

The High Cost of Health: The French System and
What It Means for the U.S.

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I. INTRODUCTION

The French health care system has been heralded as the best in the world.¹ The entire population receives health care that is provided by both private entities and government.² The country has a low infant mortality rate while maintaining one of the highest birth rates in Europe.³ The French are said to live longer and be healthier, but funding quality health care is expensive.⁴ Globally, the health care program in France is one of the most expensive.⁵ In 2007, the country experienced \$9 billion in debt.⁶ This forced President Nicolas Sarkozy to approve charging more for basic care.⁷ With the first steps of implementing expanded health care in the U.S. already in place,⁸ the U.S. health care system is facing untenable costs similar to those of France.⁹ Providing quality medical care for the entire

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1. Joseph Shapiro, *Health Care Lessons from France*, NPR (July 11, 2008), <http://www.npr.org/templates/story/story.php?storyId=92419273>.

2. *Id.*

3. Joseph Shapiro, *France's Model Health Care for New Mothers*, NPR (July 10, 2008), <http://www.npr.org/templates/story/story.php?storyId=92116914>.

4. Shapiro, *supra* note 1.

5. *Id.*

6. *Id.*

7. *See id.* (reporting that the French President charged patients more for drugs and ambulance services).

8. *See The Affordable Care Act*, WHITEHOUSE.GOV, <http://www.whitehouse.gov/healthreform/healthcare-overview#healthcare-menu> (last visited Mar. 26, 2012) (explaining and listing the effects of the Affordable Care Act on health coverage for consumers).

9. Pierre Loiseau, *When the Clouds Hung Oppressively Low in the Heavens: Unhealthy Cost-Cutting in France and in the U.S.*, 70 LA. L. REV. 945, 947 (2010).

U.S. population will require more than a commitment to access; sustainable financial planning is imperative.¹⁰

This article begins by introducing the basic structure of the French health care system and deficiencies in access to care. Second, it will analyze the varying quality in medical care under the French system. Next, this article will detail the financial structure of the French model and discuss the rising costs of medical care. Finally, it will compare the financial weaknesses of the French system to the expected fiscal defects of the expanding U.S. health care system.

II. ACCESS TO HEALTH CARE

To begin, health care systems are unique to each nation's history and politics.¹¹ The French system can be traced back to the French Revolution, where the principle of solidarity was derived.¹² Solidarity means that all people have access to health care irrespective of their ability to pay.¹³ It is the notion that universal access to health care is provided while maintaining substantially the same benefits for everyone.¹⁴ Based on this principle, France committed to universal health care shortly after World War II, despite economic struggles.¹⁵

France's universal health care system is structured based on what is

10. See David Gauthier-Villars, *France Fights Universal Care's High Cost*, WALL ST. J., Aug. 7, 2009, <http://online.wsj.com/article/SB124958049241511735.html> (discussing the similar fiscal problems in the health care systems of France and the U.S.).

11. Timothy Stoltzfus Jost, *Global Health Care Financing Law: A Useful Concept?*, 96 GEO. L.J. 413, 416 (2008).

12. Vassilis Hatzopoulos, *Financing National Health Care in a Transnational Environment: The Impact of the European Community Internal Market*, 26 WIS. INT'L L.J. 761, 769 (2008).

13. Timothy Stoltzfus Jost, Diane Dawson & Andre den Exter, *The Role of Competition in Health Care: A Western European Perspective*, 31 J. HEALTH POL. POL'Y & L. 687, 688 (2006).

14. *Id.*

15. See Arnold J. Rosoff, *Of Stars and Proper Alignment: Scanning the Heavens for the Future of Health Care Reform*, 159 U. PA. L. REV. 2083, 2089-90 (2011) (discussing France's push to implement universal health care as soon as possible after WWII).

known as the Bismarkian model.¹⁶ Under this model, people receive insurance because they are employed or participate in a professional organization or similar group.¹⁷ Complementary programs cover those people who do not fall within a sector-specific scheme.¹⁸ This model results in many funds that are public or private, and each fund operates differently from another.¹⁹ In addition, clinics, hospitals, and other facilities offering medical care are either public or private.²⁰ Because of the differing types of funds and the manner in which they operate, planning and coordinating health care under the Bismarkian design is complicated.²¹ Nonetheless, the model allows France to provide medical insurance for 100% of the population.²²

However, all members of the population do not have equal access to health care.²³ The country has faced difficulties in coordinating health care for the elderly,²⁴ and there are disparities in geographically distributing health care resources.²⁵ Most French find that the proximity of health care services is acceptable, but the number of hospitals and providers in rural areas is limited.²⁶ A recent survey revealed that roughly one-third of

16. Hatzopoulos, *supra* note 12, at 767. Chancellor Bismarck of Germany was the first to establish this model in the 1870s. *Id.*

17. *Id.*; see David Marrani, *Exclusion and Human Rights: The French Case*, 12 J.L. & SOC. CHALLENGES 38, 47 (2010) (criticizing the requirement to work to benefit under the health care system).

18. Hatzopoulos, *supra* note 12, at 767.

19. *Id.*

20. *Id.*

21. *Id.*

22. See Loiseau, *supra* note 9, at 946 (listing the different schemes under which the French population is insured).

23. See *infra* notes 24-31 and accompanying text (discussing the shortcomings in access to health care).

24. Chris Ham, Victor G. Rodwin, Editor, *Universal Health Insurance in France, How Sustainable?*, 33 J. HEALTH POL. POL'Y & L. 841, 842 (2008) (book review). In 2003, 15,000 elderly died because of a heat wave. Olivier Moréteau, *Policing the Compensation of Victims of Catastrophes: Combining Solidarity and Self-responsibility*, 54 LOY. L. REV. 65, 81-82 (2008). The deaths raised questions about care for the elderly in France. *Id.*

25. Ham, *supra* note 24, at 841-42.

26. *France*, KAISEREDU.ORG, <http://www.kaiseredu.org/Issue-Modules/International->

respondents living in rural areas indicated that specialists were located too far away.²⁷ The country has also cut services.²⁸ For example, in June of 2009, France closed a hospital—including a maternity ward—in a southern village to reallocate resources.²⁹ As a result, expectant mothers must travel thirty miles to the nearest hospital.³⁰ In addition, when a flu and bronchitis epidemic spread in December of 2004, hospitals were not equipped with enough beds to treat the sick.³¹ These complications illustrate the gap between France's universal coverage in theory and providing access in practice.

III. QUALITY OF CARE

The standard of care that physicians in France provide is ranked well internationally.³² Patients may choose which doctors and hospitals they would like to provide their care.³³ Patients may also obtain elective surgery or see a specialist for treatment without the inconvenience of waiting lists.³⁴ The state even reimburses 100% of costs for patients with long-term illnesses such as cancer, diabetes, and mental afflictions.³⁵ The government also funds cancer patients' costs for expensive and experimental drugs.³⁶ In addition, costs for prenatal and postnatal care for mother and child are fully reimbursed, regardless of whether care is provided by hospitals or self-

Health-Systems/France.aspx (last visited Mar. 26, 2012).

27. SIMONE SANDIER, VALÉRIE PARIS & DOMINIQUE POLTON, EUR. OBSERVATORY ON HEALTH SYS. & POLICES, HEALTH CARE SYSTEMS IN TRANSITION, 63 (Sarah Thomson & Elias Mossialos, eds., 2004), available at http://www.euro.who.int/__data/assets/pdf_file/0009/80694/E83126.pdf.

28. Gauthier-Villars, *supra* note 10.

29. *Id.*

30. *Id.*

31. *French Healthcare Is 'Badly Run'*, BBCNEWS, (Jan. 23, 2004), <http://news.bbc.co.uk/2/hi/europe/3423159.stm>.

32. *Id.*

33. Jost, Dawson & Exter, *supra* note 13, at 694.

34. Shapiro, *supra* note 1.

35. *Id.*

36. *Id.*

employed physicians.³⁷ Furthermore, the insurance system covers required and recommended vaccination and alcohol and drug abuse prevention.³⁸ Generally, patient satisfaction is high and health outcomes are favorable according to international standards.³⁹

Despite satisfaction with the overall care, the quality is uneven and results in disparities in health by social class.⁴⁰ The health care system lacks coordination and continuity of care, particularly where isolated professionals provide services.⁴¹ To illustrate, a national study found that only forty percent of diabetes patients undergo an annual eye examination—as recommended by national guidelines—evidencing that physicians cannot monitor the entire process of their patients' care.⁴² Because doctors can choose where they practice, the geographic concentration of physicians varies.⁴³ More physicians practice in Paris and southern France even though residents in northern areas are in poorer health.⁴⁴

Furthermore, France's system has been criticized for shortcomings in continuing medical education⁴⁵ and monitoring medical practices.⁴⁶ Before the 1990s, only insurance fund medical advisers monitored abuses in practice.⁴⁷ The government then issued recommendations and guidelines for clinical practices including treatment, diagnosis and supervision.⁴⁸ Because of the guidelines, physicians significantly changed their

37. SANDIER, PARIS & POLTON, *supra* note 27, at 58.

38. *Id.* at 58-59.

39. Ham, *supra* note 24, at 841.

40. *Id.* at 842.

41. SANDIER, PARIS & POLTON, *supra* note 27, at 66.

42. *Id.*

43. *Id.*

44. *Id.*

45. Monika Steffen, *The French Health Care System: Liberal Universalism*, 35 J. HEALTH POL. POL'Y & L. 353, 382 (2010).

46. SANDIER, PARIS & POLTON, *supra* note 27, at 63.

47. *Id.*

48. *Id.*

prescribing behavior.⁴⁹ Ordinances in the 1990s also mandated continuing education and even established sanctions for failure to comply.⁵⁰ However, because implementing the system has been difficult, continuing education for doctors has seen no progress.⁵¹

IV. FINANCING

In addition, assuring high quality of care is increasingly difficult because of rising costs.⁵² The means through which France finances its health care system is subject to criticism.⁵³ In France, the employed pay roughly twenty-one percent of their income to fund the national insurance, or public, program.⁵⁴ Employers also pay taxes to fund the program.⁵⁵ Semi-public insurance companies use these funds to negotiate with medical unions to determine physicians' fees.⁵⁶ The government then reimburses patients for roughly seventy percent of their costs.⁵⁷ Because the public system does not cover all medical costs,⁵⁸ individuals obtain private complementary or supplementary insurance to reimburse the remaining thirty percent,⁵⁹ and half the cost of the supplemental insurance for complementary coverage is funded by their employers.⁶⁰ More than ninety percent of the population obtains complementary insurance to fund services the public system does

49. *Id.* at 65.

50. *Id.*

51. *Id.*

52. J. Paul Singleton, *The Good, the Bad, and the Ugly: How the Due Process Clause May Limit Comprehensive Health Care Reform*, 77 TENN. L. REV. 413, 435-36 (2010).

53. See Gauthier-Villars, *supra* note 10 ("Since the 1970s, almost all successive French health ministers have tried to reduce expenses, but mostly managed to push through only minor cost cuts.").

54. Shapiro, *supra* note 1.

55. *Id.*

56. *Id.*

57. *Id.*; see Hatzopoulos, *supra* note 12, at 769 (noting that the government reimburses some medical costs).

58. Roger Feldman, *Quality of Care in Single-Payer and Multipayer Health Systems*, 34 J. HEALTH POL. POL'Y & L. 649, 660 (2009).

59. Shapiro, *supra* note 1.

60. France, *supra* note 26.

not cover.⁶¹ The government also provides complementary insurance coverage for those who are not able to afford it⁶² and regulates drug prices to keep them low.⁶³ With input from manufacturers, the government approves drug prices and reimburses the manufacturers.⁶⁴ This system renders France a country with one of the highest per capita government health expenditures in the world.⁶⁵

Although the French model is more progressive in comparison to those of other countries,⁶⁶ long-term funding issues question its sustainability.⁶⁷ The country has faced significant debt for several decades.⁶⁸ The government has attempted to reduce the deficit through other taxes, but the deficit still remains.⁶⁹ In 1984 and 1989, the country placed budgetary responsibility on hospitals in hopes of ensuring “efficiency through accountability,” rather than allowing the state to control.⁷⁰ The country also attempted to control the costs of ambulatory care by encouraging negotiations between government insurance providers and medical

61. Jonathan P. Weiner, Joanna Case Famadas, Hugh R. Waters & Djordje Gikic, *Managed Care and Private Health Insurance in a Global Context*, 33 J. HEALTH POL. POL'Y & L. 1107, 1118 (2008).

62. *France*, *supra* note 26.

63. Davina Rosen, Comment, *Balancing Business & National Health: The Impact of Legislation on Pharmaceutical Drug Prices*, 26 TEMPLE J. SCI. TECH & ENVTL. L. 341, 352 (2007).

64. Todd A. Rosenfield, Comment, *The Counterfeit Drug Invasion: How Drug Reimportation Unjustifiably Poses a Threat to the Health of the U.S. Public*, 25 U. PA. J. INT'L ECON. L. 1047, 1053 (2004), available at [http://www.law.upenn.edu/journals/jil/articles/volume25/issue3/Rosenfield25U.Pa.J.Int'lEcon.L.1047\(2004\).pdf](http://www.law.upenn.edu/journals/jil/articles/volume25/issue3/Rosenfield25U.Pa.J.Int'lEcon.L.1047(2004).pdf).

65. See Eleanor D. Kinney & Brian Alexander Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INT'L L.J. 285, 295 (2004) (ranking France's per capita government expenditures for health care).

66. Jennifer Prah Ruger, *Health, Capability, and Justice: Toward a New Paradigm of Health Ethics, Policy and Law*, 15 CORNELL J.L. & PUB. POL'Y 403, 450 (2006).

67. *Ham*, *supra* note 24, at 842.

68. *France*, *supra* note 26.

69. *Ham*, *supra* note 24, at 842.

70. Patrick Hassenteufel, Marc Smyrl, William Genieys & Francisco Javier Moreno-Fuentes, *Programmatic Actors and the Transformation of European Health Care States*, 35 J. HEALTH POL. POL'Y & L. 517, 520 (2010).

professionals.⁷¹ But by the mid-1990s it was clear that the negotiations and shift in budgetary responsibility were incapable of curbing the growing deficit.⁷²

Although the French system appears inexpensive from the American perspective, it is costly compared to those of its European neighbors.⁷³ Part of the cause stems from the reluctance to encourage competition in the health care field because privatization, which could contain costs, is a strong departure from the fundamental philosophy of solidarity.⁷⁴ Even though France has a combination of private and public health care institutions, the government imposes a ceiling on profits that private facilities may generate.⁷⁵ Furthermore, employers question the financing system because they heavily fund the public insurance program through payroll taxes.⁷⁶ France's financial dilemma is also compounded by a growing demand for health care because the French are taking better care of themselves and they have access to new treatments.⁷⁷ France's budgetary crisis illustrates the difficulty in providing universal, quality medical care while controlling costs.

V. LESSONS FOR THE U.S.

France's health care system is considered to be more similar to the system in the U.S. than those of Germany, Britain, and Canada, yet France

71. *Id.*

72. *Id.* at 521.

73. Ham, *supra* note 24, at 842.

74. *France, supra* note 26; see Achim Schmid, Mirella Cacace, Ralf Götze & Heinz Rothgang, *Explaining Health Care System Change: Problem Pressure and the Emergence of "Hybrid" Health Care Systems*, 35 J. HEALTH POL. POL'Y & L. 455, 470 (2010) (privatizing health care is an efficient means of cost containment).

75. Hans Maarse, *The Privatization of Health Care in Europe: An Eight-Country Analysis*, 31 J. HEALTH POL. POL'Y & L. 981, 996 (2006).

76. Ham, *supra* note 24, at 843.

77. Gauthier-Villars, *supra* note 10.

spends less on health care than the U.S. while still performing efficiently.⁷⁸ Roughly 46.4 million people are completely uninsured in the U.S. and an additional number are underinsured,⁷⁹ while the entire population in France is covered.⁸⁰ France also has a healthier population than the U.S., even though its health care expenditure was roughly half that of the U.S. per capita.⁸¹ Despite their structural differences, both countries face growing unemployment, higher drug costs, and aging populations.⁸² The U.S. is now presented with the problem of providing medical coverage for the entire population.⁸³ In doing so, the U.S. may gain valuable insight from France's health care coverage system.⁸⁴

Although there is general agreement on the need for universal coverage in the U.S.,⁸⁵ achieving this goal will not be cheap.⁸⁶ In 2009, the U.S. spent \$2.5 trillion in health care.⁸⁷ The U.S. is expected to consume roughly twenty percent of its GDP in health care by 2016,⁸⁸ and it is predicted to spend \$4.5 trillion by 2019.⁸⁹ The eighty-two percent of nonelderly Americans who do have health insurance pay considerably more out-of-pocket than they have in past years.⁹⁰ Furthermore, many employers are eliminating health insurance benefits or passing on the cost to their

78. Ham, *supra* note 24, at 841.

79. Susan Adler Channick, *Will Americans Embrace Single-Payer Health Insurance: The Intractable Barriers of Inertia, Free Market, and Culture*, 28 L. & INEQ. 1, 1 (2010).

80. Gauthier-Villars, *supra* note 10.

81. Jeffrey W. Stempel, *Adam, Martin and John: Iconography, Infrastructure, and America's Pathological Inconsistency About Medical Insurance*, 14 CONN. INS. L.J. 229, 304 (2008).

82. Gauthier-Villars, *supra* note 10.

83. Loiseau, *supra* note 9, at 947.

84. Gauthier-Villars, *supra* note 10.

85. Channick, *supra* note 79, at 18.

86. See Meir Katz, *Towards a New Moral Paradigm in Health Care Delivery: Accounting for Individuals*, 36 AM. J.L. & MED. 78, 79 (2010) (noting that health care is costly).

87. *Id.*

88. Channick, *supra* note 79, at 2.

89. Katz, *supra* note 86, at 79.

90. Channick, *supra* note 79, at 1-2.

employees.⁹¹ In addition, fewer and fewer Americans receive health insurance through their employers because the employee share of the costs renders the coverage unaffordable.⁹²

To remedy the lack of insurance coverage for many Americans, more efficient financing can help ensure universal access.⁹³ Currently, the driving costs of health care are “overuse of hospital emergency departments, too much uncompensated care, unnecessary or non-efficacious treatments, continuous improvements in expensive technology, uncoordinated care, coverage and reimbursement of administrative costs, the heavy presence of the for-profit sector, grossly disproportionate compensation arrangements in both the for-profit and non-profit sectors, and insufficient preventive care.”⁹⁴ These costs can be contained by providing universal care.⁹⁵ Because roughly eighty-five percent of Americans are already insured, finding an incentive to provide coverage for the remaining fifteen percent can be difficult.⁹⁶ But affordable access to care may encourage people to seek out preventative care, reducing unnecessary treatment costs in the future.⁹⁷ However, in taking steps to guarantee universal care, the U.S. must still consider the unique complications that such vast coverage generates.

President Barack Obama’s Patient Protection and Affordable Care Act (PPACA) and related regulations promise to provide care for more Americans and cut costs.⁹⁸ For example, similar to France’s reimbursement

91. *Id.* at 2.

92. *Id.* at 19.

93. *See id.* (“As the cost of health care continues to outstrip the growth of the economy, thereby eroding the employer-based system, satisfying the insured population will become less important politically, and other models may become more attractive.”).

94. *Id.* at 31-32.

95. *See id.* at 31 (arguing “that cost containment will not be achieved without universal access.”).

96. *Id.* at 5.

97. *Id.* at 29.

98. Adam Marks, Comment, *Good Health and Low Costs: Why the PPACA’s*

strategy that minimizes out-of-pocket costs, the PPACA prohibits cost-sharing for certain preventative services, eliminating deductibles and other expenses for patients with group and individual health insurance.⁹⁹ Covered preventative services include immunizations for children and screenings for cholesterol, diabetes, obesity and vitamin deficiencies during pregnancies.¹⁰⁰ Providing such preventative services can help contain diseases, improve health, and curb mortality rates.¹⁰¹ Taking preventative measures can avert forty million cases of chronic illnesses by 2023.¹⁰² This would reduce anticipated health care expenses by \$1.1 trillion in that year.¹⁰³ However, availability of preventative services does not necessarily translate into effective care.¹⁰⁴ For example, many Americans are reluctant to seek preventative medical care; they currently use preventative services at only half the recommended rate.¹⁰⁵ Americans are more likely to seek care in response to a medical problem.¹⁰⁶ Therefore, participation in these services is not guaranteed.¹⁰⁷

In addition, the PPACA heightens the tension between individualized physician-patient interaction and notions of solidarity.¹⁰⁸ Unlike France's commitment to solidarity, the U.S. has historically adopted individualism

Preventative Care Provision May Not Produce Expected Outcomes, 23 LOY. CONSUMER L. REV. 486, 486-87 (2011).

99. *Id.* at 488-89.

100. *Id.* at 490.

101. *Id.* at 492-93.

102. Channick, *supra* note 79, at 29.

103. *Id.*

104. See Marks, *supra* note 98, at 494 (“While one might expect a no-cost benefit to increase consumption, healthcare generally does not operate in the same manner as other consumer markets. Rather, there are other factors to consider that may impact the success of the PPACA’s efforts in creating a healthier population.”)

105. *Id.* at 494-95.

106. *Id.* at 495.

107. *Id.*

108. Theodore W. Ruger, *Can a Patient-Centered Ethos Be Other-Regarding? Ought It Be?*, 45 WAKE FOREST L. REV. 1513, 1513 (2010).

and capitalism as core values,¹⁰⁹ and the PPACA draws out the debate about whether the PPACA compels participation in social insurance “for the common good” or interferes with individual rights.¹¹⁰ For example, the PPACA obligates almost all Americans to purchase insurance or pay a penalty,¹¹¹ and it is not surprising that citizens have lobbied for “health insurance freedom” in opposition to the requirement.¹¹² For many people, paying the penalty and buying insurance only when they need it will be cheaper than buying insurance immediately.¹¹³ Although some Americans oppose the PPACA, the statute aims to protect the individual from serious financial risk by obligating him or her to buy insurance.¹¹⁴ In effect, the PPACA promotes solidarity and collective responsibility as a means of cost containment.¹¹⁵

VI. CONCLUSION

Increasing accessibility, decreasing costs, and increasing consumer insulation from those costs are competing health care objectives.¹¹⁶ Health care policy can only achieve two of these objectives at a time.¹¹⁷ The French health care system illustrates this concept; it ranks well compared to other industrialized countries, but it faces rising health care costs.¹¹⁸ Providing universal health care for the U.S. population may require taking a

109. See Nan D. Hunter, *Health Insurance Reform and Intimations of Citizenship*, 159 U. PA. L. REV. 1955, 1967-68 (2011) (noting the political need to preserve capitalism and individualism in the New Deal era).

110. *Id.* at 1980-81.

111. *Id.* at 1959.

112. *Id.* at 1981.

113. J. Paul Singleton, *Can You Really Have Too Much of a Good Thing?: How Benevolent Tax Policies Have Contributed to the Explosion of Health Care Costs and How New Policies Threaten To Do More of the Same*, 8 DEPAUL BUS. & COM. L.J. 305, 325-26 (2010).

114. Hunter, *supra* note 109, at 1996.

115. *Id.* at 1995-96.

116. Singleton, *supra* note 113, at 324-25.

117. *Id.* at 325.

118. Gauthier-Villars, *supra* note 10.

few lessons from France.¹¹⁹ Though the PPACA is taking steps towards reducing health care expenses, sustainable financial planning is imperative.

119. *Id.*