

Differential Diagnoses

■

A COMPARATIVE HISTORY OF HEALTH
CARE PROBLEMS AND SOLUTIONS IN
THE UNITED STATES AND FRANCE

■

Paul V. Dutton

ILR Press *an imprint of*
Cornell University Press
Ithaca and London



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First published 2007 by Cornell University Press

Printed in the United States of America

Library of Congress Cataloging-in-Publication Data

Dutton, Paul V.

Differential diagnoses : a comparative history of health care problems and solutions in the United States and France / Paul V. Dutton.

p. cm.—(The culture and politics of health care work)

Includes bibliographical references and index.

ISBN 978-0-8014-4512-5 (cloth : alk. paper)

1. Social medicine—United States—History—20th century.
2. Social medicine—France—History—20th century. 3. Medical policy—United States—History—20th century. 4. Medical policy—France—History—20th century. 5. Medical care—United States—History—20th century. 6. Medical care—France—History—20th century.
7. Insurance, Health—United States—History—20th century. 8. Insurance, Health—France—History—20th century. I. Title. II. Series.

RA418.3.U6D88 2007

362.1—dc22

2007010775

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Cloth printing 10 9 8 7 6 5 4 3 2 1

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COMMON IDEALS, DIVERGENT NATIONS

Healing is a matter of time, but it is sometimes a matter of opportunity.

HIPPOCRATES

Washington, D.C. I'm attending a good-bye party for a friend who is leaving her job at a local museum. A friendly group has gathered at a fashionable northwest restaurant for drinks and hors d'oeuvres. I find myself face to face with an art historian from the National Portrait Gallery. I get the standard question, "What do you do?" I tell the interrogator that I'm writing a book on U.S. and French health care. "Oh really," he responds. "Theirs is government imposed, isn't it?" Another scene. Flagstaff, Arizona. A Halloween party for kids, mostly of faculty from Northern Arizona University. I'm talking with a biologist. She asks about my research. I say it's on health care in France. I pause for the reaction, to which by now I've become accustomed. She replies, as if on cue, "You mean socialized medicine?" Back in Washington, at the Brookings Institution, a public policy research institute. It's intermission at a conference on transatlantic relations. I've just met a French businesswoman; she's curious about my work, so I recount the two scenes above. "Socialized medicine!" she exclaims in English, "That's the British!"

Americans often assume that all European health care systems are alike, something called "socialized medicine," under which the government, for good or ill, runs everything. Most do not understand that there are major differences among European countries in how they pay for and deliver medical care. More to the point, because European health care systems are dubbed—and dismissed as—"socialized medicine" Americans do not understand that they can learn much from how different health care

systems address and resolve problems of cost, efficiency, and access. This is particularly important today as Americans consider how to cope with a health care crisis that often appears intractable.

By analyzing the historical development of the contemporary French and U.S. health care systems, I hope to advance this understanding, so that those concerned with health care policy in both countries—and ordinary citizens whose lives depend on the health care system—can avoid the pitfalls described by the historian Marc Bloch in his classic appeal on behalf of comparative history nearly a century ago. Bloch argued against the tendency to limit histories to one region or another. Historical research undoubtedly requires language expertise and in-depth knowledge of the society under scrutiny. Historians' specialization along regional and national lines has made possible enormous progress in understanding peoples and places on their own terms, free from any imperative to relate their past—or present—to some "other."

Yet with this practice of writing place-bound histories comes a certain danger. Authors quite naturally seek the causes and effects of the change they wish to describe within those boundaries. Much of the time they are justified in doing so. But in some cases, more general factors, which might be shared by more than one society or nation, go unnoticed. That is why Bloch advocated such a grand place for comparative history. Only through it, he believed, can we observe resemblances and differences across diverse lands and thereby perceive larger dimensions of the past that would otherwise remain unperceived, or worse, misperceived.²

In this book I present a comparative history of health care in the United States and France, from the early years of the twentieth century to the present day. I examine employers, labor unions, political groups, insurers, the state, and medical professionals to reveal their various influences on the French and U.S. health care systems and on the pursuit of health security by the citizenry of each nation. I consider not only what Americans have to learn from France but what the French have to learn from the U.S. example. Indeed, some of those on the U.S. side of the Atlantic who advocate a switch from the "french fry" to the "freedom fry" might be surprised to know how many values the two nations share and how much they are borrowing from one another. For example, the United States, quite by accident and with virtually no comprehensive planning or debate, is headed toward a public-private mix of health care financing that is far more French than most Americans realize. As a result, a better understanding of France's public-private health care system, its management, historical origins, and

present challenges would be constructive in the U.S. search for health care solutions. The French, meanwhile, are busily adapting U.S. managed care techniques and hospital payment methods to their public and private health insurance. What more can these two countries learn and adapt (or adopt) from each other as they struggle with their respective health care crises?

What the French and U.S. health care systems share, as well as what divides them, is reflected in the various interpretations of their eighteenth-century revolutions. Both the American and French revolutionaries hailed the Enlightenment ideals of individual rights and popular sovereignty, leading to an inherent tension between personal liberty and social equality in the republics they formed.² This tension has been evident in virtually all health care reform initiatives since the First World War (1914–1918), which sought to compel citizens to participate in health insurance. Such debates have recurred on five occasions in the United States and twice in France. In each of these instances, a central question was whether individual liberty should be sacrificed for the sake of collective equality and the common good. In both countries, the debates exhibited nuanced arguments that sought to reconcile liberty and equality. Proponents argued that to compel a sacrifice on the part of the individual in the form of a small tax, would, in fact, free him or her from fear of medical indigence. The net outcome, they argued, was more liberty, not less. Meanwhile, opponents of compulsory health insurance consistently promoted voluntary measures, which made a powerful appeal to individual liberty, personal responsibility, and worker autonomy.

These questions remain at the heart of contemporary health care debates in both nations. How should one interpret the terms "liberty" and "equality" today? Does liberty require that health care be free from government intervention? Does equality entail equal access to medical care without regard for ability to pay? Or does it mean that insurers must take all comers? Should health care be linked to employment, as it is in both countries? How has this link constructed our views of the "deserving" and "less deserving" sick? How does one address the financial and professional concerns of vital health care actors, especially physicians? The tension between liberty and equality has been characterized in different ways over the course of the twentieth century: as personal responsibility versus social welfare, private enterprise versus communism, voluntarism versus compulsion, and individualism versus interdependent citizenship, to name a few. Just below the surface of all these designations lay fundamental tensions that were inescapable, given the founding ideals of both nations.

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
<i>Demography and Economics</i>		
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%
<i>Health Care System</i>		
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	3.0
<i>Health Status of Population</i>		
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	18.6
Infant mortality per 1,000 live births (2003)	4.0	6%
Tobacco consumption (percentage of population 15 years or older smoking daily) (2002)	28.0%	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

revolutionaries could only contemplate. Most notably, the founders of the United States refused to grant equality to nearly a million of their countrymen and -women who had been forcibly brought to the States as slaves.¹⁷

De Tocqueville's remark also belies the influence of the eighteenth-century political philosopher Jean-Jacques Rousseau on French republicanism. Next to inalienable individual rights, which are foundational to the republics of France and of the United States, Rousseau posited the existence of a *general will*, a sort of infallible common good to which all citizens should (and must) submit.¹⁸ But if the French republican state, even to the present day, can more easily intervene in the social and economic affairs of the nation, this does not mean there is no pluralism or protest in France's politics. On the contrary. As anyone who has witnessed French workers or students on strike will attest, those in the street can just as easily claim to possess the general will as those who occupy the government ministries. Indeed, France has experienced a fractious historical struggle over how to pay for and deliver health care, one that is just as contentious as that in the United States. By the same token, both countries have divided sharply over the state's power of compulsion. That explains why early in the twentieth century Americans and the French turned to nonprofit, independent associations that offered health security in the workplace.

In both nations, political leaders rightly surmised that highly centralized government-directed health care would be unpopular. Instead, they advocated a leading role for civil society organizations, considering them the best suited to reconcile liberty and equality in the pursuit of health. In France, these organizations were known as mutual aid societies, which long served as private health insurance clubs for stably employed men, usually through their workplace or professional association.

In 1930, French legislators empowered mutual societies to serve as insurance carriers under the country's first compulsory health insurance law. The lawmakers' decision was a compromise. They hoped to make compulsory health insurance fit with France's longstanding tradition of voluntary, private approaches to health security. At about the same time, U.S. workers and employers were embracing Blue Cross, voluntary, nonprofit plans for group prepayment of hospital care, a model that was soon adapted for physician services under the name "Blue Shield." By the outbreak of the Second World War, employers and workers in both nations were sharing the risk of illness on an unprecedented scale by using nonprofit, nongovernment actors as intermediaries. In so doing, they preserved the traditional practices associated with private health insurance. Yet employment-based

health security in both the United States and in France had unfortunate side effects where equality was concerned.

As some workers gained access to workplace health insurance, which they received in exchange for lower cash wages, they saw themselves (and were viewed by others) as responsible citizens who “deserved” any medical care they might need in the event of unexpected illness or accident. The “deserving” citizen was celebrated for his work and rewarded with health security. As defensible as this ethic may sound, its ugly underside was the belief that many citizens who, through no fault of their own, lacked access to workplace health insurance were “less deserving” of health security. Their only option was charity care, which did not come with the same guarantees of quality and patient choice that “deserving” citizens enjoyed. This development had a particularly negative impact on women and minorities, who were (and are) much more likely to be considered “less deserving.”¹⁹

In both France and the United States, comprehensive health insurance—whether compulsory or voluntary—first became prevalent among industrial workers. Industry was a man’s world where women were recognized only as adjuncts to the male worker’s productive capacity. Most women worked at home and in nonmanufacturing jobs and could therefore gain insurance benefits only by virtue of their status as dependents. Employment-based health insurance thus served to reinforce decidedly unequal conceptions of gender and limited women’s social mobility. Grouped with children as dependents of the male breadwinner, women were denied the dignity and liberties men enjoyed to pursue educational and employment opportunities.

In the United States, the industrial origins of health insurance affected agricultural workers in a similar manner and created disparities of health care access along racial and ethnic lines. By the late 1950s, most white unionized industrial workers in the northern and midwestern manufacturing centers had won generous health benefits at the collective bargaining table. Meanwhile, a disproportionate share of African American agricultural workers in the South, and of Latino farmworkers in the Southwest and California, lacked the economic and political power to obtain similar protections against illness and accidents.²⁰

The notion of “deserving” and “less deserving” citizens persists in the United States and, despite the universality of *Sécurité Sociale*, even in France. In recent years, more and more middle- and upper-income French people have grown reliant on France’s booming private supplemental insurance industry; these policies cover most of the difference

between public insurance reimbursement and actual physician fees. Yet nearly 15 percent of the population lacks such coinsurance, meaning higher out-of-pockets costs for many who can ill afford it.²¹ In fact, a recent study that controlled for socioeconomic, demographic, and health status factors found that French adults with supplemental insurance are 86 percent more likely to seek medical care than those without such coverage. This disparity nearly matches that found between the likelihood of insured and uninsured adult Americans seeking care, even though the financial burden of treatment for uninsured Americans is far greater than that for those who lack supplemental coverage in France.²²

But nowhere is the distinction between “deserving” and “less deserving” citizens more apparent than in the U.S. health care program for the poor, Medicaid. Because Medicaid generally reimburses medical providers at lower rates than private insurers or Medicare, many clinics and physicians simply will not accept Medicaid patients. It appears to be a straightforward business decision, and physicians often justify it on those grounds. In a country with falling rates of private health coverage, however, Medicaid’s inability to attract medical care providers exacerbates discrepancies in U.S. health care availability and quality. A 2005 study that measured quality and access to a set of core health services found that, a startling 85 percent of the time, poor people receive medical care of substantially lower quality than their higher-income compatriots. And that trend has worsened rather than improved in recent years.²³ Yet although low socioeconomic status has become the best predictor of an individual’s quality of care, middle-income Americans still suffer serious consequences because of the nation’s reliance on the workplace for health security.

Take the case of the San Diego physical therapist Amy D. Before September 2004 neither Amy nor her husband, Chris, would have viewed their family as vulnerable to health care insecurity. Amy, the daughter of a physician and sister of a surgeon, knew a great deal about health coverage through her family and her medical practice. She had been employed at the same clinic for six years; Chris worked for a small engineering firm through which they purchased comprehensive health insurance for themselves and their two children. In August 2004, however, Chris was laid off, leaving the family with two months to arrange new insurance. The following week, Amy was diagnosed with invasive breast cancer.

Because Chris’s firm employed fewer than twenty employees (like 87 percent of all businesses, covering 19 percent of the U.S. labor force), the family could not take advantage of a federal law, known as COBRA, to buy

continued group health coverage through Chris's workplace, even if he had been willing to pay both the employer and employee portions of the premium.²⁴ Meanwhile, Amy faced immediate surgeries and chemotherapy. She took a leave from her job on California state disability, which permitted her to purchase health insurance for herself through the clinic's Aetna group policy at six hundred dollars per month. Yet with Chris unemployed and Amy's disability stipend well below her usual income, the family could not afford the several hundred dollars more that would have been necessary to cover the entire family. Their home mortgage and mounting out-of-pocket coinsurance payments for Amy's treatment were just too high. Instead, they purchased catastrophic coverage for Chris and the children, which left Chris to seek care for his high blood pressure out of his own pocket. Yet this prudence only led to further health insecurity. When Chris landed a new job, his new employer's group policy excluded any coverage for illness related to his high blood pressure for one year, simply because he had wisely sought treatment for it.

Meanwhile, Amy's oncologist had placed her on Hercepton, an expensive (five thousand dollars per month) but highly effective treatment for some breast cancers. The regimen appeared to be working and Aetna was paying for most of it. But Chris's new employer group plan did not include Amy's oncologist in its provider network. Nor would the plan extend any dependent coverage at all if the employee's spouse could purchase coverage through her or his own workplace. Hence, because of Chris's new employment, which should have been cause for celebration, Amy had to quit a job she loved to gain affordable health coverage for the family. Even then, continuity-of-care imperatives for a life-threatening condition dictated that Amy remain with her original doctor, which she did, paying the 30 percent out-of-network coinsurance for Hercepton (fifteen hundred dollars a month) out of the family budget. Thankfully, Amy is a cancer survivor. Yet that status means that both she and Chris must forever weigh their employment decisions based on health insurance, not necessarily professional skill or salary.²⁵

What happened to the D. family could not occur in France, because a series of reforms beginning in 1945 effectively severed the connection between an individual's employment status and health security. The sick, injured, or unemployed need not qualify for poverty assistance to enjoy public health insurance benefits, as they must in the United States. Indeed, unlike in the United States, the sicker you become in France, the greater your health care benefits. Inpatient hospital care for grave illnesses, for

example, are covered 100 percent, while ambulatory care usually requires a steep coinsurance payment of 30 percent.

Yet France's past, when health security was dependent on employment, still exerts a powerful influence. Because of it, the French (like the Americans) continue to pay for their health insurance—and therefore much of their health care system—through paycheck deductions. French employers and their employees together pay wage levies of 20 percent; employers contribute 13 percent and workers 7.²⁶ Because of this reliance on payroll taxes, France is very different from Great Britain or Scandinavian countries such as Denmark, where diverse income and property taxes pay for 80 percent of the public health care system.²⁷ The French, even more than the Americans, possess a long enmity with income tax, and their government has relied on it only sparingly. In 2004, only 60 percent of all households were subject to income taxes, and even then the tax raises less than a fifth of government revenue, versus more than a third in the United States. France relies far more heavily on consumption taxes and payroll levies.²⁸

Simple comparisons between U.S. and French health insurance payroll levies are difficult because of the wide array of U.S. medical insurance plans whose premiums vary by firm size and the "risk class" of the employees, a development whose origins I will explore in depth. Suffice it to say for now that U.S. health insurance is not priced as a percentage of wages, as in France, but in accordance with the health experience of the group or individual being insured. A large employer, such as the state of Arizona, which splits the cost of a family Blue Cross-Blue Shield preferred provider organization (PPO) plan with employees, paid over fifteen thousand dollars a year per enrollee in 2005. Hence, for a moderate-income earner (fifty thousand dollars annually), the cost of medical insurance relative to wages is significantly higher in the United States—30 percent, versus 20 percent in France—even for a large group purchaser like a state government. Similar Blue Cross-Blue Shield coverage for an employee who works for a small firm in San Francisco can easily reach forty thousand dollars a year, or 80 percent of gross wages. To be sure, some U.S. employers pay more than others toward their workers' coverage, but virtually all insist that rising health insurance premiums inevitably reduce cash wages. Thus, it was bad news for U.S. employers and workers when premiums for employer-based health coverage rose on average 7.7 percent in 2006, twice as fast as workers' wages (3.8 percent).²⁹

In France, *Sécurité Sociale* health premiums flow into one of several public insurance funds—not the government treasury—and are jointly

administered by employer and union representatives. Along with the government, *Sécurité Sociale* negotiates national medical fee schedules with the leading physician associations and other medical practitioner groups. These *conventions*, as they are called, form the basis of physicians' remuneration. Although close to a third of French physicians now charge fees above *convention* rates, their patients' reimbursement is tied to them.³⁰ Thus, as in the United States, where private insurers and Medicare use fee schedules to determine payments to physicians, French doctors' fees are ultimately constrained by insurers' willingness to pay.

Although a Frenchman or Frenchwoman's medical insurance no longer relies on a particular job, France's legacy of employment-based health security remains stubbornly evident in the joint administration of *Sécurité Sociale* by unions and employers. This arrangement has made health care reform extremely difficult, especially when the reform threatens the present reliance on paycheck deductions. Employers and labor leaders alike know that if health insurance premiums are "fiscalized," transferred away from payroll levies to a generalized income tax, their claims to control *Sécurité Sociale* governing boards would surely diminish, which could threaten their administrative prerogatives and generous worker benefits. This inertia in France's *Sécurité Sociale* is not unlike employers' and unions' addiction in the United States to the tax deductibility of health insurance premiums and policies, which are priced according to the policyholder's risk experience. These policies permit large employers and unions to purchase comprehensive health coverage at rates well below what small firms and individuals pay.

Workplace Health Security: An Artifact of the Twentieth Century

Workplace-related health security, whether through a direct link between employer and employee (as in the United States) or through public health insurance funds managed by labor and business leaders (as in France), are an artifact of the first half of the twentieth century. This artifact now hampers the resolution of health care crises in both nations. The downside of workplace-linked health insurance, which was embraced by workers and employers before and during the Second World War, now far outweighs its original civil society and associational benefits. Most obviously, there is a problem of equity. When one relies on wage levies to pay for health care, whole classes of income earners—those profiting from rents and investment dividends—make relatively small sacrifices yet still

enjoy the most technologically advanced health care systems in the world. Even more damaging is the stultifying effect of workplace-related health security on employment freedom.

France has suffered from persistent high unemployment, nearly 10 percent, since the 1980s. At least some of this unemployment is caused by what economists call an "insider-outsider" problem.³¹ "Insiders" are long-time employees with secure jobs; they enjoy good benefits, including *Sécurité Sociale*, as well as employer-provided supplemental health insurance. "Outsiders" are the unemployed or those in insecure, temporary positions. "Outsiders" would like a shot at an "insider" job but are stymied, not because they lack the skills but because employers face such high compulsory nonwage costs, for example, *Sécurité Sociale* payroll taxes. Employers hire only when they are absolutely certain that the new employee's additional productivity will translate into sufficiently higher and enduring firm revenues to justify the commitment. French employers also face far more cumbersome (and therefore costly) firing rules than their U.S. counterparts, rules that union leaders, who represent "insiders," are loathe to see weakened.³² The end result, which is linked to France's payroll-financed health care, is that employers are reluctant to hire, leaving potentially productive workers in unemployment lines.

Well aware of this drag on employment, the French government in recent years has created a series of waivers whereby employers are excused from *Sécurité Sociale* charges, but only for a limited period. While this tactic has spurred hiring, somewhat driving unemployment down, it has also turned a stratum of France's workforce into temporary contract employees who are often let go when their employer's waiver expires. To be sure, because of *Sécurité Sociale* these workers enjoy far better health security during their temporary jobs and spells of unemployment than Americans in similar circumstances. Indeed, *Sécurité Sociale* maintains special health insurance funds for the unemployed and for those in unstable or seasonal work. Yet the link between employment and *Sécurité Sociale* remains an obstacle to more efficient labor markets and higher economic growth, which together constitute the most promising long-term solutions to France's high unemployment.

The relatively unregulated labor markets in the United States have helped it achieve higher levels of employment than France. That said, the United States appears to be developing its own version of the "insider-outsider" problem. As in the French case, this problem is closely tied to nonwage labor costs, but the U.S. version is even more directly caused

by the health care system. A growing body of evidence shows that the U.S. economy suffers from "job lock" as a result of rising health care costs and health insurance underwriting practices.³³ Job lock occurs when a worker makes career decisions based on the imperative to maintain affordable medical insurance coverage or to avoid the exclusion of a preexisting condition for herself or for a family member.

Studies indicate that employer-provided health insurance reduces job mobility anywhere from 25 to 45 percent in the U.S. economy.³⁴ For economists, this is a frightening statistic, since the nation's economic health ultimately relies on an efficient match between workers' skills and their jobs. If a growing number of workers seek, first and foremost, not jobs where their skills pay them higher wages but jobs that provide them with good health insurance, then productivity and, eventually, economic growth and the U.S. standard of living will suffer. Most worrisome, this phenomenon is commonly observed at the cutting edge of economic innovation and entrepreneurship. Workers who might be most productive if they were to start their own firms choose not to do so because the self-employed and small firms face the highest health insurance costs. Needless to say, someone with a preexisting condition often cannot buy health insurance at any price to cover the malady and is therefore far more likely to remain in his or her current job, however unproductive.

Just as U.S. workers are limiting their own job choices in search of health security, employers too seek shelter from health care risks. This translates into employers' reluctance to take on full-time employees, instead favoring temporary and part-time workers, who are often ineligible for health benefits. Temporary workers' share of the labor market is growing far faster than the labor market as a whole.³⁵ Another response, which is not available to French employers, has been to screen workers for their potential health care costs to the company. In 2005, the nation's largest employer, Wal-Mart, promulgated plans to "dissuade unhealthy people from coming to work at Wal Mart."³⁶ Yet the far more common response, also an impossibility in France, is to reduce or drop health coverage altogether, or to transfer a greater share of cost increases to employees. The proportion of Americans under the age of sixty-five who received insurance from their employers (or a family member's employer) fell from 67.7 percent to 63.1 percent between 2000 and 2004. Employers who offered health coverage fell from 69 to 60 percent between 2000 and 2005.

Taken together, these developments explain much of the recent rise in the number of uninsured Americans. Although temporary workers and

employees at small firms have been most affected, “insiders” in the United States—those who work in solidly unionized industries or for large firms—have also suffered from steep rises in their health insurance premiums. Between 2000 and 2005, premiums rose 73 percent, towering over the cumulative inflation rate (14 percent) and wage growth (15 percent).³⁷

All this points to a tremendous irony. If current trends continue, Americans’ historical attachment to employment-based private health insurance will lead inexorably to a publicly financed health care system. Workers who cannot find health security where it has traditionally been most available to them since the 1940s are already turning to Medicaid in unprecedented numbers, both during their working years and for nursing home care after they retire. Medicaid had more than 50 million beneficiaries in 2004, making it a larger program than Medicare. Meanwhile, those who earn too much to qualify for Medicaid but too little to afford private insurance join the ranks of the uninsured, a group that will grow to 56 million nonelderly adults by 2013, up from 45 million in 2003.³⁸ To be sure, the uninsured include young healthy adults who forgo coverage of their own volition. Yet whether by choice or not, when serious illness or accident strikes, the uninsured inevitably rely on some level of care at public expense, even as they themselves face financial ruin. Add to this the nearly \$600 billion cost of the new Medicare prescription drug benefit and total U.S. national health expenditures will shift from being primarily private to being mostly public by 2014.³⁹ What is more, these calculations do not even include lost government revenue (a form of public subsidy) as a result of employers’ and employees’ health insurance tax deductions, valued at \$188 billion in 2004, a number that has been growing at a 9.2 percent annual rate since 1998.⁴⁰

The legacy of workplace-linked health security must be recognized for what it is—a twentieth-century solution that is failing to solve twenty-first-century health security problems. Because of its extraordinary cost, U.S. health care, like the French, has now passed from being primarily a private affair to a public-private endeavor. With this shift, the burdensome link between employment and health security has become all the more evident.

Liberty, Equality, and Medicine

Much of this book concerns the response of physicians to various health care challenges. During the twentieth century and into the present, French and U.S. physicians have had a common political ideology,

espousing the medical profession's sovereignty over health care. Doctors' struggle to defend their clinical freedoms and medical decision making has long been aided by a shared U.S. and French attachment to private practice, under which doctors and other medical care providers are paid for each individual service. In its purest form, fee-for-service medicine—*paiement à l'acte* in French—permits patients to choose their own doctors and physicians to set their own fees. Equally important, proponents of fee-for-service medicine historically protected the sanctity of the doctor-patient relationship with almost religious fervor, especially against any encroachment by the state.

Doctors' battles against government plans for compulsory health insurance were enormously important in shaping the health care systems of both nations. French physicians agreed to cooperate with compulsory health insurance plans for industrial workers only in 1930, when they obtained valuable guarantees regarding their right to set fees, exercise clinical freedoms, and allow a patient to choose the practitioner. Likewise, U.S. physicians, though fiercely opposed to Medicare in the early 1960s, ultimately obtained similar assurances that protected their clinical freedoms vis-à-vis the state. What is often overlooked, however, is that private insurers—not the state—have historically posed the greater threat to physicians' sovereignty over medical decision making and to a patient's choice of health care provider.

French mutual aid societies served as insurance carriers for compulsory health insurance in the 1930s. Much as U.S. managed care corporations would do in the 1980s and 1990s, mutual societies threw vast resources into building clinics and surgery centers, then staffed them with doctors whom they compensated through a combination of capitation and salary.⁴¹ Patients who patronized these facilities enjoyed lower out-of-pocket costs, but their choice of physician was limited, and financial incentives that might have conflicted with their best interests were ever-present. By providing medical services in much the same way that managed care does today, mutual societies directly violated legal protections of French physicians' fee-for-service practice, leading to successful legislative, legal, and professional action against the offending societies and complicit doctors.

At about the same time, the American Medical Association (AMA) launched professional and legal attacks against group medical practices, such as Kaiser Health Plans, which accepted prepayment for services and restricted a patient's choice to doctors in the plan. In these

battles, the AMA usually prevailed. But they lost the war. Lacking the legal protections of private-practice medicine that French doctors gained in successive compromises on national health insurance, U.S. physicians were overwhelmed in the 1990s by a coalition of employers and insurers who sought lower prices through managed care. A new generation of U.S. physicians was soon signing up with managed care corporations, which now monitor doctors' treatment regimens, doling out incentives and punishments, in ways that would have horrified their elders.

Because of the continued upward spiral of health care costs in France, physicians there are under similar, if less heavy-handed, pressure to abide by clinical practice norms. Indeed, if U.S. health care is becoming more French in its reliance on public funds, France's *Sécurité Sociale* is behaving more and more like a U.S. managed care corporation. Recent reforms have made *Sécurité Sociale* increasingly assertive in its quest to curb hospital stays, pare physicians' use of expensive diagnostic technologies, and mold their habits for prescribing drugs. In fact, the health policy scholar Victor Rodwin has labeled France's ongoing reforms "the birth of state-led managed care." With the introduction of computerized medical records, medical practice guidelines, and gatekeeping primary care physicians, *Sécurité Sociale* hopes to take what it deems the best from U.S. managed care but leave its more unpopular initiatives behind.⁴² The strategy has an appeal. Because nearly 99 percent of France's ambulatory care doctors contract with *Sécurité Sociale*, French patients will never face the maze of provider networks and exclusionary underwriting practices that hamper quality, access, and continuity of care in the United States.

Nevertheless, though France's relatively centralized public insurance system appears a promising candidate for managed care techniques, there is a powerful cultural counterforce rooted in the nation's historical embrace of individualism. Not unfamiliar to Americans, it 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. The tremendous value placed on the individual, combined with physicians' sovereignty over medical decision making, means that French health care reforms that rely on managed care techniques will continue to face difficult if not insurmountable obstacles.⁴³ What is clear is that in both nations, physicians' diagnostic, prescriptive, and therapeutic liberties remain at odds with efforts to rationalize health care, control its costs, and spread its benefits.

Medical Practice Then and Now

As a starting point, we should recognize that at the beginning of the twentieth century, medicine in France and the United States closely resembled each other in both practice and ideals. Medical science had only recently begun to make good on its ambitious promises. In France, the discoveries of Louis Pasteur established the prestige of scientific medicine, setting it apart from popular and folk medicine for the treatment of infection and the promotion of public health. The German Robert Koch identified the tubercle bacillus, thereby demonstrating the power of medical science to isolate the cause of the era's most feared killer, tuberculosis. Also extremely important were improvements in anesthesia, which, by relieving pain, permitted surgeons—then a far less respected branch of practitioners than physicians—to perform what had been impossible procedures on the body's major organs.

Yet the empirical and theoretical case for scientific medicine took decades to advance. The late 1800s were not the late 1900s when discoveries and improved techniques could be quickly shared across the globe. Well into the twentieth century, folkways and patent medicines of dubious value held sway. What mattered most to people, then as now, were results. And since medical science could often do little better than the traditional treatments, and often simply waited for the malady to run its course, the public had nowhere near the respect for doctors that they do today. Physicians' socioeconomic status has always closely reflected the effectiveness of the medical science of their day; this relationship helps us understand physicians' response to health care change.

Had we been able to eavesdrop on a conversation between two typical general practice doctors, one American and one French, posted to the western front during the First World War, in 1917, their conversation would have attested to ideological and practical kinship. Reminiscing about their lives back home, the physicians would have found they had both been raised in petty bourgeois families and had been drawn to medicine in hopes of earning a respectable but not lavish income. Their solo medical practices relied on tiresome travel between rural and working-class households struck by illness. Both doctors would have bemoaned miserly contracts, which, out of financial necessity, they had signed with mutual aid societies or fraternal lodges—contracts that bound them to treat the group's entire membership for a low fixed price. The two practitioners would have been equally upset with industrialists who resisted paying

them on a fee-for-service basis, wanting instead to make them mere employees in their growing enterprises. Their loudest exhortations, however, would have been reserved for their respective governments: both would have sworn to fight any further government meddling in medical care, now that workers' compensation laws had been fully implemented in France and American state governments were approving them at a lively pace.⁴⁴

This Franco-American camaraderie would have stood in stark contrast to the circumstances and ideals of doctors on the other side of the barbwire or to those of a British physician who happened to be standing nearby. Germany had created Europe's first compulsory health insurance for about 4 million industrial workers in 1883, a move that drastically affected the relationship between doctors and their patients, and between doctors and the government. Indeed, if our U.S. and French doctors had been able to share editorials from their medical journals, they would have seen that in both nations medical leaders defined virtually all that was good and noble about medicine by contrasting it with anything and everything German. Likewise, British doctors had flocked to Britain's National Insurance Act, passed in 1911, which, though less constraining than German illness insurance, nonetheless put the country squarely on the side of government-directed health care.

Today, a comparable conversation between two typical primary care physicians in private practice—great-granddaughters, let us say, of our World War One comrades—would also attest to sociological and practical kinship. A typical physician in both nations is nearly as likely to be a woman as a man, and she is very likely to hail from a professional, upper-middle-class family—a daughter of a doctor or lawyer, not a baker. As important as these commonalities may be, the great-granddaughters would find many more differences in their practices than had their great-grandfathers. Virtually all the French physician's patients would be eligible for public health insurance, *Sécurité Sociale*, a circumstance shared by the U.S. doctor only if she restricted her care to Medicare and Medicaid patients, not a common practice. The U.S. doctor's income would be much higher, just over five times the average U.S. wage, while the French doctor would earn only about twice the average earnings of her compatriots. As a primary care practitioner, however, the French doctor would have many more colleagues, about half of all doctors in France, and a relatively easy time flying solo in her own office. Primary care physicians constitute only about a third of U.S. doctors and, because of the almost overarching need to hire non-medical personnel to handle the cumbersome and various insurance billing

procedures, solo medical practices are now far less common in the United States. Despite differences in their offices, both physicians would surely agree that the radically higher incomes of specialists in both countries were out of proportion to their extra training. Primary care physicians work just as hard, they would insist, and entrance to medical school is fiercely competitive in France and in the United States, regardless of whether one plans to pursue a specialty. Finally, for all her envy of her U.S. colleague's higher income, the French doctor could take comfort that she paid only nominal malpractice insurance premiums and had never borrowed to pay medical school tuition. Like all French universities, medical schools are tuition free. If the U.S. practitioner recounted her travails with insurers and her occasional practice of "defensive medicine" to guard herself against lawsuits, the French physician might conclude that doctoring in France may be less remunerative, but it is considerably more hassle-free.⁴⁵

The patients these physicians admitted to hospitals would also be very different from their early-twentieth-century predecessors. At that time, aside from facilities for veterans, which have illustrious histories in both nations, hospitals were local institutions. Most were owned and operated by municipalities, religious groups, or nonprofit organizations whose mission included community service, for example, universities, which built teaching hospitals for their medical students. Publicly traded, for-profit hospital chains were unknown.⁴⁶

Today, France's hospital sector is dominated by community and university hospital medical centers. Yet, as with ambulatory care, where private insurers round out public coverage, private hospitals (both for profit and nonprofit) offer care that complements inpatient services in the public sector. In fact, France possesses the largest private hospital sector in Europe, accounting for 36 percent of all beds for acute cases, a public-private mix that has not changed in the last fifteen years. Generally, the patients with the most serious and complex cases end up in public hospitals, with private hospitals specializing in more routine obstetrics, elective and cardiac surgery, psychiatric care, and radiation therapy. Ultimately, however, the choice of hospital is up to the patient, his or her *Sécurité Sociale* coverage being the same in both the private and public sectors.⁴⁷

Public community hospitals now account for only a quarter of hospitals in the United States. Moreover, in contrast to its French counterpart, the U.S. hospital sector has witnessed a vast transformation in its public-private mix in recent decades. Between 1985 and 1995, the number of public hospitals declined by 14 percent. Of these, nearly two-thirds converted to

private ownership or management, while the remainder closed their doors entirely. Hence, once again, as in the case of public versus private health insurance, the United States and France present mirror images of each other in their emphasis on public versus private ownership or control.

The phenomenon of U.S. hospital closures provides a poignant example of how and why comparative historical approaches to health care are vitally important. U.S. observers generally attribute the closures to a 1980s switch from cost-plus reimbursement (under which hospitals charged insurers their actual costs plus a margin) to a case-based system (whereby hospitals are paid according to the patient's diagnosis). The resulting incentives translated into shorter hospital stays and therefore a decline in the total number of beds, since longer patient stays cost the hospital more without increasing its revenues.⁴⁸ Certainly there is something to this explanation. Yet France also adopted case-based hospital reimbursement in the 1980s. Indeed, it was the first country outside the United States to do so. But France has maintained its relatively high ratio of beds per capita—3.8 per thousand compared with 2.8 per thousand in the United States. And France continues to do so at lower costs. The answer to this paradox is best apprehended through a historical approach, wherein health care is viewed not just in technical terms but also as a nexus of culture, politics, and economics.

The Pitfalls of Language

A history of health care, especially a comparative one, faces several pitfalls. Language is perhaps the most treacherous. One cannot blithely assume that words possess a constant meaning over time and in different countries.⁴⁹ To begin with, the same political term may have very different meanings on either side of the Atlantic, both historically and in contemporary usage. *Liberalism* in France denotes political beliefs that most would identify with fiscal conservatives or libertarians in the United States: advocacy of markets, deregulation, private enterprise, and balanced government budgets. Indeed, a private-practice physician who insists on billing and clinical freedoms in France is known as a "liberal doctor" (*un médecin libéral*); and the burgeoning private-practice medical sector is known collectively as "liberal medicine" (*la médecine libérale*). For the sake of clarity in both interpretation and translation, I use functional terms in the pages that follow—for example, *private-practice*—that correspond with their practical signification in time and place.

Another lexical difficulty in comparing U.S. and French institutions concerns *the state*. The distinction between the United States' federal and

state governments is readily apparent. The term "French state" (*l'Etat français*), however, often capitalized in French documents, includes a civil service whose power relative to the elected government is greater than its U.S. counterpart. To be sure, the federal bureaucracy is no pushover when a new U.S. president wishes to implement substantial change, nor can any governor in the country assume that her state bureaucracy will cooperate fully when directed to execute reform.

Yet in France's more unified political structure, bureaucrats, especially high officials, who usually devote their careers to public service, enjoy an autonomy and public trust not present in the United States. The founding director of *Sécurité Sociale*, Pierre Laroque, is a preeminent example. Very few Americans could name the first director of a comparably popular domestic program, such as Social Security or Medicare. By contrast, in France, it is Laroque, not the prime minister who held the reins of government in 1945, who is widely known and celebrated as "the father" of *Sécurité Sociale*. Yet Laroque was never elected to any office. Indeed, in high state officials, as much as anywhere else in Paris, resides Rousseau's general will, that is, a public perception of the common good. Thus, more so than in the United States, when private interests look to the state to arbitrate a conflict, implement reform, or simply guarantee their rights, they are appealing as much to an elite administrative corps as to elected political leaders.⁵⁰

Next, we must address several terms related to health. A *health care system* today comprises the totality of activities, actors, and institutions devoted to the financing of efforts to prevent, treat, and cure illness or injury. By that definition, the U.S. and French health care systems touch almost every aspect of our societies—from employers to governments to schools to places of worship, not to mention health care providers, insurers, and patients. Yet *health care system* is certainly not a term that would have been understood by someone in 1900. At that time, the broadest comparable concept would have been *public health*, which encompassed the concepts of hygiene, living conditions, and medical facilities that were largely devoted to charity care.⁵¹

In the same way, a *hospital* of 1900 had little in common with today's gleaming medical complexes, staffed as they are by highly trained specialists, equipped with sophisticated diagnostic tools, and filled with effective pharmaceuticals. Hospitals at the turn of the twentieth century were social prisons, hostels for the helplessly destitute, the chronically ill, the tubercular, and the insane. For its residents, the hospital may have been better