



2009

*Differential Diagnosis: A Comparative History of Health Care Problems and Solutions in the United States and France.* Paul V. Dutton. Reviewed by Krista Drescher Burke.

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Recommended Citation

Burke, Krista Drescher (2009) "*Differential Diagnosis: A Comparative History of Health Care Problems and Solutions in the United States and France.* Paul V. Dutton. Reviewed by Krista Drescher Burke," *The Journal of Sociology & Social Welfare*: Vol. 36 : Iss. 1 , Article 11. Available at: <https://scholarworks.wmich.edu/jssw/vol36/iss1/11>

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present texture to institutional responsiveness to the demands of different groups. Perhaps the most interesting chapter unequivocally rejects fears that recommodification, immigration and the European Union has led to the death of the nation state. Hjerm uses a multi-level model to find no significant differences between 1995 and 2003 panels of attitudes towards national sentiments. The book closes with a brief summary of scholarship on voting behavior and the welfare state.

The strength of the edited work is in its use of cutting edge statistical procedures on large multi-country data sets to test hypotheses grounded in the rich literature of political sociology. The editor acknowledges the limits of the cross sectional data and recommends that the European Union launch a true longitudinal social survey so that individual level attitude changes about the welfare state may be modeled directly. The biggest absence in the volume, arguably driven by comparable data, is the failure to include nation states outside of the OCED.

I recommend this book for active empirical researchers of the welfare state. It may be too technical for scholars in related fields because it assumes working knowledge of the literature. However, any emerging scholar who works with large clustered data may find it instructive because the methods are described in operational detail.

*Richard J. Smith, University of California, Berkeley*

Paul V. Dutton, *Differential Diagnosis: A Comparative History of Health Care Problems and Solutions in the United States and France*. Ithaca, NY: Cornell University Press, 2007. \$29.95 hardcover, \$19.95 papercover.

Although many social policy scholars believe that the French health care system is substantially more socialized than the U.S. system, this is far from accurate. The U.S. system is more socialized than many people realize due to tax breaks employers get for employer-based health care, the increase in the rolls of both Medicaid and Medicare, recent Medicare expansion, and the high costs of care associated with an aging

population who heavily rely on Medicare. Although there are meaningful differences in the two countries' systems, there are also similarities. In France, despite enjoying the WHO-ranked best health care system in the world (the U.S. is 37<sup>th</sup>), insurance is universal, but as in the U.S., disparities exist between the rich, who often have employment-based supplemental insurance in addition to public insurance, and the poor, who rely on the public plan and who must pay the difference between physician fees and reimbursement rates. Those without supplemental insurance in France are far less likely to seek medical care than are those with supplemental insurance, in the same way as care seeking differs in the U.S. between those with and without health insurance.

Dutton discusses these phenomena and traces the evolution of health care in both countries starting in the early 20<sup>th</sup> century, emphasizing the similarities in ideals of the countries and discussing where they diverged to result in such different health care systems. Both countries have traditionally embraced ideals of patient choice of physician, physician sovereignty, and fee-for-service medical care. U.S. doctors have historically been opposed to government-subsidized, compulsory insurance, fearing government control over medical practice. French doctors, alternatively, have reached an agreement with the government where they enjoy autonomy and freedom to set fees, but the government sets reimbursement rates and allows for a booming private insurance sector to cover the difference between fees and reimbursement.

In both countries, health care costs began to increase significantly in the 1940s with the rise in insurance utilization, expensive new lifesaving technologies and fee-for-service reimbursements that encouraged doctors to treat more while having no incentive to maintain or restore patients' health. The two systems have evolved in different ways to control costs, with the U.S. system adopting a capitation and salary-oriented system with the rise of HMOs, and the French maintaining the fee-for-service system, but with restrictions in place.

Both countries also tie insurance firmly to employment. In the U.S., most health insurance is obtained through employers, and the majority of uninsured individuals are workers and their dependents whose employers do not provide insurance,

or whose work group is experience-rated such that insurance is too expensive for employers to subsidize. In France, payroll levies finance public health insurance, and only wage earners and their employers pay for public health insurance, though everyone benefits, including those whose income comes from investments and property. Dutton argues that this connection is outdated, and that the link between insurance and employment stymies economic growth and must be cut for meaningful reform to occur. In the U.S., workers are hesitant to switch jobs for fear of losing insurance, resulting in a mismatch between worker and job, and thus lost productivity. In France, companies are hesitant to hire workers because of the increased levies they must pay to finance the health care system.

Dutton's conclusions and suggestions vis-à-vis the U.S. health care system are insightful, if not entirely novel, and most experts would agree with him. His discussion of interest groups including insurance providers, employers, unions, and physicians suggests that major health care reform is an extremely challenging task that will not be easily accomplished, if history is any guide.

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Felicia Kornbluh, *The Battle for Welfare Rights: Politics and Poverty in Modern America*. Philadelphia, PA: University of Pennsylvania Press, 2007. \$49.95 hardcover, \$24.95 papercover.

For most of human history the concept of social welfare has been linked to charitable giving and has been regarded as the responsibility of the churches, mosques or temples or otherwise of the benevolence of charitable individuals or organizations. The charitable conception was gradually undermined in the 20th century as governments expanded social service programs and assumed greater responsibility for welfare. It was also undermined by the increasingly popular argument that welfare is a human right and that all citizens are entitled to receive support when in need. Today, international human rights instruments proclaim the duty of the state to provide