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Classifying healthcare systems at introduction: Types of healthcare systems under public responsibility

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Abstract

This paper provides a descriptive account of types of healthcare systems under public responsibility as they were introduced worldwide. Based on the actor-centred typology proposed by Frisina Doetter et al. (2021) and a definition for emergent healthcare systems (de Carvalho & Fischer, 2020), we have examined 167 independent countries with a population of more than 500,000 and classified healthcare systems as they were shaped at inception. The classification results in 14 types of healthcare system with distinct actor combinations in regulation, financing, and service provision. If only the regulation and financing dimension are considered, healthcare systems can be condensed into six deductively created clusters. The focus on the regulation dimension reveals two worlds of healthcare – a state-regulated and a societally regulated world. While systems that rely on societal actors mainly emerged prior to the mid-20th century, state-based systems have characterized system introductions since then.

Zusammenfassung

In diesem Arbeitspapier untersuchen wir die Ausgestaltung von „öffentlich verantworteten“ Gesundheitssystemen zum Zeitpunkt ihrer Einführung. Mittels einer von Frisina Doetter et al. (2021) vorgestellten akteurszentrierten Typologie und einer Definition für die Einführungszeitpunkte von Gesundheitssystemen (de Carvalho & Fischer, 2020) klassifizieren wir Gesundheitssysteme in 167 Ländern mit einer Bevölkerung von über 500.000 Einwohnern. Die Klassifizierung ergibt 14 Gesundheitssystemtypen mit einer spezifischen Konstellation von Akteurstypen in der Regulierungs-, Finanzierungs- und Leistungserbringungsdimension. Werden nur die Regulierungs- und Finanzierungsdimensionen betrachtet, so lassen sich die Systeme in sechs Cluster unterteilen. Legt man das Augenmerk allein auf die Regulierungsdi-mension, so ergeben sich eine staatsregulierte und eine durch gesellschaftliche Akteure regulierte Welt von Gesundheitssystemen. Bis Mitte des 20. Jahrhunderts wurden überwiegend Gesundheitssysteme eingeführt, in denen gesellschaftliche Akteure eine maßgebliche Rolle spielen. Danach dominieren staatsbasierte Systeme bei der Einführung des Gesundheitssystems.

Contents

1. Introduction

The introduction of a social health insurance in Germany in 1883 marks the starting point of a welfare state expansion by which in the meantime 164 countries around the world with at least 500,000 inhabitants have introduced healthcare systems under public responsibility. Following de Carvalho & Fischer (2020, p. 13) the constitutive elements of a healthcare system under public responsibility include (i) its establishment by national legislation, (ii) statutory entitlements to healthcare, and (iii) the integration of the system by means of designated institutions and responsibilities. While healthcare was provided long before such systems came into existence, without a healthcare system under public responsibility access to healthcare was dependent upon the individual ability to pay, charity, or membership of privileged groups who could afford some form of mutual insurance. We are, however, interested in the emergence of healthcare systems guaranteeing statutory rights to healthcare.

Applying the above definition, de Carvalho et al. (2021) describe the timeline of introduction while Polte et al. (2021) also test some explanatory hypotheses for the introduction of a healthcare systems. However, healthcare systems in different countries differ substantially in terms of financing, service provision and regulation. The questions thus arise how these healthcare systems can be characterized and categorized as they emerge, whether certain system types have been more prominent than others, and how the structure of healthcare systems at their inception has changed over time.

In Section 2 we lay the theoretical foundations for answering these questions by selecting and describing the typology we subsequently use. Section 3 summarizes the data and methods used to classify healthcare systems with respect to the chosen typology, while Section 4 presents the results of this classification exercise. The discussion of these results and a conclusion follow in Section 5.

2. Theoretical framework

In order to present the theoretical framework employed to classify and compare healthcare systems at the time of their introduction, we first describe and identify strengths and limitations of the most influential healthcare systems typologies. Second, we elaborate on the analytical framework proposed by Frisina Doetter et al. (2021) as an advancement of Wendt et al. (2009), justifying its use in this study.

2.1 Overview of extant healthcare systems typologies

Comparison is a fundamental part of social science research, as it is useful for understanding particular phenomena, identifying empirical manifestations and patterns, and finding (ir)regularities (Della Porta, 2010). One of the most widely used tools in comparative research is typologies (Powell & Barrientos, 2015). A typology is a conceptual framework for grouping together instances bearing a shared set of attributes, and is useful for ordering, reducing complexity, showing patterns, displaying dissimilarities in a systematic manner, and facilitating theory building (Freeman & Frisina, 2010; Collier et al., 2012). Typologies have become a widely used tool in the healthcare field since Roemer's world mapping of the relationship between public health departments and medical care administrations as early as the 1960s. His research culminated in a typology comprising four main types of systems: free enterprise, social insurance, public assistance and universal service (Roemer, 1960). A systematic literature review conducted by de Carvalho et al. (2020) identified over 40 studies spanned across six decades claiming to have created of new classificatory tools for

healthcare systems. Although the examined scholarship varies in terms of period of observation and scope of enquiry, most typologies share similar features with regard to criteria for classification, adopted methods, as well as analysed cases. This section reviews the five most cited studies up until April 2021 among the 41 typologies analysed by de Carvalho et al. (2020) according to Google Scholar and Web of Science citation metrics[1].

Developed over a series of studies, the OECD (1987) typology has been one of the most frequently adopted tools for classification, often serving as a starting point for the development of more refined frameworks (e.g. Freeman & Schmid, 2008). The typology groups countries into three models on the basis of three main dimensions, namely coverage, funding, and ownership. The first type is the national health service, characterized by the use of taxation to fund its services, public ownership of service provision, and universal coverage. The second is the social insurance model, also characterized by universal coverage but financed through social insurance contributions and with services provided in public and/or private hospitals and by employed physicians. Finally, the third type, the private insurance model, is marked by private insurance coverage, funding and service provision. Though vastly employed, the OECD typology is not without criticism. The types strongly rely on the cases of the United Kingdom, Germany and the United States as the basis for each respective model, making their use problematic for broader cross-country comparisons involving a greater variety of systems (Wendt et al., 2009).

One of the most comprehensive typologies with the highest level of abstraction was developed by Moran (2000) and attempts to classify eight OECD countries/regions. This framework introduces the concept of the healthcare state, comprising the institutions related to governing consumption, provision and production. These sets of institutions vary according to the level of public control, resulting in four healthcare groups: the entrenched command and control state, in which consumption, provision and production are governed by the state; the supply state, where consumption and provision are mainly market-based/private; the corporatist state, in which consumption is dominated by public law bodies and provision by doctors' associations; and insecure command and control states, in which nationalized and private sectors coexist. Moran's main contribution is the emphasis on the responsibility of the state across all healthcare system dimensions.

Expanding on Esping-Andersen's (1990) notion of decommodification by including healthcare services, Bambra (2005) promotes the concept of health decommodification, referring "to the extent to which an individual's access to healthcare is dependent upon their market position and the extent to which a country's provision of health is independent from the market" (Bambra, 2005, p. 33). Eighteen OECD cases are grouped into three clusters: high, medium and low-decommodification groups. Further, Wendt (2009) classifies 15 European countries based on expenditures, financing source, provision and access to healthcare. In this way the study identifies three clusters of healthcare systems. The types differ in terms of the importance of service provision in the outpatient sector, coverage levels, and levels of healthcare expenditure. Both studies are highly inductive and empirically driven, making these typologies unfit for classifying cases that cannot be quantitatively measured.

By contrast, Wendt et al. (2009) have taken a deductive approach, referring to financing, provision, and regulation as the basic responsibilities of healthcare systems. They characterize these dimensions along predominant actor types. Based on health systems literature (e.g. Blank & Burau, 2004;

1 Appendix I shows a list with references and number of citations.

Giaimo & Manow, 1999; Hsiao, 1995; Moran, 2000; Powell, 2007), as well as observations of OECD healthcare systems, they differentiate state, societal, and private actors. Crucially, the authors assume that each actor type manifests itself in distinct, idealized patterns across the three dimensions. By way of example, state-led systems are typified by tax financing, public provision and hierarchical regulation. Ultimately, by combining dimensions and actors, Wendt et al. (2009) arrive at a matrix of 27 types. It bears noting that Böhm et al. (2013) tested the usability of this typology for the OECD world, concluding that only 10 out of the 27 possible types are plausible and only 5 suffice to classify all countries under scrutiny.

Overall, the most prominent classifications understand healthcare systems in terms of (aspects of) three dimensions: financing, service provision, and regulation. Moran (2000) adds technology to this list. The studies limit their analysis to OECD countries, developing frameworks that are only useful to describe systems with the highest levels of financial and technical resources and institutional capacity. The focus on high-income economies translates into typologies that do not consider the particularities of countries outside the OECD context, where external financing and other forms of involvement by non-domestic actors may play a prominent role, and where out-of-pocket payment is often the main source of funding (de Carvalho et al., 2020). None of the reviewed typologies, however, take into account the influence of foreign actors and the difference between private insurance premiums and out-of-pocket payments despite their considerable importance in healthcare systems, especially in systems of the Global South[2].

2.2 An actor-centred typology for global comparison

As the study conducted by de Carvalho et al. (2020) and our brief review demonstrate, the limitations of existing healthcare system typologies point to the need for a more comprehensive tool to serve as a universal framework for global comparison. The actor-centred typology proposed by Frisina Doetter et al. (2021), which is an extension of the framework developed by Wendt et al. (2009) and further refined by Böhm et al. (2013), shares the strengths of existing approaches, such as the healthcare dimensions (i.e., regulation, financing, and service provision) and the adaption to the whims of data availability[3], while at the same time addressing some of their shortcomings.

The proposed typology adds a new layer to the well-established national actor constellation with the *state-society-market* trichotomy commonly used in the comparative welfare states literature, borrowing from novel research strands such as transnational interdependencies (e.g. Obinger et al., 2013) and Global Social Policy (e.g. Kaasch, 2015) scholarships to include non-domestic players to the mix. The reasoning behind the inclusion of *global actors* is that – especially in countries under resource constraints – non-domestic actors may take the lead in healthcare. Global actors could thereby be differentiated according to the state-society-market trichotomy (see Table 1), but are merged for reasons of practicability. The actor-centred typology also differentiates itself from the existing literature by virtue of the distinction between *private-collective* and *private-individual* actors in the financing dimension (see Table 1 for examples). These neutralize, or at least minimize, a potential Global North bias, as its flexibility allows for the use of different data, the choice of

2 We understand as the Global South the countries that are not classified as high-income by the World Bank (2021).

3 For a detailed account of the different healthcare functions see Wendt et al. (2009) and Böhm et al. (2013).

Table 1.
Healthcare system actors' constellation

	Domestic	**Non-domestic**
State	Government (national, regional, local), ministries, health authorities	Supra- and International organizations (EU, WHO, World Bank, OECD, IMF, etc.), foreign governments
Societal	Non-governmental regulatory bodies of health insurance funds and healthcare providers, social health insurance funds, panel doctor associations, non-profit organizations providing healthcare, charitable organizations, etc.	Non-governmental organizations and foundations (Doctors Without Borders, Red Cross, other humanitarian aid associations, etc.)
Private collective	For-profit providers of healthcare, private health insurance funds, enterprises.	Internationally operating medical industry, international private health insurance funds
Private individual	Individuals and households	Individuals and households

Source: Frisina Doetter et al., 2021, p. 5.

quantitative versus qualitative methods, the differentiation between private insurance premiums and out-of-pocket payments, as well as the importance of global actors in the healthcare field. Table 1 shows examples of each actor type.

In line with Wendt et al. (2009) and Böhm et al. (2013), the authors assume that each of the healthcare systems dimensions are dominated by a specific actor type. The framework presumes that the same constellation of actor types can be applied regardless of the amount of resources that goes into the system and the timing in which it has been developed, which makes the typology useful for global and historical comparison. The actor constellation (i.e. types of actor) remain constant over time and over a heterogeneous set of cases. Taking the three dimensions and the number of actors into account, the typology arrives at 80 potential healthcare system types (4 x 5 x 4, Table 2).

Regarding regulation, the actor that primarily coordinates the relationship between beneficiaries, financing institutions and providers is considered to be the main regulatory authority. In general, the state has the jurisdiction to define the competence of all other actors. However, governments may entrust societal and private actors with regulatory powers. Global actors may shape the regulation of the system indirectly, through recommendations, or directly, through conditionalities and coercive prescriptions. In cases where state capacities are limited or failed, global actors may take on core responsibilities in the coordination of the system. The service provision dimension deals with the ownership of providers. Where the dominant form of service delivery is provided by non-profit, autonomous institutions such as charities and foundations, provision is classified as societal. In the cases where services are mainly provided by for-profit hospitals and clinics, the typology is categorized as private. Provision in state-run facilities and public workforces demonstrates the interest of the state in healthcare. Finally, international governmental organizations and foreign non-governmental organizations can act as the main source of medical professionals and facilities.

Concerning the financing dimension, responsibility is assigned according to funding sources, whereby taxation is the main state financing form, social insurance contributions are the main societal funding source, and external spending and aid the primary global source. In this dimension, the framework differentiates private collective and private individual actors. The former refers to voluntary private health insurance schemes, in which risks are pooled. The latter comprises out-of-pocket payments, where individuals/

Table 2.
Matrix of potential healthcare system types

Actors in regulation	Actors in financing	Actors in provision			
		State	Societal	Private	Global
State	State	*Type 1*	Type 2	Type 3	Type 4
	Societal	Type 5	Type 6	Type 7	Type 8
	Private collective	Type 9	Type 10	Type 11	Type 12
	Private individual	Type 13	Type 14	Type 15	Type 16
	Global	Type 17	Type 18	Type 19	Type 20
Societal	State	Type 21	Type 22	Type 23	Type 24
	Societal	Type 25	*Type 26*	Type 27	Type 28
	Private collective	Type 29	Type 30	Type 31	Type 32
	Private individual	Type 33	Type 34	Type 35	Type 36
	Global	Type 37	Type 38	Type 39	Type 40
Private	State	Type 41	Type 42	Type 43	Type 44
	Societal	Type 45	Type 46	Type 47	Type 48
	Private collective	Type 49	Type 50	*Type 51*	Type 52
	Private individual	Type 53	Type 54	*Type 55*	Type 56
	Global	Type 57	Type 58	Type 59	Type 60
Global	State	Type 61	Type 62	Type 63	Type 64
	Societal	Type 65	Type 66	Type 67	Type 68
	Private collective	Type 69	Type 70	Type 71	Type 72
	Private individual	Type 73	Type 74	Type 75	Type 76
	Global	Type 77	Type 78	Type 79	*Type 80*

Source: Frisina Doetter et al., 2021, p. 6. The types in the grey-shaded cells are characterized by the same actor type dominating all dimensions.

Table 3.
Global typology of healthcare systems overview

	Regulation	Financing	Service Provision
State	Regulated by governments/ parliament	Taxation/other state revenue	Public provision
Societal	Regulated by associations of social insurance and providers	Social insurance contributions	Non-profit organization provision
Private collective	Regulated by private insurers or providers of services in out-of-pocket transactions	Private insurance contributions	For-profit private provision
Private individual		Out-of-pocket payments	
Global	Regulated by international organizations, non-governmental organizations, or foreign governments	External/Foreign spending	Global actor provision

Source: own presentation based on Frisina Doetter et al., 2021, p. 6.

households have to bear the full costs of services, without risk-pooling. Table 3 summarizes the behaviour of each actor type within each functional dimension.

3. Data and methods

In order to classify systems at the time of their inception, we first present the definitions employed in this research[4]. We understand healthcare systems as the sum of all formal arrangements concerning the financing, regulation and provision of qualified health services within a society dealing specifically with healthcare as an area of social protection. What we call 'systems under public responsibility' come into being when they meet three preestablished criteria: (a) the first national legal act is ratified, (b) entitlement to healthcare benefits is granted, and (c) the elements of the healthcare system are integrated. Condition (a) specifies the national level as the locus of legislative action, mainly for reasons of practicability in analysing as many as 167 countries. Systems implemented by regional and/or local authorities are excluded from the analysis even when they precede arrangements at the national level. Condition (b) refers to the existence of statutory rights to medical care as opposed to merely voluntary benefits or sick pay. Condition (c) helps to distinguish healthcare systems from rudimentary policies or programs. To operationalize the point of introduction of said systems, we rely on the judgement of experts, in particular agreement in the existing scholarship, about when a healthcare system has been introduced. The points of introduction are extracted and evaluated according to a five-steps approach. First, a system must be introduced by a national legal act. Second, this legislation must be the first ratified act of its kind. Third, an institution or a set of institutions must be explicitly responsible for healthcare. Fourth, the legal act must establish entitlements to healthcare. Finally, these entitlements must identify the population group(s) that can access the benefits. Table 4 summarizes our operationalization.

In addition, to identify introduction dates, the period of observation starts in 1880 with the origin of the modern welfare state (Stolleis, 2013). Also, we have restricted our empirical procedure to countries with more than 500,000 inhabitants in 2017. We thus started to examine 167 currently independent states for the emergence of healthcare systems complying with the aforementioned criteria.[5] Since the shape of states has changed over the very long observation period, we also look for legislation in the sovereign states preceding the currently existing sample of states. If the state used to be part of an independent predecessor such as an empire or confederation, we refer to this predecessor. Since we focus on legislation in sovereign states, we do not consider regulations of colonial administrations to identify the emergence of a healthcare system. Former colonies are therefore only considered after achieving independence.

Once the introduction date was identified, we collected information on the most relevant actors responsible for the regulation of the system, the main financing schemes and the types of service providers. For this purpose, we use information provided by legislation as well as government documents, secondary literature, and at times, healthcare statistics. Based on the actor-centred typology for global comparison proposed by Frisina Doetter et al. (2021) (Table 1 and

4 For a detailed description of the definitions and operationalizations adopted in this research, see de Carvalho and Fischer, 2020.

5 Appendix IV: Country-specific sources for classification (provided in a separate file). Appendix IV shows the introduction dates and sources for all classified cases. According to our conceptualization and operationalization of healthcare system introduction, Chad, the Central African Republic and Somalia had not yet implemented systems as of April 2021.

Table 4.
Operationalization procedure

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

Source: own presentation based on de Carvalho and Fischer, 2020, p. 14.

Table 5.
Identifying the dominant actor

Dimension	Dominant actor according to	Sources
Regulation	Main actor type responsible for the regulation of relations between beneficiaries, financing institutions and providers	Legislation, government documents, secondary literature
Financing	Relative majority of financing share for expenditures of the healthcare system by actor type	Legislation, government documents, secondary literature, national and international health expenditure statistics
Service Provision	Relative majority of hospital beds and physicians within the healthcare system by actor type	Legislation, government documents, secondary literature, national and international healthcare resources statistics (hospitals and physicians)

Source: own presentation.

Table 3), we aim to identify the predominant actor types – state, societal, private (individual/collective), and global – for each of the dimensions. We thereby, refer to the introduced system as the cohesive set of regulations, financing schemes, and provider arrangements applying to the defined groups of population covered by that healthcare system.

Concerning the actors in the *regulation dimension*, we are interested in the main institutions organizing the relations between beneficiaries, financing institutions, and providers. This includes regulations such as the specification of the benefit package, the collection, pooling and allocation of funds, and contracting, employing, and controlling providers. *State actors* in regulation comprise the legislative or executive branches of government at different territorial levels. *Societal actors* are characterized as private non-profit institutions or non-governmental bodies typically including representatives of societal groups such as unions, employer associations, associations of financing agents or providers, the community, or patients. *Private actor* regulation refers to the voluntary contractual relations between financing institutions such as private insurance companies, for-profit providers and households. *Global actors* as we operationalize them for the typology embrace all non-domestic actors irrespective of their state, societal or private character (see Table 1).

The *financing dimension* is classified according to the major financing share from the

different sources specified in Table 3. Here, we aim to ascertain the financing share for the specific healthcare system implemented. Therefore, we often have to rely on the financing sources specified in the legislation or secondary literature rather than health expenditure statistics, which tend to report the financing shares at country level. Furthermore, many healthcare systems were introduced before reliable and internationally comparable accounting of health financing was implemented. Where valid quantitative information is available, the classification is based on the relative majority of financing shares. Financing shares at country level are only used when system-specific information is missing. Concerning the different financing categories, *state financing* generally corresponds to taxes, but also includes other general government revenues. Social insurance contributions, by contrast – the main *societal financing* form – are managed by insurance funds with non-profit character and autonomy from the state budget. Social insurance contributions are mandatory and imply entitlements to medical care. By the same token, legal obligations for employers to finance and provide medical care for their employees are categorized as societal financing. Such mandatory employer liability schemes are similar to company-based social insurance where the employer bears the full costs. By contrast, *private collective* financing refers to private insurance premiums which are by definition voluntary. Furthermore, the *private individual* financing category refers to all direct payments by patients to providers as fees for service or as co-payments. Finally, the *global actor* category includes all non-domestic sources of healthcare financing.

In order to classify the *service provision* dimension, we evaluate the type of providers specified in the legislation. If insurance institutions are free to contract different types of providers, or patients are free to choose providers, then hospital ownership and the status of physicians in outpatient care are used as a means to identify the dominant actor type. Ideally, we estimate the size of the hospital and the outpatient sector by the financial resources allocated to each sector. In the hospital sector, the share of hospital beds owned by state, societal, private or global actors determines the dominant actor. In the outpatient sector, the share of physicians in private for-profit practice relative to physicians employed in public outpatient care facilities, or in those owned by private non-profit/societal institutions or non-domestic/global actor institutions measure the dominant actor in outpatient care. The relative size of hospital and outpatient sectors is then used as a weight, to reveal the main actor type in service provision. Applying this quantitative approach to ascertain actor types at inception is, however, for many countries constrained by data availability. While we aim to maintain the logic of the quantitative approach, we use cruder indicators, if little or no other country-specific data or information is available. For instance, we use expert judgements about the relevance of the hospital as against the outpatient sector, the share of hospitals by ownership instead of hospital beds, and information in secondary literature about the role of healthcare providers. The sources used to classify each country are listed in Appendix IV.[6]

4. Results

In this section, we present the results of this classification exercise and seek to highlight some patterns in the emergence of healthcare systems. The purpose of this section is to give a descriptive account of types, while more systematic explanatory studies will be the subject of subsequent papers.

6 Data on system inception by country, classification of each dimension, and sources will also be made available in the Welfare State Information System (WeSIS) provided by the CRC 1342.

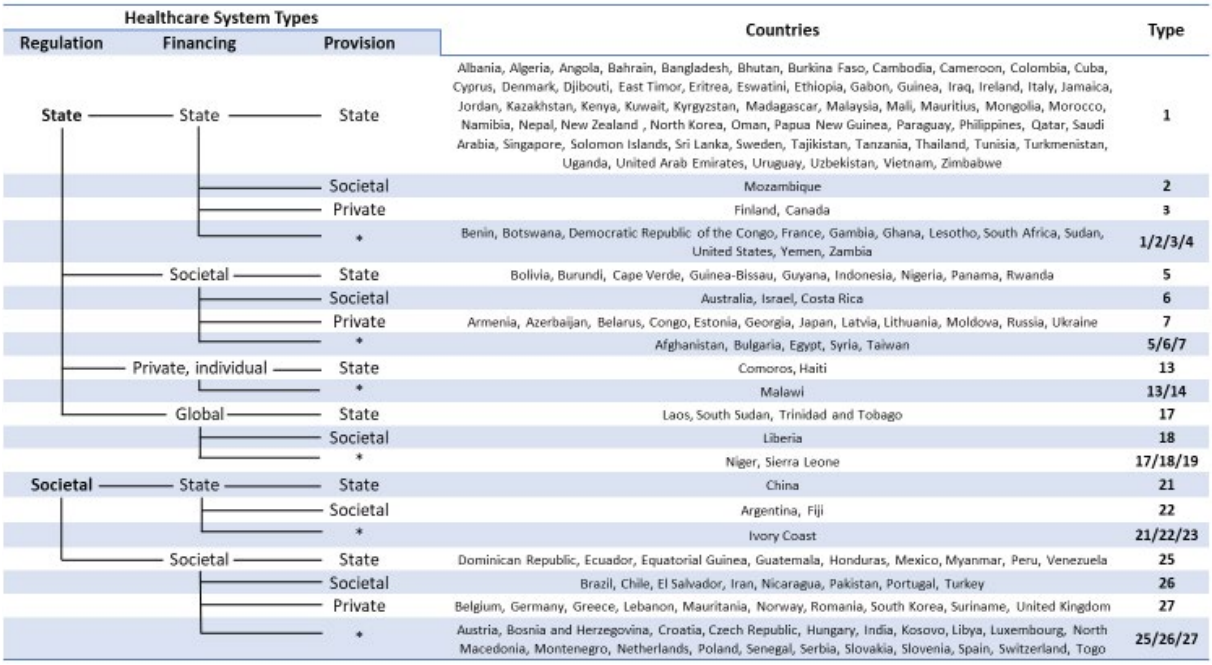
Table 6.
Matrix of healthcare system types

Actors in regulation	**Actors in financing**	**Actors in provision**			
		State	Societal	Private	Global
State	State	*Type 1 N=60*	Type 2 N=1	Type 3 N=2	Type 4 N=0
	Societal	Type 5 N=9	Type 6 N=3	Type 7 N=12	Type 8 N=0
	Private collective	Type 9 N=0	Type 10 N=0	Type 11 N=0	Type 12 N=0
	Private individual	Type 13 N=2	Type 14 N=0	Type 15 N=0	Type 16 N=0
	Global	Type 17 N=3	Type 18 N=1	Type 19 N=0	Type 20 N=0
Societal	State	Type 21 N=1	Type 22 N=2	Type 23 N=0	Type 24 N=0
	Societal	Type 25 N= 9	*Type 26 N=8*	Type 27 N=10	Type 28 N=0
	Private collective	Type 29 N=0	Type 30 N=0	Type 31 N=0	Type 32 N=0
	Private individual	Type 33 N=0	Type 34 N=0	Type 35 N=0	Type 36 N=0
	Global	Type 37 N=0	Type 38 N=0	Type 39 N=0	Type 40 N=0
Private	State	Type 41 N=0	Type 42 N=0	Type 43 N=0	Type 44 N=0
	Societal	Type 45 N=0	Type 46 N=0	Type 47 N=0	Type 48 N=0
	Private collective	Type 49 N=0	Type 50 N=0	Type 51 N=0	Type 52 N=0
	Private individual	Type 53 N=0	Type 54 N=0	Type 55 N=0	Type 56 N=0
	Global	Type 57 N=0	Type 58 N=0	Type 59 N=0	Type 60 N=0
Global	State	Type 61 N=0	Type 62 N=0	Type 63 N=0	Type 64 N=0
	Societal	Type 65 N=0	Type 66 N=0	Type 67 N=0	Type 68 N=0
	Private collective	Type 69 N=0	Type 70 N=0	Type 71 N=0	Type 72 N=0
	Private individual	Type 73 N=0	Type 74 N=0	Type 75 N=0	Type 76 N=0
	Global	Type 77 N=0	Type 78 N=0	Type 79 N=0	Type 80 N=0

Source: own presentation based on Frisina Doetter et al., 2021, p. 6.
See Appendix II for a full list of countries and numbers of countries by type.

Table 6 reveals which of the potential system types in Table 2 could empirically be found when analysing systems at their point of introduction. The table includes 112 countries in which at inception a single dominant actor could be identified for each dimension, thus constituting a distinct actor combination. There are, however, another 52 countries for which we were unable to identify the dominant type of provider. For three countries (Central African Republic, Chad, and Somalia), we could not detect any form of healthcare which might meet our criteria for a healthcare system under public responsibility (see Table 4). Overall, there are 14 distinct actor combinations of which the *state-led system* is the most prominent, with 60 countries introducing entitlements to healthcare through state-owned medical facilities, financed and controlled by public authorities. In Table 6, this cell (Type 1) is highlighted since the same actor type is assigned to all three dimensions. Such a uniform combination can also be found for societal actors (*societally led system*, Type 26). Those eight countries introduced self-regulating insurance schemes and service provision by private non-profit organizations, often in the form of integrated care with sickness funds providing the healthcare infrastructure. Other uniform actor constellations could not be identified. Indeed, a notable observation is the high number of empty cells. Out of 80 theoretically possible actor combinations, 64 are not observable in the emergence of a healthcare system under public responsibility. In particular, private actors and global actors do not play a major role in the regulation of healthcare systems. Nor were global actors found to be the main providers of healthcare

Figure 1.
Healthcare system types flowchart



Healthcare System Types			Countries	Type
Regulation	Financing	Provision		
State	State	State	Albania, Algeria, Angola, Bahrain, Bangladesh, Bhutan, Burkina Faso, Cambodia, Cameroon, Colombia, Cuba, Cyprus, Denmark, Djibouti, East Timor, Eritrea, Eswatini, Ethiopia, Gabon, Guinea, Iraq, Ireland, Italy, Jamaica, Jordan, Kazakhstan, Kenya, Kuwait, Kyrgyzstan, Madagascar, Malaysia, Mali, Mauritius, Mongolia, Morocco, Namibia, Nepal, New Zealand , North Korea, Oman, Papua New Guinea, Paraguay, Philippines, Qatar, Saudi Arabia, Singapore, Solomon Islands, Sri Lanka, Sweden, Tajikistan, Tanzania, Thailand, Tunisia, Turkmenistan, Uganda, United Arab Emirates, Uruguay, Uzbekistan, Vietnam, Zimbabwe	1
		Societal	Mozambique	2
		Private	Finland, Canada	3
		*	Benin, Botswana, Democratic Republic of the Congo, France, Gambia, Ghana, Lesotho, South Africa, Sudan, United States, Yemen, Zambia	1/2/3/4
	Societal	State	Bolivia, Burundi, Cape Verde, Guinea-Bissau, Guyana, Indonesia, Nigeria, Panama, Rwanda	5
		Societal	Australia, Israel, Costa Rica	6
		Private	Armenia, Azerbaijan, Belarus, Congo, Estonia, Georgia, Japan, Latvia, Lithuania, Moldova, Russia, Ukraine	7
		*	Afghanistan, Bulgaria, Egypt, Syria, Taiwan	5/6/7
	Private, individual	State	Comoros, Haiti	13
		*	Malawi	13/14
	Global	State	Laos, South Sudan, Trinidad and Tobago	17
		Societal	Liberia	18
		*	Niger, Sierra Leone	17/18/19
Societal	State	State	China	21
		Societal	Argentina, Fiji	22
		*	Ivory Coast	21/22/23
	Societal	State	Dominican Republic, Ecuador, Equatorial Guinea, Guatemala, Honduras, Mexico, Myanmar, Peru, Venezuela	25
		Societal	Brazil, Chile, El Salvador, Iran, Nicaragua, Pakistan, Portugal, Turkey	26
		Private	Belgium, Germany, Greece, Lebanon, Mauritania, Norway, Romania, South Korea, Suriname, United Kingdom	27
		*	Austria, Bosnia and Herzegovina, Croatia, Czech Republic, Hungary, India, Kosovo, Libya, Luxembourg, North Macedonia, Montenegro, Netherlands, Poland, Senegal, Serbia, Slovakia, Slovenia, Spain, Switzerland, Togo	25/26/27

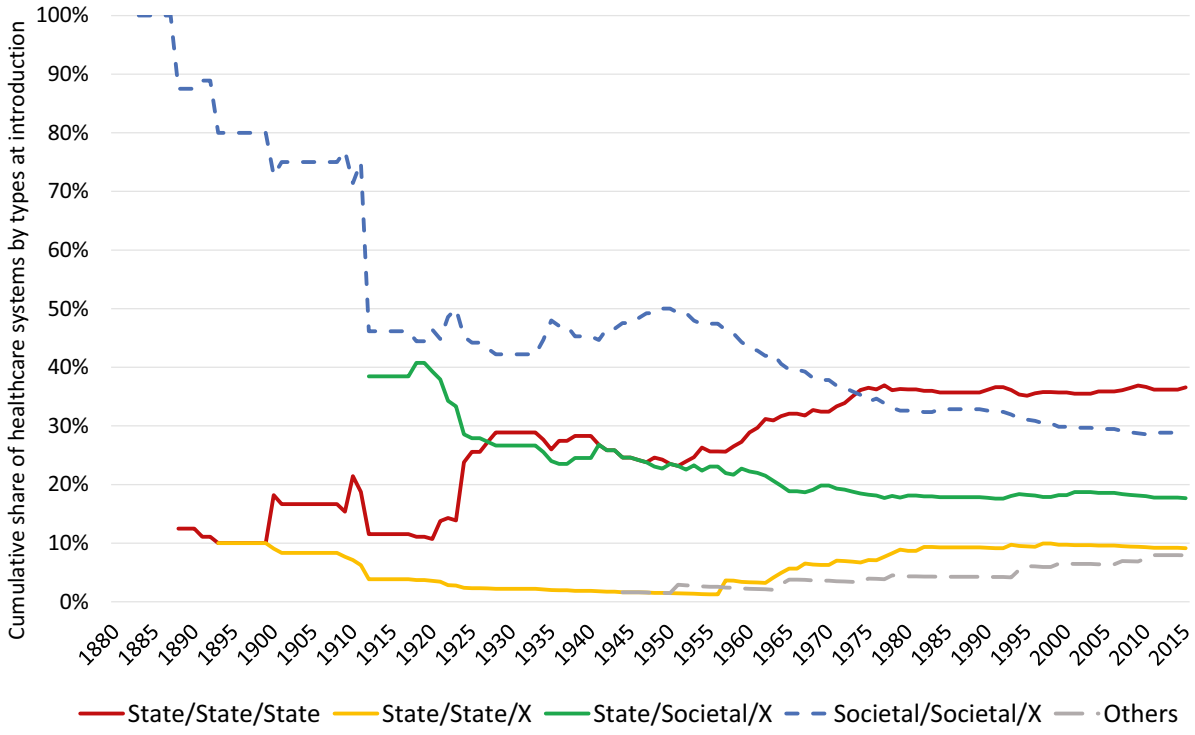
Source: own presentation. The asterisk denotes systems for which it was not possible to ascertain a dominant actor type in the provision dimension. The list of types in the respective lines represent potential types. Thus, while there is no empirical example for Type 4, in the group of countries with state regulation, state financing, and * provision, Type 4 could be represented.

services in newly established systems. Nevertheless, in a few cases, they were the main source of finance for bringing systems into being.

The flowchart in Figure 1 presents the system types displayed in the above matrix including the respective countries. The chart also adds the 52 healthcare systems of countries where a single dominant actor type could be identified in the regulation and financing, but not in the provision dimension. This is mainly due to the fact that state or societal financing institutions were allowed to contract different sorts of providers, or patients had free choice of providers. Moreover, these 52 systems concern countries of the Global South with fragmentary statistics on providers, but also early adopters of a system with similar problems in the historical statistics of the late 19th and the first half of the 20th century. While, as a rule, there is some information on the number of hospitals and physicians, statistics on hospital ownership, the employment status of physicians, and the size of hospital and outpatient sectors is missing.

The flowchart depiction highlights two larger clusters. The *state-based branch* with state-regulation and financing through the state budget comprises 75 countries, corresponding to about 45 % of the country sample (Types 1-4). Furthermore, there is a societally based branch including 47 countries (28 % of all countries) consisting of Types 25-27. This observation seems to reflect classical approaches of the Beveridgean health service model and the Bismarckian social insurance scheme in the emergence of healthcare systems. Indeed, many of the societally based adoptions in Europe were inspired by the German health insurance law of 1883 (Köhler & Zacher, 1981). While in the larger group of *state-based systems*, several countries follow Beveridge's ideas, but also socialist plans of universal healthcare for the whole population, while others introduced government healthcare focussing on vulnerable groups (e.g., France, Italy, Thailand or the US).

Figure 2.
Cumulative share of state- and societal-based healthcare systems



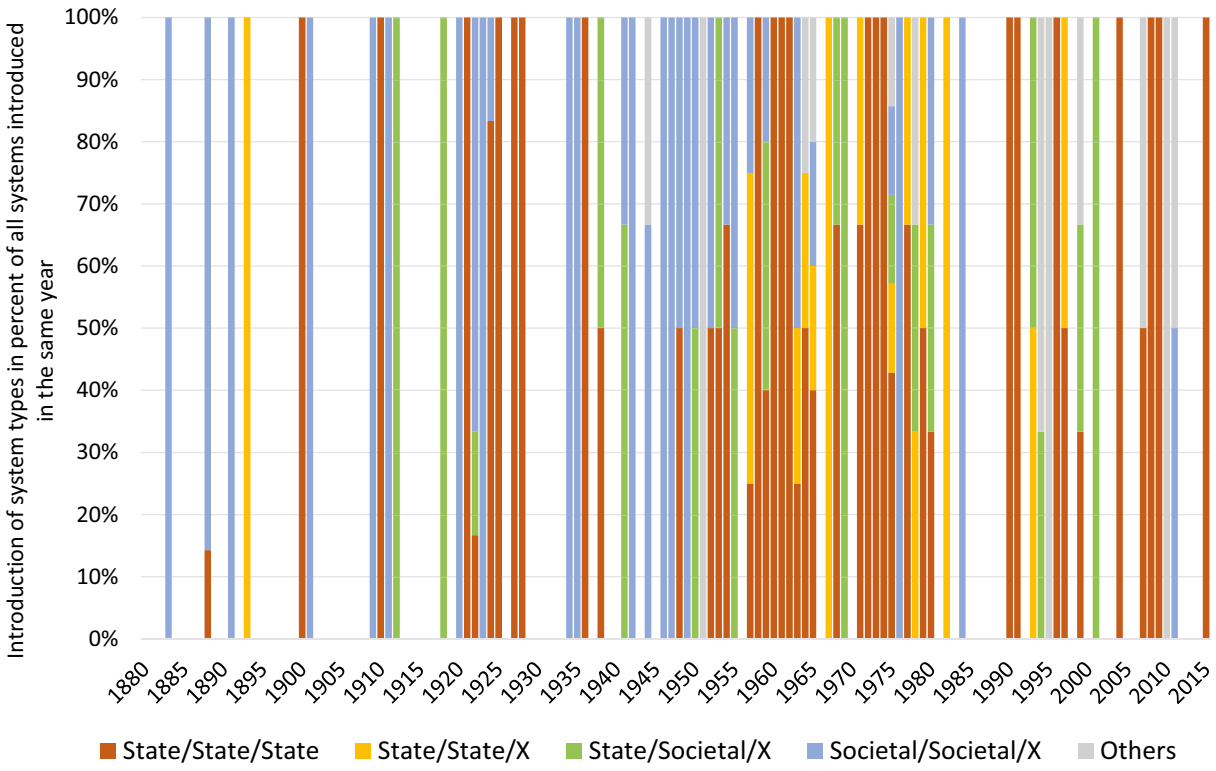
Source: own presentation.

A further 29 countries implemented insurance under government control (Types 5,6, and 7 including the group "5/6/7" without a dominant actor in provision). Some of these systems make use of autonomous insurance funds managed by non-governmental agencies, with the state maintaining tight control over benefit packages and fee schedules, for example, and in some cases assuming responsibility for healthcare delivery (Type 5). This cluster also includes 13 countries with employer liability schemes. However, the types can be traced back to two single laws, applicable to the countries of Tsarist Russia (1912) on the one hand, and to Egypt and Syria on the other, the latter two countries forming a political union when they introduced the system in 1959.

The combination of state regulation and private individual financing stands out as a rare specimen (Type 13/14). At first glance, it seems inconsistent to grant entitlements to medical care while relying on out-of-pocket payments that impede entitlement for those with limited abilities to pay. In such cases, as in the Comoros, for example, the state affirms responsibility for medical care, but determines the charges for public services, which are only waived exceptionally, leading to a high proportion of out-of-pocket spending on health. Finally, while global actors are not the decisive actors in regulation and healthcare delivery, they provided substantial financial support for the establishment of healthcare systems in several countries of the Global South (Types 17-19).

In the following we take a look at the *timing of introductions* and temporal patterns relating to the system types. In doing so, we merge the less frequent types to broader categories. The *state-led system* (state regulation, state financing and state provision), a *state-based system* category with multiple providers (state/state/x), a *societally based* category with multiple providers (societal/societal/x), a *mixed system* (state/societal/x) with state regulation and societal financing, and a residual category of system types.

Figure 3.
Share of state- and societal-based healthcare systems per year of introduction



Source: own presentation.

The data basis for Figure 2 is the cumulative number of systems introduced for the defined categories. For the interpretation of the figure, we must bear in mind that we count the numbers of independent countries today. The system inauguration of some countries coincided with that of other countries as they belonged to confederations or larger realms when the healthcare system was established in the respective territory.[7] Figure 2 indicates that in the first phase of healthcare system adoption, up until 1920, societally based schemes prevailed. Mainly, these systems pertain to Bismarck-inspired health insurance for workers in the growing industrial sector in Europe. The shift in 1912, with the emergence of the *mixed state-regulated and societally financed system*, is due to the Russian legislation affecting several of today's independent countries. In the 1920s, state-led systems show an increase which is attributable to common regulations applying to five Central Asian Republics of the Soviet Union. In the following two decades from 1930 to 1950, societally based systems are again more prevalent. Now, European and many Latin American countries are among the adopters. From the early 1950s until 1980, state-led and state-based systems take the dominant role in the emergence of healthcare systems. This wave of introductions mainly occurs in Asian and African nations as they gain independence.

Figure 3 illustrates the waves of healthcare system implementations using the share of system types introduced in a specific year

7 This refers to the introduction of the healthcare systems in the Austrian Monarchy in 1888 (which included Austria, Bosnia and Herzegovina, Croatia, Czech Republic, Slovakia, and Slovenia), Tsarist Russia 1912 (Baltic and Caucasian states, Belarus, Russia, and Ukraine), the Kingdom of Yugoslavia 1922 (Serbia, Kosovo, North Macedonia, Montenegro), and the USSR 1924 (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan).

as a percentage of all systems introduced in that year. This illustration emphasizes the predominance of societally based systems until the early 1950s. The typical first legislative or executive act establishing entitlements to medical care in this time period are social insurance schemes for workers in manufacturing industries or for public employees. Often, the systems built upon prior company-based voluntary schemes and use the existing administrative infrastructure. The laws stipulate mandatory insurance and provide a framework for the definition of contribution rates and medical benefits. The smaller number of state-led inceptions of healthcare systems in this period tend to be attributable to public health or hospital laws which codify government responsibility for healthcare delivery to vulnerable groups of the population.

From about 1950 to 1980, new healthcare systems are introduced almost every year. Apart from some late adopters among the more advanced economies such as the USA in 1965, system introductions in less industrialized nations of Asia and Africa characterize this period. While there is only a weak correlation between GDP and the emergence of healthcare systems limited to the time period before World War II (Polte et al., 2021), there seems to be a tendency of less wealthy economies to introduce state-led and state-based systems. The birth of those systems prevails from the mid-20th century onward. Among those countries, there are also several newly independent nations which have established a socialist political regime, with a planned economy constraining private healthcare delivery and following strong preferences for universal government healthcare.

5. Discussion and conclusion

In order to capture the variety of systems which might unfold globally as governments seek to establish social protection against the risk of sickness, we have applied a deductively developed roster that allows a maximum of 80 theoretically possible types. The first remarkable finding of this exercise is that only 14 types with distinct actor combinations could be identified for system introduction. In particular, the inferior or absent role of private and global actors in the regulatory dimension reduces the number of observable types. To some extent this finding is related to our definition of system inception, since we focus on systems under public responsibility and look for legislative or executive acts specifying entitlements to medical care, which requires state intervention. This approach neglects voluntary private social protection schemes. Nevertheless, the results show that legislators have not entrusted private actors with the regulation of the healthcare system; global actors play a major role in financing healthcare in only very few countries, and otherwise lend their support to domestic actors.

The observed 14 types clearly exceed the five types that were identified in a similar exercise for countries of the Global North (Böhm et al., 2013). Moreover, the classification results include combinations which seem implausible according to Böhm et al.'s premises, thus highlighting the need to adjust conceptual understandings when countries of the Global South are included.

As the identification of a dominant actor in the provision dimension has proven to be difficult, we conflated systems with specific actor combinations in regulation and financing, irrespective of the actor in the service provision dimension. As a result, six clusters can be identified, three of which comprise the overwhelming majority of countries, while the others are much smaller with 3, 4, and 6 countries. (Table 7). The *state-based cluster* includes as many as 75 countries, the *societally based cluster* 47 countries, and the *state-regulated, societal financing cluster* 29 countries. Merging all clusters with the same dominant actor in the regulation dimension, finally, yields two worlds of healthcare sys-

Table 7.
Healthcare system clusters and worlds of healthcare

Regulation	Worlds of healthcare regulation	N	Financing	Clusters of healthcare regulation and financing	N
State	(I) State-regulated world of healthcare	113	State	(1) State-based cluster	75
			Societal	(2) State-regulated societal-financing cluster	29
			Private, individual	(3) State-regulated individual-financing cluster	3
			Global	(4) State-regulated global-financing cluster	6
Societal	(II) Societally regulated world of healthcare	51	State	(5) Societally regulated state-financing cluster	4
			Societal	(6) Societally based cluster	47

Source: own presentation.

tems: the state-regulated and the societally regulated world of healthcare system types.

The emergence of healthcare systems until the mid- 20th century is mainly related to societally regulated healthcare models (clusters 5 and 6) and the state-regulated, societal financing cluster (2). From then on, the state-based system cluster dominates the emergence of healthcare systems under public responsibility. There is also a regional and economic component to this evolution pattern. The early spread of societally regulated systems until 1920 pertains to industrializing European nations. A further expansion of the societally regulated model until the 1950s includes Latin American alongside European countries. By contrast, the emergence of state-based systems since the 1950s relates to Asian and African nations gaining independence.

The factors favouring the advancement of these systems have to be explored in further research. The legacy of health policies focusing on public health and the control of epidemics and organized through public authorities, for instance, might have paved the way for state-based schemes, while lower levels of industrialization and formal employment might impede the establishment of societal insurance systems. The lack of company-based voluntary insurance, which can serve as a nucleus for societally based schemes, might also be relevant. Besides, larger political trends have to be taken into account, as for some countries independence coincides with the establishment a communist regime and a planned economy with strong ideological preferences for a state-led healthcare system (e.g., Laos, Mongolia, North Korea, or North Vietnam. Last but not least, the negative example of Latin American countries in which attempts to develop social insurance schemes covering the middle classes into a universalistic scheme might have detracted reformers from following this road.

The dualism of state-regulated and societally regulated systems at the time of healthcare system introductions reflects the contrast between Beveridgean ideas and Bismarckian social insurance (Freeman & Schmid, 2008). This duality can also be found in the National Health Service and the social health insurance models proposed by the OECD (1987), which additionally finds a private insurance model. By relating our findings to other classifications, it has to be borne in mind that we focus on the introductory phase of healthcare systems, while other classifications tend to refer to more developed systems at country level. This applies all the more so since a distinct majority of those studies is concerned with countries of the Global North (de Carvalho, Schmid, & Fischer, 2020). Restricting

the classification to the very first systems ever introduced in a country, precludes the observation of segmented systems (i.e., a different set of regulations, financing schemes, and provider arrangements pertaining to specific population groups) at the country level. Segmentation has been identified as a characteristic element of healthcare systems in countries of the Global South (de Carvalho, Schmid, & Fischer, 2020).

While our results focus on the emergence of healthcare systems, we can still try to take a look at system evolution for 28 countries of the Global North by referring again to Böhm et al.'s (2013) classification of healthcare systems as they were shaped around 2010. Comparing two snapshots, one at system inception and one around 2010, covers a time span of up to 127 years. Over this period, medical advancements, economic growth and welfare state expansion have changed healthcare systems fundamentally, while we see both stability and change in terms of dominant actor types (for details see Appendix III). In six of 19 countries for which actors were ascertained in all dimensions, the actor combination remained the same (Canada, Denmark, Estonia, Germany, and Sweden). In seven countries the actor combination changed in one dimension only. In France and the USA two dimensions changed, while only four countries had a full switch from a societally based system to a state-led system (Norway, Portugal, Spain, UK). What is most interesting is the evolution of a mixed type, with state regulation, societal financing and private provision being the most frequent type found by Böhm and colleagues (2013). This system can mainly be observed in countries which set out from societally based systems. In the current systems, the state took on regulatory competence, while there has been a manifestation of private actors in the provision dimension (Belgium, Czech Republic, Slovakia, Poland, Hungary, Netherlands, and South Korea).

To the best of our knowledge, this is the first endeavour to classify healthcare systems as they emerged as the first social protection schemes against the risk of sickness from a global perspective. Admittedly, the focus on the first system implemented with an actor-centred typology implies a degree of limitation, as it obviously neglects important features of the healthcare system such as, for instance, inclusiveness in terms of population covered under public responsibility, and the scope of benefits provided. Both features would contribute to a more comprehensive understanding of healthcare systems. Besides a more systematic analysis of introduction by system type has still to follow, including (political) causes for the preference of state-led and state-based over societally based systems for late adopters, as well as the rationale for a limited number of countries contradicting this pattern.

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de Carvalho, G., Schmid, A., & Fischer, J. (2020). Classifications of health care systems: Do existing typologies reflect the particularities of the Global South? *Global Social Policy, Online First* (Nov 3, 2020). doi:https://doi.org/10.1177/1468018120969315

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Appendix

Appendix I. Healthcare systems typology scholarship by number of citations up to April 2021

Source	Number citations Google Scholar	Number citations Web of Science
Anderson, O. W. (1963). Medical care: Its social and organizational aspects. Health-services systems in the United States and other countries – Critical comparisons. ***New England Journal of Medicine 269***, 839–843.	31	14
Bambra, C. (2005). Worlds of welfare and the health care discrepancy. ***Social Policy & Society 4***(1), 31–41.	211	71
Bertin, G., & Pantalone, M. (2018). Comparing hybrid welfare systems: The differentiation of health and social care policies at the regional level in Italy. ***Italian Sociological Review 8****(1), 1–23.*	3	Information not found
Borisova, L. V. (2011). Health care systems as determinants of health outcomes in transition countries: Developing classification. ***Social Theory and Health 9***(4), 326–354.	24	8
Docteur, E., & Oxley, H. (2003). Health-care systems: Lessons from the reform experience. DELSA/ELSA/WD/HEA. OECD Health Working Papers 2003(9).	Information not found	Information not found
Elling, R. H. (1994). Theory and method for the cross-national study of health systems. ***International Journal of Health Services 24***(2), 285–309.	43	20
European Union (2012). The management of health systems in the EU member states – the role of local and regional authorities. European Union.	Information not found	Information not found
Ferreira, P. L., Tavares, A. I., Quintal, C., et al. (2018). EU health systems classification: A new proposal from Euro-Healthy. ***BMC Health Services Research 18***(1), 511–511.	9	6
Field, M. G. (1973). The concept of the 'health system' at the macrosociological level. ***Social Science & Medicine 7***, 763–785.	155	42
Freeman, R., & Schmid, A. (2008). Western Europe, health systems of. In: K. Heggenhougen (Ed.), ***International Encyclopedia of Public Health*** (pp. 579-589). Amsterdam: Elsevier.	Information not found	Information not found
Freeman, R. (2000). The politics of health in Europe. Manchester: Manchester University Press.	Information not found	19
Frenk, J., & Donabedian, A. (1987). State intervention in medical care: Types, trends and variables. ***Health Policy and Planning 2***(1), 17–31.	83	Information not found
Frenk, J., & Londoño, J.-L. (1997). Structured pluralism: Towards an innovative model for health system reform in Latin America. ***Health Policy 41***(1), 36.	155	123
Hagenaars, L. L., Klazinga, N. S., Mueller, M., et al. (2018). How and why do countries differ in their governance and financing-related administrative expenditure in health care? An analysis of OECD countries by health care system typology. ***The International Journal of Health Planning and Management 33***(1), e263–e278.	13	8
Hurst, J. W. (1991). Reforming health care in seven European nations. ***Health Affairs 10***(3), 7–21.	275	0
Jakubowski, E., & Busse, R. (1998). Health care systems in the EU. A comparative study. In European Parliament (Ed.), ***Directorate General for Research Working Paper***. Luxemburg: European Parliament.	Information not found	Information not found
Joumard, I., André, C., & Nicq, C. (2010). Health care systems: Efficiency and institutions. OECD Economics Department Working Papers. Paris: OECD Publishing.	251	Information not found
Kam, Y. W. (2012). The contributions of the health decommodification typologies to the study of the East Asian welfare regimes. ***Social Policy & Administration 46***(1), 108–128.	21	12

Lassey, M. L., Lassey, W. R., & Jinks, M. J. (1997). Health care systems around the world: Characteristics, issues, reforms. Upper Saddle River, NJ: Prentice Hall.	Information not found	Information not found
Lee, S.-Y., Chun, C.-B., Lee, Y.-G., et al. (2008). The national health insurance system as one type of new typology: The case of South Korea and Taiwan. ***Health Policy 85***(1), 105–113.	94	48
Mackintosh, M., Channon, A., Karan A., et al. (2016). What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. ***The Lancet 388***(10044), 596–605.	153	75
Maxwell, R. (1975). Health care. The growing dilemma. New York: McKinsey and Company.	Information not found	Information not found
Mesa-Lago, C. (2007). Reassembling social security: A survey of pensions and health care reforms in Latin America. Oxford: Oxford University Press.	Information not found	Information not found
Moran, M. (2000). Understanding the welfare state: The case of health care. ***British Journal of Politics and International Relations 2***(2), 135–160.	262	102
Organization for Economic Co-operation and Development (OECD) (1987). Financing and delivering health care: A comparative analysis of OECD countries, OECD Social Policy Studies. Paris: Organization for Economic Co-operation and Development.	522	Information not found
Reibling, N. (2010). Healthcare systems in Europe: Towards an incorporation of patient access. ***Journal of European Social Policy 20***(1), 5–18.	96	41
Roemer, M. I. (1960). Health departments and medical care – A world scanning. ***American Journal of Public Health and the Nation's Health 50***(2), 154–160.	37	12
Roemer, M. I. (1991). National health systems of the world. New York: Oxford University Press.	81	0
Saltman, R. B., & Figueras, J. (1998). Analyzing the evidence on European health care reforms. ***Health Affairs, 17*** (2), 85-108.	181	99
Sam, Y. (2014). Studying the health care systems in seven East Asian countries by the cluster analysis. ***Development and Society 43***(1), 81–107.	11	Information not found
Santerre, R. E., & Neun, S. P. (2010). Health economics: Theory, insights, and industry studies. Mason, OH: South-Western, Cengage Learning.	Information not found	Information not found
Terris, M. (1978). The three world systems of medical care: Trends and prospects. ***American Journal of Public Health 68***(11), 1125–1131.	115	Information not found
Thomson, S., Foubister, T., & Mossialos, E. (2009). Financing health care in the European Union. Challenges and policy responses. Copenhagen: European Observatory on Health Systems and Policies.	242	Information not found
Toth, F. (2010). Is there a Southern European healthcare model? ***West European Politics 33***(2), 325–343.	35	11
Toth, F. (2016). Classification of healthcare systems: Can we go further? ***Health Policy 120***(5), 535–543.	43	18
Toth, F. (2018). Integration vs separation in the provision of health care: 24 OECD countries compared. ***Health Economics, Policy and Law 15***(2), 160–172.	4	1
Tuohy, C. H. (1999). Dynamics of a changing health sphere: The United States, Britain, and Canada. ***Health Affairs 18***(3), 114–134.	132	44
Wendt, C. (2009). Mapping European healthcare systems: A comparative analysis of financing, service provision and access to healthcare. ***Journal of European Social Policy 19***(5), 432–445.	292	110
Wendt, C. (2014). Changing healthcare system types. ***Social Policy & Administration 48***(7), 864–882.	63	20
Wendt, C., Frisina, L., & Rothgang, H. (2009). Healthcare system ***types: A conceptual framework for comparison.*** Social Policy & Administration 43(1): 70–90.	336	115

Source: own presentation.

Appendix II. Healthcare system type overview

Type	N	Countries
Type 1	60	Albania, Algeria, Angola, Bahrain, Bangladesh, Bhutan, Burkina Faso, Cambodia, Cameroon, Colombia, Cuba, Cyprus, Denmark, Djibouti, East Timor, Eritrea, Eswatini, Ethiopia, Fiji, Gabon, Guinea, Iraq, Ireland, Italy, Jordan, Kazakhstan, Kenya, Kuwait, Kyrgyzstan, Madagascar, Malaysia, Mali, Mauritius, Mongolia, Morocco, Namibia, Nepal, New Zealand, North Korea, Oman, Papua New Guinea, Paraguay, Philippines, Qatar, Saudi Arabia, Singapore, Solomon Islands, Sri Lanka, Sweden, Tajikistan, Tanzania, Thailand, Tunisia, Turkmenistan, Uganda, United Arab Emirates, Uruguay, Uzbekistan, Vietnam, Zimbabwe
Type 2	1	Mozambique
Type 3	2	Canada, Finland
Type 2-4	12	Benin, Botswana, Democratic Republic of the Congo, France, Gambia, Ghana, Lesotho, South Africa, Sudan, United States, Yemen, Zambia
Type 5	9	Bolivia, Burundi, Cape Verde, Guinea-Bissau, Guyana, Indonesia, Jamaica, Nigeria, Rwanda
Type 6	3	Australia, Costa Rica, Israel
Type 7	12	Japan, Tsarist Russia, Europe and Caucasia (Armenia, Azerbaijan, Belarus, Estonia, Georgia, Latvia, Lithuania, Moldova, Russia, Ukraine), Congo
Type 5-7	5	Afghanistan, Bulgaria, Egypt, Syria, Taiwan
Type 13	2	Comoros, Haiti
Type 13-14	1	Malawi
Type 17	3	Laos, South Sudan, Trinidad and Tobago
Type 18	1	Liberia
Type 17-19	2	Sierra Leone, Niger
Type 21	1	China
Type 22	2	Argentina, Fiji
Type 21-22	1	Ivory Coast
Type 25	9	Ecuador, Peru, Mexico, Venezuela, Guatemala, Dominican Republic, Myanmar, Honduras, Equatorial Guinea
Type 26	8	Brazil, Chile, Portugal, El Salvador, Turkey, Iran, Nicaragua, Pakistan
Type 27	10	Germany, Norway, United Kingdom, Romania, Greece, Belgium, Lebanon, Mauritania, South Korea, Suriname
Type 25-27	20	Austrian Monarchy (Austria, Bosnia and Herzegovina, Slovakia, Slovenia, Croatia, Czech Republic), Hungary, Kingdom of Yugoslavia (Serbia, Kosovo, North Macedonia, Montenegro), India, Libya, Luxembourg, Netherlands, Poland, Switzerland, Senegal, Spain, Togo

Source: own presentation.

Appendix III. Comparison of current system types (Böhm et al. 2013) with system types at introduction

Type 2010	Country	System introduction: Regulation/Financing/Provision	Time
NHS-Type (State/ State/ State)	Denmark	State/State/State	1921
	Finland	State/State/*Private*	1963
	Sweden	State/State/State	1928
	Norway	*Societal*/*Societal*/*Private*	1909
	Portugal	*Societal*/*Societal*/*Societal*	1935
	Spain	*Societal*/*Societal*/*Societal*	1942
	UK	*Societal*/*Societal*/*Private*	1911
National Health Insurance Type (State/ State/ Private)	Australia	State/*Societal*/*Societal*	1953
	Canada	State/State/Private	1957
	Ireland	State/State/*State*	1953
	New Zealand	State/State/*State*	1900
	Italy	State/State/*State*	1888
Etatist Social Health Insurance Type (State/ Societal/ Private	Belgium	*Societal*/Societal/Private	1944
	France	State/*State*/*State*	1893
	Estonia	State/Societal/Private (introduction under Russian rule)	1912
	Czech Republic	*Societal*/Societal/* (introduction under Austrian rule)	1888
	Slovakia	*Societal*/Societal/* (introduction under Austrian rule)	1888
	Poland	*Societal*/Societal/*	1920
	Hungary	*Societal*/Societal/*	1891
	Netherlands	*Societal*/Societal/*	1941
	Israel	State/Societal/*Societal*	1994
	South Korea	*Societal*/Societal/Private	1976
	Japan	State/Societal/Private	1922
Social Health Insurance Type (Societal/ Societal/ Private)	Austria	Societal/Societal/*	1888
	Germany	Societal/Societal/Private	1883
	Switzerland	Societal/Societal/*	1911
	Luxembourg	Societal/Societal/*	1901
Private Health Insurance Type (Private/ Private/Private)	USA	*State*/*State*/*	1965

Source: own presentation.

Note: Changing dimension in italics. The asterisk denotes systems for which it was not possible to ascertain a dominant actor type in the provision dimension.

Appendix IV: Sources

Country	Year of System Introduction	Sources: System Introduction	Sources: Classification of System Type
Afghanistan	1955	(Health Policy Project, 2015).	(Health Policy Project, 2015)
Albania	1927	(Druga, 2021)	(Druga, 2021; Gjonca, Wilson, & Falkingham, 1997; Nuri, 2002)
Algeria*	1973	(Algeria, 1974)	(Algeria, 1974; Brahamia, 1991)
Angola	1975	(Fustukian, 2004; Frøystad, Mæstad, & Villamil 2011; Hilhorst & Serrano, 2010; Pavignani & Colombo, 2001; Queza, 2010; SSA, 2019a; Tiago, 2011)	(Foster, 2012; Frøystad, Mæstad, & Villamil, 2011; Fustukian, 2004; Hilhorst & Serrano, 2010; Pavignani & Colombo, 2001; SSA 2019a; Tiago, 2011; WHO, 2021; World Bank, 2018)
Argentina	1944	(Argentina, 1943; Argentina, 1944; Arce, 2013)	(Argentina, 1944; Belló & Becerril-Montekio, 2011; Gerges Geagea, 2014; Golbert & Roca, 2010; Penchaszadeh, Leone, & Rovere, 2010; Ross, 2007)
Armenia	1912	see Russia	see Russia
Australia	1953	(Australia, 1953; Hilles & Healy, 2001)	(Australia, 1953; Hilles & Healy, 2001)
Austria	1888	(Bachner, Bobek, Habimana, Ladurner, Lepuschütz, & Ostermann, 2018; Hofmarcher & Rack, 2006; Köhler & Zacher, 1981; Steiner, 2019)	(Bachner, Bobek, Habimana, Ladurner, Lepuschütz, & Ostermann, 2018; Hofmarcher & Rack, 2006; Köhler & Zacher, 1981; Steiner, 2019)
Azerbaijan	1912	see Russia	see Russia
Bahrain	1973	(Al Ghafri, 2007; Kronfol, 2012; RHSO, 2007)	(Al Ghafri, 2007; Bahrain, 1943; Kronfol, 2012; RHSO, 2007)
Bangladesh	1972	(Ahmed, Alam, Anwar, Begum, Huque, Khan, & Osman, 2015; Rahman, 2020)	(Ahmed, Alam, Anwar, Begum, Huque, Khan, & Osman, 2015; Islam & Biswas, 2014; Rahman, 2020)
Belarus	1912	see Russia	see Russia
Belgium	1944	(Belgium, 1944; Corens, 2007; Farman, 1950; Sécurité Sociale, 2020)	(Belgium, 1944; Corens, 2007; Delvaux, 1986; Farman, 1950; Sécurité Sociale, 2020)
Benin*	1997	(Benin, 1997)	(Adeya, Bigirimana, Cavanaugh, & Miller Franco, 2007; Benin, 1997; Beyer, 1998)
Bhutan	2008	(Bhutan, 2008)	(Bhutan, 2008; Dorji, 2013; Thinley, Tshering, Wangmo, Wangchuk, Dorji, Tobgay, & Sharma, 2017; Tobgay, Dorji, Pelzom, & Gibbons, 2011)
Bolivia	1938	(Bolivia, 1938; Ledo & Soria, 2011; Lozano, 2002)	(Bolivia, 1938; Ledo & Soria, 2011; Lozano, 2002)
Bosnia and Herzegovina	1888	(Cain & Jakubowski, 2002); see Austria	see Austria
Botswana	1971	(Botswana, 1971)	(Seitio-Kgokgwe, Gauld, Hill, & Barnett, 2015; Seitio-Kgokgwe, Gauld, Hill, & Barnett, 2016; Seloilwe & Thupayagale-Tshweneagae, 2007; WHO & Regional Office for Africa, 2013)
Brazil	1923	(Albuquerque, 1981; Batich, 2004; de Carvalho, 2020)	(Albuquerque, 1981; Brazilian Senate, 2019; Batich, 2004; Cruz, 2017; IBGE, 2019)
Bulgaria	1918	(Balabanova, 2001; Dimova, 2018; National Health Insurance Fund, 2009; Whitney, 1943)	(Balabanova, 2001; Whitney, 1943)

Country	Year of System Introduction	Sources: System Introduction	Sources: Classification of System Type
Burkina Faso*	2015	(Burkina Faso, 2015)	(Burkina Faso, 2015; Ministère de la Santé Burkina Faso & Organisation Mondiale de la Santé, 2017)
Burundi	1980	(Arhin, 1994; Human Rights Watch, 2006)	(Burundi, 1980)
Cambodia	1997	(Annear, Grundy, Ir, Jacobs, Men, Nachtnebel, Oum, Robins, & Ros, 2015; Grundy, Hoban, & Allender, 2016; Soth, 2016)	(Grundy, Hoban, & Allender, 2016; Thin, 2016)
Cameroon	1968	(Fouomene, 2013)	(Cameroon, 1968; Fouomene, 2013)
Canada	1957	(Brewster, 1959; Deber, 2003; Evans, 1992; Gelber, 1959; Irvine & Ferguson, 2002; Manga, Broyles, & Angus, 1987; Marchildon, 2013; Naylor, 1999; Ostry, 2009; Taylor, 1987; Turner, 1958)	(Brewster, 1959; Deber, 2003; Evans, 1992; Gelber, 1959; Irvine & Ferguson, 2002; Manga, Broyles, & Angus, 1987; Marchildon, 2013; Naylor, 1999; Ostry, 2009; Taylor, 1987; Turner, 1958)
Cape Verde	1978	(SSA, 2019a)	(SSA, 2019a)
Central African Republic*	N/A		
Chad*	N/A		
Chile	1924	(Chile, 1924; Kritzer, 1983)	(Chile, 1924; Kritzer, 1983)
China	1951	(State Council of China, 1953; Xi, 2018; Zhongwei, Jia, & Zhao, 2017)	(China, 1951)
Colombia	1938	(Colombia, 1938; Gutiérrez, 2010)	(Colombia, 1938; Gutiérrez, 2010)
Comoros	1994	(Comoros, 1994; United Nations, 2002; World Bank, 1998)	(Comoros, 1994; Comoros, 1995; World Bank, 1998)
Congo	1975	(Congo, 1975)	(Congo, 1975)
Costa Rica	1941	(Casas & Vargas, 1980; Costa Rica, 1941; del Rocío Sáenz, Bermúdez, & Acosta, 2010; Gonzalez Block & González McQuire, 2017; Mesa-Lago, 1985; Morgan, 1987; Pesec & Bitton, 2017; Pesec, Ratcliffe, Karlage, Hirschhorn, Gawande, & Bitton, 2017; Unger, De Paepe, Buitrón, & Soors, 2008; Vargas & Muiser, 2013)	(Casas & Vargas, 1980; Costa Rica, 1941; del Rocío Sáenz, Bermúdez, & Acosta, 2010; Gonzalez Block & González McQuire, 2017; Mesa-Lago, 1985; Morgan, 1987; Pesec & Bitton, 2017; Pesec, Ratcliffe, Karlage, Hirschhorn, Gawande, & Bitton, 2017; Unger, De Paepe, Buitrón, & Soors, 2008; Vargas & Muiser, 2013)
Côte d'Ivoire	1965	(Côte d'Ivoire, 1965; Ouattara, Houngbedji, & Koudou, 2013)	(Côte d'Ivoire, 1965; Ouattara, Houngbedji, & Koudou, 2013)
Croatia	1888	see Austria	see Austria
Cuba	1961	(Cuba, 1961; Delgado García, 1998; Ruiz Hernández, 2015; Sixto, 2002; Stusser, 2017; SSA, 2019b; Waitzkin, 1983)	(Cuba, 1961; Delgado García, 1998; Ruiz Hernández, 2015; Sixto, 2002; Stusser, 2017; SSA, 2019b; Waitzkin, 1983)
Cyprus	1960	(Antoniadou, 2005; Dimitrakopoulos & Sapountzi-Krepia, 2017; Theodorou, Charalambous, Petrou, & Cylus, 2012)	(Antoniadou, 2005; Dimitrakopoulos & Sapountzi-Krepia, 2017; SSA, 2018)
Czech Republic	1888	(Alexa, Rečka, Votápková, Van Ginneken, Spranger, Wittenbecher, 2015); see Austria	see Austria
Democratic Republic of the Congo	1982	(Democratic Republic of Congo, 2001; Mbeva, Prudence, & Karamere, 2018; Waldman, 2006)	(Democratic Republic of Congo, 2001; Mbeva, Prudence, & Karamere, 2018; Waldman, 2006)

Country	Year of System Introduction	Sources: System Introduction	Sources: Classification of System Type
Denmark	1921	(Kuhnle, 1978; Olejaz, Nielsen, Rudkjøbing, Birk, Krasnik, & Hernández-Quevedo, 2012; Preker, 2018)	(Olejaz, Nielsen, Rudkjøbing, Birk, Krasnik, & Hernández-Quevedo, 2012; Preker, 2018)
Djibouti	1991	(Hatem, 1996; RHSO, 2006a)	(Djibouti, 1991)
Dominican Republic	1947	(Dominican Republic, 1947; Farman, 1947)	(Dominican Republic, 1947; Farman, 1947)
East Timor	2004	(East Timor, 2004)	(Alonso & Brugha, 2006; East Timor, 2004; Guinness, Paul, Martins, Asante, Price, Hayen, Jan, Soares, & Wiseman, 2018; WHO, 2000)
Ecuador	1935	(Apella, 2020; Ecuador, 1935; Galiano Maritan & Bravo Placeres, 2019; IESS, 2020; López Arteta, 1944; Lucio, Villacrés, & Henriquéz, 2011; Sánchez, 2019; SSA, 2019b; Whitney, 1939)	(Apella, 2020; Ecuador, 1935; Galiano Maritan & Bravo Placeres, 2019; IESS, 2020; López Arteta, 1944; Lucio, Villacrés, & Henriquéz, 2011; Sánchez, 2019; SSA, 2019b; Whitney, 1939)
Egypt	1959	(Abo El-Ata, 2014; Abo El-Ata & Nahmias, 2005; BLS, 1965; Gaballah, 2018; United Arab Republic, Central Ministry of Social Affairs and Labour, 1960)	(Abo El-Ata, 2014; Abo El-Ata & Nahmias, 2005; BLS, 1965; Gaballah, 2018; United Arab Republic, Central Ministry of Social Affairs and Labour, 1960)
El Salvador	1949	(El Salvador, 1949; Escalante Medrano & Nerio Diaz, 2006; SSA, 2019b)	(El Salvador, 1949; Escalante Medrano & Nerio Diaz, 2006; SSA, 2019b)
Equatorial Guinea	1984	(Equatorial Guinea, 1982; Muñoz, 2016; Serrano & Abogo, 2006; SSA, 2019a)	(Equatorial Guinea, 1982; Muñoz, 2016; Serrano & Abogo, 2006; SSA, 2019a)
Eritrea	1996	(Eritrea, 1996)	(Habtom, 2017; Kirigia, Zere, & Akazili, 2012; World Bank, 2003; World Bank, 2004)
Estonia	1912	(Habicht, Reinap, Kasekamp, Sikkut, Aaben, Van Ginneken, 2018); see Russia	see Russia
Eswatini	1968	(Eswatini, 1968)	(Kober & Van Damme, 2006; Nomaxhule, Masilela, & Matsebula, 1998; Sukati, 1997; Yoder, 1989)
Ethiopia	1959	(Ethiopia, 1959)	(Barnett & Tefera, 2010; Dunning, 1970; Kloos, 1998)
Fiji	1978	(Negin, Roberts, & Lingam, 2010; WHO, 1978; WHO, 2008)	(Negin, Roberts, & Lingam, 2010; Roberts, Irava, Tuiketei, Nadakuitavuki, Otealagi, Singh, Pellny, Mohammed, & Chang, 2011)
Finland	1963	(Alestalo & Uusitalo, 1986; Hakkinen & Lehto, 2005; Preker, 2018; Saaeivirta, Consoli, & Dhondt, 2010)	(Järvelin, Rico, & Cetani, 2002)
France	1893	(Cucarull, 1992; France, 1893; Nay, Bejean, Benamouzig, Bergeron, Castel, & Ventelou, 2016)	(Cucarull, 1992; France, 1893; Hollingsworth, Hage, & Hanneman, 1990; Nay, Bejean, Benamouzig, Bergeron, Castel, & Ventelou, 2016)
Gabon*	2008	(Gabon, 2007, 2008)	(Gabon, 2007, 2008)
Gambia	1979	(Lochting, 2008; The Republic of Gambia & Ministry of Health and Social Welfare, 2017; World Bank, 1987)	(Lochting, 2008; The Republic of Gambia & Ministry of Health and Social Welfare, 2017; World Bank, 1987)
Georgia	1912	see Russia	see Russia
Germany	1883	(Alber, 1992; Busse, Blümel, Knieps, & Bärninghausen, 2017; Germany, 1883; Köhler & Zacher, 1981)	(Alber, 1992; Busse, Blümel, Knieps, & Bärninghausen, 2017; Germany, 1883; GESIS Historical Statistics & Spree, 1990; Köhler & Zacher, 1981)

Country	Year of System Introduction	Sources: System Introduction	Sources: Classification of System Type
Ghana	1957	(Addae-Korankye, 2013; Adisah-Atta, 2017; Ghana, 1957)	(Addae-Korankye, 2013; Adisah-Atta, 2017; Aikins & Koram, 2017; Durairaj, D'Almeida, & Kirigia, 2010; Ghana, 1957; Mercy & Patience, 2011; Twumasi, 1979)
Greece	1934	(Economou, 2010; United States Department of Labor, 1955; Venieris, 1994)	(Economou, 2010; United States Department of Labor, 1955; Venieris, 1994)
Guatemala	1946	(Guatemala, 1946; USAID, 2015)	(Guatemala, 1946; USAID, 2015)
Guinea*	1958	(Camara, Camara, & Camara, 2017)	(Camara, Camara, & Camara, 2017)
Guinea-Bissau	1993	(Embaló & Rouberte, 2014; Jaló, Biai, Pereira, Pina, Aleluia, da Costa Pereira, Djicó, Samati, Nhaga, & Thierry, 2007)	(Embaló & Rouberte, 2014; Jaló, Biai, Pereira, Pina, Aleluia, da Costa Pereira, Djicó, Samati, Nhaga, & Thierry, 2007)
Guyana	1969	(Gafar, 2005; Guyana, 1969; ISAGS, 2012a; Misir, 2015; National Insurance Board, 1970; PAHO, 2001; SSA, 2019b; WHO & Ministry of Health Guyana, 2008)	(Gafar, 2005; Guyana, 1969; ISAGS, 2012a; Misir, 2015; National Insurance Board, 1970; PAHO, 2001; SSA, 2019b; WHO & Ministry of Health Guyana, 2008)
Haiti	1995	(Ministry of Public Health Haiti, 1995; PAHO, 2003; Wamai & Larkin, 2011)	(Ministry of Public Health Haiti, 1995; PAHO, 2003; Wamai & Larkin, 2011)
Honduras	1959	(Díaz, Guivobich, & Palacio Mejía, 2006; Franzoni, 2008; Honduras, 1959)	(Díaz, Guivobich, & Palacio Mejía, 2006; Franzoni, 2008; Honduras, 1959)
Hungary	1891	(Gaál, Szigeti, Csere, Gaskins, & Panteli, 2011; Szikra, 2004)	(Gaál, Szigeti, Csere, Gaskins, & Panteli, 2011; Szikra, 2004)
India	1948	(Ahuja, 2021; India, 1948)	(Ahuja, 2021; India, 1948)
Indonesia	1968	(Jung, 2016; Mahendradhata, Trisnantoro, Listyadewi, Soewondo, Harimurti, Marthias, & Prawira, 2017; Pisani, Olivier Kok, & Nugroho, 2017)	(Mahendradhata, Trisnantoro, Listyadewi, Soewondo, Harimurti, Marthias, & Prawira, 2017)
Iran	1952	(BLS, 1964; Hsu, Majdzadeh, Harichi, & Soucat, 2020; Schayegh, 2006)	(BLS, 1964; Doshmangir, Bazyar, Rashidian, & Gordeev, 2021; Schayegh, 2006)
Iraq	1964	(Al Mosawi, Al Hasnawi, & Al Khuzaie, 2009; Iraq, 1964; Kronfol, 2012)	(Al Mosawi, Al Hasnawi, & Al Khuzaie, 2009; Iraq, 1964; Kronfol, 2012)
Ireland	1953	(Ireland, 1953; Maguire, 1986)	(HIA, 2018; Ireland, 1953)
Israel	1994	(Arian, 1981; Clarfield, Manor, Bin-Nun, Shvarts, Azzam, Afek, Basis, & Israeli, 2017; Cohen & Farman, 1954; Mirvis, 1997; Rosen & Hadar, 2009; Rosen, Waitzberg, & Merkur, 2015)	(Arian, 1981; Clarfield, Manor, Bin-Nun, Shvarts, Azzam, Afek, Basis, & Israeli, 2017; Cohen & Farman, 1954; Mirvis, 1997; OECD Health Statistics, 2020; Rosen & Hadar, 2009; Rosen, Waitzberg, & Merkur, 2015)
Italy	1888	(Bassetti, Gulino, Gazzaniga, & Frati, 2011)	(Bassetti, Gulino, Gazzaniga, & Frati, 2011)
Jamaica	1974	(Campbell, 2013; Jamaica, 1974; Leavitt, 1992)	(Campbell, 2013; Jamaica, 1974; Leavitt, 1992)
Japan	1922	(HGPI, 2018; Ikegami, Yoo, Hashimoto, Matsumoto, Ogata, Babazono, & Kobayashi, 2011)	(HGPI, 2018; Sakai, 2011; Sugita, 2012; Waggaman, 1935)
Jordan	1963	(Ajlouni, 2011; Al-Khalidi, 1992; Kronfol, 2012)	(Ajlouni, 2011; Al-Khalidi, 1992; Kronfol, 2012)
Kazakhstan	1924	see Turkmenistan	see Turkmenistan

Country	Year of System Introduction	Sources: System Introduction	Sources: Classification of System Type
Kenya	1965	(Abuya, Maina, & Chuma, 2015; Chuma & Okungu, 2011; Künzler, 2015; Munge & Briggs, 2014; Mwabu, 1995; Wamai, 2009)	(Abuya, Maina, & Chuma, 2015; Chuma & Okungu, 2011; Künzler, 2015; Munge & Briggs, 2014; Mwabu, 1995; Wamai, 2009)
Kosovo	1922	see Serbia	see Serbia
Kuwait	1962	(Meleis, 1979; RHSO, 2006b)	(Kuwait, 1962)
Kyrgyzstan	1924	see Turkmenistan	see Turkmenistan
Laos	1975	(Akkhavong, Paphassarang, Phoxay, Vonglokham, Phommavong, & Pholsena, 2014; Jönsson, Phoummalaysith, Wahlström, & Tomson, 2014; Thome & Pholsena, 2009)	(Jönsson, Phoummalaysith, Wahlström, & Tomson, 2014)
Latvia	1912	(Tragakes, Brigis, Karaskevica, Rurane, Stuburs, Zusmane, 2008); see Russia	see Russia
Lebanon	1963	(Abyad, 2001; El-Jardali, Bou-Karroum, Ataya, El-Ghali, & Hammoud, 2014; Kronfol, 2012)	(Ammar, 2003, 2009; Van Lerberghe, Ammar, El Rashidi, Sales, & Mechbal, 1997)
Lesotho	1993	(Lesotho, 1993)	(Akinkugbe, Chama-Chiliba, & Tlotlego, 2013; Lesotho, 1993; WHO, 2014)
Liberia	2007	(Achgill, Geray, El Hachimi, Jadhav, Mullins, Reddy, & Walker, 2014; Wang, Temsah, & Carter, 2016; Zolia, Harris, Gebrekidan, Karamagi, Tumusiime, Dahn, & Wesseh, 2017)	(Achgill, Geray, El Hachimi, Jadhav, Mullins, Reddy, & Walker, 2014; Wang, Temsah, & Carter, 2016; Zolia, Harris, Gebrekidan, Karamagi, Tumusiime, Dahn, & Wesseh, 2017)
Libya	1957	(Imneina & Alfarsi, 2020; Libya, 1957; SSA, 2019a; Wasfy, 1967)	(Libya, 1957; SSA, 2019a)
Lithuania	1912	("Sickness Insurance and Benefits", 1928); see Russia	see Russia
Luxembourg	1901	(European Observatory on Health Care Systems, 1999; Köstler, 1996; Luxembourg, 1901)	(European Observatory on Health Care Systems, 1999; Luxembourg, 1901)
Madagascar*	1960	(Merlin, Mafart, & Triaud, 2003)	(Merlin, Mafart, & Triaud, 2003)
Malawi	1994	(Malawi, 1994; United States Agency for International Development, & Advancing Partners and Communities, 2017)	(Borghi, Munthali, Million, & Martinez-Alvarez, 2018; Malawi, 1994; Mchenga, Chirwa, & Chiwaula, 2017; United States Agency for International Development, & Advancing Partners and Communities, 2017; World Bank, 2017; Zere, Walker, Kirigia, Zawaira, Magombo, & Kataika, 2010)
Malaysia	1957	(Chee & Barraclough, 2007; Jaafar, Noh, Muttalib, Othman, & Healy, 2007)	(Chee & Barraclough, 2007; Jaafar, Noh, Muttalib, Othman, & Healy, 2007)
Mali*	1964	(Deville, Hane, Ridde & Touré 2018; Konaté & Kanté 2005; Lamiaux, Rouzaud, & Woods 2011)	(Deville, Hane, Ridde & Touré 2018; Konaté & Kanté 2005; Lamiaux, Rouzaud, & Woods 2011)
Mauritania	1963	(Mauritania, 1987; Roemer, 1987; SSA, 2019a)	(Mauritania, 1987; Roemer, 1987; SSA, 2019a)
Mauritius	1975	(Mauritius, 1975)	(Bah, 1992; Mauritius, 1975; Nundoochan, Thorabally, Monohur, & Hsu, 2019)
Mexico	1942	(Castro, 2014; Frenk & Gómez-Dantés, 2019; González Block, Reyes Morales, Cahuana Hurtado, Balandrán, & Méndez, 2020; Knaul & Frenk, 2005; Mexico, 1942; Rohen y Galvéz, 1943; SSA, 2019b)	(Castro, 2014; Frenk & Gómez-Dantés, 2019; González Block, Reyes Morales, Cahuana Hurtado, Balandrán, & Méndez, 2020; Knaul & Frenk, 2005; Mexico, 1942; Rohen y Galvéz, 1943; SSA, 2019b)

Country	Year of System Introduction	Sources: System Introduction	Sources: Classification of System Type
Moldova	1912	see Russia	see Russia
Mongolia	1922	(Neumann & Warburton, 2015; Tsilaajav, Ser-Od, Baasai, Byambaa, & Shagdarsuren, 2013; World Bank, 2007)	(Neumann & Warburton, 2015; Tsilaajav, Ser-Od, Baasai, Byambaa, & Shagdarsuren, 2013; World Bank, 2007)
Montenegro	1922	see Serbia	see Serbia
Morocco*	1959	(Idrissi, 2002)	(Idrissi, 2002)
Mozambique	1977	(Cliff, Kanji, & Muller, 1986; Mbofana, 2019; Mitano, Ventura, Lima, Balegamire, & Palha, 2016; Mozambique, 1977; Pfeiffer, 2003; SSA, 2019a)	(Cliff, Kanji, & Muller, 1986; Mbofana, 2019; Mitano, Ventura, Lima, Balegamire, & Palha, 2016; Mozambique, 1977; Pfeiffer, 2003; SSA, 2019a)
Myanmar	1954	(Myanmar, 1954; "Pyidawtha", 1953; Sein, Myint, Tin, Win, Aye, & Sein, 2014)	(Myanmar, 1954)
Namibia	1990	(Namibia, 1990)	(Brockmeyer, 2012; Iita, Iipinge, & Van Dyk, 2016; Janssens, Gustafsson-Wright, Beer, & van den Gaag, 2018; Krämer, Haupt, Coetzer, & van Blomberg, 2014; Nord, 2014; van Rooy, Mufune, & Amadhila, 2015; Wang, Temsah, & Carter, 2016)
Nepal	2007	(Adhikari, 2015; Marasini, 2003; Mishra, Khanal, Karki, Kallestrup, & Enemark, 2015)	(Adhikari, 2015)
Netherlands	1941	(Bertens & Vonk, 2020)	(Bertens & Vonk, 2020; Companje, Hendriks, Veraghtert, & Widdershoven, 2009)
New Zealand	1900	(Ashton, 1996; New Zealand, 1900)	(Ashton, 1996; New Zealand, 1900)
Nicaragua	1955	(Donahue, 1983; Farman, 1957; Nicaragua, 1956)	(Donahue, 1983; Farman, 1957; Nicaragua, 1956)
Niger	1999	(African Development Fund, 2001; International Monetary Fund, 2013; Republic du Niger, 2002)	(Republic du Niger, 2002)
Nigeria	1999	(Nigeria, 1999)	(Nigeria, 1999)
North Korea	1946	(Kichae & Hyejin, 2018; Soh, 2016)	(Kichae & Hyejin, 2018; Soh, 2016)
North Macedonia	1922	see Serbia	see Serbia
Norway	1909	(Kuhnle, 1978; Preker, 2018)	(Kuhnle, 1978; Preker, 2018)
Oman	1975	(Alshishtawy, 2010; RHSO, 2006c)	(Alshishtawy, 2010)
Pakistan	1965	(Ibrar, Naqvi, Safdar, & Ranja, 2015; Pakistan, 1965a, 1965b)	(Pakistan, 1965a; Punjab Employees Social Security Institution, 2018)
Panama	1941	(Panama, 1941; Renán Esquivel, 1981)	(Panama, 1941; Renán Esquivel, 1981)
Papua New Guinea	1977	(Grundy, Dakulala, Wai, Maalsen, & Whittaker, 2019)	(Bolger, Mandie-Filer, & Hauck, 2005; Campos-Outcalt, 1989)
Paraguay	1936	(Mancuello-Alun & Cabral de Bejarano, 2011; Paraguay, 1936)	(Mancuello-Alun & Cabral de Bejarano, 2011; Paraguay, 1936)
Peru	1935	(De Las Casas Grieve, 1967; Peru, 1935, 1936)	(De Las Casas Grieve, 1967; Peru, 1935, 1936)
Philippines	1954	(Ford & Cruz, 1957; Magsaysay, 1955; Romualdez, de la Rosa, Flavier, Quimbo, Hartigan-Go, Lagrada, & David, 2011)	(Ford & Cruz, 1957; Magsaysay, 1955; Romualdez, de la Rosa, Flavier, Quimbo, Hartigan-Go, Lagrada, & David, 2011)

Country	Year of System Introduction	Sources: System Introduction	Sources: Classification of System Type
Poland	1920	(Bureau of Labor Statistics, 1921; Grata, 2015; Sagan, Panteli, Borkowski, Dmowski, Domanski, Czyzewski, & Kowalska, 2011)	(Godycki-Ćwirko, Oleszczyk, & Windak, 2010; Grata, 2015; Sagan, Panteli, Borkowski, Dmowski, Domanski, Czyzewski, & Kowalska, 2011)
Portugal	1935	(Campos, 2013; Pita Barros, Ribeirinho Machado, & de Almeida Simões, 2011; Portugal, 1935)	(Campos, 2013; de Almeida Simões, Augusto, Fronteira, & Hernandez-Quevedo, 2017; Fernandes, Burnett, Major, & Figueiredo, 2017; Ferrinho, Conceição, Rosa Biscaia, Fronteira, & Antunes, 2006; Guibentif, 1997; Pereirinha & Carolo, 2009; Pita Barros, Ribeirinho Machado, & de Almeida Simões, 2011; Santana, Dias, Souza, & Rocha, 2007)
Qatar	1971	(Qatar, 1965, 1996)	(Alshamari, 2017; RHSO, 2006d)
Romania	1933	(Dinu, 2017; Marian, 2018; Spiru, Trascu, Ileana Turcu, & Marzan, 2011)	(Plata-Stenger, 2020; Spiru, Trascu, Ileana Turcu, & Marzan, 2011)
Russia	1912	(Ewing, 1991; Goudima & Rybalko, 1996; Nolken, 1914)	(Ewing, 1991; Goudima & Rybalko, 1996; Nolken, 1914; Reshetnikov, Ekkert, Capasso, Arsentyev, Mikerova, & Yakushina, 2019)
Rwanda	2001	(Letourmy, 2008; Lu, Chin, Lewandowski, Basinga, Hirschhorn, Hill, Murray, & Binagwaho, 2012; Musango, Doetinchem, & Carrin, 2009; Ruberangeyo, Ayebare, & de Laminne de Bex, 2011; WSM, 2011)	(Letourmy, 2008; Lu, Chin, Lewandowski, Basinga, Hirschhorn, Hill, Murray, & Binagwaho, 2012; Musango, 2005; Musango, Doetinchem, & Carrin, 2009; Ruberangeyo, Ayebare, & de Laminne de Bex, 2011; WSM, 2011)
Saudi Arabia	1925	(Al-Hashem, 2016; Almalki, Fitzgerald, & Clark, 2011; Kaliq, 2012)	(Almalki, Fitzgerald, & Clark, 2011; Almasabi, 2013)
Senegal	1975	(Alenda-Demoutiez, Antwi, Mendo, & Ba, 2019; Department of Labor Statistics and Studies Senegal, 2017; Senegal, 1975; Snyder, 1973)	(Alenda-Demoutiez, Antwi, Mendo, & Ba, 2019; Department of Labor Statistics and Studies Senegal, 2017; Senegal, 1975; Snyder, 1973)
Serbia	1922	(Bjegovic-Mikanovic, Vasic, Vukovic, Jankovic, Jovic-Vranes, Santric-Milicevic, Terzic-Supic, & Hernández-Quevedo, 2019; BLS, 1943; ISSS, 2020)	(Bjegovic-Mikanovic, Vasic, Vukovic, Jankovic, Jovic-Vranes, Santric-Milicevic, Terzic-Supic, & Hernández-Quevedo, 2019; BLS, 1943; Džakula, Sagan, Pavić, Lonččarek, & Sekelj-Kauzlarić, 2014; ISSS, 2020)
Sierra Leone	2010	(Witter, Wurie, & Bertone, 2015)	(Donnelly, 2011; Government of Sierra Leone, & Ministry of Health and Sanitation, 2010; Maxmen, 2013; Witter, Wurie, & Bertone, 2015; Wurie & Witter, 2014)
Singapore	1965	(Haseltine, 2013; Li, 2006)	(Haseltine, 2013; Li, 2006)
Slovakia	1888	(Smatana, Pazitný, Kandilaki, Laktisová, Sedláková, Palusková, Van Ginneken, & Spranger, 2016); see Austria	see Austria
Slovenia	1888	see Austria	see Austria
Solomon Islands	1979	(Asante, Graham, & Hall, 2012; Hodge, Slatyer, Skiller, 2015; Solomon Islands, 1979; SSA, 2017)	(Asante, Graham, & Hall, 2012; Hodge, Slatyer, Skiller, 2015; Solomon Islands, 1979; SSA, 2017)
Somalia	N/A	N/A	N/A
South Africa	1977	(Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; South Africa, 1977)	(Benatar, 1997; Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Shadrack, 2018)
South Korea	1976	(Chun, Kim, Lee, & Lee, 2009; Kwon, 2008; Nam, 2015)	(Chun, Kim, Lee, & Lee, 2009; Kwon, 2008; Nam, 2015)

Country	Year of System Introduction	Sources: System Introduction	Sources: Classification of System Type
South Sudan	2011	(South Sudan, 2011)	(Basaza, Alier, Kirabira, Ogubi, & Loro Lako, 2017; Comparative Constitutions Project, 2020; Dowie, 2012)
Spain	1942	(Blendon, Donelan, Jovell, Pellisé, & Costas Lombardia, 1991; Cutler & Johnson, 2004; Garcia-Armesto, Abadía-Taira, Durán, Hernández-Quevedo, & Bernal-Delgado, 2010; Pagán Lozano, 2009; Perdiguero-Gil & Comelles, 2019; Pons Pons & Vilar Rodríguez, 2012; Rodriguez, Gallo de Puelles, & Jovell, 1999; Rodríguez Ocaña, 2001; Spain, 1942)	(Blendon, Donelan, Jovell, Pellisé, & Costas Lombardia, 1991; Cutler & Johnson, 2004; Garcia-Armesto, Abadía-Taira, Durán, Hernández-Quevedo, & Bernal-Delgado, 2010; Pagán Lozano, 2009; Perdiguero-Gil & Comelles, 2019; Pons Pons & Vilar Rodríguez, 2012; Rodriguez, Gallo de Puelles, & Jovell, 1999; Rodríguez Ocaña, 2001; Spain, 1942)
Sri Lanka	1952	(Jayasuriya, 2001; Rannan-Eliya & Sikurajapathy, 2008; Sri Lanka, 1952; Uragoda, 1987)	(Rannan-Eliya & Sikurajapathy, 2008; Sri Lanka, 1952)
Sudan	1967	(Abdu, Mohammed, Bashier, & Eriksson, 2004; Ebrahim, Ghebrehiwot, Abdalgfar, & Juni, 2017; Salim & Hamed, 2018)	(Abdu, Mohammed, Bashier, & Eriksson, 2004; Ebrahim, Ghebrehiwot, Abdalgfar, & Juni, 2017; Salim & Hamed, 2018)
Suriname	1980	(Eichler & Amanh, 1999; ISAGS, 2012b; Larye, Goede, & Barten, 2015; PAHO, 2002; Smits, Toelsie, Eersel, & Krishnadath, 2018; SSA, 2019b; Suriname, 1980)	(Eichler & Amanh, 1999; ISAGS, 2012b; Larye, Goede, & Barten, 2015; PAHO, 2002; Smits, Toelsie, Eersel, & Krishnadath, 2018; SSA, 2019b; Suriname, 1980)
Sweden	1928	(Anell, Glenngard, & Merkur, 2012; Committee on Labor and Public Welfare, and Subcommittee on Health, 1972)	(Anell, Glenngard, & Merkur, 2012; Committee on Labor and Public Welfare, and Subcommittee on Health, 1972)
Switzerland	1911	(Alber & Bernardi-Schenkluhn, 1992; BMJ, 1911; Bundesamt für Sozialversicherung der Schweiz, n.d.; De Pietro, Camenzind, Sturny, Crivelli, Edwards-Garavoglia, Spranger, Wittenbecher, & Quentin, 2015; Köhler & Zacher, 1981)	(Alber & Bernardi-Schenkluhn, 1992; BMJ, 1911; De Pietro, Camenzind, Sturny, Crivelli, Edwards-Garavoglia, Spranger, Wittenbecher, & Quentin, 2015; Köhler & Zacher, 1981)
Syria	1959	(Syria, 1959)	(Syria, 1959)
Taiwan	1950	(Hye Kyung Son, 2001; Liu, 2017; Lu & Chiang, 2011)	(Chung-Tung, 1998; Hye Kyung Son, 2001)
Tajikistan	1924	see Turkmenistan	see Turkmenistan
Tanzania	1977	(Tanzania, 1977)	(Kumaranayake, Mujinja, Hongoro, & Mpembeni, 2000; Mubyazi, Massaga, Kamugisha, Mubyaziy, Magogo, Mdira, & Sukwaz, 2005; Mujinja & Kida, 2014; Tanzania, 1977)
Thailand	1974	(NHSO, 2019; Rajatanavin, Chunharas, Sawasdivorn, Jongudomsuk, & Thammatacharee, 2019)	(Rajatanavin, Chunharas, Sawasdivorn, Jongudomsuk, & Thammatacharee, 2019¸ Tangcharoensathie, Patcharanarumo, Kulthanmanuso, Saengruang, & Kosiyaporn, 2019; Thaiprayoon & Wibulpoiprasert, 2017; Towse, Mills, & Tangcharoensathien, 2004)
Togo	2011	(Atake & Amendah, 2018; Djahini-Afawoubo & Atake, 2018; Togo, 2011)	(Bakai, Ekouevi, Beweli, Iwaz, Thomas, Khanafer, Goilibe, Sewu, Kassankogno, & Voirin, 2019; Togo, 2011; WHO, 2016)
Trinidad and Tobago	1964	(Hezekiah, 1989)	(Hezekiah, 1989)
Tunisia*	1991	(Tunisia, 1991)	(Tunisia, 1991)

Country	Year of System Introduction	Sources: System Introduction	Sources: Classification of System Type
Turkey	1950	(Grütjen, 2017; Kohlwes, 2014; Ministry of Health Turkey, 2018; SSA, 2018; Tatar, Mollahaliloglu, Sahin, Aydin, Maresso, & Hernandez-Quevedo, 2011)	(Grütjen, 2017; Kohlwes, 2014; Ministry of Health Turkey, 2018; SSA, 2018; Tatar, Mollahaliloglu, Sahin, Aydin, Maresso, & Hernandez-Quevedo, 2011; Yilmaz, 2013)
Turkmenistan	1924	(Goudima & Rybalko, 1996; Popovich, Potapchik, Shishkin, Richardson, Vacroux, & Mathivet, 2011; Reshetnikov, Arsentyev, Boljevic, Timofeyev, & Jakovljevic, 2019)	(USSR, 1924)
Uganda	1962	(Uganda, 1962)	(Carlson, 2004; Mukasa, 2012; Tashobya, 2004; Zikusooka, Kyomuhang, Orem, & Tumwine, 2009)
Ukraine	1912	see Russia	see Russia
United Arab Emirates	1971	(RHSO, 2006e; United Arab Emirates, 1971, 1972)	(RHSO, 2006e; United Arab Emirates, 1971, 1972)
United Kingdom	1911	(Foerster, 1912; Harris, 1920; United Kingdom, 1911)	(Foerster, 1912; Harris, 1920; United Kingdom, 1911)
United States	1965	(Booth & Mor, 2007; Grabowski, 2007; Gruber, 2000; Hacker, 1998; SSA, 2009; United States, 1965)	(Berkowitz, 2005; Currie & Duque, 2019; Grabowski, 2007; Provost & Hughes, 2000; SSA, 2009; United States, 1965)
Uruguay	1910	(Ferrari, 2010; Government of Uruguay, 1913, 2020; Muñoz, Galeano, Olesker, & Garrido, 2010; Puñales, 2002)	(Ferrari, 2010; Government of Uruguay, 1913, 2020; Muñoz, Galeano, Olesker, & Garrido, 2010; Puñales, 2002)
Uzbekistan	1924	see Turkmenistan	see Turkmenistan
Venezuela	1944	(Bonvecchio, Becerril-Montekio, Carriedo-Lutzenkirchen, & Landaeta-Jiménez, 2011; Powell, 1946)	(Bonvecchio, Becerril-Montekio, Carriedo-Lutzenkirchen, & Landaeta-Jiménez, 2011; Powell, 1946)
Vietnam	1954	(Birt, 1990; Ladinsky & Levine, 1985; London, 2008; Matsuda, 1997)	(Birt, 1990; Ladinsky & Levine, 1985; London, 2008; Matsuda, 1997)
Yemen	1978	(Lackner, 2017; WHO, 1979)	(Lackner, 2017; Saleh, Alameddine, Natafgi, Mataria, Sabri, Nasher, Zeiton, Ahmad, & Siddiqi, 2014; WHO, 1979; Yemen, 1978)
Zambia	1964	(Zambia, 1964)	(Burdette, 1988; Freund, 1986; Hjortsberg & Mwikisa, 2002; Valentine, 2017)
Zimbabwe	1980	(Zimbabwe, 1980)	(Nyazema, 2010; Osika, Altman, Ekbladh, Katz, Nguyen, Rosenfeld, & Tapera, 2010; Sanders, Kravitz, Lewin, & McKee, 1998; Schultz Hansen & Chapman, 2008; Sithole, 2013; Woelk, 1994)

*Introduction years for countries signalled with an asterisk need further validation from experts.

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