern Africa	Africa	Low income	1963	1963	1962
Ukraine	UKR	Eastern Europe	Europe	Lower middle income	1954	1948	1912
United Arab Emirates	UAE	Western Asia	Asia	High income	1972	1972	1971
United Kingdom	UKG	Northern Europe	Europe	High income	1919	1946	1911
United States	USA	Northern America	Americas	High income	1980	1948	1965
Uruguay	URU	South America	Americas	High income	1919	1949	1910
Uzbekistan	UZB	Central Asia	Asia	Lower middle income	1992	1992	1924
Venezuela	VEN	South America	Americas	Upper middle income	1958	1948	1944
Vietnam	DRV	South-eastern Asia	Asia	Lower middle income	1992	1950	1954
Yemen	YEM	Western Asia	Asia	Low income	1965	1953	1978
Zambia	ZAM	Eastern Africa	Africa	Lower middle income	1964	1965	1964
Zimbabwe	ZIM	Eastern Africa	Africa	Lower middle income	1980	1980	1980

* Introduction years for countries signaled with asterisks need further validation from experts.

Appendix B. Health care systems introduction in former colonies

Colonial Power	Country	Year Health care system introduction	Year independence (CoW, 2021)
France	Algeria*	1973	1962
Portugal	Angola	1975	1975
Spain	Argentina	1944	1841
Great Britain	Australia	1953	1901
Great Britain	Bahrain	1973	1971
Great Britain	Bangladesh	1972	1971
France	Benin*	1997	1960
Great Britain	Bhutan	2008	1971
Spain	Bolivia	1938	1848
Great Britain	Botswana	1971	1966
Portugal	Brazil	1923	1822
France	Burkina Faso*	2015	1960
France	Cambodia	1997	1953
France	Cameroon	1968	1960
Great Britain	Canada	1957	1841
Portugal	Cape Verde	1978	1975
France	Central African Republic*	N/A	1958
France	Chad*	N/A	1958
Spain	Chile	1924	1839
Spain	Colombia	1938	1831
France	Comoros	1994	1975
Spain	Costa Rica	1941	1920
France	Ivory Coast	1965	1960
Spain	Cuba	1961	1909
Great Britain	Cyprus	1960	1960
France	Djibouti	1999	1977
France	Dominican Republic	1947	1844
Portugal	East Timor	2004	2002
Spain	Ecuador	1935	1854
Great Britain	Egypt	1959	1922
Spain	El Salvador	1949	1875
Spain	Equatorial Guinea	1984	1968
Great Britain	Eswatini	1968	1968
Great Britain	Fiji	1978	1970
France	Gabon*	2008	1958
Great Britain	Gambia	1979	1965
Great Britain	Ghana	1957	1957
Spain	Guatemala	1946	1868

France	Guinea*	1958	1958
Portugal	Guinea-Bissau	1993	1974
Great Britain	Guyana	1969	1966
France	Haiti	1995	1934
Spain	Honduras	1959	1899
Great Britain	India	1948	1947
Great Britain	Iraq	1964	1932
Great Britain	Jamaica	1974	1962
Great Britain	Jordan	1963	1946
Great Britain	Kenya	1965	1963
Great Britain	Kuwait	1962	1961
France	Laos	1975	1953
France	Lebanon	1963	1946
Great Britain	Lesotho	1993	1966
France	Madagascar*	1960	1960
Great Britain	Malawi	1994	1964
Great Britain	Malaysia	1957	1957
France	Mali*	1975	1960
France	Mauritania	1963	1960
Great Britain	Mauritius	1975	1968
Spain	Mexico	1942	1821
France	Morocco*	1959	1956
Portugal	Mozambique	1977	1975
Great Britain	Myanmar (Burma)	1954	1948
Great Britain	New Zealand	1907	1907
Spain	Nicaragua	1955	1900
France	Niger	1999	1960
Great Britain	Nigeria	1999	1960
Great Britain	Oman	1975	1971
Great Britain	Pakistan	1965	1947
Spain	Panama	1941	1903
Spain	Paraguay	1936	1876
Spain	Peru	1935	1839
Great Britain	Qatar	1971	1971
Great Britain	Saudi Arabia	1932	1932
France	Senegal	1975	1960
Great Britain	Sierra Leone	2010	1961
Great Britain	Singapore	1965	1965
Great Britain	Solomon Islands	1979	1978
Great Britain	Somalia	N/A	1960
Great Britain	South Africa	1977	1910
Great Britain	South Sudan	2011	2011
Great Britain	Sri Lanka	1952	1948

Great Britain	Sudan	1967	1956
France	Syria	1961	1961
Great Britain	Tanzania	1977	1961
France	Togo	2011	1960
Great Britain	Trinidad and Tobago	1964	1962
France	Tunisia*	1991	1956
Great Britain	Uganda	1962	1962
Great Britain	United Arab Emirates	1971	1971
Great Britain	United States	1965	1776
Spain	Uruguay	1910	1882
Spain	Venezuela	1944	1841
France	Vietnam	1954	1954
Great Britain	Yemen	1978	1967
Great Britain	Zambia	1964	1964
Great Britain	Zimbabwe	1980	1965

* Introduction years for countries signaled with asterisks need further validation from experts.

Appendix C. Sources

Country	Year of System Introduction	Sources: System Introduction
Afghanistan	1955	Health Policy Project. (2015). A Health Insurance Feasibility Study in Afghanistan: Learning from Other Countries, a Legal Assessment, and a Stakeholder Analysis. Futures Group. Health Pol-icy Project. Retrieved from https://www.healthpolicyproject.com/pubs/756_AfghanistanHealthInsuranceFeasibilitFINAL.pdf
Albania	1927	Druga, E. (2021). The Health Care System in Albania (Social Policy Country Briefs, No. 8). CRC 1342. Retrieved from https://www.socialpolicydynamics.de/f/7cf906fb8e.pdf
Algeria*	1973	Algeria. (1974). Ordonnance no 73-65 du 28 décembre 1973 portant institution de la médecine gra-tuite dans les secteurs sanitaires (Journal officiel n° 1 du 01.01.1974), Algeria.
Angola	1975	Frøystad, M., Mæstad, O., & Villamil, N. (2011). Health Services in Angola: Availability, Quality and Utilisation (R2011:9). Retrieved from https://www.cmi.no/publications/file/4319-health-services-in-angola.pdf. Fustukian, S. (2004). Case Study 2: Review of Health Service Delivery in Angola. DFID Report on Service Delivery in Difficult Environments. Retrieved from https://sarpn.org/documents/d0001276/P1514-Angola_Fustukian.pdf Hilhorst, D., & Serrano, M. (2010), The humanitarian arena in Angola, 1975–2008. Disasters, 34(s2), 183-201. Retrieved from https://doi.org/10.1111/j.1467-7717.2010.01153.x Pavignani, E., & Colombo, A. (2001). Providing Health Services in Countries Disrupted by Civil Wars. A Comparative Analysis of Mozambique and Angola 1975–2000. World Health Organi-zation. Retrieved from https://apps.who.int/disasters/repo/14052.pdf Queza, J.A. (2010). Sistema de Saúde em Angola: Uma Proposta à Luz da Reforma do Serviço Nacio-nal de Saúde em Portugal (Master's thesis, Universidade do Porto, Faculdade de Medicina, Porto, Portugal) Retrieved from http://hdl.handle.net/10216/50407 Tiago, J. (2011). A formação de auxiliares e técnicos de Enfermagem nos períodos colonial e pós-independência: um estudo dos egressos da Escola Técnica Profissional de Saúde de Luanda, Angola (Doctoral dissertation, Fundação Oswaldo Cruz. Escola Nacional de Saúde Pública Sergio Arouca, Rio de Janeiro, Brazil). Retrieved from https://www.arca.fiocruz.br/handle/icict/12354
Argentina	1944	Arce, H. E. (2013). Evolución histórica del Sistema de Salud argentino a lo largo del Siglo XX (Docto-ral dissertation, IUCS - Fundación H. A. Barceló, Buenos Aires, Argentina). Retrieved from http://repositorio.barcelo.edu.ar/greenstone/collect/tesis/index/assoc/HASH6ecf.dir/Tesis%20Doctorado%20Arce%20Hugo%20Eduardo.pdf Argentina. (1943). Decreto N.° 12.311/1943, que se crea la Dirección Nacional de Salud Pública y Asistencia Social, Argentina. Argentina. (1944). Decreto N.° 30.655/1944, que crea la comision de servicio social para propulsar la implantación de servicios sociales en establecimientos de cualquier actividad, Argentina.
Armenia	1912	see Russia

Australia	1953	Australia. (1953). Act No. 95 of 1953, Relating to the Provision of Pharmaceutical, Sickness and Hospital Benefits, and of Medical and Dental Services, Australia. Hilless, M., & Healy, J. ([]2001)[]. Health care systems in transition: Australia. World Health Organiza-tion. Regional Office for Europe. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/108466/HiT-3-13-2001-eng.pdf?sequence=8&isAllowed=y
Austria	1888	Bachner, F., Bobek, J., Habimana, K., Ladurner, J., Lepuschütz, L., & Ostermann, H. (2018). Aus-tria: Health System Review. Health Systems in Transition, 20(3), 1-258. Hofmarcher, M.M., & Rack, H.M. (2006). Gesundheitssysteme im Wandel: Österreich. Kopenhagen: WHO Regionalbüro für Europa. Köhler, P.A., Zacher, H.F. (Eds.). (1981). Ein Jahrhundert Sozialversicherung in der Bundesrepublik Deutschland, Frankreich, Großbritannien, Österreich und der Schweiz. Berlin: Duncker & Humblot. Steiner, G. (2019). Die Sozialversicherung in Österreich von den Anfängen bis zum Ende der Mo-narchie. Soziale Sicherheit, April, 158-72.
Azerbaijan	1912	see Russia
Bahrain	1973	Al Ghafri, A.S.H. (2007). Health systems performance assessment and sustainable improvement in Bahrain, Kuwait and Qatar (Doctoral dissertation, Imperial College, London, United Kingdom). Retrieved from https://spiral.imperial.ac.uk/bitstream/10044/1/74957/1/AlGhafri-A-2019-PhD-Thesis.pdf Kronfol, N.M. (2012). Historical Development of Health Systems in the Arab Countries: A Review. Eastern Mediterranean Health Journal, 18(11), 1151-1156. Regional Health Systems Observatory [RHSO]. (2007). Health System Profile: Bahrain. World Health Organization. Retrieved from http://digicollection.org/hss/documents/s17291e/s17291e.pdf.
Bangladesh	1972	Ahmed, S. M., Alam, B. B., Anwar, I., Begum, T., Huque, R., Khan, J. A., & Osman, F. A. (2015). Bangladesch: Health System Review. Health Systems in Transition, 5(3), 1-188. Rahman, R. (2020). Shrinking the State: The Rise of Private Sector Healthcare in Bangladesh. Journal of International Development, 32(5), 717-726. Retrieved from https://doi.org/10.1002/jid.3474
Belarus	1912	see Russia
Belgium	1944	Belgium. (1944). Social Security Act (Arrêté-loi concernant la sécurité sociale des travailleurs), Belgium. Corens, D. (2007). Belgium: Health System Review. Health Systems in Transition 9(2), 1-174. Farman, C. H. (1950). World Developments in Social Security. Social Security Bulletin 13(3), 3-12. Sécurité Sociale. (2020). L'apparition de la séurité sociale en Belgique. Retrieved from https://www.socialsecurity.be/citizen/fr/propos-de-la-securite-sociale/l-apparition-de-la-securite-sociale-en-belgique/1944
Benin*	1997	Benin. (1997). Décret No. 97-321 du 17 Juillet 1997. Portant règlementation des Secours en Répu-blique du Bénin.
Bhutan	2008	Bhutan. (2008). Constitution of Bhutan.
Bolivia	1938	Ledo, C. & Soria, R. (2011). Sistema de salud de Bolivia. Salud Pública de México, 53(2), 109-119. Lozano, G. M. (2002). Historia de la Salud Publica en Bolivia. De las Juntas de Sanidad a los Direc-torios Locales de Salud. La Paz, Bolivia: OPS/OMS.

Bosnia and Herzegovina	1888	Cain, J, & Jakubowski, E. (2002). Health Care Systems in Transition: Bosnia and Herzegovina. The European Observatory on Health Care Systems. Retrieved from https://www.euro.who.int/__data/assets/pdf_file/0018/75132/E78673.pdf see Austria
Botswana	1971	Botswana. (1971). Public Health Act 44, 1971.
Brazil	1923	Albuquerque, M. M. (1981). Pequena história da formação social brasileira. Rio de Janeiro, Brazil: Graal. Batich, M. (2004). Previdência Do Trabalhador: Uma Trajetória Inesperada. São Paulo Perspectives, 18(3), 33–40. de Carvalho, G. (2020). The Health Care System in Brazil (CRC 1342 Social Policy Country Briefs, No. 1). CRC 1342. Retrieved from http://dx.doi.org/10.26092/elib/529
Bulgaria	1918	Balabanova, D. C. (2001). Financing the Health Care System in Bulgaria: options and Strategies (Doctoral dissertation, London School of Hygiene & Tropical Medicine, London, United Kingdom). Retrieved from http://dx.doi.org/10.17037/PUBS.00682297 Dimova, A. (2018). Health System Financing in Bulgaria. Varna, Bulgaria: Medical University Varna. National Health Insurance Fund. (2009). Healthcare in Bulgaria. Retrieved from https://www.en.nhif.bg/page/healthcare-in-bulgaria Whitney, A. L. (1943). Labor Conditions in Bulgaria. Monthly Labor Review, 57(4), 672-688.
Burkina Faso*	2015	Burkina Faso. (2015). Loi n° 060-2015/CNT portant régime d'assurance maladie universelle, République Burkina Faso.
Burundi	1980	Arhin, D. C. (1994). The Health Card Insurance Scheme in Burundi: A Social Asset or a Non-viable Venture? Social Science & Medicine, 39(6), 861-870. Human Rights Watch. (2006). Burundi: A High Price to Pay Detention of Poor Patients in Burundian Hospitals. Human Rights Watch, New York. Retrieved from https://www.hrw.org/sites/default/files/reports/burundi0906webwcover_0.pdf
Cambodia	1997	Annear, P.L., Grundy, J., Ir, P., Jacobs, B., Men, C., Nachtnebel, M., Oum, S., Robins, A., & Ros, C.E. (2015). The Kingdom of Cambodia. Health System Review. Health Systems in Transition, 2015(5), 1-174. Grundy, J., Hoban, E., & Allender, S. (2016). Turning Points in Political and Health Policy History: The Case of Cambodia 1975-2014. Health History, 18, 89-110. Soth, S.B. (2016). Social and Cultural Rights Theory and Praxis in the Cambodian Context. In: P. Hor, P. Kong, & J. Menzel (Eds.), Cambodian Constitutional Law (pp. 557-679). Phnom Penh, Cambodia: Konrad-Adenauer-Stiftung.
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Central African Republic	N/A	
Chad*	N/A	
Chile	1924	Chile. (1924). Ley N.° 4054, de 26 de septiembre de 1924, Chile. Retrieved from http://bcn.cl/2fa0w Kritzer, B. E. (1983). Chile Changes its Health Care System. Social Security Bulletin, 46(12), 16-18.
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Congo	1975	Congo. (1975). Congo Code du travail, Loi n°45-75 du 15 mars 1975 (Congo Labour Code, Law No. 45-75 of March 15, 1975).
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El Salvador	1949	El Salvador. (1949). Decreto N.° 329, Ley del Seguro Social, El Salvador 1949. Escalante Medrano, C. P., & Nerio Diaz, A. V. (2006). El Proceso de Globalizacion y su Incidencia en la Violacion al Derecho de Libre Sindicalizacion de los Trabajadores del Instituto Salvado-reño del Seguro Social. San Salvador, El Salvador: Universidad de El Salvador, Facultad de Jurisprudencia y Ciencias Sociales. United States Social Security Administration. (2019b). Social Security Programs Throughout the World: The Americas, 2019. Retrieved from https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/americas/ssptw19americas.pdf
Equatorial Guinea	1984	Equatorial Guinea. (1982). Ley Fundamental de Guinea Ecuatorial. Promulgada por Decreto nº 65/1982 de fecha 7 de septiembre. Muñoz, D.C. (2016). Descentralización de los sistemas de salud: revisión sistemática de la literatura y estudio de caso en Guinea Ecuatorial (Doctoral dissertation, Universidad Complutense, Madrid, Spain). Retrieved from https://eprints.ucm.es/id/eprint/38887/1/T37686.pdf Serrano, A.C., & Abogo, P.M. (2006). Trabajo y Libertades Sindicales en Guinea Ecuatorial. Retrieved from DOI: 10.13140/RG.2.2.25854.43843.
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Eswatini	1968	Eswatini. (1968). Swaziland Independence Act, 1968.

Ethiopia	1959	Ethiopia. (1959). The Health Tax Decree No. 37 of 1959 (Negarit Gazeta 18th Year No. 14).
Fiji	1978	Negin, J., Roberts, G., & Lingam, D. (2010). The evolution of primary health care in Fiji: past, present and future. Pacific health dialogue, 16(2), 13–23. World Health Organization. (1978). Declaration of Alma-Ata. International Conference on Primary Health Care. Retrieved from https://www.euro.who.int/__data/assets/pdf_file/0009/113877/E93944.pdf World Health Organization. (2008). Fiji: Primary Health Care in Action. World Health Report. Country Examples. Retrieved from https://www.who.int/whr/2008/media_centre/fiji.pdf
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Gambia	1979	Lochting, L. I. (2008). The price to pay for maternal health care in rural Gambia (Master's thesis, University of Oslo, Oslo, Norway). Retrieved from https://core.ac.uk/download/pdf/30858933.pdf Republic of Gambia, & Ministry of Health and Social Welfare. (2017). Roadmap to Revitalize and Scale-up Primary Health Care in the Gambia 2018-2022. Banjul, Gambia: Republic of Gambia. World Bank. (1987). The Gambia - National Health Development Project. Retrieved from https://documents1.worldbank.org/curated/en/103401468030277449/pdf/multi0page.pdf
Georgia	1912	see Russia
Germany	1883	Alber, J. (1992). Das Gesundheitswesen der Bundesrepublik Deutschland. Entwicklung, Struktur und Funktionsweise. Frankfurt, New York: Campus. Busse, R., Blümel, M., Knieps, F., & Bärnighausen. T. (2017). Statutory health insurance in Ger-many: a health system shaped by 135 years of solidarity, self-governance, and competition. The Lancet, 390(10097): 882-897. Germany. (1883). Health Insurance Act (Nr. 1496) (1883). Köhler, P.A., Zacher, H.F. (Eds.). (1981). Ein Jahrhundert Sozialversicherung in der Bundesrepublik Deutschland, Frankreich, Großbritannien, Österreich und der Schweiz. Berlin: Duncker & Humblot.

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Guinea*	1958	Camara, M. E., Camara, A. Y., & Camara, N. (2017). The Healthcare System in Africa: The Case of Guinea. International Journal of Community Medicine and Public Health, 2(4), 690–692
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Guyana	1969	Gafar, J. (2005). The Impact of Economic Reforms on Health Indicators in Guyana. Caribbean Studies, 33(1), 149-176. Guyana. (1969). Act No. 15 of 1969, Guyana. ISAGS. (2012). Health System in Guyana. In ISAGS (Ed.), Health Systems in South America: chal-lenges to the universality, integrality and equity (pp. 505-541). Rio de Janeiro, Brazil: ISAGS. Misir, P. (2015). Health Care in Guyana. Social Medicine, 9(1), 36-47. National Insurance Board. (1970). National insurance and Social Security Guyana 1970. Report. Retrieved from https://www.nis.org.gy/sites/default/files/NIS%20Annual%20Report%201970.pdf Pan American Health Organization. (2001). Health Systems and Services Profile of Guyana. Retrieved from https://www.paho.org/hq/dmdocuments/2010/Health_System_Profile-Guyana_2001.pdf United States Social Security Administration. (2019b). Social Security Programs Throughout the World: The Americas, 2019. Retrieved from https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/americas/ssptw19americas.pdf World Health Organization & Ministry of Health, Guyana. (2008). WHO-AIMS Report on Mental Health System in Guyana. Retrieved from https://www.who.int/mental_health/guyana_who_aims_report.pdf

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Israel	1994	Arian, A. (1981). Health Care in Israel: Political and Administrative Aspects. International Political Science Review / Revue internationale de science politique, 2(1), 43-56. Clarfield, A. M., Manor, O., Bin Nun, G., Shvarts, S., Azzam, Z.S., Afek, A., Basis, F., & Israeli, A. (2017). Health and Health Care in Israel: An Introduction. The Lancet, 389(10088), 2503-2513. Cohen, W. J., & Farman, C.H. (1954). Social Security in Israel. Social Security Bulletin, 17(7), 3-8. Mirvis, D. M. (1997). Health Care Reform in Israel: An Historical and Sociopolitical Conundrum. International Journal of Public Administration, 20(10): 1703-1720. Rosen, B., & Hadar, S. (2009). Israel: Health System Review. Health Systems in Transition, 11(2), 1-227. Rosen, B., Waitzberg, R., & Merkur, S. (2015). Israel: Health System Review. Health Systems in Transition, 17(6): 1-215.
Italy	1888	Bassetti, C., Gulino, M., Gazzaniga, V., & Frati, P. (2011). The Old Roots of the Italian Health Legislation. Mediterranean Journal of Social Sciences, 2(2), 9-14.
Jamaica	1974	Campbell, A. (2013). The Abolition of User Fees in the Jamaican Public Health System (Doctoral dissertation, Victoria University of Wellington, Wellington, New Zealand). Retrieved from https://core.ac.uk/download/pdf/41338009.pdf Jamaica. (1974). The Public Health Act, Jamaica, 1974. Leavitt, R.L. (1992). Disability and Rehabilitation in Rural Jamaica: An Ethnographic Study. Teaneck, NJ: Fairleigh Dickinson University Press.
Japan	1922	HGPI, H. a. G. P. I. (2018). Japanese Health Policy NOW. Retrieved from http://japanhpn.org/wp-content/uploads/2019/10/JHPN_ENG_2019.pdf Ikegami, N., Yoo, B.-K., Hashimoto, H., Matsumoto, M., Ogata, H., Babazono, A., & Kobayashi, Y. (2011). Japan: Universal Health Care at 50 Years 2 Japanese Universal Health Coverage: Evolution, Achievements, and Challenges. The Lancet, 378(9796), 1106–1115. Retrieved from https://doi.org/10.1016/S0140-6736(11)60828-3
Jordan	1963	Ajlouni, M. T. (2011). Health Systems Profile: Hashemite Kingdom of Jordan. World Health Organi-zation, Eastern Mediterranean Regional Office. Retrieved from http://dx.doi.org/10.13140/RG.2.1.5182.3125 Al-Khalidi, M. (1992). The Determinants of Health Status in Jordan 1960 – 1988 (Doctoral disserta-tion, London School of Economics and Political Science, London, United Kingdom). Re-trieved from http://etheses.lse.ac.uk/id/eprint/1327 Kronfol, N.M. (2012). Historical Development of Health Systems in the Arab Countries: A Review. Eastern Mediterranean Health Journal, 18(11), 1151-1156.
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Kenya	1965	Abuya, T., Maina, T., & Chuma, J. (2015). Historical Account of the National Health Insurance Formulation in Kenya: Experiences from the Past Decade. BMC Health Services Research, 15(1), 56.

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Kosovo	1922	see Serbia
Kuwait	1962	Meleis, A. I. (1979). The Health Care System of Kuwait: The Social Paradoxes. Social Science & Medicine, 13(A), 743-749. Regional Health Systems Observatory [RHSO]. (2006). Health System Profile: Kuwait. World Health Organization. Retrieved from http://digicollection.org/hss/documents/s17297e/s17297e.pdf
Kyrgyzstan	1924	see Turkmenistan
Laos	1975	Akkhavong, K., Paphassarang, C., Phoxay, C., Vonglokham, M., Phommavong, C., & Pholsena, S. (2014). Lao People's Democratic Republic: Health System Review. Health Systems in Transition, 4(1), 1-136. Jönsson, K., Phoummalaysith, B., Wahlström, R., & Tomson, G. (2014). Health Policy Evolution in Lao People's Democratic Republic: Context, Processes and Agency. Health Policy Plan, 30(4), 518-527. Thome, J.-M., & Pholsena, S. (2009). Lao People's Democratic Republic: Health Financing Reform and Challenges in Expanding the Current Social Protection Schemes. Retrieved from https://www.social-protection.org/gimi/RessourcePDF.action;jsessionid=0gH29VCPcyMlP1G13WLPWHhtBrX66HU9PZ3CBgVCTVnbhohta1hR!1750948109?id=19822
Latvia	1912	Tragakes, E., Brigis, G., Karaskevica, J., Rurane, A., Stuburs, A., Zusmane, E. (2008) Latvia: Health System Review. Health Systems in Transition, 10(2), 1-253. see Russia
Lebanon	1963	Abyad, A. (2001). Health Care for Older Persons: A Country Profile—Lebanon. Journal of the American Geriatrics Society, 49(10), 1366-1370. El-Jardali, F., Bou-Karroum, L., Ataya, N., El-Ghali, H. A., & Hammoud, R. (2014). A retrospective health policy analysis of the development and implementation of the voluntary health insurance system in Lebanon: learning from failure. Social science & Medicine, 123, 45–54. Retrieved from https://doi.org/10.1016/j.socscimed. 2014.10.044 Kronfol, N.M. (2012). Historical Development of Health Systems in the Arab Countries: A Review. Eastern Mediterranean Health Journal, 18(11), 1151-1156.
Lesotho	1993	Lesotho. (1993). Constitution of Lesotho 1993, Act. No. 1.

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Lithuania	1912	"Sickness Insurance and Benefits". (1928). Sickness Insurance and Benefits. Monthly Labor Review, 26(6), 77-87. see Russia
Luxembourg	1901	European Observatory on Health Care Systems. (1999). Health Care Systems in Transition: Luxembourg. WHO Regional Office for Europe, Copenhagen. Köstler, U. (1996). Das Luxemburger Sozialversicherungssystem soll um eine Pflegesozialversicherung erweitert werden. Arbeit und Sozialpolitik, 50(5/6), 53-59. Luxembourg. (1901). Worker's Health Insurance Act, (July 31, 1901).
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Mauritius	1975	Mauritius. (1975). Labour Act 50 of 1975, Mauritius.
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Moldova	1912	see Russia
Mongolia	1922	Neumann, N., & Warburton, D. (2015). A Review of the Modern Mongolian Healthcare System. *Central Asian Journal of Medical Sciences, 1*(1), 16-21. Tsilaajav, T., Ser-Od, E., Baasai, B., Byambaa, G., & Shagdarsuren, O. (2013). Mongolia: Health System Review. Health Systems in Transition, 3(2), 1-163. World Bank. (2007). The Mongolian Health System at a Crossroads. An Incomplete Transition to a Post-Semashko Model. Working Paper. Washington, DC: World Bank Group.
Montenegro	1922	see Serbia
Morocco*	1959	Idrissi, K. S. (2002). La Sante dans le Royaume du Maroc. Médecine Tropicale, 62(5), 489–496.

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Namibia	1990	Namibia. (1990). Medical Scheme for Members of the National Assembly, Judges and Other Office-bearers Act, 1990. No. 23, Namibia.
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Nigeria	1999	Nigeria. (1999). National Health Insurance Scheme Decree (No. 35 of 1999), Nigeria.
North Korea	1946	Kichae, M., & Hyejin, K. (2018). Changes in the North Korean welfare System. North Korean Re-view, 14(2), 46-63. Soh, E. J. (2016). The Emergence of an Informal Health-Care Sector in North Korea. The Asia-Pacific Journal, 14(11), 1-15.
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Norway	1909	Kuhnle, S. (1978). The Beginnings of the Nordic Welfare States: Similarities and Differences. Acta Sociologica, 21(Special Congress Issue: The Nordic Welfare States), 9-35. Preker, A. S. (2018). Financing Universal Access to Healthcare: A Comparative Review of Landmark Legislative Health Reforms in the OECD. Singapore: World Scientific Publishing Company.
Oman	1975	Alshishtawy, M. M. (2010). Four Decades of Progress: Evolution of the Health System in Oman. Sultan Qaboos University Medical Journal, 10(1), 12-22 Regional Health Systems Observatory [RHSO]. (2006). Health System Profile: Oman. World Health Organization. Retrieved from http://digicollection.org/hss/documents/s17304e/s17304e.pdf
Pakistan	1965	Ibrar, M., Naqvi, R.H., Safdar, S., & Ranja, A.N. (2015). Historical Development of Health Care System in Pakistan: An Overview. PUTAJ-Humanities and Social Sciences, 22, 119-132. Pakistan. (1965). The Provinvial Employees' Social Security Ordinance, 1965 (W.P. Ord. X of 1965). Pakistan. (1965). West Pakistan Ordinance X of 1965
Panama	1941	Panama. (1941). Ley No. 23, de 21 de Marzo de 1941, por la cual se crea la Caja de Seguro Social, Panama. Renán Esquivel, J. (1981). La Revoluciòn de Panama en el Campo de la Salud. Panama City, Panama: Universidad de Panama, Facultad de Ciencias Naturales y Farmacía.
Papua New Guinea	1977	Grundy, J., Dakulala, P., Wai, K., Maalsen, A., & Whittaker, M. (2019). Independent State of Papua New Guinea Health System Review. World Health Organization. Regional Office for South-East Asia. Health Systems in Transition, 9(1), 1-201.
Paraguay	1936	Mancuello Alun, J. N., & Cabral de Bejarano, M. S. (2011). Sistema de Salud de Paraguay. Revista Salud Pública Paraguay, 1(1), 13-25. Paraguay. (1936). Ley N.° 2001/Ministerio de Salud Publica (M.S.P.), de 15 de Junio de 1936, Paraguay
Peru	1935	De Las Casas Grieve, J. (1967). Social Insurance and its Achievements in Peru. International Social Security Review, 20(4), 446-452. Retrieved from https://doi.org/10.1111/j.1468-246X.1967.tb00011.x Peru. (1935). Ley N.° 8124, de 12 de septiembre de 1935, creación del Ministerio de Salud. Peru. (1936). Ley N.° 8433, de 12 de agosto de 1936, que crea el Seguro Social Obrero Obligatorio y la Caja Nacional del Seguro Social.

Philippines	1954	Ford, M. J., & Cruz, A. H. (1957). The Rural Health Unit in the Philippines. Public Health Reports, 72(8), 687-695. Magsaysay, R. (1955). President Magsaysay's speech at the 48th Annual Meeting of the Philippine Medical Association at Baguio City, April 27, 1955. Official Gazette of the Republic of the Philippines, 51(5), 2348-2350. Romualdez, A.G., de la Rosa, J.F.E., Flavier, J.D.A., Quimbo, S.L.A., Hartigan-Go, K.Y., Lagrada, L.P., & David, L.C. (2011). The Philippines: Health System Review. Health Systems in Transition, 1(2), 1-142.
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Portugal	1935	Campos, A.M.F. (2013). Assistência médica e desigualdade social no Estado Novo. Revista Estudos do Século XX, 13. Retrieved from http://dx.doi.org/10.14195/1647-8622_13_20 Pita Barros, P., Ribeirinho Machado, S., & de Almeida Simões, J. (2011). Portugal: Health System Review. Health Systems in Transition, 13(4), 1-156. Portugal. (1935). Lei n.° 1884, especifica as instituições que ficam reconhecidas como sendo de previdência social, Portugal.
Qatar	1971	Qatar. (1965). Decree law 6 of 1965 on organizing medical care in state facilities (September 20, 1965), Qatar. Qatar. (1996). Law No. 7 of 1996 Organizing Medical Treatment & Health Services within the State (May 20, 1996), Qatar.
Romania	1933	Dinu, E.-S. (2017). The Health Regulations of the Romanian Old Kingdom at the End of the 19th Century and the Early 20th Century. Research and Science Today, 13(1), 6-11. Marian, B. (2018). The Evolution of the Social Security System in Romania. Law Review, 8(2): 76-88. Spiru, L., Trascu, R.I., Ileana Turcu, I., & Marzan, M. (2011). Perpetual transitions in Romanian healthcare. EPMA J, 2(4): 341-50.
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Slovakia	1888	Smatana, M., Pazitný, P., Kandilaki, D., Laktisová, M., Sedláková, D., Palusková, M., Van Ginneken, E., & Spranger, A. (2016). Slovakia: Health System Review. Health Systems in Transition, 18(6), 1-210. see Austria
Slovenia	1888	see Austria

Solomon Islands	1979	Asante, A., Graham, R., & Hall, J. (2012). A review of health leadership and management capacity in the Solomon Islands. Pacific Health Dialogue, 18(1), 166-177. Hodge, N., Slatyer, B., & Skiller, L. (2015). Solomon Islands: Health System Review. Health Systems in Transition, 5(1), 1-126. Solomon Islands. (1979). Chapter 100, Laws of Solomon Islands, Health Services, Act, 1 October, 1979. United States Social Security Administration. (2017). Social Security Programs Throughout the World: Asia and the Pacific, 2016. Retrieved from https://www.ssa.gov/policy/docs/progdesc/ssptw/2016-2017/asia/ssptw16asia.pdf
Somalia	N/A	Brown, B. (n.d.): Beyond the Brink: Somalia's Health Crisis. Retrieved from https://www.du.edu/korbel/hrhw/researchdigest/mena/HealthCrisis.pdf. Danish Immigration Service. (2020). Somalia: Health System. Retrieved from https://www.nyidanmark.dk/-/media/Files/US/Landenotater/COI_report_somalia_health_care_nov_2020.pdf?la=en-GB&hash=3F6C5E28C30AF49C2A5183D32E-1B68E3BA52E60C. Qayad, M. G. (2008). Health Care Services in Transitional Somalia: Challenges and Recommendations. Bildhaan: An International Journal of Somali Studies 7, 190-210. Regional Health Systems Observatory (EMRO). (2006). Health System Profile Somalia. Retrieved from http://digicollection.org/hss/documents/s17309e/s17309e.pdf.
South Africa	1977	Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges. The Lancet, 374(9692), 817-834. Retrieved from doi:10.1016/S0140-6736(09)60951-X South Africa. (1977). Health Act No. 63 of 1977, South Africa.
South Korea	1976	Chun, C.B., Kim, S.Y., Lee, J.Y., & Lee, S.Y. (2009). Republic of Korea: Health System Review. Health Systems in Transition, 11(7), 1-184. Kwon, S. (2008). Thirty Years of National Health Insurance in South Korea: Lessons for Achieving Universal Health Care Coverage. Health policy and planning, 24(1), 63-71. Nam, I. (2015). Democratizing Health Care. Welfare State Building in Korea and Thailand. Houndsmills, Basingstoke, United Kingdom: Palgrave Macmillan.
South Sudan	2011	South Sudan. (2011). The Transitional Constitution of the Republic of South Sudan, 2011.
Spain	1942	Blendon, R. J., Donelan, K., Jovell, A., Pellisé, L., & Costas Lombardia, E. (1991). Spain's Citizens Assess Their Health Care System. Health Affairs, 10(3), 216-228. Cutler, D. M., & Johnson, R. (2004). The Birth and Growth of the Social Insurance State: Explain-ing Old Age and Medical Insurance Across Countries. Public Choice, 120(1), 87-121. Garcia-Armesto, S., Abadía-Taira, M., Durán, A., Hernández-Quevedo, C., & Bernal-Delgado, E. (2010). Spain: Health System Review. Health Systems in Transition, 12(4), 1-295. Pagán Lozano, J. A. (2009). El Sistema Nacional de Salud de España. 1er. Congreso Internacional sobre Medicina y Salud. Hacia una Cobertura Universal en Salud. Retrieved from https://www.paho.org/mex/index.php?option=com_docman&view=download&alias=547-memoria-1er-congreso-internacional-sobre-medicina-y-salud-hacia-una-cobertura-universal-en-salud-22-24-abril-2009&category_slug=documentos-ops-y-oms&Itemid=493#page=83

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Sri Lanka	1952	Jayasuriya, L. (2001). The Evolution of Social Policy in Sri Lanka 1833-1970: The British Colonial Legacy. Journal of the Royal Asiatic Society of Sri Lanka, 46, 1-68. Rannan-Eliya, R. P., & Sikurajapathy, L. (2008). Sri Lanka: "Good Practice" in Expanding Health Care Coverage. Research Studies Series 3. Colombo, Sri Lanka: Institute for Health Policy. Sri Lanka. (1952). Health Services Act 1952 (April, 9), Sri Lanka. Uragoda, C.G. (1987). A History of Medicine in Sri Lanka. Cambridge, United Kingdom: Cambridge University Press.
Sudan	1967	Abdu, Z., Mohammed, Z., Bashier, I., & Eriksson, B. (2004). The impact of user fee exemption on service utilization and treatment seeking behaviour: the case of malaria in Sudan. International Journal of Health Planning and Management, 19(1), 95-106. Retrieved from doi:10.1002/hpm.777 Ebrahim, E. M. A., Ghebrehiwot, L., Abdalgfar, T., & Juni, M. H. (2017). Health Care System in Sudan: Review and Analysis of Strength, Weakness, Opportunity, and Threats (SWOT Analysis). Sudan Journal of Medical Sciences, 12(3), 133-150. Retrieved from doi:10.18502/sjms.v12i3.924 Salim, A. M. A., & Hamed, F. H. M. (2018). Exploring Health Insurance Services in Sudan from the Perspectives of Insurers. SAGE Open Medicine, 6, 1-10. Retrieved from doi:10.1177/2050312117752298
Suriname	1980	Eichler, R., & Amanh, F. (1999). Suriname - Health Sector Assessment. Inter-American Development Bank. Retrieved from https://publications.iadb.org/publications/english/document/Suriname-Health-Sector-Assessment.pdf ISAGS. (2012b). Health System in Suriname. In ISAGS (Ed.), Health Systems in South America: challenges to the universality, integrality and equity (pp. 670-711). Rio de Janeiro, Brazil: ISAGS. Larye, S., Goede, H., & Barten, F. (2015). Moving toward Universal Access to Health and Universal Health Coverage: a Review of Comprehensive Primary Health Care in Suriname. Revista Panamericana de Salud Pública, 37(6), 415-421. Pan American Health Organization. (2002). Health Systems and Services Profile of Suriname. Re-trieved from https://www.paho.org/hq/dmdocuments/2010/Health_System_Profile-Suriname_2002.pdf Smits, C., Toelsie, J., Eersel, M., & Krishnadath, I. (2018). Equity in health care: An urban and ru-ral, and gender perspective; the Suriname Health Study. AIMS Public Health, 5(1), 1–12. Suriname. (1980). Decreet van 19 november 1980, houdende machtiging tot oprichting van de Stichting Staatsziekenfonds (S.B. 1980 no. 120).

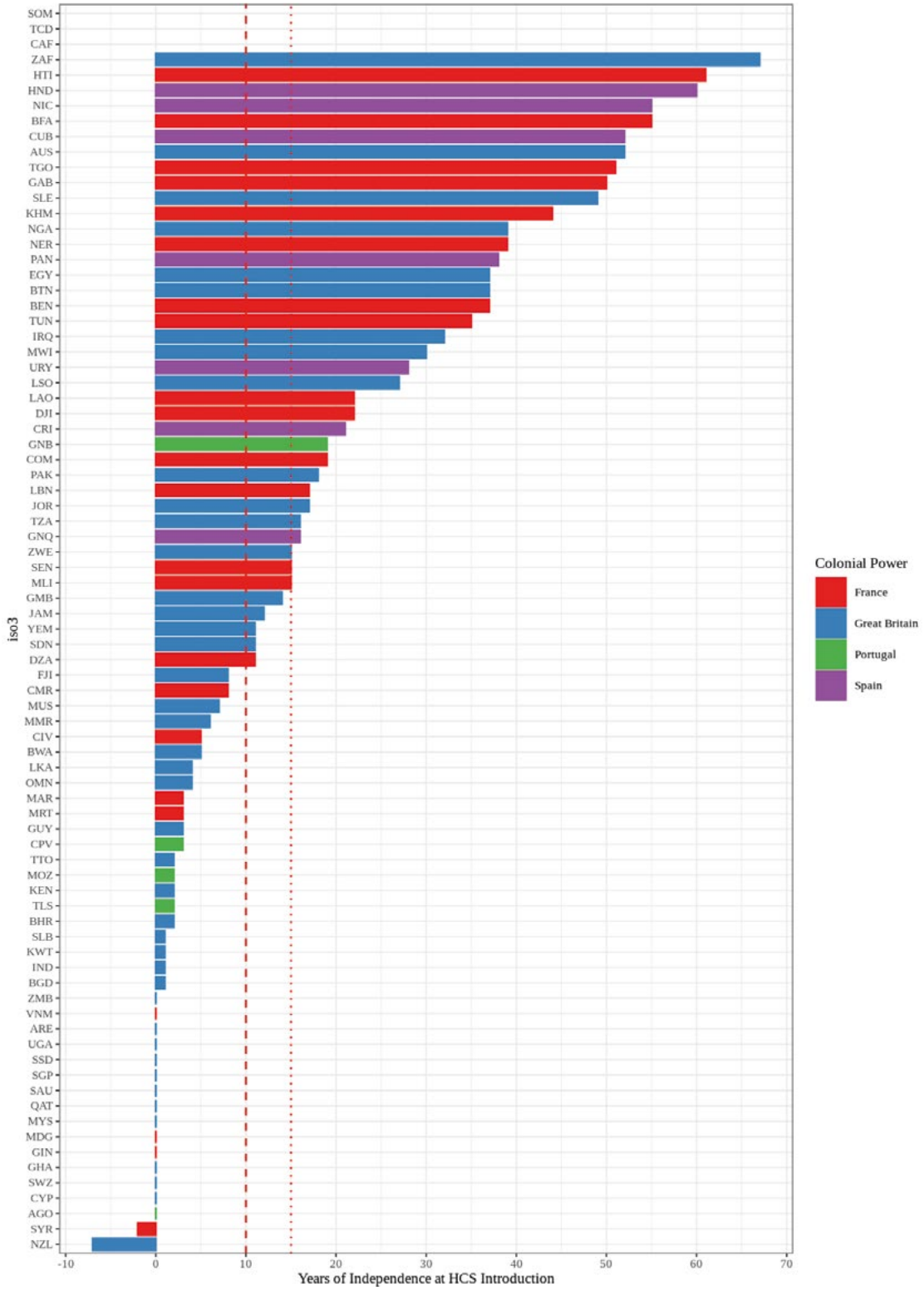
Sweden	1928	Anell, A., Glenngard, A.H., & Merkur, S. (2012). Sweden: Health system review. Health Systems in Transition. Health Systems in Transition, 14(5), 1–159. Committee on Labor and Public Welfare, and Subcommittee on Health. (1972). Factfinding Visit to Europe and Israel. Washington, DC: Congress.
Switzerland	1911	Alber, J., & Bernardi-Schenkluhn, B. (1992). Westeuropäische Gesundheitssysteme im Vergleich: Bundesrepublik Deutschland, Schweiz, Frankreich, Italien, Großbritannien. Frankfurt a.M., Germany: Campus Verlag. BMJ, British Medical Journal. (1911). National Sickness Insurance in Switzerland. The British Medi-cal Journal, 2(2650), 925-929. Bundesamt für Sozialversicherung der Schweiz. (n.d.). Anzahl Mitglieder einer Krankenkasse, nach Geschlecht und % der Bevölkerung, 1914-1960. Retrieved from: https://www.geschichtedersozialensicherheit.ch/fileadmin/redaktion/Zahlen/G12.jpg?v=1390394619 De Pietro, C., Camenzind, P., Sturny, I., Crivelli, L., Edwards-Garavoglia, S., Spranger, A., Wit-tenbecher, F., & Quentin, W. (2015). Switzerland: Health System Review. Health Systems in Transition, 17(4), 1-288 Köhler, P.A., Zacher, H.F. (Eds.). (1981). Ein Jahrhundert Sozialversicherung in der Bundesrepublik Deutschland, Frankreich, Großbritannien, Österreich und der Schweiz. Berlin: Duncker & Humblot.
Syria	1959	Syria. (1959). Syrian Arab Republic, Law No 91, 1959 –Labour Code (1959.04.05), Syria.
Taiwan	1950	Hye Kyung Son, A. (2001). Taiwan's path to national health insurance (1950–1995). International Journal of Social Welfare, 10(1), 45–53. Liu, M. S. (2017). Transforming Medical Paradigms in 1950s Taiwan. East Asian Science, Technology and Society, 11, 477–497. Retrieved from doi:10.1215/18752160-4197874 Lu, J.-F. R., & Chiang, T.-L. (2011). Evolution of Taiwan's Health Care System. Health Economics, Policy and Law, 6(1), 85-107.
Tajikistan	1924	see Turkmenistan
Tanzania	1977	Tanzania. (1977). The Private Hospitals (Regulation) Act, No.6/1977, Tanzania.
Thailand	1974	NHSO. (2019). Thailand UHC and overview of the universal coverage scheme of the National Health Security Office. Bangkok, Thailand: NHSO. Rajatanavin, R., Chunharas, S., Sawasdivorn, W., Jongudomsuk, P., & Thammatacharee, J. (2019). Resilient Health System and UHC. Bangkok, Thailand: P.A. Living Co.,Ltd.
Togo	2011	Atake, E.-H., & Amendah, D.D. (2018). Porous safety net: catastrophic health expenditure and its determinants among insured households in Togo. BMC Health Services Research, 18(175). Retrieved from https://doi.org/10.1186/s12913-018-2974-4 Djahini-Afawoubo, D.M., & Atake, E.-H. (2018). Extension of mandatory health insurance to in-formal sector workers in Togo. Health Economics Review, 8(22). Retrieved from https://doi.org/10.1186/s13561-018-0208-4

Trinidad and Tobago	1964	Hezekiah, J. A. (1989). The Development of Health care Policies in Trinidad and Tobago: Autonomy or Domination? International Journal of Health Services, 19(1), 79-93.
Tunisia*	1991	Tunisia. (1991). Loi n° 91 -63 du 29 Juillet 1991, relatif à l'organisation Sanitaire, République tunisienne.
Turkey	1950	Grütjen, D. (2017). The Transformation of the Turkish Welfare State. Conceptualizing the Role of the State, the Market, Non-governmental Actors, and the Family in Healthcare Financing, Provision, and Regulation (Doctoral dissertation, Freie Universität Berlin, Berlin, Germany). Retrieved from http://dx.doi.org/10.17169/refubium-2322 Kohlwes, S. (2014). Governing Health. Transformations in the Turkish Health Care System. GeT MA Working Paper Series. Berlin, Germany: Department of Social Sciences, Humboldt-Universität zu Berlin. Ministry of Health Turkey. (2018). History. Retrieved from: https://www.saglik.gov.tr/EN,15601/history.html United States Social Security Administration. (2018). Social Security Programs Throughout the World: Europe, 2018. Retrieved from https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/europe/ssptw18europe.pdf Tatar, M., Mollahaliloglu, S., Sahin, B., Aydin, S., Maresso, A., &, Hernandez-Quevedo, C. (2011). Turkey: Health System Review. Health Systems in Transition 13(6), 1-186.
Turkmenistan	1924	Goudima, T., & Rybalko, L. (1996). Social Insurance in Russia: History and Contemporaneity. Nordisk försäkringstidskrift, 1996, 342-50. Popovich, L., Potapchik, E., Shishkin, S., Richardson, E., Vacroux, A., & Mathivet., B. (2011). Rus-sian Federation: Health System Review. Health Systems in Transition, 13(7): 1-190. Reshetnikov, V. A., Arsentyev, E.V., Boljevic, S., Timofeyev, Y., & Jakovljevic, M. (2019). Analy-sis of the Financing of Russian Health Care over the Past 100 Years. International Journal of Environmental Research and Public Health 16(10), 1848. Retrieved from http://dx.doi.org/10.3390/ijerph16101848
Uganda	1962	Uganda. (1962). The Uganda (Independence) Order in Council, 1962 and The Constitution of Uganda.
Ukraine	1912	see Russia
United Arab Emirates	1971	Regional Health Systems Observatory [RHSO]. (2006e). Health System Profile - United Arab Emirates. World Health Organization. Retrieved from http://digicollection.org/hss/documents/s17313e/s17313e.pdf United Arab Emirates. (1971). Constitution of the UAE. United Arab Emirates. (1972). Federal Law 1/1972, UAE.
United Kingdom	1911	Foerster, R.F. (1912). The British National Insurance Act. The Quarterly Journal of Economics, 26(2), 275-312. Harris, H.J. (1920). The British National Health Insurance System, 1911-1919. Monthly Labor Review, 10(1): 45-59. United Kingdom. (1911). The National Insurance Act, c. 55, 16 December, 1911, United Kingdom.

United States	1965	Booth, M., & Mor, V. (2007). Long-term Care in the USA: Lessons for New Zealand? Social Policy Journal of New Zealand, 32, 17-31. Grabowski, D. C. (2007). Medicare and Medicaid: conflicting incentives for long-term care. The Milbank quarterly, 85(4), 579–610. Gruber, J. (2000). Medicaid (Working Paper 7829). Retrieved from https://ssrn.com/abstract=238476 Hacker, J. S. (1998). The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy. Studies in American Political Development, 12, 57-130. United States Social Security Administration. (2009). Annual Statistical Supplement to the Social Security Bulletin. Retrieved from https://www.ssa.gov/policy/docs/statcomps/supplement/2009/supplement09.pdf. United States. (1965). Public Law 89-97, July 30, 1965, Social Security Amendments.
Uruguay	1910	Ferrari, J. (2010). A 100 Anos de la ley de Asistencia Pública Nacional. Sociedad Uruguaya de Histo-ria de la Medicina. Retrieved from https://www.smu.org.uy/dpmc/hmed/historia/articulos/100apn.pdf Government of Uruguay. (1913). La Asistencia Pública Nacional. Montevideo, Uruguay: Talleres Graficos Barreiro y Ramos. Government of Uruguay. (2020). Ministerio de Salud Pública. Creación y evolución histórica. Retrieved from https://www.gub.uy/ministerio-salud-publica/institucional/creacion-y-evolucion-historica Muñoz, M., Galeano, M., Olesker, D., & Garrido, J. (2010). La construcción del Sistema Nacional Integrado de Salud. Ministerio de la Salud Pública. Retrieved from https://www.paho.org/hq/dmdocuments/2010/construccion_sist_nac_integrado_salud_2005-2009-uruguay.pdf Puñales, S. (2002). Historia de la enfermería en Uruguay. Montevideo, Uruguay: Ediciones Trilce.
Uzbekistan	1924	see Turkmenistan
Venezuela	1944	Bonvecchio, A., Becerril-Montekio, V., Carriedo-Lutzenkirchen, A., & Landaeta-Jiménez, M. (2011). Sistema de salud de Venezuela. Salud Pública Mexico, 53(2), 275-286. Powell, O. M. (1946). Social Insurance in Venezuela. Social Security Bulletin, 9(4), 3-8. Retrieved from https://www.ssa.gov/policy/docs/ssb/v9n4/v9n4p3.pdf
Vietnam	1954	Birt, C.A (1990). Establishment of Primary Health Care in Vietnam. British Journal of General Practice, 40(337), 341-344. Ladinsky, J.L., & Levine, R.E. (1985). The Organization of Health Services in Vietnam. Journal of Public Health Policy, 6(2), 255-268. London, J.D. (2008). Reasserting the State in Viet Nam Health Care and the Logics of Market-Leninism. Policy and Society, 27(2), 115-128. Matsuda, S. (1997). An Introduction to the Health System in Vietnam. Environmental Health and Preventive Medicine, 2(3), 99-104.
Yemen	1978	Lackner, H. (2017). The People's Democratic Republic of Yemen: Unique Socialist Experiment in The Arab World at a Time of World Revolutionary Fervour. Interventions-International Journal of Postcolonial Studies, 19(5), 677-691. World Health Organization. (1979). Report to the International Commission for the Certification of Smallpox Eradication in the People's Democratic Republic of Yemen, April 1979. Geneva, Switzerland: World Health Organization.
Zambia	1964	Zambia. (1964). Zambia Independence Act, 1964.
Zimbabwe	1980	Zimbabwe. (1980). The Constitution of Zimbabwe, 1980.

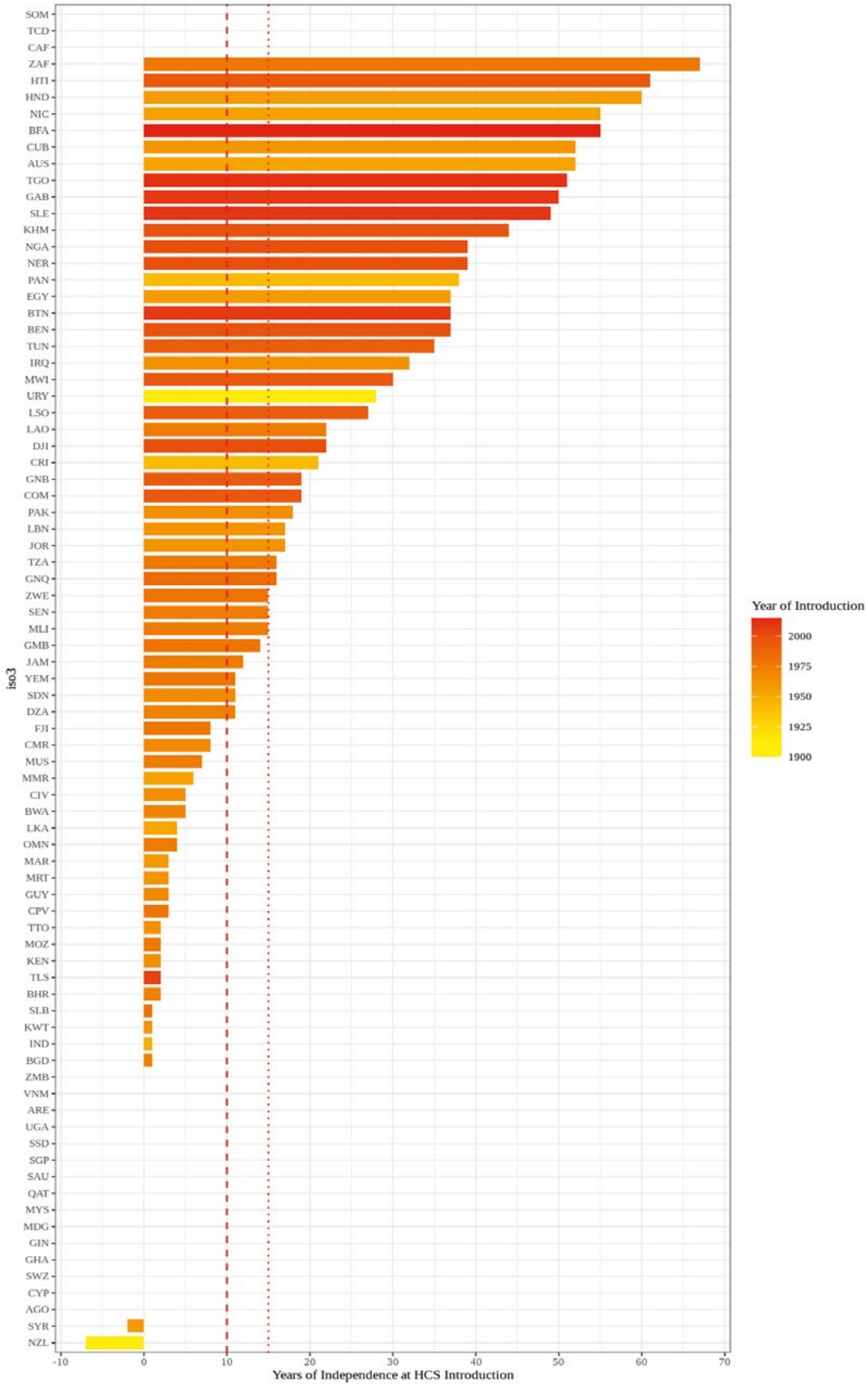
* Introduction years for countries signaled with asterisks need further validation from experts.

Figure 9.
Health care system introduction in former colonies by colonial power



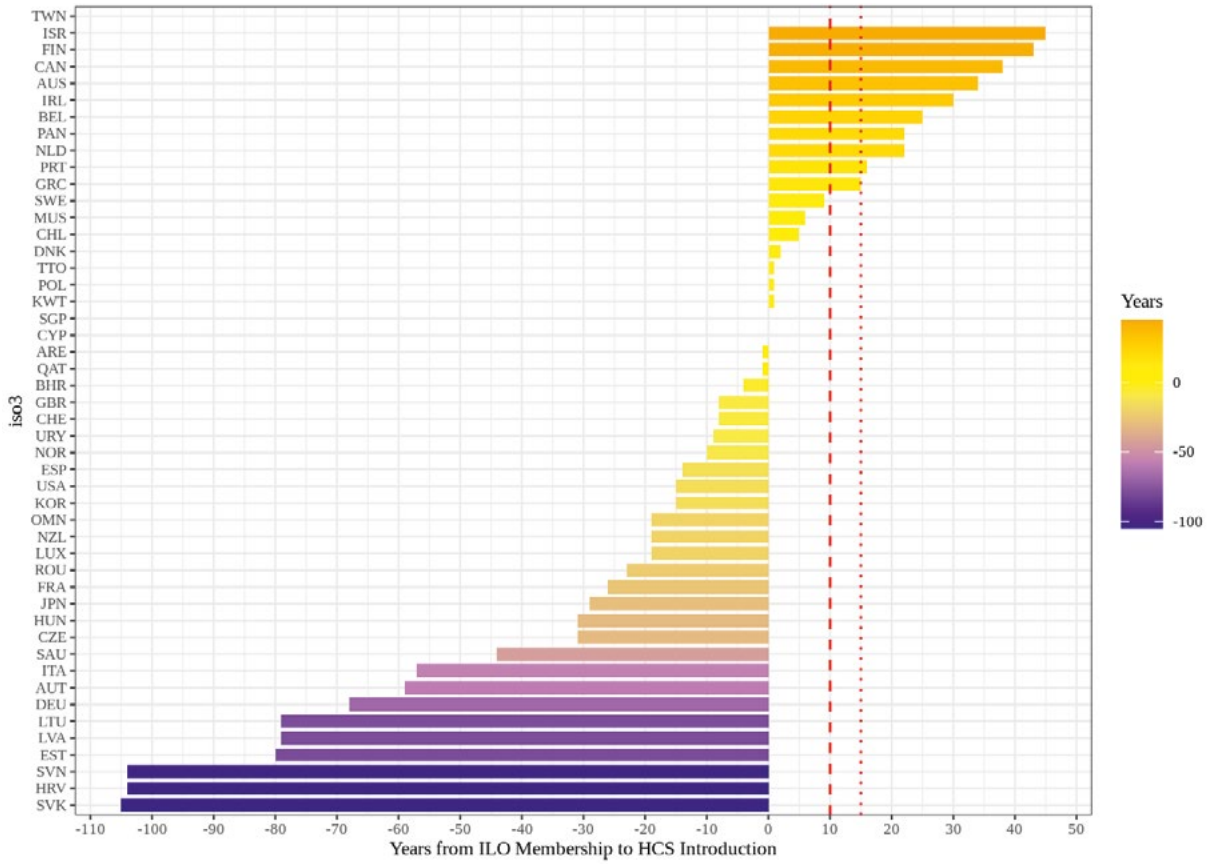
Source: own presentation.

Figure 10.
Health care system introduction in former colonies by introduction year after independence



Source: own presentation.

Figure 11.
Health care system introduction in high-income ILO country members

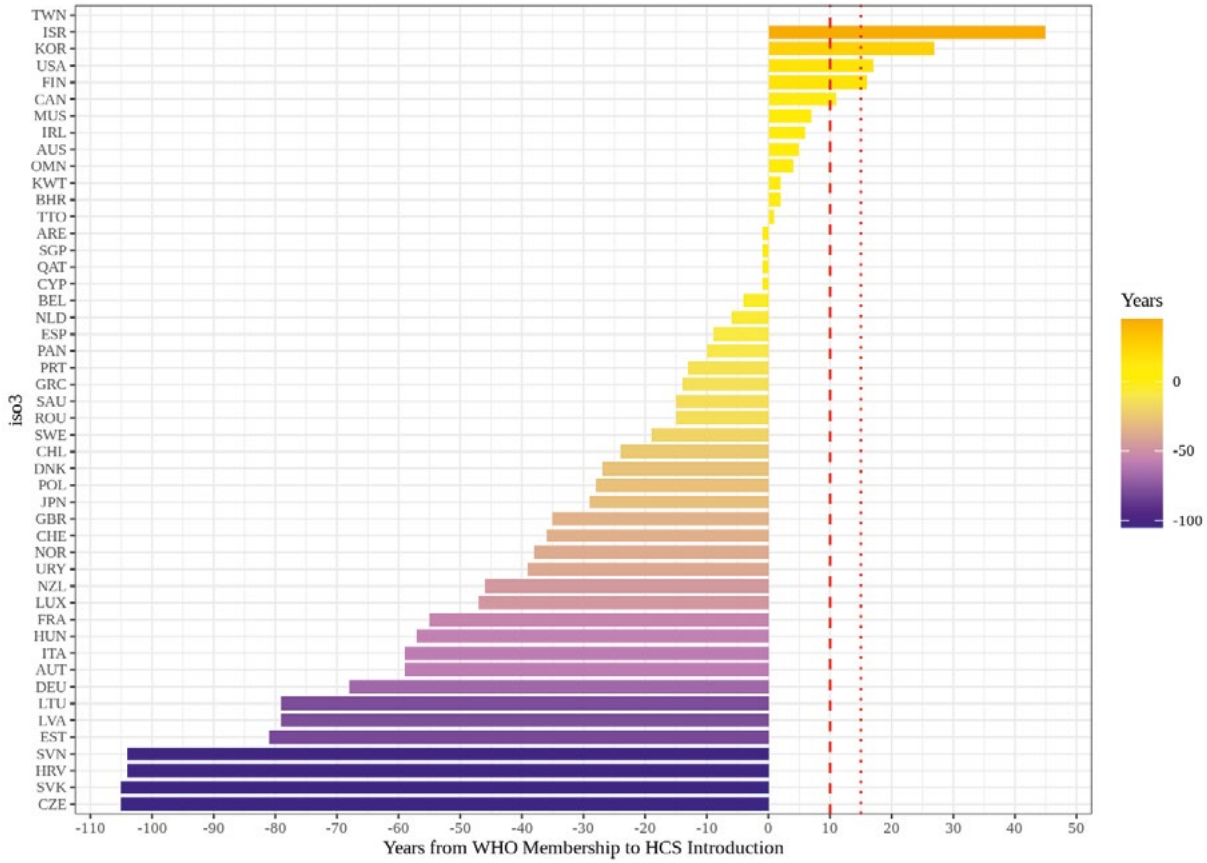


Source: own presentation.

Figure 12.
Health care system introduction in LMI ILO country members

Source: own presentation.

Figure 13.
Health care system introduction in high-income WHO country members



Source: own presentation.