"Un-American" or Unnecessary? America's Rejection of Compulsory Government Health Insurance before 1930

J.C. Herbert Emery[*]
Dept. of Economics
University of Calgary
hemery@ucalgary.ca

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Between 1915 and 1920, 16 US states investigated, but rejected, introducing compulsory state health insurance. This outcome has been interpreted as a social policy failure that arose due to Americans viewing social insurance as "Un-American". An alternative explanation for the failure of Americans to implement government health insurance is that for most Americans, compulsory health insurance was "un-necessary" since the American labor market generated incomes sufficient to allow wage-earners to purchase voluntary coverage or to save for a rainy day. Progressive reformers advocating for compulsory social insurance dismissed the latter explanation on the grounds that their evidence showed that American households were incapable of having the necessary budget surplus due to the high cost of the "American standard of living". In this paper, I revisit the reformers' case that American wage earners needed social insurance and I present estimates of household budget surpluses. This evidence supports the claims of opponents of compulsory health insurance that the existing voluntary arrangements for coping with the costs of sickness were adequate for most American families before 1930.

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Between 1883 and 1920, many European countries introduced compulsory (government) health insurance. Most were social insurance arrangements with little redistribution financed by employers and employees, or a state promoted expansion of existing voluntary mutual benefit arrangements. Between 1883 and 1911, there was apparently no interest in the United States in developing comparable government programs, but between 1915 and 1920, 16 US states investigated, but rejected, introducing compulsory state health insurance. Voluntary health insurance arrangements in Europe and North America were similar before 1920, and as these arrangements were the foundation of Compulsory Health Insurance in England and Europe, the US had the "seeds" of compulsory health insurance. In addition, with the introduction of Workmen's Compensation in many states, there was an expectation amongst some Americans that government health insurance would be implemented. Rubinow (1931) argued that in 1916, health insurance was the "next step in social progress" but by 1930, "that particular step has not been taken."

State provided health insurance has been interpreted as the necessary and inevitable response to the apparent moral and economic inadequacies of the existing voluntary self-help arrangements in protecting households against the consequences of sickness (Peebles 1936, Rodgers 1998, Horrell and Oxley 2000, Hoffman 2001). Fox (1983, 599) argues that as many scholars and reformers have viewed the failure of the United States to enact a national health insurance program as symbolic of the incomplete evolution of the U.S. From this perspective, that the United States remains the only Western-developed country without national (compulsory) health insurance represents a

social failure, or at least a missed opportunity, that continues to have lasting effects.[1]

Why was Compulsory Health Insurance (CHI) rejected by Americans? What can this tell us about why the US today is the only industrialized nation not to adopt national health insurance? Most explanations in the literature that address the failure of this early American health insurance movement are supply side explanations for the adoption of government programs; taking the existence of need or demand for the program as given, the adoption/non-adoption reflects capability of centralized government insurance to be implemented.[2] The need for state provided health insurance was taken for granted by proponents of compulsory health insurance before 1920.[3] Fox (1983) suggests, most scholars who have studied the failure of the United States to enact Compulsory Health Insurance have accepted the claims of these reformers without criticism. Rodgers (1998, 255) describes social policy historians as engaged in a search for "structures and materials distinctive to the United States" to explain "American failure". This search for exceptional characteristics inevitably settles on explanations emphasizing unique American ideology, and/or institutional structures, and/or interest group powers.[4] These explanations also suggest that there is path dependence in the evolution of government

[1] Hoffman (2001) argues that this early rejection of government health insurance is the reason that the US does not have national health insurance today. With the rejection of Bill Clinton's attempts to move the U.S. towards national health insurance in the 1990s, it would seem that the reasons behind American resistance to government health insurance persist. Since these early European social insurance programs paved the way for the expansion of the welfare state, and the US rejection of this early form of health insurance is possibly the reason that the US does not have a European style welfare state today (Costa 1996).
[2] A notable exception is Peter Lindert's (1994, 1996 and 2004) work that addresses how income levels, income distribution and age distribution influenced social spending.
[3] Anderson (1950, 366). Rubinow (1913) went so far as to indicate that the need for social insurance in the US was self-evident.
[4] Beland and Hacker (2004) suggest that most explanations for "American Exceptionalism" can be classified as societal theories or historical institutional explanations. Societal explanations focus on economic conditions, cultural values, class conflict or interest group power, factors that are seen as independent of political institutions. Historical institutional explanations, in contrast, focus on the distinct development and structure of U.S. political institutions. It is argued for the U.S., political institutions did

policies as the initial conditions that encouraged, or discouraged, the adoption of government health insurance would not be expected to change over time. [5] Thus, from common patchworks of inadequate voluntary health insurance arrangements in Europe and England and the United States, different values/ideologies/institutions led to different paths of state social insurance development. It follows that the failure of Americans to implement CHI before the Depression of the 1930s is significant for explaining why the U.S. does not have, and is unlikely to have in future, national health insurance.[6]

Rodgers (1998) declares that the least satisfactory arguments for the lack of compulsory social insurance in the United States are those that claim that there exists a "special `American idea' inhibitive to the adoption of social insurance." Rodgers points out that there was nothing in the American debates over social insurance that had not also been present in the "equally polarized rhetorical contests in Germany in the 1880s and in Britain after 1908." These explanations are also not particularly useful for explaining why Australia, Canada and some other early non-adopters, did adopt government health insurance after World War II, nor are they easy to reconcile with the fact that the US adopted public old age insurance in the 1930s, but not public health insurance (Beland and Hacker 2004). The passage of Social Security Legislation in 1935 is an important development to consider since, like compulsory health insurance, compulsory Old Age Insurance generated little support from working Americans before 1920 and the early

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not allow the necessary consolidation of political authority to implement social insurance programs.

[5] Path dependence does not describe all supply side explanations. Daniel Fox (1983) describes a sociological perspective that social evolution outpaces the capacity of some individuals and groups to adapt to it. Compulsory Health Insurance in the US was not adopted before 1920 because the reformers, primarily academic physicians and economists, promoting it failed to adequately educate lagging fellow Americans. Presumably, if American workers could be educated as to their true needs, government health insurance could be introduced.

[6] For example, concerning the failure of the CHI movement in New York, Jacobs (2002) asks "why did no state enact a compulsory government health insurance program that could serve as a beachhead for further

movement for it died along with that for Compulsory Health Insurance. It must also be reconciled why five US states did enact sickness insurance laws to pay cash benefits between 1942 and 1968.

An alternative explanation to societal and institutional "American exceptionalism", concerns whether the need/demand for social insurance arrangements in North America was as great as in Europe. Anderson (1968, 87) argues that there was no broad base of support, or opposition, for compulsory health insurance in the United States. This observation has been interpreted in two ways to explain the failure of the US CHI movement. Social reformers such as the members of the American Association for Labor Legislation (AALL) interpreted the indifference of the public as to CHI as evidence that wage earners 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. This void of support for CHI left groups with political clout and vested interests in the defeat of CHI to determine the outcome. In contrast to the interpretation of the social reformers leading the CHI movement, the "moneyed interests" in the US (as they were known by the social reformers) such as business organizations, employers associations and insurance companies interpreted the lack of public interest in CHI as evidence that social insurance was unnecessary in America due to the superior earning power and the greater capacity to save or purchase insurance coverage through voluntary arrangements relative to European wage-earners. If American workers did not need state insurance in this early period, then there is no particular reason to believe that the failure to develop national health insurance reflects a path dependent process, and should the need for government health insurance develop, then it is likely that some U.S.

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emulation by other states and the national government?"

States may introduce government health insurance arrangements.

In this paper, I investigate the case put forward by the reformers that American workers needed compulsory health insurance to assess whether the divergent paths of social insurance development after 1900 on either side of the Atlantic resulted from differences in values, institutions and interest groups, or from differences in income levels, labour market conditions and consequent savings patterns. In particular, I re-visit the case put forward by the reformers that American households were incapable of saving for a rainy day due to incomes that were deficient for what was required to provide households with the ability to live with the minimum standard of decency. I then present evidence from the 1889-90 and 1917-19 Cost of Living studies to demonstrate that American wage earners were able to save more than their European counterparts and the savings rates of Americans were rising before the 1930s and not falling as the reformers had claimed. The evidence suggests that American households were able to meet the expected costs of sickness as the opponents of Compulsory Health Insurance argued. The devastating economic conditions of the 1930s created the political support for social insurance legislation by diminishing what had been an adequate voluntary system.

Voluntary Health Insurance Arrangements and the Rise of Compulsory State Health Insurance before 1920

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.[7] The costs of sickness and poor health include lost income, direct medical costs of hospitalization, physician care and medicine, and for society, lost productivity. Up to 1920, lost income was the important risk for workers.

[7] Rubinow (1913a), Fisher (1917), Armstrong (1932), Horrell and Oxley (2000), Hoffman (2001).

Sickness/health insurance in this earlier era was for income stabilization, which was thought to be useful for the prevention of poverty.[8] Medical costs were rising after 1920 and the significant 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). By the late 1920s, costs associated with medical treatment and hospitalization were equal to the size of income loss (Davis 1934). Later health insurance movements in the United States, and centralization of health care administration in the UK were intended to address direct medical costs that carried the risk of catastrophic loss (enormous costs).[9]

Prior to the introduction of state health insurance programs in Europe, similar "patchworks of protection" -- that included fraternal organizations, trade unions and workplace based mutual benefit associations with sick benefits, commercial insurance contracts, discretionary charity and self-reliance through thrift -- were available to workers on both "sides of the pond". Within the patchwork the largest source of income protection was through the voluntary organizations that provided stipulated amounts of "relief" for members who sick and unable to work.[10]

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[8] Armstrong (1932) discusses the evidence that showed that sickness was a leading cause of poverty.
[9] Armstrong (1932, 334) reports that in 1915, the proportion of health insurance benefits paid in cash versus "in Kind" were 72.5% in Belgium, 42% in Denmark, 98% in Sweden and 70% in Switzerland. By the late 1920s, these proportions were 18% in Belgium, 16% in Denmark, 93% in Sweden and 56% in Switzerland.
[10] Friendly society sick benefits exemplified classic features of working-class insurance: a low cost and a small benefit of fixed amount equal to part of the wages of a worker with average wages. For most of the friendly societies, local bodies of the organizations paid the sick claims of its members. See Gosden (1961), Hopkins (1995) and Riley (1997) for discussions of the evolution of friendly societies in England. Starr (1982) and Rodgers (1998) provide descriptions of voluntary sickness insurance arrangements in Europe. Emery and Emery (1999) and Beito (2000) discuss sickness insurance arrangements in North America. In England, the U.S. and Canada, these bodies were often called "lodges", "courts" and in some cases "hives". In the Germanic countries, the "kassen" of the "Krankenkassen" were the local bodies. Mutual help societies were known as "friendly societies" in England, Societes de Secours Mutuel in France and Belgium, Krankenkassen in the Germanic countries, Societa di Mutuo Soccorso in Italy, and the Sygekassen in Denmark (Rubinow 1913a, 225).

For the United Kingdom near the peak of the self-help movement in the 1890s, estimates of participation in friendly societies and trade unions for insurance against the costs of sickness and/or burial range from as many as 20 percent of the population (Horrell and Oxley 2000), to 41.2 percent of adult males (Johnson 1985) to one-half or more of adult males and as many as two-thirds of workingmen (Riley 1997). Rodgers (1998) reports a lower estimate for 1911 of one registered friendly society membership for every eight persons (adults and children) in Britain. Rubinow (1913, 224-225) cites that registered friendly society members in England represented 13 percent of the population before National Insurance went into effect. In the first decade the twentieth century, in France, 10 percent of the population were members of such mutual societies; 5 percent in Belgium; 27 percent in Denmark; 10 percent in Sweden; less than 3 percent in Italy and less than one-half of a percent in Spain. Rodgers (1998) highlights that estimates for participation in self-help organizations in North America are more a matter of guesswork due to an absence of a system of official registration for friendly societies similar to Britain's.[11] Rodgers asserts that the system of workers' mutual assistance in the United States was extensive and comparable in structure to that of contemporary Europe. Millis (1937) reports that 30 per cent of Illinois wage-earners had market insurance for the disability risk in 1919 where fraternal organizations were the principal source of market insurance. Beito (1999) argues that a conservative estimate of participation in fraternal self-help organizations in the United States would have one of

[11] In England, the affiliated friendly societies were required to register with the Registrar of friendly societies. The Registrar required the registered societies to undergo periodic valuations to ensure that they were solvent. In North America, there was no similar regulation of friendly societies and the extent of regulation depended upon state/province and federal laws governing insurance and benefits. Fraternal orders that provided life insurance typically had to be registered and report financial data. More often than not, friendly societies that provided only sick and funeral benefits were not required to register.

three adult males as a member in 1920, "including a large segment of the working class."[12]

Despite the similarity of organizations and the high rates of participation in them in the late nineteenth and early twentieth centuries, the role of self-help organizations diverged on either side of the Atlantic. Table 1 shows that between 1883 and 1914 in several countries in Europe, the "administrative machinery" of friendly societies and other Mutual Benefit Societies was the vehicle for introducing and delivering compulsory government sickness/health insurance. By 1930, 22 countries had enacted compulsory health insurance laws.[13] In North America the friendly society sickness insurance arrangement declined from at least the 1890s despite growing memberships in the organizations up to the 1920s.[14]

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[12] Studies of British friendly societies suggest that friendly society membership was the "badge of the skilled worker" and made no appeal whatsoever to the "grey, faceless, lower third" of the working class (Johnson 1985, Hopkins 1995, Riley 1997). The major friendly societies in North America found their market for insurance among white, protestant males who came from upper-working-class and lower-middle-class backgrounds (Fisher 1917, Emery and Emery 1999). Rubinow (1913b, 166) argued that voluntary insurance as exemplified by the mutual societies "protected only the upper layers of the working class". Beito's (2000) work shows that while the poor, non-whites and immigrants were not found in IOOF memberships or the other larger Orders, members of these populations had their own organizations to secure mutual aid.

[13] 23 countries if Switzerland is included. In Switzerland, two Cantons introduced compulsory insurance. Lindert (1994) provides an alternative perspective on government health insurance by examining social spending on health in a set of countries as opposed to an classification of whether the country had government insurance or not. Lindert's data reveals that Denmark was the pioneering nation for social spending and not Germany. In addition, the US spending on subsidies for health care, as a percentage of GNP, exceeded that of many countries that had adopted government Compulsory Health Insurance. Castles (1992) raises a similar consideration for Australia that has also been portrayed as a laggard nation in the development of health insurance as its first national law was not enacted until 1944. Castles argues that as part of the "wage earner's welfare state", arbitrated wage awards stipulated that wages could not be reduced if a worker was absent from work due to sickness. In 1921 the stipulations were added that employees must provide proof that their absence was due to illness/ill health and payment for non-attendance due to ill health was capped at 6 days in each year. As such, Australia should be considered as having had an effective equivalent form of compulsory health insurance as early as 1921.

[14] Emery and Emery (1999). While friendly society sickness insurance declined, government showed little activity on the health/sickness insurance field. Only through the 1930s did commercial and non-profit group health and hospital insurance plans and government social programs rise to primacy in the sickness and health insurance field in North America.Employer-purchased/provided group plans came to be the most common source of the health insurance coverage in the United States (Applebaum, 1961; Follmann, 1965; Davis, 1989; Thomasson 2002). In Canada, health insurance arrangements developed in the same

Rubinow (1913b) described the evolution of compulsory health insurance from voluntary arrangements as beginning with the regulation of voluntary benefit societies to ensure their safety and efficiency; subsidies to stimulate the growth of voluntary insurance institutions followed, and ultimately leading to the "modern system of sickness insurance" as pioneered by Germany. Small subsidies to extend voluntary insurance were used in Sweden from 1891, Belgium from 1904, and France since 1910. Rubinow suggested that Denmark (since 1892) and Switzerland (since 1912) provided more substantial subsidies. [15] According to Rubinow, the "evolved nations" of Europe that had national compulsory health insurance were Germany (since 1884), Austria (1888), Hungary (1891), Norway (1909), Great Britain (1911) and Russia (1912). With Rubinow's (1913b) depiction of the natural evolution of social insurance, the US emerges as a laggard nation as it did not even regulate voluntary insurance organizations. Fisher (1917, 15) argued that while the "the most enlightened and progressive nations of the world have, one after another, adopted compulsory health insurance" the US could be grouped with the European countries without government health insurance; Italy, Spain, Portugal, Greece, Bulgaria, Albania, Montenegro and Turkey.

The social insurance arrangements implemented by government (and as proposed in the U.S.) closely resembled the contracts of friendly societies and mutual benefit societies.[16] The principle differences between voluntary arrangements and compulsory (government) arrangements were the sources of finance, the extent of coverage in the

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way as in the US until provincial government health insurance plans, with universal coverage, replaced the work-place based arrangements in the 1960s (Maioni 1998).

[15] Armstrong (1932, 332) estimates that government subsidies for voluntary insurance represented 39% of insured members contributions in Belgium in 1926, 50% in Denmark in 1928, 17.8% in Sweden in 1928 and 31.3% in Switzerland in 1929.

[16] Government centralization of the provision of health insurance tended to occur after World War II with the rise of direct medical costs (Gosden 1973).

population and often the expansion of coverage for costs of medical services. Before 1920, Compulsory Health Insurance paid, or proposed to pay, cash benefits for prime aged workers under an income ceiling.

Government Health Insurance in the earlier era was not universal insurance. Typically, the arrangements excluded the self employed, agricultural workers, and often, dependents of workers. Epstein (1933, 469) reports that voluntary subsidized health insurance rarely covered more than a small proportion of the population. Denmark with its generous state subsidies had 57% of population covered by voluntary health insurance; Belgium was next highest with 14% of the population covered, then Sweden with 12% and the rest of the countries with voluntary systems below 10%. In France, membership in voluntary insurance funds was 6% of population in 1914 and declining to 1925. In contrast, the extent of insurance coverage in the 22 countries with compulsory health insurance by 1927 ranged from 15% to 86% of the employed population, with the differences in coverage reflecting the relative importance of the wage earning population in each country and the inclusiveness of the insurance laws.[17] The greater extent of coverage in the compulsory systems was interpreted as a success for those arrangements compared to the voluntary insurance systems.

The impetus for government compulsory health insurance in the United States was the formation and efforts of the American Association for Labor Legislation (AALL) in 1906, which by 1913 had 3300 members consisting largely of academics, academic

[17] Armstrong (1932, 348) reports that by the mid-1920s, the proportion of population represented by the compulsorily insured was 34.3% in Austria, 4.74% in Bulgaria, 19.25% in Czechoslovakia, 32% in Germany, 35% in Great Britain, 11.65% in Hungary, 21.3% in Norway, 7% in Poland and 6% in Russia/USSR.

physicians, intellectuals and social reformers.[18] The first steps towards public agitation for state health insurance came with an AALL committee report in 1912 that recommended some form of insurance to offset income losses associated with accident and illness. By 1914, the AALL was drafting model legislation for a public health insurance system that could be used by states interested in introducing legislation. Between 1915 and 1920, 16 US States investigated Compulsory Health Insurance, but only in California and New York did any developments towards actual legislation occur.[19] California held a referendum in 1918 on a proposed constitutional amendment that would have allowed the State's legislature the power to introduce government health insurance (Costa 1996). In 1917, the State Senate and State Assembly both passed the proposed amendment by votes of 32-3 and 55-11 respectively. On California's election day in 1918, 492,182 of 715,525 voters, voted on the health insurance amendment that went down to defeat by almost a three to one margin. Model legislation for government health insurance was proposed in the New York Legislature in 1919, but the Davenport-Donohue Bill never made it to a vote (Beito 2000, Hoffman 2001).

Anderson (1950) argues that the AALL movement peaked in 1918. Epstein (1933, vii) suggested that the movement towards social insurance and social legislation in the United States "suffered a serious setback during the prosperity boom" in the 1920s as

[18] Anderson (1968), Rodgers (1998). Economists Richard T. Ely and John R. Commons were the first president and secretary respectively of the AALL.

[19] Anderson (1968).There were 11 official state commissions reported on compulsory health insurance. Massacheusetts (1917), California (1917 and 1919), New Jersey (1918), Ohio (1919) and New York (1919) had commissions that reported in favor of compulsory health insurance. Connecticut (1919), Wisconsin (1919), Illinois (1919) and Massacheusetts (1918) reported against compulsory health insurance (Lapp 1920). Thomasson (2002) reports that 16 states in total considered CHI but I have not been able to find a reference to which states would make up the other 7. One Canadian Province, British Columbia, investigated government health insurance in 1919.

wage earning Americans lost sight of their true need for social insurance.[20] While there was little or no activity towards the development of state health insurance in the U.S. in the 1920s, several countries in Europe introduced compulsory health insurance, as well as Japan (1922) and Chile (1924).[21] When the dire conditions of the 1930s were thought to have revealed the transitory nature of the strong economic conditions of the 1920s for Americans, the social insurance movement was re-invigorated. Unlike the earlier era, however, the discussion of health insurance shifted away from insuring the income loss of sickness and towards the coverage of medical services and hospitalization.

Was Compulsory Health Insurance "Un-American"?

Anderson (1950, 387) suggests that the greatest surprise of the proponents of compulsory health insurance was the indifference of the general public. Rubinow (1931, 185), in looking back at the failed compulsory health insurance movement, blamed the failure of the health insurance movement on the failure to adequately educate labor "to appreciation of its own interests." By 1920, it seemed to be the case that only group in favor of government health insurance was the AALL. Business, labor, private (Life) insurers, and medical professionals were apparently all allied against Compulsory Health Insurance in the United States by 1920 despite the fact that comparable interests in Europe had benefited materially from government Health Insurance.[22] Rubinow (1934,

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[20] Douglas (1939, 3-4) noted this possibility with respect to savings for old age:
"The consensus of public opinion was that American citizens could in the main provide for their own old age by individual savings. This individualistic attitude towards meeting of great social risks was, of course, characteristic of the America of the twenties. The belief in rugged individualism, first created by the frontier but finding emotional support from the upward surge of the stock market, was a powerful force holding back all protective legislation while the rise in real wages lulled the majority of the working class into a condition of more or less acquiescent satisfaction."
[21] According to Armstrong (1932), after World War I compulsory health insurance was adopted in Bulgaria (1918), Portugal (1919), Poland (1920), Czechoslovakia (1920), Greece (1922), Yugoslavia (1925) and the Netherlands (1929).
[22] Anderson (1950,1968), Fox (1983, 1987), Starr 1982, Hoffman 2001. For example, where life insurers

214) identified this lack of support amongst Americans as the reason why it appeared that "everybody was against it".

> And who was for it? An energetic, largely self-appointed group, which could compensate by its enthusiasm and literary ability what it lacked in numbers and which carried with it the profession of social work, to some extent the university teaching groups, the economic and social sciences, and even the political progressive organizations, but very little support beyond these narrow circles.

Anderson (1968, 87) concluded that "during this early period of agitation for health insurance, there was no broad base of support – or, for that matter, of opposition. The fight was between individual giants on Olympus, to which the general public seemed to pay only passing interest."

Why was there so little interest in state health insurance amongst American wage earners? Hoffman (2003) argues that health insurance was viewed as "un-American" since it would subvert individual initiative and self-reliance. Lindert (1994, 28) suggests that the peculiar distaste that Americans have for government aid is durable. Costa (1996) suggests that after World War I, health insurance was seen as too "socialist" and too "Prussian". Fisher (1917, 14-15) addressed the argument made by "certain interests"

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were allowed to provide Health Insurance under the Approved Societies arrangement in England, before 1920, Life Insurers were not included in US proposals resulting in their opposition to government health insurance (Beito 2000). It has also been argued that since the AALL's proposed health insurance legislation included funeral benefits that would have undermined the demand for voluntary industrial/burial insurance (Fox 1987, 13). Doctors organized through the American Medical Association have been identified as having provided the strongest opposition to state sponsored health insurance before 1920 despite the fact that physician incomes would be enriched if the state took over responsibility for paying for physician services (Fox 1983, Anderson 1950, 384). The AMA and most state medical societies were initially supportive of government health insurance (Anderson 1950, 1968, Fox 1987, Lundberg 2002). Lundberg (2002) suggests that American physicians were supportive of government health insurance in 1912, but they lost interest in it during World War I and by 1920, they were clearly opposed to it. There were several reasons for physician opposition to state health insurance in the US, but it seemed to come down to a situation of AALL legislation proposed to re-organize how medical services were provided along with insurance, without any clear benefits for physicians to compensate for the loss of professional autonomy (Anderson 1968). While many labor leaders expressed support for compulsory health insurance, one the highest profile labor leaders, Samuel Gompers who was president of the American Federation of Labor, opposed compulsory insurance based on his belief that higher wages would solve workers' problems

opposed to compulsory health insurance on the grounds that it would be "un-American interference with liberty". According to Fisher, their logic meant that "in order to remain truly American and truly free", was "to retain the precious liberties of our people to be illiterate, to be drunk, and to suffer accidents without indemnification, as well as to be sick without indemnification." Rubinow (1913b) identified the American "fetishism of self-help" as the greatest force to be overcome in introducing compulsory social insurance. Lubove (1968, 2-3) argues that the ideology of voluntarism in the United States and the institutional interests that it nurtured resulted in the existence of voluntary institutions that failed to respond to the security needs of most Americans and that undermined government efforts to meet those needs. Starr (1982) and Fox (1986) argue that in contrast to British and European workers who were pre-disposed to social insurance due to their experience with mutual benefit funds for sickness insurance, a lack of like institutions meant that Americans had a weaker tradition of voluntary health insurance. Thus, Starr argues that Americans had "less interest in health insurance and less familiarity with it".

Rodgers (1998) declares that the least satisfactory arguments for the lack of compulsory social insurance in the United States are those that claim that there exists a "special `American idea' inhibitive to the adoption of social insurance." Rodgers points out that there was nothing in the American debates over social insurance that had not also been present in the "equally polarized rhetorical contests in Germany in the 1880s and in Britain after 1908." Rodgers (1998, 258) argues that mixed and ambivalent attitudes towards compulsory social insurance on the part of organized labor was not unique to the

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arising from illness. Beito (2000, 159) cites the results of a poll of Utica factory workers that showed that 12,875 respondents opposed the idea of compulsory health insurance and that only 112 supported it.

United States. Before 1914, labor organizations were not a significant force in the adoption of social insurance or involved in the design of the schemes. Labor organizations throughout the North Atlantic economy resisted the levies on wage earners that social insurance required.[23] North America also had an abundance of friendly societies like Europe so Americans were not lacking in experience with voluntary sickness insurance. Rodgers (1998) argues that American mutual system extensive and comparable in structure to those found in Europe. There was considerable familiarity and expertise with sickness insurance in NA. "The assurance of a stipulated sum during sickness," the president of the Prudential Insurance Company conceded in 1909, "can only safely be transacted … by fraternal organizations having a perfect knowledge of and complete supervision over the individual members."[24]

Weaver (1982, 200) confronts the argument that Compulsory Old Age Insurance was un-American during the push for that form of social insurance that coincided with the Compulsory Health Insurance movement. In Weaver's assessment, the "ideology view" for the failure to see social insurance enacted in the U.S. has been accepted prematurely.

[23] Starr (1982) describes another view that Compulsory Health Insurance was intended to address "social discontent" or "socialist unrest" and ensure worker loyalty to the state rather than to Labor interests. Thus, the United States did not adopt government health insurance because it lacked the necessary number of socialists and levels of social discontent. In the absence of threat to political stability, there was no incentive for interest groups to develop legislation through compromise. Why was there less unrest and socialism in the US when many immigrants came from countries with these characteristics? It must not have been the culture or values of the populations but instead, the economies and societies in which they lived. Rodgers (1998, 242) notes the irony that Bismarck had introduced social insurance as an "antisocialist" project but in the United States in the AALL campaign for compulsory health insurance, it was a reframed as a socialist demand.

[24] Cited in Starr (1982, p. 242). British industrial-life companies did not offer sickness insurance until 1911, when government allowed them qualify as approved societies under the National Health Act. In acting as approved societies, their motive was not to write sickness insurance, but rather to protect their interest in burial insurance. See Beveridge, 1948, p. 81; Gilbert, 1966, p. 323.

> Considering social insurance as a wealth enhancing institutional alternative to the market, that is, if ideology did indeed prevent passage of compulsory OAI, then it should be possible to (1) pinpoint significant failures in private markets that made government action a collectively profitable alternative, and (2) establish how social insurance was the appropriate mechanism for capturing these political gains. Alternatively, if social insurance is more appropriately considered a mechanism for redistributing society's wealth, not increasing it, then if ideology was an important deterrent to enactment, it should be possible to pinpoint a not insignificant interest group that would have profited from enactment, was in a position to effect policy, and yet, by opposing the legislation, chose not to do what was in its own self-interest.

One response to Weaver would be the line of argument that US political power was too decentralized to facilitate the introduction of government health insurance and other large scale social programs (Starr 1982, Costa 1996, Beland and Hacker 2004). Starr (1982) observes that the U.S. had universal male suffrage early on its history, but Compulsory Health Insurance was introduced first in authoritarian and paternalistic regimes and only later in liberal democratic societies. Beland and Hacker (2004) argue that the United States has never experienced the degree of centralization as in the nation states of Europe, in part because the Constitutional structure of the country that divides political power so as to discourage the construction of authoritative majorities and powerful bureaucracies. Costa (1996) suggests that centralized political power and a lack of referenda could help to explain why CHI was introduced in Europe, but not the US.

While this explanation may be useful for explaining why the US has not adopted national health insurance, it is not so convincing for explaining why individual states could not enact government health insurance. Perhaps the greatest challenge for proponents of this explanation is to explain why institutions would be a barrier to the development of national compulsory health insurance, but not for public pension legislation in 1935, nor for workmen's compensation before World War I. It must also be

reconciled why five States did enact sickness insurance laws to pay cash benefits between 1942 and 1968, one of which was New York.[25]

Was Compulsory Health Insurance in the United States Un-necessary?

Was there a need for compulsory health insurance amongst enough Americans to yield the necessary political outcome? Certainly, key reformers like Rubinow, Fisher and Falk asserted that the need existed due to their beliefs in the shortcomings of voluntary arrangements, including the capacity of households to save.[26] To support their case, they compiled data and provided statistics to demonstrate the need for compulsory social insurance to prevent households from falling into poverty and to meet medical costs.

On the other side of the debate, opponents of Compulsory state health insurance, and even organized labor, proposed higher wages, voluntary thrift, voluntary insurance and public health initiatives as workable alternatives to state insurance. The National Civic Federation (NCF), an alliance of American Employers and conservative labor leaders, "American workers were too well-off to require such a system (like the British insurance system)… British workers were so low paid that the Insurance Act "is a boon to them," but "prosperous American workers would reject similar assistance from the state."(Hoffman 2001, 54)

This business view of the superiority of labour market opportunities, earnings and the ability to accumulate wealth for American workers compared to European workers would seem to be one that is difficult to contest. Americans on average were wealthier

[25] Sickness insurance programs were introduced in Rhode Island (1942), California (1946), New Jersey (1948), New York (1949) and Hawaii (1968). Social Security Administration, 1989.
[26] Rubinow (1913, 28) asks a"Is there any urgent need for a policy of social insurance in the United States?" He claims that the answer to this question in the affirmative was for many "self-evident"

than their European counterparts.[27] American workers benefited from a labour market that produced higher income levels, higher income growth rates and lower risk of unemployment. As Hoffman (2001 58) points out, this was one of the biggest challenges for the reformers pushing for health insurance for Americans:

> Insurance proponents were forced to defend the very idea that the United States had grave industrial problems comparable to Europe's. Reformers struggled against the notions of exceptionalism that defined the American economy as essentially different from, and superior to, that of other industrial nations… America was exceptional according to health insurance opponents, not simply for its wealth but for the liberty and independence of its working men. America's working classes were more dignified than Britain's or Germany's, and so neither needed nor desired state assistance… Compulsory health insurance was unwarranted, announced the NCF, `because the economic condition of the average American workman enables him to provide for medical attendance and pecuniary support during sickness in his own way and at his own cost.'

Rubinow (1913a, 28-29) took up the challenge, asserting the lack of differences between America and Europe with respect to the needs of the workingman since:

> The economic development of America proceeds along the lines very much similar to those of development in Europe, and as a result the same problems arise and the same remedies suggest themselves… social insurance is not a specific feature of economic development of any one country, but of all industrial countries…

Rubinow went so far as to suggest that American workers lived with the risk of more accidents, more sickness, more premature old age and invalidity and more unemployment in the United States than most European Countries.

Rubinow then addressed the objection to a policy of social insurance in the United States that was

[27] Haines and Goodman (1995) find that there were higher rates of home ownership in the US, and higher levels of wealth. There was a more egalitarian distribution of wealth in the US than in the UK (Shanahan 1995, Lindert 2000).

> based primarily upon the plausible arguments that the economic condition of the working class is such as to enable it to meet the financial dangers without systematic assistance or state interference, and the degree of active interference of the state with the personal freedom of both employer and employee, and with the relations of capital and labor which a social insurance policy presupposes, is contrary to the spirit of American life and government.

Rubinow identified the key issue for debate as one of whether the American wage-earning family has the necessary surplus in their budget to save for the rainy day or to buy the insurance that they needed. Rubinow conceded that wages of Americans were higher than for European workers but he argued that they were still inadequate for American households to accumulate and protect themselves against economic hardship from events like sickness, unemployment, old age and invalidity. Rubinow (1934) re-iterated his 1913 claim that a sizeable proportion, as much as 95%, of wage earners had insufficient income to maintain a "normal" standard of living and in Rubinow's opinion, to have a surplus. Rubinow's (1913, 9) view was that "Under such conditions saving for all possible future emergencies must necessarily mean a very substantial reduction of a standard already sub-normal."

Opponents of CHI argued that the growing numbers of depositors in savings banks, and growing size of savings bank deposits, indicated that workingmen were able to accumulate money for a rainy day. Drawing on data for the State of Connecticut, Rubinow guessed that of the large total value of deposits, "at best, the workingman's deposits represent only one-third of the total deposits." Most reflected the deposits of the "middle class". In the Connecticut savings banks, 85 percent of depositors in 1910 had savings deposits of less than $1000. The average size of deposit for this group was

$202.44.[28] Rubinow also inferred from the Connecticut data that average savings of the working-class had not increased since 1880 despite the increasing cost of living, hence the actual level of savings had decreased "materially". Rubinow argued that "the increased savings of the wage-workers are a myth without much foundation in fact even to justify it." Rubinow (1913, 1934) and Epstein (1933) interpreted the savings of workingmen to be too small to provide any true economic security. Rubinow (1934, 33) assessed that "the average amount which the workingman is able to retain in the bank is paltry. The nest-egg … is extremely useful when the rainy day comes, but it offers no solution to the serious economic problem, no remedy in the case of economic catastrophe except for a limited time."

Rubinow's view of the inability of the American family to save to address income risks was not an evaluation of actual savings experiences of households. Rubinow's case was based on the comparison of earnings to an ideal cost of living. He did not regard accumulation, savings, or extra income as legitimate protection if it was not the product of one earner per household or if the other standards of decency in consumption were not met. Thus, while Rubinow (1913) conceded that the level of American wages was higher than that that for most European countries, but the "American standard of wages must be considered and judged in conjunction with the American cost of living and the "American Standard of life". Rubinow was thus comparing the level of American wages against what the American standard of living "ought to be"; not how the majority of the

[28] Rubinow (1934, 32) argued that Epstein (1933) had done the definitive critique of the claim that Americans savings eliminated the need for social insurance in the US. Epstein (1933, 115) "There is no way, under present conditions, to determine the actual amount of personal thrift in the United States, but it is certainly no more than a fraction of the reported totals. Except in New York and New England, even so-called savings are of very limited importance, and there is every evidence that the worker's portion is very small, even in the East. Not only has there been no rise in the real value of the average savings of the smaller depositors – the wage-earners – but, on the contrary, the sums they owned have actually declined

working class lived, but the standard that existed for some wage-workers and that workingmen would aspire to. Rubinow drew on John Mitchell's ideal described in his book *Organized Labor*:

> The American standard of living should mean, to the ordinary unskilled workman with an average family, a comfortable house of at least six rooms. It should mean a bathroom, good sanitary plumbing, a parlor, dining room, kitchen, and sufficient sleeping room that decency may be preserved and reasonable degree of comfort maintained. The American standard of living should mean to the unskilled workman carpets, pictures, books, and furniture with which to make the home bright, comfortable, and attractive for himself and his family, an ample supply of clothing suitable for winter and summer, and above all a sufficient quantity of good, wholesome, nourishing food at all times of the year. The American standard of living, moreover, should mean to the unskilled workman that his children be kept in school until they have attained to the age of sixteen at least, and that he be enabled to lay by sufficient to maintain himself and his family in times of illness, or at the close of his industrial life, when age and weakness render further work impossible, and to make provision for his family against his premature death from accident or otherwise.

What would this ideal standard of living cost? To maintain a proper standard of living, the evidence seemed to suggest that an annual income in 1913 of $900 maintained the normal standard. Rubinow (1913a, 32) assessed that "Families having from $900 to $1,000 a year are able, in general, to get food enough to keep body and soul together, and clothing and shelter enough to meet the most urgent demands of decency." Rubinow then showed that 90% of males living east of the Rockies and north of the Mason Dixon line earned less than $800 a year. 95% of female workers earned less than two-thirds of the amount necessary for "physical efficiency and decent existence." Rubinow concluded that a surplus in the workingman's budget is becoming a very rare phenomenon. Rubinow reported the results of statistical investigations that indicated that a "substantial

during the past few decades."

surplus" (defined as $50 or more) in a workingman's family appears only when the income exceeds $1,000 and for families with a small number of children.[29]

According to the reformers, conditions of working Americans got worse, not better after World War I. Abraham Epstein (1933, 96-99) was able to present a survey of 44 estimates of "Weekly budgets for a standard of health and decency for a family of five" that were produced between 1920 and 1931 for a variety of American locations and industrial groups. Epstein assessed that throughout the 1920s, "The absolute minimum required for the decent support of a worker's family was about $35.00 per week", or $1,820 per year. Epstein declared this amount as the minimum for "decent subsistence". When Epstein compared earnings data from the National Industrial Conference Board for the 1920s to this estimated "minimum budget", even if it was assumed that workers were employed for 50 weeks throughout the year, not a single group of workers could have earned this minimum amount in any year of a particularly prosperous decade in American history. Epstein's tables show that the average gap between the minimum budget and actual average earnings could be as high as $400. As few workers worked 50 weeks in a year, Epstein also examined NBER earnings data that he considered to be "the probable actual earnings" for the 1920s. As these earnings estimates were lower than the NICB estimates, actual earnings of less than $1,200 per year fell well short of the minimum budget.

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[29] For example, Rubinow (1913, 39) reported that "According to the investigation of the U.S. Bureau of Labor, carried on over ten years ago, and embracing 25,440 families, 12,816 families, or a little over one-half, had a surplus at the end of the year. The average surplus was quite high -- $120.84. But the fact that among the 11,156 normal families with only one worker the wage surplus was only $33.18 is significant as explaining the origin of the surplus. Then again, we find that a substantial surplus in these families was only possible in the absence of more than two children." He described another study of 361 families found that only 36% showed a surplus, and the percentage with a surplus increased from 20 for families earning less than $600 per year to 48 percent of families earning 800 to 900 dollars per year, and 44 percent of families with more than $1000 in income.

A second source of inadequacy of American wages came from the belief that there should be a single breadwinner per household. Rubinow (1913, 33,34) noted that many families resorted to having more than one worker in the family. Only 36% of families relied on the father's/husband's income alone, including those families earning between $800 and $1000 per year. Rubinow reports that an (undated) BLS study of 25,440 families showed that average income per family was $749.50, with the average earnings of the father being $621.12 or 83% of family income. For "normal" families with only the father at work, the average income was $659.68.[30]

Epstein's (1933, 101) examination of the adequacy of earnings was based on the needs of a family of five with a single wage-earner, not because all families looked like this but because "the American standard assumes a normal family of man, wife, and two or three children, with the father fully able to provide for them out of his own income". According to Rubinow (1913a, 34), any financial accumulation that was gained by deploying women and children to work represented a vice of thrift.

> It is true that the presence of two or more workers in the family materially improves its economic status… An additional worker may be found in the wife or in the children, but the necessity for the wage-worker's wife who is a mother, to look for additional income, is, of itself, a symptom of economic distress. It is pregnant of serious influences upon the hygienic and moral standard of the family life… Evidently a theory of the economic status of the worker's family, of the necessary standard, of the probability of a surplus, and the possibility of savings, must be based upon the earnings of the head of the family exclusively.

[30] Rubinow does not discuss the implications for the observation that in the savings studies, over half of households surveyed in one investigation had a deficit between spending and earning. This suggests that households had access to credit which is another way to insure against interruptions to income. Access to credit is a substitute for the sorts of protection provided by social insurance. In all likelihood, if resorting to having more than one worker per household was considered an undesirable approach to dealing with household income risks, then borrowing as a solution would not have been endorsed either.

Epstein (1933, 102) made a strong conclusion as to the poor economic condition of wage-earning Americans:

> It is safe to conclude as a result of this study that in the last decade only very few of our workers have earned enough to maintain for themselves and their families a decent American standard of living. Their average yearly earnings have in general fallen short, even in good times, and during depressions have rarely exceeded one-half, of the necessary amounts. The have rarely been able to meet fully the day-by-day expenses of decent living, let alone laying aside any savings against rainy days.

In the minds of the reformers, a growing American economy was not going to solve the problems of the working class and eliminate the need for social insurance. Where the general statistical pattern was believed to have shown dramatic increases in wages between 1866 and 1900, Rubinow (1913, pages 34-37) presented indices showing that real weekly earnings were not rising much between 1890 to 1907 because of falling hours of work per week and rising food costs. Rubinow's table of five year moving averages for 1890 to 1907 to smooth away "relative wage" fluctuations showed that the average earnings since 1896 to 1900 had been slowly, steadily declining.

Assessing the Reformers' Case

Rodgers (1998, 243) describes how some proponents of compulsory health insurance in the United States viewed such a program as nothing more than a complicated scheme for compulsory savings.[31] The main purpose of CHI would have been to compel wage-earners to purchase higher levels of insurance coverage. If implemented in the US, then the cost of CHI coverage was expected to be 1.5%, or 4%, and possibly 7% of a wage-earners annual income depending on how much of the cost could be shifted onto

[31] In Contrast, I.M. Rubinow argued that social insurance was class legislation that should incorporate income redistribution as part of its design.

employers or the State.[32] Assuming a CHI premium of 4% of earnings, a wage earner with annual income of $600 would have been compelled to pay $24 per year for health insurance coverage. If the cash benefit paid while sick would have been 2/3 of the weekly wage as proposed by the AALL, then for $600 annual earnings, the cash benefit would have been $9 to $10 per week of sickness. Consider that in friendly societies like the Independent Order of Odd Fellows, wage-earners could choose to purchase sickness insurance coverage for $6 to $10 per year to obtain cash benefits equal to $3 to $5 per week.[33] For our $600 earner, the cost of insurance was 1% to 1.5% of annual earnings. Additional insurance could be obtained by joining higher auxiliary orders of an organization or more than one organization if a worker so chose. The main advantage of CHI would have been the coverage for lengthier, but infrequent, bouts of illness and the inclusion of coverage for medical costs. The advantage of precautionary savings (holding some of current income in reserve) was that if the breadwinner was not sick, the savings remained available to the family whereas the health insurance premium was not returned. Unlike CHI, the household's savings could be used for covering any losses of income due to illness, or unemployment.

Was it true that American wage-earners' incomes were insufficient for households to save, or to allow households to purchase sickness/health insurance through voluntary arrangements? A worker could expect 7 days of sickness over the year with some probability of lengthier illnesses lasting several weeks.[34] Thus, on average, to meet the

[32] Fisher (1917), Starr (1982), Costa (1996).
[33] Emery and Emery (1999). Nominal values of dues and benefits paid did not typically change over time. It was the case in constant purchasing power terms, the value of these benefits was eroding over time. In 1890, $6 dues would have been 1.5% of annual earnings in the US and in return, a stipulated cash benefit of $3 per week would have replaced one-third of average earnings.
[34] Epstein 1933, Armstrong 1932.

lost income from 7 days of sickness in a given year, workers needed to be able to set aside one week's wages or, roughly 2 to 2.5% of annual income. An annual surplus, or an accumulated reserve (wealth), equivalent to 25% of annual income would be sufficient to cover the full loss of a 13 week illness. As proposed by the AALL, CHI would have covered one-half to two-thirds of wage loss, so assets or an annual surplus equal to 25% of income would have been equivalent to 20 to 26 weeks of cash benefits under CHI. CHI, however, would have cost the worker between 1.5% and 7% of his earnings each year.

How much could American wage-earners' households have saved per year? To answer this question, I use income and expenditure data from the U.S. Commissioner of Labor Survey of the Cost of Living of industrial workers in the United States and Europe for 1889-1890.[35] The survey gathered data on the demographic characteristics, occupations, incomes and expenditures of 8544 families in 24 US states and five European countries who earned income from working in nine protected industries. 32% of surveyed families earned income from employment in the cotton textile industry and another 10% of families from iron, steel, coke and iron ore industries. Wage-earners from the US and the United Kingdom dominate the total number of observations, as do male-headed households (Haines 1979). While the survey does not constitute a random sample, Haines (1979, 294) suggests that it is a representative sample of industrial wage-earners. Gratton and Rotondo (1991, 342) suggest that the 1889-90 survey's inclusion of high wage industries made the sample of households potentially more affluent than the wage-earning population but the survey should be useful representing the conditions of blue collar workers in an industrializing economy. For my purposes of evaluating the

need for CHI in the US, this sample is useful since the wage-earners represented in the survey would have been included in the compulsory health insurance arrangements.

Table 2 presents the median values for total income of the household, the husband's income and the median size of household surplus's (Total income minus total expenditures) for the U.S. and five European countries. As opponents of CHI argued, American incomes were substantially higher than incomes of European families. As proponents of CHI argued, the higher incomes were not generating unusually high surpluses for American families compared to lower earning Europeans. Only 22% of American households in this sample had incomes high enough to meet Rubinow's "minimum level of decency" in standard of living.

As compulsory health insurance would have primarily covered male household heads, I consider the size of the household surplus relative to the husband's income to measure a savings rate that would be comparable to the percentage of earnings that would have been deducted for CHI coverage. Table 2 shows that for American households in 1889-90, the median value of this measure of the savings rate was 2.2% which means that at least half of the households in the sample were able to set aside enough of current income to meet the full wage loss from 7 days of sickness.[36] It is also interesting to see that Germany that had adopted CHI in 1883 had a median savings rate of 0%, as did Belgium that implemented subsidies to extend voluntary coverage in 1894.[37] France, Great Britain and Switzerland, nations which did not move towards state insurance until after 1900 all had median savings rates twice as high as that for the US. It is also worth

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[35] These data are described in detail in Haines (1979) and Gratton and Rotondo (1991).
[36] Gratton and Rotondo (1991) point out that since mortgage payments were not reported in this survey, household expenditures of home owners are too low which will tend to inflate the size of the surplus.
[37] It is possible that premiums paid for health insurance in Germany since 1883 eliminated any surplus that

noting, however, that American households spent considerably higher expenditures reported in the survey category “sickness and dental” The median expenditure in this category for the US was $12 where European households expended less than $5. If we consider these expenditures as those which would be covered under CHI, then the median size of household surplus and expenditures on sickness and dental suggests that American households represented almost 5% of the husband’s income in 1889-90. American households were generating budget surpluses after incurring expenses related to sickness.

The estimates above also ignore life cycle developments in the capacity to save for American wage-earners’ households. Gratton and Rotondo (1991) report incomes and budget surpluses from the sample of American households in the 1889-90 cost of living survey and from another comparable sample of American households from the BLS 1917-19 cost of living survey. Figure 1 shows the savings rates by age group interpolated from the median surplus and median household head incomes in Gratton and Rotondo’s Figures 1 and 4. This figure shows that the median savings rate reported above for 1889-90 reflected those of males under age 40 who would have also had relatively low risk of sickness compared to males over age 40 (Emery and Emery 1999). After age 40, savings rates increased abruptly to over 5% of the household head’s earnings, reaching almost 10% for households with heads aged in their 50s. This increase in savings capacity over the life-cycle would have weakened demand for CHI since younger wage-earners would rationally expect that even if surpluses were small, they expected them to rise in future. As Emery and Emery (1999) argue, the need for sickness insurance for North American males was typically a transitory demand that disappeared over the life-cycle as the capacity to self-insure through savings, and additional workers

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households might have had in the absence of CHI.

in the family developed. CHI would have locked Americans into savings for a single purpose for the length of their working lives.

Did the capacity of American wage-earners to save and meet sickness related costs deteriorate after 1889-90 as the reformers claimed? Gratton and Rotondo's (1991) estimates for household incomes and surpluses for 1917-19 indicate that while the savings rates of males over 50 had not changed from 1889-90, the savings rates for males under age 40 had doubled. Even from the standards of the reformers, the condition of wage-earners' households had improved as these higher savings rates were accomplished with less reliance on income from working children. As Weaver (1982) has argued for Old Age Insurance, the need for CHI was falling between 1889 and 1920. The same forces of economic growth behind those developments were also at work with Compulsory health insurance.

The ability of households to save meet the expected income losses of most episodes of sickness is not enough to eliminate the demand for insurance. When there are potentially large losses that occur infrequently, insurance may be the preferred arrangement depending on the cost of the coverage. Rubinow (1934) assessed that the numbers of savings and other time deposit accounts suggested that over 40% of the population had accumulated savings. The aggregate amount suggested that the average account size was $500, but Epstein's (1932) "careful statistical work" showed that as the bulk of the value of aggregate savings in the US was not those of "workingmen" but of the "middle class", a better estimate of the average size of account for the workingman who did save was under $200.[38] Using Epstein's (1932,100) report "Average Annual

[38] Following the same logic of inquiry as Rubinow (1913), Epstein (1933, 110-112) reported that 1931 Connecticut figures showed that for a population of 1.6 million, mutual savings banks had a total of

Earnings of Wage-Workers Taking Account of Actual Unemployment" for 1920 to 1928, the average size of the "workingman's" deposit was 16% to 20% of annual income. In assessing an optimistic estimate that the value of aggregate savings in the US amounted to $790 per family, Epstein (1933, 115) asked "How adequate is such a sum for each family in the United States in meeting the different emergencies of modern life? … How far will it go in case of a serious illness, an accident, or surgical operation?"[39] It is possible to answer Epstein's question with respect to sickness. A reserve equal to 25% annual income was equivalent to the financial coverage that CHI as proposed by AALL would have provided. $790 per family would suggest that on average, American families had a reserve to annual income ratio of closer to 50% which would suggest that the capability to self-insure was well-developed.

Conclusions

Compulsory Health Insurance was rejected in North America because not enough American workers needed it. Due to differences in ability to save and hence, self-insure, the demand for state insurance was weaker in America than in Europe. Some workers in US would have wanted government health insurance, but not enough of them to generate the necessary political support. Weaver (1982, 295 and 300) suggests that the need for

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927,000 accounts and the value of deposits was $428 per capita. With annual incomes for the late 1920s of $1200 reported by Epstein (1933, 100), this would represent a reserve equal to 33% of average income. Epstein identified that this high average amount of savings reflected a minority of account holders with large deposits. Netting them out of the aggregate, Epstein inferred that 746,000 accounts averaged only $171 as a balance. He then added the observation that 700,000 of the State's citizens had no accounts in mutual savings banks. Still, $171 represents 14% of average income, and presumably some of the 700,000 individuals without savings accounts were dependents of other account holders.

[39] It is also important to know what was not discussed in the reformers's assessments of the adequacy of workingmen's savings. Savings deposits are only one possible savings vehicle. Without knowing how much other wealth was accumulated by workingmen in the form of equity in the home, consumer durables like furniture and so, one can only guess that the reformers' case was particularly pessimistic. It is also important to consider whether workingmen could borrow as this would represent an alternative to saving in anticipation.

social insurance in the US must not have been strong and this is a logical explanation for the lack of political action towards the enactment of social insurance legisation:

> "If, in fact, social insurance was efficiency enhancing, offering to make some or all people better off, then why was it not profitable for legislators to enact prior to the depression? For years, social insurance advocates solicited support for the program. Why were they – as political "brokers" – unable to evoke political action? Alternatively, viewing social insurance as pure redistributive, why was there any delay in enacting it?...
>
> Social insurance is a method of redistributing the cost of insurance, not reducing it."

The lack of need for CHI on the part of American wage earners means that the rejection of CHI before 1930 should not be considered a failure, nor should it be interpreted as significant for explaining the lack of government health insurance in the United States today. Continuing to perpetuate the view of institutional and ideological American exceptionalism also limits our understanding of American social policy development. As Rodgers (1998, 255) argues that social insurance was only one of many competing social policies that was being proposed in the north Atlantic economy by 1914. Thus, concluding that the U.S. was in some sense a social policy failure because of its lack of compulsory state social insurance, obscures the fact that there was an abundance of social policy initiatives. Engel (2002) suggests that in the 1930s, while Americans did not seem particularly enthusiastic about compulsory health insurance, Americans were supportive of subsidies for medical care for poor Americans. As Thomasson (2002) and Beland and Hacker (2004) observe, the US has used tax incentives to encourage the expansion private health insurance provided through the workplace and then to reserve public insurance coverage for the poor and the aged.

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TABLE 1: Dates of Enactment of Government Health Insurance Legislation

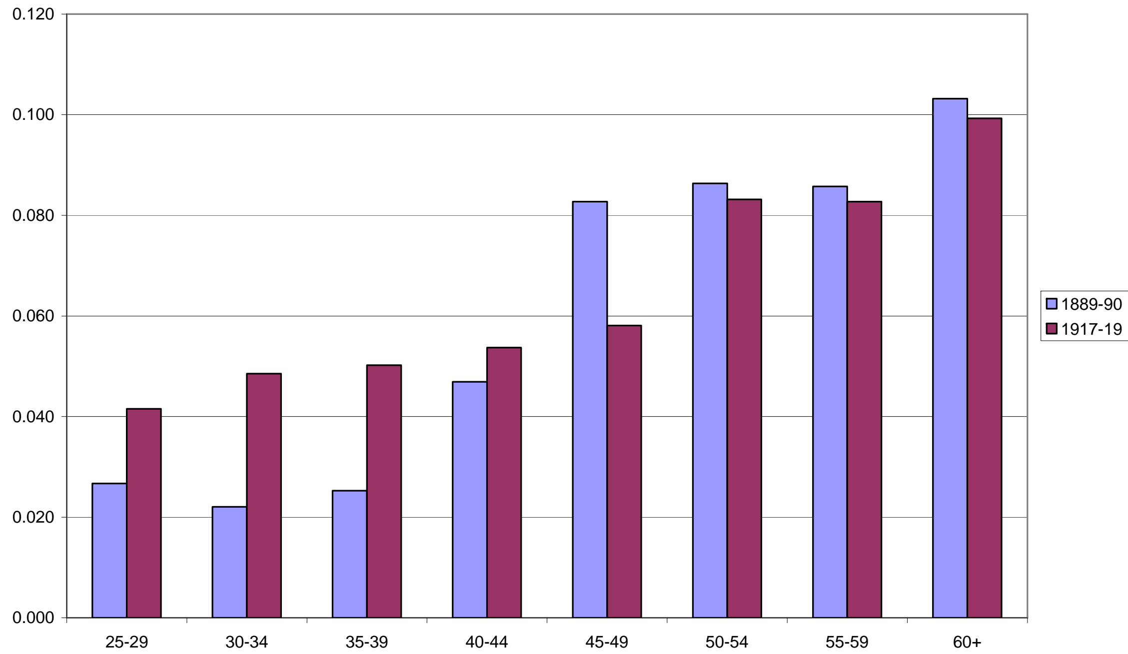
	First Legislation	Compulsory (c) or Voluntary (v)	Date of Compulsory Legislation	
	SSA 1989		Armstrong	
Germany	1883	c	1883	c
Austria	1888	c	1883	c
Czechoslovakia	1888		1920	c
Hungary	1891	c	1891	c
Sweden	1891	v		
Denmark	1892	v		
Belgium	1894	v		
France	1898	v	1928	c
Luxembourg	1901	c	1901	c
Norway	1909	c	1909	c
Serbia	1910	c	1910	c
Ireland	1911	c	1911	c
Switzerland	1911	v		
UK	1911	c	1911	c
Russia/USSR	1912	c	1911	c
Romania	1912	c	1912	c
Netherlands	1913	Not operative	1929	c
Bulgaria	1918	c	1918	c
Poland	1920	c	1920	c
Greece	1922	c	1922	c
Yugoslavia	1922	c	1925	c
Portugal	1919	c	1919	c
Iceland	1936			
Spain	1942			
Italy	1943			
Turkey	1950			
Finland	1963			
Australia	1944		1907	c
New South Wales	1908			
NZ	1938			
South Africa	?			
Japan	1922	c	1922	c
Canada	1966	c		
US	1965			
Brazil	1923			
Chile	1924	c	1924	c
Ecuador	1935			
peru	1936			

Colombia	1938			
Venezuela	1940			
Mexico	1943			
Paraguary	1943			
Guatamala	1946			
Bolivia	1949			
El Salvador	1949			
Honduras	1952			
uruguay	1955			
Argentina	1974			

Sources: Rubinow (1913a, 1913b), Armstrong (1932), Starr (1982), US Social Security Administration (1990)

TABLE 2: Median Values for Incomes, Household Surplus and Expenditures Related to Sickness and Dental, 1889-90 for the US, Great Britain, Germany, France, Belgium and Switzerland

	Number of Obs	Total Income	Husband's income	Husband's Income/Total Income	avg income per family member	Household Surplus	Sickness and Dental Expenses	Surplus/ Total Income	Surplus/ Husband's Income	S&D/ Husband's Income
US	5608	572	448	0.78	125.00	9.68	12.00	0.017	0.022	0.027
Great Britain	1001	462	370	0.80	103.00	16.31	2.43	0.035	0.044	0.007
Switz	52	340	181	0.53	74.00	9.15	7.72	0.027	0.051	0.043
France	319	345	241	0.70	80.40	11.73	0.68	0.034	0.049	0.003
Belgium	104	339	211	0.62	62.00	-0.30	1.93	-0.001	-0.001	0.009
Germany	142	272	225	0.83	53.00	-0.23	3.75	-0.001	-0.001	0.017
Total	7226									



SOURCE: Figures 1 and 4 of Gratton and Rotondo (1991)

Appendix: Date of First Legislation, or First Implementation of Legislation

	Sickness/Health Insurance	Old Age Insurance	Work Injury	Unemployment Insurance
EUROPE				
Germany	1883	1889	1884	1927
Austria	1888	1906	1887	1920
Czechoslovakia	1888	1906	1887	
Hungary	1891	1928	1907	1957
Sweden	1891	1913	1901	
Denmark	1892	1891	1898	1907
Belgium	1894	1924	1903	1920
Luxembourg	1901	1911	1902	1921
Norway	1909	1936	1895	1906
Ireland	1911	1908	1897	1911
Switzerland	1911	1946	1918	1924
UK	1911	1908	1897	1911
USSR	1912	1922	1912	.
Romania	1912	1912	1912	.
Netherlands	1913	1913	1901	1916
Bulgaria	1918	1924	1924	1925
Poland	1920	1927	1884	.
Greece	1922	1934	1914	1945
Yugoslavia	1922	1922	1922	1927
France	1928	1910	1898	1905
Portugal	1935	1935	1913	1975
Iceland	1936	1909	1925	
Spain	1942	1919	1932	1919
Italy	1943	1919	1898	1919
Turkey	1950	1949	1945	.
Finland	1963	1937	1895	1917
ASIA-PACIFIC				
Australia	1944	1908	1902	1944
NZ	1938	1898	1908	1930
South Africa	?	1928	1914	1937
Japan	1922	1941	1911	1947
NORTH AMERICA				
Canada	1966	1927	1908	1940
US	1965	1935	1908	1935
LATIN AMERICA				
Brazil	1923	1923	1919	1965
Chile	1924	1924	1916	1937
Ecuador	1935	1935	1921	1951
Peru	1936	1936	1911	
Colombia	1938	1946	1916	

Venezuela	1940	1966	1923	
Mexico	1943	1943	1931	
Paraguary	1943	1943	1927	.
Guatamala	1946	1969	1947	
Bolivia	1949	1959	1924	
El Salvador	1949	1953	1911	
Honduras	1952	1959	1952	
uruguay	1955	1928	1914	1944
Argentina	1974	1944	1915	1967

Sources: Rubinow (1913a, 1913b), Armstrong (1932), Starr (1982), US Social Security Administration (1990)