*Myth and Misinformation: the French Assessment of Obstacles to Health Care Reform in the US*

Policy Suggestions for a Final Bill

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**SUBMITTED TO:**

Senator Harry Reid

Senator Ben Nelson

Senator Tom Harkin

Senator Blanche Lincoln

Senator Max Baucus

Senator Mary Landrieu

Speaker Nancy Pelosi

Congressman Henry Waxman

Secretary Kathleen Sebelius

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PREFACE

*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and* ***medical care*** *and necessary social services, and* ***the right to security in the event of unemployment, sickness, disability,*** *widowhood, old age or other lack of livelihood in circumstances beyond his control.*

*—* Universal Declaration of Human Rights, Article 25(1), adopted by the General Assembly of the UN (with strong US and French support) on 10 December 1948

*My family and I often vacation in the Pacific Northwest where we have a cabin on Mount Hood, just 45 minutes from Portland. Sitting in my favorite diner on the mountain, reading the local newspaper, I came across the following letter to the editor: “I am your mail carrier, Dana Vedder. My son Dakota needs three surgeries, but we do not have health insurance. If anyone would like to make a contribution for his medical treatment, they can go to the Clackamas County Bank and make a deposit to the account for Dana Vedder. Thank you!” An editor’s note followed, explaining that five-year-old Dakota . . . suffers from a severe hearing impairment. Despite the Vedder family’s forty-six years of delivering mail on Mount Hood, as private contractors they enjoy no health coverage from the U.S. Postal Service. Needless to say, Dakota’s condition is uninsurable through an individual policy. I had alighted from a plane not ten hours before, en route from a comparatively rural region of southern France where the Vedders’ plight could not have been imagined.*

— Paul V. Dutton, *Differential Diagnoses* (Ithaca, NY: Cornell University Press, 2008), 221.

Why has the US, in spite of its affluence and alleged commitment to human rights, failed to honor in policy what it pledged in word 61 years ago?

Why is the Vedders’ plight, unimaginable in France or in any other wealthy industrial nation, commonplace here?

I had no particular expertise in health care, but I wanted an answer. After all, how difficult could it be to achieve universal medical coverage if every other developed country, each in its own way, had seen the need and found the means. I first consulted the academic literature, which did everything but answer my question. I turned to journalistic and political sources – and turned away when it became obvious that my simple “*pourquoi?*” had been lost in a dense jungle of agenda justification and ideological warfare.

Having lived in France before health care became the prominent political issue it is today, and having uncovered and published analyses of several items of political and economic interest little known in the English speaking world,[[1]](#footnote-1) I decided that a return to the country now ranked by the WHO as having the world’s best health care system might suggest an answer to that elusive “why.” Through a better understanding of the French *système de santé* and a first-hand grasp of the way in which *the French interpreted America’s failure*, I hoped to gain a fresh perspective on the causes of our borderline paralysis.

The findings of my research trip, generously financed by American Public University System, exceeded all expectations. I want to provide you with partial reconstructions of my more significant interviews, as I think their content will be of use to you as you consider a final bill on health care reform in the United States. The language of my reconstructions diverges at points from the exact wording of the interviews (conducted in French), but the substance remains unchanged.

JEAN-JACQUES GUĖRIN[[2]](#footnote-2)

Thomas Kirkwood: *As I was saying, those of us who would like to see meaningful health care reform are worried about its impact on the budget. In other words, it’s going to be expensive. I didn’t understand what you meant when you spoke of our tendency as a nation to abstract public budgets out of their societal context.*

Jean-Jacques Guérin: Let me try another example. We here in the affluent nations of the European Union spend today somewhere in the range of 10-11% of our GDP on health care. In the United States, you spend in the range of 16% **of a larger per capita GDP**. This translates roughly into an individual health care expenditure in your country which is twice the European average. Yet by all measures – life expectancy, patient satisfaction, accessibility to care and the like – we have achieved better outcomes. This would indicate that health care systems with universal coverage are both more effective *and* less expensive. This being the case, how is it possible to argue that it is going to cost more than you are already spending to achieve the results that we have already achieved? This is clearly nonsense; we must assume a “global” rather than a strictly budgetary assessment to arrive at an accurate calculation of health care costs. You, however, look only at your national budget, which represents a significant but by no means comprehensive measure of actual pluses and minuses. This is especially true when a public program that shows up on government books as an expenditure produces large savings in the private sector.

*Could you give me a couple of examples that relate specifically to health care?*

Of course. Consider a young entrepreneur who believes she has an idea that will prove both practical and profitable. This entrepreneur is not destitute, not a candidate for your basic government medical coverage for the very poor —

*You’re speaking of Medicaid?*

Yes. And she is not old, not a candidate for your government insurance for the elderly. Now, let us assume that she has a preexisting medical condition —

*Such as pregnancy?*

(Laughs.) I was thinking more in terms of a chronic condition, say diabetes or severe asthma, some affliction that makes it impossible for her to buy a private insurance policy or, if she can buy one, only at an exorbitant price. Either way, she is chained to a financial yoke that makes the realization of her idea unlikely. In France she has no expenses associated with her condition, as all illnesses of long duration are covered 100% by State health insurance, a branch of our *Securité Sociale*.

*Yes, I understand. That’s something I find commendable. But if health reform succeeds in the United States, won’t taxes on income from her realized project eventually show up in the federal budget?*

That income might show up in the budget but it cannot be projected as income. We cannot assume *a priori* that the woman in question will succeed. That would be preposterous. However, on a national level we know that a climate more conducive to such ventures will produce income for the State. It is nonetheless one of those “pluses” that cannot be estimated. Hence, it finds no place on the positive side of the ledger in a public budget. You can speak of the expense of universal health insurance with some precision, but *not* – at least empirically – of its ability to stimulate the production of wealth. Another example. We have various insurance funds that cover workers or salaried employees who are between jobs as they search for positions better suited to their skills and interests, positions that are likely to produce higher tax revenues when found. It’s a simple matter of utilizing the positive side of the free market. If you take one such example and project it onto the national level, you are again looking at an enormous source of public revenue. Yet it does not show up on the public balance sheet when you calculate the costs of health care reform. Again, we in Western Europe spend less on health than Americans by a factor of two, yet achieve better medical outcomes. This, I believe, is because thousands of examples like the two I have given generate public income that cannot be projected in hard numbers when you are in the process of instituting reform. Finally, and most obviously, Americans who have expensive private policies that would be less expensive in a system of universal government health insurance would receive an enormous collective increase in disposable income. This new income would generate tax revenues at some point, but it is difficult to know how much and when. Therefore, such private gains from public policy are generally not included in budget projections. As I said at the start of this talk, to look at the cost of universal health care by looking at a public budget tells you nothing. Double entry book keeping has been with us for many centuries. When it comes to health reform, it is as if you Americans have forgotten that there is a “credit” column and listed only costs or debits. European expenditures on health care in systems that provide universal coverage should make sufficiently clear that your approach is flawed . . .

**Policy Suggestion # 1: Dismiss the unsubstantiated notion that health care reform in the United States is going to add to the country’s financial burden. Evidence throughout the affluent democratic world makes such a claim untenable if not ridiculous.**

BĖATRICE NORMAND[[3]](#footnote-3)

Thomas Kirkwood: *You have spent considerable time in the States. I assume that you understand the aversion most Americans have to “socialized medicine.”*

Béatrice Normand: What is socialized medicine?

*Well . . . how should I define it? Perhaps a national or governmental system of health care.*

Let me help you avoid being misled by one of your country’s historical narratives or myths. We must be precise when we speak of “socialized” or we’ll never understand the basics of health care provision – and the role of the State therein. Do you have a socialized army? Is NASA a socialized entity? What about the private sector? Is automobile insurance, whose explicit purpose is to “socialize” risk, in fact socialized?

*I’m afraid I’m not following.*

You are not following because the word “socialized” in American English is not defined in the manner in which words that have specific meaning are defined. It is understood emotionally rather than rationally and tends to conjure up the specter of a vague threat to individual freedom. It can be applied to almost any aspect of public-private relations without losing its affect.

*In other words, most of us don’t know what the word “socialized” means.*

That has been my experience. You will perhaps be surprised to learn that our physicians harbor two great fears. One of these is of “socialized medicine.” When they refer to socialized medicine, however, they are referring to something specific. Your medical community is not, which prevents it from looking beyond your shores for possible solutions to your problems.

*And that “something specific” would be?*

The end of fee-for-service private practice medicine, to which the great majority of our practitioners subscribe. Providing public health insurance to every Frenchman and every person legally in France is one thing. We might speak here of the “socialization” of insurance, as it is in large part a public affair. But socialized insurance and socialized medicine have nothing in common. In fact the former and the latter fit quite nicely together. In the United Kingdom, on the other hand, you have a system in which most doctors are employees of the National Health Service. That – if “socialized” is properly defined as government control – is socialized medicine.

*I have to admit I wasn’t aware that French medicine is primarily based on private practice. But even if this becomes known in the States, it will be widely argued that government insurance is a sort of “foot in the door” that will lead to a government takeover of medicine.*

When in reality quite the opposite is true. French medical associations, professional groups of doctors roughly comparable to your AMA, decided back in the Thirties that they could better protect their status as private practitioners if they joined the government, the unions, mutual societies, citizens groups and the like in working out a coherent public health insurance policy. Having a seat at the table, they were able to extract concessions from those wanting broader insurance schemes than they, concessions that included the guarantee of physician autonomy. By autonomy I mean retention of fee-for-service private practice medicine, freedom to prescribe treatments and tests without the intervention of a third party, absolute doctor-patient confidentiality. For patients it meant something as well: a guarantee of the free choice of doctors. You will remember that I spoke of the second great fear of French doctors. I’ll come right out and say it, not to offend but to give you a better understanding of where we stand as medical professionals today. That fear is of what we call “Americanized medicine,” and it is shared by doctors and patients alike. I’m not speaking of the lack of regard for human rights in your national health policy, though this is perceived equally by our Left and Right as appalling. Let me begin with our patients. The French would not tolerate the restrictions you have placed on the free choice of doctors. Nor would they accept the long waiting lists, virtually unknown in France, which you ingeniously if disingenuously call “next available appointment.” I suppose you’re going to tell me you don’t have waiting lists.

*No. I understand what you mean. I’ve had an appointment for three months to see a dermatologist and still have to wait a month after my return from France. Why this is so? Why do we often have to wait so long for the “next available appointment” with a specialist?”*

Because you don’t have enough doctors, and those you do have don’t always practice in the areas in which they are needed.

*Do you have some figures handy that I could cite?*

Certainly. France has approximately 3.4 doctors per 1,000 inhabitants, directed into the areas in which they are needed by a so-called numerus clausus system at the university level. The US has about 2.3 doctors per 1,000 inhabitants whose training is unrelated to the needs of your population. These are all statistics you can research on your own, so I’d prefer not to spend our remaining time on them.

*I’ll research them , of course. You’ve mentioned waiting lists as a big problem in the US, which I’ve never heard anyone at home mention. We talk about them, but in Canada or Britain. So if we don’t believe it’s a problem, I don’t think it’s fair of you to characterize it as one – even if I agree with you that they in fact exist. I’m not being defensive. I would like to know about the other aspects of “Americanized medicine” French MDs and French patients fear.*

What they fear are the restrictions placed on your professionals and patients by Health Management Organizations, whose goal is to increase profits by creating so-called networks of subscribing doctors. Patients who belong to an HMO, increasingly the case in the United States, must stick with “in-network” providers or pay a heavy supplemental charge. They are also at the mercy of HMOs to fund or not to fund doctor-recommended procedures and tests – and must forfeit their choice of specialists if such tests are seen as indicated. Doctors are powerless to fight these organizations. French doctors have a seat at the bargaining table, even though the table includes the State, and they have used that seat to protect their autonomy in ways that American doctors cannot. Of course, things are changing here due to rising costs and demographic trends, but hardly to the same extent . . .

**Policy Suggestion #2: Stress the difference between national insurance and socialized medicine; point out the restrictions faced by American doctors which could possibly be lessened by a shift from private HMO-based health insurance to a national plan in which doctors would have meaningful input.**

ALAIN FAURE[[4]](#footnote-4)

Alain Faure: I don’t understand why you keep returning to the topic of private insurance and the way in which it is affected by a “public option.” This doesn’t strike me as a question of any importance in the French context. As I explained, everyone who is a French citizen or a legal resident receives medical coverage for approximately 75% of expenses incurred. Payment comes from one of six or seven funds (*caisses*) within the General Scheme of *Securité Sociale* whose revenues are paid by employer-employee contributions; or from other *caisses* funded by the CSG or by agricultural co-ops.

Thomas Kirkwood: *I’ll come to my interest in your public option in a moment; I’m sure you are aware of the divisive issue it has become in the United States. But you mentioned an acronym I’m not familiar with and no doubt should be. What is the CSG?*

A progressive income tax we French pay on all income: capital gains, dividends and inheritances as well as normal earnings. CSG . . . the *Contribution sociale generalisée*. It’s been with us since the 1990s and is meant to cover increases in the cost of medical services without recourse to the employment-based revenue sources already disproportionately taxed as globalization and other factors steadily reduce the percentage of the work force involved in traditional employment.

*Thank you. I’ve read about the tax but didn’t associate it with the letters. Let me get to your concern. I understand that Securité Sociale is the primary insurer and that households contribute a percentage to the payment of medical services as well. It’s that slice in between the two, that 15-16% of medical costs covered by supplementary insurance that interests me because it includes both public, non-profit and private insurers from which you can choose. I’m interested in the impact that the existence of what we call the “public option” has on the private plans. Does it force them to lower premiums to compete and thereby contribute to cost control? In the US this is an enormous question, as the type of reform we are likely to end up with might or might not include a public option; and because none of our population that is neither old nor extremely poor is covered at present by a government insurance plan. I thought that your experience in this area – your experience as a nation – might provide me with a sort of microcosm of what we can expect.*

You won’t find a microcosm in France. People choose a more expensive private plan because it covers more of the cost of tier-two and tier-three doctors[[5]](#footnote-5), those specialists who have decided to reject the fee schedule for various procedures that has been negotiated between doctors’ associations, public medical boards and other social partners.

*But that’s precisely what I’m interested in.*

I assure you it’s not. First, only around 3% of all medical costs in France are reimbursed by private insurers. Second, supplementary insurance, public or private, is not expensive in France because insurers don’t have to worry about paying for expensive medical conditions. This is one of the practical side effects of ALD, which was established for reasons of human decency, not actuarial soundness.

*Then let’s talk about ALD.*

You know what it is, correct?

*I could use a refresher course.*

Very well. I think you’ll find part of the answer to your “public option” questions here. As a nation, you can’t just let people go broke, lose their homes, go bankrupt when they are already under the terrible stress of having to cope with a chronic and often fatal disease. If you allow this, you not only violate all standards of morality, of decency, of human rights; you needlessly force an entire population, or at least those of a certain age, to live in constant fear of what *could* happen. It’s a no-win situation that will weaken a country in more ways than I have time to go into. Hence the commitment of *Securité Sociale* to deal with all cases of ALD (Afflictions of Long Duration.) In such cases, supplementary insurance – public or private – as well as household contributions, are suspended. National health insurance pays 100% of all drugs, treatments, surgeries and the like . . . as well as providing financial assistance to help make up for lost income. You will remember that we have had conservative governments for fourteen years running now. This isn’t a political issue; it is the execution of a primary purpose of the nation-state. I’m speaking of course of the protection of nationals from calamity. If your government were to assess its own attitudes toward human security, I cannot imagine that there would be serious debate on the implementation of such a program. After all, you seem to put human security in the forefront when anything but sickness is concerned. But returning to my point: were private insurers in your country relieved of the worry that they might be taking on a client who posed a serious financial risk, would they really be so determined to provide insurance only to those considered “low risks?” I think not. A bad risk in terms of the probability of a financially draining illness becomes a “good risk” with ALD because the insurance company’s obligation drops from something to nothing. This type of program in a country willing to pay for two wars seems to us both practical and ethical. If you force private insurers to take all applicants, you aren’t really addressing the problem. Companies will protect their profits by lowering the standard of care they allow in-network doctors to provide. High risk individuals will of course be most affected by these profit-driven “cost-cutting” measures, since they are the ones who will have the most interaction with their insurers. These people will tend, quite predictably, to gravitate toward the government program, where considerations of profit disguised as economizing measures will be absent. The result is that, with time, the public option, no matter how it is paid for, will become more expensive than the private insurance whose premium prices it is meant to hold down. You Americans cannot shake your faith in market forces. But as you certainly know the market functions poorly in providing health care. Profits are sought; profits are earned. But the losers are not inefficient producers; the losers are the sick.

**Policy Suggestion #3: Understand that a public option will gradually transfer the cost of treating those who are now “uninsurable” to the State. If public insurance *is not universal* it will end up as an ineffectual tool with which to control the price of private insurance and the spiraling costs of medical care in the United States. A final bill must at very least contemplate this contingency and provide the means for dealing with it, should it arise.**

ANOUK PALIÈRE[[6]](#footnote-6)

Thomas Kirkwood:  *How can you run a medical office without hordes of receptionists, nurses, accountants and repairmen for the copier?*

Anouk Palière: Why would I need an army? You see that the office and examining rooms are small. We’d be tripping all over each other.

*Well, what about billing? Who does all of your billing? I’ve noticed, sitting here, that you have no shortage of patients.*

Everyone in France has a *carte Vitale* from his or her insurance caisse embedded with a microchip containing, among other things, the administrative details needed for billing. The patient pays me directly. I insert the *carte* in a transmitter that I’ll show you later, then enter the services I performed, nothing complicated. Each service has a predetermined price that doctors’ associations have negotiated with the social partners. The patient is reimbursed, minus a small co-payment (the *ticket modérateur*), within a few days. The entire process takes me two seconds and there’s no paperwork involved.

*You don’t set your own fees, then?*

No, because I chose not to. A tier-one doctor is a doctor who accepts the negotiated fees and does not deviate from them. You are free to declare yourself a tier-two doctor and set your own fees, but your patients must make up the difference between the negotiated fee and the doctor’s fee. Almost all Frenchmen, over 90% if I’m not mistaken, have supplementary insurance which can be helpful when you choose a tier-two specialist. Then there are those famous doctors who opt out of the system entirely. They can charge whatever they want but the patient must pay the entire amount. You have a lot of choices when it comes to making medical decisions. Everyone has basic care, most have options on top of that care due to supplementary insurance or private means and no one interferes with the ability of the affluent to buy whatever treatment they want . . . and from whomever they want it. On occasion I read material on French health care in the American press. The amount of misinformation is shocking. Private practice medicine thrives in France in tandem with universal public insurance. We sit down with the State and discuss problems of cost and take whatever action we can to contain them. Your doctors sit down with no one from what I understand, and insurers who are not the best judge of medical needs set fees and limit your choice of doctors. The French would find such interference in their professional lives, whether from the State or from insurance companies, entirely unacceptable. But I digress and we have little time.

*I found everything you said very interesting and very much in line with what I have heard in the last ten days. I’ll try to be brief. Do you have electronic medical records? I’ve gotten contradictory answers.*

Yes and no. A 2004 law mandated them, but there have been problems and court challenges over confidentiality. Our Minister of Health, Roselyne Bachelot, is a strong believer in the need for such and has kept alive an initiative that might have withered away. We will be running pilot tests all over France in 2010 and hope to have the system in place soon. You began by asking about my ability to run a medical practice alone. It is quite possible now and will even easier when the DMPs (*Dossiers Médicaux Personnels*) are in place . . .

**Policy Suggestion #4: Be certain that the Final Bill contains adequate provisions for the way in which medical services are billed, whether to a public or private provider. No paper work should be involved, as this consumes time and effort better spent on medical care. Be certain that the Final Bill contains adequate funds and provisions for the computerization of all medical records in a manner consistent with the privacy demands of existing law. It would be helpful to be familiar with French legal challenges to electronic medical records, since the Final Bill should profit from the French experience by including safeguards that will keep the implementation of reform out of the courts.**

ROMAIN DE CHADELAT[[7]](#footnote-7)

Thomas Kirkwood: *What, exactly, is a tier-three practitioner?*

Romain de Chadelat: A doctor who has opted out of the public medical insurance network. Unlike a tier-two doctor, whose patients are partially reimbursed by *Securité Sociale*, a tier-three doctor sets his own fees and is responsible for their collection. Sometimes the patient has supplementary private insurance that helps to cover medical expenses; sometimes the patient simply pays out of pocket.

*You said earlier that you specialize in hip and knee replacements. Aren’t these surgeries, together with hospital costs, prohibitively expensive?*

I suppose that depends on how rich you are. I don’t mean to boast, but I am considered among the top ten or so surgeons in Europe performing these procedures.

*What if someone is not rich by anyone’s definition and needs a hip replacement? Do you simply turn her away?*

I would have to if your hypothetical situation ever materialized. It doesn’t, though. Thousands of joint replacements are performed each year in France with a high rate of success. But they are performed by tier-two surgeons. To begin, those with superior credentials receive patient reimbursement in excess of the negotiated fee for such procedures – sometimes significantly greater. Reimbursements from the patient’s supplementary insurance, public or private, are added to enhanced payments from *Securité Sociale*. If the patient is not financially able to make up the unpaid balance, the State steps in. Simply put, if you need an artificial knee or hip you will not be denied on the basis of ability to pay. **We do not ration medical care in France as you do in the States.**

*Meaning?*

Meaning, quite simply, that you will receive the treatment you need irrespective of your ability to pay for it. After all, one of the obligations of the modern State is to provide for the well-being of citizens who are unable to do so themselves.

*Yes, all right, that sounds reasonable. But here we are in the most expensive restaurant in Toulon, where it would appear that you are rather well-known to the staff. You drove me here from your office in a car most people could not buy with a lifetime of savings. In other words, you represent what Americans would not usually associate with any kind of universal medical care. Essentially, you care for the rich, among them the foreign dignitaries you spoke of. Don’t think me rude for asking this, but I’m really curious. You’re in a profession devoted to the care of others. How can you enjoy all of these things you obviously enjoy when there is suffering all around you?*

It’s a fair question and I’m going to give you a good answer. I’m a Frenchman. I’m not out to save the world but I do care about my country. I also care about myself. I inherited a sizeable amount of money and founded a private *clinique* after it became clear that I had a gift for the profession I’d worked harder than most to master. I felt that I deserved material compensation for my achievements – not so much for treatment of the rich but for the contributions I have made – and am still making – to the field of orthopedic medicine. I like to eat. I like to drive and to sail. I like my home and my second and third homes. I love my wife and my children. And here is the best answer I can give you. I could not enjoy these things that I feel I have earned if I knew that one . . . just one . . . of my countrymen did not have access to basic medical care. No doctor of any nationality, in my view, has a right to an income greater than that of an average citizen of his or her country *until all citizens have medical care.* Even though I chose to opt out of our system, I fought to make universal medical care a reality. Now we have it, and now I intend to enjoy the things I’ve earned.

**Policy Suggestion #5: Be certain that the Final Bill spells out clearly that there is room in the medical profession for doctors who expect monetary rewards for superior achievement as well as for doctors who prefer to practice in a financially secure environment with added emphasis on doctor-patient contact, not paperwork and billing. The bill should also stress in unambiguous language the obligation of the modern State to protect its citizens not just from terrorism but also from preventable illness.**

CC: Senator Harry Reid

Senator Ben Nelson

Senator Tom Harkin

Senator Blanche Lincoln

Senator Max Baucus

Senator Mary Landrieu

Speaker Nancy Pelosi

Congressman Henry Waxman

Secretary Kathleen Sebelius

1. See, for example, Thomas Kirkwood, “The Worker Priest in France,” *Contemporary Review* (London), May 1977, 261-267. [↑](#footnote-ref-1)
2. All interviews were conducted on background with the promise of anonymity. To this end, names and places have been changed. Jean-Jacques Guérin is senior editor at a university press. [↑](#footnote-ref-2)
3. Béatrice Normand is an official in the French Ministry of Health [↑](#footnote-ref-3)
4. Alain Faure is CEO of a public interest group whose mission is to offer an arena for policy coordination for all groups, public and private, involved in the provision of health services. [↑](#footnote-ref-4)
5. The tier system is addressed in a later interview. [↑](#footnote-ref-5)
6. Anouk Palière is a tier-one primary care physician who practices alone in a middle-class section of Cherbourg [↑](#footnote-ref-6)
7. Romain de Chadelat is a tier-three orthopedic surgeon in Toulon. [↑](#footnote-ref-7)