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V R Fuchs
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Prologue: America’s occasional flirtations with national health insurance have been a footnote to our history for most of the twentieth century. Once again, as health costs sour for people with insurance and access to care erodes for the disenfranchised, the United States is discussing health financing reforms.

One of our nation’s most astute observers of this long saga is Victor Fuchs, the Henry J. Kaiser, Jr. Professor at Stanford University. In this essay, Fuchs revisits the subject in the context of a paper he wrote fifteen years ago entitled, “From Bismarck to Woodcock: The ‘Irrational’ Pursuit of National Health Insurance.” When Fuchs begun to practice health economics in the mid-1960s it was little more than a gleam in the eye of the broader discipline of economics. In the ensuing years, it has taken U.S. health policy making by storm, leaving the allied disciplines of the social sciences, for better or worse, in the dust. One of the many interesting messages Fuchs has sought to deliver over the years should (but at this point clearly does not) resonate with health policy practitioners who look to health financing reform as a nirvana that will dramatically improve the health of the nation. In his influential 1974 book, Who Shall Live?, Fuchs wrote: “Today . . . differences in health levels between the United States and other developed countries or among populations in the United States are not primarily related to differences in the quantity or quality of medical care. Rather, they are attributable to genetic and environmental factors and to personal behavior. . . . Indeed [except for the very poor] higher income often seems to do as much harm us good to health, so that differences in diet, smoking, exercise, automobile driving and other manifestations of ‘life-style’ have emerged as the major determinants of health.”
Proposals for national health insurance are once again making the headlines, as they have periodically in the United States since World War I. Advocates of national health insurance have, as always, diverse goals: to expand access to health care for millions of uninsured Americans; to stem the rapid escalation in the cost of health care; and to improve the overall health status of the population and reduce socioeconomic differentials in life expectancy. Vigorous opposition to national health insurance is not a new phenomenon. Insurance companies, physicians, and others directly involved in the health field see national health insurance as a threat to their roles and interests; in addition, many Americans with no direct involvement in health issues oppose expansion of government on general principle. The huge federal budget deficit contributes to the difficulty of enacting a major new domestic program, in health or any other area. Thus, the debate among those for and against national health insurance does not appear to be headed for resolution any time soon.

Fifteen years ago, I discussed the popularity of national health insurance around the world and offered four reasons why the United States was the last major holdout: distrust of government; heterogeneity of the population; a robust voluntary sector; and less sense of noblesse oblige. In this essay, I consider whether these explanations are as relevant today as they were in the past. First, however, I discuss several issues that put the universal insurance controversy in clearer perspective. Why are so many Americans uninsured? How do conflicting views of health insurance shape attitudes toward national health insurance? What is the connection between national health insurance and the cost of care? Would national health insurance reduce socioeconomic differentials in health?

The Uninsured

With some exceptions, such as Medicare, health insurance in the United States is a private, voluntary matter. The demand for insurance, like the demand for any product or service, depends on consumers’ ability and willingness to pay for it. Some of the uninsured cannot afford health insurance; others are unwilling to acquire it. In all, the uninsured can be grouped into six categories.

The poor. The largest group of uninsured consists of individuals and families whose low income makes it infeasible for them to acquire insurance, either on their own or as a condition of employment. About 20 percent have no connection with the work force, but nearly 80 percent either are employed or are the dependents of employed persons. The Health Insurance Association of America (HIAA) estimates that 31
percent of the working uninsured earned less than $10,000 in 1989; another estimate puts the figure at 63 percent. In any case, it is clear that the great majority of uninsured workers cannot afford to give up a substantial fraction of their wages to obtain health insurance.

Most uninsured workers are employed in small firms, but the frequently heard explanation, “Small employers can’t afford health insurance,” is as misleading as the phrase “employer-provided health insurance.” Employers do not bear the cost of health insurance; workers do, in the form of lower wages or forgone nonhealth benefits. A more accurate description of the problem would be, “Many workers in small firms can’t afford health insurance.” Note that lawyers, accountants, computer consultants, and other highly paid professionals organized in small firms usually have health insurance, although they often face extra costs, as discussed below.

The sick and disabled. Many men and women who are not poor are still unable to afford health insurance because they have special health problems and therefore face very high premiums or are excluded from coverage entirely.

The “difficult.” Some individuals are neither poor nor sick but have difficulty obtaining insurance at average premiums. They may be self-employed, work in small firms, or be out of the labor force entirely. To insure such individuals, insurance companies incur abnormally high sales and administrative costs. They also encounter the problem of adverse selection: if an insurance company offers a policy to individuals or small groups at an average premium, those who expect to use a great deal of medical care are likely to buy, and those who do not will refrain from buying.

The low users. Some people do not expect to use much medical care. They may be in particularly good health; they may dislike going to physicians; or, like Christian Scientists, they may not believe in the efficacy of medical care. For them, health insurance is a “bad buy” unless they can acquire it at a below-average premium.

The gamblers. Most people buy health insurance in part because they are risk averse. They would rather pay a fixed, known premium (even above the actuarial level) than risk a huge expense in the event of serious illness. But not everyone is risk averse about health expenditures, or risk averse to the same degree. People in this category prefer to take their chances with continued good health and save the premium payment.

The free riders. The final category consists of individuals who remain uninsured because they believe that in the event of serious illness they will get care anyway, and others will pick up the bill. They save the cost of insurance and “ride free” on the coattails of those who pay into the health care system. There may be elements of free riding in the behavior of the low users and the gamblers as well; it is often difficult to distinguish
among the three categories of individuals who are able to pay for insurance but are unwilling to do so.

From an analytical perspective, it is not difficult to achieve a national health insurance system; all it requires is subsidizing those who are unable to afford insurance and requiring purchase by those who are unwilling to acquire it voluntarily. No nation achieves universal coverage without subsidization and compulsion. Thus far, Americans have resisted both.6

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Two Models Of Health Insurance

Part of the current debate over national health insurance is rooted in two conflicting visions of how the cost of health care should be shared. We can designate one as the casualty insurance model and the other as the social insurance model. Casualty insurance, which usually refers to automobile collision, residential fire, and similar risks, is premised on the idea that premiums should (to the extent feasible) be set according to expected loss. Other things being equal, policyholders with better driving records or with smoke detectors in their homes pay lower premiums; poorer risks pay higher premiums. Social insurance, which is the basis for national health insurance, provides for extensive cross-subsidization among different risk groups; it ignores expected loss in allocating costs.

Advocates of the casualty approach argue that, as applied to health insurance, it is more efficient and more equitable than the social insurance model. They assert that use of care depends, to some extent, on personal behavior and choice. If premiums vary with expected use, individuals have an incentive to choose healthier behavior and to make more cost-conscious decisions about their use of care for any given health condition.7 A clear example is charging cigarette smokers higher premiums than nonsmokers are charged. This may decrease the number of smokers, and even if it does not, advocates of the casualty model argue that it is fair for smokers to bear the extra cost of their unhealthy habit.

Even when there is no possibility of altering behavior, and even if use of care is unrelated to insurance coverage, the casualty model still offers an efficiency advantage in any system of voluntary health insurance. The alternative—a uniform premium for all individuals, including those with major health problems—will discourage purchase of insurance by those without such problems because the premium would be unreasonably high.

Advocates of the social insurance model rely heavily on arguments that appeal to one’s sense of justice or collective responsibility. In earlier times, these feelings of mutual responsibility were often evident within families and within religious communities. In modern times, many countries have extended the concept to encompass the entire nation. The philosophical
foundation for such arguments can be discerned in John Rawls’s discussion of making choices behind a veil of ignorance. For example, suppose, before you were born, you did not know if you were going to be rich or poor, sick or healthy; you might (assuming some risk aversion) prefer to be born into a society that would provide health care on the same basis for, say, persons born with a genetic disease as for those born without such a problem. Advocates of the social insurance model also point to efficiency arguments. Because everyone must participate, there can be savings in sales and administrative costs that offset other efficiencies achieved through the casualty approach.

Whether one model or the other is more conducive to an efficient health care system is primarily an empirical question (interwoven with value judgments) that cannot be answered a priori. Which approach is more just is primarily a value question (individual versus collective responsibility), but empirical information concerning the reasons for variation in use of care is relevant. In my experience, the same audiences that overwhelmingly approve charging smokers a higher premium because they use more care strongly oppose a premium surcharge for individuals whose high use is attributable to genetic factors. If cigarette smoking should turn out to have a significant genetic component, opinions concerning the smoker surcharge would presumably change. One consequence of the genetics revolution may be to shift public sentiment toward the social insurance model.

### National Health Insurance And Health Care Costs

Opponents of national health insurance frequently assert that it would result in a substantial increase in total health care costs. Both theoretical and empirical research support the view that the lower the price of care to the patient, the more care he or she will want. The logic of this argument suggests that those countries with universal coverage spend more on medical care than does the United States. In fact, the reverse is true. Adjusting for differences in real income, the United States spends much more per person on medical care than does any other country. For instance, the average American spends about 40 percent more than the average Canadian, even though the difference in real income per capita is less than 10 percent. And Canada spends more per capita than does any European country. How can this be? Countries with universal coverage find other methods to contain health care spending, methods that apparently are more effective than financial constraints on patients.

The most obvious source of savings under a national health insurance system is in reduced administrative costs. Approximately 6 percent of
U.S. health expenditures are in “program administration and net cost of private health insurance.” Several additional percentage points must be added to account for costs incurred by providers for billing and other administrative activities directly attributable to the U.S. system offinancing care. By contrast, the Canadian system of provincial health insurance imposes minimal administrative and billing costs on providers and payers; the insurance plans themselves are inexpensive to run because everyone must join, and premiums are collected through the tax system.

But savings in administrative costs are only part of the answer. Nearly all countries with national health insurance rely heavily on what I call “upstream resource allocation.” The key to this is control over capital investment in facilities and equipment, specialty mix of physicians, and the development and diffusion of high-cost new technologies. Such control usually results in less excess capacity, in both physical and human capital. In Canada, for example, relatively scarce high-tech equipment, such as magnetic resonance imaging (MRI) or computerized axial tomography (CT) scanners, is used intensively, while the proliferation of such equipment in the United States results in considerable idle time. There are more physicians per capita in Canada than in the United States, but fewer physicians there specialize in complex surgical and diagnostic procedures. As a result, the average Canadian specialist has a full workload, while his or her American counterpart does not.

The price that Canadians and Europeans pay for such controls is delay or inconvenience in receiving high-tech services, or sometimes not receiving such services at all. Whether such delays or denials have a significant effect on the health of the population is not known with certainty; the limited evidence now available suggests that they do not.

Countries with national health insurance also contain costs by using their centralized buying power to squeeze down the prices of resources, especially drugs and physician services. Drug prices in the United States usually contain significant monopoly rents as evidenced by the willingness of the drug manufacturers to sell the identical products overseas at much lower prices.

Canadian and European physicians do not enjoy net incomes that are as high as those of American physicians, even after adjustment for international differences in the general level of wages. But this does not mean that American physicians are more satisfied with their lot or that American medical schools find it easier to attract high-quality, well-motivated applicants. Compared with physicians in most countries with national health insurance, American physicians experience more bureaucratic supervision from public and private insurance plans and greater interference with the day-to-day practice of medicine.
It is important not to overestimate the amount that can be saved by reducing physicians’ incomes. U.S. physicians’ net incomes account for about 10 percent of all health care spending. If these incomes were reduced by 20 percent (the approximate differential between the United States and Canada after adjusting for specialty mix, the exchange rate, and the general level of wages), the saving would be only 2 percent of health care spending. Also, this is not a saving of real resources, but only a money transfer from physicians to patients and taxpayers.

Cost containment under a national health insurance system often relies on single-source funding set prospectively (for example, the global budget given to each Canadian hospital at the beginning of each year). Samuel Johnson once said, “When a man knows he is to be hanged in a fortnight, it concentrates his mind wonderfully.” Much the same seems to be true of health care. When physicians and hospital administrators know that there is a certain pool of resources at their disposal and that no more will be forthcoming, they seem to figure out ways to do the job with what they have. To be sure, this inevitably involves limitation of some services, but most health professionals prefer having some control over the allocation of the scarce resources available to them.

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**National Health Insurance And Health**

Does national health insurance improve the health of the population by increasing access to care, or does it worsen health by constraining the introduction of new technology and destroying incentives for physicians and hospitals? There is no conclusive answer to this question; in my judgment, such a system has little effect on health one way or the other. The evidence regarding life expectancy differentials, however, is more compelling. Universal coverage does not eliminate or even substantially reduce differentials across socioeconomic groups. In England, for instance, infant mortality in the lowest socioeconomic class is double the rate of the highest class, just as it was prior to the introduction of national health insurance. The relatively homogeneous populations of Scandinavia not only enjoy universal coverage for health care but also have many other egalitarian social programs. Nevertheless, life expectancy varies considerably across occupations; the age-standardized mortality ratio for male hotel, restaurant, and food service workers is double that for teachers and technical workers. A study of age-standardized death rates in Sweden among employed men ages forty-five to sixty-four found substantial differentials across occupations in 1966–1970 and slightly greater differentials in 1976–1980.

The failure of national health insurance to eliminate or reduce mor-
tality differentials is not necessarily a decisive argument against its adoption. Bruce Vladeck argues that curing disease and improving functional outcomes are not the only benefits of medical care. He writes, “We expect the health system to take care of sick people whether or not they are going to get better, as much for our benefit as theirs.” The caring services provided by health professionals have value even when they do not change health outcomes.

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### Prospects For National Health Insurance In The United States

What changes have occurred since 1976 that might modify Americans’ resistance to national health insurance? Here I evaluate the four factors that I advanced in 1976 to explain the absence of national health insurance in the United States in light of recent sociopolitical trends.

**Distrust of government.** The typical American’s distrust of government is probably stronger now than it was in the mid-1970s. Jimmy Carter was elected as an “outsider,” and he did little to enhance the image of the presidency or of government in general during his four-year term; Ronald Reagan maintained an antigovernment posture throughout his two terms; and George Bush, while he may be more pragmatic and less ideological, still commands wide support with the message, “Government is the problem, not the solution.”

The recent debacle with the savings and loan industry also provides ample cause for concern. It did not come upon us suddenly; it was a well-diagnosed, localized cancer that government allowed to metastasize to its present level. What is particularly disturbing is that the blame cannot be laid on one political party or branch of government. Moreover, not just the federal government was derelict; state regulatory agencies and legislatures also failed to meet their responsibilities to the public.

Our government is built on checks and balances. If these checks and balances failed so badly with savings and loan institutions, many observers wonder how well they would do with health care, which is so much larger, more complex, and more vulnerable to mismanagement and dishonesty.

**Heterogeneity of the population.** In 1976, I argued that the heterogeneity of the U.S. population helped explain a reluctance to embrace national health insurance. Unlike the Swedes, Germans, Japanese, and many other peoples, most Americans do not share centuries of common language, culture, and traditions; thus, there is less sense of national identification and empathy. In 1991, this explanation probably has even more force. The celebration of “multiculturalism” in the United States in the past fifteen years appears to have led to a heightened sense of separateness among the country’s many ethnic, religious, and racial
groups. Glorification of the “pluribus” at the expense of the “unum” does not enhance the prospects for national health insurance.

Heterogeneity of values also fuels resistance to national health insurance. No nation should expect or desire uniformity of opinion, but the name calling and physical violence that often accompany debates in the United States over values undermine the ability of the nation to undertake collective efforts for collective well-being. Americans might consider the words of British historian R.H. Tawney: “The condition of effective action in a complex civilization is cooperation. And the condition of cooperation is agreement, both as to the ends to which efforts should be applied and the criteria by which its success is to be judged.”

A robust voluntary sector. The United States has always been distinguished by its highly developed private, nonprofit institutions devoted to health, education, and social services. These institutions, often founded and supported by religious groups, perform many of the functions that government undertakes in other countries. During the past fifteen years, however, the ability of nonprofit hospitals and the Blue Cross/Blue Shield organizations to provide a form of social insurance through free care, cost shifting, and community rating of insurance premiums has been seriously compromised. The “competition revolution” has imposed the casualty approach to health insurance as a condition for survival. The growth of managed care entities and tough bargaining by all third-party payers have sharply diminished the capacity of nonprofit institutions to act as redistributive agents. The declining importance of philanthropy relative to private and public health insurance also decreases the ability of nonprofit institutions to act as quasi-governmental agencies. In health care, the “thousand points of light” are fainter now than in the past. I conclude that the “voluntary sector” explanation for the absence of national health insurance in the United States has less force now than it had in the 1970s.

Less noblesse oblige. The two central ideological forces of American society have been a commitment to individual freedom and, at least in the abstract, to equality. Tension has always existed between these forces, with the emphasis on individual opportunity and achievement prevailing most of the time, but the egalitarian emphasis much in evidence in the 1930s and 1960s. Even the egalitarian ideology, however, has focused more on equality of social status, equality under the law, and equality of opportunity than on equality of outcomes. Because so many Americans of humble origins could and did gain wealth and high social position, the sense of noblesse oblige that motivates many of the well-born in other nations to vote for social programs to aid the less fortunate has never been as evident in the United States. While I find it difficult to judge accurately, I suspect that the absence of noblesse oblige may be slightly more
relevant today than in 1976. In the 1980s, the rhetoric of most of the American right wing was “laissez-faire,” not “Tory conservative.” Moreover, the left wing’s infatuation with the vocabulary of “rights” (divorced from obligations) often diminishes a feeling of mutual responsibility.

In summary, the distrust of government, the population heterogeneity, and the lack of noblesse oblige explanations are probably more relevant today than in 1976. Only one explanation—the robustness of the voluntary sector—is definitely weaker now. It is ironic that the “competition revolution,” which erodes the ability of not-for-profit health care institutions to provide a modicum of social insurance, may prove to be a significant factor leading the country toward national health insurance.

Nevertheless, in my view, the prospects for national health insurance in the short run are poor. The forces actively opposed to it are strong, are well organized, and have a clear sense of what they do not want. The forces actively in favor are relatively weak, disorganized, and frequently at odds regarding the reasons for wanting national health insurance or the best way to obtain it. The great majority of Americans are not actively involved in the debate one way or the other but tend to be opposed for the reasons I have indicated. Some public opinion polls seem to indicate a readiness for national health insurance, but they are not credible indicators of political behavior.

In the long run, national health insurance is far from dead; the need to curb cost while extending coverage will continue to push the country in that direction. The process will accelerate as nonprofit health care institutions lose their ability to provide some social insurance as an alternative to national health insurance. Moreover, the current trend of basing insurance premiums on expected utilization will strike more people as unjust because most disease will be found to have a significant genetic component. Also, as employers’ hiring decisions and employees’ job choices become increasingly constrained by health insurance considerations, there will be more appreciation of the efficiency advantages of making health insurance independent of the labor market.

The timing of adoption of national health insurance will depend largely on factors external to health care. Major changes in health policy, like major policy changes in any area, are political acts, undertaken for political purposes. That was true when Bismarck introduced national health insurance to the new German state over a hundred years ago. It was true when England adopted national health insurance after World War II, and it will be true in the United States as well. National health insurance will probably come to the United States in the wake of a major change in the political climate, the kind of change that often accompanies a war, a depression, or large-scale civil unrest. Short of that, we should
expect modest attempts to increase coverage and contain costs, accompanied by an immodest amount of “sound and fury.”

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NOTES

1. National health insurance can take many forms. Emphasis here is on a national system that provides universal coverage with equitable financing and strong cost control.
6. The United States has some compulsion and some subsidization in large companies. In the typical case, all workers participate, and the firm rarely adjusts the individual worker’s wages or premiums to take full account of differences in expected utilization.
7. The RAND Health Insurance Experiment clearly showed that utilization is greater when patients do not bear some of the cost of care. See W.G. Manning et al., “Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment,” The American Economic Review (June 1987): 251–277.
10. Ibid.
12. The effect of national health insurance on health depends on the product of two elasticities: (1) the responsiveness of the quantity of medical care to national health insurance, and (2) the responsiveness of health to changes in the quantity of medical care. In developed countries, the product of these terms is apparently very small.