ABSTRACT

The Price of Healthiness: The Role of Employers, Government, and Physicians in the Evolution of the Health Care Systems in France and the United States

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The United States has one of the most expensive health care systems in the world, yet there are no comparable outcomes associated with access and quality of care. While other countries consider access to health care services a human right, the United States has maintained a system where too many people are uninsured and are, therefore, not readily able to gain access to these services. Rising costs and a growing vulnerable population led the United States to pass the Patient Protection and Affordable Care Act (ACA) in 2010. France, however, has had compulsory health insurance, fulfilled through *Sécurité Sociale*, for several decades. The current state of both health care systems offers an interesting comparison of how employers, government, and physicians exerted their influence on the eventual passing of compulsory health insurance. Important to this comparison is that even though France has succeeded in completely insuring all of its citizens, a current issue the country must address is the financial burden of keeping a program of such magnitude afloat. Entwined in their history, France and the United States share a commonality in problem and solution, which is ultimately connected to the continual evolution of what defines *healthiness*.

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THE PRICE OF HEALTHINESS: THE ROLE OF EMPLOYERS, GOVERNMENT, AND PHYSICIANS IN THE EVOLUTION OF THE HEALTH CARE SYSTEMS IN FRANCE AND THE UNITED STATES

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TABLE OF CONTENTS

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CHAPTER ONE

The Evolution of Health Care

Introduction

The provision of health care has undergone tremendous transformations all over the world. Today, hospitals are state-of-the-art facilities with a multitude of staff members. Physicians are a fixture of these organizations, but as time has passed, they have been joined by other modern occupations with tasks that a constantly evolving infrastructure requires. Being a physician is no longer a one-man job. There is a whole staff of teammates that not only help physicians with their work but also help keep hospitals up and running. All over the world different health care systems have appeared throughout history with their own players and rules.

Hospitals initially grew out of the need to care for people in various states of their lives, for better or for worse. These changes resulted in the major players involved at the negotiation table. Although both the United States and France have different health care systems, three key groups have exerted their influence on what has now become the present state of these systems: employers, government, and physicians.

Health Care Delivery

Hospitals as Institutions of Religious Healing

Today, hospitals have become centers that house the most advanced technologies used in medical diagnosis and treatment, as well as centers for training various types of

health care personnel.[1] Needless to say, health care around the world has come a long way from its feeble origins. The healing capabilities of hospitals have improved in such a way that maladies previously thought to be incurable are no longer hindering the lives of people in the same magnitude. However, the exponential growth of hospitals and the complications that come with managing such huge corporations has created multiple business ventures, which has removed some of the "humanity" at the foundation of original hospitals.

The first "hospitals" were humble institutions that served predominately religious purposes. They were mainly utilized to provide care for those who fell ill while participating in religious activities and pilgrimages.[2] This religious undertone continued as hospitals increasingly became prime locations where the poor and destitute were provided a roof over their heads.[3] The scope of their services was limited, but these early hospitals occupied a position many were not willing to occupy: prolonged interaction with the outcasts of society. As time would tell, the expectations of the services provided by hospitals grew, and these organizations developed the responsibility of not only providing a place of refuge for the vulnerable but to also heal physically what was once incurable.

Initially, hospitals were not the ideal location to seek care, and a positive image of hospitals did not take hold until hospital conditions improved between the two World Wars.[4] In fact, the first hospitals were considered "social prisons, hostels for the

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[1] Leiyu Shi and Douglas Singh, *Essentials of the U.S. Health Care System*, 3rd ed. (Jones & Bartlett Learning, 2012), 63.

[2] Bryan S. Turner, "Hospital," *Theory, Culture & Society* 23, no. 2–3 (May 1, 2006): 573.

[3] Ibid.

[4] Paul V. Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 1st ed., The Culture and Politics of Health Care Work (New York: ILR Press, 2008), 26.

helplessly destitute, the chronically ill, the tubercular, and the insane."[5] In France, the French Revolution provided the catalyst for many changes involved in the viewing of hospitals as a place of refuge for sick patients. The traditional hospital was viewed as a representation of the corruption of the *Ancien Régime*, and the family home was encouraged to be the "natural place for the cure of the sick."[6] Original hospitals were specialists in religious cures, yet they lacked the medical expertise characteristic of medical facilities today.

Over time, hospitals became places where technology and science-based discoveries took precedence over spiritual healing. In France, hospitals had, for several centuries, a history of religious charity care.[7] Hôtel-Dieu illustrates a specific example of the drastic transformation of hospitals into entities that became more secular in their purpose. As its name implies, Hôtel-Dieu or literally "House of God" traces its origins to a religious-based tradition of serving the poor.[8] Since being built in the 16th century, Hôtel-Dieu had grown exponentially; so much so that the "House of God" actually caused an increase in the rate of mortality, morbidity, and spread of the disease due to being unable to efficiently care for the multitude of patients that passed through its doors.[9] It did not make sense to have a facility unable to achieve the sole task it was given: keep the workforce strong and healthy. If this task was unfulfilled, the nation as a whole could suffer.[10] The mentality behind this idea was that sick workers could not contribute to the overall wealth of the country. Concerned that not addressing the issue

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[5] Ibid., 25.

[6] Turner, "Hospital," 574.

[7] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 184.

[8] Louis Greenbaum, "Science, Medicine, Religion: Three Views of Health Care in France on the Eve of the French Revolution" 10 (August 1, 1981): 384.

[9] Ibid., 274–275.

[10] Ibid., 376.

would cause more damage, on June 22, 1787 King Louis XVI decided that Hôtel-Dieu had to go, and, by his orders, it was decided that the thousand-year-old hospital was to be demolished and rebuilt as four different locations.[11]

As it turned out, Hôtel-Dieu was not demolished, but it illustrates the problems that can evolve from an institution trying to do more than it can handle and separate factions arising to protect their own agendas. At the time it was ordered to be closed down, it housed an alarming 3,000 patients, larger than 84% of the cities of France at the time, in cramped quarters.[12] After the order issued by King Louis XVI, several groups became entrenched in the politics of running a hospital. All were trying to protect their roles in the hospital and vying for influence. Physicians were concerned for their patients and their livelihood, scientists were concerned about the logistics of taking care of patients with new technologies, and Augustinian nuns were concerned that God was being replaced in the healing process.[13]

The Augustine sisters held onto the belief that they had been divinely appointed to serve the "suffering Christ" in each of the patients they served, and they placed a greater priority on treating the soul than on attaining physical wellness.[14] The sisters felt that any new ordinance compromised their presence and duty as stewards of God's glory. Eventually, the hospital administration, which had become increasingly exasperated with the demands of the Augustine nuns, lessened their role and, effectively, the role of religion in hospitals. Changing Hôtel-Dieu's name to "le Grand Hospice d'Humanité"

[11] Ibid., 373.
[12] Ibid.
[13] Ibid., 374, 377.
[14] Greenbaum, "Science, Medicine, Religion: Three Views of Health Care in France on the Eve of the French Revolution."

completed the transformation of a previously religious institution to a secular, public, state-supported health center.[15]

Hôtel-Dieu was in danger of being closed down because it was inefficient and could not offer acceptable care to its patients. Arguably, many hospitals today share similar issues. The institutionalization of health care occurred in Europe before the United States, but hospitals quickly became centers for advanced technology and training of various types of health care personnel.[16] As technology has advanced, the demand for the newest cures has also increased. Due to this growth in demand, health care systems risk becoming overwhelmed. Without regulation, these health care institutions and health care systems could spiral out of control and become more cumbersome than helpful. Like Hôtel-Dieu, numerous parties with their own agendas have hindered the development of both health care systems. Without change and without a united front, patients' best interests may be overlooked.

Hospitals: Medical Meccas

In 2000, the World Health Organization gave the French health care system the distinction of being the best health care system in the world because it met criteria based on overall satisfaction and support from its people.[17] On the other hand, the United States' fragmented health care "system" has stepped into the political limelight multiple times to fix its various issues, and the Affordable Care Act (ACA) of 2010 was passed to tackle the issue of unequal access to health care services for Americans.

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[15] Ibid.

[16] Shi and Singh, *Essentials of the U.S. Health Care System*, 63.

[17] Victor G. Rodwin, "The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States," *American Journal of Public Health* 93, no. 1 (January 2003): 31.

Unlike France and many other developed countries, the United States does not have a universal health insurance program where the government plays a dominant role. In fact, throughout history the United States has gone through great lengths to distance itself from "socialized medicine." The characteristic difference between these countries and the United States is the view that all of these developed countries believe that citizens are entitled to receive health care services because it is their *right*; however, in the United States, only insured Americans have the privilege of obtaining routine and basic health care services on a continuous basis.[18] In the United States, the private sector has played the greater role in providing health care to American citizens, while the government has, until recently, largely been confined to filling the gaps that the private sector was unable to fulfill.[19] Recently, the tides have changed and the role of the government in the U.S. health care has continued to grow, especially due to growing costs associated with the provision of health care.[20] The passing of the Affordable Care Act (ACA) on March 23, 2010 signified a more hands-on approach that the government was going to take regarding the issue of rising health expenditures and the influence that uninsured citizens have on that number. Because the ACA is early in its tenure, it is hard to surmise the impact, positive or negative, that it may have in the future on the provision of health care.

France was unable to completely cover the remaining 1% of its uninsured population with *Sécurité Sociale* until January in 2000.[21] This was able to occur through incremental reform; however, in contrast, the steps the United States has taken in passing

[18] Shi and Singh, *Essentials of the U.S. Health Care System*, 1.
[19] Ibid., 315.
[20] Ibid., 314–315.
[21] Rodwin, "The Health Care System Under French National Health Insurance," 31.

the Affordable Care Act would still leave an estimated 21 million people uninsured.[22] Similar to the French, the United States had, since the early to mid-1900s, attempted various plans and proposals to move the nation towards a national health care; however, these efforts have been mostly unsuccessful until recently. The reluctance to move towards "socialized medicine" can be traced back to the insistence of a select few that adopting an overhaul of the health care system in the United States in this way would align it with what they considered "communism."[23] Because most of these feelings were adopted during times of crisis, especially when Germany became the poster child for any kind of socialist programs and patriotism ran rampant, the feelings that persisted after the end of these disputes lingered on for several more decades.

As new technologies have changed the capabilities of medicine, the United States has found itself on the forefront of many of these new discoveries. New medical technology has led to increased demand for expensive treatments with the capability of treating a variety of ailments that were previously incurable.[24] Although the United States boasts a very successful research background, it also has the most expensive health care system in the world. In 2011, the United States' total expenditure on health as a percentage of gross domestic product was 17.7, while France's total expenditure on health measured 11.6. France may not have the most expensive health care system in the world; however, it still possesses the "illustrious" second position.[25] Even though the United States spends an alarming amount of money on health care, many individuals still have only limited access to basic care. Health insurance in the United States is the

[22] Shi and Singh, *Essentials of the U.S. Health Care System*, 339–340.
[23] Ibid., 337.
[24] Ibid., 11.
[25] OECD, "Total Expenditure on Health," *Health: Key Tables from OECD* No.1 (2013).

primary means of ensuring access to health care services, but in 2010 the number of uninsured Americans was estimated to be about 48.2 million or 18.2% of the population.[26] It is apparent that having the latest technological innovations does not necessarily equate to guaranteeing access to health care services to the whole American population, which is an issue that has gained considerable attention as of late.

Between France and the United States, several interesting statistics potentially show the inefficiencies that plague the United States' health care system. The United States may invest a substantial amount of money on its research programs, but the French were still found to live longer on average than their United States counterparts. In France, the life expectancy at birth for the total population was 82.2 for 2011; in contrast, the United States average life expectancy at birth for 2011 was 78.7.[27] Infant mortality in 2011 measured in deaths per 1000 live births was 3.5 in France, while in the United States it was 6.1.[28] These statistics could suggest that the mindset of modern medicine in the United States is in the wrong place, and, perhaps, a focus on preventative care instead of episodic care could prove helpful in the long term. Many European countries put more emphasis on preventative care, while the United States has evolved into a system, which treats the illness and not the patient. In general, it is a common belief that increasing the quality and quantity of primary care services will lead to an overall improvement in population health.[29] Another troubling occurrence is the presence of a dichotomy

[26] Shi and Singh, *Essentials of the U.S. Health Care System*, 12.

[27] OECD, "Life Expectancy at Birth, Total Population," *Health: Key Tables from OECD* No. 11 (2013).

[28] OECD, "Infant Mortality," *Health: Key Tables from OECD* No. 14 (2013).

[29] Leiyu Shi, "The Impact of Primary Care: A Focused Review," *Scientifica* 2012 (2012): 7, accessed April 4, 2014, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/.

between the amount of time and money spent on the latest technological advances and the number of people who may actually be able to afford to use them.

Considering that physicians are the primary deliverers of health care, it is interesting that France averaged 3.1 physicians per 1000 population, while the United States averaged only 2.4 per 1000 population.[30] With slightly more physicians per 1000 population, the French were more likely to go see their physicians. Physician office visits in France were 6.0 per capita; while in the United States it was 2.8 in 1999. They were also more likely to be admitted and stay longer in the hospital than their American counterparts. The average length of stay for all inpatient hospital services in 1999 was 10.6 for France and 7.0 for the United States, and the admission rate for short-stay hospital services per 1000 population was 170.1 in 2000 for France, while it was 118.0 in 1998 in the United States.[31] Another interesting statistic is that magnetic resonance imaging (MRI) use per 1000 population was 102.7 in the U.S., which, when compared to the 67.5 that France measured in 2011, seems an unreasonably high number.[32] These numbers may reflect the increasing trend for U.S. physicians to engage in *defensive medicine* over fear of potential malpractice lawsuits.[33] Prescribing additional diagnostic tests can be unnecessary, help drive up costs, and promote inefficiency.[34] In general, there is no stigma associated with longer stays in France, and their compulsory health insurance is more generous without the negativity associated with being a Medicaid beneficiary. Unlike the United States where health care costs increase with deteriorating

[30] OECD, "Practising Physicians (doctors)," *Health: Key Tables from OECD* No. 29 (2013).
[31] Rodwin, "The Health Care System Under French National Health Insurance," 34.
[32] OECD, "Magnetic Resonance Imaging (MRI) Exams, Total," *Health: Key Tables from OECD* No. 46 (n.d.).
[33] Shi and Singh, *Essentials of the U.S. Health Care System*, 290.
[34] Ibid., 20.

health status, coverage in France increases as individual costs rise.[35] Not only must a family deal with the overwhelming stress of having a sick loved one, they must also undergo the burden of paying for the care received after their death or successful treatment. Coinsurance and direct payment is an important part of the French national health insurance (NHI) or *Securité Sociale*, but a patient is exempted from these costs when they meet certain criteria. These criteria include: expenditures exceeding $100, hospital stays exceeding 30 days, suffering from serious, debilitating or chronic illness, or when the patient income is below a minimum ceiling, which would qualify them for free supplementary coverage.[36] With this in mind, it makes sense that French citizens would feel more inclined to make an appointment to see their physician if they felt a little under the weather. In the United States, however, there may be an underlying negative stigma preventing patients from seeking the care of their physicians when they need it most due to the connection that health care is expensive.

A variety of sociological reasons could also be attributed to the disparity in these numbers; however, the general consensus is that spending more than any other country on health care does not necessarily mean the actual health care delivery of services will meet the standards of or be better than other developed countries. Although France does not fare much better than the United States in terms of money expended towards its health care system, it is important to note that the health care system currently in place in France was achieved over a long period of time, allowing the changing social environments to mold it into its present state. All things considered, France was able to provide health care services more efficiently and with less money, which is a promising example that the

[35] Rodwin, "The Health Care System Under French National Health Insurance," 32.
[36] Ibid., 35.

same could be possible in the United States. The health care systems of France and the United States may be strikingly different; however, both countries had the opportunity to respond to the same social pressures throughout history. As politicians in both countries sit down to talk about the direction of the health care systems respective of each country, they will have to tackle issues associated with access to health care services, as well as the ability for both systems to support themselves financially. In this way, not only are France and the United States similar, but they could both use help from opposite sides of the pond.

Health Security: Changing the Name of the Game

In France, hospital bed use measured according to density per 1000 population decreased from 7.2 to 6.7 from 2005 to 2011, while the U.S. remained steady with a change of only 3.2 to 3.1 from 2005 to 2011.[37] In 2008, there were about 960 million visits, or more than three visits per person, to office-based physicians in the United States.[38] Although there was a slight decrease in bed use in the United States, a total of 36,156,245 admissions were measured in all U.S. registered hospitals in 2012.[39] Contrary to the number of admissions into U.S. hospitals, access to health care services in the United States is still limited.

The United States may have some of the best medical care available in the world, but many times these services are not available to those without health insurance plans. Individuals that are uninsured have limited options and, instead of paying physicians directly and seeking care from safety net providers, they opt to use hospitals' emergency

[37] OECD, "Hospital Beds," *Health: Key Tables from OECD* No. 30 (2013).
[38] Shi and Singh, *Essentials of the U.S. Health Care System*, 161.
[39] American Hospital Association, "Fast Facts on US Hospitals" (Health Forum LLC, 2014), http://www.aha.org/research/rc/stat-studies/fast-facts.shtml.

department services. Because of the Emergency Medical Treatment and Labor Act of 1986, hospitals are not allowed to deny care to anyone who walks through their doors, regardless of their ability to pay. This has resulted in an abuse of the services offered by emergency departments and subsequent cost-shifting of these fees to privately insured individuals, employers, and the government.[40]

In the United States, the healthcare industry has become the largest employer in the nation, employing at least 13% of the total labor force. Economically, in 2010, it contributed 18% to the gross domestic product.[41] These numbers reflect the increased demand for health care services; however, the actual delivery of these services is not so clear cut. With the volume of patients visiting hospitals and receiving health care services soaring, it is becoming apparent that many changes need to be made to ensure that everyone is not only receiving needed health care services but that these services are good quality.

The basis for what health care entails is a complicated subject because the term *health* has changed its meaning throughout history based on the capacity of the hospital to heal. According to today's standards, a *health care system* is an entity and all of its components "devoted to the financing of efforts to prevent, treat, and cure illness or injury,"[42] a definition that implies current health care systems *should* include much more than just the provision of medical care.[43] In fact, the World Health Organization (WHO) defined *health* in 1948 as being the "complete state of physical, mental, and social well-

[40] Shi and Singh, *Essentials of the U.S. Health Care System*, 19.
[41] Ibid., 79.
[42] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 25.
[43] Shi and Singh, *Essentials of the U.S. Health Care System*, 31.

being, and not merely the absence of disease or infirmity."[44] Both of these definitions exemplify a shift in thought from *health* as a term referring to the absence of physical disease or injury and towards the ability to upkeep bodily function, as well as mental wellness.[45] Further, new definitions make the implication that more of society is now intimately involved in the task of keeping people healthy, which marks a great divergence of what was understood as *health care* in the 1900s. The changing image of what "health" entails has influenced the paths many health care systems have taken because a more complicated definition of *health* has resulted in more elaborate solutions to ensure the entire biopsychosocial aspects of a person.[46]

The changing landscape of medicine has also brought certain players to the forefront, especially in the United States. During the late 1800s, medical education and practice were more advanced in Great Britain, France, and Germany than in the United States. At this time, medical education was not supplemented by science, and the medical practice was, therefore, more a trade than a profession.[47] With changes in medical education, technological advances, and favorable economic changes, U.S. doctors, who previously lacked prestige and demand for their services, were no longer forced to seek business by going to the homes of their patients. Setting up personal offices allowed physicians to treat more patients, and a rise in income, along with a boost in reputation, followed. In the early 2000s, French physicians' average annual income was $55 000, which is barely one third of what American physicians made ($194 000).[48]

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[44] Ibid.
[45] Ibid.
[46] Ibid.
[47] Ibid., 5.
[48] Rodwin, "The Health Care System Under French National Health Insurance," 35.

With the growth in influence of physicians, the changing definition of health, and the increased health care needs of people all over the world, it is becoming difficult to not only finance this intrinsic necessity but also to figure out how each component fits into the grand scheme of things. France's controversial distinction as the best health care system is not without flaws. A huge issue for France will be discussions about how to maintain a system that has been mounting more and more costs. The cost of health care is also problematic in the United States, but at this point it is unclear if the Affordable Care Act will be able to remedy this growing issue. Throughout history, health care systems have been shaped by similar social and political forces. Taking different paths has led the two systems to where they are today; from the outside they seem to be at odds to each other, yet many of their current problems are one and the same. Because the United States' health care system is in a state of flux, it is easy to look towards other countries as examples of what the United States should put into place. In the eyes of the World Health Organization, France may be the better of the two based on numbers and, from this perspective, the United States may have a lot to learn from their friends across the pond. However, France is also experiencing rising health care costs comparable to the levels of their U.S. counterparts. Steps that the United States takes to address these issues could also lead to similar solutions in France.

How Did We Get Here and How Do We Get Out?

Three groups that have influenced the present state of the health care systems in the United States and France are employers, the government, and physicians. Employers started offering insurance benefits as a negotiation tool, and now many different types of insurance companies have a stake in the current changes the United States' health care

system is undergoing. Today, employer-based insurance could be considered an obsolete concept that hinders the ability of Americans to be competitive in the job market, especially when most consider employer-provided insurance an important condition for seeking employment at any company.

The governing bodies for the two countries have both had their roles in shaping their countries toward socialized medicine. With government intervention, an increase in the number of people covered has been realized, but rising costs jeopardize maintaining the progress. Changes suggested or attempted by these governing bodies have had varying results due to the insistence of some groups to fight for their own agendas or the legislative action being too narrow in scope.

Lastly, physicians have had a huge influence on the many directions the health care systems have taken in both countries. Due to their rising prestige, physicians have been able to hinder certain laws from passing. Perhaps to protect their hard-earned autonomy and financial wealth, physicians are less willing to change.

The roles of these three groups in shaping the present health care systems may provide clues to future solutions. Key to improvements for the populations of these countries as a whole is to change the current mindset of each entity operating according to its own wants and desires. An important issue that has come up in both countries is how to solve the rising health care costs, while still being able to guarantee that the quality of care does not suffer. Removing the dependency of health security on employer-based insurance and focusing on primary care could help address these issues and will be addressed in the following chapters. However, this may prove extremely difficult as this involves an overhaul in how these entities operate and think. If all of

these groups were to focus their efforts on a common goal, they could very well help to address the issue of guaranteeing everyone good quality care without the high costs associated with fragmented systems.

CHAPTER TWO

The Rise of Employer-Based Insurance

State of Emergency

Post-World War I

Throughout history, France and the United States have had to adapt to the ever-changing issues of their nations. Following the First World War (1914 – 1918), a combination of new ideas and an influx of people moving from rural to urban areas caused a snowball effect of change. More people were moving to the city and becoming nonagricultural workers. From 1860 to 1910, the number of Americans living in the cities had increased substantially from less than one fifth to almost fifty percent of the population.[1] Combined with the effects of the war, this mass movement of people influenced how health care would be provided.

Following the First World War, an increased demand for war-materials led to a larger number of employees who contributed to the increase in union membership. After the Armistice, a large portion of these employees in both the United States and France partook in strikes, which, according to the opinions of many employers, had a detrimental effect on the economies in both countries. In an effort to maintain control, many companies in the late 1910s and early 1920s began employing company doctors to handle the health issues of their employees or provided employer-funded benefits themselves.[2]

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[1] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 33.

[2] Ibid., 43–44.

Private health insurance in the United States originated from disability coverage provided to employees if they were to suffer temporary disability.[3] The effect of implementing mutual benefit associations increased loyalty to employers and less resentment among workers and union leaders; however, only 10% of U.S. industrial firms had these types of programs in place by 1917.[4] Because the First World War proved deadlier and costlier than anticipated, popular support was only maintained by promises to increase the rights and prosperity for everyone.[5] The increase in industrialization, paired with increases in urbanization, social displacement, and economic power made implementing these promises difficult,[6] but motivation for pursuing solutions to these problems was consistent throughout the duration of both World Wars.

With a new emphasis on health security, employer-provided health care took root. A growing workforce with very little savings was threatened by the greater potential to lose wages due to illness. This was a time when the costs associated with medical expenses were nowhere near the damage one could incur if illness prevented the ability to bring in a paycheck.[7] The importance of remaining healthy in order to be productive in the workforce gave way for private health insurance to become more prevalent in the United States. The first broad-coverage health insurance in the United States manifested itself as workers' compensation where cash payments were made to workers for wages they lost due to job-related injuries and disease.[8]

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[3] Shi and Singh, *Essentials of the U.S. Health Care System*, 64–65.
[4] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 45.
[5] Ibid., 34–35.
[6] Ibid., 34.
[7] Ibid., 40.
[8] Shi and Singh, *Essentials of the U.S. Health Care System*, 64.

Post-World War II

Throughout history, employers have had a substantial role in the evolution of health security. Concerned employers vocalized their concern about the possible negative effects that compulsory health care would have on the ability of workers to compete in world markets. Medical insurance and other forms of nonwage compensation had been commonly used by employers as mechanisms to protect their sovereignty and gain popular support amongst their employees. There was a fear associated with the inability to use promises of compensation as leverage to keep workers satisfied if compulsory health insurance was implemented.[9] The first broad-coverage health insurance in the United States gave way to further experimentation with the idea of government-sponsored health insurance.[10] However, unfavorable conditions that included the growth of private health insurance, or voluntary health insurance, and a thriving economy prevented a national health care program from becoming a feasible alternative in the United States.[11] With similar problems, French employers utilized the same technique and implemented sickness insurance funds for their employees.[12]

The popularity of employer-based health insurance would continue to increase in the United States for several reasons related to World War II and the expanding role of the government. During the Second World War, the U.S. Congress attempted to control wartime inflation by imposing wage freezes. Employees saw employer-paid health insurance as a satisfying alternative to the loss of raises in their salaries during the

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[9] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 43.

[10] Shi and Singh, *Essentials of the U.S. Health Care System*, 64.

[11] Ibid.

[12] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 32–45.

Second World War. The relationship between health insurance and employers was further strengthened when the U.S. Supreme court ruled in 1948 that employee benefits were a legitimate part of union-management negotiations. It is no surprise that health insurance became an important component of collective bargaining between unions and employers. Lastly, Congress made a change in 1954 to the Internal Revenue Code that made employer-paid health coverage nontaxable. Employees saw this as the equivalent of receiving a raise without having to pay additional taxes.[13] The result of this occurrence was the growing reliance on employers for obtaining health security, which would become a permanent fixture in the United States' health care system.

Rising Costs and Inefficiencies

After 1930, the wider availability of private health insurance allowed an increasing number of people the ability to pay for hospital services, especially with early plans providing generous coverage for inpatient care with fewer restrictions placed on the use of hospital-based services that had become more unaffordable as demand had risen.[14] Having greater accessibility and resources to spend, many people took advantage of these favorable conditions to utilize health care services more reasonably available to them. Until 1977, health coverage, whether through private or public insurance, was constantly increasing, covering about 85% of the population.[15] Combining greater accessibility with advancing medical technologies created a dangerously promiscuous relationship. Being *healthy* is no longer defined as being merely *illness-free*, instead it is associated with a

[13] Shi and Singh, *Essentials of the U.S. Health Care System*, 66.
[14] Ibid., 189.
[15] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 182.

wide range of mental and social factors.[16] Changing the definition of what is *healthy* and how one could obtain it has made controlling health care costs incredibly challenging. In other developed countries equal access to health care services is seen as a right of the citizen. However, it is very difficult to tell an American citizen to stop using health care services when part of the reason they are able to receive health care services is through their employment and, therefore, their hard-earned money.

One of the contributing factors to the high expense of health care services is third party payment for the majority of these services. Patients generally pay a price that is drastically lower than the actual cost of the service.[17] It has become common for patients to utilize health care services more often when they are covered by insurance, leading to excessive utilization of health care services, and, thus, contributing to growing costs of health care services.[18] Possessing health insurance has the effect of desensitizing the provider against the price of services, resulting in the delivery of additional and more expensive services that may have no added health benefits.[19] When patients are not paying for the bulk of the services they use, they are shielded from the actual cost of health care, and, therefore, they have little incentive to be cost-conscious when someone else is taking care of the majority of the tab.[20] Insurance requires some type of cost sharing to reduce the misuse of insurance benefits, which is why the insured assumes part of the risk through premiums, deductibles, and copayments.[21] In order to promote more

[16] Ibid., 11; Shi and Singh, *Essentials of the U.S. Health Care System*, 25.
[17] Shi and Singh, *Essentials of the U.S. Health Care System*, 284.
[18] Ibid., 132.
[19] Ibid.
[20] Ibid., 288.
[21] Ibid., 134.

responsible behavior in health care utilization, many of the available types of health insurance options encourage the insured to pay for part of the services used.[22]

Private health insurance or voluntary health insurance is not mandatory. In France, all residents are automatically enrolled into insurance funds based on their occupational status, but 90% of the population opts to subscribe to additional supplementary health insurance to cover other benefits that are not covered by the French national health insurance (NHI), or Sécurité Sociale.[23] In contrast, the United States' government has long fulfilled a minimal role in health insurance, only paying for the instances that the private sector is unable to cover.[24] The modern health insurance industry in the United States is pluralistic because private insurance includes many different types of health plan providers, including commercial insurance companies, Blue Cross/Blue shield, self-insured employers, and managed care organizations (MCOs).[25]

In the United States, large employers are more likely than small employers to offer health insurance benefits to part-time workers. Among employers offering health insurance, there are 79% of workers eligible for health insurance, yet only 65% decide to take the coverage.[26] If the majority of workers are more likely to consider jobs that provide health insurance, why would someone opt out of accepting when health insurance is viewed as a privilege that few can benefit from? The main reasons someone may not take their own employer's health insurance may have to do with coverage under a spouse's plan, low wages, and young age.[27] After the initial spike in insured persons

[22] Ibid., 135.
[23] Rodwin, "The Health Care System Under French National Health Insurance," 36.
[24] Shi and Singh, *Essentials of the U.S. Health Care System*, 315.
[25] Ibid., 135.
[26] Ibid.
[27] Ibid.

before 1977, the 1980s experienced a reversal of sorts. The rate of health coverage fell from 87% to 84% by 1992 because of an economic recession.[28]

The problem associated with a third party payment system is that the insured may never be aware of what the true cost of health care is. In this way, a single-payer health care system may cut health care administrative costs, such as management of financing, insurance, delivery, and payment functions, by half because the government would, instead of private insurers, pay for all health care costs.[29] However, the French health care system illustrates that a single-payer system is not necessary to achieve universal coverage. The eventual coverage of all French citizens through incremental reform is also different than the instantaneous changes the United States wants to make. What might prove to be more productive is piecemeal reform that extends coverage to portions of the population with the eventual goal being equal coverage for all.[30]

Many French beneficiaries continue to rely on employers to purchase supplemental mutual society health coverage that make up the difference between what *Sécurité Sociale* could cover through reimbursements and physician fees. Payroll levies continue to take a flat percentage of workers' wages without regard for their overall income.[31] Health insurance coverage more than doubled, from 45%to 95% of the population by 1967; however, health care spending grew at twice the rate on average of what *Sécurité Sociale* offered to new beneficiaries, far surpassing general economic growth. Due to this fact, health care has continued to consume more of France's national

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[28] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 192.

[29] Shi and Singh, *Essentials of the U.S. Health Care System*, 289.

[30] Rodwin, "The Health Care System Under French National Health Insurance," 36.

[31] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 153.

income every year since 1947, and the United States has had similar outcomes as well.[32] U.S. Medicare had a similar effect on health care financing because the Medicare wage levy was also a regressive tax, which meant it took a large quantity from the disposable incomes of low-wage workers compared to some better-paid coworkers.[33]

Health maintenance organizations (HMOs) and managed care have overtaken the bulk of providing health care services to Americans.[34] The earliest example of an HMO-like program in the United States was during the early 1900s when salaried physicians offered their services for certain railroad, mining, and lumber companies.[35] Managed care and HMOs evolved out of the employers' and insurance companies' lack of incentive to manage the delivery of health care services or payments made to providers.[36] Encouraged by the escalating costs of health care expenditures, especially those associated with Medicare and Medicaid, President Richard Nixon signed the Health Maintenance Organization Act in 1973 into law.[37] HMOs were not popular in the 1970s because of the associated stigma of prepaid group practices that limited patient choice of doctor and a physician's clinical freedom.[38] Initially unpopular in the 1970s, this changed when President Jimmy Carter loosened some restrictions, such as waiving its obligation to community rating and altering the definition of comprehensive medical coverage.[39]

At first HMOs did not catch on quickly; however, a substantial increase in enrollment occurred during the 1980s and 1990s. In 1971, 33 HMOs were serving 3.6

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[32] Ibid., 156.
[33] Ibid., 153.
[34] Ibid., 168.
[35] Shi and Singh, *Essentials of the U.S. Health Care System*, 215.
[36] Ibid., 212.
[37] Shi and Singh, *Essentials of the U.S. Health Care System*; Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 168.
[38] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 170.
[39] Ibid., 171.

million enrollees, and by 1985, 377 HMOs covered 16.7 million subscribers.[40] By 2002, 95% of all employees insured through employer-sponsored health insurance were enrolled in managed care plans.[41] HMOs have not only decreased the amount of Americans enrolled in traditional fee-for-service plans and increased those covered by managed care plans, but they have also become a primary means of delivering health care services to many Americans today.[42]

The passing of the Health Maintenance Organization Act of 1973 brought along hopes of reducing costs, stimulating competition among health plans, increasing efficiency, and slowing the rate of growth of health care expenditures.[43] In this kind of system, medical care providers have a shared responsibility with insurers for their patients' health and financial responsibility for health and eventual recovery of the patient.[44] A single organization takes the responsibility of managing the financing, insurance, delivery, and payment involved with each patient's utilization of health care services.[45] Not only does a managed care organization (MCO) function like an insurance company by assuming all risk, but they also negotiate premiums between the employers and themselves, arrange to provide the health care services by establishing contracts with providers, and encourage cost-conscious payment methods, such as capitation or discounted fee-for-service.[46] In this type of setting, there is an incentive for physicians and hospitals to quicken the healing process because additional tests and therapies

[40] Ibid.
[41] Shi and Singh, *Essentials of the U.S. Health Care System*, 212.
[42] Ibid., 217.
[43] Ibid., 215.
[44] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 168.
[45] Shi and Singh, *Essentials of the U.S. Health Care System*, 212.
[46] Ibid., 212–214.

increase the plan's cost and do not bring along the reward of additional revenue.[47] After the appearance of the first HMO, several different types of managed care plans, such as Preferred Provider Organizations (PPOs) and point-of-service (POS) plans, have evolved because of three factors: differing freedoms in choice of providers, different ways of arranging the delivery of health care services, and differences in payment and risk sharing.[48]

France experienced similar experimentation with managed care techniques, as well, especially as the division of French doctors into different sectors gave way for more cost shifting to patients.[49] Under the tenure of Prime Minister Edouard Balladur, there was a general consensus that physicians and patients needed to become "self-rationing providers and consumers of medical care."[50] Employer and employee contributions remained a predominant form of health insurance funding, and by 1994, it had reached 19.6% of gross wages. Of the 19.6%, employers paid 12.8%, while employees contributed 6.8%.[51] Prime Minister Alain Juppé proposed a partial abandonment of employment-based financing of *Sécurité Sociale* and wanted to depend more on income tax, or the Contribution Sociale Généralisée (CSG). He hoped this change would result in economic growth, which would contribute to the revenues collected by *Sécurité Sociale*.[52] Even after Juppé's reform, French workers still found themselves paying for

[47] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 168.
[48] Shi and Singh, *Essentials of the U.S. Health Care System*, 222.
[49] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 177.
[50] Ibid., 200.
[51] Ibid., 201.
[52] Ibid.

about 75% of their health care through insurance premiums deducted from their paychecks.[53]

Similar to the United States, supplemental health insurance coverage grew in popularity after the 1970s. Between 1980 and 1987 reimbursements for medical procedures slipped about half a percent per year, and by 1994, France had the lowest reimbursement rate for ambulatory care when compared to the15 countries of the European Union.[54] Because they could not rely on *Sécurité Sociale* to reimburse the majority of their health care costs, most French citizens turned to supplemental health coverage. Of the 83% that chose to look toward the private, for-profit insurance industry or traditional, non-profit mutual societies, half of all supplemental coverage was provided through the workplace.[55] Even then, of the 83% that obtained private supplemental coverage by 1995, only 68% of skilled wage earners were able to obtain supplemental health insurance. In comparison, 90% of white-collar managers were able to enjoy the same privilege.[56] With increased accessibility, those with supplemental insurances were 86% more likely to seek medical care than those without this coverage, which matches the trend that occurred in the United States.[57]

Today, employer-based insurance has done more to hinder economic growth than help it. Employer-based insurance evolved out of the needs of a once dominant industrial economy, and was convenient for a time when medical expenses did not outweigh the value of lost wages. Now the opposite is true, due to the rising cost of health care.[58]

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[53] Ibid., 202.
[54] Shi and Singh, *Essentials of the U.S. Health Care System*, 202.
[55] Ibid.
[56] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 203.
[57] Ibid.
[58] Ibid., 219–220.

When job growth moved from manufacturing to service-focused occupations, health security became increasingly more important in the 1990s.[59] A study that took place from 1985 to 1991 showed that for every 100 manufacturing jobs lost, 224 workers and dependents lost their health insurance. It also showed that for every 100 new service jobs, only 40 workers and their dependents gained coverage.[60] This study illustrates the growing importance of having health insurance but the waning ability of employers to provide such benefits. As such, this may indicate alternatives should be considered, one of which is to separate the connection between employers and insurance.

In the United States, there is an association between "job lock" and employer-provided insurance. This term refers to workers, especially those with families, being forced to seek jobs that provide health security, instead of choosing the more competitive and better paying positions. Both the United States' high payroll-financed health insurance premiums and France's health-related *Sécurité Sociale* wage levies have become barriers to labor mobility and higher employment rates.[61] In the United States alone, the connection between employment and health security has excluded millions of people from securing access to health care because of their positions in the labor force, especially when they belong to small businesses or other companies where group coverage is not available or too expensive.[62]

Although France chose to move away from a purely "employer-specific health security" that is still popular in the United States, the influence of employers and French main unions still strain *Sécurité Sociale*. Due to this influence, *Sécurité Sociale* has had

[59] Ibid., 155.
[60] Ibid.
[61] Ibid., 219–220.
[62] Ibid., 218.

to decrease its budget, which helped fuel health care inequality by providing a perfect environment for private employment-based supplementary insurance to take root among higher working classes.[63] Instead of *Sécurité Sociale*'s wage levies and the United States' payroll-financed health insurance premiums, a progressive income tax may help remove barriers to labor mobility, stimulate higher employment rates, and contribute to a greater equality in the financing of health care.[64]

[63] Ibid., 218–219.
[64] Ibid., 219–220.

CHAPTER THREE

Rule with an Iron Fist: The Government Intervenes

Incremental Change

Love thy enemy: Germany Leads by Example

In 1918, France regained Alsace and Lorraine, two previous territories that were lost to Germany during the Franco-Prussian War of 1870. This provided the first key step in France's eventual change to "socialized medicine." Years under Germany's jurisdiction meant that inhabitants of Alsace and Lorraine had grown accustomed to the health benefits that their system provided.[1] They feared that reintegration into France following the end of World War I meant that they would lose the health benefits they had been guaranteed under the German system.[2] These fears were addressed by France's commissioner general Alexandre Millerand who was quoted saying:

> "The three branches of your social insurance [health, disability, and old age] will be maintained in their entirety… [France] will not only conserve the advantages enjoyed by the workers of Alsace-Lorraine under current legislation but will borrow appropriate elements of this legislation in order to improve its own laws and procure new benefits for all French workers."[3]

Although these circumstantial events prompted national leaders to look toward a possible overarching change to health insurance in France as a whole, even resorting to examining a constant nemesis for inspiration, taking action proved a little more difficult. However,

[1] Ibid., 36.
[2] Ibid., 39–40.
[3] Ibid., 40.

this provided the means for eventual incremental coverage of all of France's people in the twenty-first century.

The end of the First World War marked the first efforts of a changed France to attempt reforming their health care system, but it was not until Pierre Laroque, who originally envisioned that *Sécurité Sociale* would eventually be able to provide all French people health care coverage, that specific steps were made towards this more focused goal. The first reform bill France released was called the Vincent Bill, which was heavily influenced by German health insurance. Afterwards, it was followed by the Grinda Bill. Both bills were unsuccessful in bringing about immediate change to the evolving French health care system, but both were successful in opening the door for future talks about compulsory health insurance.[4]

Stubborn as a Mule: America Resists Change

While France was entertaining the idea of compulsory health insurance, there were similar attempts by Americans to garner interest and implementation for compulsory health insurance in the United States. However, it was difficult for any of these suggestions to gain momentum when there were conflicting thoughts based on the founding principles that the United States fully embraced: individual liberties and the role of the state to mediate these issues.[5] So strong were these patriotic views that conservatives who opposed any kind of government intervention verbally attacked reformers and claimed that compulsory health insurance was "un-American."[6]

[4] Ibid., 41.
[5] Ibid., 48.
[6] Ibid., 57.

Even though Britain, America's ally in the war, had just implemented its own compulsory insurance, conservatives used Germany and Russia as examples to deter the general public from supporting similar changes in America, which would liken itself to the Socialist ideals of the enemy.[7] This illustrates a stark contrast from the original idea of compulsory health insurance as a mechanism to instill community and a level playing field; however, with involvement in the war, the momentum for the implementation of compulsory health insurance was hindered because it was now synonymous with "Russian Communism."[8]

The French experienced similar feelings of apprehension. Although they were known to have heavily regarded voluntarism and individual self-help as important components of French culture, the German-style of compulsory social protections was at odds with the concept of *liberté* contained within their motto "*liberté, égalité, fraternité.*"[9] As mentioned earlier, the change to compulsory health insurance was aided by France's reacquisition of the Alsace-Lorraine territories from Germany. The popularity of German social insurance in Alsace-Lorraine led national leaders to consider implementing a change for the rest of the country. These circumstantial events were not as problematic as it would have been in the United States due to different historical foundations for these two respective countries. The United States has a history of fighting against centralized power and prided itself in having implemented a federal system that guaranteed the rights of individual states by law. However, the French Revolution resulted in the rise of power of Napoleon who created a highly centralized

[7] Ibid.
[8] Ibid., 58.
[9] Ibid.

administrative State, and this may have contributed to France's earlier adoption of "socialized medicine."[10]

Even then, the idea of compulsory health insurance was not met with open arms by all. André Jayle, a conservative French physician, strongly opposed compulsory health insurance because he thought that "German thinking" violated all that it meant to be French.[11] The French motto "*liberté, égalité, fraternité,"* meaning "liberty, equality, fraternity (brotherhood)," is aligned with their emphasis on liberty and self-help over social welfare.[12] Jayle is quoted as saying that to implement this in France was "dangerous for humanity…the strong and solid… pay for the sickly and weak…The result is to overburden the strong that, from the eugenic perspective, must run society."[13] However, as time would tell, this way of thinking could not and would not stop France from adopting compulsory health insurance, and the result of these decisions continues to exist today.

Dramatic Changes at the Forefront

It was the Best of Times, It was the Worst of Times: 1930-1940

The conditions during the Great Depression proved favorable for a variety of changes in both France and the United States.[14] Encouraged by increasing unemployment and plummeting economies, the government took a more involved role in the lives of its beneficiaries. In America, federal public works initiatives, a compulsory pension

[10] Ibid.
[11] Ibid., 59.
[12] Ibid., 53.
[13] Ibid., 59.
[14] Ibid., 65.

program, and national poverty assistance programs were arguably the first of their kind.[15] The United States had seen a range of developments in the 1920s, which had brought about much cultural change, including technological innovations, positive employment rates, and a booming economy.[16] During this prosperous time, the ideals of "individual liberty and self-help" dominated, and government intervention was minimal, even looked down upon.[17] Efforts to implement, let alone suggest compulsory health insurance were seen as futile.

The Depression paved the path allowing increased government intervention into the most personal of rights. The Social Security Act of 1935 established old age insurance with benefits similar to the French social insurance law of 1930.[18] The level of government involvement was unprecedented, but this time was characteristically marked by the plethora of public works and poverty relief programs that were implemented to aid consumer demand.[19]

In both countries, there was an increase in expenditures spent on health, but occurred for different reasons. With the implementation in 1930 of compulsory health insurance in France, half of all French social insurance revenues were being spent on health care by 1938. Although health costs were also rising in the U.S., the reason was more for private initiative than government intervention. Because the Social Security Act of 1935 did not include health insurance, private insurers took the role of providing the bulk of health care costs.[20] There was some enthusiasm related to the possibility of

[15] Ibid.
[16] Ibid., 66.
[17] Ibid.
[18] Ibid., 67.
[19] Ibid.
[20] Ibid.

including health insurance in the Social Security Act; however, actions from the American Medical Association made it seem unlikely that any change to the Social Security Act would occur without jeopardizing its passing.[21] Unlike the compulsory health insurance in France, the Social Security Act was "less invasive" as it mainly dealt with old age and unemployment benefits paid for by equal contributions between employers and workers.[22]

Complications associated with the rising cost of health care put more pressure on the working class. By 1930, there had been a renaissance of new medical care techniques and advances, which gave way to a different health care reform model.[23] Throughout the 1920s the fees doctors charged experienced an incline. Medical schools had finally formalized curricula and lengthened the amount of time required to finish studies, and physicians started using radiological and laboratory services.[24]

Encouraging Change during the Second World War: 1940-1945

In France, compulsory health, pension, maternity, and disability insurance had been approved in 1930, with additional family welfare entitlements in 1932, 1938, and 1939.[25] However, France's defeat by Nazi Germany in 1940 presented a roadblock to these recent improvements. After its defeat, an authoritarian regime took hold in Vichy. On July 10, 1940, Parliament placed Philippe Pétain, a respected general of the First World War, as their head of state. During May 1940, German forces had blindsided

[21] Ibid., 82–83.
[22] Ibid., 84.
[23] Ibid., 69.
[24] Ibid.
[25] Ibid., 66.

French forces, causing France's republican government to retreat to Bordeaux.[26] This inopportune set of events helped stall immediate improvements but also helped them put into perspective the changes that needed to take place in order to reinvigorate a previously proud nation. This "National Revolution" paved the way for the government to begin expanding its role in health care and for corporatism where "workers and employers cooperate under government supervision for the common good."[27] Another emphasis of the Vichy regime was to open more hospitals to the general public and improve the state of health care in rural France.[28] With mothers and their children in mind, they expanded efforts for strengthening many primary care services. France began instructing impressive networks of free prenatal, well-baby, and pediatric clinics because rebuilding a nation began with strengthening the younger generation.[29] This shift in thought resulted in increased efforts to invest in the success of the youth in order to ensure that France would be successful, and this mindset still exists today.

Following the brazen D-Day attack in June 1944 was the near-end of the Vichy government. After the end of the war, the puppet government was dissolved, and the Free French planners, who had spent much of the Second World War in London, were finally able to return and prepare for the reestablishment of the republic and a reinvigoration of its people.[30] Not all of the changes that had taken place during the Vichy government's reign were retained, but it offered an important transition in thought amongst their people. Events during the war provided necessary motivation for implementing compulsory health insurance.

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[26] Ibid., 97.
[27] Ibid., 98.
[28] Ibid., 99.
[29] Ibid., 97–101.
[30] Ibid., 101–102.

Reaffirming Liberté, Égalité, Fraternité with Sécurité Sociale : 1945-1960

While the Vichy government was in place, a group of French social reformers were in London planning for the changes that would take place once the Germans were ousted.[31] Of those involved, Pierre Laroque is the one who spearheaded *Securité Sociale*.[32] French leaders were motivated to seek coverage of all French citizens because they viewed class conflict as a major factor in the nation's swift defeat to Germany in 1940. The "laissez-faire" capitalistic movement that occurred prior to their defeat was seen negatively because it did not help them against the Germans. This changed mentality lead to the Resistance planners embracing more forceful government intervention to ensure health security after the war.[33] Instead, history would show the État (the State) taking increasingly intimate roles in the affairs of its people.

Pierre Laroque had briefly worked for the Vichy government, before being forced out of government service because of his Jewish ancestry. He was then recruited by the Resistance, and on his return to Paris, he assumed leadership of *Securité Sociale* that was newly created in 1945.[34] Minister of Labor Alexandre Parodi was technically in charge of the program, but Laroque was able to exercise great administrative powers because of the connections he had made during the Resistance movement with Charles de Gaulle and other members of the Provisional Government.[35] Laroque had three goals for *Securité Sociale*: to establish administrative unity, national solidarity, and democratization.[36] This program was successful in creating a single institution meant to

[31] Ibid., 115.
[32] Ibid., 116.
[33] Ibid., 115.
[34] Ibid., 116.
[35] Ibid.
[36] Ibid.

govern health, maternal, accident, disability, and retirement programs. In terms of national solidarity, Laroque hoped to expand the coverage provided by *Securité Sociale* to all citizens in France, no matter what their occupation was. Democratization would be achieved by having social insurance funds managed by beneficiaries, which helped change the relationship between employers and employees, regarding health security.[37]

Sécurité Sociale was officially put into place October 4th, 1945, and it has gone through significant changes within that time period. The system was originally enacted with the goal to "garantir la sécurité du lendemain" or continue guaranteeing the security of individuals in the coming days, especially related to health risks, injuries concurred while working, old age benefits, and compensation of charges associated with educating the youth.[38] In 1967, *Sécurité Sociale* was further divided into four branches: "maladie, famille, retraite et recouvrement" or illness, family, retirement, and accident.[39] This division allowed the government to better manage the diverse functions and responsibilities of *Sécurité Sociale*. Having a "séparation des risques" allowed each branch, with its own administration, to have better control over evolving expenditures and balancing budgets.[40]

The history of health care in France and the United States was similar up to this point; however, the creation of *Sécurité Sociale* marked a sharp divergence in the solutions both countries had previously taken to solve their health care problems. Under the "Quatrième République," the principle laws, now staples of *Sécurité Sociale,* were adopted. Under the "Cinquième République" or the French Fifth Republic, led by de

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[37] Ibid., 117.

[38] Bruno Palier, "Les transformations du modèle social français hérité de l'après-guerre. (French)," *Modern & Contemporary France* 16, no. 4 (Nov2008): 438.

[39] Ibid., 439.

[40] Ibid.

Gaulle after the Second World War, *Sécurité Sociale* gained foothold as a permanent fixture of French healthcare.[41] Since then, this program has continued to expand and transform. The system was reorganized between the years 1958 and 1960, resulting in the creation of four branches still present today.[42] During this time, labor leaders, employers, and government officials raised the health insurance wage levy from 6 to 6.5%. This was the first hike since 1945, and it was paired with a simultaneous decrease in reimbursement for many ambulatory care procedures from 80% to only 70% reimbursement. Inpatient hospital visits would continue to be covered fully.[43] From its conception until its present state, *Sécurité Sociale's* mission has always been to guarantee the social rights, and especially the rights of those who work and their families. However, this mission created a means by which there was a shift in power to the government who oversaw the financing.[44] Even today, the centralized nature of France's governing body means that the government continues to take a hands-on approach to a variety of issues.

France has a semi-presidential system where the President must work in tandem with the Prime Minister in domestic affairs. Alain Juppé was the Prime Minister of France from 1995 to 1997, and during his tenure, he was able to suggest some progressive changes towards *Sécurité Sociale*, including abandonment of employment-based financing in favor of a reliance on an income tax, the Contribution Sociale Généralisée (CSG). He experimented with placing a greater importance on having gatekeepers to prevent patients from seeking redundant care and multiple pharmaceutical

[41] Ibid., 437.
[42] Ibid.
[43] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 156.
[44] Palier, "Les transformations du modèle social français hérité de l'après-guerre. (French)," 437.

prescriptions. His end goal, however, was to guarantee universal coverage to all French people, which manifested itself into the creation of Couverture Medicale Universelle (CMU) after his tenure.[45] CMU assured supplemental insurance coverage for those who were between jobs, the indigent, and others who had somehow fallen through the cracks of *Sécurité Sociale.*[46]

The United States Dabbles

Medicare and Medicaid

Although most Americans did not want increased government intervention, they were ironically less opposed to reform initiatives for underprivileged classes.[47] In 1965, a three-part program was adopted. Part A and Part B of Medicare (*Title 18* of Social Security Amendment of 1965) provided publicly funded financed health insurance to all elderly individuals, regardless of income. Part A drew from Social Security funds to finance hospital insurances and short-term nursing home coverage after discharge from a hospital. Part B covered physicians' bills through government-subsidized insurance, but the elderly were still responsible for a portion of premiums. Medicaid (*Title 19*) was the third layer to this program and covered the eligible poor. It was financed through federal matching funds to the states according to each of their per capita incomes. In 1973, Congress extended coverage through the Medicare program to nonelderly disabled people receiving Social Security for a minimum of 24 months and people with end-stage renal disease. In 1997, another coverage option was made available under Part C, and in 2003,

[45] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 203–204.
[46] Ibid., 204.
[47] Shi and Singh, *Essentials of the U.S. Health Care System*, 69.

Part D, a prescription drug benefit, was also added.[48] The creation of Medicare and Medicaid during this time signified the increasing importance the United States was beginning to put on the overarching health status of their people. Extension and improvement of insurance coverage became a key goal in the following years.[49]

By 1970, Medicare had helped 20.4 million individuals receive medical care, and 17.6 million individuals received care through Medicaid.[50] The United States viewed the creation of Medicare and Medicaid in 1965 as a great success, but did not pay as much attention to the programs' contributions to inflation.[51] Compared to the French government, the United States' government is highly fragmented, and has historically had little direct regulation of social welfare.[52] Although government intervention on both sides of the pond were instrumental in providing more access to health care services, without being thoroughly thought out, these programs also contributed to many problems still in existence today. One of these issues is the unrelenting rises in health care costs.

Obamacare: The Future of America?

Efforts to implement national health insurance in the United States began in 1912 with Theodore Roosevelt when many presidential candidates were thought to have run on a platform of health care reform for "ideological reasons."[53] Since then, attempts to pass health reform have failed, and in every instance where a presidential candidate made the creation of a national health insurance their top priority, the American people were not

[48] Ibid., 70.
[49] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 158.
[50] Shi and Singh, *Essentials of the U.S. Health Care System*, 70.
[51] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 158.
[52] Shi and Singh, *Essentials of the U.S. Health Care System*, 66–67.
[53] Leiyu Shi and Douglas Singh, *An Update on Health Care Reform in the United States, First Edition* (Jones & Bartlett Learning, n.d.), 2.

the ones specifically requesting these changes. It was not until 1992 when talks about health care reform rematerialized with Bill Clinton, but this did not translate into viable change toward that goal.[54] However, among all of the national social policy legislation from the early 1900s to now, three successes have moved the United States closer to achieving universal health insurance: Franklin Roosevelt's Social Security Act of 1935, Lyndon B. Johnson's Amendments to the Social Security Act of 1965, including the addition of Medicare and Medicaid, and finally, Barack Obama's Patient Protection and Affordable Care Act of 2010.[55] The passing of the Affordable Care Act, or Obamacare, was done in the hopes of addressing the 15 to 16% of the population that, for the past 15 years, have been uninsured.[56] It did not become law without some controversies, including debates over its constitutionality and the fact that many American people had been kept in the dark about the specifics surrounding its contents.[57]

The ACA is supposed to be fully effective in 2014 with provisions having been rolled out slowly since 2010. Under this law, those who had health insurance plans before the signing of the law are exempt from certain provisions under a "grandfathered" clause. Some of the main provisions of the law state that those under the age of 26 are allowed to be covered by their parents' health insurance plans, those with preexisting conditions cannot be turned away, all new insurance plans are required to include recommended preventative services and immunizations where no deductible and copayments apply, the appearance of state-based exchanges, and expansion of current

[54] Ibid.
[55] Ibid., 1–2.
[56] Ibid., 2.
[57] Ibid., 4.

health care workforce, especially focusing on the primary care workforce.[58] One of the controversies associated with the ACA was the question of whether the government had the power to fine people for not obtaining health insurance. The Supreme Court decided that this mandate was constitutional on the grounds that Congress has the power to tax.[59] The "penalty tax" will steadily increase each year an individual and their family refuse to become insured. By 2016, the penalty tax will rise to $695 or 2.5% of the household's income, whichever is more.[60] Although the U.S. Supreme Court found that the penalty tax was constitutional, it did not require states to expand their Medicaid programs, citing that the federal government could not threaten to eliminate funding for existing Medicaid programs if the state chose otherwise.[61] This would hinder a subset of the American population from receiving health insurance. According to the Congressional Budget Office (CBO), about 30 million Americans will remain uninsured in 2016, but they will be exempt from the penalty tax.[62]

The ACA requires health plans to offer comprehensive packages of services, or Essential Health Benefits (EHB), to be certified and offered through the government's exchanges. The services must include items and services within 10 categories: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, (6) prescription drugs, (7) rehabilitative and habilitative services and devises, (8) laboratory services, (9) preventative and wellness services and chronic disease management, and (10) pediatric

[58] Ibid., 5–6.
[59] Ibid., 9.
[60] Ibid., 8.
[61] Ibid., 10.
[62] Ibid., 11.

services.[63] Also included in the document are details of the four standardized plans offered: bronze, silver, gold, and platinum. Each plan differs in the level of cost sharing or actuarial value (AV), and each tier differs in the amount that consumers will pay for premiums and out-of-pocket costs associated with deductibles and copayments.[64]

To cover the implementation of such a massive undertaking, the Internal Revenue Service (IRS) is responsible for enforcing the 47 provisions of the ACA. Most of these changes were supposed to have taken effect in 2013, and some of them included: a 10% excise tax on tanning services, a tax increase for high-income taxpayers, a 2.3% excise tax on certain medical devices, and a requirement for employers to start reporting the cost of employer-sponsored health coverage on W-2 forms.[65]

The issues the ACA will have to address are overwhelming. Not only will a large portion of the American population still be unable to receive medical care, but there will also be shortages of physicians. With more people being brought into the health care system, the question remains: will there be enough physicians able to care for them? The Association of American Medical Colleges estimates a projected shortage of 63,000 physicians in 2015, 91,500 in 2020, and 130,600 in 2025. Among these numbers, the shortages are going to be most felt among primary care physicians. The implication of physician shortages is the possibility of unintentional health care rationing taking place, causing longer wait times and unnecessary extra procedures. Another issue that the ACA does not necessarily address is caring for illegal immigrants because it denies the coverage or provision of benefits to this group of individuals. According to a study the

[63] Ibid., 8.
[64] Ibid., 8–9.
[65] Ibid., 9–10.

American Hospital Association (AHA) conducted in January 2013, U.S. hospitals provided $41.1 billion in uncompensated care to illegal immigrants and the uninsured.[66]

In January 2013, the national debt was almost $16.5 trillion, which was an increase of 65% in 4 years. The ACA does little to address this growing issue and, if there are cost savings, they would not amount to much. Beyond the costs associated with implementing the ACA, there are the costs related to Medicare, Medicaid, and Social Security that are a cause for concern, as well.[67] Although the ACA does address the issues of uninsured Americans, the full scope of its influence is cloudy at-best because the extent of its influence cannot be accurately measured at this time. The ACA does, however, fail to address the complications and fragmentation of the United States health care system.

The Growth of Sécurité Sociale

The National Health Insurance (NHI) of France, or *Sécurité Sociale,* was created in 1945 by Resistance planners during the Second World War; however, it was unable to completely cover the French population until 2000.[68] Unlike the United States where the pursuit for universal health care has had more of a political motive,[69] the incremental changes to the NHI have been due to the demands of the people for extension of their coverage.[70] Initially, it only covered qualified salaried workers in industry and commerce who earned below a low ceiling. Later in 1945, it stretched coverage to all industrial and

[66] Ibid., 11–12.
[67] Ibid., 13.
[68] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 112.
[69] Shi and Singh, *An Update on Health Care Reform in the United States, First Edition*, 2.
[70] Rodwin, "The Health Care System Under French National Health Insurance," 32.

commercial workers and their families, regardless of wages earned. In 1961, 1966, 1974, and 2000, more incremental changes concerning who could be covered took place. Farmers and agricultural workers were covered in 1961; independent professionals gained coverage in 1966; in 1974, a law that specifically detailed the intentions to make the NHI universal was passed; and finally in 2000, coverage of the entire French population was accomplished.[71]

The NHI is considered a subset of France's social security system, which is very different from "social security" in the United States. As stated previously, *Sécurité Sociale* is made up of four branches, and each of these branches is managed separately. There are 3 main NHI funds that are involved in covering the health insurance for all French residents. *Caisse National d'Assurance Maladie des Travailleurs Salariés,* or CNAMTS is responsible for salaried workers, *Mutualité Sociale Agricole*, or MSA for farmers and agricultural workers, and *Caisse Nationale d'Assurance Maladie des Professions Indépendantes*, or CANAM for independent professions. There are also another 11 smaller funds dedicated to a variety of other specific occupations and their dependents.[72] The CNAMTS covers 84% of legal residents in France, while the CANAM and MSA cover 7% and 5%, respectively. The other 4% are covered by the remaining four funds.[73] All of these funds are private organizations responsible for providing public services, and in some sense, they are "quasi-public organizations" that are overseen by a part of the government specifically responsible for supervising the actions carried out by *Sécurité Sociale.*[74]

[71] Ibid.
[72] Ibid.
[73] Ibid., 32–33.
[74] Ibid., 32.

In France, the idea that there be "mutual aid and cooperation between the sick and the well, the active and the inactive, and that health insurance should be financed on the basis of ability to pay, not actuarial risk" is prevalent, which is why the old and unemployed are automatically covered by the funds they qualified for when they were able to work.[75] This is the reasoning behind France's efforts to invest in the success of its younger generations. France highly recommends and encourages families to have children, giving them "allocation familial" to help pay for any associated costs of taking care of a baby. The State even provides generous maternity leave and paternity leave to parents, so they can appropriately take care of their children. The French health care system could only work if there was a large younger generation. Under this mindset, once the younger generation starts working, the taxes collected from their paychecks would pay for the care of the old. The only problem with this mentality is that chronic illnesses are becoming more common as headway is being made on other curable diseases, which means that the number of young people needed to contribute toward funding the older generation's growing health care costs is high. There's also abuse of the generosity offered by the State in collecting "allocation familial." The more children one has, the greater the sum one receives. In some cases, families have many children in order to collect a sort of second income. This in itself has many social implications as well. Unlike the United States where there is an associated increase in cost with the increased use of health care services, patients in France who become very ill experience an improvement in their health insurance coverage and decreased costs.[76] How will this

[75] Ibid., 33.
[76] Ibid., 34.

benefit be able to continue with a dwindling younger generation unable to fund the growing needs of the older generation?

Health insurance in France is compulsory, with many people opting to buy supplementary insurance if they feel like they want more coverage.[77] Although France boasts a system with the ability to cover all of its inhabitants, the woes that France has suffered can be connected to the extreme centralization and chronic deficits.[78] The availability of health care services advertised by universal coverage seems flawless, but there are still many disparities connected with geographical location and social class.[79] The problem with these issues is that they are far beyond the scope of what any increase in health care financing and reorganization could solve. Instead, these problems would need to be addressed by stronger public health interventions.[80]

There is also an associated high cost with providing all of a country's people universal coverage. The probable solution would be to curtail costs, but the convenient low cost of health care services has been met with tensions from health care providers in France. In fact, the average net annual income of $55,000 that French physicians take home is a little over a quarter of what physicians in the United States make ($194,000).[81] In many places in Europe, higher level education is free, which is in contrast to the high costs associated with United States' medical schools. This may be the reason why more French physicians choose to be general practitioners because they do not have debts to pay after leaving medical school. American medical students, however, are highly motivated to pursue specialties to help pay for accrued debt. The result is inconsistencies

[77] Ibid., 35.
[78] Ibid., 31.
[79] Ibid., 35.
[80] Ibid.
[81] Ibid.

in the number of family practitioners and other primary care physicians in the United States and higher costs associated with seeing specialty physicians.

Increasing costs

Although Medicare was considered an overall success, the first year of its implementation saw an increase in hospital charges by 16.5%, and physician fees also went up by 7.8%. These numbers were twice as much as they were in previous years.[82] One of the reasons for the increase in costs was due hospital services under Medicare being billed on a "cost plus" basis where hospitals charged for their services and then on top of that an extra percentage for depreciation of plant and equipment.[83]

The French law of May 1960 attempted to control this issue by subjecting French physicians to strict fee schedules; however, these physicians continued to bill their patients directly and got around this law by simply intensifying the care they provided, ordering additional tests and procedures.[84] It goes without saying that the law of May 1960 did not help control rising health care costs because the government and physicians were unable to work together.[85]

By 1970, both countries had two of the most expensive health care systems in the world. The United States spent 7.4% and France spent 5.6% of their GDPs on their health care systems. It did not help that between 1960 and 1993, the United States experienced consumer price inflation at an annual average rate of just over 11%. France suffered a similar event between 1960 and 1978 when their annual health care costs

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[82] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 153.
[83] Ibid., 152–153.
[84] Ibid., 152.
[85] Ibid., 155.

increased about 15% compared to their average general inflation rate of about 6.3%. In 1987, France was paying about 8.6% of its national income on health care, which was greater than any other major western European country. Meanwhile, the United States had spent 11.2% of its national income on health care in the same year.[86]

Increases in expenditures on health care were in some part due to the "hospital construction spree" that took place in both countries after the Second World War. In the United States, the Hill-Burton Act of 1946 allocated billions of dollars from general tax revenues to increase the amount of hospitals throughout the nation. U.S. hospital care alone accounted for 53% of the national health care spending by 1974. A similar occurrence happened in France because an increase in *Securité Sociale* payroll taxes between 1945 and 1967 and money from the health ministry provided the funds to partake in a similar expansion project. What they would later find out, however, is that once these facilities were built they ended up being even more expensive to operate than older hospitals.[87] With increasing costs looming overhead, the United States took a stance of slowing hospital expansion. Even with the Hill-Burton Act allocating federal funds for hospital construction based on local and state criteria, the United States only possessed 2.8 acute care beds per thousand residents, compared to the 3.8 acute care beds per thousand residents France boasted in 2008. While the United States chose to slow its hospital expansion, France's Ministry of Health tightened its criteria for capital expansions in hopes of preventing wasteful expenditures on too many beds or unnecessary technologies. The Hill-Burton Act did not reach its full potential because its

[86] Ibid., 159.
[87] Ibid.

criteria excluded many poor rural communities and the law did not require any collaboration between facilities.[88]

The government attempted to remedy increasing health care costs by implementing and encouraging the creation of HMOs. They were initially unpopular when President Richard Nixon first signed the Health Maintenance Organization Act into law in 1973 because of a stigma associated with prepaid group practices; however, after 1976, President Jimmy Carter waived many of the HMOs obligations to community rating and loosened the definition of what was considered an HMO. The effects of this change was that by 1985, 377 HMOS had 16.7 million subscribers and additional HMO-like managed care plans arose, such as Preferred Provider Organizations (PPO) or Point-Of-Service (POS).[89] By 2003, HMO and PPO plans had about 185 million enrollees, which represents 65% of the total population. HMOs did help slow overall health care expenditures for a while, until the mid-1990s when health care inflation began to increase again. The efforts by the government to control costs did, however, change what it meant to be a doctor because there was now an increased concern for limiting costs and legal woes.[90]

Although the government has had a huge role on the health care systems in both countries, more work needs to be done on both sides to continue progress. For the Americans, additional funding options need to be brought to the table. Considering that many Americans will still be uninsured after the full implementation of the Affordable Care Act, it may be wise for the U.S. government to consider alternative options. If the ACA is only going to achieve a portion of its goal, is there really a point to having

[88] Ibid., 185.
[89] Ibid., 168–171.
[90] Ibid., 181–183.

implemented such a cumbersome and expensive law? Since France already has universal health care, the issues they will need to address involve keeping the program viable. How will France be able to keep their current system when it is becoming increasingly more expensive? Will France have to reorient its budget or increase taxes, which is commonly the least popular choice? These questions will have to be addressed in the coming years.

CHAPTER FOUR

Physicians Rise through the Ranks

Emergence of the Modern Physician

Physicians have an important, central role in the medical delivery process, having the ability to evaluate a patient's condition, diagnose numerous abnormalities, and prescribe appropriate treatment.[1] With these capabilities, it is no surprise that physicians have evolved into an occupation quite different than it was in the past. Today, there is an overwhelming number and types of physicians available at one's disposal, while historically, health care services were less curative and more religious in nature. Similar to how hospitals began as institutions of religious healing, physicians evolved from a humble trade into a lucrative, respected profession.

In the pre-industrial United States, physicians lacked the prestige that they currently garner. Anyone could become a physician if they chose to, and it was common that well-educated clergymen and government officials were more learned than many physicians during the time. This occurred because, without scientific-backing, medical practices were more a trade than a profession. In fact, family knowledge was held in higher regard than the repertoire that physicians possessed. Lacking social status and customers, many physicians found it necessary to pursue a second occupation because income earned from practicing medicine was inadequate to raise a family.[2]

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[1] Shi and Singh, *Essentials of the U.S. Health Care System*, 82.
[2] Ibid., 55–57.

An increase in urbanization created more demand for the specialized skills of paid professionals. As more people moved farther and farther away from one another, office-based practices began to replace family-based care. The new scientific breakthroughs created an increased demand for the services that now only physicians could provide.[3] Having increased geographic proximity meant that physicians could see more patients in a given amount of time, and because the capabilities of physicians were now expanded beyond the capabilities of old wives' tales, their incomes and reputations increased immensely.[4] Changes in the social standing of physicians in postindustrial America meant that they had an increased influence on health care in the United States, and in fact, they would greatly impact the direction that health care took.

Growth in numbers

Medical advances played favorably for the economic status of physicians. Previously, doctors' services were only sought after when all other options failed, but with medical breakthroughs like anesthesia and antiseptics, the skills of doctors became prized and much sought-after.[5] Although medicine has far exceeded its previous limitations, the rising cost of health care is a cause for concern of many families throughout the United States, especially when it comes to having coverage in life-or-death situations.[6] This occurrence further influenced the meaning of economic and health security, which effectively became the act of "ensuring a patient's access to sophisticated

[3] Ibid., 59–60.
[4] Ibid., 63–64.
[5] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 69.
[6] Ibid.

medical facilities and protection from large medical fees for such care."[7] Continuing advances in technology and medical knowledge have further increased the demand for physicians, and in effect, their role in the provision of health security.[8] The United States has one of the most advanced and best-funded sources of biological and medical research, which have become multibillion-dollar international endeavors. Any new discoveries are shared globally, which results in many countries having access to the new information and benefit from it. However, this has contributed to the unrealistic expectations the public has about the capabilities of modern medicine. In general, the public has come to believe that anything is possible, which has effectively fueled the demand for expensive procedures and resulted in higher health care costs.[9]

Organized Efforts

The AMA Takes a Stand

The American Medical Association (AMA) played a critical role protecting the interests of physicians by preventing the passage of compulsory health insurance. Founded in 1847, the AMA did not achieve the might of its true power until it organized its members into county and state medical societies.[10] The AMA, which relied on the concerted activities of physicians, would continue to influence the path that the United States' health care system would take because it believed that national health care

[7] Ibid., 70.
[8] Ibid., 75.
[9] Ibid., 160.
[10] Shi and Singh, *Essentials of the U.S. Health Care System*, 62.

opposed the private practice of medicine.[11] This organization was solely responsible for the failures of several bills related to national health insurance in the early 1940s.

The AMA did much to fuel the negative stigma associated with employment of physicians by hospitals and insurance companies. Independent practices were seen as the only acceptable option, and through its efforts, the AMA saw that the incomes of physicians, as well as their social status, grew.[12] However, their influence did not stop there, and by 1950, the AMA was successful in influencing the majority of America's opinions against national health insurance. Arguably, residual resentment against compulsory health insurance still exists because of the extensive nature of the AMA's propaganda.[13]

CSMF and FMF at Odds with Each other

Likewise, in France, physicians also played a dominant role in curtailing the efforts by the government to change the system. The Confédération des Syndicats Médicaux Français (CSMF) and Fédération des Médecins de France (FMF) rarely agreed with each other. However, because they were never able to create a united front against the government, this did not play into their favor like it did for the AMA.[14] When the CSMF wanted a uniform fee schedule in 1960, the group of physicians that would become the FMF denounced the CSMF because they felt it had sold out the freedoms associated with private-practice medicine. In an ironic turn of events, a physician from FMF signed contracts with *Securité Sociale* for part-time practices, while also relying on

[11] Ibid., 62,67.
[12] Ibid., 62.
[13] Ibid., 67–68.
[14] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 177.

salaried hospitals positions. The CSMF were obviously perturbed, cried hearsay, and looked toward the national convention as a means to diminish the individual physician contracts and reunify their profession under the same leadership. During these events, the physicians were also under attack by employers who were starting to question the growing power and near-monopoly they wielded.[15]

In 1980, *Securité Sociale* reported that monitoring physician treatment practices under that national convention of 1971 was not successful in minimizing the utilization of medical services. On the contrary, demand for health care services continued to increase, along with the number of doctors in France. Having already enacted tighter restrictions under its "*numerous clausus"* powers, France hoped this would restrict the number of students entering medical school. However, there was still a 120% rise in the number of practicing physicians in France from 1955 to 1979.[16]

Another change that occurred in 1980 was the attempt by Prime Minister Raymond Barre to change the national budget, but he could not receive positive reinforcements from the CSMF. Therefore, he turned to FMF, which, although a lot smaller than CSMF, signed the new national convention in 1980 because more doctors would be given greater billing freedoms. The thought process behind allowing doctors greater privileges in billing was that these doctors would charge more than standard fees for their services. Thus, rising prices would help curtail demand and, hopefully, relieve the financial issues that had plagued *Securité Sociale* since the onset of rising health care

[15] Ibid., 162–163.
[16] Ibid., 173.

costs.[17] This is comparable to the United States' initial experimentation with managed care.

Similar instances of greater physician power would continue to develop. After 1980, French doctors could choose from three sectors of practices. Sector 1 physicians went along with the standard convention fees already in place, except they were granted the ability to command higher fees than normal if dealing with more difficult cases. In these cases, the physician could seek special dispensation. Some physicians continued to benefit from the 1971 national convention that gave them waivers to exceed the standard fee because they were exceptionally experienced, but newer physicians were not allowed to have the same waivers.[18] If newer doctors wanted the freedom to bill as they wished, they joined Sector 2. Although these doctors were capable of charging their own fees, the patients were only reimbursed based on the standard fee. As a result, patients had to make up the difference with out-of-pocket funds or supplemental insurance. In order to prevent physicians from flocking away from Sector 2, the government granted substantial tax breaks and *Sécurité Sociale* retirement.[19] In Sector 3, patients only received nominal reimbursements of their medical fees because the "boutique" of allopathic or alternative medical practices, like acupuncture or homeopathy, wished to have as little connection to *Sécurité Sociale* as possible.[20]

Most of the doctors who remained in Sector 1 without fee waivers were general practitioners. Of the 12% of doctors *claiming* fee waivers under Sector 1, 80% of those were specialists. In Sector 2, 7.5% of the physicians declaring their prices under this

[17] Ibid., 174–175.
[18] Ibid., 175.
[19] Ibid.
[20] Ibid.

sector were specialists.[21] The division of French doctors into three separate sectors set the stage for further cost-shifting to patients and influenced the move to more managed care techniques in France, which was similar to the United States switching to HMOs in the 1970s.[22] However, each of these groups had their role in changing several legislative matters.

Proliferating Influence

Under the compulsory health insurance implemented in France in 1930, a social insuree had the option of being cared for by his or her physician of choice. After receiving care, the doctor's bill was to be paid in full based on a fee schedule that was previously negotiated between the patient's health insurance fund and the local medical *syndicat*. The patient was to be reimbursed 80% for most procedures from their fund; however, most physicians understood this arrangement to be a "suggestion" of minimum charges and most ended up charging more than this value. As physicians raised their fees, the mutual societies could not raise premiums to match, and patients found that their procedures were only 40 or 50% reimbursed.[23] This created an increasingly negative view of mutual societies, which led many to become involved in the direct provision of health care to their customers. Many mutual societies joined together to pool money, which they used to build surgery and diagnostic centers across France.[24]

Mutual societies, already occupying an intermediary role between patients and physicians, created an even harder environment for physicians to protect their autonomy.

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[21] Ibid., 176.
[22] Ibid., 175–176.
[23] Ibid., 74.
[24] Ibid., 75.

These mutual centers often possessed the latest available technology and offered rewarding contracts or regular salaries, which attracted many surgeons.[25] By 1939, mutual societies operated six surgery insurance funds, which covered nearly a million subscribers. The financial power held by the mutual funds gave them the ability to compete with private fee-for-service medicine, and this was further exacerbated when access to laboratories and x-ray centers put a new focus on preventative care over curative medicine.[26]

In reply to the efforts of mutual societies and rallied by medical association leader Paul Cibrie, French doctors banded together and started building their own modern surgery centers and diagnostic clinics.[27] In response to a 1933 bill sponsored by Parliament, French physicians threatened to "cease [their] collaboration with the [health insurance] law" if the bill was passed.[28] Even though there were specifics in the 1930 health insurance law that were never fully met, overall the law was viewed as a success because of its ability to create an even playing field where employers and workers shared the cost of health care across a broad segment of the population. By 1940, about 25%, or nearly 10 million people, were covered by the 1930 health insurance law.[29]

The growing influence of physicians has sometimes done more to hinder than help society. In both the United States and France, many physicians have adopted a "doctor as priest" or "doctor as seer" mentality, which has been instrumental in their blocking many health care reforms in the past. This has had the effect of disrupting their fellow citizens' pursuit of health security, for the selfish purpose of improving their own

[25] Ibid.
[26] Ibid., 76.
[27] Ibid., 77.
[28] Ibid.
[29] Ibid., 78.

economic well-being.[30] Different players have arisen to defend their own interests when it comes to providing health security, and these differences in self-interests have often had a paradoxical effect on change, either being hurtful or helpful to society.[31] With multiple forces vying for power, a single entity cannot completely dominate a system; however, at the same time, working solo also means that change with the ability to benefit the overall good of the citizen is impeded.

Primary Care Physicians as Pillars of the Community

Specialty-care domination

Hospitals became institutions that were meant to house new medical technologies and centralize them into expensive facilities because it became too costly to house them in personal physicians' offices. Today hospitals have become synonymous with centers for advanced technology used in medical diagnosis and treatment and also for training a variety of different health care personnel. These hospitals depended on physicians to fill beds and, thus, an informal alliance between the two formed with the latter having an enormous influence on hospital policy.[32]

Overemphasis on the use of technology has created a bias toward specialization in medical training, resulting in an overabundance of specialists, while also increasing the overall cost of medical care without significant improvements in the health status of Americans.[33] A number of factors contribute to the characterization of the United States health care delivery system by an imbalance between primary and specialty care

[30] Ibid., 217.
[31] Shi and Singh, *Essentials of the U.S. Health Care System*, 18.
[32] Ibid., 63–64.
[33] Ibid., 60–61.

services.[34] From 1965 to 1992 the number of primary care physicians only increased by 13%, while the number of specialists increased by 121%. Between 1949 and 1970, a sharp drop in the number of primary care physicians took place, and ever since then the number has continued to decline.[35] The number of positions filled in family practice residency programs initially increased during the early 1990s, but a slow decline has been recorded ever since 1998.[36] These numbers illustrate the general disinterest in primary care among medical graduates, and one of the key reasons for this change is the development of medical technology. Specialty maldistribution exists because advances in technology have improved medical technology so immensely that the diagnostic and therapeutic options available to physician specialists are overwhelming. Specialists also earn higher incomes than primary care physicians, and many have more predictable hours and higher prestige.[37] Influenced by society's view of specialists, medical students tend to lean towards specializing because it is seen as being more intellectually challenging, more lucrative, and more valuable in the eyes of their peers.

However, the issue with having too many specialists is that the higher occurrence of intensive, expensive, and invasive medical services contributes to ever-increasing health care costs.[38] In most instances, seeking care directly from specialists is often less effective than seeing primary care physicians because they are able to provide early intervention before complications develop. In fact, higher numbers of primary care

[34] Ibid., 82.
[35] Ibid., 87.
[36] Ibid., 88.
[37] Ibid.
[38] Ibid.

physicians has been associated with lower overall mortality and lower death rates from cardiovascular disease and cancer.[39]

The Importance of Primary Care physicians

The World Health Organization and the IOM Committee on the Future of Primary Care have similar definitions of primary health care. The IOM's definition of primary care is:

> "The provision of integrated, accessible health care services by clinicians who are accountable for addressing a majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[40]

Primary care physicians also hold an important role in the provision of health care services to minorities, the impoverished, and people living in underserved areas. A study performed by Parchman and Culler demonstrated that poor primary care resources were independently associated with higher rates of hospitalization for conditions that could otherwise be prevented by adequate primary care.[41] Studying primary care physician-to-population rations, there is an associated relationship between having a greater emphasis on primary care resulting in much lower total health care costs than other areas and lower rates of self-reported poor health in 60 representative U.S. communities.[42] Increases in the supply of primary care physicians has also been connected with decreases in overall and cause-specific population mortality rates, which translates to a greater life expectancy of that population.[43] There are also no associated differences in health outcome when

[39] Ibid., 89.
[40] Shi and Singh, *An Update on Health Care Reform in the United States, First Edition*, 171.
[41] Ibid., 179.
[42] Ibid., 178–179.
[43] Ibid., 180.

receiving treatment for a common illness by a specialists or primary care physician, except care provided by a specialist is more expensive.[44]

Although the number of physicians entering the workforce is growing, certain areas are still lacking physicians. Geographic maldistribution exhibits the issue of encouraging physicians to practice in underserved locations when most of these places are seen as undesirable places of residence. Not only are physicians choosing to specialize, physicians are also choosing to live and practice in urban areas because they offer a lifestyle that rural areas cannot match.[45] The result is individuals in rural and other underserved areas suffering the most due to shortages of physicians, and more specifically, primary care physicians.[46]

The landscape of medicine has also changed from treating acute diseases to chronic disease, which means there is a greater need for health services professionals able to address health risks, consequences and prevention.[47] Reasons for this change in mindset are associated with the ability of modern medicine to cure many diseases previously incurable. People are now living longer than they once were, and this is possible because of the capabilities that have now been afforded to medical discoveries. In developed countries, less people are dying from acute diseases and more are beginning to suffer from chronic illnesses, such as diabetes and obesity. Characteristic of these illnesses is that they do not have immediate cures and may require long-term use of medication. Implications from this change mean that medical costs will continue to

[44] Ibid., 178.
[45] Shi and Singh, *Essentials of the U.S. Health Care System*, 87.
[46] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 89.
[47] Shi and Singh, *Essentials of the U.S. Health Care System*, 88.

increase as older generations are dealing with chronic illnesses, many associated with old age.

There are many differences between primary and specialty care. One of these differences is that primary health care is seen as a portal to the health care system. Primary care physicians are usually the first point-of-contact into the system, and they also occupy a role as a "guide." Primary care is characterized by longitudinal care, meaning the physician will follow the patient through the course of treatment and help coordinate the various activities surrounding their visit, including the initial diagnosis, treatment, further referrals, consultation, monitoring, and follow-up. In contrast, specialty care is episodic, and, therefore, care is more focused and intense.[48] Primary care also focuses on the patient as a whole, having a holistic approach to diagnosing and treating patients. These physicians work to integrate the multiple factors that a patient's condition may have. In these cases, specialty care is called upon only when needed and only after first making contact with the primary care physician.[49] This is a characteristic of managed care programs where health services are integrated and primary care physicians serve as gatekeepers. This is important in controlling costs, utilization rates, and rational allocation of resources because it prevents patients from seeking more expensive and, perhaps, unnecessary care. In this model, before one can receive specialty care, a referral from their primary care physician is recommended.[50] This, in turn, emphasizes preventative care, routine physician examinations, and other primary care

[48] Ibid., 85.
[49] Ibid.
[50] Ibid.

services, which controls the access to costly medical services and has proven to be sufficient in treating patients.[51]

However, the United States has a fragmented system, which makes it difficult for patients to receive continuous care. This system also makes it difficult for U.S. physicians to receive adequate information from other physicians regarding the care of a patient.[52] Changing the United States to a more primary care-focused system is a difficult task because not only must a patient be encouraged to seek care from these physicians, but there must be a way to help patients navigate the U.S. health care system as well.[53] Involving primary care physicians is a must, but it is also important to have multidisciplinary teams and facilities dedicated to the same task. Funding for a primary care-oriented system will also be an issue. Even though it is projected that visits to primary care physicians instead of specialists will help save money, money is wasted when systems are not well-integrated. In other words, there are issues that would need to be addressed other than just the issue of receiving primary care over secondary care. Another aspect of the complexities of the U.S. health care system is its health insurance system. A study by the Institute of Medicine estimated that due to the confusing nature of the United States' health insurance system, almost $360 billion per year is added to the cost of health care with a majority of this sum considered unnecessary, wasted costs. Because insurers have access to patient information, they may have the ability to bridge the gap between patients and the navigation of an inefficient system. These insurers

[51] Ibid., 220.

[52] Cathy Schoen et al., "Access, Affordability, And Insurance Complexity Are Often Worse In The United States Compared To Ten Other Countries," *Health Affairs* 32, no. 12 (December 1, 2013): 2214.

[53] Martin Roland and Ellen Nolte, "The Future Shape of Primary Care," *British Journal of General Practice* 64, no. 619 (February 1, 2014): 63.

could help health care providers deliver more continuous care by providing information exchange for practices that are not formally linked to integrated systems.[54]

As of late, doctors have become more "aggressive clinicians," ordering multiple tests to be absolutely sure that they have not missed anything. Because of increasing legal issues, many clinicians are adopting the same mentality and practicing "defensive medicine." These additional check-up appointments, tests, opinions, and maintaining many medical documents can be extremely costly, unnecessary, and inefficient.[55] In France, the same type of thing has started to become more common. *Le nomadisme médical* describes patients who seek multiple diagnoses and prescriptions from multiple specialists for the same conditions because all of these services are covered by *Securité Sociale* without question.[56]

Physicians are an integral part of the health care systems throughout the world because they have the knowledge and skill to provide care to patients. As physicians' notoriety has increased throughout the years, exercising their power has also influenced the paths both the United States' and France's health care systems have taken. Some of these changes have hindered the full capacity of the health care systems to better address the needs of the patient. Throughout the years, there seems to be a more focused mission to advance one's economic position has replaced the most important role physicians are tasked with: take care of those that are less fortunate.

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[54] Schoen et al., "Access, Affordability, And Insurance Complexity Are Often Worse In The United States Compared To Ten Other Countries," 2214.

[55] Shi and Singh, *Essentials of the U.S. Health Care System*, 159; Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 159.

[56] Dutton, *Different Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*, 160.

This change in mindset is exemplified in the current trends of medical students choosing to become specialists, instead of pursuing primary care. Should more value be placed on preventative care because of its positive effects on mortality, community health status, and overall affordability? A stronger emphasis needs to be placed on the patients needing care and a revival of looking at the patient as a whole. The practice of medicine started out as a humble occupation, then grew in power, and is now in a position to influence the current state of health care. Without changing the way patients and practitioners use medical resources, health care costs will continue to increase. If nothing but health care costs is changing, one can expect an increase in the number of people suffering at the hands of the current inefficiencies of the provision of health care. The Affordable Care Act is already projected to leave many Americans uninsured, which means that a large number of individuals will still be unable to receive the care they need. On top of that, underserved areas have an even more difficult time gaining access to health care services because of physician shortages. How will the United States government hope to address providing equal access to health care *for all*?

CHAPTER FIVE

Stalled at a Crossroads: A Conclusion

The passing of the Patient Protection and Affordable Care Act on March 23, 2010 signified that the United States health care system was in store for some drastic changes. The general consensus with these changes is confusion and bewilderment. Questions, such as what does this all mean, what will happen, and who will benefit, seem to litter the articles and news broadcasts dedicated to discussing the current state of health care in the United States. One of the reasons why this is such a grave concern is that health security is no longer merely being illness-free. Being healthy now involves a variety of factors and, understandably, the overall health of a patient is the responsibility of many parties, including the physician diagnosing the patient. Associated with this change in definition is an overhaul in the delivery of health care services. Paired with technological advances and increased demand, health care costs are going up and less people are able to afford them. Without the ability to pay for insurance, either due to lack of access to employer-based insurance or because health insurance is just becoming too expensive, more people are turning towards emergency care services. The result is that the costs continue to rise, some people are not receiving adequate access to health care services, and some people are resorting to using emergency care services. In the end, someone else ends up footing the bill, whether this ends up being employers, the government, or those who already have insurance.

Outside of the United States, France has one of the "best" health care services. In terms of quality one could make the case that France offers a successful template that many countries should follow; however, boasting the second most expensive health care system would seem to indicate that France has problems of its own. Although France was able to achieve universal health coverage earlier than the United States, introducing *Securité Sociale* amidst a time when defeat to Germany during the Second World War brought about a revival of *libérté, égalité, fraternité*, it was still only able to insure all of its population in 2000. The maintenance of this program has continued to be a huge ordeal for the government of France because guaranteeing health care to all of its citizens means that more money must be expended to keep it afloat.

With the diagnosis that the United States is unable to provide equal, high quality, low cost health care services and with France having similar issues, it would seem that what most separates these two countries is only their distance from each other. Their histories also reveal further similarities. Entwined in the stories of both countries are three groups becoming key players in the direction that the health care systems took. Each of these three groups worked against each other to encourage change that focused on the specific wants of these groups. Employers wanted protection and needed their workers to stay healthy to advance economically. Advances in technology created a niche for doctors to further their prestige and incomes. The government attempted to enact legislation that could have potentially pushed the countries to adopt universal health care earlier; however, individual groups, such as physicians and employers providing employer-based insurance, hindered many of these changes from taking hold.

Employer-based insurance evolved out of the need for employers to appease their workers. Both countries experienced a mass movement of people from rural to urban areas following the World Wars. During periods of economic prosperity, employers needed more workers to keep up with the demand in materials that they provided. Health insurance was offered as a way to not increase wages during times of war and was an attractive advantage to employees because it was nontaxable in the United States. Paired with this occurrence was the fact that paying for health care services was not as cumbersome as and was less serious than not receiving wages due to illness. What resulted from these series of events was the growing importance of employers in connection with obtaining health security.

After the first employer-based insurances appeared, other insurance providers evolved. Health insurance became more obtainable, fueling the demand for the newest technologies. Eventually, the most common way for a person to receive health care services in the United States was by having health insurance. To further complicate things, having health insurance was reserved for those whose place of occupation provided it. In contrast to other developed nations, the United States could only guarantee access to health care to a select few, while other countries saw the provision of health care as a right of their citizens. Paired with these discrepancies is the increased prevalence of "job lock." When health security is associated with employment, it limits the positions that one can take and limits the economic advancements that a person can make. Because health security is not only the absence of illness, employers are finding that it is harder and less economically feasible to provide these perks to their employees.

With employers losing the ability to provide the coverage like before, many people are finding that they must find ways to cover the increasing costs of health care on their own.

An obvious difference between the governing bodies in the United States and France is that the latter is more centralized. The United States was founded on the principle that the power of the states was integral to the country without one governing body having the ability to exercise more power than other entities. The result of this difference was that France was able to convert to universal health coverage sooner. Having a fragmented health care system and non-centralized government has made it difficult for the United States to enact progressive social reforms in the past. And even if changes were to be made, the results of these changes would vary from state to state because each is privy to its own rules.

Another obstacle to the passage of more socialized reforms is the presence of groups like the American Medical Association (AMA), which adopted a policy of obstructing the passage of any law that would threaten the autonomy of the physicians in the United States. Government intervention was similarly seen the same way in France, and too much interference struck a chord with the Confédération des Syndicats Médicaux Français (CSMF) and Fédération des Médecins de France (FMF); however, bickering among these two groups prevented the creation of a united front against the government and allowed France to enact more overarching legislation.

As time went on, the political environment allowed France and the United States to broaden their powers. In France, the passage of *Sécurité Sociale* and its expansion was aided by the government's insistence that insurance coverage should be available to all of its citizens. Because of a history of associating social reform with "communism," similar

changes in the United States had a more difficult time being enacted. Following the Great Depression, more emphasis was placed on these social reforms, and the Social Security Act was born. Although not as encompassing or generous as *Sécurité Sociale*, it was one of the first instances where the government began dipping its toes into becoming more involved in the intimate affairs of its people.

Following the passage of the Social Security Act, expansions of the law involved Medicare and Medicaid. Considered a success because it covered some of the most vulnerable members of society, the indigent and elderly, it has also contributed to the rising costs of health care services. It is a growing concern that these programs will be too costly for the United States to fund. However, the creation of these services marked the United States' foray into exercising more power than what had traditionally been given and helped pave the path for eventual passage of the ACA in 2010. Although the ACA was created to aid in providing health insurance to those who could not receive it before, the ACA will potentially leave about 21 million Americans uninsured after being fully implemented. Not only will the United States government have to find a way to continue keeping these programs afloat, but it will also have to find ways to fulfill the initial promises of the ACA. Each of these is an expensive pursuit and a complicated aspiration.

Another group that has had an important role in influencing the current health care systems in France and the United States is the physician. Today, physicians garner a grandiose amount of prestige and are economically better-off than their predecessors. With this increase in social standing, physicians have become obstacles to certain changes that could potentially disadvantage them in any way. The creation of the AMA,

the CSMF, and the FMF were inspired by the overall want of the physician to protect their own personal agendas in light of any changes that could also potentially benefit the patients they treat. The AMA alone had a huge role in preventing compulsory health insurance from taking hold in the United States immediately, and the CSMF and FMF complicated the reforms that the French government wanted to pass.

With the esteem and the monetary benefits associated with physicians, more people have pursued this career as an attractive occupation. Of those choosing a career in medicine, there is a trend that more medical students are choosing to specialize instead of choosing primary care medicine. Increased numbers of primary care physicians have been associated with better overall community health and less expensive health care. However, students succumb to society's view that a specialty is more challenging and pays more, which makes this occupation more valuable and prestigious to obtain. Another trend is the lack of physicians practicing in rural areas because they do not offer the amenities that bigger cities boast. Unfortunately, these areas are the most in need of health care services. These discrepancies concerning specialty versus primary care physician and practicing in urban versus rural areas can be traced back to the increasing prestige that physicians have experienced throughout history.

All three of these groups have immensely influenced the health care systems in the United States and France. Although there have been positive outcomes due to each of these groups' actions, evolutions in society has placed a greater stress on providing health care to everyone, no matter what their income, location, or occupation. When new discoveries are made, not everyone benefits, and with the passing of the ACA, there will still be those left uncovered.

The United States spends more money funding its health care system than any other nation, yet it is unable to provide high quality care to all of its citizens. The well-being of a person is no longer an individual pursuit because more people are becoming invested. If these three groups were somehow able to work together for the greater good, there would be fewer discrepancies in the United States concerning overall health status. Progress could start with tweaking of the ACA and a more hands-on approach by the government. Changing how people receive insurance and relieving employers of their duties of providing insurance to all of their employees could help spark competition. Reforming aspects of the physician "world" could also impact the current state of the health care system for the better. Similar to how Hôtel-Dieu had to transform to better care for their patients, the United States need to overhaul its mindset. Health care systems operate under a team mentality, which means a single entity has the ability to hinder the reaching of a goal set by all members. Working together would prevent this occurrence. These three groups had a big role in influencing the health care systems of today, and together they could offer potential answers to the systems' current inefficiencies. The solution is complicated because there are a variety of factors to consider, but a positive change can only be achieved by a cohesive effort from those coming from different backgrounds.

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