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FROM BISMARCK TO WOODCOCK: THE "IRRATIONAL" PURSUIT OF NATIONAL HEALTH INSURANCE

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"Uniformity of practice seldom continues long without good reason."
--Samuel Johnson, 1775

"If an economic policy has been adopted by many communities, or if it is persistently pursued by a society over a long span of time, it is fruitful to assume that the real effects were known and desired."
--George Stigler, 1975

Almost a century ago Prince Otto Edward Leopold von Bismarck, the principal creator and first Reichschancellor of the new German nation-state, introduced publicly-financed health insurance to the Western world. Since then, nation after nation has followed his lead until today almost every developed country has a full-blown national health insurance plan. Some significant benchmarks along the way are the Russian system (introduced by Lenin after the Bolshevik Revolution), the British National Health Service (Beveridge and Bevan, 1945), and the Canadian federal-provincial plans (hospital care in the late 1950s, physicians' services in the late 1960s). In nearly all cases these plans built on previous systems of medical organization and finance that reflected particular national traditions, values, and circumstances.[1]

In some health plans, such as those in the communist countries, the government has direct responsibility for providing services. In others, the production of medical care is still at least partially in the private sector, but the payment for care is through taxes or compulsory insurance premiums which are really ear-marked taxes. Even in the United States, the last major holdout against the world-wide trend,

government funds pay directly for almost half of all health care expenditures and pay indirectly for an appreciable additional share through tax exemptions and allowances.[2] Moreover, most observers believe it is only a question of when Congress will enact national health insurance, not if it will.

Almost as obvious (to many economists) as the rise of public subsidy of health insurance is the "irrational" aspect of such programs. Health insurance, in effect, reduces the price the consumer faces at the time of purchase of medical care and therefore induces excessive demand. Because the direct cost to the consumer is less than the true cost to society of providing that care, he tends to over-consume medical care relative to other goods and services. This misallocation of resources results in a significant "welfare loss," which Martin Feldstein has estimated at a minimum of $5 billion per annum in the United States.[3]

Not only does society seem to be irrationally bent on encouraging people to over-use medical care, but in the free market for health insurance people also tend to buy the "wrong" kind. Most economists agree that to the extent that health insurance serves a useful purpose it is to protect consumers against large, unexpected bills for medical care. All insurance policies are actuarily "unfair," that is, they carry a load factor for administrative costs, but if consumers are risk averse, it is worthwhile for them to pay these costs in order to protect themselves against unpredictable (for the individual) large losses. It follows, therefore, that consumers should prefer major medical (catastrophe) insurance, i.e. plans with substantial deductibles or co-payment provisions for moderate expenses but ample coverage for very large expenses.

Instead, we observe a strong preference for "first dollar" or shallow coverage. Of the privately held hospital insurance policies in the United States, the number covering the first day of hospitalization are several times greater than the number covering long-term stays.

Another apparent irrationality with respect to health insurance was alleged by Milton Friedman in a Newsweek column in April, 1975. He noted that Leonard Woodcock, President of the United Automobile Workers, is leading the drive for universal comprehensive national health insurance despite the fact that such a measure is

> . . . against the interest of . . . members of his own union, and even of the officials of that union. . . . The UAW is a strong union and its members are among the highest paid industrial workers. If they wish to receive part of their pay in the form of medical care, they can afford, and hence can get, a larger amount than the average citizen. But in a governmental program, they are simply average citizens. In addition, a union or company plan would be far more responsive to their demands and needs than a universal national plan, so that they would get more per dollar spent.[4]

Friedman says that Woodcock is an "intelligent man," and therefore finds his behavior a "major puzzle."

From Bismarck to Woodcock, it seems that economists are drowning in a sea of irrationality. But other economists warn us against jumping to the "irrationality" conclusion. In particular, George Stigler has taught us to look beyond the surface appearance of political actions in search of their actual consequences and of the interests that they serve. He writes,

> It seems unfruitful . . . to conclude from the studies of the effects of various policies that those policies which did not achieve their announced goals, or had perverse effects . . . are simply mistakes of the society.[5]

In short, when confronted with some consistent and widespread behavior which we cannot explain, we should not blithely assume that it is

attributable to lack of information or bad judgment. We should be wary of what might be called the "fallacy of misplaced ignorance." It may be that the behavior we observe is more consistent with the self-interest of particular individuals or groups than it first appears.

It is to George Stigler that we are also indebted for the "survivor principle," one of his many contributions to the study of industrial organization.[6] The basic notion is simple: if we want to learn something about the relative efficiency of differently sized firms in an industry, Stigler tells us to look at that industry over time and notice which size classes seem to flourish and which do not. Can the "survivor principle" be applied to institutions as well? If so, national health insurance seems to pass with flying colors. No country that has tried it has abandoned it, and those that have tried it partially usually expand it. It may not be unreasonable to infer, therefore, that national health insurance does serve some general interests. That is, there may be some welfare gains lying below the surface that more than offset the losses so apparent to many economists. An exploration of some of the special or general benefits that might explain the widespread pursuit of national health insurance follows.

The U.S. Already Has Implicit National Health Insurance

Some of the observed behavior would seem less irrational if we assume that the U.S. already has implicit national health insurance, especially for catastrophic illness. If it is true that most uninsured people who need care can get it one way or another--through government hospitals, philanthropy, or bad debts--then it may be rational for people

to buy only shallow coverage, or indeed, not to buy any insurance at all. To suggest that there is implicit insurance in the United States covering nearly everyone is not at all to suggest that there is equal access to equal quality care. We know that so-called free care may often have some stigma attached to it, may be less pleasant and less prompt, and may fail in other ways as well. But it cannot be denied that a good deal of medical care is delivered every year in the United States to persons who do not have explicit insurance or the money to pay for it.

Those persons without explicit insurance are essentially free-riders. Those who do carry extensive insurance, such as the automobile workers, in effect pay twice--once through the premiums for their own insurance and again through taxes or inflated costs to cover care for those without explicit insurance. If this is a significant factor, it could be perfectly rational for the automobile workers to support universal compulsory insurance. Why society provides implicit or (in most countries) explicit coverage for all remains to be explained.

An Attempt to Control Providers

Another reason why the UAW leaders and others may favor a single national health plan is in the hope of gaining some control over the providers of medical care--the hospitals and the physicians. In recent years one of the major frustrations faced by the auto workers and other groups with extensive insurance coverage is the rapid escalation in the price of medical care. They may believe that only a single source national health insurance plan will be in a position to control provider behavior and stop the escalation in costs. Moreover, there is strong

evidence that they are not alone in this view. One of the puzzles for economists has been to explain the traditional opposition of the medical profession to legislation which, at least in the short run, increases the demand for their services. This opposition probably stems in part from the belief that national health insurance would ultimately result in an increase in government control over providers.

Tax Advantages

Why do people buy shallow coverage--where the administrative load is high and the risk element relatively small? One reason is that when the premium is paid by the employer the implicit income is free of tax. Even health insurance premiums paid by the individual are partially deductible from taxable income. If the tax laws allowed employers to provide tax-free "food insurance," we would undoubtedly see a sharp increase in that type of fringe benefit. But again the explanation is not very satisfactory. Why do the tax laws encourage the purchase of medical care but not food, clothing, or other necessities? In an attempt to answer this question,we should consider some of the characteristics of medical care and health insurance that are different from conventional commodities.

Externalities

One explanation for the popularity of national health insurance that has great appeal for economists at the theoretical level is that there are substantial external benefits associated with the consumption of medical care. If this were true, then governmental subsidy of care

need not be irrational; indeed it might be irrational not to provide that subsidy. The best example of potential externalities is the prevention or treatment of communicable diseases such as tuberculosis. In earlier times these diseases constituted a very significant portion of overall health problems, but are much less important today. Furthermore, if a concern with externalities were the chief motivation, it would be logical and feasible to subsidize those services (e.g. venereal disease clinics) which are clearly addressed to the communicable diseases. However, even economists who are strong advocates of national health insurance, such as Lester Thurow, do not rely on the externality argument. Thurow writes "Once a society gets beyond public health measures and communicable diseases, medical care does not generate externalities."[7]

Mark Pauly has called attention to one special kind of externality which probably is operative. It involves the satisfaction people get from knowing that someone else who is sick is getting medical attention.[8] This satisfaction could be purchased by voluntary philanthropy, but the total amount so purchased is likely to be less than socially optimal since each individual's giving tends to be based on his or her private satisfaction, ignoring the effects on others. The solution may be compulsory philanthropy, i.e. tax-supported programs.

A Matter of "Life or Death"

Another explanation for national health insurance that has great appeal at the theoretical level but carries less conviction empirically is that "the market should not determine life or death." This theme is advanced by Arthur Okun in his new book, Equality and Efficiency, the Big

Tradeoff, and is a basic tenet of those who argue that "health care is a right." There is considerable logic in the argument that society may be unwilling to accept the consequences of an unequal distribution of income for certain kinds of allocation decisions such as who serves in the army during wartime, who gets police protection, and who faces other life-threatening situations. It may be easier and more efficient to control such allocations directly than to try to redistribute money income (possibly only temporarily) to achieve the desired allocation.

Although this explanation has a certain thoretical appeal, one problem with it is that the vast majority of health services do not remotely approach a "life or death" situation. Moreover, the ability of medical care to make any significant contribution to life expectancy came long after Bismarck and Lenin advocated national health insurance. Even today, when some medical care is very effective, it is possible that housing, nutrition, and occupation have more influence on life expectancy than does medical care, yet we allow inequality in the distribution of income to determine allocation decisions in those areas. According to Peter Townsend, there is no evidence that the British National Health Service has reduced class differences in infant mortality, maternal mortality, or overall life expectancy.[9] If equalizing life expectancy were society's goal, it is not at all clear that heavy emphasis on national health insurance is an optimal strategy.

The emphasis on medical care rather than other programs that might affect life expectancy is sometimes defended by the statement that it is more feasible. Although diet or exercise or occupation may have more effect on life expectancy than does medical care, it may be

technically simpler to alter people's consumption of medical care rather than to alter their diet, etc. It has also been argued that it is politically more feasible to push medical care rather than alternative strategies. The distinction between technical and political feasibility is not, of course, clear cut because the former depends in part on what we are willing to do in the way of permitting government to intrude on personal decisions--a political question. However, to the extent that the popularity of national health insurance is said to be attributable to its political feasibility, we have really not explained much. Its political popularity is precisely the question we started with.

The Growth of Egalitarianism

Life expectancy aside, one way of interpreting the growth of national health insurance is as an expression of the desire for greater equality in society. British economists John and Sylvia Jewkes have written,

> The driving force behind the creation of the National Health Service was not the search for efficiency or for profitable social investment. It was something quite different: it was a surging national desire to share something equally.[10]

An American economist, C. M. Lindsay, has developed a theoretical model which analyzes alternative methods for satisfying the demand for equality of access to medical care. Among other things, he shows that if this demand for equality is widespread, there are externalities similar to those discussed by Pauly in connection with philanthropy. Thus a free market approach will result in less equality than people really demand. He also shows that the British National Health Service

can perhaps best be understood as an attempt to satisfy this demand for equality. He concludes, ". . . the politician's sensitive ear may read the preferences of his constituents better than the econometrician with his computer."[11]

Why the demand for equality has grown over time and why it should find expression in medical care more than in other goods and services are not easy questions to answer. Is there really more altruism in society now than before? Were Bismarck and Lenin the most altruistic political leaders of their time? Is it simply the case that equality is a normal "good", i.e. we buy more of it when our income rises? If this is the explanation, what are the implications for equality in a no-growth economy?

Perhaps there has been no real increase in altruism at all. Perhaps what we observe is a response to an increase in the ability of the less well-off to make life miserable for the well-off through strikes, violence, and other social disruptions. On this view health insurance is part of an effort to buy domestic stability. It may be that industrialization and urbanization make us all more interdependent, thus increasing the power of the "have-nots" to force redistributions of one kind or another. Or perhaps there has been a decline in the willingness of the "haves" to use force to preserve the status quo.

Such speculations, if they contain some validity, would explain a general increase in egalitarian legislation, but they would not help much in explaining why this legislation has focused heavily on medical care. Indeed, is it not curious that society should choose to emphasize equality in access to a service that makes little difference at the

margin in life expectancy or to economic or political position and power? A cynic might argue that it is not curious at all since it is precisely because medical care does not make much difference that those with power are willing to share it more equally with those with less. Indeed, one might argue that the more a society has significant, enduring class distinctions, the more it needs the symbolic equality of national health insurance to blunt pressures for changes that alter fundamental class or power relationships.

One egalitarian goal that has always had considerable acceptance in the United States is equality of opportunity. Thus, a popular argument in favor of national health insurance is that it would help to equalize access to medical care for children. Some recent theoretical work on the economics of the family, however, calls into question the effectiveness of such programs. Gary Becker has argued that the thrust of programs aimed at increasing investment in disadvantaged children can be blunted by parents who can decrease their own allocation of time and money to their children as investment by the state increases. The increase in the welfare of the children, therefore, may be no greater than if a cash subsidy equal to the cost of the program were given directly to the parents. The ability of the "head" to reallocate family resources may not, however, be as unconstrained as Becker's model assumes. There may be legal or social constraints, or there may be a desire on the part of the head to maintain the child's obedience, respect, or affection. Thus the importance of the reallocation effect is an empirical question, about which at present we know virtually nothing.

"Papa Knows Best"[12]

An argument advanced by Thurow in favor of transfers in kind--such as national health insurance--is that some individuals are not competent to make their own decisions. He writes,

> Increasingly we are coming to recognize that the world is not neatly divided into the competent and the incompetent. There is a continuum of individuals ranging from those who are competent to make any and all decisions to those who are incompetent to make any and all decisions.[13]

Thurow argues that if society desires to raise each family up to some minimum level of real welfare, it may be more efficient to do it through in-kind transfers than through cash grants. Even if we agree with this general argument, it does not follow as a matter of logic that subsidizing medical care brings us closer to a social optimum. It may be the case, for instance, that the "less able" managers tend to overvalue medical care relative to other goods and services, in which case Thurow ought to want to constrain their utilization rather than encourage it.

More generally, there is the question whether government will, on average, make "better" decisions than individuals. As Arrow has stated in a slightly different context, "If many individuals, given proper information, refuse to fasten their seat belts or insist on smoking themselves into lung cancer or drinking themselves into incompetence, there is no reason to suppose they will be any more sensible in their capacity as democratic voters."[14] Two arguments have been suggested to blunt Arrow's critique. The first is that the "less able" are less likely to vote; therefore the electoral process produces decisions that reflect the judgment of the more able members of society. Second, it has been suggested that there is considerable scope for

discretionary behavior by elected representatives; they do not simply follow the dictates of their constituents.[15] It may be that their judgment is generally better than that of the average citizen.

An Offset to an "Unjust Tax"[16]

Suppose the U.S. were defeated by an enemy in war and had to pay an annual tribute to the enemy of $100 billion. Suppose further that the enemy collected this tribute by a tax of a random amount on American citizens chosen at random. The U.S. government might decide that this tribute tax was unjust and that it would be more equitable for the federal government to pay the tribute from revenues raised by normal methods of taxation. If the enemy insisted on collecting the tribute from individual citizens on a random basis, the government could choose to reimburse those paying the tribute.

Some observers believe there is a close parallel between the tribute example and expenditures for medical care. They see ill health and the consumption of medical care as largely beyond the control of the individual citizen--the cost is like an unjust tax--and the purpose of national health insurance is to prevent medical expenditures from unjustly changing the distribution of income. There is, of course, the question whether, or how much, individuals can influence and control the amount of their medical expenditures. Putting that to one side, however, and assuming that the analogy is a good one, there are still some questions that arise.

One might ask why the government has to intervene to protect people against the tribute tax? Why couldn't citizens in their private

lives buy insurance against being taxed for tribute? The total cost and the probabilities are known; therefore private insurance companies could easily set appropriate premiums. One answer might be that this is also inequitable to the extent that some people can afford the insurance more easily than others. The government could easily remedy this, however, by some modest changes in the distribution of income.

Another problem, of course, is that some people might not buy the insurance. They would be "free riders" because if they were hit with a big tribute tax they would be unable to pay and others would have to pay in their place. Furthermore, they would be wiped out financially, so that society would have to support their families.

To be sure, the government could both redistribute income to take care of the premium and make insurance compulsory, but that becomes almost indistinguishable from a national insurance plan. The only difference then would be whether there is a single organization, the government, underwriting the insurance, or whether there are several private insurance companies.

In the tribute tax example we have assumed that the probability of loss would be identical across the population, but this is clearly not true for health insurance. One argument advanced in support of national health insurance is that it does not require higher risk individuals to pay higher premiums. A counter argument is that individuals do have some discretion concerning behavior that affects health and concerning the utilization of medical care for given health conditions. National health insurance, it is alleged, distorts that behavior. A related argument is that medical care will always have to be rationed in some

way and that national health insurance requires the introduction of rationing devices other than price and income. These devices carry their own potential for inequity and inefficiency.

The Decline of the Family

Illness is as old as mankind, and, while frequently in the past and not infrequently today, there is little that can be done to change the course of disease, there is much that can be done to provide care, sympathy, and support. Traditionally most of these functions were provided within the family. The family was both the mechanism for insuring against the consequences of disease and disability and the locus of the production of care. The only rival to the family in this respect until modern times was the church, a subject to be considered below.

With industrialization and urbanization, the provision of insurance and of care tended to move out of the family and into the market. Thus, much of the observed increase in medical care's share of total economic activity is an accounting illusion. It is the result of a shift in the production of care from the home, where it is not considered part of national output, to hospitals, nursing homes and the like, where it is counted as part of the GNP. Unlike the production of bread, however, which also moved from the family to the market (and stayed there), medical care, or at least medical insurance, increasingly became a function of the state.

One possible explanation is that the state is more efficient because there are significant economies of scale. With respect to the production of medical care, the economies of scale argument can fairly

safely be rejected. Except for some exotic tertiary procedures, the economies of scale in the production of physicians' services and hospital services are exhausted at the local or small region level. For the insurance function itself, there may be significant economies of scale. Definitive studies are not available, but the proposition that a single national health insurance plan would be cheaper to administer than multiple plans cannot be rejected out of hand.[17] To be sure, a single plan would presumably reduce consumer satisfaction to the extent that the coverage of the plan would represent a compromise among the variety of plans different individuals and groups might prefer.

The relationship between the declining importance of the family and the growing importance of the state is complex. Not only can the latter be viewed as a consequence of the former, but the causality can also run the other way. Every time the state assumes an additional function such as health insurance, child care, or benefits for the aged, the need for close family ties becomes weaker. Geographic mobility probably plays a significant role in this two-way relationship. One of the reasons why people rely more on the state and less on their family is that frequently the family is geographically dispersed. The other side of the coin is that once the state assumes responsibilities that formerly resided with the family, individuals feel freer to move away from the family, both literally and figuratively.

It has often been alleged that these intra-family dependency relationships are inhibiting and destructive to individual fulfillment. Whether a dependency relationship with the state will prove less burdensome remains to be seen. There is also the question whether the efficient provision of <u>impersonal</u> "caring" is feasible.

The Decline of Religion

In traditional societies when the family was unable to meet the needs of the sick, organized religion frequently took over. Indeed, practically all of the early hospitals in Europe were built and staffed by the church and served primarily the poor. The development of strong religious ties, with tithes or contributions frequently indistinguishable from modern taxes, can be viewed as an alternative mechanism for dealing with the philanthropic externalities discussed previously. Moreover, at a time when technical medical care was so ineffective, religion offered a particular kind of symbolic equality--in the next world if not in this one. Thus, the decline of organized religion, along with the weakening of the family, may have created a vacuum which the state is called upon to fill.

The "Political" Role

When refugees from the Soviet Union were interviewed in Western Europe after World War II, they invariably praised the West and disparaged life in Russia--with one notable exception. They said they sorely missed the comprehensive health insurance provided by the Soviet state.[18] It may be that one of the most effective ways of increasing allegiance to the state is through national health insurance. This was undoubtedly a prime motive for Bismarck as he tried to weld the diverse German principalities into a nation. It is also alleged that he saw national health insurance as an instrument to reduce or blur the tension and conflicts between social classes.

We live at a time when many of the traditional symbols and institutions that held a nation together have been weakened and have

fallen into disrepute. A more sophisticated public requires more sophisticated symbols, and national health insurance may fit the role particularly well.

Why Is the U.S. Last?

One rough test of the various explanations that have been proposed is to see if they help us understand why the U.S. is the last major developed country without national health insurance. Several reasons for the lag can be suggested. First, there is a long tradition in the U.S. of distrust of government. This country was largely settled by immigrants who had had unfavorable experiences with governments in Europe and who had learned to fear government rather than look to it for support and protection. Second, it is important to note the heterogeneity of our population compared to some of the more homogeneous populations of Europe. We are certainly not a single "people" the way, say, the Japanese are. Brian Abel-Smith has noted, for instance, that the U.S. poor were often Negroes or new immigrants with whose needs the older white settlers did not readily identify.[19]

The distrust of government and the heterogeneity of the population probably account for the much better developed non-governmental voluntary institutions in the U.S. Close observers of the American scene ever since de Toqueville have commented on the profusion of private non-profit organizations to deal with problems which in other countries might be considered the province of government. These organizations can be viewed as devices for internalizing the philanthropic externalities discussed earlier in this paper, but the organizations are frequently limited to

individuals of similar ethnic background, religion, region, occupation, or other shared characteristic.

Another possible reason for the difference in attitudes between the U.S. and Europe is the greater equality of opportunity in this country. In the beginning this was based mostly on free or cheap land, and later on widespread public education. Moreover, the historic class barriers have been weaker here than in countries with a strong feudal heritage. To cite one obvious example, consider the family backgrounds of university faculties in Sweden and the U.S. Sweden is often hailed as the outstanding example of a democratic welfare state, but the faculty members at the leading universities generally come from upper class backgrounds. By contrast, the faculties at Harvard, Chicago, Stanford, and other leading American universities include many men and women who were born in modest circumstances. With greater equality of opportunity goes a stronger conviction that the distribution of income is related to effort and ability. Those who succeed in the system have much less sense of noblesse oblige than do the upper classes in Europe, many of whom owe their position to the accident of birth. In the U.S., even those who have not succeeded or only partially succeeded seem more willing to acquiesce in the results.

Summing Up

The primary purpose of this inquiry has been to attempt to explain the popularity of national health insurance around the world. My answer at this point is that probably no single explanation will suffice. National health insurance means different things to different people. It

always has. Daniel Hirschfield, commenting on the campaign for national health insurance in the United States at the time of World War I, wrote:

> Some saw health insurance primarily as an educational and public health measure, while others argued that it was an economic device to precipitate a needed reorganization of medical practice. . . . Some saw it as a device to save money for all concerned, while others felt sure that it would increase expenditures significantly.[20]

Externalities, egalitarianism, the decline of the family and traditional religion, the need for national symbols--these all may play a part. In democratic countries with homogeneous populations, people seem to want to take care of one another through programs such as national health insurance, as members of the same family do, although not to the same degree. In autocratic countries with heterogeneous populations, national health insurance is often imposed from above, partly as a device for strengthening national unity. The relative importance of different factors undoubtedly varies from country to country and time to time, but the fact that national health insurance can be viewed as serving so many diverse interests and needs is probably the best answer to why Bismarck and Woodcock are not such strange bedfellows after all.

FOOTNOTES

1. See Abel-Smith [1969].

2. For a discussion of why the United States is the last to adopt national health insurance, see page 18.

3. See Feldstein [1973].

4. See Friedman [1975].

5. See Stigler [1975].

6. See Stigler [1958].

7. See Thurow [1974].

8. See Pauly [1971].

9. See Townsend [1974].

10. See John and Sylvia Jewkes [1963].

11. See Lindsay [1969].

12. I am grateful to Sherman Maisel for suggestions concerning this section.

13. See Thurow [1974], p. 193.

14. See Arrow [1974].

15. See Breton [1974].

16. I am grateful to Seth Kreimer for suggestions concerning this section.

17. Maurice Le Clair [1975, p. 16] writes that the experience in Saskatchewan clearly indicated economies of scale in the administration of a virtually universal plan. See also further comments on this point by Le Clair on p. 24.

18. See Field [1967], p. 14.

19. See Abel-Smith [1969].

20. See Hirschfield [1970].

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