How History Helps Us Think about Contemporary Health Care Challenges

Too often, health care studies, as informative as they are, offer only a snapshot, a single frame of what is inevitably a very long movie, whose directors, producers, and actors change the plot and the script in the course of the show. Relatively few policy studies deal in any depth with what are fundamentally historical causes and questions.

To begin with, U.S. and French health care was strikingly similar a hundred years ago. How and why did the two systems diverge so dramatically by century's end? And what about the similarities that remain, namely, the shared attachment to workplace health security; ideals of patient choice and private practitioners; and a common distrust of "socialized medicine"? This shared distrust has helped to conceal—certainly in the case of the United States—the fact that in all industrialized societies, health care has been socialized to a greater or lesser degree for a long time, and fortunately so. Few seriously ill patients or accident victims could pay the actual costs of the medical and hospital services they receive. Treatment for an auto accident can easily run into the tens of thousands of dollars. Depending on the model, a pacemaker, with installation costs, can come to over a hundred thousand dollars. Even fewer of us could afford the long-term nursing and valiant end-of-life care that has become common in the United States and Europe. In fact, 80 percent of health spending in the United States goes to care for just 20 percent of the population. It is roughly the same in France. Ten percent of its citizenry account for 60 percent of health care expenditures. If you are an average American or French reader, you will incur at least half of your lifelong medical expenses during your last six months of life. The burdensome cost of twenty-first-century health care simply has to be spread over large groups. What remains undecided is how best to do it.[3]

This is why, over the course of the twentieth century, countries developed two basic ways of socializing the cost of medical care to create health security for their citizenry. Great Britain possesses the archetypal *health service,* under which funding for most medical care facilities and the remuneration of doctors and other medical personnel flow more or less directly from the government treasury. In contrast, France and the United States rely heavily on *health insurance,* wherein medical facilities and health professionals are in both the public and private sectors, and their funding flows from public insurance funds and from private insurers.[4] France has

large public health insurers, complemented by many private insurers. The United States presents a mirror image of this system. It relies heavily on large private insurers, which are supplemented by public health insurers such as Medicare. Throughout the twentieth century, France undertook successive reforms that encouraged physicians to remain in private practice, which doctors and patients alike believed was necessary to ensure ethical, quality care. Indeed, in France, discussion of a *service de santé* (a health service such as Britain's) elicits popular scorn in the same way that the term "socialized medicine" does in the United States. It is commonly viewed as antithetical to the nation's values.

In the United States, the term "socialized medicine" gained currency when opponents of President Harry Truman's national health insurance initiative in the late 1940s used it to characterize his program. As an epithet, it proved extremely effective because it bound together two emotionally charged concerns. First, it called to mind the United States' cold war with the Soviet Union and thereby tarred national health insurance as un-American and its backers as traitors. The president of the American Medical Association used to refer to proponents of national health insurance as having "a pinkish pigmentation," common parlance at the time for Communist sympathizers.[5] At the same time, "socialized medicine" invoked fear of impersonal, assembly-line medical care. Patients would not be able to choose their own doctor; medical personnel would owe allegiance not to the patient but to an anonymous and distant bureaucracy, which would require reams of paperwork and preauthorizations. Of course, as congressional testimony on the "Patient's Bill of Rights" aimed at health maintenance organizations (HMOs) in the 1990s demonstrated, impersonal treatment of patients can result from private medical bureaucracies just as well as from government ones. Yet that debate simply provides more evidence that Americans, like the French, possess strongly held beliefs about how patients should be treated and the limitations that reformers, whether public officials or private CEOs, face if they want to stem the rapidly rising cost of health care.

The United States and France share the distinction of possessing two of the world's most expensive health care systems. The U.S. system is far and away the more costly, gobbling up just over 15 percent of the gross domestic product (GDP), or $5,711, annually for every man, woman, and child in 2003. By 2014, the share of U.S. national income devoted to health care is expected to grow by nearly 25 percent, to 18.7 percent of the GDP. Meanwhile, the French have the fifth most costly health care system, spending

almost 10.5 percent of their GDP, or $3,048, per capita in 2003. That share is also expected to rise, but not as quickly as in the United States. In both countries, health care price increases run at rates well above general inflation, driven by a host of factors, notably an unquenchable demand for increasingly effective (and expensive) diagnostic techniques and pharmaceuticals, and high salaries for expertly trained medical specialists. Both nations also have aging populations, which require on average far more hospital and medical services than younger groups.[6]

Though when all is said and done, the French get a lot more for a lot less money. In 2001, the World Health Organization (WHO) named French health care the best in the world. The United States ranked thirty-seventh in the same survey. For health policy experts in Paris and Washington, the WHO report did not come as a great surprise. France shone because of its universal insurance coverage, responsive health care providers, patient and practitioner freedoms, and the impressive health and longevity of its citizens. Although the United States scored at the top in some categories, such as provider responsiveness, its overall score suffered because of the astronomical cost of U.S. health care, its well-known problems for those without insurance (fully 15.9 percent of the population, or 46.6 million individuals in 2005), and the inequities in care depending on one's race, ethnicity, and socioeconomic status. One would have to return to the France of the 1960s to find the same levels of the uninsured and the shamefully poor access to medical care. Ninety-nine percent of the French population had obtained health insurance by 1980, either through public or private insurers, as a dependent of an insured person or through special funds for the unemployed. A 2000 law extended coverage to the remaining 1 percent that had somehow fallen through the cracks.[7] Public opinion in the United States and Europe reflects the high marks the WHO report gave to France.

A 2004 Harris poll of Europe's five largest nations found that the French are by far the most satisfied with their health care system (65 percent). By contrast, only 32 percent of Britons viewed their National Health Service in a positive light; the Germans panned their country's health care, with only 28 percent happy about its performance. When the same European respondents were asked which country's health care system they most admired, France again topped the list. Few Europeans in the survey felt positively about U.S. health care (10 percent), thereby agreeing with Americans themselves. A 2003 Kaiser Family Foundation poll found that 56 percent

of Americans believed that their health care system needed major reform, while 30 percent expressed the view that it was beyond repair and should be completely rebuilt.[8]

While both nations face rapidly rising health care bills, price increases in the United States have been pushed further skyward by relatively high payroll expenses for nonmedical personnel, which includes underwriters, marketing specialists, insurance billers, and customer service agents. They

Table 1. American and French Demographic, Economic, and Health Indicators

Indicator	France	United States
Demography and Economics		
Total population (2004)	60,200,000	293,655,000
Population over 65 (2004)	16.3%	12.4%
GDP per capita (purchasing power parity) (2004)	$29,600	$39,700
GDP growth average (1994–2004)	2.3%	3.3%
Unemployment rate (2004)	10.1%	5.5%
Personal income tax of total receipts (2002)	17.3%	37.7%
Taxes on goods and services of total receipts (2002)	25.4%	17.6%
Average production worker's disposable income of gross pay (2002)	73.2%	75.7%
Health Care System		
Health care spending of GDP (2003)	10.4%	15.2%
Health care spending per capita (purchasing power parity) (2003)	$3,048	$5,711
Public portion of total health care spending (2003)	78.3%	44.6%
Practicing physicians per 1,000 residents (2004)	3.4	2.4
Physician consultations per capita (2003)	6.7	3.9
Acute care bed days per capita (2004)	1.0	0.7
Acute care beds per 1,000 residents	3.8	2.8
MRI scanner units per million residents (2004)	3.2	5.0
Health Status of Population		
Life expectancy at birth in years (2003)	79.4	77.5
Female life expectancy at 65 in years (2002)	21.4	19.5
Male life expectancy at 65 in years (2002)	17.1	16.6
Infant mortality per 1,000 live births (2003)	4.0	6.9
Tobacco consumption (percentage of population 15 years or older smoking daily) (2002)	26.0%	18.4%
Obese as percentage of population (body mass index > 30 kg m^2) (2002)	9.4%	30.6%

Source: Compiled from *OECD in Figures 2005: Statistics on Member Countries* (Paris: OECD, 2005), 6–16, 38, and *OECD Health Data 2006* (Paris: OECD, 2006). Statistics for U.S. MRI units probably understate actual number since only the number of facilities with at least one unit is reported.

have become fixtures in the U.S. health care bureaucracy at health insurance companies, hospitals, clinics, and doctors' offices throughout the country. Meanwhile, analysts inside and outside France have observed that, far from conforming to stereotypes of a bloated government bureaucracy, French public health insurance, *Sécurité Sociale*, is probably understaffed.[9] Like Medicare and Medicaid in the United States, its administrative costs are well below those of private insurance companies (6 percent versus 13 percent).[10] The predominant role of *Sécurité Sociale* in French health care translates into a relatively high level of administrative efficiency compared with the United States. For example, instead of the labyrinth of deductibles, co-payments, and networks of medical care providers in the United States, a French patient presents a single microchip-enhanced *Sécurité Sociale* card at her physician's office. The card permits a physician online access to a comprehensive medical chart. It also implements an almost immediate electronic funds payment from *Sécurité Sociale* to the patient's bank account, reimbursing her for the appropriate portion of any fees associated with the doctor's visit. In addition to dealing with myriad health insurers, U.S. physicians have also faced large increases in their medical malpractice insurance premiums, as much as 30 percent in some states in 2004. French doctors have been spared these rising costs because the country's legal system is far more adverse to tort claims than its U.S. counterpart.

No matter what the reason for the rapid rise in health care expenditures, U.S. or French political leaders who talk of initiatives that threaten patient liberties or doctors' clinical freedoms do so at their peril. Like Americans, the French have never accepted and likely never will accept waiting lists for medical procedures, as Britons and Canadians do. "Rationing" is not a word on the lips of U.S. or French politicians, at least not among those who wish to enlist support for health care reform.[11] In 1995, when France's prime minister mentioned rationing care, if only to deny that his proposal included it, he suffered a devastating political defeat, as physicians rallied their patients to oppose him. That said, no matter what kind of system is used to allocate care, medical service providers inevitably respond, to a greater or lesser degree, to the financial incentives before them. Any financial incentive can bode ill or well for patient care and must be accompanied by ethical and legal safeguards. The fact remains, then, that in both the United States and France health care is rationed in myriad ways, based on ability to pay, statutory guidelines, administrative fiat, customary treatment regimens, and scientific practice norms, to name just the most common factors.[12] This being the case, it is clear that the aversion to "rationing"

and "socialized medicine" in France and the United States is driven not by reason but by history, which it is critical to understand if we are to meet present-day challenges.

The Role of the State and the Workplace

It is difficult to imagine an institution more historically embedded in a nation's politics, economy, and culture than health care. For many social scientists, health care epitomizes a "path-dependent" creation. That is to say, at virtually every step of its development, specific conditions and events exerted formative influences that in turn induced others. As each critical historical juncture passed, its outcome influenced subsequent changes, making some results more likely than others.[13] The political scientist Margaret Levi has aptly compared such a process to climbing an old tree. The climber inevitably makes choices about which branch system to follow, and even though "it is possible to turn around or to clamber from one to another—and essential if the chosen branch dies—the branch on which a climber begins is the one she tends to follow."[14] This metaphor for how a nation's health care system evolves tells us that history matters, that singular historical moments can possess tremendous explanatory power, and that radical reversals may be hard to achieve.[15] But that does not mean that, because historical events on each side of the Atlantic are unique, the French and the Americans cannot learn how to solve their most nettlesome social problems from each other.

The French historian Alexis de Tocqueville understood this implicitly. He traveled widely in the United States during the 1830s, attempting to grasp the habits and institutions of the new nation in order to further his own understanding of France, especially its tribulations balancing liberty and equality. "In America," observed de Tocqueville, "free morals have made free political institutions; in France, it is for free political institutions to mould morals."[16] In this reflection, we see France's greater reliance on the republican state as an active agent in the quest for liberty and equality. After all, the French revolutionaries of 1789 faced a society far more rife with aristocratic privilege than the American colonies. In the revolution's most radical phase, under France's First Republic, its leaders tried and executed the king and queen, distributed the lands of the nobility and of the church to the peasantry, and banned slavery in France's colonies. These actions surely reflected the newly installed revolutionaries' willingness to use the state power that had once belonged to France's absolute monarchs, but they also showed a commitment to equality that American