

John E. Murray, The Origins of American Health Insurance: A History of Industrial Sickness Funds

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Citation

S Inrig. *John E. Murray, The Origins of American Health Insurance: A History of Industrial Sickness Funds*. The Internet Journal of Law, Healthcare and Ethics. 2010 Volume 7 Number 1.

Abstract

John E. Murray, *The Origins of American Health Insurance: A History of Industrial Sickness Funds*. New Haven: Yale University Press, 2007. 313 pp, xiv, cloth. Appendices, notes, bibliography, index.

American history and American politics are replete with discussions of American exceptionalism. Put simply, American exceptionalism is the idea that the US is special, set apart, and somehow different (read: better) than other countries. Part of this discussion includes ways that the US is different than other countries, including its championing of market economics, its belief in an almost divine destiny, and its religiosity. The US stands alone among Western nations too for its resistance to any substantive form of national health insurance. For many on the right, this is a source of pride – America provides the best health care in the world and the government doesn't ration health care. For many on the left, this is a source of shame – why is the US alone among industrialized nations in its decision not to ensure health insurance coverage for all its citizens?

A host of historians have taken up the unique American approach to health insurance, and almost all of them have tried to explain why Americans failed to secure national health insurance early in the 20th century. Into this field comes a relatively recent book by economist John E. Murray, entitled *Origins of American Health Insurance: A History of Industrial Sickness Funds*. Rather than revisiting the old arguments, Murray points to the fact that when reformers brought model legislation up for a popular vote, like in California in 1917, the Progressive health insurance measures lost by a rate of 2 to 1. Rather than assuming Americans should have national health insurance and then explore reasons why reformers have failed, Murray asks what it might have been about the American health insurance market that convinced doctors, workers, and

business owners that national health insurance was not in their best interest. For several reasons, Murray's book is an important contribution to the field.

To begin with, Murray takes readers through the shape of sickness funds in both the US and Europe, from whence the Progressive's model for national health insurance would come. Then Murray explores how sickness funds worked, why he believes they met the needs of workers sufficiently enough to overcome the call for national health insurance, and how ultimately sickness funds lost out to the more actuarially sufficient health insurance plans that emerged in the late 1920s and 1930s.

As I have mentioned, Murray's book is an important contribution because it helps explain why popular support often tipped against compulsory health insurance. Many of the studies about the Progressive era focus on the stakeholders mobilized for compulsory health insurance (like the AALL), against it (like business interest, the insurance industry, and many physicians). It is easy for historians, including this author, to present a caricature of the antagonists in one's story rather than treating taking them seriously. One strength of Murray's treatment is that he finds that "the opponents of state insurance at least sometimes had more logical and well-informed arguments than they have been given credit for" (p. 20). Murray also draws attention to reasons that normal Americans might not feel compulsory insurance was in their interest. The reality was, and still is, that health insurance is expensive. There are therefore some members of society who feel that - owing to their health status - health insurance is not something they need or that minimalist policies have more utility than comprehensive policies. To the extent that support for sickness funds played a role in the defeat of the Progressive's health care efforts, I think Murray is correct: "[sickness funds] strengths appealed

to sufficiently many workers to weaken Progressive health insurance efforts” (p. 10). Moreover, I think his argument that many workers did not consider the costs of the expensive Progressive medical insurance plans to be worth the benefits is a sound one (p. 122). These strengths will provide historians with a more balanced analysis of the history of medicine in America.

Murray’s work also serves to provide insight into the larger history of health insurance in America. Many of the historians who have explored the failure of the Progressives have laid the blame of the failure at the feet of powerful interest groups, larger cultural animosities towards the Germans, or the Progressives’ own miscalculations. Murray does historians an invaluable service because he takes the insurance products available to workers seriously. He evaluates how well the sickness funds met the populations’ needs, and he also reveals how actuarial technology evolved to improve the products and services insurance companies could offer prospective clients. It is easy to forget, when recounting or debating the history of health insurance, that health insurance is a historical product: it is both a mathematical application and a social construction. Murray takes the dynamic nature of the insurance market seriously: sickness fund operators and insurance providers were able to market products that met voting workers’ needs sufficiently enough to, when added to the other forces at work at this time, bend public opinion or the calculus of politicians against compulsory insurance.

It is in this last point, however, that my frustrations about Murray’s book lie. While Murray does elucidate the scope and role of sickness funds for historians, he does so in a way that largely ignores the historical context of the health insurance debates. Murray concludes that Progressives failed because their health insurance package did not maximize workers’ utility. He does acknowledge that businesses, labor, physicians, pharmacists, and the insurance industry also aligned against it, but he puts great weight on what he considers to be worker satisfaction with sickness funds. But this assumes too much. Murray seems to conclude that the 2 to 1 vote against health insurance in California was purely the product of rational cost benefit analysis by workers, but he completely ignores the nationalistic, anti-German factors that other commentators have highlighted. Indeed, the entire issue of the war against Germany and its impact on American culture escapes Murray’s analysis. It is undoubtedly difficult to quantify such things, but at a time when Americans were boycotting German food, American

schools were cancelling German language classes, and American towns were changing their names from Germantown to Neshoba, surely it is naïve to overlook the role of Patriotism in the failure of a German model of health insurance in the US. Add to this the high cost of the insurance model at a time of national austerity, and one can imagine the issue is more complex than merely the sufficient utility of sickness funds. Unfortunately this is only one example of many. Murray’s analysis of the rise and fall of sickness funds in the New Deal era, for example, pays little attention to debates over including unemployment insurance or health insurance in the New Deal legislation. Murray’s book should by no means be disregarded. But what historians await is a book that places Murray’s sophisticated analysis of insurance market history into the larger context of health policy and social history in the first decades of the 20th Century.

Murray’s book brings other frustrations: His statistical tables are not very clear, many of his arguments rely on extrapolations that are by no means obvious, and he draws on data from 1890 to make claims about insurance practices in the 1910s. Additionally, Murray’s numbers don’t always contest the Progressive’s claims, despite Murray’s assertions otherwise. Take his findings that poor single people didn’t buy health insurance, but wealthier married men with families did (p. 168). One can certainly argue that health insurance had greater utility for the latter group, which is why they bought it whereas healthy, poorer, single men did not. But this is not the only way to read these data. One could also obviously argue that health insurance was cost prohibitive for poorer people – whether in absolute terms or relative to their other needs. Indeed, many may have found themselves priced out of the market such that, even had they wanted to buy insurance, they could not have done so. This, of course, also falls under the “utility” rubric of insurance market, but it puts a different spin on things. Or take his example that older men saved instead of having health insurance. Murray uses these data to argue that American workers were capable of saving, which the Progressives did not give them credit for. But the reason older men saved is not because they didn’t want insurance, but rather because they could not get insurance. They, too, were barred from the market. From an actuarial stance, this made sense (pp. 99, 167-168). From the position of the workers, however, this was an example of market failure. There was no health insurance product for them. And Murray’s contention that some workers could have saved because somewhere between 19 and 35% of workers did (p. 154), rings a little

hollow when one considers that those numbers suggest at least two-thirds of workers lacked health-related savings at all. Murray often argues based on the 30 percent of folks who adopted specific behaviors (whether health insurance or health savings), but this was precisely the Progressive's point (though they thought the numbers were lower): 30 percent with insurance or with savings still leaves 70 percent without, and Progressives aimed their policies to address the needs of the 70 percent. Over time, of course, more people bought insurance. Yet obstacles to insurance remained for poorer people and older people, and these attributes of the health insurance market would continue well into the 1950s. Indeed, they would serve as the foundation upon which the US government eventually built the 1960 Kerr-Mills health benefits program for impoverished seniors and then, in 1965, Medicare and Medicaid. As health economist Uwe Reinhardt has shown, supply and demand rely both on willingness to pay the price and the ability to do so. As conservative

economists June and Dave O'Neill have written, there really is a category of people one could label the "involuntarily uninsured" (O'Neill and O'Neill, 2009). The Progressives were aiming their policies to address the needs of these people, whom even Murray's statistics suggest must have been a sizeable portion of the population.

What then to do with Murray's book. As I have contended, it is a valuable book to have to broaden the discussion in a seminar class about the history of health insurance or the history of medicine in America. Not only does it provide a valuable counterweight to some of the more partisan works on the history of American health insurance. As with other studies, Murray's book provides a skewed perspective and therefore I would encourage those professors who use the book to integrate its use with other works that address the larger context of these issues.

References

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