

CHAPTER 24

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THE POLITICAL ECONOMY
OF HEALTH CARE IN
THE NINETEENTH AND
TWENTIETH CENTURIES

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HISTORIANS who launch their narratives with great men, pivotal dates, and legislative milestones are almost certainly guilty of crude reductionism. Yet it is hard to resist beginning with Germany's Chancellor Otto von Bismarck (1815–98) and the passage in 1883 of his *Gesetz betreffend die Krankenversicherung der Arbeiter* (*Law Concerning the Health Insurance of the Worker*), which is widely held to be the foundation of health provision under the modern welfare state.¹ Bismarck's purpose was to institute a compulsory system for insuring waged labourers against sickness by providing income replacement and medical care funded with shared contributions from employers and employees. This was by no means the earliest example of organized sickness insurance, which was already deeply rooted in European civil society, and nor was it the first time the state had mandated income transfers on behalf of the sick: in Britain this may be traced to the Tudor Poor Laws. The novelty of Bismarck's strategy lay rather in the use of compulsion to broaden the risk pool beyond selective groups and to undergird the financing of collective sickness cover. In so doing, this German statute signalled an unprecedented incursion by the state into the arena of curative medicine and raised public interest questions about the behaviour of private actors who sold medical services, whether in primary care, hospitals, or pharmaceuticals.

Germany's experiment exerted considerable influence in the industrialized nations over subsequent decades, though with much local variation. For example, Denmark (1885) and Belgium (1894) responded by bolstering voluntary insurance with privileges and public subsidies, while Norway and Britain (both in 1911) introduced compulsion and employer contributions broadly on the Bismarckian model; France followed in 1930. War and political turbulence in the 1930s and 1940s did not sweep

social insurance aside and from the mid-twentieth century these systems were the foundation on which universal population coverage was built. ~~New Zealand (1941) was first to achieve this in the capitalist world, though like Britain (1948) it chose to do so on the basis of general taxation.~~ Others advanced towards universalism using the insurance principle, whether through private, employer-based, voluntary, or public funds. The exception was the United States, still famously ‘alone amongst the developed nations’ at the millennium in lacking universal coverage.² Here public programmes were debated several times after 1916, but rejected in favour of private or non-profit insurance and the more limited Medicaid and Medicare schemes in the 1960s.

In the nineteenth and twentieth centuries, then, health care increasingly became an aspect of the economic and social policy of nation-states and the purpose here is to survey this political economy of medicine. The main aim is to account for the coming of health systems within welfare states, but also to examine how these systems responded to demographic, financial, and technological changes in the contemporary period. Constraints of space dictate a focus on major industrial economies of the capitalist world, to the exclusion of communist states and of low- and middle-income countries. Socialist systems are historically important because they treated health as a common right of citizenship to be met through central planning, while transitional and poorer nations illuminate the enduring legacy of imperialism: both are explored elsewhere in this volume. Further exclusions arise from my methodology, a comparative analysis of national cases selected to exemplify different models of health system. Typologies are legion (‘entrepreneurial, welfare-oriented, comprehensive’, ‘private, pluralistic, national health insurance, national health service’, and so on), although the relative importance of private and public forms of financing and provision has typically underpinned classification.³ Here I discuss the United States because it has prioritized private and voluntary arrangements, Britain and Sweden because they demonstrate universal and comprehensive coverage largely with the state delivering services, and France, Germany, and Japan because they illustrate the social insurance principle, alongside a regulated private sector.

Through most of history, medical encounters in the West were individualized market transactions or occurred in institutions organized by religion and charity. The question of why the state entered, and then came to dominate, this arena in the recent past is therefore of over-arching importance, and the first section summarizes ~~the main~~ theoretical approaches advanced to explain this process. The second section outlines the nineteenth-century foundations of social insurance and public provision of medical facilities on which state engagement was built. The following sections trace the growth and development of health systems in the case-study countries, dividing events into three broad periods: the early twentieth century, in which they were largely put in place; the post-war ‘golden-age’ of the welfare state; and attempts since the 1970s to reform health systems in response to burgeoning costs and ideological critique. The conclusion reflects on how the different models adopted have impacted on population health.

From a methodological perspective it is important to recognize that health care has been a subject of fierce, sometimes vituperative, debate in recent democratic politics, and the Anglophone comparative literature is inevitably influenced by this. In particular, the ‘lessons’ that Europe might supply to their own country marks the work of American scholars. Nor is the terminology transparent or value free, since tropes such as ‘health security’ and ‘socialized medicine’ carry current political resonance. Even the common term ‘health system’, which helpfully denotes national arrangements for the financing, provision, and regulation of health care, is not neutral, dating to the interwar period when its usage signified the desirability of service integration and collective financing instead of an unfettered marketplace.

THEORIZING HEALTH SYSTEM HISTORIES

Theoretical analysis of the emergence of health systems is intertwined with the larger problem of explaining the welfare states of which they are a part. Evidently these were products of economic modernization, for industrialization generated the surplus wealth to fund insurance or tax-based services while also removing existing supports of kinship, church, guilds, and paternalism.⁴ But what was the process by which new forms of social protection emerged? One approach treats them as an essentially pragmatic reaction to the dislocations caused by economic liberalism. Thus, for example, Polanyi looked to anthropology to demonstrate the embeddedness of reciprocity and redistribution in human behaviour, and treated social legislation as ‘protective counter-moves’ against the inherently ‘self-destructive mechanism’ of free markets and the risks posed to life and labour in the industrial cities.⁵ Readings such as this minimize the importance of agency: welfarism was driven neither by class politics nor ideology; instead it ‘simply responded to the needs of an industrial civilization with which market methods were unable to cope.’⁶

Modernization theorists with a Marxist perspective place greater emphasis on the interests of ruling classes in effecting change. First, welfare states subsidized capital in reproducing labour power, with health and education fostering human capital, and they sustained economic efficiency, with pensions and social security regulating the labour market and maintaining demand.⁷ Second, they mediated the class tensions to which industrialization gave rise. Welfare legislation was ‘property’s ransom for security’ and the redistributive elements of health systems a concession made to legitimize the social order and stave off revolutionary change.⁸ A prime piece of evidence is the ‘Imperial Message’ introducing Bismarck’s legislation, which stressed the ameliorative value of health insurance in the wake of laws prohibiting political activities of labour organizations: ‘the healing of social wrongs must be sought not solely through the repression of social democratic excesses but by positively advancing the well-being of the workers.’⁹ However, neither ‘productivist’ nor ‘legitimation’ theories seem wholly adequate, given the scale of redistribution and the advance of equity that were

achieved. Surely efficiency and social conciliation could have been purchased more cheaply?

Perhaps then explanation should concentrate on political structures and the march of democracy in the West? The British case illustrates best the contention articulated by T. H. Marshall that the extension of political citizenship brought with it the 'social citizenship' of welfare entitlement.¹⁰ First came the 1867 Reform Act, which enfranchised working-class males, followed by the declaration by Tory premier Disraeli that 'the first consideration of a Minister should be the health of the people'.¹¹ Public Health Acts in the 1870s extended the duties and capacities of municipal government in such areas as isolation hospital provision and environmental improvement. The principle of health as a public good, funded by taxation, became entrenched, and henceforth occupied the party programmes that wooed voters. Moreover, once certain social groups gained health benefits, democratic politics empowered others to achieve extensions of entitlement. Unfortunately though, there is no straightforward causal link between democratization and expanding health coverage. Imperial Germany cannot be deemed a vigorous participatory democracy in which notions of entitlement and rights were paramount. Conversely in the United States, where democracy had arrived early (at least among white American males), voters rejected national health insurance; indeed, the only referendum held on the issue, in 1917 in California, was decisive: 133,000 for, 358,000 against.

Perhaps then a more satisfactory explanation of the differing forms and chronologies of national health systems lies with the political orientation of the protagonists who created or denied them. At the most general level explanation alludes to ingrained cultural values. For example, the Swedish emphasis on equality is traced right back to the Middle Ages, arising from the absence of serfdom and discernible in the Viking parliaments.¹² Conversely, America's comparatively late and limited recourse to mandated health coverage is attributed to its attachment to liberty, that 'dominant individualism', born of colonial rebellion and the frontier.¹³ Such nebulous appeals to national values are, however, hard to demonstrate empirically; for example, US opinion survey data from both the 1940s and 1990s revealed majorities in favour of more extensive state intervention than actually occurred.¹⁴

A more promising approach may therefore be to emphasize the social bases of welfare reform politics. The pre-eminent example of this treats social insurance as the achievement of the organized left, with the degree of egalitarianism determined by the strength of the labour movement allied with socialist parties. Scandinavia provides the *locus classicus*, with the universal coverage and equitable access of the Swedish health system attributed to the long period of Social Democrat parliamentary dominance in the mid- and late twentieth century. The creation of the British National Health Service (NHS) during a rare interregnum in which Labour held a sweeping parliamentary majority is another example. Again though, the 'labour mobilization' thesis fails to provide a comprehensive explanation. The extension of post-war coverage in countries like France and Germany, from limited social insurance in the late 1940s to almost universal inclusion by the 1960s, was not the outcome of a leftwards shift, but rather of the changing interests of other groups.¹⁵

A compelling version of the socio-political account therefore concentrates on understanding these solidaristic moments, in which working- and middle-class interests aligned sufficiently to enable the enactment of welfare legislation. The notion of solidarism is not understood in ethical terms, as middle-class humanitarianism, but rather as the outcome of self-interest, for all may stand to gain from universalist or egalitarian health systems. Thus, in Baldwin's words, a social constituency's attitude to welfare is determined not by its 'relations to the means of production', but rather its 'relations to the means of security'.¹⁶ For example, in this light, Swedish progress towards universal coverage is better explained by the 'red-green alliance' of a powerful left and an agrarian party that wanted health insurance extended to the farming sector.

Complementing this argument is the position of the institutionalists, such as Immergut, who argue that solidaristic alliances alone are not sufficient to explain change or stasis. For them the over-arching determinant is the political framework in which health care legislation is debated and the scope which institutional structures provide for opponents to frustrate reform. A strong executive committed to change and reliant on unified party support may override hostile interest groups like private insurers, professional associations and pharmaceutical companies: the treatment of the British Medical Association (BMA) by Lloyd George in 1911 and Bevan in 1946–8 are cases in point. However, executive will and broad social support for change can be frustrated if the political system contains sufficient 'veto points' at which interest groups may block legislation. The United States, with its loose party discipline, tolerance of pressure group financial activities, and its legislative process of passage through House, Senate, and congressional committees, provides many such veto points, where arguably successive health bills have foundered.

One interest group above all dominates histories of the political economy of medicine. In entering the field of health, the state challenged the independence of the medical profession. Whether through its role in purchasing or providing health services, the welfare state threatened doctors' cherished rights to diagnose and prescribe as they considered best. More prosaically its monopoly power might also drive down the price they charged. During the nineteenth and early twentieth centuries, the consolidation of professional associations promoted the interests of trained practitioners by differentiating them from the many irregulars jostling in the medical marketplace. Thus not only did doctors have local and national organizations through which to combat proposals they disliked, but they also had the expertise vital to the functioning of health systems. This gave them greater leverage than other producer groups within welfare states, in the pressure politics that determined the form health systems took.

The discussion that follows will not attempt to distil a unitary theory from this contested terrain of welfare state historiography. However, it will allude to cases when productivism and legitimation seem to have motivated the hierarchical imposition of reform. It will also highlight the different institutional structures in which social constituencies were mobilized and interest groups operated. First, though, how were health services delivered prior to the entry of the state?

BEFORE THE WELFARE STATE

The precursors to national health insurance were the contributory sickness funds that flourished in the nineteenth century, and whose own institutional antecedents were the early modern craft guilds. These were corporate bodies whose main purpose was the economic regulation of a skilled trade, but which also had welfare roles. The emergence of journeymen's associations concerned specifically with burial and health insurance, and funded by fixed dues, was apparent by the mid-eighteenth century. A transition from craft guilds to 'friendly societies' based on networks other than occupation seems to have occurred first in Britain, where membership expanded particularly (though not exclusively) in the heartlands of the Industrial Revolution. Alehouse sociability for male workers coloured their world and enshrined an ethic of patriarchal stewardship through collective endeavour. 'Open' societies emerged in other countries, such as post-revolutionary France, where *mutualités* were associated with locality and church, and Sweden, where they flourished in large towns. Income replacement was the key benefit, with the formal involvement of medical practitioners only gathering pace during the nineteenth century, first as 'gatekeepers' of the fund, authorizing claims and vetting neophytes to avert adverse selection, and only later providing medical treatment to speed recovery.

States had shown an interest in these mutual associations long before 1883, in part because they promised to reduce the tax burden of the local poor law. In Prussia, communities were empowered to enforce membership (1845, 1848) in either occupational or locally run funds, and from 1854 this became mandatory in mining and foundries. Policy might also be aimed at strengthening the security of the funds, as with the British strategy of encouraging investment in government stock at preferential rates. Another concern was to detach the welfare role of workers' sickness funds from the industrial activities of organized labour. For example, German legislation in 1876 limited them to benefit functions, though also establishing the enduring principles of employer contributions and self-government. In France, Bonapartist policy (1852) gave preferential treatment to mutuals managed and financially supported by local elites, thus lending the movement a 'rigidly conservative' character.¹⁷ After 1883 some liberal states continued this approach of bolstering voluntary insurance as a deliberate alternative to the Bismarckian model. Thus France's Mutual Charter (1898) permitted diversification and mergers, as well as boosting state subsidies, a strategy also adopted in Sweden (1891) in preference to compelling employer contributions.

For all their pioneering work, mutualist associations did not succeed in extending insurance throughout the population. Leaving aside the issue of achieving actuarial viability during a period of falling mortality and rising morbidity, the key challenge was the stability and level of income required to fund subscription over the life course. While they were certainly not the sole preserve of the skilled working class there were clear limits to coverage: Britain (12.5% of the population in 1872) was slightly ahead of

Germany (9.5%);¹⁸ Sweden's membership was predominantly urban, and only took off following the start of subsidies; while French mutualism similarly relied on subsidies and honorary contributions. In America, coverage was extensive among the industrial workforce, though excluded medical attendance. And although the mutualist savings model was not solely Western, Japan seems to have had no similar precedent; here domiciliary medical care was privately remunerated, with doctors paid twice yearly, nominally for the drugs they prescribed.

Communal arrangements for providing hospitals for the poor also have a distant history, in medieval charitable foundations endowed by urban elites. The entry of the modern state may be dated to the seventeenth century, with the building of the French *hôpitaux généraux* and the British urban workhouses. Initially intended to discipline mendicants, in practice the 'great confinement' soon became limited to orphans and the nursing care of the chronic sick, with limited medical attendance. Mental health was another area where market and philanthropy proved insufficient and in Britain, for example, the early nineteenth century saw the start of an asylum-building programme based on local taxation. Alongside these institutions were charity hospitals, for the poor, in which acute medicine was practised and teaching delivered. Poor law approaches were also adopted in the United States, where public 'almshouses' accommodating the elderly, the mentally ill, and vagrants gradually became differentiated by specialism.

Distinctive trajectories emerged in the nineteenth century. Philanthropy proved insufficient to sustain the expansion of American voluntary hospitals, and patient payments became accepted practice; the proliferation of smaller proprietary hospitals further embedded the acceptance of user fees. Different again was Scandinavia, where the insufficiency of aristocratic philanthropy put the onus onto the 'welfare municipality'.¹⁹ In Sweden, the creation of county councils with powers of tax raising and hospital administration (1862) accelerated new foundations staffed by salaried physicians; here poverty and low population density impeded the growth of private medicine and most practitioners relied at least in part on a public appointment. The state also loomed large in Japan, though here as a result of the Meiji policy decision to replace indigenous healing with European biomedicine; there had been no prior tradition of charitable provision and beyond the medical schools public institutions were limited to a few military and municipal poor hospitals.

Crudely then, while Scandinavia's unitary tax-funded hospitals laid the foundations of a 'social democratic' model, ~~elsewhere a 'liberal democratic' model obtained, in which public institutions catered mainly to the dependent poor and voluntary or proprietary hospitals to the 'respectable' population.~~²⁰ Stigma and under-resourcing attached to the former, status and scientific repute to the latter, though by 1900 both types of institution still intended their services for poorer people. This though was starting to change, as rising faith in biomedicine, post-Pasteur, coupled with technological transformation made hospital admission attractive to the middle class. Shifting patterns of demand and the escalating costs of medical care posed new questions of access and funding for governments.

HEALTH SYSTEMS IN WELFARE STATES

1883–1945: Social insurance versus private interests

As noted above, the case of Germany is fundamental to understanding the coming of health systems in welfare states. First it is important to correct two misconceptions about 1883. Though associated with Bismarck, credit for the legislation belongs to Theodor Lohmann (1831–1905), a Christian social reformer and civil servant. Lohmann's interest lay in integrating the worker into society through institutions that furthered moral development, in contrast to Bismarck's more autocratic notion of binding the subject to the state: hence the reform built on existing mutual aid associations, rather than a single bureaucratic fund preferred by Bismarck. More crucially, new research has revealed that Bismarck's prime motivation was not to pacify the left. Instead his 'carrot and stick' rhetoric was primarily designed to satisfy the Kaiser and sceptics in the Reichstag. The real agenda, first with accident insurance, the precursor, and then with health insurance, was to aid German productivity. Compulsory coverage against accidents streamlined a system becoming mired in costly workmen's compensation cases while sickness insurance also aimed to boost economic growth, not least by aiding the mobility of labour.²¹ Thus 'legitimation' now seems less important than 'productivism' in explaining the first case of state intervention.

These factors can also be discerned in the enactment of national health insurance (NHI) in Britain (1911) and Japan (1926). Of course, this is also explicable as a policy transfer: the German innovation had its adherents among Japanese and British civil servants. However, both nations legislated at a time of incipient labour movement strength and in neither case was NHI part of the social democratic programme. Britain's Labour Party had recently won its first election victories and trade union membership had climbed steeply to 2.5 million in 1907.²² The background to Japan's Health Insurance Act was the growth of a socialist movement, the granting of universal male suffrage (1926), and the repressive Peace Preservation Act (1925), which proscribed leftist groups. The importance of population health to imperial economies also loomed large. The debilitated state of army recruits in the Boer War had scandalized British public opinion and the welfare reform era also inaugurated a school medical service. Nationalist and militarist imperatives in Japan drove the expansion of NHI beyond large companies by establishing subsidized, locally based funds to cover the self-employed in rural areas (1938), then incorporating white-collar workers (1941) so that coverage exceeded 70% by 1943.

Germany, the pioneer, was also first to confront the inherent conflict between provider interests and NHI funds, as growing coverage threatened the market for private medicine. Doctors formed a national association, the 'Hartmannbund', and in 1911 forced two key concessions, a free choice of physician by the insured and payment based on fee for service determined by the doctor. Soon after, in 1913, corporatist regional machinery was established through which doctors could negotiate with funds to resolve

contentious issues such as remuneration. Britain by contrast drove a tougher bargain, conceding free choice of doctors on a local 'panel', but remunerating according to capitation (the number of patients on a practitioner's list) with the level set well below that demanded by the BMA. The result though was to discourage doctors from treating the insured as generously as their private patients, and to embed a less expansive approach in the British system.

As the viability and popularity of NHI became evident, other liberal states confronted the interest politics standing in the way of its establishment. France's preference for voluntary solutions was undermined by the 1919 peace settlement, in which it regained Alsace-Lorraine from Germany, incorporating a population enjoying Bismarckian health insurance. French labour endorsed proposals for NHI (though not the communists) and solidaristic support deepened as the petite bourgeoisie recognized the advantages to be gained from access to hospital care. Observing the political mood, centrist doctors struck a compromise, accepting NHI in return for concessions. Thus the Social Insurance Law (1930) made enrolment in the existing mutuals compulsory for blue-collar employees, extending by 1939 to about half the population. It also enshrined a 'medical charter' guaranteeing free choice of practitioner and remuneration by fee for service, with reimbursement claimed by the patient, not the doctor. Solidarism and a favourable institutional context eased the process in Sweden, which in 1931 advanced towards NHI through rationalizing the subsidy system for mutuals and standardizing their medical benefits. Here reform proposals emanated from the Liberals and a consensus including social democrats and employers was forged within a committee system, through which pre-legislative objections were resolved outside the politicized parliamentary arena. Although the Swedish Medical Association appealed to conservative politicians to veto change the latter were unwilling to disrupt this accord.

In the United States meanwhile, reform efforts met with failure. In the 1910s NHI proposals for blue-collar workers were put forward by Progressive intellectuals and the American Association for Labor Legislation, based largely on productivist arguments. Several state legislatures discussed and rejected such plans, before war with Germany and isolationist suspicion of European innovations terminated the policy debate. In the New Deal era President Roosevelt briefly considered reviving NHI in his 1935 social security bill, which laid the basis of America's welfare state. However, fearing that its political contentiousness might endanger other parts of the bill, he set it aside. As the New Deal gave way to wartime mobilization, Congressional Democrats tried again in 1939 and 1943, though without success. Why the different outcome?

First, there was no legitimation imperative, as the state did not confront a social democratic political party threatening the status quo. Second, labour did not mobilize behind NHI. Like its European counterparts, it initially feared health insurance would undermine trade unionism and the struggle to raise wages. Moreover, existing industrial sickness funds were extensive and robust and the Progressive alternative looked financially unattractive. The scope for a solidaristic alliance with less fortunate groups was further narrowed in the 1930s and 1940s with the rapid rise of the voluntary sector Blue Cross and Blue Shield prepayment plans, widely offered as a benefit in the wartime

labour market. Third, institutional factors accorded hostile interests, such as employers, commercial insurers, and doctors, the opportunity to obstruct legislation. In particular, the wealth and organization of the American Medical Association (AMA) underpinned propaganda campaigns that influenced public opinion and stymied consensus, even against the wishes of the executive. The weak party whip permitted vested interests considerable influence over legislators with Southern Democrats, notably impeding reform attempts in the mid-twentieth century.²³

Turning now from payment mechanisms to service provision, the early twentieth century also saw an increasing public role. In part this followed the concentration of expertise in the hospital, alongside technological changes such as laboratories, X-rays, and radiotherapy equipment. This broadened the social base of utilization: in Paris, for example, the proportion of births in hospital rose from about 55% in 1912 to 79% in 1919.²⁴ Gradually the vestiges of refuge and stigma were shed from British workhouse infirmaries, the French '*maison de pauvres*', and major public hospitals in the United States. Thus in France a state-funded building programme underwrote departmental hospital centres and from 1926 opened public institutions to private or means-tested patients; as NHI expanded, so demeaning 'assistance' transmuted into 'assurance'. In Britain many municipal hospitals were taken out of the poor law, bringing greater investment and integration with local voluntary institutions and medical schools. As in America, the voluntary/public distinction remained in place, though the rise in demand and escalating costs saw the dwindling of hospital philanthropy, to be replaced in Britain by the mass contributory schemes, and in the United States by Blue Cross, user fees, and ~~industrial pre-payment funds~~, such as the Kaiser plan introduced in 1938.

The interwar labour movement increasingly advocated access to health care, but with mixed results. In Britain, the ~~Left~~ was uncertain whether to support the extension of NHI or a tax-funded local government service, and in the event it was Conservative legislation that refashioned the poor law and expanded municipal medicine. Leftist initiatives elsewhere capitalized on the purchasing power of insurance funds. In Germany, the self-governing structure of the *Krankenkassen* encouraged experiments that challenged the market in the interest of the patient. These included efforts to standardize prescription costs and the foundation of polyclinics run by salaried physicians and providing comprehensive services. Such innovations were condemned by local doctors as 'Marxist power lust' and the profession subsequently aligned itself with the Nazis, benefiting from their purge of socialist fund representatives, as well as Jewish and radical doctors.²⁵ A ban on polyclinics, state control, and the loss of the workers' majority quickly followed, though otherwise the core functions of NHI were compatible with the population policies of fascism. Similarly, in Japan communist-sponsored hospitals and clinics for farmers and workers mounted a short-lived challenge to private medicine before suppression in the 1930s. Here it was militarism, not socialism, which challenged the market, with the government's 'Healthy People, Healthy Soldiers' programme driving health centre development, followed by the wartime nationalization of hospitals under the Japan Medical Corporation (1942). Thus although labour mobilization behind health systems reform was discernible by 1945, it was not a decisive force.

1945–1975: Health systems in the ‘golden age’

Growth economists characterize the three post-war decades as a ‘golden age’ in Western Europe and Japan, with per capita gross domestic product (GDP) rising at unprecedented rates between 1950 and 1973.²⁶ Prosperity was driven by many factors, including the impact of the Marshall Plan, technology transfers of American production techniques, high investment rates, ample and mobile labour, and a long period of political stability founded on national institutions that sustained social consensus. Central to these were welfare states, and the keynote of this phase of health system development was expanded population coverage and escalating expenditure. Sturdy comparative data on health spending became available from 1960 and, as Figures 24.1 and 24.2 show, this rise was evident in real terms and as proportion of GDP. The long-run climb in real expenditure reflects two factors above all: the costs of the labour and technology of curative medicine; and the ever-growing demands arising from greater longevity and the heightened morbidity of old age. The differing national trajectories, however, demand explanation.

A combination of labour mobilization, solidarism, and institutional factors meant that Britain moved decisively away from its mixed economy of health care. At a stroke, the NHS (1948) brought universal coverage, funding from general taxation, and state provision of facilities free at the point of use. Though characteristically attributed to the

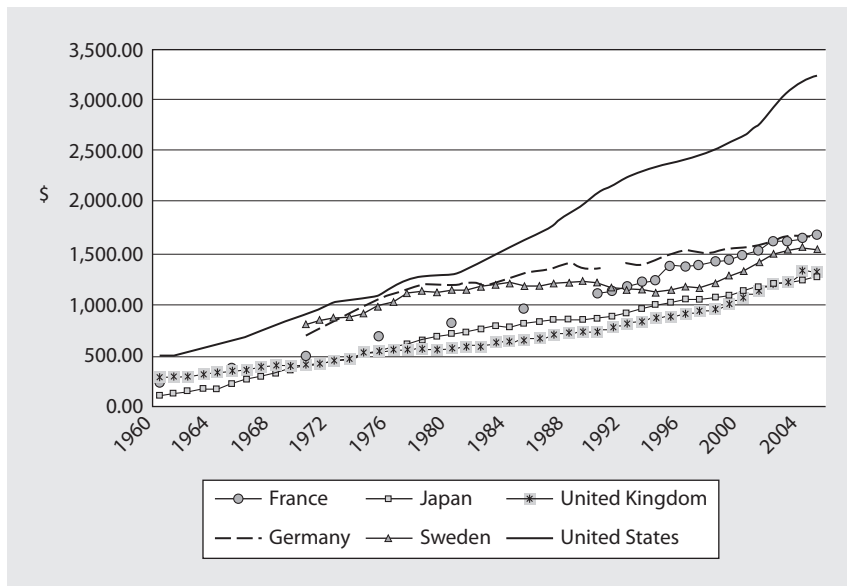


FIGURE 24.1 Per capita health expenditure in selected developed nations, US\$ (purchasing power parity) at constant prices (1983).

Source: OECD Health Data 2008—Selected Data. URL: <http://stats.oecd.org/index.aspx>

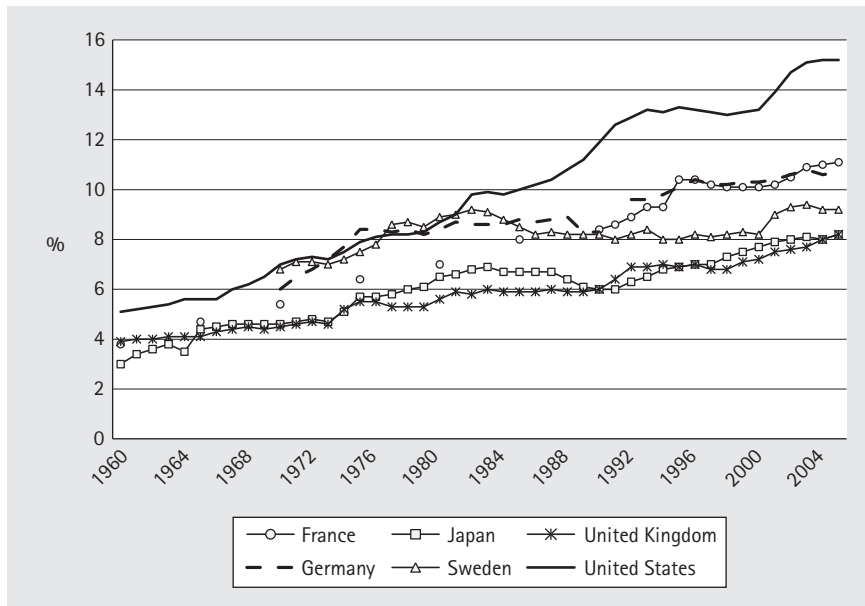


FIGURE 24.2 Health expenditure as percentage of GDP in selected developed nations.

Source: OECD Health Data 2008—Selected Data. URL: <http://stats.oecd.org/index.aspx>

progressive Left, personified by Labour's Minister of Health, Aneurin Bevan, it built on bipartisan consensus. Broad support for welfarism was fostered by the 1942 Beveridge Report, (in which health barely figured), and while wartime social solidarity should not be exaggerated, an appetite for change produced a large Labour majority in the 1945 election. This provided an opportunity for a decisive executive with a broadly united cabinet to carry a fundamental reform. There were, however, limits to its radicalism. Private medicine was still permitted, with user fees soon returning for dentistry and prescriptions, and there was no place for the grassroots participation hitherto encouraged by local politics or voluntary action. Alongside a 'democratic deficit', the other serious charge is that Bevan's model institutionalized frugality. As the expenditure data show, the single-payer system, where the Treasury set a global budget, was comparatively highly effective in cost containment. In the early years such parsimony was not politically problematic and after a straitened start investment began to flow to hospitals and primary care.

Elsewhere proposals for deep reform in the post-war moment had more muted results. The West German Left pushed for a single insurance fund to replace the existing *Krankenkassen*, with the prospect of monopoly power ensuring equitable benefits. However, the election of conservative Christian Democrats in 1949 meant that the system was rebuilt on similar principles to the Nazi era.²⁷ Swedish socialists also proffered a radical blueprint for replacing private medicine with a salaried service based in state

health centres. This time Sweden's deliberative committee system allowed opponents to resist this, although 1955 saw the establishment of NHI with fee for service reimbursement; universal coverage was achieved by 1962. In Japan too there was discussion of a national health service patterned on the wartime emergency structure, but this was blocked by American occupying forces. Hospitals reverted to private ownership and most physicians remained in private practice; the tripartite insurance structure stayed in place, with employer, government, and subsidized community funds. Post-war planners in France also created a new political and social compact, carried through by de Gaulle, who capitalized on a mood of national unity. The Social Security Law (1945) established compulsory health insurance run by statutory funds, under the democratic management of boards dominated by trade unions. Again though, radicalism was limited: coverage was not universal, medical practitioners continued to set billing levels, and the existence of co-payments guaranteed the survival of the *mutualités*.

These structures provided the basis on which universal coverage was achieved. Explanation emphasizes ~~legitimation and~~ social conciliation in Japan, with mandatory insurance finally introduced in 1958 by a conservative government after socialist electoral success in rural areas. In France and West Germany, analysis highlights another solidaristic moment in the 1960s, when the relatively poor position with regard to welfare entitlements of small businesses, the agricultural sector, and some professionals and managers prompted these groups finally to embrace statutory insurance.²⁸ Both nations achieved virtually complete coverage by the early 1970s. Only in America was a different path taken. Here the post-war window had seen reform fall due to familiar institutional and pressure group factors, with AMA propaganda now playing on incipient Cold War sentiment to tarnish NHI as either socialist or fascistic. Other than federal support for hospital building, US policy now relied on the voluntary and private sectors to deliver population coverage. By the early 1960s, it was apparent that the post-war boom had extended this to only some 75% of the population and Democratic Congressional strength in the Johnson era, coupled with self-interested solidarism of older citizens, opened the way to new initiatives. This was the creation of Medicare, under which ~~the elderly~~ received medical benefits under Social Security and subsidized insurance, and of Medicaid, a limited safety net for the uninsured poor.²⁹

These were the settings for the upward course of real expenditure. The higher costs of America's system were evident by the 1960s, as providers responded to the new incentives of Medicare reimbursement by increasing their activities. Japanese spending grew from a low base, its rise reflecting expansion in privately owned hospital bed capacity and the decision in 1972 to lift co-payments for the elderly, meeting excess costs from general taxation. As in Germany a stable corporatist negotiating structure allowed Japanese doctors and bureaucrats to agree a uniform fee schedule that moderated expenditure growth. France and Germany meanwhile, starting from a higher base, found the fee for service model inflationary; Germany's differentiation between the industrial and white-collar funds (*Ersatzkassen*), with high earners opting into private insurance, created a further 'ratcheting up' effect, as the better benefits enjoyed by the few were increasingly desired by the many. Like Japan, 1960s France took steps to rein

back doctors' charging practices by compelling them to agree contracts with the *Sécurité Sociale*, binding them to a fee schedule. Even so, practitioner earnings continued to rise as new technology allowed them to intensify their activities. Nor were the tax-based systems necessarily more restrained, as Sweden, which combined fee for service NHI reimbursement and county level tax-financing, demonstrates. A combination of social democratic political control and traditional willingness to fund municipal hospitals kept spending high. The leftist hegemony also saw private medicine in retreat before a salaried service delivering care through public health centres and hospitals, though this did not restrain costs. Here and elsewhere, containment would not begin until changes in the macro-economic environment ended the expansionary phase.

1975–2005: The 'crisis' of the welfare state

The mid-1970s saw a halt to the era of buoyant economic growth. Investment rates fell, while oil shocks prompted escalating prices and wage demands, heralding a period in which inflation and unemployment rose simultaneously. The social and political compact sustaining welfare states began to founder as conservative politics returned, accompanied by neo-liberal critiques of 'provider capture' and bureaucratic inflexibility. Expenditure curbs and strategies to enhance efficiency therefore characterize this period, though different approaches were employed and different spending trajectories resulted. Despite all the talk of a fiscal and political crisis of the welfare state, overall health expenditures broadly maintained their upward course, as Figures 24.1 and 24.2 show. These do not differentiate public from private spending, but if they did they would reveal a similar trend. In the United States, for example, the costs of Medicare, Medicaid, and other public programmes climbed from 2% of GDP in 1976, to 2.9% in 1989, to 4% by 1993, and 5% in 2005.³⁰ This is because the inflationary drivers of technological change in medical science and the demands of an ageing population still remained. Drug costs were a key factor, representing about 14% of health expenditures in the six countries, 1980–2005.

Figures 24.1 and 24.2 also suggest that despite rising real costs states successfully reined back outlays as a proportion of national wealth, though chronologies of containment varied. The British single-payer system presented the Thatcher/Major governments with a lever to achieve this, though legitimization concerns compelled them to ensure the NHS's core principles remained 'safe with us'.³¹ Policy therefore focused on lifting productivity with fewer resources, initially through managerial reforms designed to improve cost-effectiveness. Next came a refashioning of governance structures to establish a quasi-market, in the expectation that internal commissioning would introduce competitive efficiencies. Labour's return brought higher investment but broad policy continuity, now with private sector contracting for capital projects and tougher regulation of drug treatments through the National Institute of Clinical Excellence. Sweden deployed similar policies. Ceilings on local taxation were imposed and hospital funding moved from a calculation based on patient visits to a more restrictive capitation

basis. Conservative revival in the 1990s brought experimentation with a British-style purchaser-provider split and the use of patient choice in elective surgery to instil competitive incentives. Private medical practice in hospitals and health centres also re-emerged, though here too the political premium on equity ensured the continuing predominance of public financing and anxieties about spatial and social justice.

In countries that combined social insurance with predominantly private supply the focus was on the charging practices of health providers. Germany moved in the 1980s to enforceable regional budgetary caps, then to federal price setting of drug costs with co-payments for expensive prescriptions. The peculiar challenge of integrating the East German system after reunification (1990) was met by tightening reimbursement practices, for example fixing fees according to diagnosis, and by the cross-subsidization of poorer funds by the wealthy. This cross-subsidization device had been tried earlier in Japan to tackle the disadvantage of community funds with greater numbers of elderly poor. As in Britain, a rightwards political shift in the 1980s saw Japanese policy towards providers become more assertive, with a biennial price survey to hold down pharmaceutical costs and a stricter doctors' fee schedule that compensated for the 'natural increase' in their volume of work. France too tackled doctors' charges, here subject to upward pressure because supplementary insurance and co-payments encouraged billing in excess of approved fees. Tax and pension incentives now bound doctors into the fee schedule, while global budgets were set for hospitals in place of individual negotiation. However, conservative attempts at imposing tighter controls in the 1990s were blocked by labour mobilization, aligned with the self-interest of practitioners. Juppé's proposals included a national health budget, restrictions on clinical freedoms in respect of costly drugs and therapies, and limiting patients' free choice of specialists. Their defeat left France amongst the highest spending nations at the new millennium.

As to the biggest spender, why did the 1980s see America's medical costs diverge irreversibly from its peers? The pursuit of profit in private health care had intensified as large corporations superseded small firms in hospital management and supplies, forcing non-profit providers towards more commercial practices. President Reagan's introduction of a European-style fee schedule for Medicare reimbursement (1983) could not stifle inflationary pressures, which now came from new, largely private sector actors, the Health Maintenance Organizations, introduced by President Nixon to encourage membership of group prepayment plans. Nor had these solved the problem of incomplete coverage and the Clinton presidency began with a complex health reform proposal. This suggested mandatory employer contributions and state-level 'alliances' to achieve universalism, and federal regulation of private plans to control costs. As previously though, the favourable conjunction of circumstances required for success was absent. Solidaristic support was elusive, with labour already alienated after Clinton's embrace of free trade and the comfortable middle class fearful of new spending obligations, thanks to the Republican legacy of public indebtedness. Institutional and pressure group factors also resurfaced, this time with insurers leading the propaganda war and conservative Democrats from the South and West once more undermining congressional party unity. Again reform prospects faded and incomplete coverage remained. By 2006, 46 million

Americans lacked health insurance and the promise of another reform attempt was central to Democratic resurgence under Barack Obama. His Patient Protection and Affordable Care Act of 2010 (to be phased in by 2014) aimed to extend cover and restrain costs. The strategy was to expand coverage under the private insurance industry, using a mix of subsidies, incentives, and mandates on individuals and employers, and to increase consumer protection for the insured. A more radical option suggested by the President, of a public health insurance plan that might have competed with private providers, was rejected by Congress. Despite this, the Act provoked great political bitterness and was met by threats of repeal by Republicans.

CONCLUSION

By the later twentieth century, then, advanced capitalist nations all operated health systems that combined insurance, tax-funded provision, and private medicine, though the mix of elements varied substantially. In considering how and why the different national health systems developed, these limited case studies illustrate the combination of pressures—political, institutional, economic, industrial, military, ideological, and professional—which could determine diverse outcomes. Nonetheless, readers may be asking themselves at this point whether any of this really matters. Did the type of system adopted have any bearing on national population health?

International comparison to address this question has until recently relied on the gold standard indicators of life expectation and infant mortality rates (IMR). These are shown for the case study countries in Table 24.1 and demonstrate that all experienced improvements. Yet they also reveal that by the end of the twentieth century, the United States fared comparatively poorly in demographic terms, despite its far higher costs, while of the lower spenders, the United Kingdom had become worse off than Japan, which by the 1980s enjoyed the best indicators. Of the higher spenders, Sweden, with greater tax-funding and state ownership, consistently outperformed the social insurance nations, France and Germany. Of course, more comparators are needed to permit generalization and a recent survey of twenty-one European countries sought definitively to adjudicate between NHS-style and social insurance models, using time series data for 1970–2003.³² The broad conclusion was that both types of health system were converging with respect to life expectation and IMR, but that the social insurance nations historically had a slight edge. Otherwise, NHS models were better at cost-containment, though with risks of under-spending, and incurred greater patient dissatisfaction.

Arguably, though, the standard indicators are misleading guides of health system productivity. After all, public health academics have long argued that curative services made only a modest contribution to the modern mortality transition and that factors ranging from income inequality to environment and individual behaviour were the key determinants of levels of sickness.³³ For example, did American excess mortality result

Table 24.1 Population health indicators in selected developed nation* Pre-2000 data for Federal Republic of Germany only.**
Italicized number = ranking out of 19 OECD countries.

	Life expectancy at birth		Infant mortality		Amenable mortality	
	1960–9	1980–9	1960–9	1980–9	1997–8	2002–3
	Decadal mean		Decadal mean		Standardized death rate, ages 0–74	
France	71.1	75.4	23.5	8.6	75.6 (i)**	64.8 (i)
Germany*	70.2	74.2	26.6	9.7	106.2 (ii)	90.1 (ii)
Japan	70.1	77.5	21.2	5.9	81.4 (2)	71.2 (2)
Sweden	73.8	76.8	14.1	6.5	88.4 (5)	82.1 (6)
UK	70.8	74.5	20.5	10.0	130.0 (i8)	102.8 (i6)
USA	70.3	74.6	24.0	10.9	114.7 (i5)	109.6 (i9)

* Pre-2000 data for Federal Republic of Germany only.

** Italicized number = ranking out of 19 OECD countries.

Source: OECD Health Data 2008—Selected Data; E. Nolte and C. M. McKee, 'Measuring the Health Of Nations: Updating an Earlier Analysis', *Health Affairs*, 27 (2008), 58–71.

in part from the unusually high tobacco consumption of earlier birth cohorts; and did Japanese longevity owe something to benign dietary habits?

In response to such criticism researchers have developed smarter metrics to isolate the contribution made by health care. This builds on the broad consensus, *pace* McKeown, that in the post-war period there are certain diseases whose outcomes were clearly affected by the curative services.³⁴ One strategy has been to monitor mortality and survival rates from different cancers. Another has been to derive a composite death rate from a group of diseases whose progress is deemed amenable to health services intervention.³⁵ Robust comparative data on ‘amenable mortality’ only extend back about thirty years but a key finding is that it has contributed significantly to rising life expectation, particularly through the impact of health services on infant mortality. Amenable mortality also provides a more sensitive gauge of comparative performance and Table 24.1 shows recent rates and rankings of the case study countries. France, which as we have seen was a higher spending, social insurance nation that historically set great store on patient choice and clinical autonomy, emerges as a top performer. Britain, a NHS system that has arguably been chronically underfunded, does poorly, though continuing improvement and the moderate rise in rankings by 2002–3 may reflect Blair’s investment hike. The United States, the highest spender with its historic attachment to market solutions, also fares badly, inviting the judgement that lack of universal coverage has disadvantaged its citizens.

Such assessments, however, move from the realm of historical appraisal to epidemiological controversy and ultimately political argument. Others can and will disagree. A more modest conclusion is that the historical developments described here remain relevant, because health systems *do* matter to the people’s health. Yet as we have seen, an unalloyed concern to achieve the best possible standards for its citizens was rarely government’s top priority in the political economy of health care.

NOTES

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