The political economy of rationing in social health insurance*

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Abstract. Due to the rapid progress in medical technology social insurance systems will soon no longer be able to grant health services without limits but must employ non-price rationing devices. This raises the question how these limits will be determined. Here we consider a direct democracy where the size of the social health insurance plan is determined in a popular referendum using simple majority rule. Moreover, two different kinds of rationing are distinguished according to whether additional private purchases of health care are allowed. For both systems we examine the size of the social insurance system in a political equilibrium, and we compare the results in particular with respect to their distributional effects.

1. Introduction

In some of the richest industrial nations of the western hemisphere, the institution of a social (health) insurance within the last century has helped to bring about a considerable degree of equality in the distribution of health care services. Since this contributed to a tremendous increase in life expectancy, it is with some justification regarded as a major achievement of modern societies. At least in this respect, the so-called “social” market economies have simultaneously reached a continuous improvement as well as some equality in the well-being of all members of society. Wealth and poverty are responsible for different consumption possibilities, but no longer for the survival chances as such. Life-prolonging health services are not allocated according to the willingness and ability to pay but almost exclusively according to criteria of medical “need”.

The overall wealth has enabled these privileged societies to withhold the resources needed to extend human life and enhance its quality from the usual

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struggle for distributive shares. Fundamental norms of solidarity, which were pre-
viously considered as unachievable ideals, have to a large extent been realized in
the institutions of social insurance in general and the health care system in par-
ticular. At the same time, it did not seem necessary to introduce explicit non-price
rationing methods since all services demanded at zero price could at least in prin-
ciple be supplied by the health care providers and financed through payroll taxes.

Today it is certain that this happy era of at most marginal inequality in the
provision of health services has already ended or must soon do so. Due to the
rapid progress in medical technology an allocation of health services unrelated to
willingness or ability to pay and yet free of non-price barriers to consumption will
no longer be feasible. According to the opinion of health care experts the in-
dustrial countries will very soon reach a point where their entire national product
could be (effectively!) spent on health services. This means that access to health
services can not be granted without limits but must be rationed. This would be
true even if the supply free of charge could be restricted to those services that
would undoubtedly yield positive utility in terms of lengthening the recipient’s life
or at least improving his well-being.

Therefore, even fundamental survival chances — as far as they can be in-
fluenced by health care consumption — will eventually have to be distributed by
some rationing device. Since this problem will be “solved” by the institutional ar-
rangements of the health system in any event, it is consistent with the spirit of
democratic societies to solve it with the use of some explicit rationing method
rather than implicitly.

The normative problems involved in the different possible types of rationing
have been intensively discussed elsewhere (see Breyer and Kliemt 1994 and the
literature quoted therein). The present paper addresses the positive aspect of the
problem. It starts from the assumption that in a democratic society any type of
rationing has to be accepted by the majority of voters. Thus I leave the paradigm
of a “benevolent dictator” usually employed in normative analysis and assume in-
stead that explicit democratic decisions are taken on the size and composition of
the “health care budget”, i.e. the services that will be provided through social
health insurance to every member of society free of charge. Furthermore, to
simplify the analysis, I shall consider a direct democracy where the size of the
social health insurance plan is determined in a popular referendum using simple
majority rule.

However, I shall distinguish two different kinds of rationing: “strong ration-
ing” means that no member of society will be allowed to consume additional
amounts of health (insurance) services beyond those provided within the social
insurance system. Moreover, I shall assume that this rule, which is supported by
many as ensuring “equality before death”, can be effectively enforced. “Weak
rationing”, on the other hand, means that such additional consumption is legal.
It is plausible that the availability of additional services will have an effect on the
optimum size of the social insurance system desired by voters, and — considering
the redistributive feature of the social insurance system — that this effect will dif-
fer across income groups. Therefore I shall, after introducing the model in Sect.
2, examine both cases separately (in Sects. 3 and 4) before I turn to a comparison
of the results in Sect. 5 and some concluding remarks in Sect. 6.