French-American Foundation

French and U.S. Health Care: Shared Ideals and a Much-Needed Common Reform

Paul V. Dutton

Associate Professor of History at Northern Arizona University

Fellow of the Woodrow Wilson International Center for Scholars

A Policy Brief from the French-American Foundation

28 West 44th Street, Suite 1420, New York, NY 10036 +(1) 212-829-8800 www.frenchamerican.org

Popular stereotypes describe France as a land of socialized medicine. In reality, the French system is a mix of public and private care, just as in the United States. Moreover, the two nations share common ideals of patient choice, primacy of private-practice physicians, and rejection of rationing. Both countries face a similar challenge, as changes in economic structure and health technology mean that employment-linked health insurance is no longer the most efficient way to deliver care.

Contrasting Performances

The World Health Organization considers France's health care system to be the best in the world whereas the U.S. ranks 37th. The French enjoy universal coverage while 47 million Americans go without any health coverage, a number that is expected to rise to 56 million by 2013. Many more Americans are so underinsured that their access to medical care is severely restricted. France's health indicators are better in virtually every category; from infant mortality to life expectancy, the United States lags well behind. France has more physicians per one thousand residents than the United States (3.4 versus 2.4) and the French see them more often—6.7 times per year on average versus the American average of 3.9 times per year. Acute care in France is dominated by public and academic hospital medical centers. Yet the French may also choose services from the largest private hospital sector in Europe, accounting for 36 percent of all beds. Together France's public hospitals and private *cliniques* provide the country with 26 percent more acute care beds per each thousand residents than the United States (3.8 versus 2.8). Moreover, the cost of U.S health care is nearly 50 percent more per capita, and U.S. prices are rising even faster than those in France. French health expenditures were recently at 10.4 percent of GDP, while U.S. health care spending, recently at 15.2 percent, is projected to reach 20 percent by 2016. Despite these contrasting statistics, U.S. and French health care share much in common.

Shared Ideals and Divergent Systems

Patients in both countries hold very similar ideals, which are quite different from those of patients in Great Britain or Canada. Both France and the United States prize patient choice of physician; they both accept doctors' century-old argument about the salutary effects of fee-for-service medicine on the doctor-patient relationship. They both prize private-practice physicians, and they both reject that medical care should in any way be "rationed." Indeed, although *Sécurité sociale* appears a promising candidate to adopt managed care techniques, there exists a powerful cultural counterforce that is rooted in France's historical embrace of individualism.

Sécurité sociale: The French system of institutions designed to protect individuals from social risks, including illness, old age, retirement, and unemployment. The health insurance branch of *Sécurité sociale* comprises several quasi-public insurance funds that are jointly administered by employer and employee representatives.

Also prevalent in the United States, health care individualism absolutely rejects the notion that any individual's medical treatment should be weighed against a theoretical allocation of scarce resources for the common good. Of course, such financial cost-benefit analyses lie at the heart of managed care's resource allocation efficiencies and cost control. In the United States, the tremendous value placed on the individual case, combined with the individual physician's sovereignty over medical decision-making means that French-style health care reforms that rely too heavily on managed care techniques will continue to face difficult, perhaps insurmountable obstacles. The American version of health care individualism explains the patient revolt against Health Maintenance Organizations (HMOs) in the early 1990s, which sparked Congressional hearings on a "Patient's Bill of Rights." It is also responsible for the subsequent and massive shift in enrollment away from traditional HMOs to the far less restrictive but more costly Preferred Provider Organizations (PPOs). Beyond the individual liberties prized by patients and doctors in France and the United States, how the two countries have historically paid for health insurance bears many similarities.

Employment-linked Insurance Financing

As early as the nineteenth century, workers' access to illness insurance in both countries was linked to the workplace. Whether it was a plan offered by a French mutual society or an American fraternal order, the ethic "I work, therefore I'm covered" became widely accepted during the formative stages of health insurance in both countries. In the 1940s in the United States, the first Blue Cross and Blue Shield organizations relied on employer groups to market and set the prices of their plans. Later, compulsory programs like Medicare and *Sécurité sociale* relied on the workplace to collect premiums and determine benefits, and they continue to do so right up to the present day.

Especially in the United States, the historical link with employment instilled a popular notion of "deserving" and "less deserving" citizens when it came to health care. Both Medicare and employment-based private health insurance have created an ethos according to which only those who have contributed at the workplace have legitimate rights when it comes to medical care, even though both Medicare and employment-based private insurance both rely on public subsidies. Medicare depends on the U.S. Treasury to cover its costs, and the price of private employment-based health insurance would be much higher if premiums were not tax deductible. Medicaid, meanwhile, a far less generous program for the working poor and indigent who lack access to affordable employment-based coverage stands in for physicians' charity (reimbursement to providers is relatively low) but charity it remains. In contrast to Medicare, Medicaid entails few rights and fewer political supporters.

The present battle over the State Children's Health Insurance Program (S-CHIP) is an excellent example of the centrality of the workplace in determining medical care access rights in the United States. Children's need carries less weight in the political calculus than whether someone—anyone— has contributed at the workplace and is therefore "deserving" of health care access. *A priori*, children are excluded from health coverage if their parents are moderate-income earners, even in the absence of any dispute that many families of moderate means can no longer afford private health insurance.

France has moved decidedly away from purely employment-dependent health coverage since the post-war creation of *Securité sociale* and its successive expansions. Yet the country's historical attachment to workplace-linked health coverage remains abundantly clear. French union leaders and employers still exert an influence over *Sécurité sociale* that is out of all proportion to what should be a democratically accountable institution of universal health coverage. This combination of political power and vested interests has resulted in a *France bloquée* on several occasions and remains pertinent right up to the present day. Witness the present battle over pension reform in which the historical legacy of the *régimes speciaux* (special retirement pensions) is, at bottom, the source of the conflict.

In both nations the continued link between the workplace and health coverage is akin to summertime breaks for schools. In the same way that summer breaks once permitted children to help on the family farm in an agricultural economy, employment-based insurance is a relic of once dominant but now waning industrial economies. In the United States, as the price of health care has climbed, small businesses, the self-

employed, and service sectors have been unable (or unwilling) to adhere to a model developed in the industrial world of the early twentieth century. On similar precedents, France has preserved a financial link (through payroll levies) to health insurance because of the once important might of industrial unions and the role played by occupationally organized mutual aid societies. The finance and administration of *Sécurité sociale* is an artifact of a mid twentieth-century compromise that effectively healed a nation sharply divided by class and the German occupation, yet it is now failing to respond to twenty-first century problems.

Challenges and Recommendations

Today, leaders of most political stripes in both nations advocate more flexible and highly trained workforces in order to run agile entrepreneurial firms that can compete in a fast-moving information-based global economy. This is hardly the world in which employment-based health coverage was created. To cling to it now is to be enslaved by a system that has clearly outlived its usefulness and almost certainly will lead to needless suffering, financial hardships for individuals, and the gutting of public budgets.

The link between health care finance and the calculations of workers and employers continues to hinder employment and economic growth. France's health-related *Sécurité sociale* payroll taxes and the United States' even heavier payroll-financed private health insurance premiums should instead be collected through progressive income taxes. This approach would unleash the skills and productivity of labor forces in both nations by removing barriers to labor mobility and stimulating higher employment rates. U.S. workers would be freed from "job-lock," a growing malignancy in the U.S. labor market that now determines between 25 and 45 percent of all job-taking decisions, forcing workers to seek not the best match between their skills and salary but instead to remain in (or take) jobs that provide health coverage for them or their family members. In France, the reliance on payroll taxes to pay for climbing health care costs places a heavy drag on economic growth, public budgets, and employment because high, compulsory non-wage labor costs dissuade the hiring of new workers.

The replacement of payroll levies with a progressive income tax would result in greater equity in the finance of health care. The breakthroughs in medical science and related technologies during the twentieth century have led to fantastic gains in the quality of life and life expectancy in both nations. These gains, which no one wants to see reversed, are exceedingly expensive. By maintaining health care's financial dependence on wages, the United States and France are, in essence, carrying forward a nineteenth-century practice. At that time, some workers were able to give up a modicum of their cash wages in order to protect themselves from the risk of illness or accident, using varying types of mutual aid societies or fraternal orders. However, let us also recall that in the nineteenth-century, even in the event of serious illness or accident, medical expenses were typically dwarfed by the value of lost wages. Now the reverse is true, yet we continue to rely on employers and workers to foot much of the bill for a marvelous but extremely expensive health care infrastructure and its accompanying medical personnel. Thus, even if national prosperity were not at stake, social justice demands a more equitable cost sharing of twenty-first century health care through a progressive tax that affects not only wages but also other sorts of income, profits, and rents. To be sure, France has made far more progress than the United States in this regard. The expansion of the *Contribution Sociale Généralisée* (an income tax) has offset much of what is directly deducted from a worker's paycheck, but payroll taxes on the employer side remain higher than is healthy for economic growth.

Obviously, a complete break between health coverage and the workplace would require significant reforms to American and French health care. It would change how each nation pays for and administers health insurance, including a reformulation of the very nature of insurers, especially in the United States and their relationship to government. Yet let us not forget the fundamental values of individualism, private practice physicians, and the doctor-patient relationship that the French and Americans share. Breaking the link between health insurance and the workplace need not diminish the clinical freedoms of doctors or patients' freedom of choice among them. Those ideals are even more historically entrenched and beneficial to the peoples of both nations.

French and U.S. Health Care by the Numbers	***United States***	***France***
Total expenditure on health care as a percentage of GDP	15.2 percent	10.4 percent
Total per-capita expenditure on health care ($US PPP)	$5,711	$3,048
Public expenditure on health care as a percentage of total health care expenditures	44.6 percent	78.3 percent
Practicing physicians per 1,000 population	2.4	3.4
Practicing nurses per 1,000 population	9.2	7.5
Infant mortality — deaths per 1,000 live births	6.9	4
Deaths per 100,000 population due to Diabetes mellitus	20.9	11.4
Deaths per 100,000 due to respiratory disease	61.5	31.2
Deaths per 100,000 population due to cerebrovascular diseases	39.9	34.6

Source: OECD Health Division Summary of Health Expenditures, October 10, 2006

Paul V. Dutton

Paul V. Dutton is an Associate Professor of History at Northern Arizona University and a Fellow at the Woodrow Wilson International Center for Scholars. He is the author of *Differential Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France* (Cornell University Press, 2007).

French-American Foundation—Statement of Purpose

Founded in 1976, the French-American Foundation is committed to advancing the dialogue between France and the United States. The foundation brings together key policymakers, academics, business leaders and other prominent individuals from both countries so that they may exchange their ideas and create productive bonds likely to have a lasting effect on policies in France and in the United States. To reach these objectives, the French-American Foundation creates multi-year thematic programs, holds conferences, organizes exchanges and produces publications meant to foster and share best practices between the two countries.

Contacts at the French-American Foundation:

Ioanna Kohler, Program Director

ikohler@frenchamerican.org ,**+(1) 212-829-8800/ext 15**

Andrew Hansen

ahansen@frenchamerican.org , **+(1) 212-829-8800**

Press Contact :

Margaret Bensfield, Group SJR

mbensfield@groupsjr.com, **(+1) 212-751-3476**

The views expressed in this policy brief are solely those of the author and do not reflect the views of the French-American Foundation nor its directors, officers, employees or representatives.

The French-American Foundation—January 2008