Between 1915 and 1920, as many as 18 U.S. states investigated, but rejected, the introduction of 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. I show that this perspective can explain the variation in timing of health insurance developments in Europe and why the health insurance movement was strongest in New York.

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Between 1883 and 1920, many European countries introduced compulsory (government) health insurance (CHI). Most were social insurance arrangements with little redistribution financed by employers and employees, or a state promoted expansion of existing voluntary mutual benefit arrangements. 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 U.S. had the “seeds” of compulsory health insurance. Between 1883 and 1911, there was apparently no interest in the United States in developing comparable government programs, but with the introduction of Worker’s Compensation in many states before World War I, there was an expectation amongst some Americans that government health insurance would be implemented. Between 1915 and 1920, as many as 18 U.S. states investigated, but rejected, introducing compulsory state health insurance. 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. The failure of Americans to implement CHI before the Depression of the 1930s is considered to be significant for explaining why the U.S. does not have, and is unlikely to have in future, national health insurance. As the United States remains the only Western-developed country without national (compulsory) health insurance, Fox (1983, 599) argues that many scholars and reformers have viewed the failure of the United States to enact a national health insurance program as symbolic of the incomplete social evolution of the U.S. According to Lubove (1968, 2-3) Americans have continued to rely on voluntary institutions that fail to respond to their security needs and that undermine government efforts to meet those needs.

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 the capability of centralized management to implement the program. 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 emulation by other states and the national government?”

2 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). 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 emulation by other states and the national government?”
3 See Quadagno (2005) for a similar line of argument. Hoffman (2001, 4) suggests that this early defeat of CHI was “blow against gender equality in the U.S. welfare state.”
government insurance to be implemented. The need for state provided health insurance was taken for granted by proponents of compulsory health insurance before 1920. Fox (1983) suggests that 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. These explanations also suggest that there is path dependence in the evolution of government policies as the initial conditions that encouraged, or discouraged, the adoption of government health insurance would not be expected to change over time. For example, Lindert (1994, 28) suggests that the peculiar distaste that Americans have for government aid is durable.

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.” 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 while the U.S. did not adopt CHI, Americans did introduce Worker’s Compensation before 1920 and public old age insurance in the 1930s (Beland and Hacker 2004). Lubove (1968, 24) observes that worker’s compensation programs in the U.S. demonstrated that social insurance had to be, and could be, adapted to voluntary values and institutions. Moss (1996, 176) argues, while there is still no compulsory health insurance program in the United States, “The progressive concept of security – widely attacked as socialistic and un-American during the progressive era – has developed into one of the bulwarks of American public policy.” This suggests that the rejection of CHI by Americans in this early period can be understood in terms of issues specific to CHI, rather than general to

4 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.
5 Anderson (1950, 366). Rubinow (1913) went so far as to indicate that the need for social insurance in the US was self-evident.
6 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.
7 Path dependence does not describe all supply side explanations. 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.
8 Moss (2002, 153) highlights that Americans spend more on social insurance than on any other type of government program, including defence.
American conceptions of the role of the state.

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 for, or opposition to, compulsory health insurance in the United States. This observation has been interpreted in two ways to explain the failure of the U.S. 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 U.S. (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 of American wage earners relative to their European counterparts. American wage earners had a greater capacity to save and purchase insurance coverage through voluntary arrangements. 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. As Moss (1996, 176) suggests, with changing economic conditions in the United States and economic forces that put downward pressure on the earnings of less skilled and less educated workers, Americans may embark on a reassessment of American social welfare institutions.

In this paper, I investigate the case put forward by the AALL reformers that American wage earners had the same need for compulsory health insurance as their European counterparts 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, labor market conditions and consequent savings patterns. In particular, I re-visit the case put forward by the AALL 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 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 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.

The Transition From Voluntary to Compulsory State Health Insurance

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.9 The costs of sickness and poor health include lost income, direct medical costs of hospitalization, physician care and medicine, and for society, lost productivity. Before 1920, lost income was the important risk for workers and, consequently, sickness/health insurance in this earlier era was for income stabilization, which was thought to be useful for the prevention of poverty.10 Prior to the introduction of state health insurance programs in Europe, similar “patchworks of protection” 11-- 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.12

Rubinow (1913, 224-225) cites that registered friendly society members in England represented 13 percent of the population before National Insurance went

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10 Armstrong (1932) discusses the evidence that showed that sickness was a leading cause of poverty. 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 equaled the size of income loss (Davis 1934). Later health insurance movements in the United States, and centralization of health care administration in the countries like the UK were intended to address direct medical costs that carried the risk of catastrophic loss (enormous costs). Armstrong (1932, 334) reports that in 1915, the proportion of health insurance benefits paid in cash versus “in Kind” were 72.5 percent in Belgium, 42 percent in Denmark, 98 percent in Sweden and 70 percent in Switzerland. By the late 1920s, these proportions were 18 percent in Belgium, 16 percent in Denmark, 93 percent in Sweden and 56 percent in Switzerland. Government centralization of the provision of health insurance tended to occur after World War II with the rise of direct medical costs (Gosden 1973).
11 This the term used by Hoffman (2001, 6).
12 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).
into effect. In the first decade the twentieth century members of such mutual societies represented 10 percent of the population in France; 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. Rodgers asserts that the system of workers’ mutual assistance in the United States was extensive and comparable in structure to that of contemporary Europe. Beito (2000) argues that a conservative estimate of participation in fraternal self-help organizations in the United States would have one of three adult males as a member in 1920, “including a large segment of the working class.”

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. 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. 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 (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 rise to primacy in the sickness and health insurance field in North America.

13 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.

14 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.

15 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.

16 See Appendix 1 for a list of these countries. 23 countries if Switzerland is included. In Switzerland, two Cantons introduced compulsory insurance.

17 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 way as in the U.S. until provincial government health insurance plans, with universal coverage, replaced the work-place based arrangements in the 1960s (Maioni 1998).
Rubinow (1913b) describes 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. Epstein (1933, 469) claims that voluntary subsidized health insurance rarely covered more than a small proportion of the population. In contrast, the extent of insurance coverage in the 22 countries with compulsory health insurance by 1927 ranged from 15 percent to 86 percent 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. The greater extent of coverage in the compulsory systems was interpreted as a success for those arrangements compared to the voluntary insurance systems.

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 U.S. 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 U.S. could be grouped with the European countries without government health insurance; Italy, Spain, Portugal, Greece, Bulgaria, Albania, Montenegro and Turkey. 

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18 Armstrong (1932, 332) estimates that government subsidies for voluntary insurance represented 39 percent of insured members contributions in Belgium in 1926, 50 percent in Denmark in 1928, 17.8 percent in Sweden in 1928 and 31.3 percent in Switzerland in 1929.
19 Denmark with its generous state subsidies had 57 percent of population covered by voluntary health insurance; Belgium was next highest with 14 percent of the population covered, then Sweden with 12 percent and the rest of the countries with voluntary systems below 10 percent. In France, membership in voluntary insurance funds was 6 percent of population in 1914 and declining to 1925 (Epstein 1933, 469).
20 Armstrong (1932, 348) reports that by the mid-1920s, the proportion of population represented by the compulsorily insured was 34 percent in Austria, 5 percent in Bulgaria, 19 percent in Czechoslovakia, 32 percent in Germany, 35 percent in Great Britain, 12 percent in Hungary, 21 percent in Norway, 7 percent in Poland and 6 percent in Russia/USSR.
21 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.
Given the evolution of compulsory health insurance arrangements from voluntary arrangements, it is not surprising that the health insurance arrangements implemented by government (and as proposed in the U.S.) closely resembled the contracts of friendly societies and mutual benefit societies. The principle differences between voluntary arrangements and compulsory (government) arrangements were the sources of finance, the extent of coverage in the population and often the expansion of coverage for costs of medical services. Government Health Insurance in the earlier era was not universal insurance. Before 1920, Compulsory Health Insurance paid, or proposed to pay, cash benefits for prime aged workers under an income ceiling. Typically, the arrangements excluded the self employed, agricultural workers, and often, dependents of workers.

The origin of the government compulsory health insurance (CHI) movement in the United States was the formation of the American Association for Labor Legislation (AALL) in 1906, which by 1913 had 3300 members consisting largely of academics, academic physicians, intellectuals and social reformers. 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, as many as 18 U.S. States investigated Compulsory Health Insurance. California and New York had the most advanced developments towards actual legislation. 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 (Moss 1996, Beito 2000, Hoffman 2001).

Anderson (1968, 87) observes 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

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22 Anderson (1968), Rodgers (1998), Moss (1996). Economists Richard T. Ely and John R. Commons were the first president and secretary respectively of the AALL.

23 See Anderson (1968) and Hoffman (2001, 2). Lubove (1968, 67) states that versions of the AALL draft bill for CHI were introduced into the New York, Massachusetts and New Jersey legislatures in 1916 and in 15 other states in 1917. Moss (2002, 174) reports that twelve state legislatures took up health insurance bills. There were 11 official state commissions reported on compulsory health insurance. Massachusetts (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 Massachusetts (1918) reported against compulsory health insurance (Lapp 1920). In addition to these states, Lubove (1968, 67) reports that investigating Commissions were authorized in New Hampshire, Ohio, and Pennsylvania, and the Governors of California, Massachusetts and Nevada endorsed health insurance in their inaugural messages in 1916. One Canadian Province, British Columbia, investigated government health insurance in 1919.

24 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 1995). In 1917, the State Senate and State Assembly both passed the proposed amendment but on California’s election day in 1918, the health insurance amendment went down to defeat by almost a three to one margin (Moss 1996, 151).
general public seemed to pay only passing interest.” 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. Rubinow (1934, 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 (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 wage earning Americans lost sight of their true need for social insurance.25 According to Paul Starr (1982), there was no movement for health insurance in the 1920s.26 Only 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 was the social insurance movement 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 and old-age insurance.

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. The reformers expected that the gains for industrial wage-earners from CHI would be large enough to mobilize workers’ interests to aid in the passage of CHI. With the

25 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.”

26 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). 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).
proposal that the cost of insurance be covered by contributions by the worker, the employer and the state, AALL reformers argued that workers would be paying a fraction of the cost of a generous level of health and sickness insurance coverage (Moss 1996). The AALL viewed the contributions of employers and the state for the CHI coverage as an effective way to extend insurance coverage to the lowest paid and most vulnerable of the wage earning classes (AALL 1916, 239).

Why was there so little interest in state health insurance amongst American wage earners? 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.” Hoffman (2001) argues that health insurance was viewed as “un-American” since it would subvert individual initiative and self-reliance. After World War I, health insurance was seen as too “socialist” and too “Prussian” (Costa 1995, Hoffman 2001, Quadagno 2005). Fisher (1917, 14-15) addressed the argument made by “certain interests” 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, and familiarity with, health insurance.

Rodgers (1998, 255) 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 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. 27 North America also had an abundance of

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27 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
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 North America.28

Another line of argument for the failure of Americans to adopt CHI was that U.S. political power was too decentralized to facilitate the introduction of government health insurance and other large scale social programs (Starr 1982, Costa 1995, Moss 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 (1995) suggests that centralized political power and a lack of referenda could help to explain why CHI was introduced in Europe, but not the U.S. The federal structure of the United States was also argued to be an important impediment to the passage of CHI at the national and state level. As Constitutional limits prevented the federal government from introducing national health insurance and at the state level, Moss (1996, 156-157) argues that the threat of a “competitive disadvantage” for states introducing CHI compared to states that did not introduce CHI was a critical impediment for the CHI movement.29

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 workers’ compensation laws 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.30

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.

28See also Emery and Emery (1999) and Beito (2000). "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."Cited in Starr (1982, p. 242).

29 Lapp (1920, 32) indicates that the Wisconsin commission on health insurance that reported in 1919 stated that state contributions for CHI would be unconstitutional. The AALL draft legislation proposed that the state would pay 20 percent of the premium cost.

30 Sickness insurance programs were introduced in Rhode Island (1942), California (1946), New
Lubove (1968, 66) argues that where Worker’s Compensation demonstrated the ability of voluntary interest groups to adapt their private ends to a collective welfare program, the failed campaign for CHI reflected the overwhelming and extraordinary mobilization of resources by these same interests to thwart a form of social insurance from which they anticipated no material advantages. According to Fishback and Kantor (1998) workers’ compensation legislation was established by a coalition of workers, employers and insurers who expected gains from shifting the existing negligence liability system based on common-law rule to one of strict liability. Workers and their families could expect higher post-accident benefits in the event of an accident, and better insurance for the accident risk. Employers anticipated that they would benefit from less uncertainty in sizes of payouts in the event of an accident; lower legal and administrative costs and that they would be able to pass part of the cost of the insurance on to workers through lower wages. CHI did not offer the same tangible benefits as worker’s compensation for employers. CHI would have introduced a liability for employers rather than shifting an existing liability as under worker’s compensation. According to Moss (1996, 60-64), the AALL reformers believed that social insurance as exemplified by CHI would redirect market forces so that the prevention of the leading sources of poverty, industrial accidents, disease and unemployment would be profitable for employers. Employers, employees, the worker’s family and the community that paid poor relief all stood to gain from social insurance by internalizing the “external costs” of industrial society. According to Moss, the reformers believed that the central problem of industrial society was that the employer assumed no responsibility for a worker’s human capital. When a worker fell sick, was injured on the job or was not needed when production fell, the employer either hired another worker or left the community and the family to support the idle worker which shifted the costs of health care and lost wages onto the family and the community. Since the family and community were third parties to the labor contract, and due to the unequal bargaining power between employer and employee, wage contracts failed to internalize the external costs of industrial society. Social insurance was a solution akin to a Pigouvian tax whereby employers who were required to compensate workers who were injured on the job, fell sick, or were laid off would invest in making the workplace safer and healthier and seek to regularize employment to reduce the amount of compensation that they would have to pay. The expected outcome of the social insurance was higher post-accident benefits for workers and their families; lower legal and administrative costs for employers; and a potentially expanded market for accident insurance coverage for insurers.

31 The insurance would be “purchased” by accepting lower wages. Fishback and Kantor (1992) find that between 1884 and 1903, wage levels were high enough to partially compensate accident risk. Presumably this compensating differential would be eliminated with the introduction of insurance.

32 Fishback and Kantor (1992) offer mixed evidence on this claim. With their wage data for the period 1884-1903, they find that wage levels fully compensated for unemployment risk, partially compensated accident risk but did not compensate for occupational illness.

33 According to Moss (1996), insurance and prevention were the main objectives of the AALL in
insurance induced incentives for prevention would be a society with reduced incidences of disease, accident and idleness with gains for employers, workers, their families and their communities (Lubove 1968, 76; Moss 1996). The failure of the AALL CHI movement suggests that employers were not convinced by the line of argument that social insurance would reduce their costs through the prevention of disease and illness.\textsuperscript{34}

Moss (1996, 157) concludes that CHI threatened special interests more than any other form of labor legislation.\textsuperscript{35} Unlike the workers’ compensation movement, fraternal and commercial life insurers opposed CHI since the model legislation excluded them as possible insurance carriers and included funeral benefits which would have undermined the demand for their industrial insurance.\textsuperscript{36} 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 were expected to have been 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 before 1914, but they lost interest in it during World War I and by 1920, they were clearly opposed to it (Anderson 1950, 1968, Fox 1987, Lundberg 2002). There were several reasons for physician opposition to state health insurance in the U.S., but it seemed to come down to a situation of AALL legislation proposing 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 arising from illness.\textsuperscript{37}

\textbf{Was Compulsory Health Insurance in the United States Unnecessary?}

Weaver (1982, 200) argues that the “ideology view” for the failure to see

\textsuperscript{34} See Hoffman (2001, 96-100). The Illinois and Wisconsin commissions that investigated health insurance concluded that there was no evidence that CHI promoted health. Illinois’ commission concluded that it would be unfair to charge industry with any of the cost of sickness among wage earners and their dependents (Ransom 1920, 44; Lapp 1920, 32).


\textsuperscript{36} Beito (2000), Fox (1987, 13) and Kaufman (2002). 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, 81) and Gilbert (1966, 323).

\textsuperscript{37} 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.
social insurance enacted in the U.S. has been accepted prematurely.

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.

The obvious interest group that could have influenced public policy had they shown an interest would have been the wage-earners who would have been insured under CHI. Was the lack of interest in CHI by wage-earners counter to that group’s self-interest? Was there a need for compulsory health insurance amongst enough Americans to yield the necessary political outcome? Certainly, key reformers like Rubinow, Fisher and Epstein asserted that the need existed due to their beliefs in the shortcomings of voluntary arrangements, including the capacity of households to save.\footnote{Rubinow (1913, 28) asks “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”} 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). There was also a view that the exceptional social mobility of American workers diminished their interest in socialism generally. Because workers expected large gains in their material well-being, and because the benefits of growth were shared between labor and capital, there was less need for working Americans to look to the State to improve their well-being (Sombart 1976). The Wisconsin commission on health insurance that reported in 1919 concluded that there was no demand for government health insurance in that state (Lapp 1920, 32).
This business view of the superiority of labor 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.\textsuperscript{39} Hoffman (2001 58) suggests that 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 (1913a) 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

\textsuperscript{39} Americans on average were wealthier than their European counterparts. 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).
themselves against economic hardship from events like sickness, unemployment, old age and invalidity. Rubinow (1913a, 1934) and Epstein (1933) interpreted the savings of workingmen to be too small to provide any true economic security. According to Moss (1996, 137), “careful observers estimated that typical working families saved less than a single week’s income per year.” 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. While Rubinow (1913a) conceded that the level of American wages was higher than that of most European countries, he believed that 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 comparing the level of American wages against what the American standard of living “ought to be”; not how the majority of the working class lived, but the standard that existed for some wage-workers and to which workingmen would aspire. 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. Rubinow (1913a, 9) believed that a large majority of wage earners had insufficient income to maintain a “normal” standard of living and to have a surplus. Rubinow’s (1913a, 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.”

40 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”. Rubinow argued that “the increased savings of the wage-workers are a myth without much foundation in fact even to justify it.” 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.

41 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.”
Over time, this notion of a minimum standard of decency in consumption has been interpreted as an insufficiency of income to meet subsistence needs.\textsuperscript{42}

To maintain a proper standard of living, the evidence suggested 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 percent of males living east of the Rockies and north of the Mason Dixon line earned less than $800 a year. 95 percent 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.\textsuperscript{43}

A second source of inadequacy of American wages came from the belief that there should be a single breadwinner per household.\textsuperscript{44} Rubinow (1913, 33-34) noted that many families resorted to having more than one worker in the family. Only 36 percent of families relied on the father’s/husband’s income alone, including those families earning between $800 and $1000 per year. Rubinow

\textsuperscript{42} For example, see Moss (1996, 137), Moss (2001, 7) and Glenn (2001, 640). Epstein (1933, 96-99) presented 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”, and the “minimum budget”.

\textsuperscript{43} 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. He described another study of 361 families found that only 36 percent 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. 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.

\textsuperscript{44} 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.”
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 percent of family income. For “normal” families with only the father at work, the average income was $659.68.

According to the reformers, conditions of working Americans got worse, not better after World War I. 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 (1913a, 34-37) presented indices showing that real weekly earnings were not rising between 1890 to 1907 because of falling hours of work and rising food costs. Finally, reformers like Rubinow and Epstein asserted that insurance for health and sickness that was available was not sufficient and was expensive. Proponents of state social insurance and most scholarly examinations of voluntary methods of self-help in Europe, England and North America conclude that the patchwork system of voluntary income protection was “woefully inadequate” (Horrell and Oxley 2000, 54) if not a “dismal failure for meeting the economic and medical needs of a populace” (Hoffman 2001, 9). Lubove (1968, 17) cites Rubinow’s assessment that voluntary mutual aid had been “tried and found wanting”. Rodgers (1998, 218) describes the voluntary mutual assistance arrangements in the North Atlantic economy as “both a fixture of everyday life and inadequate to it, far-flung and full of holes.” Horrell and Oxley (2000, 54) in a study of British households for 1889-90 argue that self-help benefits “did not, in

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45 When Epstein (1933) 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.

46 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 had been slowly but steadily declining.
general, appear to be very significant in offsetting even quite dramatic reductions in the earnings of a male breadwinner”. Although some form of coverage was usually purchased by the relatively well-paid industrial workers … this did not translate to significant benefits for those identified as suffering hardship.” Many authors characterize the self-help organizations like the friendly societies as plagued by financial problems associated with aging memberships.47 Finally, as AALL reformers argued, voluntary insurance arrangements would never cover the poorest classes of workingmen that were most in need of protection.48

Assessing the Reformers’ Case that American Wages Earners Needed CHI

The AALL’s (1916) draft of an act for Compulsory health insurance would have resulted in the compulsory participation in the insurance arrangement of all manual workers whatever their earnings, and other employees (mostly expected to be clerks and foremen) earning less than $1200 per year.49 The insurance benefits provided by CHI were generous and extensive. The draft act called for cash benefits equal to 2/3 of weekly wages that were to be paid commencing with the 4th day of disability to a maximum of 26 weeks in a 12 month period; medical, surgical and nursing attendance as well as medicines and surgical supplies for the insured and his/her family; for insured women and wives of insured men, maternity benefits providing medical and surgical attendance, plus 8 weeks of cash benefits equal to 2/3 of weekly wages, and a $50 funeral benefit to be paid to the survivors of insured members who died while in receipt of cash benefits, or who were within in 6 months of the discontinuance of cash benefits due to reaching the 26 week limit for their payment. Finally, the act called for extension of coverage for individuals whose contributions ceased on account of unemployment not due to sickness. In these cases, the insurance was to remain in force for one week for each 4 weeks of paid up contributions in the previous 26 weeks.

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47 Based on the presumption that members remained in friendly society memberships for a lifetime, many authors have concluded that self-help organizations were financially non-viable as aging memberships had insufficient reserves to manage the cost of increasing benefit pay-out (Kip 1953, Gosden 1961, 1973, Lubove 1968, Hoffman 2001, Kaufman 2002). Emery (1996) and Emery and Emery (1999) show that this conclusion is not supported by the experience of the IOOF in North America, and that mutual insurers were financially sound.

48 Chamberlain (1914, 53). 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 the major organizations’ memberships, members of these populations had their own organizations to secure mutual aid.

49 Other persons could join the insurance scheme on a voluntary basis, including self employed persons with earnings of less than $1200 per year.
The cost of the insurance for the employed individual was not as clear. If implemented in the U.S., then the cost of CHI coverage was expected to be between 1.6 percent and 4 percent of a wage-earner’s annual income depending on how much of the cost could be shifted onto employers and the State.\textsuperscript{50} The AALL’s belief that sharing the cost of insurance across the insured employee, the employer and the state would encourage the prevention of illness resulted in the proposal that the employee and employer would each pay 40 percent of the insurance cost, and the state would pay the remaining 20 percent.\textsuperscript{51} Assuming that the employer’s share of the cost would not be passed on to the employee through subsequent wage reductions (or reduced wage increases), this would have meant that the insured was only going to pay 1.6 percent of annual income to secure a generous level of insurance coverage. The recommendation of cost sharing was to make the plan more appealing to wage-earners since they would gain more generous insurance coverage at a lower cost than possible in the voluntary system since employers and the state paid most of the cost.\textsuperscript{52}

For wage-earners, the appeal of the proposed CHI arrangement would have depended on whether it was going to cost them 1.6 percent or 4 percent of annual income and on whether they desired such a high level of insurance coverage. To see this, consider the cost of voluntary insurance as provided through the Independent Order of Odd Fellows (IOOF), the largest sickness insurer in the United States until 1927 (Emery and Emery 1999). As a member of the IOOF, an individual was eligible for a cash sickness benefit of typically $3 to $5 per week of disability beginning with the 8\textsuperscript{th} day of disability and lasting until the 52\textsuperscript{nd} week of sickness, after which time the amount of the benefit was reduced to $1 per week. Lodges could contract with a physician to provide medical attendance and medicines for lodge members if the membership chose to do so, but attentive benefits provided by lodge brothers were mandatory. Like the proposed CHI arrangement, the IOOF offered members funeral benefits of $30 to $100 (depending on the jurisdiction/state). While there were no maternity benefits, the IOOF did provide widows and orphans benefits that were not included in the proposed CHI act. Beyond these stipulated benefits, all lodges could choose to pay higher amounts of cash relief to brothers in need, or to pay for medical attendance on a discretionary basis. In friendly societies like the Independent Order of Odd the cost of this sickness insurance coverage was $6 to

\textsuperscript{50} Fisher (1917), Starr (1982), Costa (1995). Based on German experience, the AALL suggested that a premium of 4 percent of wages was needed to finance the benefits (Lubove 1968, 71).

\textsuperscript{51} AALL draft legislation also detailed a sliding scale where the employer paid from 80 percent of the insurance costs for the lowest wage workers to 40 percent for workers with higher wages. AALL (1916, 250-255) “Health Insurance – tentative draft of an act”.

\textsuperscript{52} In making a case that CHI would not increase an employee’s financial burden, Chamberlain (1914, 64-65) reported studies that showed that households in New York with family incomes between $600 and $1100 spent 4 percent of their incomes, close to the expected cost of CHI coverage, on insurance and services that would be covered by proposed CHI legislation. Thus, CHI would secure the same benefits and services for 1.6 percent rather than 4 percent of income. Kantor and Fishback (1996) show an enormous reduction in precautionary savings following the introduction of workers’ compensation laws which also suggests that social insurance for workplace risks could have freed up a large portion of the household budget for other uses.
Further, the levels of coverage for the sickness and funeral benefit could be almost doubled by joining an auxiliary branch of the organization for roughly the same cost.\footnote{Emery and Emery (1999). There were one time joining fees of $10 to $12 as well. 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.}

CHI was more expensive than the existing voluntary insurance arrangements but it also provided more generous benefits in the event of sickness. Assuming a CHI premium of 4 percent of earnings, a wage earner with annual income of $600 would have been compelled to pay $24 per year for health insurance coverage. On the other hand, assuming that state taxes and wage rates did not change in response, if employers and the state paid 60 percent of the premium cost, then the wage earners would have secured the benefits of CHI for only $10. 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, 1.6 percent to 4 percent of annual income would have secured a benefit $9 to $10 per week of sickness. For a $600 earner, the cost of IOOF sickness insurance was 1 percent to 1.5 percent of annual earnings to secure a benefit of $3 to $5 per week of sickness. Perhaps what is most interesting about this comparison is the fact that CHI with its higher cost insurance was intended to benefit lower wage earners who chose not to purchase the lower cost fraternal sickness insurance. 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. The main purpose of CHI would have been to compel wage-earners to purchase higher levels of insurance coverage.

Further comparison of the draft CHI act and voluntary insurance arrangements requires some description of the risk of illness facing a household to determine the size of the expected income loss and the size of the expected insurance benefit.\footnote{I focus the evaluation on the value of cash benefits under the two plans which would have been the most important aspect of the insurance since income loss due to an inability to work was the important cost of illness at this time. Further, the CHI arrangement on the surface may appear to provide more than the IOOF contract in terms of insurance coverage but in practice, this may not have been the case since the IOOF provided many forms of relief on a discretionary basis, and where CHI had maternity benefits, the IOOF had widows’ and orphans’ benefits. Finally, the lower premium cost for the IOOF coverage relative to the CHI contract meant that households would have had more income under the voluntary arrangement to pay for medical attendance and medicines.} Table 1 presents data on the risk of falling sick for at least one week, and on the number of weeks of sickness conditional on being sick for at least one week, by age.\footnote{These data were compiled by the IOOF Grand Lodge of Ontario between 1896 and 1899. Comparison of these data with average claims rates and weeks of sickness in US states indicates that these data are representative of the Order’s experience in North America for the period 1902 to 1920 for which I have state level data for the Order. Further, the risk of being sick and the}
could expect to experience 0.88 weeks (6.5 days) of insured sickness per year, or 13.5 days of total sickness once one adds in the uncompensated first seven days of illness.\(^5^7\) Thus, as a fraction of 52 weeks in the year, working males could expect an average loss of 2 percent (6.5 days) to 4 percent (13.5 days) of income per year over their lifetime. This expected value, however, masks that the lifetime average probability of sickness lasting at least one week was 0.15 per year and conditional on being sick for at least one week, an insured sickness duration of 5.72 weeks (or 6.72 weeks of total sickness).

The incidence and duration of sickness related disability increased between the ages of 20 and 70. A 20 to 24 year old male had a probability of 0.09 of being sick for at least one week, 3.9 weeks of insured sickness if they fell sick for a week, and an expected duration of illness of only 2.5 insured days (or 9.5 days of total sickness). By age 40, the expected duration of illness had increased to 5 days (or 12 days of total sickness) and the risk of falling ill 0.14, and by age 60, 20 days of expected sickness and a probability of sickness of 0.3. In terms of potential income loss, workers could expect sickness to cost them less than one percent of annual earnings until age 35, less than 2 percent of annual earnings into their 40s, and over 5 percent of their annual income in their 60s.

This information on sickness experience allows us to compare the generosity of the cash benefits in the proposed CHI act with the voluntary arrangement. For example, for a $600 earner, from the CHI arrangement they could expect to receive $6.81 in cash benefits whereas with the IOOF cash benefits of $3 to $5 per week of sickness, they would have expected benefits of $2.64 to $4.40.\(^5^8\) Comparing the expected value of cash benefits to premium contributions, a CHI premium of 2.6 percent would matched the cost of IOOF sickness insurance. This suggests that a premium of 4 percent to be entirely paid by the insured individual would be too high to make CHI an attractive alternative to the available voluntary benefits in terms of dollars of expected benefit to dollars of expected contribution.

duration of illness described by these data are similar to the rates and durations for Germany, the UK, and the US in Armstrong (1932, 284-296).

\(^5^7\)As this spell is conditional on being sick for at least one week, it will overstate the expected period of sickness that includes the probability of being sick for less than 8 days. Armstrong (1932, 295-296) argues that statistics from organizations like the IOOF underestimate the incidence and duration of sickness since they include illness lasting 8 days or more, and they tend to represent the experience of members selected on the basis of age and good health. All the same, Armstrong reports a range of estimates for work days lost due to sickness of 6 to 9 per worker from studies using data from various years between 1915 and 1930. Hoffman (2001, 7) cites a 1916 U.S. Public Health Service estimate that a given worker missed an average of nine working days per year due to sickness. These estimates are close to the average length of compensated sickness spells in the IOOF data so I use the IOOF compensated spell of illness to represent the age specific duration of illness in the calculations which follow.

\(^5^8\) The expected cash benefit with CHI may have been closer to $8 since there was payment commencing on the fifth day of sickness rather than the 8th day for the IOOF. That would lengthen the insured spell by a couple of days and it would have increased the number of claims by compensating part of sickness spells lasting less than 7 days.
From the age specific calculations in Table 1, we can see that the advantage of CHI over the IOOF arrangement with respect to cash benefits was at higher ages where expected claims durations were longer. For men under age 30 earning $600 per year, the difference between the expected benefits under the two schemes was less than $2 compared to a difference in contribution amounts of $4 to $18. Consider as well that the IOOF members could effectively double the size of their cash benefit by joining the organization’s auxiliary branch for roughly the same cost as the IOOF membership. For $600 earners under age 35, this means that the voluntary arrangement could provide a similar level of benefit coverage as CHI for around $12 per year, or half of the cost of the CHI if the employee had had to pay the full cost of their insurance. The lower panel of the table calculates the size of expected benefits and costs of CHI for workers who would have been at the income ceiling of $1200. The levels of benefits that they could receive at higher ages relative the IOOF contract which had a fixed value of the weekly benefit gets much larger, but so does the cost with an annual premium of $20 to $48 dollars.

The AALL’s proposed CHI contract should have appealed more to men in the 40s and up than to men under age 40 and to males with higher incomes than lower incomes. For men under 40, and with lower incomes, the voluntary fraternal insurance arrangements provided comparable levels of benefits to CHI at a lower cost. The principle advantage of the CHI contract was to increase the level of benefits as incomes and expected sickness duration increased. It is important to note that the voluntary contract as provided by the IOOF was not particularly generous for older members of the organization because the value of the benefit remained fixed at an amount rather than paid according to a percentage of income. According to Emery and Emery (1999) this reflects that the voluntary contract was primarily demanded by younger men who had not developed their capacity to self-insure through savings and accumulated wealth.

Despite its more generous cash benefits, it is also not clear that CHI addressed the insurance needs of working Americans over the life-cycle. CHI primarily insured acute illness resulting in short spells of disability. With increasing age, the risk of illness shifts from that of acute illness to chronic illness which was not going to be adequately insured under the draft act. With chronic illness and long spells of disability, a pension arrangement would be more suited to insuring households than social insurance as under CHI. The voluntary contract as provided by the IOOF would have been more suited to insuring chronic illness since cash benefits continued for 52 weeks versus 26 weeks under CHI.

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59 Bachman and Meriam (1948) show that for the U.S. in 1940, number of days of disability per person per year from acute illness was 2.5 versus 7.3 for chronic illness. (page 256). The frequency of cases of chronic illness in the population increased with age as did the associated days of disability per year person, rising from 3.1 days for persons under the age of 25 and rising to 33.4 days for persons over age 65. The frequency of acute illness and associated days of disability did not show similar increases. Days of disability associated with acute illness increased from 2.3 per person under age 25 to 2.7 for persons aged over 65 (page 260).
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? The AALL reformers alleged that compared to how wage earners and their families should be living, as most households had deficient income to meet this standard, they could not be considered as capable of saving. To understand the reaction of wage-earners to the proposed CHI arrangement, however, requires information not on how households should live, but how they did live.

How much did American wage-earners’ households save 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 1888-1890.\textsuperscript{60} I also use data from the 1917-19 Bureau of Labor Statistics Cost of Living Survey.\textsuperscript{61} As compulsory health insurance would have primarily covered male household heads, I consider the size of the household surplus (total income minus total expenditures) 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.\textsuperscript{62} I also focus on median values of savings rates since the distribution of household surpluses is skewed to the right resulting in very high mean values for incomes and savings. And as these data are most likely representative of the better off of the wage earnings so relying on the mean of the savings rate will likely be less informative than median value for understanding how CHI would have influenced households of more modest incomes. Despite the over-representation of higher earning industrial households in these data, the data are useful for addressing the claims of the AALL reformers. For the 1889-90 sample, I calculate that only 22

\textsuperscript{60} These data are described in detail in Haines (1979), Gratton and Rotondo (1991) and Horrell and Oxley (2001). 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 percent of surveyed families earned income from employment in the cotton textile industry and another 10 percent 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.

\textsuperscript{61} 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.

\textsuperscript{62} For 1889-90, we have information on expenditures on food, rental costs, home and utilities, taxes, insurance, charity, vices and sickness and death. For 1917-19, we have information on expenditures on food, clothing, housing rent, fuel and light, furniture, insurance, liquor and tobacco, medical expenses, cemetery expenses and “miscellaneous”. Gratton and Rotondo (1991) point out that since mortgage payments were not reported in these surveys, household expenditures of home owners are too low which will tend to inflate the size of the surplus.
percent of American households in this sample had incomes high enough to meet Rubinow’s “minimum level of decency” in standard of living.

Figure 1 shows the median savings rates by age in 1889-90 and 1917-19 compared to the expected income loss due to sickness by age from Table 1. This figure shows that the median savings rate for 1889-90 for males under age 40 was low at below 2.5 percent while for males over age 40 savings rates increased to over 5 percent and reached almost 10 percent for households with heads aged in their 50s. Despite the low savings rate for males under 40, the expected percentage loss of income from sickness was less than 1 percent of income. Thus, as the size of the expected loss increased with age, so did the savings capacity of American households. 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 in the family developed.

Based on the 1889-90 savings rate estimates, a CHI premium of 4 percent would have removed any income surplus for most households with heads under age 40 to provide insurance for a risk that they could handle in the absence of CHI. This level of premium would in all likelihood have resulted in a reduced standard of living for insured households due to the high cost of the insurance. Had the AALL proposal for the cost sharing of the premium resulted in a lower premium of 1.6 percent of income, the same situation prevailed. The insurance cost would have eliminated the budget surplus of many households to provide insurance for a risk that the households were capable of managing. As Costa (1995) argues, CHI was an expensive substitute for what workers already had.

CHI would have locked Americans into savings for a single purpose for the length of their working lives. The commitment of so much of household income to the insurance of a single risk was not necessarily desirable relative self-insuring via precautionary savings. 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.

Did the capacity of American wage-earners to save and meet sickness related costs deteriorate after 1889-90 as the reformers claimed? Figure 1 shows that the estimates for household savings rates 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.63 Even from the standards of the reformers,

63 The number of US states represented in the 1917-19 Survey was larger than in 1889-90. As such we have also calculated the median savings rates for 1917-19 using data for households
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, market insurance may be the preferred arrangement over self-insurance depending on the cost of the coverage (Ehrlich and Becker 1972). Rubinow (1934) assessed that the numbers of savings and other time deposit accounts suggested that over 40 percent 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 U.S. 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. Using Epstein’s (1932,100) report “Average Annual Earnings of Wage-Workers Taking Account of Actual Unemployment” for 1920 to 1928, the average size of the “workingman’s” deposit was 16 percent to 20 percent of annual income. In assessing an optimistic estimate that the value of aggregate savings in the U.S. 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?” It is possible to answer Epstein’s question with respect to sickness. A reserve equal to 33 percent of annual income was equivalent to the financial coverage that CHI as proposed by AALL would have provided. According to Epstein’s (1933) income data for the 1920s, $790 per family would suggest that on average American families had a reserve to annual income ratio of living in States that were included in the 1889-90 survey. We find that this adjustment makes no meaningful difference from what we report for the estimates based on all US states in the 1917-19 survey.

64 See Gratton (1996) for a discussion of these developments in the United States.
65 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 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 percent 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 percent of average income, and presumably some of the 700,000 individuals without savings accounts were dependents of other account holders.
66 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.
closer to 50 percent which would suggest that the capability to self-insure was well-developed.

Were American Savings Rates Exceptional?

So far I have presented evidence to support the argument that many American households would not have needed, nor necessarily have benefited from, the CHI arrangement as proposed by the AALL. For this explanation for the failure of the CHI movement in the United States to be informative, then it should be possible to demonstrate that nations that did adopt CHI did not demonstrate the same savings capacities for households. It should also be possible to explain why some U.S. states pursued commissions, investigations and in some cases, legislation, toward the introduction of CHI while others showed no interest in the arrangement.

Table 2 presents the median values for total income of the household, the husband’s income and the median size of household surpluses (total income minus total expenditures) for the U.S. and five European countries from the 1889-90 cost of living data. As opponents of CHI argued, American incomes were higher than incomes of European families, and as proponents of CHI argued, the higher incomes were not generating unusually high surpluses for American families compared to lower earning Europeans. Table 2 shows that for American households in 1889-90, the median value of this measure of the savings rate was 2.2 percent 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 associated with the expected spell of sickness shown in Table 1. It is important to recognize that American households were generating budget surpluses after incurring expenses related to sickness. American households had considerably higher expenditures reported in the survey category “sickness and death”. The median expenditure in this category for the U.S. was $12 where European households expended less than $5. If we consider these expenditures as those which would be covered under CHI, then Figure 2 shows that the median size of household surplus and expenditures on sickness and death suggests that American households represented almost 5 percent of the husband’s income in 1889-90. In contrast Germany that had adopted CHI in 1883 had a median savings rate of 0 percent, as did Belgium that implemented subsidies to extend voluntary coverage in 1894.67 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 U.S. This would suggest that the timing of when these nations adopted government health insurance arrangements could be a product of diminishing savings capacities of households in those economies after 1890.

Figure 3 presents median savings rates by 5 year age groups for the U.S., Great Britain and Germany for 1888-89. Where the median savings rate for the

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67 It is possible that premiums paid for health insurance in Germany since 1883 eliminated any surplus that households might have had in the absence of CHI.
In the United States 18 U.S. states took some action toward investigating the need for, and the possibility of introducing, CHI. I calculate median savings rate by age group for the subset of States that I could identify as having taken some action toward CHI between 1915 and 1920 but I found that there was no difference from the median savings rate age profile generated for all U.S. states. On the surface, this might undermine the explanatory power of my hypothesis for the failure of CHI in the United States between 1915 and 1920. On the other hand, since no state adopted CHI, the choice to investigate CHI may have been the result of other forces such as the lobbying and campaigning of the AALL that occurred without an accurate understanding of the economic circumstances of the wage-earners’ households’ that they were seeking to help. The lack of need for CHI, or at least the AALL’s proposed act, was uniform across U.S. states.

It turns out, however, that I can explain more of the campaign with our data. Jacobs (2002) describes the campaign for CHI in New York as the movement’s “beach head”. The push of legislation was strongest and the development towards the introduction of CHI was greater than in the other states.68 Thus, when the movement failed in New York, the movement failed in all states. The question arises whether savings rates are useful for understanding why New York was the “beachhead”? The CHI movement in New York was principally a New York City movement. It has been argued that much of the opposition from doctors came from up-state New York. Was it the case that there may have been a demand for CHI in New York City but the not for the state overall? Figure 4 shows savings rates by five-year age groups for New York City, New York State (including NYC) and for the U.S. overall using data from the 1917-1919 Cost of Living data. This figure presents a striking finding. At the time that the AALL CHI movement was in full force in New York, in New York City there was a lower savings rate observed for household heads aged 35 to 49 which is also the age at which the incidence and duration of illness began to rise. This was not the case for the rest of New York state or for the U.S. overall so this does go some of the way to explaining the AALL targeting of New York and why the movement got as far as it did. The AALL had identified a population that was potentially in need but their miscalculation appears to have been from assuming that the economic condition of wage-earners in New York City was representative of wage-earners in other industrial states and cities. It is interesting to note as well that the impaired savings capacity relative to the state and nation overall is specific to these age groups. This suggests that there is something about the cohort of New York City residents born 1870 to 1884 who would have entered the labor force between 1890 and 1904.

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 U.S. 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 social insurance in the U.S. must not have been strong and this is a logical explanation for the lack of political action towards the enactment of social insurance legislation:

“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 U.S. 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.
References


### TABLE 1: Comparison of Sickness Experience, the AALL CHI Contract and the IOOF Sickness Insurance Contract

<table>
<thead>
<tr>
<th>Age</th>
<th>Prob. being sick at least one week</th>
<th>Weeks of Insured Sickness Conditioned on sick at least one week</th>
<th>Expected Insured Sickness Duration (Weeks)</th>
<th>Earnings 1917-19</th>
<th>CHI Contributions ($)</th>
<th>Expected Income loss due to sickness as a share of income</th>
<th>IOOF Dues per year ($)</th>
<th>Expected IOOF Cash Benefits ($)</th>
<th>Expected Cash Benefits: Contributions CHI premium that matches IOOF cost of insurance</th>
</tr>
</thead>
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<tr>
<td>Over 20</td>
<td>0.15</td>
<td>5.72</td>
<td>0.88</td>
<td>600.00</td>
<td>0.017</td>
<td>24.00</td>
<td>9.60</td>
<td>6.81</td>
<td>6.00</td>
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<tr>
<td>Over 20</td>
<td>0.15</td>
<td>5.72</td>
<td>0.88</td>
<td>1200.00</td>
<td>0.017</td>
<td>48.00</td>
<td>19.20</td>
<td>13.63</td>
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<td>20-24</td>
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<td>24.00</td>
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<td>2.58</td>
<td>6.00</td>
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<td>25-29</td>
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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

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<tr>
<th></th>
<th>Number of Obs</th>
<th>Total Income (US $)</th>
<th>Husband's income (US $)</th>
<th>Husband’s Income/Total Income</th>
<th>Household Surplus (US $)</th>
<th>Sickness and Death Expenses (US $)</th>
<th>Surplus/ Total Income</th>
<th>Surplus/ Husband's Income</th>
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Figure 1: Median Savings Rates, 1889-90 and 1917-19 and Expected Income Loss due to Illness
Figure 2: Median (Surplus/Husband's Income) and Median (Surplus + Sickness and Death Expenditures/Husband's Income) by Country, 1889-90
Figure 3: Median of Household Surplus to Husband’s Income by 5 Year Age Groups, 1889-90

- US (n=4993)
- GB (n=935)
- Germany (n=136)
Figure 4: Median Savings Rates and Expected Income Loss Due to Sickness by Age Group, New York City, New York State and the United States, 1917-19
## Appendix 1: Dates of Enactment of Government Health Insurance Legislation

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