

The American Approach to Health Insurance

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“**H**ERE WE ARE,” DECLARED DAVID LLOYD GEORGE on May 4, 1911, before the British House of Commons, “in the year of the crowning of the King . . . I think that now would be a very opportune moment for us in the homeland to carry through a measure that will relieve untold misery in myriads of homes, misery that is undeserved . . . In this country, as my right honorable friend the President of the Local Government Board said in his speech last week, 30 per cent of the pauperism is attributable to sickness . . . The efforts made by the working classes to insure against the troubles of life indicate that they are fully alive to the need of some provision being made. There are three contingencies against which they insure—death, sickness, and unemployment . . . Taking them in the order of urgency which the working classes attach to them, death would come first . . . Sickness comes in the next order of urgency in the working class mind . . . I should say that between 6,000,000 and 7,000,000 people in this country have made some provision against sickness, not all of it adequate and a good deal of it defective.”

On July 17, 1933, Mr. Lloyd George was again the principal speaker, this time at a luncheon to celebrate the twenty-first anniversary of the National Health Insurance Act which he had laid before Parliament in 1911. “The gathering,” said the *London Times* on the following day, “had been arranged by the Approved Society Organizations, the British Medical Association, the National Association of Insurance Committees, the National Dental Associations, the National Ophthalmic Associations, and the National Pharmaceutical Union ‘to meet those responsible for

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creating, fashioning, and launching the first National Insurance Act in the United Kingdom, which came into operation on the 15th of July, 1912.’”

In the program of this luncheon there were printed statistics showing that the number of persons insured on June 30, 1933, was 18,500,000; that during the twenty-one years, the national sickness insurance had disbursed the equivalent of three billion dollars in providing cash benefits and certain medical care; and, despite the depression, had accumulated a surplus equivalent to over half a billion dollars. The chairman, the Minister of Health, referred in his address to “. . . the bitter opposition which the scheme excited in its initial stages,” and compared it with “the atmosphere of friendly cooperation in which it was administered today.”

Mr. Lloyd George said, as reported in the *Times*, “that when he found himself listening to an eloquent tribute to the scheme from a distinguished Conservative and saw that the list of those present included the secretary of the British Medical Association and also the ex-secretary, and that the British Medical Association was among those who promoted the luncheon to congratulate themselves upon the success and triumph of the measure, he rubbed his eyes and said, ‘What a pleasant dream I am having. I do hope no one will wake me up.’” . . . “He would like to ‘reminisce.’ He had just been reading what happened twenty-one years ago. He had almost forgotten what a really bad time he had had until he read it up. It was like rounding Cape Horn—very chilly winds ahead, heavy seas, and some dangerous rocks ready to tear their craft. However, they sailed through, and now it was sailing the Pacific Ocean.”

Behind these remarks of Mr. Lloyd George lies significant history. Through the guilds and other mutual benefit associations, some collective provision against the calamities of sickness and death was known in Europe during the Middle Ages, but the rise of industry and of an increasing group of persons whose sole support was wages made the need for such provision greater than ever before. The law which Lloyd George fathered was built upon conditions existing at the time when he instituted it. It doubled at a stroke the number of persons in Great Britain who would receive cash benefits during sickness, reimbursing them in part for their loss of wages. It somewhat increased, and substantially stabilized, these benefits. It provided for medical care for these insured persons during sickness, on a somewhat more extensive scale and of much sounder quality than they had previously organized. It rendered the

financial support of these benefits more ample and vastly more stable by requiring contributions not only from the employees themselves but also from their employers and in a small degree from the state. Thus the scheme had two objectives: protecting against wage loss during sickness and providing medical care for the wage-earner. Both had previously been available less adequately and very much less comprehensively, but it is apparent from Mr. Lloyd George's address in 1911 and from other literature, that the prevention of poverty caused by illness and the relief of distress due to loss of wages during sickness were put forward as the primary pleas for this legislation. Even today, when the two services are measured in terms of money, the expenditures for medical benefits under the law constitute only about 40 per cent of the total annual outlay.

As Mr. Lloyd George shrewdly pointed out in 1911, he was following the psychological trend of the times in endeavoring to meet the demands of the working people themselves. Obviously no compulsory legislation affecting millions of voters could be set up, in England or elsewhere, on any other basis. Such laws can only extend what has already been prepared for in the popular mind and has been established by voluntary action sufficiently to familiarize a goodly number of people with its advantages and to supply some confidence in the practicability of its administration.

Germany had antedated Great Britain by nearly thirty years in establishing a general plan of sickness insurance. The German legislation of 1883 also grew out of long roots in the past. For many years within the mining industries, and for a shorter time in German railroads, there had been established schemes affording cash payments for loss of wages and some provision for doctors. The German law built upon this system, improved and extended it to cover more persons. In 1885, however, only about 4,200,000 persons were covered. Beginning among industrial wage-earners, subsequent legislation broadened it to reach commercial, agricultural, and other workers. Domestic servants and the bulk of agricultural workers were not included until nearly thirty years after the passage of the original law. By 1930, the number of insured persons had grown to over twenty million—30 per cent of the population of the Reich.

Fuller provision for medical care was the second direction in which the German laws have extended. This expansion has been largely by permissive legislation, making it possible, though not mandatory, for the local groups of insured persons to increase their contributions

for the purpose of extending the scope of the medical services. Gradually but steadily, more and more advantage has been taken of these permissive provisions so that in many industrial sections of Germany four-fifths or more of the whole population secure medical care through sickness insurance or through the publicly supported hospital system.

The motives which led Bismarck to introduce the sickness insurance legislation in 1881 have been variously explained. One current interpretation is that he regarded these laws as a way to forestall socialism by removing certain causes of discontent. Whether this point of view is accepted or not, there can be no doubt that discontent due to economic distress was a more significant consideration than the demand for medical care. Bismarck's motives fifty years ago, however, are less significant than the interpretations given to the sickness insurance laws by two succeeding generations of German students and administrators. Prof. Alfred Manes of Berlin, one of the best known specialists in social insurance, writing during the year when the British insurance law went into effect, defined the scope of social insurance as follows:

“Social insurance, and this is in the widest sense of the word, including even optional insurance, has to serve as protection for the following cases of exigency:

1. When there is temporary impairment of the capacity for work, and with this of the earning power, whether this comes about through causes relating to the individual (subjective causes), or through material conditions, namely:
 - a.* Through sickness (. . . sickness insurance).
 - b.* Through accident (accident insurance).
 - c.* Through child-bearing and what follows it (maternity insurance).
 - d.* Through poor conditions of the labor market (unemployment insurance).”

Without quoting this analysis further, it is clear that the approach is economic. Social insurance, according to this conception, is to be set up as protection against the impairment of earning capacity.

The origin of any institution gives it a direction and trend but does not control its future development. The historical motivation of sickness insurance was primarily economic. Medical care was clearly needed, somewhat desired, but in popular demand and political significance was

secondary to the relief of economic distress due to loss of wages. The reasons for this subordinate place of medical care must be understood not only in terms of the popular psychology which Mr. Lloyd George comprehended so well, but also in relation to the status of medical service at the time sickness insurance legislation began.

What were the characteristics of medical care fifty years ago, when the German laws were initiated? Medical practice was then simple, and only a little specialization had developed. Surgery and hospital service were sought only in exceptional cases. Preventive work was then limited to sanitation and to the attempt to control smallpox and a very few other infectious diseases. The demand for medical care arose chiefly in acute or emergent illness.

With certain modifications, the same conditions prevailed in the England of 1911, so far as the mass of the people were concerned. The medical service which was in the minds of most English wage-earners and their political representatives was care in acute or emergent illness. Specialist service had become well developed in the cities, but except in unusual circumstances was accessible to wage-earners only through the out-patient departments or the wards of the hospitals. These institutional services were wholly charitable, both the hospitals and their professional staffs rendering care without any fees. Thus hospital care and a large part of specialist service did not enter appreciably into the budget of the average wage-earner.

The financial aspects are also significant. In the Germany of the end of the 19th century and in the England of the early part of the 20th, what wage-earners spent for medical care for themselves and their families was undoubtedly much less than the amount which as individuals they might lose, and which as a group they did lose, in loss of wages on account of sickness. Thus from the economic as well as from the psychological point of view, the provision of medical care was secondary to the relief of economic distress.

Such is the background of sickness insurance. If we now shift our position to the United States and our date from the second to the fourth decade of the century, we find a foreground presenting marked contrasts. In the first place, the expenditures for medical care have become much greater than the wage losses due to sickness. During a prosperous period (1928–1930) estimates made in the Summary Volume of the Committee on the Costs of Medical Care are that the maximum annual wage-loss was less than a billion dollars, whereas the amount actually expended

for medical care by families with incomes of less than \$2,500 a year was about one and one-half billion.

Among the lower paid wage-earners, conditions are different. These families (with incomes of less than \$1,200 a year) spend a larger proportion of their income for medical care than the better paid people, but the actual amounts expended per family are smaller, partly because they secure some care at reduced fees and partly because they receive a considerable amount of care, particularly in hospitals, without any payment. The studies of the Committee on the Costs of Medical Care indicated that in 1928–1931 the average charges for care of sickness by families with less than \$1,200 income was \$49.17. The 6,000,000 families with incomes of less than \$1,200 per year, therefore, spent nearly \$300,000,000 for medical care. The 10,000,000 wage-earners in these families may be estimated to have suffered an average wage-loss of about \$25 per year because of sickness, or about \$250,000,000 for the group. The wage-loss due to sickness in this group thus appeared to be about five-sixths of their expenditures for medical care.

For families with incomes of between \$1,200 and \$2,500, the expenditure for medical care was about \$1,200,000,000. There are about 14,000,000 families in this group and about 20,000,000 wage-earners. The wage-loss in this group, averaging \$32 per wage-earner per year, would have been about \$610,000,000, or a little over half the expenditures for medical care.

This is not to state or imply that wage-loss is unimportant. It is of grave importance for the lower paid employees and it has significance for all wage-earning groups. To the American of 1930, nevertheless, the family expenditures for medical care have become a larger item financially than the wage-loss due to sickness. This is a very important conclusion, and is, moreover, a new development. The costs of medical care have been rising for a number of years and for several reasons. The apparatus and personnel involved in the diagnosis and treatment of disease have been greatly elaborated. This has enhanced the cost of service. It is still estimated that about five-sixths of all cases of illness can be cared for by a well-trained general practitioner. But a considerable proportion of these cases are minor diseases, e.g., of the upper respiratory tract, while on the other hand the remaining one-sixth of the cases of illness are of the more serious and expensive group, and this one-sixth calls forth an expenditure at least as great as the other five-sixths.

The technological development of medicine has not only increased the total cost of medical service as a whole. It has also enlarged the *range* of costs for particular diseases and conditions. Some diseases are no more expensive to diagnose and treat than they were a generation ago. Others have become vastly more expensive, presumably with justification because of the much better results obtained. But the economic effect is to increase the uneven incidence of the costs of care, since those persons upon whom these expensive illnesses happen to descend during a given year are heavily burdened financially.

The increase in the total costs of medical care and in the unevenness of the incidence of these costs have both been enhanced by the larger use of hospitals. Fifty years ago there was about one hospital bed for every 700 of the population. In 1933, there was about one hospital bed for every 125 people. Between 1910 and 1930 our population grew 32 per cent, while the number of hospital beds increased 116 per cent. Hospitalized illness constituted about 50 per cent of the total expenditure of families for all forms of medical care, according to the investigations of the Committee on the Costs of Medical Care. This has been fully confirmed by the recent study of the families of employees of the Metropolitan Life Insurance Company. Even for families of the lowest income group (\$1,200 a year or less) studied by the Committee, 48 per cent of the total annual expenditure for medical care went for hospitalized illness, the percentage being somewhat higher for families of more substantial incomes. Thus hospitalization has become a large, though not the only important, element in the increased cost of medical care.¹

In this respect a decided contrast exists between the United States and Europe. Hospital service has not appeared to any appreciable extent in the budgets of wage-earners or other people of small means in Great Britain or the European continent. In England, these persons have until very recently been served by voluntary hospitals or tax-supported hospitals both on a wholly charitable basis. On the Continent, tax-supported hospitals have provided hospital service for the great majority of people. Professional care in all these European hospitals, moreover, has been furnished by state-salaried physicians, or by a voluntary medical staff whose services are free to patients. In the United States, on the other hand, the larger part of hospital service is paid for by those receiving it, including professional fees for physicians and surgeons. In the United States about one-third of the admissions to hospitals are to tax-supported institutions to which patients make no direct payment, or to free beds in voluntary

hospitals. But there are only some 500 tax-supported general hospitals in the United States, and most of these are located in a relatively few cities and in some of the small western communities. The amount of tax-supported general hospital care is growing, but it is still true that most American wage-earners pay something for the care of hospitalized illness out of their family budget. This is clearly shown by the figures above quoted in which families with incomes of less than \$1,200 spent for hospitalized illness nearly half of their total annual outlay for medical care. Hospital bills alone constitute almost 20 per cent, excluding fees for professional services rendered in the hospital and also excluding costs of home care before or after the stay in a hospital during a given illness.

It is not only in the economic aspect of medical care that alterations have taken place during the past generation. A pervasive and fundamental change has occurred in the concept of medical care itself. Whereas medical care was formerly conceived as something to be secured when a patient is beset by pain or fear, many people now seek medical care for minor illness, and its distinctly preventive functions have also vastly increased. This is illustrated in the organized public health services conducted by governmental departments and some voluntary agencies, and also by the concept of preventive care for the individual which is fostered by many professional leaders and by some practitioners. The practice of this type of preventive medicine is most notable in relation to children, in the direction and control of diet, the guidance of personal and industrial hygiene, and in the preventive aspects of dentistry.

There has been a marked reduction in death rates from the diseases of infants and children, and from certain of the partly controlled diseases affecting other age groups. There has resulted a substantial prolongation of the average length of life and an increase in the average age of the population. The larger proportion of older people involves a changed emphasis in the practice of medicine. The care of acute communicable diseases becomes a smaller element whereas there is an increased demand for the care of chronic diseases with which the sufferer may live for many years.

All of these points are items in a general picture of change from a conception of medicine as meeting emergent needs to an ideal of medical service as the prevention and control of illness and the positive promotion of health. It is true that much knowledge of prevention and control is now possessed but not applied, or is applied only to a fraction of the people who would benefit by it. But the conception and the extent of

its actual application have already grown enough to exert important economic effects upon medical service and its future trends. We are in a position today to plan for medical service according to policies which would have been impracticable fifty years ago, even if they had been conceived at that time.

It is a paradox that discussion of the costs of medical care rose to a peak during the prosperous period of the last decade, culminating in the organization of the national committee which studied the subject in 1927–1932; and that most published complaints regarding the costs arose from the middle class. This might be explained on the ground that people of this group are more likely to express themselves in print than are individual wage-earners. The significant fact, however, is that families with annual incomes of \$2,000 to \$5,000 or more did and do complain. The studies of the Committee on the Costs of Medical Care show the reason for this. They demonstrated that about one-sixth of all families in any given year have to bear over one-half of the total expenditure for the care of sickness for all families; that the amounts expended increase with the income of the family; and that the unevenness of the incidence of expenditure is somewhat greater among the upper income groups. Sickness bills running from a third to a half of the annual income fall every year upon a small but significant percentage of middle-class families, and this fact alone is sufficient to account for an annual stream of complaint from individuals; and sickness costs less high but sufficiently large to be burdensome descend upon many middle-class families as well as upon the much larger group with smaller earnings. In former years when the range of sickness costs was lower, and few illnesses caused high expenditures, families with middle-class incomes felt financial pinch due to sickness much less frequently than today. Now, people who are economically secure, humanly speaking, against all ordinary demands, are not secure against the costs of sickness. Thus, the economic problems of medical care now implicate not merely wage-earners but the whole population, except the 5 per cent with the largest incomes.

In summary, the historical background of sickness insurance is economic, as it was developed on a comprehensive scale in Europe with the primary purpose of income protection, with paying for medical care as a secondary aim. The European experience is full of suggestions for us, but in the United States we now need a different approach, because the costs of medical care now involve larger sums of money and affect many more

people than does wage-loss due to sickness, and because the provision of adequate medical care, curative and preventive, holds vastly larger possibilities than in former times for relieving suffering, promoting health, and increasing economic efficiency. For these reasons, the problem of medical care should have priority in plans and programs of action.

The problem of wage-loss should be approached as one of the economic insecurities which is properly to be dealt with by social insurance, but should be fitted in, financially and administratively, with phases of social insurance that are primarily economic, such as unemployment insurance, or as an extension of industrial accident compensation. The evidence from European experience is that we shall interfere with or spoil comprehensive plans for adequate medical care for all the people if we begin by dealing with the wage-loss due to sickness among employed persons. We hear pleas to "separate cash benefit from medical benefit," on the ground that certification of disability by a physician interferes with the independence and effectiveness of the physician when the same man is also treating the patient. This difficulty is very real in many European sickness insurance schemes, but is a problem of organization and of finance, not of principle, for it can be rather fully overcome under conditions where salaried reviewing physicians are employed and where the method of paying the treating physician is such (as is partly true in England) that his financial interest is in the direction of keeping people well. Cash benefit—i.e., provision against wage-loss due to sickness—could be worked satisfactorily in correlation with (not as part of) a scheme of systematized payment for medical care provided we start by planning for medical care as our primary aim.

Let us therefore move forward with plans for action directed primarily towards an adequate system of curative and preventive medical services. In proceeding thus, it is well to appreciate the fact that in the United States all but the lowest paid people have been paying for medical service almost or quite enough to provide themselves with adequate care if the payments were systematically made, pooled, and used effectively. Sickness insurance would not mean taking more money from wage-earners as a group. It would mean that this group need spend only what they are spending now. We now pay for a considerable amount of medical care by taxation for the care of certain conditions, such as mental disease, venereal disease, and tuberculosis, for the general medical care of the unemployed and other dependent groups, and as a geographical equalizer to help those areas which are unable to support needed services

out of their own resources. Both the public and the medical professions would gain if most medical care were paid for by sickness insurance, supplemented by taxation. The incomes of physicians, hospitals, and other agents of medical service would be at least as large as under the present system and would be much more stable. The medical and allied professions in the United States are now evidencing a great amount of interest not only in studying the economic aspects of medicine but also in initiating or participating in new plans of group practice and group payment. There is now opportunity for those who have been thinking of health insurance from the economic approach to join with thoughtful leaders in medicine, in a cooperation such as was never displayed in any European country, for shaping a coherent and effective program of preventive and curative medical care.

Endnote

1. These figures include all illnesses which were cared for in a hospital during *any part* of their course, hence they cover some periods of home or office care as well as hospital bills and fees paid to physicians, surgeons, and nurses for services rendered while the patient was in the hospital. The costs for the hospitalized period, however, constitute fully four-fifths of the total costs of these illnesses, or 40 per cent of total family expenditures for all illnesses. It should be understood that in all these references to hospital care, the mental disease hospitals and the tuberculosis sanatoria are excluded. Nearly all these are governmental institutions. The reference is to general and special hospitals caring for acute illnesses.