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"Un-American" or unnecessary? America's rejection of compulsory government health insurance in the Progressive Era ☆

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ABSTRACT

Between 1915 and 1920, 18 U.S. states considered the introduction of compulsory health insurance. Progressive reformers expected state health insurance to be welfare enhancing for American wage-workers since it would result in lower cost insurance and an extension of coverage to more of the population. The evidence presented in this paper indicates that the absence of broad political support for health insurance legislation in this early period reflects that compulsory insurance would not have improved on what was available and affordable through voluntary arrangements and had the potential to reduce the welfare of wage-earners.

1. Introduction

Progressive reformers in the U.S. interpreted state provided health insurance as the necessary and inevitable response to the moral and economic inadequacies of voluntary insurance and self-help arrangements in protecting households against the consequences of sickness.[1] Given the developments in Europe and the introduction of Worker's Compensation in many states before World War I, the reformers believed that government health insurance was the next step in social progress for the U.S.[2] At the impetus of the American Association for Labor Legislation (AALL), between 1915 and 1920, as many as 18 U.S. states investigated but rejected compulsory-state health insurance (CHI). The AALL reformers and many scholars today consider this outcome to be a policy failure and significant for explaining why the U.S. does not have, and is unlikely to have in future, national health insurance.[3]

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[1] Peebles (1936), Gilbert (1966), Lubove (1968), Rodgers (1998), Horrell and Oxley (2000), Hoffman (2001), Kaufman (2002), Quadagno (2005).

[2] Rubinow (1931) argued that health insurance was the "next step in social progress" in 1916 but by 1930, "that particular step has not been taken." See Moss (1996).

[3] Lubove (1968, pp. 2–3), Fox (1983, p. 599), Hoffman (2001). Most explanations emphasize unique American ideology, and/or institutional structures, and/or interest group powers that are slow to change (Beland and Hacker, 2004). Quadagno (2005) argues that powerful interests (Doctors and Insurance companies) have always prevented Congress from passing national health insurance legislation. Lindert (1994, p. 28) suggests that the peculiar distaste that Americans have for government aid is durable. Bundorf and Fuchs (2007) suggest that national health insurance will only be introduced in the U.S. if there a significant change in American attitudes and beliefs toward government health insurance.

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If CHI was efficiency enhancing and stood to have made some or all wage-workers better off as the AALL reformers argued, then why were legislators and political "brokers" unable to evoke the necessary political action for its introduction? Anderson (1968, 1987) argues that the indifference of Americans towards compulsory health insurance in this early period left organized groups, such as doctors and life insurers, with political clout and vested interests in the defeat of CHI to determine the outcome. Social reformers such as the members of the AALL interpreted public indifference to CHI as evidence that wage-workers were either ignorant of their true needs for economic security, and/or ideologically driven to reject social insurance as "un-American" despite their dire needs for the programs. In contrast, business organizations, employers associations and insurance companies argued that the indifference of American wage-earners to CHI reflected that they did not need it due to their earning power. Americans had a capacity to save and to purchase insurance coverage through voluntary arrangements.

For government action on CHI to have been politically profitable for legislators and political brokers, significant failures in private markets must have existed for CHI to be a welfare enhancing institutional alternative to the market. To assess this condition for the political viability of CHI in the U.S., I quantify the frequency and duration of work-related disability and I use these estimates to value the expected insurance costs and benefits of the proposed AALL CHI legislation and available voluntary arrangements. This comparison shows that despite the AALL reformers' concerns for the lower earning wage workers, their proposed CHI contract did not offer any advantages to this target group over what was available through voluntary arrangements. The analysis provides empirical support for Costa's (1995) suggestion that CHI was, at best, an expensive duplication of insurance available through voluntary avenues.

Rodgers (1998, p. 243) describes how some proponents of compulsory health insurance in the United States viewed social insurance like CHI as nothing more than a complicated scheme for compulsory savings. The main purpose of CHI would have been to compel wage-workers to purchase higher levels of insurance coverage. Even though CHI was expensive, it could still have been welfare enhancing for wage-workers if households lacked the necessary surplus in their budgets to purchase the voluntary-insurance contracts. My estimates of household budget surpluses from data from the 1888–90 U.S. Commissioner of Labor Cost of Living study and the 1917–19 BLS Cost-of-Living Survey show that, contrary to the claims and evidence of the AALL reformers, American wage-workers could insure against sickness without CHI. Further, the capacity to self-insure, or purchase insurance coverage, increased over the life-cycle, and for wage-workers under age 40, it increased between the late nineteenth century and 1920. CHI would have locked Americans into saving for a single purpose for the length of their working lives even though the need for this insurance coverage was primarily at younger ages. The commitment of so much of household income to the insurance of a single risk was not necessarily desirable. Unlike CHI, the household's savings could be used for covering any losses of income due to illness, or unemployment.

The evidence in this paper supports that the suggestions of Costa (1995), Emery and Emery (1999), Beito (2000), Emery (2006) and Murray (2007) that CHI would not have been welfare improving for American wage-earners which in turn can explain the lack of political support for the legislation in the Progressive Era. Emery and Emery (1999), Beito (2000), Emery (2006) and Murray (2007) provide evidence that voluntary insurance funds of fraternal orders, unions and work-placed based groups were competently managed and provided meaningful assistance to the members of these organizations as late as the Depression of the 1930s. These studies provide necessary, but not sufficient, evidence to refute the progressive reformers' views that voluntary sickness insurance was an inadequate alternative to CHI. Progressive reformers acknowledged that voluntary funds worked well for the better paid of the wage-earning classes but they believed that CHI was necessary to extend coverage to the lower wage earners who would never be covered in the voluntary arrangements. As such, showing the competence of these organizations and the self-insurance capabilities of the better paid wage earners who belonged to them cannot refute the reformers' claims about the societal need for social insurance. Evidence that voluntary-insurance contracts were affordable for lower wage-earners provides direct evidence to address the reformers' case.

2. The historical background for compulsory-state health insurance in the U.S.

During the nineteenth and early twentieth century, lost income due to illness was one of the greatest risks to a wage earner's household's standard of living in North America and Europe.[4] Before 1920, lost income was the important cost of illness for workers and, consequently, sickness/health insurance in this earlier era was for income stabilization, which was thought to be useful for the prevention of poverty.[5] Prior to the introduction of state health insurance programs in Europe, similar "patch-

[4] Rubinow (1913a), Armstrong (1932), Numbers (1978), Horrell and Oxley (2000), Hoffman (2001).

[5] The costs of sickness and poor health include lost income, direct medical costs of hospitalization, physician care and medicine, and for society, lost productivity. By the late 1920s, costs associated with medical treatment and hospitalization equaled the size of income loss (Davis, 1934) and were the larger cost by the 1940s due to technical change in medical treatment, the organization of care around hospitals and the growing strength of Medical Associations in North America (Starr, 1982; Thomasson, 2002). Armstrong (1932, p. 334) reports that in 1915, for government health insurance arrangements the proportion of health insurance benefits paid in cash versus "in kind" ranged from 42% to 98%. By the late 1920s, these proportions ranged from 16% to 56%. Commercial and non-profit group health and hospital insurance plans rose to primacy in the sickness and health insurance field in North America after 1930 (Applebaum, 1961; Follmann, 1965; Davis, 1989; Thomasson, 2002).