Book Review

Prescriptions For Health Policy Paralysis
by Dale N. Schumacher and Marc Bremond

Doctors and the State: The Politics of Health Care in France and the United States
by David Wilsford
(Durham, NC.: Duke University Press, 1991), 355 pp., $49.95 (cloth), $19.95 (paper)

Western industrialized democracies pursue similar health care policy objectives. These include adequacy and equity in access, some degree of income protection for patients and their families, macroeconomic efficiency aimed at limiting the societies’ overall health expenditures, microeconomic efficiency while maximizing individual patient outcome and satisfaction, freedom of choice for consumers, and appropriate autonomy for physicians and providers.

Given this commonality of objectives and the well-documented cost and access problems in the United States, comparisons with other health care systems should yield useful lessons. This is particularly important in light of U.S. policymakers’ extraordinary ability to avoid making difficult health policy decisions. We need to better understand why other countries’ policymakers act in response to problems, while U.S. policymakers do not.

In his book, Doctors and the State, David Wilsford offers insight into this public policy paralysis by comparing health care decision making in France and the United States. Wilsford sees the United States as having a weak state (at both the federal and state levels) and strong, well-organized medical associations. He characterizes France as the opposite, with a strong central state and relatively weak and divided physician and hospital communities.

The French process. Wilsford tends to beatify the policy-making process in France. He reports that the French state tradition is to “use the public bureaucracy as the guardian of the public interest;” French civil servants are often educated at the grandes écoles and constitute a “powerful ensemble of discipline, science, doctrine, and profession” that assertively conducts the will of the people. This surprisingly wholesome relationship is reported to emanate historically from French tradition based on Jean-Jacques Rousseau and the unitary state. In this state, there is a clear linkage between the citizen and the government bureaucracy.

This bureaucracy’s power is enhanced by the paucity of health care information systems. Data for comparing hospitals’ performance, for example, are virtually nonexistent. Thus, French decisionmakers and the public are constrained from challenging or debating current health policy. Nor is the French system encumbered by professional associations, or “partial societies,” which are condemned as perverters of the general will. In fact, the French government can rule associations to be illegal if they are not functioning consistently with the public good.

One wonders whether the author’s view of the French bureaucracy would change as a result of the “AIDSgate scandal,” in which Department of Health officials “looked the other way” while blood products they sus-
pected of contamination were distributed for use. While a single point does not a line make, the moral and cultural superiority of the French bureaucracy may be on the wane. Recent years—in particular, 1990 and 1991—have not been good for centralized states facing increasingly complex economies. France now also faces the evolving European Community health care strategies that encourage patients and physicians to select the most efficient care, even if it means crossing national borders.

The American process. Wilsford identifies the principal characteristic of the American state as its “hegemony of its statelessness, or what may be termed the ideological impermeability of the permeable state.” That is, in the United States, the interest groups or associations (Rousseau’s “partial societies”), not the state, define the public interest. These groups then implement health care services in ways that meet their own perceptions of the public interest, by methods they find favorable. The power and influence these associations exert, in turn, contribute to an ineffective state by making public service less attractive and thus weakening the bureaucracy. Competition among the associations and interest groups and their ability to lobby the legislative and executive branches (particularly on narrow technical issues) segments, complicates, and further delays the already deliberative policy-making process. In this manner, such groups effectively limit assertive policy making by the state.

Physicians’ role. Wilsford believes that, contrary to the weak, fragmented, and non-influential French medical community, the U.S. physician community—particularly the American Medical Association (AMA)—is influential and discordant to the overall public policy process. Wilsford’s argument is that “curbing the influence of organized medicine-capping physicians’ incomes and reducing their clinical autonomy—has become more and more essential to providing and financing extensive, adequate health coverage.” Wilsford identifies the AMA again and again as the unifying force that “ostensibly defends the interests of the entire medical corps.” However, he expects that, over time, the fiscal imperatives brought about by the high cost of health care will “push the state and other payors everywhere to diminish significantly doctors’ traditional prerogatives in the healthcare universe.”

While the author provides stimulating arguments, not all would agree that the existing U.S. state (be it federal or state) is weak and unable to implement assertive changes. Over the past twenty years, the United States has seen the initiation of professional standards review organizations (PSROs), diagnosis related groups (DRGs), federally supported health maintenance organizations (HMOs), resource-based relative value units (RBRVUs), and sophisticated utilization review schemata that routinely require prior approval before patients can receive care. These are hardly feeble efforts. Imagine the response of university professors if their lectures, lesson plans, and even specific examination questions had to have prior approval from an outside professor or graduate who may not even be accredited in the same academic discipline!

Additionally, for the past twenty years, the very fabric of our decentralized entrepreneurial society has been to promote a competitive health care environment. The U.S. system creates market and regulatory incentives and encourages individuals to respond to them. In the 1970s, these governmental incentives led hospitals to unbundle services and physicians to establish centers for ambulatory surgery, imaging, and rehabilitation and a variety of facilities all outside the orbit of the more centralized and more easily regulated hospital. By virtue of this decentralization, it is increasingly difficult to achieve regulation and French planification in the United States. In fact, whenever U.S. physicians and hospitals consider coming together in joint, even oligopolistic, ventures, they usually are prohibited from doing so by the federal government, which encourages them to remain decentralized, heterogeneous, and competitive.

The role of U.S. physician organizations merits further explication. The AMA does not have Darth Vader on its board, nor does it represent the majority of physicians.
While it would be naive to suggest that the AMA is not self-serving, the association now deals with a wide range of positions on a wide range of issues. Through the *Journal of the American Medical Association*, the AMA has explored a variety of health system reform options. Wilsford laments that organized medicine, by way of the AMA, has caused “the language of freedom of choice . . . [to have] triumphed over the language of equality of access.” This is not true. Other medical groups have become quite activist. The American College of Physicians (ACP), for example, strongly supports access to care, and some characteristics of the ACP’s approach are similar to the Canadian health care system.\(^3\) Physician organizations also operate at the micro level, for example, in support of patient care, such as the Cancer Surveillance System of the American College of Surgeons.

Changes and imperatives. Wilsford suggests that much stability and security in American life is a consequence of three circumstances. First, we have not, with the exception of the War of 1812, been faced with an invader on our nation’s soil (although the economic invasion and resulting trade imbalance may discount this). Second, a solid economy has supported growth and perceived upward mobility (although the current recession may discount this). Third, a relative homogeneity of purpose as a nation has existed and been built upon our Judeo-Christian ethic and culture (although immigration patterns are changing this). To the extent that profound changes are occurring in these three underlying circumstances and thus to our sense of community and national direction, there may be even greater urgency to move forward with health policy reform initiatives.

If we accept Wilsford’s position that associations and interest groups dominate U.S. health care policy, then the challenge is how best to use their influence and professional expertise to achieve our health policy goals. At the patient level, we need physicians’ expertise to focus on the process of care, emphasizing “total quality improvement” approaches to achieve control of the health care process. Outcomes assessment is useful, but process control is a far more efficient and rapid mechanism for achieving cost containment. As Henry Aaron has noted: “Although large gross savings may result [from efficacy studies], they are not likely to materially slow the growth of overall health care spending. . . . The best that can be expected in the way of cost control from effectiveness research is likely to be some savings, gradually realized over a period when forces driving up costs continue to operate.”\(^4\) Aaron suggests limiting services as a more focused approach. Indeed, we have the tools: computerized databases, lists of classified diseases, and process-of-care coding systems.\(^5\) Most importantly, we have the strength of influence groups with expertise to determine technically appropriate services.

At the macroeconomic level, what the United States needs first is political leadership to determine a limit on overall health spending and, at the same time, to guarantee that all citizens have access to a minimal health benefits package. Then, with this leadership in place, U.S. health care associations should come together and, using their technical expertise and influence, agree to improvements and rational allocations of resources in the U.S. health care system. The French government, whatever the political option, has the will to implement health policy but does not have the tools; the U.S. government has the tools but lacks the will to act. Let us begin!

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