UNIVERSITY OF CALIFORNIA SAN DIEGO

Comparing Political Cultures through Comparing Healthcare Debates:
A Study of the U.S. and France

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Philosophy

in

Sociology

by

Stephanie Alaimo

Committee in charge:

Professor Richard Biernacki, Chair
Professor William Chandler
Professor Kwai Ng
Professor Gershon Shafir
Professor Christena Turner

2020

The dissertation of Stephanie Alaimo is approved, and it is acceptable in quality and form for publication in quality and form for publication on microfilm and electronically:

Chair

University of California San Diego

2020

DEDICATION

This dissertation is dedicated to every American family that has declared bankruptcy due to medical costs or debt. It is dedicated to every family that has lost homes or crowded loved ones into too few bedrooms in the face of the crippling cost of health care. It is for those that have had to choose between medical care and new school supplies for their children, utility bills, or payments on their vehicles. It is for those that have forgone treatment for long enough that they have become more seriously ill, or even died. I also dedicate this work to my parents and my husband, for without their support, I certainly would have never finished this degree. It is also for my brother, who has built his small business in the very time that I was juggling the present work with my own entrepreneurship. The solidarity of these four people has given this work meaning, even when the struggles of uninsured Americans wasn't enough to push me through revision after revision. Finally, I would like to include my cousin and her quest for adventure and truth, my ancestors, and all of the thinkers and advisors who have built the intellectual traditions on which this work stands.

EPIGRAPH

"A few conclusions become clear when we understand this: that our most cruel failure in how we treat the sick and the aged is the failure to recognize that they have priorities beyond merely being safe and living longer; that the chance to shape one's story is essential to sustaining meaning in life; that we have the opportunity to refashion our institutions, our culture, and our conversations in ways that transform the possibilities for the last chapters of everyone's lives."
― Atul Gawande, Being Mortal: Medicine and What Matters in the End

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ACKNOWLEDGMENTS

Thank you to all of the members of my committee who are listed on the cover of this dissertation. Thank you to my grad school cohort, those who put me up or otherwise facilitated my passage through field work, and my department for their support. Thank you to the Harry S. Truman Institute for awarding me a fellowship and for excellent guidance as I navigated the archives.

VITA

EDUCATION & DIPLOMAS

2005: **B.A. in Spanish with Honors**	*DePaul University, Chicago*
2007: ***Licence* (B.A.) in Sociology**	*Université de Strasbourg, France*
2008: **Master 1 in Sociology**	*Université de Strasbourg, France*
2010: **M.A. in Sociology**	*University of California, San Diego*
2013: **C.Phil. in Sociology**	*University of California, San Diego*
2020: **Ph.D. in Sociology**	*University of California, San Diego*

PROFESSIONAL EXPERIENCE

2017-Present: **Qualitative Healthcare Researcher: QualWorld:** Moderate KOL interviews, physician interviews, and patient interviews about diverse topics in pharmaceuticals and healthcare.
End Clients include: *Glaxo Smith Kline, Bristol-Myers Squibb, Kaiser Permanente, Johnson and Johnson Health, Novo Nordisk, Novartis, Ethicon.*

2016-Present: **Lead Analyst: Contractor: Ethnography Center of Excellence: Ipsos:** Select participants, create briefing decks/discussion guides, brief ethnography team before field work, lead post field work debrief calls, and design film editing guides. Consider ethnography strategy and findings in conjunction with quantitative strategy and reports. Create final, interim, and presentation reports. Present ethnographic films at clients' headquarters nationwide with the research team.
Key Skills: *Research strategy, Generative/foundational research, Behavioral science, Interviewing, Analysis and reporting, Storytelling, Client-facing presentations, Optimization recommendations.*
End Clients include: *Mars Dog, Mars Cat, Wrigley, Bank of America Consumer, Bank of America Small Business, Bank of America Charitable Giving, Nestle, Coleman, Target.*

2015-Present: **Qualitative Market Researcher: Contractor: Ready to Launch Research:** Moderate focus groups, online studies, TDIs, analysis, reporting, and discussion guide creation for diverse clients on a regular contract basis.
Key Skills: *Moderation, Research strategy, Message testing, Concept testing, Package testing, Generative/exploratory research, Analysis and reporting, Product optimization recommendations.*

End Clients include: *Byju's Learning App, Hive Smarthome, Colgate-Palmolive, Neutragena, Loreal, The Atlantic, Nutrafol, SC Johnson, Pepsi, Jeep, The Wonderful Company, New Belgium.*

2014-Present: **Independent Qualitative Market Researcher:** Research consultant, moderator, analyst, and report writer to various market research agencies. Ethnography, IDIs, data analysis, online moderating, focus groups, and report writing.
Focus on the following industries: *Health/Pharma, Technology, CPG.*
Key Skills: *Research strategy, Moderation, Generative/exploratory and evaluative/tactical research, Cognitive walkthrough interviewing, Online communities, Analysis and reporting, Optimization recommendations, Behavioral science, Storytelling, Pharmaceutical market research moderation, including many physician-facing studies.*
End Clients include: *Asus, ECi Software Solutions, CNET, Infinite Peripherals, Autonation, MedVantx, Neighborhood Healthcare, AARP, IHeartMedia, BJ's, TGI Friday's, Carnival Cruises, Walmart, The City of Boise, Loreal, Pat Catans, Purell, City of LA.*

2018: **User Experience Researcher: Contractor: Adobe:** Work with product team to design, pilot, and run UX research for Adobe Sign for small businesses and teams. Present findings to stakeholders and product teams.
Key Skills: *Mock-up/wireframe testing, Iterative testing, Workflow assessment, Cognitive walk through interviewing, Evaluative/tactical research, Mental model identification in B2B context, Product team collaboration, Product optimization recommendations.*

2014: **Research Assistant: UCSD:** Procure, manage, code, and analyze qualitative data with a research team for the project "Do Visible Taxes Cause Protest? Tax Policy and Tax Protest in 21 Rich Democracies, 1980-2012" supervised by Isaac Martin.

2011-2012: **Linguist and Interviewer: Center for Teaching Development, UCSD:** Interview and evaluate the technical English abilities of foreign instructors; make recommendations for their improvement.

2009-2012: **Teaching Assistant: Warren College Writing Program, UCSD**: Teach required courses on argumentation and writing style. Work in teams to design new courses. All classes were discussion-based courses designed for 15-20 students.

2009-2011: **Interpreter/Data Analyst: Employee Rights Center, San Diego**:
Analyze and manage data collected from client surveys for grant writing purposes, and interpret (Spanish) for clients. This volunteer work served as ethnographic field work that informed academic research.

RESEARCH GRANTS

2013: **Harry S. Truman Institute Research Grant:** Funding for qualitative dissertation research conducted at the Harry S. Truman Presidential Library in Independence, Missouri.
2014: **UCSD Sociology Travel Research Grants:** Four separate grants for qualitative dissertation research in cities across the US and France.

ABSTRACT OF THE DISSERTATION

Comparing Political Cultures through Comparing Healthcare Debates:
A Study of the U.S. and France

by

Stephanie Alaimo

Doctor of Philosophy in Sociology

University of California San Diego, 2020

Professor Richard Biernacki, Chair

This dissertation examines the cultural currents that appear in public sphere healthcare debates in the U.S. and France. It argues that France and the U.S. are on opposite poles of a continuum of values, ideology, and utilitarian responses to healthcare needs. When France has reduced the generosity of its health benefits, it has been for utilitarian reasons. When the U.S.

extends care, it has largely been for utilitarian reasons. In France, healthcare expansions are framed in terms of positive values and ideology, while in the U.S., refusals to extend care are framed in terms of positive values and ideology. These pervasive elements of public sphere discourse are derived form the *longue durée* culture of a given society, which is then leveraged to justify the shape of health policy. In this dissertation, elements of *longue durée* culture, which are leveraged by political strategists as they create messaging campaigns and are referenced by diverse interlocutors as they debate policy changes, are identified via media sources such as newspaper articles, ad campaigns, political speeches, public institutions, and letters to the editor. Policy makers and political strategists must rely upon resonant features of *longue durée* culture in order for their campaigns to be successful. This is why key elements of culture can be located via these artifacts of public sphere discourse.

INTRODUCTION

My personal interest in the differences between the French and American healthcare systems stems from my own experience receiving health care in both countries. During the three years that I lived in France during my twenties, I received intensive medical care and was hospitalized on multiple occasions. I noticed very distinct differences in not only the ways that I accessed care, but also in the beliefs, attitudes, and assumptions that my doctors had about health care. From these experiences, as well as from the conversations that I had with French friends and from the public sphere discourse that surrounds French health care, I knew that I was dealing not only with different institutional and administrative norms, but with deeply divergent cultural impacts. I became immediately curious about these cultural differences and their enormous impacts. This dissertation seeks to explain how differing cultural realities have impacted health policy discourse in the U.S. and France.

Accounts of the difficulties of the American healthcare system can be found elsewhere, as can accounts of European healthcare systems. Those realities are not the stories to be explored here. Instead, it is the way that such stories are reported, commentated, and politicized that are explored in this dissertation. In these pieces of public discourse, we gain an understanding of the culture that surrounds health and health care in these two countries. By tracing this culture and public sphere discourse alongside policy outcomes, we can understand how culture impacts the shape of health policy debates.

Why This Particular Comparison?[1]

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[1] Please note that all translations of French documents throughout this dissertation are my own translations.

Since our health systems are currently in such very different states, it may seem strange to compare French health policy to American health policy, and even stranger to compare French debates about health to American ones. However, the similarities that the two health systems shared prior to 1945 and their subsequent divergence make these debates particularly apt for revealing the types of cultural and political tendencies that this dissertation explores. Indeed, I am not the first person to make this observation. Bruno Dumons and Gilles Pollet note that France's immediate post-World War II social protection system was remarkably similar to the Social Security Act: "The post-Second World War period was marked by the establishment of a new social protection system: social security which followed the same pattern as the Social Security Act, passed in August 1935 in the U.S." (Dumons and Pollet 2002). There are also other practical reasons for this comparison, and equally importantly, several cultural reasons for the comparison.

First, and most obviously, both countries are wealthy OCED industrial democracies that have strong economies and can afford significant investment on health care as well as on medical research. Both spend considerable percentages of their GDP on health care and both have increased that spending over time. In 2014, France spent $4690 per person, and the U.S. spent $8895 per person. That is equal to 11.7% of France's GDP, and 17.9% of the U.S. GDP (World Bank 2014). Given these numbers, many believe that France achieves a more desirable result. And the French, of course, are all very aware of the results of the WHO's 2000 report that rated their health care as the most efficient in the world (World Health Organization 2000). However, for all of their cost control measures, French health expenditures are higher than those of other OECD countries. Meanwhile, in the absence of effective cost control measures, American spending is enormously higher. Unsurprisingly, at this rate, American public health expenditures are far higher than French public health expenditures (World Bank 2014). As we shall see, the failure of the U.S. to regulate the price of medical services stems partly from ideological preferences that are mirrored in public discourse.

The frequently overlooked similarities of French and American health care also make this particular comparison an analytically fruitful one. Most popular comparisons that the American public might be familiar with focus on their differences in price and outcomes. However, the actual public/private structures which finance health care in the U.S. and France are mirror images of the same side of a coin—that is to say they are the same image, reversed in their proportions. Both systems rely almost entirely on a system of public and private insurances. In France, people are more heavily insured publicly than privately, while in the U.S. more people are insured privately.[2] In France public insurers insure workers from specific industries, so insurance is still tied to work, in a sense, and individuals may pay for a private, complementary insurance that pays for the patient portion of health care costs and services that are typically more expensive, such as optometry and dental work. Though it is exceedingly uncommon, the French may also opt out of the traditional scheme and purchase a purely private health plan.[3] Even if in most cases, health insurance options would be limited in practice to the choice of different private complementary insurances or the rare choice to opt out, the French do have some choice in their insurance. Contrary to common American beliefs about "socialized medicine," a French patient does have a great deal of say in who cares for them, who insures them, how much insurance they carry, and where they are treated.

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[2] Of course, since all health expenditures in the U.S. are so high overall, the public burden for U.S. health care is much higher than it is in France. Yet, the actual number of people insured by private insurers is higher than the number of people insured publicly.

In both countries, the actual care is provided through a network of public and private hospitals. Both French and American doctors are self-employed or employed by a hospital or both; in neither case are doctors employees of the state.[4] French people are not assigned a doctor. They may choose any general practitioner they wish, who may then help them choose specialists if needed. Americans actually have less freedom, and depending on their insurance may be rather limited in which doctors they may see or which facilities they may visit. The American ideologies of free choice and self-reliance carry more weight than the actual reality that Americans face when seeking medical care. Despite this irony, both of these ideologies have consistently shaped health reform discourse in the U.S., further revealing their power as ideologies and concepts, even if they are not made into real practice. Culturally, however, both countries place enormous importance on a patient's ability to choose their care providers, as well as great importance on the doctor-patient relationship. Both countries frequently discuss this need and this expectation as they debate policy. Proposed policies are often analyzed for their impact on patient choice, and if the public becomes convinced that a particular policy limits choices for those who fully merit health care, the proposed policy is likely to suffer a public image crisis and eventual legal challenges, such as was the case with the Affordable Care Act (ACA).

One would expect that at the very least, our health systems would be financed differently, given that Americans generally perceive France as socialist, while the French generally perceive the U.S. as ruthlessly capitalist. However, we have actually chosen remarkably similar ways to finance our social programs, including health, in general. The French health system is financed by payroll taxes, taxes on employers, contributions made by patients at the time of service,

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contributions paid by the self-employed, and state funding. In France, health care is part of *Sécurite sociale,* which refers to the ensemble of social protections offered by the state, including retirement, unemployment, childcare in certain instances, and housing subsidies. The entire system is financed largely in the same ways that American social programs are financed, though, obviously, American programs are far less numerous and far less generous. French taxes are higher in order to pay for these programs, and one might argue that the French have a generally higher tolerance for taxes. The most important thing here is that both countries' systems are so heavily financed by payroll taxes and employer contributions. This places the burden on workers specifically, and ties the financing of the system to the labor market. The largest difference of course, is that French *solidarité* allows for these funds to be distributed to the entire society—so, the payroll taxes of a marketing director will pay for her health care, as well as for the health care of an unemployed clerk or a student.[5]

All of the above means that in reality, the French system is not simply "socialized medicine" and the American system not simply its opposite. As historian Paul Dutton points out, the U.S. has been moving towards public-private cooperation more, albeit without real debate and planning, while concurrently, the French have been inspired by HMOs and have adopted rather American-seeming hospital payment policies (Dutton 2007:2). Even more simply put, the U.S. and France are moving closer together in their balance of the public/private in the arena of health care. Given the structural similarities that existed in 1945, it is conceivable that France and the U.S. could have taken similar paths in their health policy. The U.S. could have emerged from World War II and decided that the war had been won due to the war effort sacrifices of private citizens, companies, and politicians, and that all should receive health care as a marker of

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inclusion, cooperation, and as a promise between Americans to be good neighbors. Or likewise, the French could have decided that the collective would need to focus on greater rebuilding projects, and that health care for individuals would have to wait, or that the only path to a strong post-war economy would be the strong self-reliance of citizens. However, these were not the paths that were taken. Instead, the U.S. reached back to its founding culture of independence and individualism, and France reached to solidarity and fraternity. These references made all the difference. As Ann Swidler (2001) notes, cultures fall back onto their deepest held values during unsettled times. World War II was certainly an unsettled time, as was the post-war period. As a result, both France and the U.S. made health policy decisions that relied upon the deepest held values of their respective societies, and we witnessed the creation of two value-appropriate healthcare systems. The decisions made during this time, which arose directly from culture, would pattern health care decisions for decades to come.

While other countries could have also served as a comparison with the U.S., there are strategic reasons to prefer France as a comparative case. Canada could make a good comparison, but their health system was launched in the 1960s, after there had already been time to observe the success of the nascent European healthcare systems. Germany’s system began too early, under Bismarckian rule, and served as the inspiration for many other systems, making its heritage far different from France. The UK’s NHS has less involvement from private insurers, reducing the ability to compare the public-private matrix that comprises the two healthcare systems. Scandinavian countries have the strongest welfare states and social programs in Europe, including health care, making comparisons with these countries difficult. While France does have more social programs and a stronger welfare state than the U.S., the degree of difference between France and Scandinavia is large, making France the better comparison. Japan's role as a losing power in World War II and its position in the post-war world makes it too dissimilar.

Beyond the current similarities in health structures, there are also enough similarities in our debates about them to make comparison interesting. To start with, because of the similarity in health policy structures between the 1910s and the 1940s, when proposals for expanded, comprehensive plans were first discussed in both the U.S. and France, doctors, medical schools, insurers, and medical associations were vociferously against these plans. In the U.S., interest groups such as the American Medical Association (AMA) and doctors had donation drives to campaign against "socialized medicine," formed lobbies, and hired the nation's first political consultants. In the U.S., these groups succeeded at so effectively defaming Truman's dream that a legislative proposal was never even drafted during the time Truman was in office, and they squashed Earl Warren's plan for a California health insurance program. The same groups stymie health reform efforts to this day. In France, labor was initially resistant to health insurance, and trades attempted to exempt themselves from health and other social insurance programs. Employers attempted to set up parallel or alternate insurance agencies, arguing that the state would not need to intervene, as health care would be provided. Doctors and the medical profession feared regulation, and thus argued that any state organization of health care would result in a loss of health freedom.

Prévoyance (prudence) and personal responsibility became important concepts in both countries (Dutton 2007). However, these concepts have been leveraged very differently, which is reflective of the *longue durée* cultures in which they incubated. In France, *prévoyance* has more to do with not wasting medications or taking unneeded medications, not abusing social security-funded sick days, practicing good health and hygiene habits, and seeing general practitioners as opposed to specialists (in accordance with the *médecin traitant* protocols) whenever possible. In the U.S., personal responsibility has more to do with economic practices than health practices. Getting a good job so that one has access to health care, leaving a job without health care in order to find a new one, contributing to a Health Savings Account (HSA), and finding ways to refrain from using welfare programs tend to be more emphasized in public sphere discourse than are specific health practices. Nonetheless, personal health responsibility is also a factor in American debates. These show up strongly in proposals like Clinton's proposed Sin Tax to fund health care reform.

Next, both countries value personal relationships and privacy when it comes to medical care. A quick survey of medical advertising reveals that even if the average American doctor's visit only takes minutes, Americans would like to have, and maybe would even like to believe, that there is a relationship between themselves and their doctors. This desire for personal medical attention has been prevalent in dialogues since the 1940s. The role of doctor as a benevolent, competent, scientific specialist engaged in the important, personal, and almost mystical work of healing goes back several decades. Americans have been likely to believe and trust their doctors, even today, as insurance companies, tight schedules, facility availability, and mounting complications have squeezed and limited the amount of time that a doctor is able to spend with each patient. However, even if trust and confidence persist, mounting complaints and critiques in the public sphere have indeed let Americans hear each other—they are in fact not satisfied with the facetime and the level of relationship they get with their doctors, even if they might be satisfied with their overall care outcomes.

The French, on the other hand, desire the same personal medical relationship, but they generally do have these relationships. Home visits, negotiating the reimbursement rates for home visits, and when a home visit may be deemed necessary has been an equally recurrent theme for the French. Home visits may be utilized even for fairly routine care. Weekly injections for the treatment of certain illnesses, postpartum checkups, care for the elderly, and some emergency or off-hours care can still be handled at home in France. Such a thing is nearly unheard of in the U.S. French doctors seem to view it as a responsibility to see their patients through their treatments, even once they have been referred out to specialists or hospitals. While U.S. doctors are just as likely to enter the profession out of a similar feeling of moral commitment, the strains of the medical institution are often cited as factors which prevent deeper involvement.

Both American and French health critics have repeatedly promoted reducing state control of medical interventions and keeping outside interference to a minimum. Again, this sentiment has recurred on both sides of the ocean since at least the 1940s. We have clearly had different ways of interpreting exactly what this might mean. Though Americans fearing Sarah Palin's infamous "Death Panels" might balk at the French *Carte vitale* which electronically stores health data from allergies and prescriptions to test results, the French would be equally horrified by the multi-page health surveys routinely administered by American health insurance companies, the practice of dis-insuring patients who have paid premiums, or the "research" departments used by insurance companies who investigate claims with the goal of denying users care. The French would see these practices as more invasive of privacy and as more interference with the doctor patient relationship than France's centralized medical record keeping.

As was noted in relationship to insurance, both countries place a high value on personal responsibility. This shows up in more places than just their preference for insurance-based social programs. They both greatly fear that health systems or welfare programs of any sort can, or are, taken unfair advantage of. Indeed, while discussing my research with French interlocutors today, one of the first things many point out is how easy it is to take advantage of the French system. This fear is also echoed in special news reports about hospital fraud schemes, where private hospitals will bill *Sécurité sociale* for more costly operations than they are actually performing, or plastic surgery clinics that will claim that a nose job was reconstructive and therapeutic when in reality, it was merely cosmetic (Caille 2007). They fear that immigrants, the poor, the lazy, and the chronically unemployed are sponging off of the high tax rates and generous social programs. In actuality, it may not be so easy to cheat the medical system itself. Citizens' fears may be directed more towards other social security programs, which through conceptual lies are passed on to health care. Still, the French had a phenomenal public campaign promoting personal responsibility in the 1980s that focused on not wasting medications, on going to general practitioners instead of specialists first, and on not using paid sick leave as paid vacation. This campaign highlighted the dangers to the collective good occasioned when individuals abuse the system. Modernizing the definitively French concept of *solidarité* to include the importance of responsibility, this campaign laid the groundwork for multiple new cost control reforms. The *médecin traitant* reform of 2004, reforms requiring the use of generic prescriptions, tighter regulations on paid sick leaves, and the de-reimbursement of medications viewed as being less effective all followed this campaign.

Personal responsibility is also hugely important in the U.S. The Clinton health reform plan proposed Sin Tax as a way to finance health care. This proposal was phenomenally popular, with citizens writing to the president, media campaigns, and editorials stating their support for this tax. Their reasonings were multiple, but nearly all argued that those who consumed alcohol and cigarettes were causing unnecessary damage to their health with which otherwise "responsible" taxpayers should not be burdened. Though taxes on cigarettes and alcohol in

France do help fund the health system, the moralizing associated with this tax is absent. Such a tax could certainly never be called a “sin” tax in France, after all!

This particular preference for personal health responsibility is also exploited by American insurance providers. Smokers can be charged higher rates, credits can be given to employees who show that they have logged so many hours of exercise or so many steps on pedometers that they wear during the day. These credits for healthier lifestyles likely do reduce the overall cost of care and do increase overall health. Similarly, HSAs place a strong rhetorical emphasis on personal responsibility—it is the individual’s responsibility to budget and save for health needs, including emergencies. Though these strategies may save some money, they are likely to feel like they save more money than they do, on the individual level. Oberlander (2011) points out that though there are a plethora of hypothetically budget-reducing components to the ACA, these policies are very unlikely to actually slow health spending. Oberlander notes that in the U.S. context, any health plan which would truly accomplish the goal of lowering overall expenditures is very unlikely to be adopted, as the well-connected and well-heeled health stakeholders are unlikely to allow any such change. So, despite the fact that we have hypothetically cost-saving measures, we are unlikely to have any real cost savings. Instead, we have token policies which symbolize solutions to our problems. What is telling is that we do in fact have hypothetical cost-saving measures which rely on individual responsibility, planning, and prudence in order to curb costs. Even the Pay for Performance policies included in the ACA reflect this trend—though here, the medical profession itself is broken out and treated as individual, who must be held to individual standards of responsibility.

Americans will also go to great lengths to discourage any sort of public “dependency.” The stigmatization of food stamps, the AFDC, Medicaid, and any means-tested program is strong and prevalent (Hancock 2004). Beginning with Regan's mythical "Welfare Queen" and continuing through to militia-fears of immigrants stealing social services, health care, and jobs, the American public is deeply terrified of being taken advantage of, just like the French. In the U.S. context, this fear is largely fueled by a great feeling of disdain, which is kept alive not only through the media. The same stereotypes and caricatures of Welfare Queens are debated by the House of Representatives, and appear in the *Congressional Record* for HR 3734, the Personal Responsibility and Work Opportunities Act of 1996 (Hancock 2004). Similarly, Medicaid recipients are often stigmatized as poor, lazy, inept, or dysfunctional. This discourse remains strong in the debates about the ACA. Anxieties about recipients of health insurance subsidies becoming unmotivated to work are frequent, and annoyance that the more wealthy should be called upon to help fund the less wealthy is even more common. This latter sentiment betrays the lack of a concept such as *solidarité* in addition to a focus on personal investment in one's own health and life outcomes.

In the U.S., welfare recipients, regardless of the type of aid they receive, and regardless of their situations, are a highly stigmatized, non-deserving group. They are considered to have little merit as citizens, so providing aid is done begrudgingly, or not at all, in most states. This is particularly important when it comes to Medicaid. States are not required to extend Medicaid to low earners who are under 65, not disabled, and who are not pregnant. Since they are not required to do so, about half of states do not provide such programs. These states took a stand against the ACA, and declined funding from a federal Medicaid program intended to insure a greater portion of low earning adults. Included in this group are felons, who in some states, are considered "typical" welfare recipients—that is to say, they are viewed as dysfunctional and undeserving. Stripped of voting rights unless they are able to complete lengthy appeal processes, felons are also denied Medicaid coverage in states that have not accepted the ACA Medicaid expansion. Resistance to the idea of the ACA Medicaid expansion providing Medicaid to felons was particularly strong in states like Florida, Georgia, and Texas. These states and the other 16 which did not expand Medicaid, typically provide the lowest level of social support, and cling hardest to the idea that welfare recipients contribute little to society. Medicaid recipients, especially if they might be felons, are seen as the complete opposite to those with personal responsibility, initiative, and prudence. In the U.S., we value this trait so much that many states can justify denying these “irresponsible” people health insurance. In France, there is no such undeserving group.

But perhaps the most important feature to note, outside of all of the similarities and differences, is that through every evolution of the French healthcare system, great debates took place. Newspapers, radio, political speeches, editorials, political cartoons, and now the internet have been remarkable forums for debate. Through constant conversation, and constant adjustments, the French have built their healthcare system reform by reform. At this point, the French must have accepted that health care will never cease to evolve, that as medical technology, prices, culture, and economies evolve, that so too must their systems of social protections. They have constructed a health system which is as effective as it is French. It reflects their cultural and political preferences and is a testament to their values as a society.

But more important than the simple fact that the French have debated their health care is the fact that the French have consistently advanced positive health rights at nearly every juncture. Their reasons for doing so are again, culturally grounded. The French have sought to extend health care rights for greater solidarity, greater human rights, greater fairness, greater fraternity, greater inclusion, and greater national health consistently. In France, the reasons for not extending health care have been more utilitarian: logistics, planned stages of expansion or development, covering French citizens before covering all resident in the country, or covering populations more at risk prior to extending coverage to all. Here we see that in France, the reasons FOR expanding health care are value based, while the reasons for waiting are utilitarian. This is the opposite in the U.S.

Though the U.S. has effectuated fewer overall rights expanding reforms, the debates have certainly not been sparse. Health reform has a place in just about every presidential campaign. Our biggest concentrations have been on health care for the poor—Medicaid, the elderly—Medicare, and veterans—the VA. The relative success of these programs is as culturally significant as the lack of programs for the general American populace. And of course, reforms to these three programs have also been hotly debated at every potential policy shift.

In the U.S., it is the arguments against extending health care which are culturally based. These most typical values include the thought that "welfare" programs create laziness, dependency, and greed (Hancock 2004). Every American should be responsible, which means taking care of oneself. Health benefits have historically been a reward for having a full-time job—a full-time skilled job above entry level. Should the state provide benefits, people might cease to work, which would of course be undesirable. Failing to extend health care reform serves these cultural beliefs.

Any American health assistance programs that extended health rights and existed prior to 2010 were utilitarian as opposed to values based. They existed to keep poor children healthy enough to participate in society, to reward veterans for serving, to serve those suffering chronic poverty, and to care for the elderly. These sensitive groups have exceedingly difficult paths to health care in the private market, due to the prohibitive costs of care, their generally low incomes, and their lack of employment that comes with a health insurance plan. Without care, left to illness and destitution, they could pose very real problems to the rest of the society if not cared for in some way. The least of these problems would be increased deaths or upset or debt burdened families. More extreme possibilities would be lower voluntary military enrollment, increased homelessness, and increased publicly visible illicit drug usage. But, they are uninsurable due to the likelihood of severe health issues or extremely low incomes, their only recourse is the state. The American state has been reluctant to step in for any but these most extreme situations.

Culture's Impact on Health Policy Discourse

However, most studies of health policy do not leave much of a space for culture. Most generally rely upon the power of lobbies, the money in the pharmaceutical and medical industries, the sharp divisions in American politics, and policy analysis that points to path dependency to explain the defeat of earlier major reform proposals. These works are all insightful scholarship, important history, and excellent pictures of the powerful forces that have shaped our health care. They are valuable for recognizing the size and enormous power of the actors involved. But these works do little to explain why these health systems were initially acceptable to the people that they serve. They do not outline the most common objections to reform. They do not identify the ideological difficulties of reform, or the ideologies which can make reform easier. They do not explain the congruences and contradictions between ideologies, proposed policies, and successful policies.

After reviewing other literature on the topic, I wondered how decision after decision, and policy after policy in both countries seemed to contribute to solidifying or advancing the general direction of the health policy in both countries. Of course, the discourse always ran in the same directions as well. It seemed that few decisions on either side of the ocean ever seemed to deviate from the culture-driven directions that the two nations were taking. In other words, it seemed that these health policy realities were being constructed incrementally, and that culture had a large hand in shaping what these increments could be, or at the very least, how they could be spoken about. In yet other words, each incremental change would mobilize culture yet again, preserving culture's role at every juncture. As such, this dissertation examines the cultural elements that are preserved in public sphere discourse and their connection to the policy discourse and respective decisions that are subsequently made.

So, as a result of all of the above, my dissertation is a comparative cultural analysis of public sphere discussions of health policy, embedded within an analysis of health policy. As the political mapping/institutional/path dependent analysis of the failures of the American health system and the successes of the French system have already been achieved, by scholars such as Paul Dutton (2007), Lawrence Jacobs and Theda Skocpol (2010), Jill Quadagno (2005), and many others, I contribute a cultural and political analysis that is less concerned with the finest details of policy itself, and more concerned with how policy or policy proposals are received. I focus on the rhetoric surrounding these things, the ideologies they betray, and how these ideologies relate to policy and practice.

This dissertation argues that there is a strong, unifying *longue durée* culture that is relatively stable over time, and repeatedly and directly influences the shape of discourse, and in turn, health policy. The majority of the dissertation is spent tracing this *longue durée* culture and examining evidence of and discursive artifacts of this culture. Along the way, it identifies the following elements of these *longue durée* cultures. These include differing concepts of merit and stigma, the right to be unbothered by others versus a focus on solidarity, utilitarianism via expanding versus restricting health rights, and sourcing national medical pride from quality of care versus quality of social protections.

To briefly foreshadow the type of analysis that will continue throughout this dissertation, let us compare children's health policy. In France, children were among the first groups to be covered, as part of a healthcare expansion in 1958. Health care was extended to all children and pregnant women, as they were deemed incapable of working, and as such, have the French right to receive from society the means to a respectable existence.[6] In the U.S., it was the elderly that received a similar health right with Medicare. This early health care priority reflects not only the value that the French have historically placed upon the family as a strategy for nurturing healthy citizens, but the language surrounding this changes makes explicit the French belief that those who are not in a position to work should be properly taken care of by the *collectivité*.

In the U.S., by contrast, Title XIX of the Social Security Act created Medicaid alongside of Medicare. As the first federal health program that served children, Medicaid covered only low income people, and thus, only low income children. Immediately, we can see that Medicaid reacts to the problem of poor health among the poor only. It is a Band-Aid to serve one particularly needy part of the population. As opposed to positively valuing health care, all families, and solidarity across classes, it encourages every group of Americans other than the impoverished to find their own private health care. As we will see via primary documents later in this dissertation, the debate surrounding Medicare often included the thought that providing care

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[6] This was laid out in the preamble to the 1958 constitution. « La Nation assure à l'individu et à la famille les conditions nécessaires à leur développement. Elle garantit à tous, notamment à l'enfant, à la mère et aux vieux travailleurs, la protection de la santé, la sécurité matérielle, le repos et les loisirs. Tout être humain qui, en raison de son âge, de son état physique ou mental, de la situation économique, se trouve dans l'incapacité de travailler a le droit d'obtenir de la collectivité des moyens convenables d'existence ».

to all Americans would destroy work ethic or create dependency on the government, despite the fact that this notion has not been conclusively proven by research (Crouse and Waters 2013). The lack of facts in this debate indicates that we have yet another strong ideology at work that does not reflect the whole picture of the American experience. Due to this ideological framework, health care was not extended to the general population as a way to promote collectively shared values. Here, we see the deep connection between an ideology, a political outcome, and the justifications for the policies that create the outcome. This demonstrates how culture, which includes ideology, works to influence the shape of policy.

These differences can also be perceived through an analysis of how the two countries have qualified different populations for health care. Through the classifying and sorting process, and through policies that create further categories of people who are eligible for care, this dissertation examines how these utilitarian and value-based dynamics present themselves. This process was especially interesting in France, where new categories of people were insured over time, incrementally, through policy acts that supported and were supported by French ideologies. The process of expansion was surprisingly lengthy in retrospect, and the order in which people were included into the *Assurance maladie* illuminates societal priorities.

Elements of *Longue Durée* Culture

This dissertation has identified several features of American and French *longue durée* culture[7] that explain the differences between the two systems. First comes the idea that concepts of merit and stigma are different in the U.S. and in France. This influences the classificatory

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[7] Throughout this dissertation, *longue durée* culture refers to the deepest, most fundamental culture of a place. It is the culture that remains relatively unchanged over several decades. It has a great role in defining political opinion and is frequently leveraged in the service of political messages and debates. Of course, it influences things other than political opinion, but political opinion is the focus here.

work that the two states perform when deciding to whom to extend medical care and how to do so. In France, every person merits medical care. In the U.S., only those who qualify for care in very specific ways have health access via equally specific pathways.

Next, in the U.S. the right to be unbothered by others who might have needs is a very important and central right. This means that many Americans are resistant to the idea of paying taxes that would support medical care programs. In France, this is not the case. Instead, the French focus on solidarity, which requires relationships of support and care to be extended throughout the population. All must chip in via taxes to pay for the care of others, and all are expected to consume health care in responsible ways that help control the costs of the system so that more individuals can benefit. In the U.S., the right to be unbothered trumps the right of another to access health care. In France, the principle of solidarity and the right to access health care trump the right to be unbothered.

Next, French and American health-related utilitarianism follows different logics. The French view it as useful to society to extend health care to as many as is possible. The benefits that stem from a healthy population that recognizes health care as a symbol of citizenship and the French state outweigh the costs and challenges of maintaining such a system. In the U.S., extending health care to all is often believed to potentially cause moral and political decline, unfairly inconvenience others, or result in poor systems of care overall. These differences of perceived utility have led the French to extend health solidarity to all, where the U.S. has not.

Finally, the French are proud of the extensive social protection offered by their healthcare system, while the U.S. is proud of having the best care in the world, even if it is not accessible to all. As such, the French have protected their public healthcare system, publish frequent public service announcements about how to access services, and create campaigns about how to use medical care in less costly ways that make it possible to guarantee care to as many as possible. The U.S. citizenry often fears that state involvement in the healthcare system would cause the quality of care to decline. The state is not trusted to administer such a program without overreaching its jurisdictions, becoming socialist or totalitarian, or otherwise interfering negatively with the process of medical research and the administration of care. The two nations take pride and derive small bits of national identity from their medical systems, but the differences in where this pride is located have great impacts on their healthcare systems. The French are proud that they have managed to create a fully supportive and fully accessible system over time, while the U.S. is proud of having advanced health technologies and research labs. In the U.S., any threat to the profitability of pharmaceutical companies, research labs, or the medical industry in general represents a threat to one of the nation's sources of pride. It is thus easy to understand why there is not a more robust public healthcare system.

This enduring facets of *longue durée* culture appear frequently in this dissertation as they surface repeatedly in public sphere discourse about health care in France and the U.S.

Data

The data in this dissertation came from archives related to the health reforms and proposals in question. For the Truman and Clinton proposals, the best data came from the respective Presidential Libraries in Independence, Missouri and Little Rock, Arkansas. Discourse surrounding the ACA is readily available online. The French data came from *Les Archives nationales, le Musée sociale,* the press files at *Science Politiques* and *La Bibliothèque interuniversitaire de medecine*, all in Paris, and *le Musée de l'Assurance Maladie* in Bordeaux. Additional discursive artifacts were gathered online in the form of newspaper articles, online archives, and video archives. These diverse archives provide vast documentation of the conversations surrounding health reforms in various formats: newspaper articles and editorials, political speeches, public service announcements, advertisements and propaganda, letters from citizens to the president or to ministers, and the internal correspondence of various health related organizations or other interest groups. Through these documents, I have reconstructed these debates.

Overview of Chapters

To examine these debates and culturally-influenced policies, this dissertation proceeds as follows:

Chapter One is an overview of the sociological theory that I have found to be most useful in my analysis. Citizenship and welfare state theory have helped me to more clearly see the policies I examine, while cultural sociology has provided me with the deepest insights into the *longue durée* culture reflected by health care policy and health care policy debates.

Chapter Two sets the stage by deeply examining the health care debates and policies created during the post-World War II period.

Chapter Three continues the examination that began in Chapter Two. It examines policy debates and changes that occurred between the Cold War and the Affordable Care Act.

Chapter Four examines how classification and categorization plays into the expansion of health policy. Policies in both countries have relied heavily on classifying types of citizens, types of care, or types of health coverage. The differences in how these categories have been delineated reveal beliefs and *longue durée* culture in action in the service of policy. An examination of these categorical expansions shows how France's health expansions aim to cover larger portions of the population in gradual sweeps of rights expansions, while U.S. programs aims primarily to stave off public health disasters. Examining health policy changes as incremental and classificatory as dictated by culture provides an additional lens with which to compare French and American versions of health care utilitarianism.

Chapters Five and Six turn to archival documents from the U.S. (Chapter Five) and French (Chapter Six) cases. These chapters rely largely on media documents, which show how the public sphere responds to health policy issues. These chapters provide further evidence to support the idea that French and American health discourse, and in turn policies, have both been culturally influenced.

CHAPTER ONE:

THEORIZING THE POLITICS AND CULTURE OF HEALTH CARE

Longue Durée Culture

Sociologists have long analyzed welfare state formation as an institutional and politico-economic process (Aminzade 1995; Manza, Brooks, and Sauder 2005; Skocpol and Fiorina 1999; Orum 1996). In this dissertation I propose a new departure in which health care institutions take shape and are reproduced in accordance with culture. My chief contention is that 1) we have much to learn about a culture's values[8] by examining its policy, 2) political arguments, whether they correspond to eventual policy or not, are deeply informed by culture and values, and 3) even unpopular policy is a direct product of culture. It means that there are important systems to discover through these examinations. Most importantly, these premises allow for a cultural exploration of policy and political discussion as correction to institutional and politico-economic approaches.

Throughout this dissertation, I will show that enduring nation-specific *longue durée* culture was central to the health debates that I have analyzed. Holding these beliefs while conducting a thorough analysis of my data has led me to hypothesize that France uses its republican values to justify the expansion of healthcare, while the U.S. uses its capitalist values to justify not doing so. In the U.S., health care is expanded for utilitarian reasons, while in France, health expansion was slow at certain junctures for utilitarian reasons. The fundamental

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[8] I define values as relatively unchanging, deep seated, beliefs about the nature of the good. Values orient desired outcomes and the pathways that individuals are willing to take to reach these outcomes.

differences in French and American values, in addition to this opposition of the application values and utilitarianism, has led to very different policies.

Furthermore, I observe that in the U.S., arguments against expanding health care rights, whether they are through direct government provision or government support of private provision of those rights, remain remarkably unchanged over time. This stability attests to the stability and centrality of *longue durée* culture. As we will see via primary documents in later chapters, though the economic, political, and even social conditions may change, Americans seem to fall back to the same themes and thoughts when discussing health care. From the post-World War II era, to the Cold War, to the 90s and up until today, arguments about health care leverage many of the same concepts, despite the wildly different climates. Meanwhile, arguments for the expansion of health care rights, while they do contain some similarities, respond much more clearly to the way that Americans experience changes in the medical industry. They also respond to the growing differences in health rights globally, as more Americans become aware that health care costs are pushed more strongly onto U.S. consumers than they are in other countries. In the American context, it is *longue durée* culture that has prevented the extension of health care, while in France, *longue durée* culture has prevented its retrenchment. The American population remains conservative as a whole, with self-identified conservatives outnumbering self-identified liberals, often with a margin of 10-20% points over the past three decades (Saad 2018). As such, passing American health reforms has been an even more difficult task, since it is the political minority which tends to favor the reforms. Conservative ideologies, which mirror the traditional interpretations of the unalienable rights to life, liberty, and the pursuit of happiness, often do not symbolically align with the expansion of health care rights. Since the majority of Americans have conservative political orientations, conservative political views are treated as status quo American views throughout this research. These values closely match those of the Bill of Rights and the Constitution. In comparison, France has had a far more robust left movement, and has had policies which appear quite liberal in the American context throughout the duration of its modern history. Though the country has moved right in recent times (Zamora 2018), more liberal values are treated as the French status quo throughout this research. These values are taken from those implied from the constitution of the Fifth Republic.

As we will see via primary documents in later chapters, French arguments on both sides remain just as stable as American arguments against the expansion of health rights. Budgetary arguments are common in France, but do not challenge the French right to care. Arguments to expand health rights, or to spend more on health, are likely to reference solidarity in French history, especially the creation of social security. However, historical arguments about solidarity may also reach back even further (such as in the museum of health insurance where they say that the first health insurance was rural communities coming together to pay for funerals). In the U.S., historical arguments in the service of health are rare. Even references to the Bill of Rights are less common than I expected to find when I began the archival research for this project. Interestingly enough, other American political issues *are* discussed in terms of history. Discussions of immigration, the Federal Reserve, and drug policy, especially as it relates to medical cannabis, are far more likely to contain historical insights than discussions of health care.

Setting the Stage—Culture and Politics

In this chapter, I make reference to the theories I have found most inspiring and most useful for my analysis. The aim is not a comprehensive literature review on health policy, nor a comprehensive theory literature review. These, of course, can be found elsewhere. Importantly, I have always been able to find quite a bit of value in just about any social theory—even when at points that theory contradicts others that I find particularly illuminating, applicable, or relevant. Because of this, it is not my intention to position myself firmly within a theoretical camp, nor is it to defend my favorite theories from challenges. Instead, I simply present the theories that have done the most for my analysis, which have most shaped my thinking on this issue, and which are most directly applicable to the topic of my research.

My preferred culture theories are those that create space to use both Geertzian and Weberian formulations of culture in conjunction with practice-oriented formulations such as Swidler's. However, I feel that practice-oriented theories fit inside of Weberian and Geertzian webs, and that in most cases, they do not truly oppose or contradict each other. All allow culture a strong role as an independent variable at times, though Swidler's formulation allows individuals stronger agency. Ultimately, Geertzian models of culture theorize values that endure despite changes in practiced behavior, making this model the stronger of the two, and that which is most suitable for any analysis of *longue durée* culture.

Some studies that use or propose using culture to answer political questions often use culture theories both in a Geertzian way, as well as in a practice-oriented way. These theories recognize that there are multiple ways in which culture might operate, but that regardless, culture remains a strong, independent, and influential variable in political outcomes. Or, they recognize that there are multiple ways in which culture might influence a particular social environment or system. They allow for the idea that individuals might experience culture in many ways, even simultaneously. These types of theories also allow space for culture to influence larger social systems or structures in a different way than it might influence individuals or smaller group units.

To begin this review and to move it in a more topical direction, we should first turn to Geertz to see how he theorizes the link between politics and culture. Geertz writes, “One of the things that everyone knows but no one can figure out how to demonstrate is that a country’s politics reflect the design of its culture” (1973:311). Examining how culture has shaped health policy in the U.S. and France is the central goal of this dissertation. By isolating health policy, other distracting political issues can be set aside, while the real cultural phenomena at work can be focused on. This exercise ultimately isolates cultural traits that are *longue durée*, and are strong enough to influence the shape of state and policy, thus demonstrating how these two country’s politics “reflect the design” of their respective cultures. Narrowing this focus down to one particular area of policy, health policy, means removing distractions and noise, both cultural and political, so that this complex relationship can be more readily understood.

Reviewing Geertz’s conclusions on the relationship between culture and the state is crucial to the task at hand. Geertz writes, “Ideas—religious, moral, practical, aesthetic—must, as Max Weber, among others, never tired of insisting, be carried by powerful social groups to have powerful social effects; someone must revere them, celebrate them, defend them, impose them. They have to be institutionalized in order to find not just an intellectual existence in society, but so, to speak, a material one as well” (1973:314). Examining public sphere political discourse to isolate the ideas that are carried, revered, and celebrated then allows for these ideas to be mapped onto policy, which then imposes these enshrined ideals. The institutionalization of ideas is what causes them to have a long life and what transforms them from a mere idea into an element of *longue durée* culture.

But, understanding that cultural ideals must be enshrined is not enough. We must know something of how these ideals become physical through policy. Geertz continues, “The political processes of all nations are wider and deeper than the formal institutions designed to regulate them; some of the most critical decisions concerning the direction of public life are not made in parliaments and presidiums; they are made in the unformalized realms of what Durkheim called ‘the collective conscience’” (1973:316). This is to say that there is indeed a greater national collective with a sense about what is correct in terms of policy. This conscience(ness) influences what is possible and what is not possible on the policy stage. It explains why a national or single payer health care has not been possible in the U.S. The collective consciousness has simply not embraced single payer or national healthcare as the solution to the country’s health problems—it is not part of our *longue durée* culture.

There are of course people who are currently advocating for single payer health care in the U.S. or who have even been advocating for it for years. However, this addition to our political landscape is relatively new (thus, not part of our *longue durée* culture), when compared to the discursive elements that are used to argue against single payer. Differences of opinion does not mean that there is even an inconsistent culture. At most, it might mean that there is some potential for cultural shift. In this great unsettled time of American health care, this is not surprising. In regards to cultural change, Geertz writes, “This sort of social changing of the mind is a great deal easier to sense than to document, not only because its manifestations are so various and indirect, but because it is so hesitant, shot through with uncertainty and contradiction. For every belief, practice, ideal, or institution that is condemned as backward, one, often the same one and by the same people, is celebrated as the very essence of contemporaneity; for every one attacked as alien, one, again often the same one, is hailed as a sacred expression of the national soul" (1973:319). Thus, we can understand that it is not culturally inconsistent that even as single payer health care is championed by some, the same plan is derided by others. It may, or may not, simply be the process of changing minds.

Throughout this process of changing minds and changing policy, the operative policies must remain culturally coherent, as must the new policies that arise out of any new change. The Affordable Care Act (ACA) is a policy that arose out of a time of great "social changing of the mind," however, it did not closely enough resonate with American culture, which is why it became so contentious. The ACA did not feel as if it emanated from the collective consciousness or the cultural needs of the country. Geertz clarifies this problem:

> For a state to do more than administer privilege and defend itself against its own population, its acts must seem continuous with the selves of those whose state it pretends it is, its citizens—to be, in some stepped-up, amplified sense, their acts. This is not a mere question of consensus. A man does not have to agree with his government's acts to see himself as embodied in them any more than he has to approve of his own acts to acknowledge that he has, alas, himself performed them. It is a question of immediacy, of experiencing what that state "does" as proceeding naturally from a familiar and intelligible "we." (1973:317)

The ACA could not be accepted as emanating from the collective American self. This will be explored further in later chapters.

Other theorists also agree that culture has a great impact on politics, and they rely on culture as a meaningful tool for political analysis. A great example of such use of culture theory in the service of political analysis is outlined by Harry Eckstein (1988), in an article where he asks "How can culture be used to examine political change?" For Eckstein, culture affects politics by determining the context of collective and individual political decisions. Eckstein delineates these as two separate areas or contexts where culture might have a large impact on politics. However, overall, Eckstein still notes that culture is the site for everything, including politics, making culture an independent variable. Eckstein proposes a *longue durée* culture, and believes that culture has inertia, and that patterns will often continue in a new form that is adapted to the developments (1988:794). Culture can absorb structural changes without being massively disturbed (Eckstein 1988:795), is likely to become malleable while still retaining its defining characteristics, and is also likely to reinterpret its own dogma to fit new developments. This notion of culture with inertia is absolutely relevant to the staying power of the concepts observed in health policy debates. Cultural inertia explains why the same rhetoric and concepts remain in the public sphere debates for so many decades.

An example of another piece of *longue durée* American culture testifying to the inertia of culture and its long-lasting impact on policy can be found in welfare policy. Theorizing these relationships in *Politics of Disgust*, Ange-Marie Hancock writes,

> Political context, a key product of political culture, is commonly thought of as a primary influence on policy decisions. In this vein, historical and contextual changes in political culture and public discourse receive a share of the responsibility for the preservation of democracy… However, political culture encompasses more than the shared beliefs, values, and norms that coalesce to form a political context at a particular political moment. It also includes identities learned by means of experiences and relationships in institutions like families, schools, the media, and voluntary associations. (Hancock 2004:6-7)

Hancock argues that the public identity of welfare recipients (as assigned through misconceptions that are played out in the public and political discourse) interacts with “the politics of disgust” to influence policy outcomes. According to Hancock, the roots of the public identity of the “welfare queen” is based in discursive themes about the laziness and fecundity of black women that originated in slavery. These themes, now enshrined in our culture and reproduced in everything from satire, to films, to public political discourse, have endured for over a century, and have, according to Hancock, influenced welfare policy for decades. As we will see in later chapters, like welfare policy, health policy in the U.S. and in France has also been influenced by extremely enduring and potent cultural themes for decades.

As the context for action, culture is autonomous and a potentially limiting factor, even as it shapes and directs action. Importantly, Eckstein gives culture not only the role of shaping action, but also the role of shaping orientations to action (1988:790). This means that while an actor makes decisions that in turn influence politics, that same actor also has some general dispositions towards certain actions. They may or may not always act exactly according to their dispositions. They may not act at all, and instead retain their dispositions, but do nothing. However, these dispositions can be activated, expressed, discussed, or perpetuated, thus spreading these dispositions and causing other actors to potentially act in similar ways in the future. Of course, these same actors can also take concrete actions, such as voting in a particular way, joining social movements, valuing certain campaigns or initiatives, writing editorials, participating in boycotts, or contributing their time or making donations to political campaigns. All of these actions are change-making actions, especially if they are shared amongst the actor's social group. These actions create politics by creating political change, movement, or popular orientation. These types of action, when viewed as culturally informed, are clearly the types of culture that impact health policy. Though Eckstein was not directly speaking to health policy, this theory gives tremendous mileage to my project here, as it provides a lens where culture is an independent variable in the political sphere. Depending on how an individual is oriented by culture, which is part of culture, they will take different political actions, which in turn directly impact political outcomes. This formulation gives culture direct influence over politics, just as I find in my own research.

Eckstein also leaves great room for meaning. The manner of investing situations with meaning comes through socialization, primarily through early learning (Eckstein 1988:802). This process leads to the formation of attitude and opinions, and in time, the internalization of cognitive and affective meanings. Cognitions and affective responses result in goals and strategies to pursue them. Eckstein believes that political attitudes, like many other attitudes, are formed in this way. While I agree with Eckstein that meaning and investing situations with meaning is a central and integral function of culture, and that this particular mechanism has a great impact on politics, I disagree with one of his thoughts. I do not agree that the meaning given to situations comes primarily through the socialization that occurs in early learning. I believe that some dispositions must certainly come to us during early learning, but that political dispositions are equally likely to be somewhat reactionary. As change occurs, we are sometimes forced to reconsider politics. Even if we still carry very standard political values for our social milieu, which we may have even acquired during early learning, we are still likely to reinterpret these values based upon new experiences. We are more likely to have new interpretations, or new ways of applying meaning if we have moved between different cultural environments, even within the same country. The belief that meaning is acquired during a young age would seem to assume that actors are unlikely to grow and unlikely to acquire the values of a new culture that they have been exposed to. I believe instead that new meanings can be acquired and applied at any point during the life course of either an individual or a group. This may change the individual or group's orientation to action. It may change the actions that they do in fact take. It can certainly change politics. But it need not only occur during young life.

Though we can rely on Eckstein for a notion of why culture remains constant, and can find other examples of this inertia in Hancock's work, it is equally important to consider theories on just how that constant culture shapes politics. Another of my very favorite explorations of politics and the ways that culture intertwine is David Laitin's (1986) work on political and religious change in the Yoruba in Nigeria. Laitin divides culture into two halves, which he calls the "first and second faces of culture." The first is arrived at via Geertzian theories of ultimate commitments, putting them much in line with *longue durée* culture; the second, by the predecessors of Swidler's toolkit theories. This division of culture into two halves is similar to Eckstein's, and presents culture as similarly powerful enough to be an independent variable capable of influencing the development of political and social systems such as health care. Eckstein allows culture to influence politics through meaning and through orientations to action. The influence through meaning is similar to Laitin's first face of culture, while his thoughts on orientations to action best correspond to Laitin's second face of culture.

Laitin characterizes the first face of culture as able to answer questions about how culture orders political priorities, or how shared culture could mean having similar political goals. The focus of this analysis is cultural symbols as they are institutionalized into "systems of patterned activity" such as religion, language, and kinship (Laitin 1986:11-14). This face of culture allows us to interpret the meaning-containing pieces of political identity. Though culture is not reducible to values in this model, they are central and symbolic, and a deep understanding of their history and their power is required to arrive at these insights. He summarizes this theory as the idea that meanings, values, and preferences are embedded in symbolic structures, which we may analyze to understand how these symbolic structures guide political action (Laitin 1986:16).

In this dissertation, I examine healthcare systems as "systems of patterned activity." One of the most interesting things is that the U.S. seemingly has more diversity in these patterns, owing to the multitude of different ways that a person might access health care. The pathway to health care in one state might be completely different than the pathway in another. Even within the same state, costs and access vary widely, depending on many factors. This makes this diversity and the resulting inequalities part of the patterned activity of the American healthcare system. The French, who have a system that provides health access in a much more uniform way and at uniform prices across the country, make health equality part of their own patterned system.

The second face of culture sees culture as a political resource that can be mobilized towards collective action. The organizational power of culture is evidenced in how frequently cultural identity is central to collective action. If this second face were not *longue durée* culture, it would likely not be successful in mobilizing collective action. These theories seek to create far fewer categories than Geertzian theories, as they are looking to establish causal relationships between culture and action. Rational choice theory has a larger influence here, as actors can manipulate cultural identity to their greatest benefit. Actors use culture in political settings in a very calculated way—one that could even be predicted. Here, values are part of the many aspects of culture that actors can choose to manipulate when they so choose (Laitin 1986:11-14).

This aspect of Laitin's theory is powerful because it is indeed observable in health care debates. It is especially observable in France, where arguments for expanding health care frequently invoke French political beliefs and values, which have become standard aspects of French culture. In the U.S., arguments against healthcare expansions have historically been the arguments most reliant on American cultural identity. In more recent debates, the suffering of American families without health care access has caused many to attempt to fit American cultural identities to their claims, just as Laitin states is possible. Interestingly, these manipulations have taken much longer to result in any healthcare expansion. It is possible that when identities need manipulating in order to fit a campaign or goal, that they may become less effective or less resonant.

Laitin uses common sense and hegemony as the bridge between his first two schools. To do this, he uses Gramsci's hegemony. Laitin defines hegemony as "the political forging, whether through coercion or elite bargaining, and institutionalization of a pattern of group activity in a state and the concurrent idealization of that schema into a dominant symbolic framework that reigns as common sense" (1986:19). Here, in order to understand meaning in a society, we must identify the values which are embedded in the hegemonic system. When this happens, we locate the common sense, which emerges as perhaps the most important unifying aspect of culture.

Since the healthcare systems in both France and the U.S. have been forged politically, through elite bargaining, and since they certainly embody and idealize very important aspects of their respective cultures, Laitin's theories seem all the more applicable and useful. By looking at health care first through the first and second faces of culture, and then situating this analysis within hegemony, we can arrive at a useful reading of these two systems and the cultures within which they are situated. Though the analysis of health care works in a slightly different direction than Laitin's analysis of the Yoruba, the tools he presents are no less useful.

To examine hegemonic common sense, Laitin demonstrates that in the Yourba context, ancestral city politics, not world religion, creates a "pattern of group activity" which then serves as a "dominant symbolic framework." Since these ancestral politics are fashioned into the common sense because of their hegemonic position, political action is based around these values. In the case of the Yoruba, ancestral city politics provided a "symbolic repertoire" which became central to all other social systems (Laitin 1986:183). In any society, Laitin believes, symbolic repertoires form one of the many non-isolated, non-static subsystems of culture, which also partially define the identities of individuals within the society. Subsystems, like religion, shape identity, and individuals act according to these identities (Laitin 1986:180).

Laitin's use of hegemony reconciles "webs of significance" theory with toolkit-like theories because it requires a deep understanding of the values, meanings, and history of a society in order to locate the hegemonic subsystem. Understanding hegemonic subsystem itself allows us to understand political choices by providing us with the common sense of the society, upon which preferences will be based and decisions will be made. It also clearly identifies the priorities of a society, which should make it easy to predict which cultural tools will be chosen from the repertoire when collective action is needed. Indeed, I have found that the priorities of a society can be used to predict the shape of the society's healthcare system, at least for the French and U.S. cases.

Criticisms of Laitin's theory may be that having one dominant common sense for a given society is impossible, as subcultures may have markedly different values. However, hegemony does allow for other subsystems and subcultures to exist, and the sociologist need only account for the strength of their influence in defined situations, as any subculture could not be uninfluenced by the hegemonic common sense.

This dissertation specifically examines the interplay of culture, politics, and values, and the way in which these are mobilized both in health policy debates, as well as the way in which culture and values resonate with developments in health policy. I argue that while French arguments in favor of extending health care are values- and rights-based, American arguments in favor of expanding health care are utilitarian. Conversely, French arguments for extending care at slower rates (or limiting the scope of programs) have been utilitarian, while American arguments against health care extension have frequently been utilitarian. I believe that the shape that policies take, especially when they are initially formed, must deeply resonate with the common sense of a society. As Geertz states,

> If common sense is as much an interpretation of the immediacies of experience, a gloss on them, as are myth, painting, epistemology, or whatever, then it is, like them, historically constructed and, like them, subjected to historically defined standards of judgment. It can be questioned, disputed, affirmed, developed, formalized, contemplated, even taught, and it can vary dramatically from one people to the next. It is, in short, a cultural system, though not usually a very tightly integrated one, and it rests on the same basis that any other such system rests: the conviction by those whose possession it is of its value and validity. Here, as elsewhere, things are what you make of them. (Geertz 1975)

For a topical example, the rejection of socialism is part of American common sense, but in France, this is simply not the case. As Geertz states, this notion is historically constructed, judged, and even taught via political conversation and debate. This teaching aspect is quite powerful, in that it works with Laitin's conception to explain the longevity and inertia of culture. It explains the longevity of the rejection of U.S. health care policies based upon the idea that they might be socialist. I also believe that an individual's politics are largely formed through establishment of their political attitudes. I agree with Eckstein's notion that cognitions and affective responses result in goals and strategies for action. In this dissertation, I observe both goals and strategies in discourse, and I analyze discourse for the values that it contains. My version of culture and politics also situates political beliefs, preferences, and leanings within culture, and implies a strong influence of common sense. For me, actors come to political conclusions by choosing between many available political leanings, weighing them or judging them via their notion of common sense that they have been taught via their culture.

Historical studies of American culture and politics, as well as the methodologies that these studies have imparted also key analytical tools for the puzzle of health policy. Hofstadter (2008) argues that that beginning in the 1950s the American extreme right calls itself conservative in order to hide its radicalism, and that the American extreme right tends toward psychological paranoia. He further argues that the Spanish-American war was an important moment in the evolution of such movements, bringing forward a particularly strange mixture of humanitarianism and simultaneous aggression (Hofstadter 2008). I agree with his assessment of the American extreme right; it is clear that our politics have become more polarized over time (Wasserman 2017), especially as more and more Americans spend more and more time on the internet. It seems that pieces of this paranoia, which was once reserved for these undercover extremist ideologies, have come to flavor what is today's Republican party. Hofstadter uses the term "status politics," indicating that group interests may cede importance to group claims to a social identity in relation to others. However, as Sean Wilentz points out in the introduction to the 2008 edition of *The Paranoid Style in American Politics*, Hofstadter explores a type of "symbolic politics" or "cultural politics." He interprets history through these lenses, unearthing the symbolic meanings of politics, and considering American politics to be part of the cultural facts of the country. The continued relevance of this work indicates that it has isolated relevant pieces of American *longue durée* culture.

Situating Health Care as a Right Depending on National Context

Comparing rights in two developed democracies is one of the principal reasons that the present comparison works. As such, it is important to consider some of the literature examining democratic systems. Additionally, since health care is seen as a right in France but not in the U.S., this literature has much to contribute to this inquiry. Health care is central to the socio-economic functioning of most advanced liberal democracies. It is spoken of as a right in many democracies, and is guaranteed by the vast majority of developed countries. Health care Article

35 of the EU Charter of Fundamental Rights states: “Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities” (European Union Agency for Fundamental Rights 2009). This charter “enshrines into EU law a wide array of fundamental rights enjoyed by EU citizens and residents. It became legally binding on the EU institutions and the Member States with the coming into force of the Treaty of Lisbon on 1 December 2009” (European Union Agency for Fundamental Rights 2009). Interestingly, most studies of democracy use the state to explain the shape of the society, or the state to explain the shape of culture. While this dissertation works in the exact opposite way, these theories have been exceedingly useful. They are useful for examining how culture, politics, and the state could form a loop, or a system of influence. In most studies of democracy, it seems there is a feedback loop between the culture and the state that is usually theorized as less of a loop and more of a directional flow of influence. In light of my evidence, most are not useful for explaining how directly culture can impact politics, how policies can fail because they lack cultural resonance, and how political options will be overlooked due to their lack of presence within the local dominant common sense. In most of these theories, culture is explained as a result of the state’s action, whereas my research shows that policy takes shape and becomes possible and feasible as a result of culture’s influence on political beliefs and behaviors. Furthermore, these considerations are essential to understanding politics, whether we ultimately decide upon a cultural reading of policy or not.

An early study of the factors which influence democracy is Seymour Lipset’s *Political Man* (1960). Lipset treats politics and specifically democracy as measurable phenomena which can be correlated to other current societal factors. He examines factors like education, wealth distribution, the speed of economic development, and voting. Clearly inspired by Tocqueville, and writing before the cultural turn had impacted political sociology, his work focuses around what he deems to be “democracy as a characteristic of social systems” (1960:ix). In order to assess this aspect of social systems, he examines “the conditions necessary for democracy in societies and organizations; the factors which affect men’s participation in politics, particularly their behavior as voters; and the sources of support for values and movements which sustain or threaten democratic institutions” (Lipset 1960:x). These social systems, however, are characterized by characteristics of the state—in this case, its democracy. This theory’s goal of explaining the state characteristic of democracy makes this early theory very state centered. It does not truly close the loop between the state and culture, which is one of its major weaknesses. A proper theory of state functioning cannot neglect one of the greatest factors of human life.

It is equally important to note what Lipset believes about democracy, and also to recognize the historical context of his thought. Writing after World War II and in the early stages of the Cold War, Lipset views an effective democracy as an institution fully capable of delivering on its promises of wide representation, participation, and governance. In fact, democracy is the only system which can promote fairness and equality. As a state-focused theorist, he hypothesizes that this unique trait of the state will promote the desirable social characteristics of fairness and equality. However, I certainly believe that any theory of democracy must allow the citizens themselves to be part of the theory.

Lipset’s writings indicate a certain, though not unmitigated, faith in the ability of democratic citizens to function within the confines of the political system without compromising each other’s liberties, should the system prove to be effective and legitimate such as a “political formula" specifying which institutions are legitimate and "accepted as proper," acting political leadership, and a political system where established parties seek new office (Lipset 1960:45-50). Of this list, legitimate and "accepted as proper" institutions are the most important for considerations of health care, which may or may not be accepted as legitimate and proper, according to Geertzian common sense. This would, in the end, indicate that the culture of the citizens must be reasonably in line with the state and the politics of a place. It also seems to be a very rosy and ideal version of democracy that is discussed here, one that does not seem to match with the current state of American democracy, even if it did match in Lipset's days. In any case, when we attempt to apply Lipset's theory to the case of health care, we can see that in the U.S. case, democracy does not lead to distribution of health care in an equitable manner, while in France, it does. The puzzle here is explaining the extreme cross-national divergence on health care within broadly similar institutions of democracy. Lipset's theory does not provide any clarity on this. One would expect to find that two democracies would have similar results in terms of rights and fairness. However, from these differences, we can see that the *longue durée* culture within which the state is situated has a great impact on the outcomes of the state.

William Kornhauser's (1959) anxieties about mass society and Tocqueville's (2003) predictions about tyranny of the masses do not seem problematic to Lipset. Unlike elite theorists like C. Wright Mills (1956), Lipset does not believe that that individuals living within a proper democracy will manipulate a democratic system to the point of excluding other members or collect undue benefits from their positions in society. To Lipset, these dangers, as well as other threats to democracy, could be avoided through the creation or maintenance of social conditions conducive to democracy, as it is the democratic system that, once in place, serves to regulate inequality, exploitation, and tyranny (Lipset 1960:xxxii). Here, we see again that Lipset believes that society is quite under the influence of the state. If a democratic state system is so powerful as to be able to regulate inequality, exploitation, and tyranny, any other form of state should also have equally large effects on the society it governs. Likewise, a great amount of the society would also be explainable through the state. This could even mean that the state creates culture. To me, it seems that the state is more likely to be a promoter or sponsor of culture than a creator of culture, in all but the very most authoritarian regimes. This is one reason why I believe that culture will have some impact upon the state.

Just a few years post-Lipset, the centrality of the state already begins to be questioned by theorists working on very similar questions. Culture, which was left out of the analysis to the detriment of these arguments, starts to appear in these theories. Bringing considerations of culture into political analysis is very important groundwork for the analysis in this dissertation. I find that culture has a very strong influence on the success of policy, which shows just how linked policy and culture are. These early conceptions of the relationship between state and culture remain useful and valid for the puzzle at hand. In *The Civic Culture*, political scientists Gabriel Almond and Sidney Verba argue that democracy must be based in participatory culture in order to remain stable (1963:2). Citizens must learn a political culture through experiences with the political system, and that political learning consists of cognitive processes, political feelings, expectations of the political system, and the political evaluations they make (Almond and Verba 1963:266). Through this, they argue that the political system is internalized as political culture in cognitions, feelings, and evaluations. Though this theory is already less state-centric than Lipset's, and gives a much larger role to culture, it still prioritizes the state and misses the true influence that culture has on the state. For Almond and Verba (1963), the internalized state creates the culture which must support democracy. Given the close relationship that the state and culture have in this theory and the explanatory power that this theory still holds, these theories must still be considered today.

Taking culture to politics was still new at the time of *The Civic Culture.* It uses culture as a combined tool with the state, but its goal is not to theorize cultural diversity, pluralism, gender, race, or ethnicity as some later political culture studies do. It is also distinct in that it does not seek to explain disadvantage through cultural difference or minority status. Rather, it simply uses politics and culture to examine the stability of democracy as a state system. So, while it may include culture as an element, it still seeks to explain a purely political and even state-based phenomenon. This keeps even this political culture theory closer to other state-centered arguments. This argument does seem to play out in my data. U.S. and French arguments that surround health care remain rather stable over time, generally speaking. This attests to the stability of democracy that Almond and Verba (1963) point to. Though they do not specifically state that they expect values, policy arguments, and priorities to remain stable as a result of democracy, it is possible to extend their argument to include such things.

It is important to note the thematic similarities of *Political Man* and *The Civic Culture* as well as their theoretical similarities. Democracy was one of the most frequent inquiries at the time, due to the political climate of the Cold War. Both of these studies explore the ideal conditions for democracy and assume democracy as a good, but they vary in several important ways. In *The Civic Culture,* durable and legitimate democracy is constructed through symmetry of the political culture, individual political groups, political culture, political system and political institutions. Influence flows back and forth between government, institutions, and citizens. This vision of political institutions and cultures is far more interdependent and interlocking than the picture presented in Lipset's *Political Man*, in which it is the government's responsibility to maintain systems of education and equality (health care would be included here) and to minimize conflict (health care could also fit in here, and underserved, unhealthy populations are likely to be conflictual). Both of these works rely upon the condition of the citizens to support democracy, but Lipset's theory gives government more power to form citizens into political participants that value the democratic process. My research reflects that there is validity to the need for citizens to support democracy, as their opinions and values must be in alignment with the course of how the society develops. However, the moral and values-based vision of what is fair, just, decent, or what constitutes a right will vary from society to society, largely due to the culture of the place. Citizens live in culture, and while I do not disagree that part of culture could be formed or reproduced by the state, it is simply most important to recognize the importance and impact that culture has on political developments.

Both works make the psychology of citizens important to the democratic outcomes of the society, as much as the culture. In *Political Man* disadvantaged populations are psychologically damaged by their poverty and are therefore likely to support authoritarian regimes (Lipset 1960:97-126). However, it is the neglected *longue durée* culture that would cause a developed, wealthy nation to refrain from equalizing wealth distribution in order to avoid psychological damage caused by poverty among citizens. We are seeing this play out today, and right-wing movements have gathered quite a bit of steam across Europe and the U.S. These movements have largely been fueled by an underrepresented and floundering middle class. *The Civic Culture* uses psychological interactions to internalize political process. In their estimation this helps to bridge the gap between micro and macro political analysis (Almond and Verba 1963:32). The legitimacy of the political system is also largely achieved by matching the politics to the psychologies of the citizens. Citizens must also have a psychological nature and attitudes conditioned to support democracy (Almond and Verba 1963:43). This allows influence to reside both in government, as well as in the populace, creating, as noted above, more feedback between citizens and the government. If it is accepted that many important psychological factors arise from cultural influences that also influence the state, my research can support such a notion. However, Lipset's use of psychology makes citizens a product of the type of governance they have experienced in the past, in so much as their relative wealth, breadth of experience, and education levels (and other things) are dependent on the political system. This gives the political institutions a larger amount of power over even the psychological characteristics of its citizens than is reasonable.

In the analysis I take in this dissertation, citizens are the politicized "in-group" and nationalized conduits of culture who help to shape a political system. But they also represent the culture to which policy and government must speak. They are also the actors in which culture partially resides, they are the preservers and enactors of that culture, and they are the meaning makers and the interpreters of symbols. They are the participants in a culture and in a political culture that may or may not vote, may or may not be given to political participation, and may or may not have social citizenship rights. Citizens are joined by disenfranchised citizens (such as felons in the U.S.), non-citizens, or non-nationals, who may be present in the society, whose impact may be felt in national debates and political discussions, and who may even contribute to gradual changes of mind. Their influence can be great, as they add new perspectives and new issues to national politics, even if they are unable to vote or otherwise participate in the democratic process.

Alternate theories leave room for neither culture nor citizens. This is entirely problematic. C. Wright Mills (1956) is far less trusting of the democratic system and would view the state as beholden to the socially powerful elites. This theory is important to address, as it would certainly be supported by many who theorize the condition of health care in the U.S. as a result of strong lobbies and interest group politics that are able to dictate policies that serve their own interests at the expense of smaller or less empowered groups a key potential objection to my argument. My objection to these theories is that they do not involve culture. Even if powerful interest groups are more likely to get their way than others in the U.S., this power is granted or made possible because the values of the society allow for such a division or power. Though this trust is eroding, elites are trusted in the U.S. in a way that they are not in France. This is evidenced by U.S. policies that have historically favored free-market solutions to even social problems. The determination of the U.S. to find private solutions to health care, versus the French reflex to find a state solution, illustrates this difference.

This has enabled the American health, insurance, and pharmaceutical industries to dominate policy and shape the landscape of American health care. In France, there are other operative values that trump trust in business and industry elites. This has allowed for solidarity to guide the development of policy more than elites. Most importantly, it is cultural variation that creates systems where medical industry elites could have enough influence to shape systems as they see fit. In other words, American culture allows powerful networks of elites to influence important aspects of society (here, namely health care) while in France, there is no cultural space for this type of group to hold this type of influence.

In *The Power Elite* C. Wright Mills documents the interconnected and overlapping of elite groups and details the truly undemocratic level of influence that these small groups have. He notes that in order to understand the American elite class, we must understand the following: 1) social and psychological similarities amongst the group; 2) the structure and mechanics of elite hierarchy; 3) elite cooperation as it varies in degree overtime is the result of elites realizing that their interests can best be served through cooperation (Mills 1956:21). In asking these questions, he identifies a centralized, interconnected, exclusive, and largely separate group of elite individuals connected by their wealth as well as by political and social connections. Small elite groups control the military, corporations, and national security—the three of which have become centralized to the point of convergence, allowing top positions in any of the power institutions to be interchangeable (6). While certain American classes have access to incredible health care options, and certain key stakeholders profit from health care and health insurance immensely, later chapters will show that this disparity is supported by *longue durée* American culture, including American notions of merit and stigma.

Lipset's faith in democracy as well as his belief that the state operates independently distinguishes him from his contemporary, Mills. Mills could not believe, as Lipset does, that the state would be capable of reshaping social life, since the socially elite control everything from the financial system to the professions to the military. Seemingly taking the legitimacy of American democracy for granted, Lipset is seeking to map the conditions which are needed to sustain a modern democracy, rather than expose how power moves within a democracy, as Wright Mills does. Lipset's conclusions could not be more different than Mills's, as he does not see American democracy as a system controlled by elites, corporations (including health insurance companies or the medical industry), or political in-crowds, but rather as a legitimate consensus. Almond and Verba also maintain a deep faith in democracy, as does Lipset. Though Mills's state is controlled by elites and Lipset's and Almond and Verba's state is a legitimately democratic one, the theories focus on the shape of the state and the way in which the state generates influence over society. However, these theories fail to account for the fact that governments and politics are created within a cultural context, and that these systems are generated to serve a particular culture with its own values, common sense, and symbols.

However, these studies laid the groundwork for important studies of democracy that do more to recognize the important role of culture. These new studies of democracy are different from the original studies of democracy within political sociology because they a) have very different research methodologies, namely, they rely less on statistics, b) make different assumptions about democracy, and c) are able to take new findings on globalization, race/gender/ethnicity, elitism, and pluralism into account. They are also more likely to examine social or political failure due to cultural change (Putnam 1993), than they are to study why the system is working, as Lipset (1960) and Almond and Verba (1963) do. This tends to be the case in newer studies on democracy and rights, as in Manza and Uggen’s work on felons’ voting rights (2006). This research is more inspired by social problems, many of which have increasingly come to light beyond the Cold War Era. They are also influenced by the cultural turn, which is why they do not completely overlook culture.

My work here assumes that while the integrity of our democracy may be questionable, the shape that policy takes and the arguments that surround it still must be compatible with core beliefs of the culture. This means that even if a political elite has more to do with shaping policy than voters, the political elite will still seek to justify its actions with culturally relevant arguments. As such, analysis of the arguments surrounding policy debates in a democracy remain valid sources of insight, even in less than ideal democracies. However, there are limits to what can be accepted by a culture, meaning that culture serves to limit policy or elite impact. This is especially visible in that the U.S. allows elites a particularly large sphere of influence when it comes to health care, while in France, health care is a culturally protected value, making it far less susceptible to attacks by elites.

The relevance of culture to politics became apparent to politicians in the 1940s. Political consulting, which became an American institution starting in the 1940s, has made and destroyed campaigns (starting with Earl Warren's push for a California universal healthcare system, and immediately followed by the destruction of Truman's attempt at a national health system) by using the entire arsenal of marketing and market research techniques in the service of politics (Lepore 2012). The practice of engaging in extensive focus groups for the message testing of campaign speeches, policy names, and platforms has meant that every political message is exhaustively vetted to ensure maximum impact, relevance, and resonance. This expensive and debatably democratic practice results in political rhetoric designed with the consumers of policy and politics in mind. These consumers, of course, are normal everyday citizens and voters. Politics is a product which seeks to deliver an enticing message by mobilizing values, reinforcing and appealing to affects, attitudes, and other culturally derived orientations, in order to inspire actors to create a political strategy, or choose a political action via their vote and their other political activities. Authentically democratic or not, our political debates are designed with our culture and values in mind, and our policies are marketed and explained to us in exactly the same way. As Elizabeth Rosenthal points out in her book *An American Sickness*, health care initiatives are named in ways that will appeal to the public, and cultural expectations about the role of insurance, employers, and medicine shape demands for certain types of programs (Rosenthal 2017:17-19).

Bringing the Analysis Up to Date

Even without addressing the ramifications of political consulting, prior theorists were promoting the idea that politics and culture are closely involved. A preeminent sociologist of this nexus, Mabel Berezin (1997) argues that politics and culture are not even separable. She identifies four areas in which this is particularly clear: 1) political culture, concerned with democracy and civil society; 2) institutions, including the state and citizenship; 3) political communication and meaning; and 4) cultural approaches to collective action. Berezin also defines the important distinction between "politics and culture" and "political culture." She states that politics and culture "suggests that there are broad cultural themes that are sometimes mobilized in the service of politics and sometimes not. These themes would exist independently of their political uses" (Berezin 1997:363). "Political culture" according to Berezin, is a "matrix of meanings embodied in expressive symbols, practices, and beliefs that constitute ordinary politics in a bounded collectivity" (1997:364).

Berezin contends that cultural themes may or may not be mobilized in service of politics. Though I might be able to imagine situations where cultural themes are not mobilized in politics, I do find it rather difficult. Imagining politics without cultural themes is something like imagining politics without themes at all. Perhaps politics are less culturally informed when they are less public-facing, yet it seems just a bit imprecise to not specify when culture may or may not be active when it comes to culture. However, Berezin's conception of political culture as a matrix of meanings is extremely powerful. Though I am not truly sure how a "matrix of meaning" might be different from a "web of significance," the application of the concept to politics is essential. It provides us with a with a way to situate politics within everything that our culture is made from. In examining health care debates, we can reconstruct a "matrix of meaning" or a "web of significance" that we can use to unearth greater insights into the political culture of these two countries. Such an endeavor can also allow us to isolate particular elements within the culture matrix or web for later study.

Still, this culturally situated politics is not complete if we do not consider the very real fact that actors are constantly making decisions, even as they form their political opinions, create political advertisements, or write newspaper editorials. One way of analyzing this constant decision making process would be to look at practice orientated formulations of culture. A useful tool for this is Ann Swidler's updated toolkit model of culture in *Talk of Love* (2001). In this formulation, she relies more heavily on Weber than she did for her original model, though individual action is still very important to her. Swidler notes that Weber theorizes culture as the ideas that work as "switchmen" on the track of action, and that ideas influence action by shaping both motives and means (2001:45). Here, ideas provide the ends and constrain the means by which individuals may act (Swidler 2001:78). However, in order to have this power ideas must be coherent, or "rationalized" and applied to daily life. They lose all power if they are unsystematic (Swidler 2001:69). Weber's analysis of action largely focuses around the relationship between class and status claims, and the deductions that individuals would make in response to these (Swidler 2001:188). What is important here is that we have a model for understanding ideas and status as the determinants for leveraging cultural tools.

Ideas, their generation, and their impact on action become especially important to Swidler as she discusses settled and unsettled times. These distinctly different types of historical moments have a great impact on how culture is used as an organizing societal force. This concept is especially important to my analysis of health care, since the post-World War II period was when both countries laid the groundwork for what their health systems would become. France and the U.S. were most certainly both unsettled by the war and the immense post-war efforts to rebuild both physical and social infrastructure and to welcome veterans back into society. According to Swidler (2001), settled times are those times where actors are secure and not in a period of cultural innovation or flux. During settled times, culture and life experience seem to reinforce each other, making it difficult to discern what is truly cultural. Practice undergoes less self-examination, since it seems natural and logical, and individuals are less likely to feel disturbed by new or different cultural elements. The cultural system is stable.

During unsettled times, culture influences action very directly, because change requires individuals to acquire new behaviors and modes of thinking. As a result, the systematized and explicit part of culture has a very discernible influence during these periods of change. When expectations, needs, and the economy are shifting in response to wider societal or economic changes, agents seek coherent ideologies to organize their action, therefore, ideologies will be stringently applied. Individuals in this phase seek high levels of congruency between their experience and culture, so they will reconcile their actions with culture. This means that in unsettled times, culture has a greater influence on actions (Swidler 2001:100).

According to this important theory, we would expect that culture, and more specifically national ideologies and values, were extremely prominent as the French were building their healthcare system during the unsettled times after World War II in 1945. As a major step in establishing the Fifth Republic after the war, French health policy making in de Gaulle's transitional governments needed to be emblematic of what the society aspired to. Every new policy created during this time would be a reflection of a society clinging to cultural codes for direction and identity. Equally unsettled, the U.S. of the post-war and early Cold War era was adapting to a new position of global power and taking a staunch stand against communism. U.S. policy also reflected a society with a strong need to use its values to determine its direction going forward. As we will see in the later chapters of this dissertation that delve into the public sphere discourse, cultural references to established values were especially pronounced in both countries during these times.

Eckstein's models of political change (1988) are also worth considering in answering the questions at hand, whether we are examining settled or unsettled times. He writes about two broad types of changes. First, those that arise naturally from changes in situations and structural conditions, second, those that arise from artifice, or direct attempts to change political structures or behavior. Eckstein notes novel situations are usually more challenging to deal with, and that new developments, especially economic developments, can cause confusion on either an individual or societal level. However, Eckstein believes that culture has inertia, and that patterns will often continue in a new form that is adapted to the developments (1988:794). Culture can absorb structural changes without being massively disturbed (Eckstein 1988:795), because it is likely to become malleable while still retaining its defining characteristics. Its dogmas are likely to be reinterpreted to fit new developments. While Eckstein does not close the loop on how culture influences policy or the shape of the state, his theory does explain why political discourse must continue to resonate with the same, familiar cultural elements for many, many decades. In other words, he explains *longue durée* culture. The differing health policy outcomes in the U.S. and France, despite their democratic, developmental, and economic similarities, attest to the fact that policies must align with culture in order to garner enough public support to be successful.

To shed more light on how health care-related unsettled times might be navigated, it is useful to combine Swidler's and Eckstein's theories. While Swidler (2001) points out that disrupted individuals are likely to lean on culture for identity in times of change, Eckstein (1988) points out that culture has an inertia that can survive multiple types of political change. The culture that people fall back on when things are in flux is thus very stable, potentially old, familiar, and deep-seated. Culture and its inertia is called upon in these instances. As we will see in later chapters, the same language about health appears in decade after decade for this reason. Again, we can apply this theory to both France and the U.S. We see that there have indeed been many types of political changes since 1945 in both countries, and that, as I will demonstrate later, the culture and values reflected in political rhetoric have remained quite stable. During the Obamacare debates, a truly new, unsettled time regarding health care, we see great reliance on the oldest culturally-enshrined language, both in the critiques of the plan as well as in discussions of the plan itself.

When I imagine troubling, unsettled times, and a social group that relies upon its culture to remain centered, I think of our notions of common sense. In a confusing time, common sense is a grounding, centering, and obvious comfort. While it may seem that culture is ad hoc in these instances, it is not devised to serve the purpose of creating stability and comfort in times of change. Rather, it simply provides comfort because of its naturalness in times when things feel unnatural; it is simply providing relief due to its very nature. Of course, Geertz's theories of common sense are among the most influential for understanding how common sense could fulfill this role. Geertz observes several recurring characteristics of common sense. These characteristics are naturalness, practicalness, simpleness, immethodicalness, accessibleness. Yet, common sense is so fabulously diverse that we must look for it in all sorts of places within a culture. I would posit that we should also be looking for it even within our politics. Geertz describes common sense wisdom thusly: "Common-sense wisdom is shamelessly and unapologetically ad hoc. It comes in epigrams, proverbs, obiter dicta, jokes, anecdotes, contes morals—a clatter of gnomic utterances—not in formal doctrines, axiomized theories, or architectonic dogmas" (Geertz 1975). Geertz's common sense is part of the web-like thing of culture that holds us in place so effectively that we can barely notice it.

To update these questions, Gorge Steinmetz assembles several critical articles by diverse scholars in the space in his volume *State/Culture: State Formation After the Cultural Turn* (1999). He believes that previous conceptualizations of culture as influenced by the state, or weak versions of culture that reduce down to national values are incomplete, and do not afford culture its true formative role (Steinmetz 1999:3). To rectify this issue in accordance with Steinmetz's views, the viewpoints contained in the volume

> … make powerful claims for the shaping of states by culture, whereas others emphasize causal flows running in both directions—and some reject the analytical distinction between culture and nonculture altogether. Some emphasize linguistically mediated culture, and others focus on nonlinguistic forms of subjectivity. Some analyze culture in structuralist terms; other deconstruct the categories and meanings of the state. What all the contributions share is a willingness to take culture seriously, to view it as more than simply a 'dependent variable' or product of a supposedly more fundamental, acultural phenomena. (Steinmetz 1999:3)

Though it seems that Steinmetz endorses several readings of the of the relationship between culture and the state, what is undeniable is that he views culture as a central independent variable capable of shaping the state.

However, as we will see in later chapters, the state can also leverage existing culture to advance goals. The culture leveraged must be resonant, of *longue durée*, and have the type of momentum and inertia described by Eckstein. In *State/Culture*, Berezin (1999:355) examines how Mussolini leveraged the existing culture and emotions surrounding religion and family to construct Fascist citizens. She notes that "the Italian case suggests that even a regime that claims to be totalitarian cannot create a national aesthetic" (Berezin 1999:355). In an earlier article on the same topic, Berezin finds that Italian fascism was not strong enough to influence the output of Italian cultural institutions, indicating that culture stands up to even a repressive state (Berezin 1991). She writes, “tradition and popular taste will daunt even the most dedicated and repressive regime. Propaganda is useless if no one sees it. Cultural products must resonate sufficiently with past cultural experience to command an audience” (Berezin 1991:644). From Berezin’s work, we learn that while states may use or manipulate culture, they cannot create culture. They most certainly cannot use or create a culture that does not resonate with current and established culture.

From Berezin, we can better understand why the forms of health care in the U.S. and France have been so enduring. She writes, “I show that even a regime that claimed to be totalitarian could not completely redesign a cultural institution. Political process—the interaction between specific historical constraints and opportunities—superseded ideological imperatives in policy formation” (Berezin 1991:648). In later chapters of this dissertation, we will see that France’s *securité sociale* has many of the aspects of a cultural institution, as does private health care in the U.S. This is why these systems have been so enduring, and in the American case, why such a broken system has been so difficult to repair. Given that changing a cultural institution is work that even the most oppressive regimes have great difficulty accomplishing, it is no surprise that a non-oppressive democratic government has not been able to impact the culture that supports these systems.

Health Care as a Culturally Variable Aspect of Citizenship

It is also important to consider theories of rights and citizenship in this examination of health policy. Health care, along with the other social rights that are administered by social security, is considered a human right in France and in the European Union. On the French *securité sociale* website, on a page titled "Understanding Social Security" visitors are informed that "social security rests on two principal texts." These texts are the Ordinance of October 4th 1945, and the Universal Declaration of Human Rights of 1948 (*Securité sociale* 2018). Basing the *securité sociale* system on these two documents illustrates that *securité sociale* is seen as a primary way of guaranteeing human rights to those living in France. This system is therefore synonymous with the protection of human rights. As we will see in later chapters, this is a crucial part of French culture, though it happens to take the form of rights and the political structures that protect them. In the U.S., anything beyond emergency health services is most commonly treated as a consumer service or as an employment benefit, not as a right (Rosenthal 2017:17-19). It is a perk or a benefit, but not an inalienable human right that the state has a moral obligation to guarantee. This large difference in ideas, which is held in place by culture as per Geertz, has had massive impacts on policy. As we will see in later chapters, this lack of rights and the private sector systems that have arisen to provide the service or employment benefit of health care is also culturally defined.

The U.S. is quite the outlier among developed democracies in its treatment of health care, which stems from the idea that it is not a human right. T. H. Marshall's (1998) theory of citizenship would have us expect the U.S. to offer health care rights as extensively as European countries. In his typology, increasing rights became available to increasing numbers of citizens as democracy matured. A citizen was someone to whom these rights were given, based upon their inclusion in the national community. These rights drive social equality, and for him, are the marker of modern citizenship in modern societies. Marshall states: "the modern drive towards social equality is, I believe, the latest phase of an evolution of citizenship which has been in continuous progress for some two hundred and fifty years" (1998:93). It is argued that

Marshall’s typology does not allow for the removal or weakening of rights, despite the fact that we have frequently seen the reduction of social rights, or that rights may develop in an order different than he theorizes, especially outside of western Europe (O’Donnel 2001). More importantly, Marshall assumes that the mature state develops both the capacity as well as the desire to extend rights to their citizens, and that rights are defined similarly across cultures. Our comparison of the U.S. and France suggests that these latter two assumptions are likely false.

Citizenship has been a larger consideration than rights within political sociology, perhaps partially because *longue durée* culture has not been integrated into most political studies. Sommers and Robberts (2008) note that sociology has spent far more effort theorizing citizenship than it has spent on rights. They note that sociology prefers citizenship to rights, despite the fact that citizenship *includes* rights (Sommers and Robberts 2008). Sommers and Robberts conclude that this is partially due to the fact that citizenship is easier to interrogate than rights, which are more likely the subjects of philosophy. They note: “citizenship is a social artifact of law, politics, and the public sphere… Rights (in the abstract) are theorized to be found in a notional state of nature alleged to protect against coercive state power and political tyranny.” It follows that “Rights take the form of claims and in this sense are made intrapsychic (we use the language of rights consciousness, but rarely that of citizenship consciousness), so in this sense rights are less substantive and less a natural target for sociological analysis, although social movements to secure rights have long been studied” (Sommers and Robberts 2008:387). In order to circumvent this difficulty, this dissertation examines how rights are discussed in political discourse. It examines the values that can be detected in discussions of rights, and the way in which appeals to rights are made in the service of health care debates. I am not examining rights as intrinsic things or moral truths. What matters is how they are discussed when it comes to health and society. I have found, of course, that France is much more generous than the U.S. in its vision of both human rights and citizenship rights. Of course, this is a feature of *longue durée* culture, and the differences are clearly visible in our health policy. As such, we can see that the features of citizenship and the definition of rights are culturally defined.

Other scholars have provided very useful readings of rights as social policies that indicate the overall status of particular groups in society. The approach of interpreting institutions for their content, meaning, and what they indicate about the values of a society, and the place of individuals allows for a deeper examination of social policy and status as seen through the lens of meaning. Judith Shklar (1991) approaches the problem of citizenship from such an angle. She interprets the historical meanings of American citizenship as struggles for standing, not just for rights. These struggles are culturally defined in that groups that are marginalized are in their weaker positions due to challenges that stem from culture. These struggles among American women and blacks translated into demands for inclusion in the political community in the forms of voting and earning, and were eventually met with greater inclusions. Rather, the social classification of individuals and how it translates into specific rights is the most important. For Shklar (1991), the historical struggle for inclusion indicates as much about the society as does the present institutions. Her work is powerful because she makes her point in few pages, and shows us how the historical moments speak to the condition of American society. I endeavor to provide an equally rich analysis of the meanings of these two country's health institutions.

But as Swidler teaches us, culture lives in practices and behaviors as well as in meanings and values. Kathleen Jones provides a gendered critique of citizenship, which places behavior at the center of citizenship. She notes that "Whom we recognize as citizens depends upon what qualifies as the behavior of citizens" (Jones 1998:223). In Jones's conception, citizenship is not universal and cannot be based upon rights. Instead, it is predicated on behavior. This theory also takes the definition of citizenship away from passport status granted by the state, and locates it in individual action and social conditions. For Jones (1998), the decentered state's ability to regulate meaningful citizenship policy is almost inconsequential, since the state cannot re-engineer social condition, behavior, or culture. In this analysis, Jones moves away from the actual content of institutions and policy, instead basing her analysis on behavior and experience. This methodology is dissimilar from my own method, but it is nonetheless very useful, as it points out the differences in what institutions are dictating formally and the realities of what the institutions create. In the case here, it is not gender, but class, defined as the behavior of earning or not earning a low enough income, that causes citizens to fall into different classes of rights. The ACA dictates that health insurance should be accessible to all. However, in 2018, despite the legislation, premium costs have risen to the point where many middle-class Americans cannot actually access health insurance. In late 2017, approximately 7.5 million Americans purchased health insurance individually and received no ACA subsidy. With premium hikes of up to 50% in one year, many middle class families are so squeezed by prices that health coverage is simply no longer an option. Falling into the wrong income bracket cuts many middle-class families off from this right. Similarly, Choudhry (2010) notes that although bills of rights are central and quasi-obligatory to any new constitution, these theoretically guaranteed rights are not necessarily guaranteed in practice. Rather, the inclusion of a bill of rights is more standard practice in order to keep the new constitution from coming under international scrutiny. Due to significant news coverage, it is certainly not a secret to our neighbors around the world that Americans do not have health rights even after the ACA. Also, it is not a secret to Americans that the citizens of other nations do have health rights. However, it seems that these international pressures have not yet been enough to spread health rights to the U.S. This is because culture is stronger than the influence of rights that may be granted in other countries. Choudhry also encourages an analysis of what rights are actually being granted as opposed to what the state might be promising simply in order to live up to international norms. This is an especially important consideration in our globalized world.

In its narrowest conception, the welfare state is thought of as any state run financial redistributive system meant to guarantee the basics of human necessity and provide protection from the shocks of the market (Wilensky 1974). By this definition, health care provided by the state might only be a welfare program if it is available only to the needy or the poor. If health care is a service distributed to every citizen, its redistributive effect as a program is smaller than that of housing programs or food benefits like SNAP or WIC. Discomfort with redistributive programs is particularly American, and has fueled the rejection and general stigmatization of welfare programs and social programs across the country. France has not been without debates over the level of support for the poor or the level of redistribution. However, like most European societies, these programs are mostly viewed as essential to maintaining a healthy society. These differences of opinion are *longue durée* cultural beliefs which have influenced the shape of welfare policy.

Studies of the welfare state range from historical analysis of its origins, to its political functions, to its relative strength over time. Some of these argue that it arose in opposition to socialism and laissez-faire liberalism (Janoski, Alford, Hicks and Schwartz 2005), or that the welfare state was instrumental in stabilizing absolutist rule (Janoski, Alford, Hicks and Schwartz 2005). Other studies emphasize the state's capacity for diagnosis of social problems through welfare policy (Janoski, Alford Hicks and Schwartz 2005), or examine the state's role in the reform of clientelistic systems (Orloff and Skocpol 1984). Pierson (1994) argues that despite critics' fears, the welfare state has not in fact been retrenched, largely because the Regan and Thatcher administrations were not politically strong enough to do so. These studies do an excellent job describing individual mechanisms of the welfare state, but most do not aim to explain that these systems arise from the culture that they serve, nor that these cultures greatly impact the shape of these policies.

Chad Allen Goldberg (2007) shows that American citizenship and the welfare state went through very messy periods of reshaping as we transitioned from poor relief policies to welfare state policies. He argues that the rights of American welfare recipients are frequently limited, placing them into different citizenship categories than those who receive no aid. These struggles embody debates about what it means to be a full citizen. As I consider the question of health care in light of Goldberg's work, I see that these struggles are still present in today's health debates.

Cultural explanations for the welfare state, or for other public policy, have become increasingly popular in political sociology. Beland argues that the ideological repertoire in any given country must be invoked successfully any time a policy is changed or created, even before the legislative moment (2005:4). He finds that because of this, race is invoked far more in debates of the American welfare state, despite the fact that the impacts of welfare policy on gender are far greater. I find this to be true up to a certain point in the American health care debate. However, while Beland (2005) notes that ideological repertoire is invoked even before the legislative moment, this theory does not recognize that these repertoires are more than just repertoires. They are enduring pieces of *longue durée* culture that have the power to change the shape of vast political institutions that serve entire national communities.

I take all of these theories as a jumping off point for my analysis. They have led me to a vision of rights, citizenship, and health care that are uniquely informed by culture. Clearly, my vision of *longue durée* culture is stronger than many, though it also allows ample room for the choices of actors as part of that *longue durée* culture. my analysis focuses on the uniquely French and American aspects of the respective countries' health care debates. From these, there is much to learn not only about beliefs about health in the two countries, but also about the pieces of their *longue durée* culture which inform their political institutions.

CHAPTER TWO:

HISTORICAL ORIGINS

Historical Origins

Health policy in both France and the U.S. has been slowly crafted over the past seven decades. While the real starting point for my analysis is 1945, and while I focus primarily on just a few key policy innovations, it is important to have a larger perspective on the evolution of these two health systems. So, this chapter is exactly that—an overview of major health policy innovations in both the U.S. and France. It includes innovations in technology, medical care, and major historical events that are analytically important for explaining the development of health policy. Some of these innovations have served as policy disruptors, and some have invoked great cultural discussion. Policy must react to these changes, and the policy reactions provide insight into the *longue durée* cultural underpinnings of these political systems. Whenever a society is in unsettled times of rapid change, as in the post-World War II period when modern health care and welfare systems were established, it relies upon its deep culture as an ideological guide (Swidler 2001:100). The deeply unsettled times following World War II led both the U.S. and France to draw on their deepest, most ideological versions of *longue durée* culture to inform the creation of health care policies that would set the stage for now nearly a century of health care policies. This chapter will demonstrate the impact of French and American *longue durée* culture on the shape of health care policies in these two countries. In France, for example, the collective was leveraged in service of health care, and "illness was no longer considered as an expiatory plague attacking individuals; it was, rather, a collective danger from which society must protect itself" (Dumons and Pollet 2002). Indeed, the post-war period was a pivotal moment in health care, where the decisions made in accordance with *longue durée* culture would create the policy frameworks that would endure for generations.

The inspiration for many of the world's greatest health systems came from the Bismarckian welfare state's health policy, the "Sickness Insurance Law" which was created in 1883. The goals of this system were to create a way to pay for health that imposed minimal extra taxes, was universal and mandatory, and protected citizens from the everyday calamity of illness. The system was financed through payroll withholdings and payroll taxes on employers. It is the base model for the currently existing French and the American healthcare systems, as well as many other systems around the world.

Otto von Bismarck called his welfare system *Der Staatssozialismus*, or state socialism, and further referred to it as "a program of applied Christianity" (Reid 2009:73). Expanded social rights replaced expanded political rights under his regime, and the programs served to unify what was at the time a new nation. Perhaps most importantly, social rights financed by payroll taxes were a Bismarckian innovation. France, the U.S., and many other countries still use this system to fund an important part of their social programs.

Still, despite today's use of a structurally Bismarckian system, Americans for generations have been using the origin of these health care schemas as a reason to invalidate them. These arguments first arose before Medicare was created, thus predating the American use of this system as a way to finance health care. Consider the following letter. In it, Lewis J. Moorman, editor in chief and secretary treasurer of the Oklahoma State Medical Association, writes to Truman about his feelings regarding Truman's plans for health reform. He writes,

> Recently the world was shocked by the revelation of mass medical murder in Germany under the Hitler regime. This could never have happened if Bismarck had not clandestinely murdered the free spirit of medicine and of the people through his social security program including compulsory health insurance… One

> hundred years of compulsion in Germany destroyed professional freedom, robbed the individual doctor of personal liberty, and left him without a choice between right and wrong. Because of the inferior quality of regimented medicine, it represents insidious mass murder which gets under way as soon as any compulsory health insurance program is instituted… Democracy is destroyed by so-called social security and Government paternalism. (Moorman n.d.)

While Moorman himself certainly seems to believe that Bismarckian national healthcare can be blamed for the Holocaust, his argument does not clearly or convincingly connect the two events. The logical and argumentative lapse indicates that his comments are ideologically and *longue durée* culture based—as we can expect them to be given what we know from Swidler about the nature and needs of unsettled times. As we will see in later chapters, arguments similar to this one in its color, anger, and likening of national healthcare to socialism and communism are still made throughout the Obama era as well.

Moorman is not the only person to use Bismarck to argue against American health policy reforms or extentions. For now, consider the following. Michael Bernstam, writing for *Fox News*, uses Bismarck to argue that the Affordable Care Act (ACA) is an impossible proposition. He writes: "Ever since Chancellor Bismarck introduced national health insurance in Germany in 1883, nations have struggled with the above trilemma of universality, comprehensiveness, and affordability" (Bernstam 2013). With a very quick analysis of other healthcare systems, Bernstam argues that national health insurance can never achieve its central objectives of being universal, comprehensive, and affordable. He argues that the ACA is inherently impossible, largely because other healthcare systems have not been able to perfectly meet all of their inherent objectives. Though his argument reads as more practical than ideological or emotional, a deeper anti-national healthcare leaning is certainly detectable. Here, Bismarck is used to dismiss the ACA not because national healthcare systems destroy freedom or causes murder, but because when the successes and failures of historical healthcare systems like Bismarck's are undermined with a very superficial examination of their effectiveness, they can be used to discredit current policy due to the way that it is related to that historical policy.

In the U.S., payroll taxes go towards financing social security and Medicare, but not health care for the general population (Marmor 2000). Since only a minority of Americans are eligible for Medicaid, since Medicaid programs receive about 60% of their funding from states, and since the origin and generosity of these funds vary widely by state, this program has no egalitarian appeal (Marmor 2000). Still, as will be discussed in later chapters of this dissertation, there are cultural beliefs which hold up these less egalitarian taxes, funding, and health policies. The point is not that tax structures dictate how people feel about social programs, but that how people feel about social programs shapes the required tax structures and policies.

What is most interesting in contrast to the American illustrations above, is that as opposed to disparaging national healthcare for its Bismarckian origins, the French are more likely to debate the merits of Bismarckian and Beveridigian methods for extending social rights (*Alternatives Economiques* 1995; Leparmentier 2015; *Les Echos* 1997). It is less a matter of debating whether citizens should have social rights including health care, and more a debate about how this could be best accomplished. One letter to the editor in *Les Echos* (1997) reflects on the differences between policies that redistribute funds from single taxpayers to families versus a policy that redistributes from wealthy taxpayers to taxpayers with lower incomes. The writer reflects that ultimately, France has attempted a policy that blends both Beverdigian and Bismarckian policy. The writer fears that universal coverage may be maintained, but only at a very low level of service, due to financial inefficiencies of the French system. Ultimately, the writer prefers Bismarckien policy to Beverdigian policy, because the writer feels that Bismarckien policy is better able to sufficiently cover families when hardship arrives, even if there are lower coverages during periods that do not include hardship. Here, the right to access health comes into play most clearly when workers are most vulnerable. This viewpoint is nuanced, and it is largely contrary to much of French thought on the matter. What it illustrates is that in France, even those who find fault with the system agree that social protections are crucial rights. They do not simply disparage the system due to its "German" origins or "socialist" origins. In the face of unsettled health care times, the French discuss how best to distribute funding throughout the greater system of social protections, defaulting to the *longue durée* cultural concept of social protections, including health care, as fundamental rights.

Still, what is most impressive about the Bismarckian payroll tax financing system is that the Germans have not only preserved this system, but that it has been modified and adopted by many other countries. Perhaps because of the clear heritage of these systems, ideologically charged criticisms have remained one of the best ways to turn the public against any health care proposal in the U.S. Most commonly, calling even a minor policy change "socialist" is a certain way to alienate many American voters. While this topic will be examined in more depth in subsequent chapters, consider the following article from ABC News by Daniel Rivero. Rivero's 2013 article, "Why Calling Obamacare Socialism Makes No Sense: It's Not Socialism, and We Need a New Label for What's Going On," clearly would never have been written if the ACA had not been continuously called a socialist policy by all sorts of commentators, critics, and writers of letters to the editor. In the article, Rivero aptly notes, "The conservative debate over the individual mandate is one largely of semantics. It assumes that if the government mandates something, that it is overreaching its power and inching the country closer to socialism" (Rivero 2013). This article neatly attests to the reality that calling policies socialist is a quick and easy, *longue durée* culture way of disparaging a policy.

Fear, Trust, and Socialism

Even policies which rely exclusively on private medicine or private health insurance providers can "credibly" be stained as socialist. This is exactly what happened with the ACA, where it was not the origin of the funding for the program, but the mandate to acquire health insurance and the subsidies to consumers which were attacked as socialist. But, why would modern American programs be attacked as socialist? Citing Robert Putnam's work comparing southern and northern Italy, Lixing Sun (2016) argues that the key factor in Americans' fears about social programs in general, and quickness to reject anything that they can call socialist is a lack of trust. I believe that this societal and cultural lack of trust has long and deep roots that have endured because they have evolved out of the alignment of *longue durée* culture and values.

There are many pieces of deep mistrust embedded within American culture. Some have historical roots, others political, and many are class or ethnically based. Trust, however, is culturally created or conditioned. Eric Uslaner, in his work about societal trust, explains: "In many ways, trust is cultural. Individualist societies are more trusting than collectivist ones. And that explains why trust is an enduring value. Trust *does* vary over time, but it is rather stable across individuals and especially across countries… Trust not only carries over from one generation to another, but also within ethnic groups moving from one nation to another" (Uslaner 2002:252). There are several cultural origins for the distrust that Uslaner finds is growing in the U.S. Uslaner explains: "As inequality grows, the perception that people have a common stake in society's well being withers" (2002:253). Growing American inequality is extensively documented elsewhere, however, there are many other factors that have also contributed to American distrust that have become deeper and more divisive over generations. McCarthyism relied on suspicion, lack of trust, and fear at the moment when European countries were working out their social programs, including health care. Racial distrust and distrust of the poor underlie the distrust of black welfare recipients (Hancock 2004). Anti-immigrant sentiment has grown during the Trump era. All of these factors, combined with a complex ethnic heterogeneity and growing inequality mean that it is culturally difficult to garner support for a national healthcare initiative in the U.S. Sharing costs and risks across populations that are culturally less trusting is simply difficult. Given low levels of trust in the U.S., which are cultural in their reproduction and *longue durée* staying power as per Uslaner, it is not surprising that national healthcare programs only exist for the most trustworthy and meritorious of all populations, such as the elderly and veterans. Medicare for the poor is a begrudging allowance in these conditions, and it is unsurprising that national healthcare programs have not been able to survive long enough to become effective and truly widespread.

First Efforts

The French are quick to identify 1945 as the start of their modern health insurance system, and of course they are right. This is the moment when French society truly mobilized to make health care a national priority, drawing upon *longue durée* culture to navigate unsettled times. Health care moved into the public sphere and became the responsibility of the collective and the government, and French values like solidarity were drawn upon to orient changes in this arena (Dumons and Pollet 2002). But, just like in the U.S., there were largely employer based and industry-based insurance plans before this time in France. The legislation of April 5th, 1928 and April 30, 1930 established these plans (Dutton 2002). They included health insurance, disability, maternity support, old age pensions, and life insurance if the employee died in the line of work. These first programs were criticized by the CGT, the powerful communist union, as fascist less because they were compulsory and more because they effectively created strong ties between employers and employees (Dreyfus 2005:133-144; Simon 1987). It is easy to understand why the CGT would question this link. Consider the following text from the 1943 *Ministre de l'interieur*:

> The Council approved the decisions made by the Committee of the Workforce in France, to provide workers to certain sectors of the economy where more workers are needed. Doctor Grasset, secretary of the State of Health and Family, brought it to the attention of the ministers that the sanitary services must be taken to assure good hygiene among workers. Supplementary credits will be given to him so that he can make sure that preventative measures can be taken and contagious diseases can be treated.[9] (Ministre de l'interieur 1943)

It is rather clear here that health services are not being provided to these workers so that they may enjoy a higher quality of life. Rather, health care is being extended so that hygiene and communicable illnesses are less likely to negatively impact the workforce and the productivity of the industry that depends upon them. This is rather unlike the concept of health rights, where there is no expected benefit to either industry or the state as a result of the extension of health care. In the case of health rights, the only expected beneficiary would be the person receiving medical care, not the state, and not the industry, factory, or company that benefits from a healthy workforce.

Given this, it is easy to see why the CGT might not trust employers, making these programs unpalatable. The CGT worried that health benefits granted by employers would make workers dangerously dependent on their employers. French workers at that time could lose their health benefits if they went on strike, and just like in the U.S. today, even after the ACA, losing a job or changing jobs would usually mean that a person would lose their current employer

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[9] My translation.

sponsored health coverage (Dutton 2002). In opposing a national healthcare system, an organization like the CGT would be reverting to its own established ideology to help guide its way via *longue durée* culture during an unsettled time in health care policy. While it is now rather uncontested that *assurance maladie* is beneficial for French workers as long as the system is not retrenched and made inegalitarian, this could not have been clear to the CGT prior to the establishment of the system. In needing to take a stance and fulfill its mission of protecting workers, the organization would have needed an established, trusted, and reproduced-within-its-own-institution cultural-ideological lamppost to guide its official political positions.

The CGT was not the only French organization or population that was initially wary of social security including *assurance maladie.* Consider the following advertisement by the (*Confédération des syndicats médicaux français*), Confederation of French Medical Unions. Proudly displayed at the Musée national de l'Assurance maladie (National Museum of Health Insurance) in Bordeaux, the advertisement from 1929 reads:

> To the future socially insured: Note that the Medical Corps is not opposed to the principal of social insurance, but, it does not want to help support caricatured insurances… The Medical Corps wants the socially insured to benefit from the same treatment as its private clients. To achieve this goal, French doctors demand: free choice of doctor by the patient, respect of patient privacy, direct dealings between the patient and the doctor, therapeutic freedom and all the remedies needed that should be prescribed to the socially insured, processing of payments for patients via insurance bodies and medical unions. Under these conditions, the doctors will collaborate with the law of April 5th 1928. They want to provide patients with normal medicine. (Confédération des syndicats médicaux Français 1929)[10]

As we will see in later chapters, the critique from the French medical profession is more aligned with health rights, supporting patients, and the ability to provide proper care than political critiques, fear of losing professional control, fear of government supervision, financial structure,

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[10] My translation.

or socialism. Here, French doctors, who were as strongly organized as American physicians, were asking for a more robust system, in which patients would have direct access to doctors, without an intermediary, an employer at that time. Societal trust does not seem low in this critique. Rather, the advertisement calls for a more robust system that could be properly extended to all, without compromising patient protections or freedoms.

With these examples, it is easy to see that social programs require a reproducible culture of societal trust in order to be appealing. This includes the trust that no one group will be taken advantage of, manipulated, oppressed, or exploited via a program that appears on face value to benefit them, as could be the case with medical coverage. As we understand from Uslaner (2002), trust is largely cultural and in part political. Societal trust requires the belief that individuals have a common stake in society. The CGT, representing workers that industry saw essentially as tools to be maintained in order to ensure high yields, certainly found it difficult to trust a conception of health insurance provided by employers. The *Confédération des syndicats médicaux Français* had doubts about the qualities of the health insurance program that was being provided and advocated for direct care that would give patients the freedom to access and choose doctors of their own accord. To guarantee proper care to patients, they could not trust a system that could come between a patient and a doctor, such as an employer managed system.

Social Security and Health Care in the U.S. and France

The term "social security" was brought into usage in the U.S. by FDR in 1932 during the New Deal. The French will later borrow this term as they expand their welfare state, but the term in France will take on a new and more cohesive meaning. In 1932 America, the term included workers compensation, disability, and old age insurance, or as it is still called today, Social

Security. These programs have pivotal economic and social roles in the country, despite being centralized government programs. Social Security is arguably the most important American social program, with any proposal to reform it having massive impacts on the viability of presidential candidates. Social Security is seen as an economic issue as much as it is seen as a social issue, and as Alvarez and Nagler find (1995, 1998), economic factors have great impacts on the outcomes of American elections. Social Security itself is also an ideological issue. Many have found that ideological issues are just as important as economic issues when it comes to capturing votes (Carmines and Stimson 1980; Jackson 1975; Key 1966; Page and Brody 1972; Page and Jones 1979; Pomper 1972 cited in Alvarez and Nagler 1995), doubling Social Security's importance in election years. Furthermore, Cook, Barabas, and Page (2002) find that policy elites ranging from subject matter experts, to congressional representatives, to interest group leaders all leverage public opinions as reflected in polls in their public discourse surrounding Social Security. This indicates that policy elites are speaking the language, reflecting the values, and reflecting the desires of constituents in their policy discourse leading up to elections.

The fact that Social Security has never been seen as a consumer commodity, the way that health care has been seen, may explain why its traditionally Bismarckian funding sources have not offended most American voters. More importantly, in the U.S., Social Security benefits the elderly or disabled population in the main. In the U.S., the elderly merit care because they are trusted. They have already served society with a lifetime of work and tax contributions, and Social Security checks for the elderly are commensurate with the amount of taxes an individual has paid. This apparently prevents critics from calling Social Recipients "free loaders" as they do with welfare and Medicaid recipients. Equally importantly, the elderly as a group are free from ethnic, cultural, or class stigma because simply being old does not indicate membership into any other groups stigmatized as untrustworthy, freeloading, lazy, or otherwise unworthy of support. All of these cultural factors work together to protect American Social Security from retrenchment, negative political discourse, and the stigmatization of its beneficiaries.

But why didn't FDR manage to create a health program as he was creating so many other policies? It would be tempting to believe that interest groups prevented FDR from moving forward with national health insurance, but despite the power of these groups, it is still not a satisfactory answer. As later chapters will show, the AMA was already lobbying against any sort of regulation of the health field at this time. The AMA objected that FDR's proposal was "compulsory insurance," and therefore objectionable, and the "socialism" of a government regulated or administered health insurance. These themes would resurface repeatedly, specifically in regards to health care, even up to the 2008 ACA.

An official historian of the Social Security Administration would disagree that FDR simply abandoned health insurance because of interest group resistance. This historian notes that even given the war effort, health issues were not simply cast aside. The historian states, "If anything, deficiencies in our healthcare system were underscored by the wartime strain of providing medical care on scores of military battlefields around the globe. And a congressional investigation of the high rate of draft rejections showed that between 30 and 40 percent of all draft-age men were physically or mentally unfit for military service" (Social Security Administration n.d.). In 1934 Roosevelt called for a social insurance system that extended "from the cradle to the grave," and the Wagner, Murray, Dingell bill, which was perhaps the most comprehensive social insurance bill in American history, was introduced (Social Security Administration n.d.). However, FDR did not endorse this bill, despite the fact that he continued to call for policies that would ensure the health security of Americans. Behind the scenes, the Social Security Board drafted a Presidential message on health matters that FDR never managed to deliver before his death in 1945 (Social Security Administration n.d.). FDR had in fact been working to advance health care for all Americans, but the war effort was grueling, and absorbed nearly all political resources at the time. Even more unfortunately, FDR simply did not live long enough to continue to work to establish national healthcare.

If FDR was spread too thin to work on health insurance or health care, it would have been because there was only so much available money and time available for policy. Though health programs were tacked onto other social assistance programs, such as the Farm Security Administration's efforts to help rural communities, no comprehensive national plan was attempted. As such, the need to establish health insurance systems was being felt. Prices were already rising, and science was providing solutions to a number of health issues that could not previously have been solved. The first private hospital and medical insurance plans were founded in this period, with Blue Cross in 1929 and Blue Shield ten years later. These plans were sold to employers for their employees, just as they are now. Over time, insurance benefits became an expected perk of middle class employment, and employer financed private insurance funds became the norm—just like in pre-World War II Germany; with the exception that the U.S. would not attempt any industry controls on medical care and insurance companies until the ACA in 2008. The reluctance to place any industry controls on medical care and insurance companies is cultural as well as political, and it indicates that Americans continue to prefer to trust corporations.

An official historian of the Social Security Administration believes that national health insurance was never enacted because of the inability to find a political compromise that suited both Republicans and Democrats, as well as intraparty disagreements about what should be done with policy. The historian notes that many in the U.S. believe that should there be a majority viewpoint, that viewpoint should be immediately acted upon by policy makers. Concurrently, the U.S. is sensitive to tyranny by the majority. Yet when there is a vocal but important and fiercely committed minority that opposes legislation, many believe that the policy procedure of going slowly in attempts to suit all sides should be followed (Social Security Administration n.d.). In the post-war period, Republicans remained unhappy with the New Deal, even if Democrats approved and overseas democracies were establishing their own Social Security systems, including national healthcare. If we agree with Social Security's own historian, U.S. political culture would not allow national health insurance to become a reality because opinion was too divided and because the minority felt too passionately about the subject. There was not enough of a cultural consensus or resonance for national healthcare legislation to pass. To this theory, I offer the cultural thesis that the particular blend of objections to national healthcare were particularly potent and difficult to overcome. Given the unsettled times of the post-war period, Americans defaulted to their *longue durée* culture and all of the ideology that this entailed. This meant that social programs like national health insurance were read as the creators of laziness, the harbingers of socialism or communism, killers of the individual inspiration to work hard, and the opposite of capitalism and democracy—essentially, all of the traits that allowed the U.S. to win World War II. Regardless of which voice was loudest or strongest, defaulting to these *longue durée* culture viewpoints in order to find stability during unsettled times has had the result of Americans going without national health insurance for generations.

During the economic hardships of the thirties, France also enacted major social insurance policies aimed at improving living conditions and stimulating the economy. Between 1929 and

1939, there were 10 major social security expansions, covering health, pensions, maternity and disability (Dutton 2007:66). Family welfare rights were also expanded three times in the same period. The *Musée de Assurance Maladie* commemorates this expansion with an exhibit near the entrance of the exhibit. The exhibit explains the first wave of these expansions:

> *The law of 4/20/1930 about social insurance for salaried workers in commerce and industry.* Three factors contributed to its creation: 1) The weak impact of health mutual insurances on the working class, due to the elective character of membership. 2) The failure of the law of 1910 about retired workers and farmers. 3) The return of Alsace and Lorraine, where the population benefitted, until now, from German social protection. *The themes of this law.* Obligatory coverage exclusively concerns the workers that have a salary that is inferior to the membership ceiling of about twice the salary of manual laborer. Executives also conserve the possibility of refusing to accept the social coverage. *Covered risks.* Sickness, disability, death, maternity, old age. *Free choice of insurer.* The socially insured can freely choose which insurer will insure them. A departmental insurer will insure the workers that do not make a choice. (Musée national de l'Assurance maladie n.d.b)[11]

First, it is clear that the French value social security and health insurance extremely highly via the *Musée de Assurance Maladie* (Museum of Health Insurance). France celebrates its *patrimoine* vociferously, whether it is artistic, cultural, or political, and creating a museum to health insurance is just one of the ways that it does so. Commemorating this particular piece of legislation is important because it indicates a particularly strong attachment to the fact that the most vulnerable, lower earning workers were among the first to be brought into the social insurance system. Furthermore, *Assurance maladie* was one of the first types of insurance offered through this program, even if a compulsory program is needed once a voluntary program has failed. Contrary to the U.S. case, it was not important to the French to conserve freedom of choice in so far as joining or not joining the social insurance program. This became especially true after voluntary insurance programs failed, as the exhibit explains. While there certainly may

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[11] My translation.

have been mixed feelings among workers about being forced into coverage, it was simply more important to protect these vulnerable populations from a rather significant number of social risks. The French chose social protection for the vulnerable over the absolute freedom of workers to remove themselves from the system.

In France, in 1938, all insurance, including, *Assurance maladie* was managed through insurers that were generally industry specific. The *Musée de Assurance Maladie* also commemorates these insurers. An exhibit next to the exhibit about the law of 4/20/1930 details all of the insurers that existed prior to the reforms 1945. In addition to the general departmental insurers, these insurers included insurers for veterans, gas company employees, maritime and colonial workers, wine and spirits industry, chemical industries, food industries, leatherworkers and hunters, and oil industry employees. The exhibit lists 32 insurers in total, most of which are industry specific (Musée national de l'Assurance maladie n.d.a). Non-industry specific insurers are location or department based.

These *caisses*, as they are still called, initially provided several types of insurance, as noted above. As in the U.S., there was no business interest to compete with in order to provide workman's compensation or unemployment insurance services or funding, so opposition to these programs was less organized and not very unified, even though the programs were seen as a tax increase on employees and employers alike (Dutton 2002). These taxes were more of an inconvenience or an annoyance, and they did come accompanied with a tangible service that could certainly provide benefits and security in times of need.

The differences in coverage rates in France and the U.S. certainly show which approach was most effective at getting people health coverage. By 1933, 25% of the French had health insurance under one of these programs, while in the U.S., only 6% were covered. By this time, the costs of medical care had just begun to become a concern in both the France and the U.S., though the rising costs were still manageable enough for many middle class individuals. In the U.S., they were certainly manageable enough for anyone who was covered through their employer. Though medical technology had not yet begun to advance at the exponential pace that it would hit after the war, hospital construction, the formalization of treatment procedures, and the growth of medical education and licensing, improvements like anesthesia, radiology and more advanced lab work had begun to drive basic prices upward. Working families had just started to worry about their ability to pay for illness should it occur, and for the first time, discussions about health insurance became as important as securing paid sick leave once had been (Dutton 2007:69).

Next Steps—Post World War II

World War II and its aftermath constituted an extremely unsettled time. As such, both France and the U.S. relied extensively on the most ideological versions of their respective *longue durée* cultures when assessing how best to move forward and meet the many challenges of the post-war era. The health policies that were created during this time directly corresponded to *longue durée* culture as a result, and the debates that surround these health policies invoke *longue durée* culture directly, clearly, succinctly, and unwaveringly. It was these conversations and these policies that would set both countries down their respective health policy paths.

From this point, in the U.S., private medical insurance provided by employers continued to grow, without further provisions for public medical care. Price controls and wage caps were implemented in an effort to stimulate the economy, create jobs, and foster investment. Employers, still wanting to be able to hire competitively in a time when labor was already scarce because of the war, offered medical plans and other benefits even more frequently, further cementing the expectation that these types of benefits would be provided by employers. In 1951, the IRS made these plans tax deductible for employers, and the generosity of the benefits packages became a significant form of compensation. Though employers were not required to provide any health care to their employees, the frequency with which they did so continued the expectation that health care would come with employment, and the idea that a person who was dutifully employed would be taken care of, no matter whether they had a union job or belonged to a profession. Of course, these "benefits" were never culturally referred to as rights. In the U.S., they were merely an expected perk of employment.

This is in great contrast to France, where health care made the transition from benefit to right easily, and was soon protected and expanded as such. Consider Jacque Doublet's 1955 article about the frontiers of "Social Security and Forming of International Rights." Doublet was the General Director of Social Security when he wrote this article. As a thought and policy leader, his writing tells us much about the direction that the French were endeavoring to go with social security at this moment. Doublet was concerned about the difficulty that foreign workers faced across Europe when they traveled. Namely, he was concerned about the fact that hard-won and "precious" rights could not follow workers across national boundaries because of specific policies about nationality, length of time in the country, or industry. He writes:

> For this reason, foreign nationality is often the source of hardship, since many rights are reserved for nationals, whether they are rights funded by the general budget, or whether they are advantages that address a strictly national policy, or require one to be born in the country… The efforts of European states have brought about a real internationalization of Social Security. Since the International Organization of Labor adopted Contention 102, fixing the minimums of social security, and since the Council of Europe put a European Code of Social Security in place, multiple negotiations intended to assure the necessary liaisons between national social security regimes so that the rights that are being successively acquired, in diverse regimes of affiliation, and to make

> them aware of the benefits which are due to them, regardless of their residence. For this reason, foreign nationality is often the source of hardship, since many rights are reserved for nationals, whether they are rights funded by the general budget, or whether they are advantages that address a strictly national policy, or require one to be born in the country. (Doublet 1955)[12]

It is truly remarkable that the General Director of Social Security is concerned about the rights of non-French workers in 1955. His concern for unbroken access to rights as they were being established throughout Europe speaks to a deep concern for the realities of workers in need of social protection, even across national borders. The belief that these protections should be made available, protected, and that they should follow workers as they move about Europe speaks to the desire for solidarity across the continent and above all to the deep belief that rights are essential, tied to humanity, and needed for society's development and progression. Emerging from World War II, the need for human rights and social rights was clear, and the French were eager to establish, protect, and expand these rights. During this period, the French are both reinforcing and expanding the *longue durée* culture of solidarity that orients their decision making in unsettled times.

In the U.S., any talk of medical care or health insurance as a right would take many more decades to begin to emerge, becoming a consideration only once many middle class American families were already suffering from want of medical care due to skyrocketing costs, unemployment, and employers backing away from providing "benefits" including health insurance. As we will see in later chapters, some Americans in the Clinton era begin to discuss health rights. However, no state action was taken to guarantee these rights to average citizens who are not elderly, disabled, indigent, or veterans until the ACA, which would eventually be retrenched by the Trump administration. Health care as a right or as solidarity is not part of

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[12] My translation.

American *longue durée* culture. Instead, it is more likely to be seen as a program that impinges upon personal freedoms, the quality of medical care, and as a political threat than as a right. Due to the cultural mismatch, efforts to expand health rights have not been successful, and those that have been marginally enlarged have quickly come under attack.

In France, once the war ended, there were many decisive long-range social decisions to be made. France brought Charles de Gaulle back, and with his provisional government, he set about creating programs to rebuild the country's social fabric as well as its infrastructure. De Gaulle's provisional government, together with the "father" of French social security, Pierre Laroque, established a long list of reforms. They founded the general social security regime, established that participation in the old age, health, maternity, and work accidents programs would be obligatory, set up a financing system of automatic payroll deductions and employer contributions, and established the goal of gradually covering the entire population by expanding the programs. This important project would be at the heart of French social policy for the next 70 years and continues to this day. It is often referenced in newspaper coverage, political discourse, and even in public service announcements for various parts of the social security system decades after the fact. For example, the outline for a television program discussing the 1987 *Etats généraux* social security debates reveal that the foundations of the social security reforms, specifically Pierre LaRoque's role in the formation of the system, were used as the introduction to the entire program (Market Place 1987). In France's post-war climate, societal trust and solidarity were at all-time highs, as is the case after societal trauma (Sun 2016), making the establishment of greater social protections culturally feasible.

At the same time, a significant amount of work also went into defining particular insurance regimes. The general regime aimed to regroup wage workers in the public and private sectors, agricultural workers, and independent workers and professionals. Through all of these reforms, special allowances that had been granted to more particular groups of workers or populations would be preserved, creating some more generous or specific benefits for specific classes of workers. Other legislation recognized and supported the role of the *mutuelles*, which would be derived from existing insurance funds, and which could be used to provide coverage for the costs not reimbursed by the health insurance provided by *Sécurité sociale*. Today, *mutuelles* are still an important feature of the French health insurance system. They are private, and there are over 400 of them in existence. These mostly private "health complements" (*complémentaire santé*) cover any health costs that go above and beyond what is normally covered by national French health insurance. Some French analysts will even remark that having a private *mutuelle* is also a right, in addition of course, to the right to the basic health care provided by *Sécurité sociale*. Today, there is even a program designed to provide *mutuelle* coverage to those who earn below certain income levels. According to the current *Sécurité sociale* website, this program requires that an individual has resided in France for at least three months, is in a correct and legal immigration situation, and make less than €12,084 annually for an individual, or €25,376 for a household of four. Clearly, the French have indeed decided that full health coverage is a right, that equality is priority, and that they trust each other as well as legal foreign residents enough to protect each other through such programs. Via this program, we can see that French solidarity extends even beyond the policies of *Sécurité sociale*. French solidarity is a central and strong enough concept that programs that reach above and beyond the solidarity of social security, such as this program, have been established.

When the 1946 constitution of the Fourth Republic was drafted, its first article read: "The organization of social security is established in order to protect workers and their families against risks of any nature that could reduce or eliminate their ability to earn a living, to cover the costs of maternity as well as the families that they support."[13] The preamble to the same constitution guaranteed "protection of health, material security, rest, and leisure activities. Every human being that finds themselves incapacitated to where they cannot work has the right to obtain from the collective the means of a decent existence."[14]

In this emblematic text, France places workers at the center of their social security program, but "human beings" at the center of social rights. The first article of the constitution of the Fourth Republic aims to protect workers against any sort of risk which would reduce or destroy their ability to earn. This policy seems to have a collective utility that is not seen in the U.S. The families of workers are included in this protection, being seen as dependent on the worker for both their safety, but also for their inclusion in the social protections provided by the nation. If the language were left here, France's health policy could have easily developed in much the same way as the U.S. policy, where for many years one of the few ways to obtain any sort of health insurance was through one's work, or through a parent's or spouse's work. The only difference would have been that in the U.S., the state did not initially endeavor to provide or require these employer-sponsored benefits.

However, the Preamble to this constitution extends rights to any human being that is unable to work as well. This individual would have "the right" to a decent existence. This right should be provided not by the state, not by an employer or an ex-employer, not from the church or some other religious, charitable, or membership-based interest group, but from "the

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[13] My translation. "Il est institué une organisation de la Sécurité sociale destinée à garantir travailleurs et leurs familles contre les risques de toute nature susceptibles de réduire ou de supprimer leurs capacités de gain, à couvrir les charges de maternité ou les charges de famille qu'ils supportent."

[14] My translation. "« la protection de la santé, la sécurité matérielle, le repos et les loisirs. Tout être humain qui (…) se trouve dans l'incapacité de travailler a le droit d'obtenir de la collectivité des moyens convenables d'existence »"

collective.” Here French people have rights guaranteed only by the fact that they are human and deserve a certain quality of life as such. They do not need to merit a quality of life based upon the work that they can do, a service they can provide, or the amount of money that they can earn and pay taxes on. Their value lies elsewhere, in their humanity, and this alone qualifies them for a certain level dignity and a certain level of care. The national collective is tasked with looking after this dignity.

Successful and Unsuccessful Efforts to Expand Healthcare

With these rights and dignities as their goals, France established several different national health insurance funds over the years, each serving different parts of their population. This created a slowly expanding system, which could be planned for and managed as it grew. It also required a very specific type of classification of citizens to take place. Which workers would fall into which categories? What about the professions? What about children, orphans, and widows? What about the homeless, immigrants, or refugees? Next, what actually constituted health care? Would vision and dental be covered? What sorts of women’s health care could be provided? Would prevention be a better strategy? All of these decisions were made gradually. Along the way, premiums were paid, as they still are, partially by employers, and partially by payroll taxes on employees. They did not, and still do not, cover the entirety of medical costs for most people, but rather a significant portion of the costs. The French established this baseline of health coverage, and then worked until 1999 to extend coverage to every resident.

Of course, health care was just one part of *Sécurité sociale* in France. Unlike in the U.S., social security, even in common parlance, does not refer to one single program to help elderly folks with income security—rather, it refers to the ensemble of social protections and rights granted either to French citizens or to residents of France. At least compared to the American system, it is a cohesive package of social programs that, true to its name, aims to provide for the security of all things human and social in life. It aims to fulfill the mission of providing an adequate standard of life to any person who can or cannot work, just as the constitution of the Fourth Republic affirmed.

In 1945, the policy elites and public spokespersons in the U.S. felt quite differently than did their counterparts in France. Health care provisions had been removed from the New Deal, and Theodore Roosevelt's health reform plans had not worked out a few years prior, potentially due to lack of working class support. Most union leaders, after all, feared the power that could be leveraged against workers by whomever was providing health insurance or health care, be it the state or employers. As we will see in later chapters, the idea that any sort of national health plan or even health legislation was socialist or communist or even simply "Anti-American" was becoming pervasive. These programs reminded Americans of Germany, of course.

In the post-World War II climate, when patriotic enthusiasm was high, the economy was moving, and the country was newly powerful, there was very little inclination to experiment with anything that seemed even remotely socialist. It was in this climate that Harry Truman began his campaign for National Health Insurance in 1945. It may not have been the most auspicious time. It was also right at the beginnings of political consulting, and political campaigns managed by consultants and consultant firms (Lepore 2012). Earl Warren's plan for health insurance for the state of California would be defeated by the same political strategy group, Whitaker and Baxter, that the AMA would later hire to fight against Truman's plans.

Though it would be very easy to blame political consulting for the outcomes of Truman's plan, political consulting firms do base their campaigns on evidence. They know well enough that they cannot craft an effective message if that message does not strike a chord with voters. Political consultants conduct polls, focus groups, and media discourse analysis studies so that they may leverage powerfully relevant cultural data in the service of these campaigns. These consultant groups are powerful and strategic, but their power comes directly from the very culture that they are appealing to in their messaging and campaigns. As such, any successful political campaign, whether consultants are involved or not, is a cultural win as well as a political one. In fact, a campaign that does involve consultants is likely to be even more culturally relevant and aligned than one that does not due to the amount of cultural research that political consultants conduct.

In the case of Truman's health care plan, the messages centered around the threats of foreign influence, socialism, Americans turning lazy and entitled (a form of suspicion or distrust), the possibility of losing medical choice, and a possible decline in quality of care.[15] These tapped into the cultural factors that were stacked against Truman's health plans. In an interview, Oscar Ewing, administrator of Truman's Federal Security Agency, reflected on how it came to be that Truman's national healthcare plan came to be called socialist. He reflected in particular on the role of Clem and Baxter and states that insiders knew that Whitaker and Baxter knew that in order to successfully culturally cast national healthcare in a bad light they would "have to give the program a bad name and we're going to call it 'socialized medicine' because the idea of socialism is very unpopular in the U.S. We'll give it this bad name. No one wants to be, or at least very few want to have the tag socialist attached to them" (Fuchs 1969).

It also would not help that the organization of the Truman administration and his Health Care Task Force left a bit to be desired. His plan never made it through either the House or the

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[15] These fears crystallized into the *Waiting Room Willie* comic book referenced in Chapter Four.

Senate. Whether his plan was ever even truly specified remains murky. The clearest action taken during the Truman administration was a bill sent to the House in 1949 that would have provided health insurance to those over 65. Even that bill failed, as it was blocked by the Ways and Means Committee. The failure to cover elderly Americans at this moment is truly remarkable. It indicates that fears of socialism were strong enough to trump coverage even for generally trusted and deserving, meritorious retired seniors. This was a moment of uniquely high anxiety in the U.S.

Still, most of Truman's speeches on the issue never clearly delineated a true plan, and his appeals to the public failed to make culturally relevant pitches for the benefits of the program. We will see in later chapters that his appeals did not appeal to post-war American common sense. They did not effectively leverage *longue durée* cultural concepts or ideologies. Given the highly unsettled times of the era, effectively leveraging *longue durée* culture was an essential strategy that the Truman health care campaign did not take. Fighting a cultural-research-armed opponent, this was a weakness from which Truman never recovered. As we will see in later chapters, criticism from the media, the AMA, and individual doctors was very frequent. The medical profession, advised by their campaign consultants, warned Americans that they would lose control over their medical care. They warned that the government would dictate which doctors they could see, for what, and when. During the Cold War and the era of the Truman Doctrine, it seems that it was just too easy for health care to be painted as "communist" and "socialist," especially in light of these sorts of criticisms. The well-funded and well-researched campaign by the AMA leveraged *longue durée* culture and its ideological underpinnings expertly. It had so many effective, well-researched cultural ideologies to mobilize in its cause that the relatively small and disunited campaign mounted by the White House, which did not do nearly as much cultural research, simply could not compete. As a result of the White House's lack of cultural research, the campaign did not have the tools needed to create messaging that could stand up to the AMA and its consultants. National healthcare did indeed become synonymous with "socialism," demonstrating just how easy it may be to leverage culture in the service of major political campaigns.

Though Truman's intention for National Health Insurance did not come to fruition, other important health legislation made it to the table during his time. The 1946 Hill Burton Act provided federal funds for hospital construction, especially in rural communities. It could easily be argued that this was a subsidy for medical providers more than any sort of social protection, since the simple construction of the facilities did not guarantee any group of citizens access to services. It also took a large step towards ending segregation, as any hospital built with the funding could not be a segregated facility. In theory, this type of embedded social legislation helped to provide health access for African Americans. However, access to these facilities or the affordability of care was not guaranteed by any part of the Hill Burton Act, meaning that low income individuals would still not be able to access care at these new hospitals. These types of measures did not go towards directly supporting the health of American citizens. They did not create a right to health care, or even a pathway for those in need of care to seek aid. Instead, they expanded the available health infrastructure where Americans could seek treatment, should they be able to access such infrastructure, and should they be able to afford to pay their hospital bills. And of course, the care provided within these hospitals was part of the emerging private health insurance programs. Instead of creating hospitals that could expand the types of care provided by the state, they provided new opportunities for health insurance companies to reach rural communities, making private health insurance even an even bigger and more widespread part of the American health care landscape. These programs may have been a step towards ending medical racial segregation, but they did not put health care into the social arena as a part of the American civic experience, as part of American national identity, or as part of the rights bound to American citizenship. They did not extend solidarity, trust, or merit to rural residents, as evidenced that they were not true social programs, but rather subsidies sent to the medical industry.

At the end of the post-World War II period, France and the U.S. had reached very different conclusions about the role of the state in health care. Their *longue durée* cultures were deciding factors in public opinion, public discourse, policy proposals, policy decisions, and the implementation of health policies. France left this period with the beginnings of a comprehensive healthcare system that would be expanded over time to eventually cover all legal residents of the country. The U.S. made no moves towards a national healthcare system. Instead, health care was left up to private insurers, employers, and patients. This foundation of state disengagement with health care for the general, non-retired, non-indigent, civilian population would remain untouched though not unquestioned until a policy that had at least some ability to correspond to American *longue durée* culture surfaced in the form of the ACA. The decisions made at this time in accordance with *longue durée* culture created the shape of the policies, debates, and public opinions for the next century. Any subsequent policies would need to align with the policies initially established after World War II. Public sphere debates would need to leverage the same arguments, fears, common sense, and assumptions in order to be compelling, and policy proposals would need to speak to these public sphere expectations in order to gain any traction. As such, turning to ideals and *longue durée* culture during an unsettled time shaped health care policy in the U.S. and France more than any other factor during this pivotal period.

CHAPTER THREE:

TECHNOLOGICAL ADVANCEMENTS AND DIVERGENCE BETWEEN FRENCH AND AMERICAN POLICY

Health care is unique compared to other technologies in that as it improves by creating more treatments, more procedures, and, as a result, longer lifespans. These advances paradoxically mean that demographic changes, problems of financing, access, and equality become increasingly difficult to consider and solve. Societies must draw on *longue durée* culture in order to navigate the difficult challenges that appear as health care improves and expands. When new health care technologies emerge, they must be accommodated by existing healthcare systems, budgets, political systems, cultures, patient expectations, and societal definitions of health. It must be ensured that these treatments become available to patients within the frameworks of existing healthcare systems, existing financial models, and existing views about health. In order to do so, *longue durée* culture is leveraged in the debates about how to adapt to the changing health care landscape. Whether the debate involves deciding whether or not to extend coverage to a new group, cover emergent treatments, or balancing the health care budget long term, *longue durée* culture dictates the possibilities within the realm of health care. Of course, at the moment of these new conversations, *longue durée* culture has already dictated the greater shape of the health policies into which these new technologies must fit. This preemptively limits options to those who are already in line with *longue durée* culture. Indeed, we see a sort of cultural path dependency that both looks back to *longue durée* culture as health technologies advance, but also depends on the systems that have already been established in accordance with *longue durée* culture. Essentially, what we notice through all of this is that even as health care evolves and new technologies emerge, *longue durée* culture stays the same, its impact stays the same, and its influence on policies is unwavering. The examination of health care debates and policies in this chapter will demonstrate this phenomenon. It will also demonstrate how the distinct *longue durée* cultures of the United States and France contributed to creating divergent, but culturally adapted, healthcare systems.

As the French were establishing and improving their healthcare system and the U.S. was supporting the growth of for-profit insurance companies and hospitals, vast technological advancement spurred further growth in the medical field, as well as ever expanding medical costs and increasing demands for medical care. The dynamic innovations that occurred between the 1950s and the 1980s allowed for the treatment of many more diseases. Of course, this led to ever-increasing demand for medical care and services, which created an even greater need to address the issue of health insurance. Consider the following list of medical innovations from this period: 1946 Hermann Joseph Muller discovers that radiation can cure cancer (for which he won the Nobel Prize), 1952 first open heart surgery, 1954 first kidney transplant, 1956 metastatic cancer first cured with the drug methotrexate, 1957 first bone marrow transplants for cancer, 1962 hip replacement surgery, 1962 beta blocker for angina, 1964 measles vaccine, 1967 mumps vaccine, 1967 first heart transplant, 1967 first liver transplant, 1970s imaging tests first used on cancer patients to avoid exploratory surgery, 1974 mammograms, 1975 cat scans, 1978 ultrasound, 1978 meningitis vaccine, 1978 glucose meter, and finally, 1983 first anti-rejection drug cyclosporine. Of course, none of these technologies existed when France was creating the health insurance programs included in their social security, requiring some very complicated budget adjustments and strategies over the years. The increases also came after several failed attempts to create national health insurance for the U.S. Perhaps one of these reform attempts would have passed if anyone had anticipated such incredible increases in the costs of care down the road.

Importantly, the French have maintained their commitment to social security throughout each of the three constitutions they have had since 1945. Again, in 1958, with the start of the Fifth Republic, they reaffirmed the right to a decent standard of living to all, as a responsibility of the "collective." They committed to this in the preamble to their new constitution:

> The Nation assures that the individual and the family will have the necessary conditions for their development. It guarantees to all, especially to children, to mothers, and to old workers, the protection of health, material security, rest, and leisure. Every human being who, because of their age, physical or mental state, or owing to their economic situation, finds themselves incapable of working has the right to obtain from the collective the means to a sufficient existence.[16]

This preamble is fundamentally different from the American right to "life, liberty, and the pursuit of happiness" from the preamble to the American Declaration of Independence in that here, there is a responsibility placed upon the society at large. Not only is an individual to be free from interference to pursue happiness, but society must work together to see to the material needs and right to life of citizens. This is not simply a statement about what should be, or what rights might hypothetically exist. Instead, it is a direct declaration of responsibility and duty. It has been followed by societal action to protect these rights and extend them to their fullest possible expression. Furthermore, these opinions persist. In the "American and Western European Values Gap" study of 2011, The Pew Research center found that 58% of Americans value "the freedom to pursue one's goals" above state initiatives to ensure that "nobody is in need." Only 35% of Americans found it more important that the state protect against neediness.

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[16] My translation. "La Nation assure à l'individu et à la famille les conditions nécessaires à leur développement. Elle garantit à tous, notamment à l'enfant, à la mère et aux vieux travailleurs, la protection de la santé, la sécurité matérielle, le repos et les loisirs. Tout être humain qui, en raison de son âge, de son état physique ou mental, de la situation économique, se trouve dans l'incapacité de travailler a le droit d'obtenir de la collectivité des moyens convenables d'existence"

Among the French, 64% feel that it is more important that the state ensures that nobody is in need, while 36% valued more highly the ability to pursue goals in an uninhibited fashion (Pew Research Center 2011). These differing societal values are plainly visible in the way that social policy has been crafted. It could be hypothesized that perhaps the French definition of freedom includes provisions of necessities to use it, while the American definition of freedom only includes the freedom to meet one's own needs. If this were to be the case, which I would expect, it would suggest that there are different definitions of what individualism means to these two societies as well. Potentially, France and the U.S. could be equally as individualist if it is the definition of individualism that shifts according to context, and where French individualism assumes freedom from disabling need as the true definition of freedom.

Still, any societal priority needs to be backed up with infrastructure as well. The 1958 reform Debré comprised a series of ordinances that established the *centres hospitalo-universitaires* (CHU—Hospital-University Centers) and staffed them with full-time doctors. It established a national selection process for the heads of these hospitals and reinforced the administrative powers of the heads of hospitals, as well as the representation of social security in health administration. These centers would be important for both medical education and research, as well as for primary treatment centers. However, unlike in the U.S., this infrastructure expansion and organizational shuffling had already been accompanied by establishing the means for at least some of the French population to have access to the facilities. Establishing protocols for selecting the heads of hospitals and defining the role of social security in the health administration could easily be seen as simple centralized bureaucracy creation, but these actions were also the French expression of guaranteeing health care to as many people as possible. The French have a stronger centralized administration than the U.S., and this administrative tradition influences their policy initiatives (Crozier 1964). This preference was originally grounded in France's history, but is now a cultural standard. It makes sense that this part of French culture would be reproduced as the country expanded its healthcare system. As new institutions, systems, and governmental bodies expand, they should mirror other parts of the culture, or at least the political culture and political traditions of the society (Dobbin 1994). In this case, the elements of French culture that were being reproduced via these hospitals was health care as a right, solidarity via social security and health care, a preference for strong, centralized, bureaucratic systems, and the desire for equality in health access across populations.

Continuing to Expand Coverage in France

With newly expanded hospital systems and a new constitution, the tone and the direction had been set for French health policy in the 1960s. Throughout the decade, France expanded coverage to ever more groups of individuals. This started in 1961 with legislation creating an autonomous health, maternity, and disability insurance plan for agricultural workers administered by the CNAM (Caisse nationale d'assurance maladie des professions indépendantes).

Agricultural workers were covered first separately, since they already had a *caisse* that had been serving their health insurance needs. Of course, the government could have chosen to create one central mandate or insurance regime for all, but instead, they targeted particular groups, one at a time. Serving agricultural workers first makes sense, in that agricultural workers were mostly located in rural areas, where they had greater difficulty sorting out their health insurance. Creating a new body to serve them would have helped raise awareness of the services provided. Agricultural workers were also likely to suffer specific health issues related to their profession. They were likely to need health services or to have been ignoring their health in order to continue working. As non-salaried workers, health challenges could prove especially damaging to their businesses, careers, or livelihoods. They had also not yet benefited from workers compensation and disability coverage, which could have provided some industry- and work-specific protection for their particular types of work-related health issues. France has had the tendency to cover the most vulnerable populations first, as evidenced by their early focus on maternity care, children, and the elderly. Agricultural workers likewise were more vulnerable to work accidents and other long-term health issues than were those living in cities.

Beyond the structural realities described above, there are cultural reasons why the French would have looked to protect agricultural workers first. France identifies with its farmers and peasants, even today in the face of globalized food sources and agriculture. Sarah Waters (2010) finds that peasant and agricultural identities have so much power, despite their minority status, that they come to represent "an antidote to all the evils of a globalizing world, one in which identity is reaffirmed, tradition is preserved and social bonds are restored." French farmworker protests are famous and gain traction because of the symbolic power that Waters identifies. Consider the fame and national hero status of José Bové, the sheep farmer and activist famous for his opposition of globalization, most memorably by physically attacking and protesting McDonalds (Northcutt 2003). French farmers and peasants have symbolic power for decades. Therefore, finding a way to protect French farmers very early on in the expansion of social rights and healthcare expansion was a moment of reliance on French common sense and *longue durée* culture.

Then, in 1966, legislation created a separate, obligatory work accident, non-work accident, and work-related illness insurance plan for agricultural workers. This finally brought agricultural workers fully into the fold of French social protections. The goal of these social programs was to create a cohesive system of social protections that would cover everyone in France, beginning with meritorious, symbolic, and vulnerable groups. Social security became part of the national identity, and would in time become a real symbol of the nation and of French citizenship.

It might have been difficult for these programs to be part of this important identity-building program, had agricultural workers been allowed to stay outside of the system. Agriculture is a large enough part of France's economy, and attachment to French lands and agricultural products is strong. Since farm workers are so very symbolic in France, including this profession immediately in the expansion of national health insurance offered important synergy. This idealized group symbolizes the nation while national health insurance and social security symbolize the nation and citizenship. Farmers were covered first because it is in accordance with *longue durée* culture to extend maximum solidarity to this symbolic group.

These and other expansions would take place up until a few final ones in 1978, with a new regime for ministers and religious leaders, as well as a new personal insurance for "remaining populations." However, this final provision for "remaining populations" was still not able to expand coverage as widely and completely as the French wanted, and roughly 1-3% of the population remained uncovered. Ministers and religious leaders were covered last, as they would have had their religious communities in place to take care of their needs up until that time. This demonstrates the French *longue durée* cultural imperative to make sure that those who might be in need are served. Clergy members, being less likely to be left with a health need, were one of the last groups to be covered simply because they were less likely to be in need of health care. The French covered the most symbolic, the most meritorious, the most vulnerable, and the most needy first. Still, covering clergy was fated to become a very important conversation, as the separation of church and state, or *laïcité*, is taken very seriously in France. France has declared itself "a secular republic" since the 1905 law, and there have been many controversies since. However, to the French, clergy are certainly still French, so worthy of health care, despite the endorsement of *laïcité.*

Medicare and Medicaid. Caring for the Deserving and the Trustworthy in the U.S. while Stigmatizing Others

1965 saw a massive expansion of medical social rights in the U.S. While France was working towards its goal of covering all French people regardless of employment, marital status, disability, or age, the U.S. had concluded that something had to be done to help the poor, the elderly, and the disabled to obtain medical care. These populations were deemed largely helpless or indigent (in the case of the poor and disabled) and as deserving, trustworthy, and meritorious (in the case of the elderly). The passage of Medicare and Medicaid was the largest expansion of medical coverage to that date. Providing health insurance to the elderly had been attempted at least twice before, as Truman had submitted a bill that would have provided health insurance to those over 65 to the House in 1949. Kennedy had also attempted to begin such a program in 1962, only to have the bill fail in the Senate by just a few votes. FDR had planned on such a program, but it never materialized. The difficulty of passing legislation which would provide health insurance shows that even in the case of the elderly, who have come to be nearly unquestioned in meriting health care, shows that expanding health care for Americans as a right of citizenship is very far indeed from being a true national goal. Health care and health insurance are simply not generally interpreted as rights in the U.S. If health care as a right had been part of the *longue durée* culture, passing health care provisions for those among the least stigmatized of groups, the elderly, would not have been a struggle.

Not until decades later did citizens suffering financial hardship and ruin, or being denied care due to their inability to pay for it, gradually filter into the American dialogue about health care rights. Once the burden of health care costs became so great, the freedom to obtain health care became elusive for too many. The debate may continue to shift as Americans continue to have difficulties facing health care, although the Trump retrenchments of the Affordable Care Act (ACA) indicate that the actual trend is unclear. In any case, the debate about health care as a right is real, as evidenced by this personal anecdote from a *Washington Post* article by a medical school professor:

> Earlier this year, as I walked along the National Mall, I saw a sign on a church placard that read "Health Care is a Basic Human Right." As I took a picture of the sign, a gentleman walked by and yelled, "When will you people learn? The idea is ridiculous." The debate has permeated politics for over a century, and despite dramatic policy shifts in the medical profession and in government, it seems we are no closer to resolving it. (Jones 2018)

To add color and context to this debate, consider the following opinions about health care as a right. The American Bar Association (ABA), for example, includes an undated opinion on its website extolling health care as a right. It states:

> There are rights to which we are entitled, simply by virtue of our humanity. Human rights exist independent of our culture, religion, race, nationality, or economic status. Only by the free exercise of those rights can we enjoy a life of dignity. Among all the rights to which we are entitled, health care may be the most intersectional and crucial. The very frailty of our human lives demands that we protect this right as a public good. (Gerisch n.d.)

Here, the ABA is making an argument about rights that is utterly out of alignment with historical American *longue durée* culture regarding rights and health care. While this viewpoint from an important organization may represent the thinking of elite attorneys, it shows one of the reasons that American claims to health rights have likely been unsuccessful. Failing to leverage appropriate *longue durée* culture, this argument is formal, legalistic, and tone deaf like many other ABA positions on American life.

Consider as well how Kyle Bradford Jones argues that it is time to recognize health care as a right because a majority of Americans now support the means by which the right would need to be guaranteed. He writes:

> The debate over health care as a right guaranteed by the U.S. government that each individual deserves, versus a privilege only for those who can afford it, generates politically charged questions about the role of government in American life. Such a right could be implemented in a number of ways: a government program, such as a federal single-payer system or federally owned health-care system like the Department of Veterans Affairs; government provision of private health care; or through a requirement for employment-provided coverage. (Jones 2018)

To support the need for this, he cites Pew's finding that "Six-in-ten Americans say it is the federal government's responsibility to make sure all Americans have health care coverage" (Kiley 2018). Jones' argument is much closer to being able to strike a chord with American *longue durée* culture. However, given American fear of the tyranny of the majority and consideration for vociferous and committed minorities (Social Security Administration n.d.), the historical power of the once-majority-turned-minority that opposes government supported health rights, and the deeply entrenched nature of *longue durée* culture, turning the tides on the health care as right debate will require far more disruption than we have seen thus far.

One of the reasons that this shift would be so difficult is that health care as a right has been historically perceived as a challenge to the American definition of freedom as simply the freedom to pursue one's own goals, including not paying for others' health care. Viewing health care as a right would require a revision of American *longue durée* culture to include placing solidarity over the individual right to not be imposed upon for the sake of other citizens. An excellent example of this exact reasoning can be found in Stephen Chapman's 1991 *Chicago Tribune* article "Is healthcare an inalienable right?" After comparing the right to medical care to the right to an attorney and freedom of the press he writes: "A right to medical care, on the other hand, means the government has to provide you with things that are far more expensive than a printing press. It is blank check drawn on the bank accounts of the taxpayers at large. Instead of protecting your liberty and property, as rights are meant to do, this one lets you infringe on the liberty and property of others" (Chapman 1991).

Consider another example of very similar logic from the angle of the health care or rights "consumer." Here, it is the fact that rights beneficiaries cannot opt out of rights that the author finds disturbing. Roy Avik explained in *Forbes*, noting that the problem applies to Medicaid recipients that are barred from making up the cost difference between the care they can access and the care they cannot in cash, the young who want to opt out of the ACA, as well as retirees: "In other words, that basic right—the right of a retiree to turn down a federal program, and pay for the health insurance plan of his [sic] choice, is one that every retired American has been denied by his government" (Avik 2013). This demonstrates just how far the U.S. remains from accepting health care as a right of citizenship. In the U.S., it is as if health care were often closer to an anti-right or the source of rights violations for taxpayers.[17] In France, health care is a positive right worth imposing taxes to finance. In the U.S., it is an obligation, a violation, and an abuse of taxpayers. These two nations are entirely opposite in their *longue durée* culture as it relates to rights and health care.

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[17] Health care as a right is also extremely offensive to libertarians. Consider the following from P. J. O'Rourke, a research fellow for the Cato Institute. "Freedom is not empowerment. Empowerment is what the Serbs have in Bosnia. Anybody can grab a gun and be empowered. It's not entitlement. An entitlement is what people on welfare get, and how free are they? It's not an endlessly expanding list of rights—the "right" to education, the "right" to health care, the "right" to food and housing. That's not freedom, that's dependency. Those aren't rights, those are the rations of slavery—hay and a barn for human cattle" (O'Rourke 1993).

Despite this, Medicare and Medicaid profoundly changed American health in several ways. Most obviously, it provided access to care for individuals who were in most cases struggling to afford it. These beneficiaries, especially the elderly, would become vociferous defenders of these policies when funding to the program was at stake (Marmor 2000:124). Few these days truly question whether the elderly deserve Medicare or Social Security. Rather, it is accepted that they have paid into the systems for the duration of their careers and are now thus entitled to such care. Once Medicare passed, the idea that the elderly deserve care has held up. Even as politics changes rapidly under the Trump administration, challenges to Medicare remain very infrequent.

The poor, however, have not benefited from the transformation to be considered deserving of social rights, and as such Medicaid is often a highly stigmatized program (Hancock 2004; Stuber and Kronebusch 2004; Stuber and Schlesinger 2006; Yellowitz 1995). This indicates that Americans find the poor to be the least trustworthy population, along with immigrants from certain countries. The pervasiveness of Reagan's fake welfare queen stereotype offers a ready demonstration. The fact that the establishment of Medicare resulted in a change in acceptance of social rights for a select group, while the establishment of Medicaid did not result in such a change is truly profound. I believe it indicates that granting social, health care rights to senior citizens resonated with American culture, while granting social, health care rights to the poor does not resonate with American culture. I believe that this resonance is largely because of the fact that we trust seniors to have already have contributed to society and to have done their part, in contrast to the poor. As we saw above, one of the most important rights in the U.S. is the liberty to not be availed upon by ones' fellow citizens. Since Medicaid is not just for poor seniors, but for any senior, it is very easy to trust that any given senior has worked and paid their taxes for decades. Furthermore, being unprepared to cope with the costs of health care is understandable in old age, and we have compassion for this. However, the poor are not seen as contributing, financially or otherwise, to American society. Therefore, they do not merit care. As discussed above, as a result, many Americans are prepared to say that their own right to be unbothered and untaxed trumps a poor person's right to medical care. In contrast to sympathy for seniors, we have little compassion for the working-age poor, as many Americans feel that they should be capable of providing for their own needs. This inability to pay for care is interpreted as poor planning at best, or perhaps irresponsibleness or recklessness, or finally as willful manipulation, drug abuse, or moral failing at worst (Hancock 2004).

Medicare and Medicaid also had profound impacts on health economics. As the largest government health plans in the country, these programs have been the focus of many budgetary debates and anxieties. Some commentators believe that the programs are set to run out of their "trust funds" soon. Others criticize these programs not only for the expense, but for their poor results relative to their expense. However, these criticisms are often made in a vacuum. The cost of the programs, the success rates, and the ideologies are evaluated without examining why the programs might be so expensive or why they might be less effective, especially relative to the results that similar programs report in other countries. Ideological criticisms, especially of Medicaid, become much easier once these superficial examinations of outcomes are accepted. This is commonly the case in many criticisms of the programs, though Medicaid bears the brunt of these sorts of perfunctory sideswipes. It is difficult to avoid concluding that the differential rates of criticism stem from the way that rights for the elderly resonate with American culture, while social rights for the poor do not.

Most importantly, the policy makers who worked on Medicare and Medicaid had the opportunity to give the government the ability to set price controls and bargain on behalf of the public for lower prices, but they elected not to. Paul Starr (2013) notes that this single decision would underscore American health policy woes for the coming decades. He notes that the decision not to set price controls, as well as the decision to forbid the federal government from negotiating prices on behalf of consumers with pharmaceutical companies, hospitals, and the medical industry at large has been a great contributing factor to the exponential growth in our health care costs. Price control and government bargaining are fundamental features of every other OEDC healthcare system (Reid 2009). These arrangements serve to limit price gouging and secure better prices on health care for consumers. In the U.S., the absence of these defensive strategies have been a principal factor in the explosion of health care costs in America relative to other countries. As noted earlier, Americans have generally had a tendency to shy away from certain types of business regulation. While the strength of the medical and insurance lobbies has had an undeniably large hand in preventing the regulation of their industry, the public has not cried out for regulation in a particularly noteworthy way. A Google Trends comparison of the search terms “regulate pharmaceuticals” and “repeal Obamacare” reveals that between April 2018 and April 2019, the searches for “repeal Obamacare” outnumber the number of searchers for “regulate pharmaceuticals” at average factor of almost 25 to one (Google Trends: Pharmaceutical Regulation vs. Repeal Obamacare 2019). Searches for “ACA” outnumber searches for the very neutral “price pharmaceuticals” at a factor of almost 57 to one (Google Trends: Pharmaceutical Price vs. ACA 2019). Americans are more concerned with and more focused on Obamacare itself than the lack of regulations placed on pharmaceutical companies, and perhaps even more than on the staggering prices of pharmaceuticals themselves. This indicates that despite the fact that soaring pharmaceutical prices are one of the main contributors to the high cost of care in the U.S., the ACA remains the focus of attention. Culturally, Americans have been reticent to confront the idea that a lack of price regulations are having a negative impact on American health care, equality, and access.

Coping with Rising Costs—A New Era

By the 1970s, many began to feel that American health care was becoming far too expensive. As a result, the 1970s brought several unsuccessful proposals for universal health care (Marta Griffith's proposal in conjunction with the AFL-CIO, Javits' Medicare for all plan, and Ted Kennedy's plan, developed with the UAW). Of all the failed proposals, Nixon's 1974 health reform proposal, which many have argued was, for all intents and purposes, the 2008 ACA, must be the most ironic now (Reich 2013). Irony aside, some solution had to be found even though none of these proposals were successful. The creation of HMOs became the health reform of the decade. The 1973 Health Maintenance Organization Act created legislation that would guarantee HMOs a place in American health care. The act provided grants and loans to start new HMOs or to expand existing ones, and created a federal HMO certification program that allowed the removal of certain state regulations if certain conditions were met. While this legislation did little to provide insurance to the uninsured, it did provide some temporary reduction in costs and tax burden for employers providing HMO plans, as well as for the employees who paid their parts of these plans. The hope would have been that these reductions in costs would lead to employers sponsoring more health insurance policies for their employees. However, yet again, the legislation did nothing to regulate the price of treatments or the rapid cost increases across the medical industry, and did little to increase coverage rates among those who had been chronically uninsured. Still, Americans hypothetically possessed the freedom to pursue their wants, needs, and goals, so this status quo seemed acceptable. Things would become even more stagnant for health reform when recession hit in the mid-seventies, inspiring Gerald Ford to declare in 1975 that he would veto any health reform plan (Dutton 2007:168-183).

By this time, health policy in France and the U.S. had far less in common than it did before policies greatly diverged in the 1940s. However, both nations would begin to feel the increasing costs of medical care, due simply to increasingly expensive and innovative technologies. Both countries would need to find tactics to control the rising costs. In France, the eighties saw heated debates, measures to control health spending, and social reforms. In 1982, the retirement age in France dipped to 60, placing an extra economic strain on social security. The 1982 Bérégovoy Plan created a day rate for lodging fees at the hospital and lowered the reimbursement for certain medications. In 1985, the Dufoix Plan further lowered reimbursements on 379 pharmaceutical products (IRDES 2015). This all created quite a stir, as many of the French feared that this would cause a slide into continually lowered reimbursement rates to patients. Newspapers and TV news warned that should the trend continue, France would start to see a privatized, “American” healthcare system, where middle class families struggle to pay for medications and medical procedures (*20 Heures* 1985; *Humanité* 2005). This warning would resurface in the future, during any discussion of cutting reimbursements or funding, during discussions about infrastructure, medical education, and especially during discussions about *mutuelles,* the private complementary insurances to which only some French people for a while had access. In these debates, the fear of creating an American healthcare system in France arises from the French values of fraternity and solidarity, and the fact that French social security programs, such as health insurance, are an important definition of French citizenship. *Longue* *durée* culture informs this reaction. The French have celebrated social security and its medical coverage for generations as a part of national identity. Loss of this identity and the potential retrenchment of rights that are central to the experience of French citizenship poses issues that extend beyond the obvious need for reliable, affordable, and familiar health care.

Shortly thereafter, to mitigate the fears and discomfort about lowered reimbursement rates, The Séguin Plan added 25 more diseases to the list of diseases which excused a person from paying the *ticket moderateur* (akin to a very low copay) (IRDES 2015). These were more serious, chronic illnesses that required ongoing treatment, frequent doctor visits, frequent tests, and which were likely to cause some degree of disability if left untreated. The 1988 Évin Plan would continue with this, by specifying certain medications and by adding more general chronic illnesses to the list of those excused from the *ticket moderateur* (IRDES 2015). This expansion may have mitigated fears of retrenchment of the healthcare system. In light of the Évin Plan, the program of a continually expanding healthcare system was still on track. Care was continually being made more accessible, even if certain medications had been made slightly more expensive a few years earlier. The French narratives of expanding care continually and completing the 1945 goals for social security, solidarity, and citizenship could still be viewed as being fulfilled. Deviating from these historical precedents would require an important revision of national identity, values, goals, and intentions. These sorts of revisions could not be culturally easy or smooth given how deeply the French celebrate and commemorate both social security and its health insurance. To illustrate the depth of the commitment to solidarity via social security and health insurance, consider the following script from one of the many televised reports from the *Etats Generaux de la Sécurité Sociale* of 1987:

> We have two alternatives: let Social Security become the privilege of the few, or extend the benefit to all. It would not be acceptable, after 40 years of developing

> Social Security, to not choose the later, to not truly choose the principle of solidarity, letting those that have the means to do so cover those that do not have the means. A society that lets the food bank go quiet, what security would it have to offer to all? On the other hand, wouldn't a society where Social Security is offered to all citizens equitably, according to their needs be able to minimize poverty? (Wresinski 1987)[18]

All of these reforms in the eighties were made all the more visible with Philippe Séguin's *Etats Généraux de la Sécurité Sociale* ("General State of Social Security"). In 1986, Séguin organized a massive national debate about social security. He formed a committee of "sages" to discuss problems facing the population and their most logical solutions. There were television spots, polls, and roundtables. Few things proposed during the debates were ever adopted, but the participatory debates kept social security and its health insurance at the front of the French psyche. The *Etats généraux de la sécurité sociale* had as a basic premise that citizens had a right to be involved in the process of social policy, social security, and social services. Though the program was arguably less effective at producing changes desired by the public, its intention to spark debate and encourage public input was clear. The connection between citizenship rights, Frenchness, social security, health care, and participation was important. *Le Figaro* extensively covered the program and reported that "more than 20,000 participants across France practiced a new form of direct democracy"[19] (Taupy 1987). This program was similar to the *Musée d'assurance maladie* in that it was a grand show of national identity in public celebrations of solidarity via social security. French *longue durée* culture includes a deep relationship between solidarity, social security, and rights, which are kept very top of mind for French citizens via these sorts of public dialogues and commemorations. Given the power of these commemorations,

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[18] My translation.

[19] My translation.

failing to extend health solidarity to all would be perceived as a great disappointment, failing, or weakness of the society or government to protect its most loudly proclaimed values.

1980s: Challenges in the U.S.

In the U.S., the 1980s saw several reforms to Medicare and Medicaid, as well as the creation of COBRA. In 1981, funding was provided to hospitals that could show they were taking higher than average numbers of Medicaid recipients and other low-income patients. The same initiative allowed Medicaid to pay lower rates than Medicare, allowed states to mandate managed care for certain Medicaid groups in some circumstances, and required nursing homes to be paid "reasonable and adequate" rates, as per the Boren Amendment. These measures, while attempts to control rising prices, likely created more difficulties. In the nineties, it would become common for Medicaid patients to complain that it was difficult to make appointments to see certain doctors, especially specialists (Freudenheim 1992). Since only Medicaid would pay reduced rates, not Medicare or privately insured patients, it is clear why physicians would not want to accept Medicaid patients. At hospitals or medical facilities that had not received additional funding for treating the now less profitable Medicaid patients, there would be no benefit or incentive to treat such patients. The hospitals that would accept Medicaid patients would be booked nearly exclusively with Medicaid patients, and it could take long wait times to receive any care, as these hospitals became overburdened. This policy could only be conceived of in a medical system where standard reimbursable treatment rates had not been set. Economically, it is a difficult sell to doctors to take on patients who will be worth less than others. It seems quite shocking that this outcome of lower reimbursement for Medicaid patients was not anticipated. My interpretation of the symbolic nature of this policy is that Medicaid patients, as part of a stigmatized, less trusted group, are seen as lucky to receive what aid they do, even if it is of lower quality than what the rest of the population might expect since they must avail upon others in order to access health care. Our *longue durée* culture dictates that the right to be undisturbed by the needs of others trumps the health care needs of the poor. As Hancock (2004) points out, welfare recipients are stigmatized as lazy, undeserving, freeloading individuals who do not really deserve the aid they receive. To illustrate this, consider the following statement about welfare cuts from President Reagan in 1981:

> The main focus of these cuts is aimed at correcting those abuses that come about through the interpretation of regulations that allow people that do not have real need that justifies their imposing on their fellow citizens for sustenance, for them to still be able to take advantage of these programs. The person with real need, we still want to help. At the same time, when you force someone to go out and seek work, the whole target of social reforms always should have been to find a way to salvage that person and make them self sustaining, as opposed to perpetuating them as part of the third and fourth generation of wards of the government. (*NBC Nightly News* 1981)

Clearly, Reagan and his supporters do not trust the poor to take only what they need without freeloading. His policies reflect the viewpoint that if the poor are well enough and young enough to work, they not deserve care as the elderly do. Indeed, there are no health rights in the U.S., simply a few programs that may or may not be truly accessible to those in need, as is illustrated by the design of this policy and Reagan's comments.

Children, however, can sometimes benefit from a greater level of protection and compassion, even from conservative leaders. There was another smaller Medicaid update in the 1980s that responded to another very specific, exceptionally vulnerable population's needs. After the nationally publicized Katie Beckett case, as of 1981, Medicaid could be extended to disabled children who were being cared for at home as opposed to being institutionalized for care (Shapiro 2012). As has often been the case in American public health policy, children's issues are addressed quickly and provisions are made for their protection. In this particular instance, a policy change was made after just one public case highlighted the need for reform. Children are innocent, and so inherently trusted. They are not thought to be freeloaders or welfare queens. By the nature of their age and helplessness, they merit assistance, advocacy, and even policy change in times of sickness and need in a way that their parents do not. Katie Beckett was left severely disabled after contracting encephalitis while still an infant. Her ongoing care, it turned out, would cost six times as much if it had been administered in a hospital. However, due to Medicare rules, she could only receive aid if she were cared for in the hospital. After her mother advocated for her cause, spoke about her case publicly, and contacted lawmakers, Reagan granted an immediate exemption for Katie. Medicare policy was modified shortly thereafter. In tune with his administration, Reagan used the case as an opportunity to talk about the ills of bureaucracy, short-sighted policy, and over-regulation. On *NBC Nightly News* in 1981, he stated:

> We just recently received word of a little girl who spends most of her life in a hospital. The doctors are of the opinion that if she could go home, and receive her care at home, it would be better for her. Spending most of her life there, away from the home environment is detrimental for her. It would cost $1000 a month for her particular ailment to send her home. Her parents have no way that they can afford that. The regulations are such that Medicaid cannot pay that if she goes home. So, instead, Medicaid continues to pay $6000 a month to keep her in a hospital, when the doctors say she would receive better treatment at home. But her parents can't afford to have her taken off Medicaid. By what sense do we have a regulation in government that says we will pay $6000 a month to keep someone in a hospital, but the family can't afford to pay one sixth of that to keep them at home. (*NBC Nightly News* 1981)

Katie's case and the swift policy action that was taken to help her family demonstrates just how far policy makers can go in the service of individuals who are deemed to merit care. In this case, Katie's family merited care because Katie was a child incapable of working, who happened to become ill through no fault of her own. American *longue durée* culture seeks to extend solidarity to young, needy people only if they are deemed trustworthy enough to not impinge upon others if there is any other way at all for them to access care.

Diagnostic Related Groups (DRGs) were created in 1983 as part of Medicare's administrative system. They were rolled out as part of Medicare's Prospective Payment System. This move was an attempt to preserve the Medicare hospital funding, which was spending its budgets down quickly. This classification system was intended to help group patients by category of diagnosis so that a hospital's effectiveness could be measured, so that costs could be estimated, and so that resource use could be more effectively tracked. This classification is now central to how a hospital estimates costs, so it translates into how they bill private insurance companies, and of course, how Medicare reimbursements are set.

However, most importantly, DRGs were also intended to help hospitals control costs. Since hospitals were to be reimbursed for the DRG value of a patient's treatment, regardless of the actual amount spent on that treatment, hospitals would have an incentive to treat patients in the most efficient and cost-effective ways possible and allowed them to keep any surplus. Hospitals would also absorb the loss incurred if they exceed the treatment budget for a particular patient set by the DRG. This change from cost reimbursement to per case reimbursement was a very important shift. This innovation was important enough that it would be eventually adopted by other healthcare systems around the world. Even France would eventually adopt this system.

What is interesting about DRGs is that they are clearly a cost cutting measure *á l'Americain.* This system aims to be as non-meddlesome as possible, while providing an incentive to save money. It does not specify where hospitals should try to pick up their margins, and it does not specify how different diagnoses should be treated. It does not set or negotiate prices, or otherwise "interfere" with the business practices of any insurance company or hospital.

Instead, it creates a pathway to higher profits if hospitals treat patients for less money. Criticisms of this system include the potential for “DRG creep,” or the practice of hospitals placing patients into more expensive groups in order to gain the higher reimbursement rates.

One of the most controversial pieces of U.S. health policy is EMTALA (Emergency Medical Treatment and Active Labor Act), passed in 1986 as part of COBRA (Consolidated Omnibus Budget Reconciliation Act). It required any hospital participating in Medicaid to stabilize emergency patients regardless of their ability to pay for services. This was intended to prevent private hospitals from dumping patients off at public facilities for treatment, without even taking the time to at least stabilize and evaluate them first. Most of the services that are covered under EMTALA end up being emergency room services, which of course, are very costly. However, this act did not provide funding to pay for these medical services, meaning that it is the hospitals and emergency rooms that absorb these costs. This is typical of the Reagan administration, which did not want to increase spending on any social program, ever, since of course, welfare recipients were seen as untrustworthy and are particularly likely to exploit the system during this era. In 2000, Congress would crack down on EMTALA enforcement, issuing increased fines for doctors and hospitals which failed to treat emergency uninsured patients.

Debates and even lawsuits ensued about doctors’ sending patients away for being poor, such as in the case of Rosa Rivera and Dr. Michael Burditt. Rivera came into Burditt’s rural Texas hospital in labor with her sixth child, and with extremely high blood pressure. Burditt transferred Rivera to a hospital 170 miles away. Burditt insisted that his decision was medical in nature because he could not treat her high blood pressure. However, he was sued for sending her away for being poor, and the commentators raged (Lewin 1991). Dr. Burditt was sued. Consider for a moment the likelihood of a similar case happening in France. The entire situation is unthinkable if solidarity that extends to all members of the population is part of *longue durée* culture. However, in the U.S., health solidarity is not part of *longue durée* culture and there are no true health rights. This debate is one illustration of the results of the failure to establish health rights, provide health funding, and ensure that patients have access to care and doctors are compensated. Health rights, after all, can only be provided if government, or some other body, assumes the financial responsibility for care. In this case, passing policy that prohibits doctors from denying care to poor patients is a direct result of the failure of government to provision funds for health care.

Also in 1986, what is typically thought of as COBRA was established, which allows employees who have lost jobs to continue paying for health insurance entirely on their own for up to 18 months after the loss of the job. While this provision likely prevented many Americans from losing their health insurance, COBRA rates were expensive for almost any person who had just lost a job. This solution was not truly a solution for those who were confronting the difficult financial and medical realities of job loss that also meant health insurance loss. It only meant that there was technically a way to stay insured, not that it was a viable option for an American worker in a difficult transition period. Covering the issue in 1986 in the *New York Times*, Leonard Sloan writes:

> Those who choose to continue their coverage can be charged up to 102 percent of the premium paid by the employer for each similarly situated worker. The additional 2 percent was put into the law to cover the extra expenses for the company involved. “The employer’s cost is usually substantially less than an individual would have to pay,” said Lawrence Lenahan, a consultant at Buck Consultants, a benefits concern. “The benefits under most group plans are substantially more generous than would be available under an individual policy.” (Sloane 1986)

Truly, the *longue durée* culture that informs COBRA is remarkably different from French *longue durée* culture. In France, when an individual is most vulnerable and most in need of solidarity, they receive more support, even when it costs the state more. In France, chronic illnesses are covered at higher rates. In the U.S., chronic illnesses are pre-existing conditions that until the ACA, could entirely prohibit a person from obtaining medical insurance. In France, medical coverage also increases with a person is unemployed. In the U.S., up until the passage of the ACA, if a person wished to retain any sort of insurance coverage after losing a job, they would need to pay 102% of the original cost of the plan, which would likely have been far higher than the cost they had been used to paying, since many employers cover anywhere from half to the entire cost of employee health insurance. In the U.S., care is entirely conditional and circumstantial. Differences in *longue durée* culture have informed health policy to such a strong degree, that they have created entirely different health experiences, rights, and realities for French and American citizens.

The U.S. also expanded coverage incrementally during certain periods. However, due to differences in *longue durée* culture these expansions were not similar to France's incremental expansions. Incremental healthcare expansions in the U.S. never had the stated goal of covering the entirety of the population eventually. They were not intended to be the establishment of a citizenship right. Instead, they were measures used to correct severe problems of health accessibility in only the most vulnerable populations. The fact that the general population was never covered with such an expansion suggests that the aid extended was meant to be a temporary fix to being in poverty. Any enduring health right tied to citizenship would need to cover the general American population, not just the indigent. Furthermore, it would be fanciful to think that American *longue durée* culture would support a right tied to citizenship that only applies to stigmatized populations, not the general, unstigmatized population.

To illustrate the above, consider the following U.S. policy innovations. The Medicaid budget measure which may have inspired Reagan's spectacular welfare queen caricature was passed in 1986 and expanded again in 1987. OBRA (Omnibus Budget Reconciliation Act) expanded access to prenatal care. Lowering infant mortality rates was the most important goal of this expansion. Infant mortality rates had skyrocketed, as over time, income-based eligibility had disqualified many pregnant women from receiving Medicaid. In order to receive Medicaid for prenatal care in 1986, a woman needed to earn 48% of the poverty level or less (Hill 1990). In order to improve this, separating Medicaid for AFDC (Aid to Families with Dependent Children) was necessary, and this legislation allowed this to happen. The legislation allowed states to participate in this program to expand their programs to new levels. OBRA allowed states to extend Medicaid to infants, young children, and pregnant women at 100% or less of the poverty level for children up to five years of age, regardless of whether they were already receiving other forms of public support. This expansion would continue incrementally. OBRA 1987 expanded coverage to pregnant women making 185% of the poverty level and children up to 8 years of age. The Medicare Catastrophic Care Amendments of 1988 mandated that any state that had not expanded coverage in response to the previous two reforms expand coverage to women and children at or below 100% of the poverty line. Finally, OBRA 1989 superseded MCAA and mandated that states expand coverage to pregnant women and children up to six years of age at or below 133% of the poverty level (Hill 1990). While these expansions may seem out of line with American thinking on health care rights and *longue durée* culture, they are not. They are a crisis response to a worsening health access problem. While the U.S. does not have the *longue durée* culture to support true health rights, the country also does not have the *longue durée* culture to allow indigent women and children to remain entirely uncared for and destitute.

However, receiving this emergency care comes at a high price. The stigma incurred from benefiting from one of these programs indicates that even though these programs exist, they are not rights. This aid is begrudgingly given to the most needy, who are then stigmatized for accepting. This is in great contrast to France, where the ability to provide solidarity and support is part of the celebrated national identity, commemorated in museums and formalized societal discussions like the *Etats généraux*.

These incremental increases in eligibility also needed to be accompanied by structural changes which would help women and children receive care. Ineligibility was not the only problem facing women and children. The stigma attached to applying for aid, difficult application processes and inaccessible application centers, limited awareness of expansions, the low quality and availability of Medicaid prenatal services, and lack of cooperation between state agencies would all need to be addressed in order to make care accessible, even once women and were eligible (Hill 1990). Individual states addressed these issues with varying degrees of success. Still, the presence and impact of the stigma of benefitting from these programs suggests that these programs could not be further from rights. Exercising a right bears no stigma whatsoever. In fact, exercising a right is commonly celebrated, as is the right to vote in the U.S. A right can also be celebrated as a marker of national identity and belonging to the national community, as social security and health insurance is celebrated in France.

Furthermore, in the U.S., these incremental expansions for the indigent were made only when the situation had become dire and the need for aid was extreme. While French healthcare expansions were often made incrementally, these expansions still seem to have quite a different nature. First, France swiftly covered all children and all pregnant women early in their path towards universal health insurance. The U.S., on the other hand, very, very slowly covered poor women and poor children, and only when it became obvious that these populations were suffering and affecting the health of the country as a whole. In 1986, the U.S. ranked behind 17 other industrialized nations in terms of infant mortality, and infant mortality in African American communities was nearly double that of the national average (Hill 1990). These catastrophically awful results were a possible impetus to the reforms of the late 1980s. These populations needed health care, but had no access to care because the public health system had not yet been extended to them, and their employers were not required to offer health coverage to low earning or part time workers. Of course, workers with young children, or the unemployed with children, could not purchase private health insurance plans, so these individuals were truly shut out of the medical system. These expansions were not discussed as human rights, nor as American rights. In fact, the programs still carried so much stigma, that though coverage rates and sign-up rates increased, many avoided the services (Hill 1990). As noted frequently in this chapter, welfare recipients, especially “welfare queens,” the Reagan term for women with children on welfare, were the most highly stigmatized of groups.

Lessening the burden on emergency rooms could have been a secondary impetus for extending care to poor mothers and their children, but it is equally possible that it was the entire impetus, furthering the case that these expansions were far more about relieving burdens on the medical system than they were about rights. With the passage of EMTALA, the care of poor mothers and children would have been exclusively burdening emergency rooms, which would be entirely unsustainable and financially unviable. Given Reagan’s thoughts on Katie Beckett detailed above, it is clear that avoiding cost redundancies was a big enough impetus to change health policy in the U.S. Therefore, it is very reasonable to read this policy not as rights-based, but as a way to funnel indigent care to less costly channels. An emergency room is an extremely costly place to have a baby or receive prenatal care.

The failed Medicare Catastrophic Coverage Act (MCCA) serves as an example of how American *longue durée* culture informs feelings about when individual price increases on health care are tolerable. The MCAA expanded Medicare to include prescription drugs and placed a cap on patients' out of pocket spending. It included hospital costs, physician care, and prescription drugs. However, these provisions proved unpopular, with seniors believing that the costs of the program, born by seniors themselves, outweighed the benefits. The program was therefore repealed the following year. This was the first time that a Medicare provision had been reversed (Rice, Desmond, and Gabel 1990). The MCAA was cancelled after widespread outcry, mostly from seniors who already had full health insurance from a prior employer (Rice, Desmond, and Gabel 1990). They resented paying an extra "tax," when they would not benefit from any extra care, insurance, or lowered costs. Unlike other Medicaid provisions, this one was financed entirely by the elderly (Rice, Desmond, and Gabel 1990). Even the prescription drug benefit, which was a new and significant expansion and which formed part of this legislation, proved to be unpopular when financed this way. The increased political participation of seniors, the trust they are granted, and their experience of this expanded right helped them to repeal this unpopular policy. Though the prescription drug provisions addressed in-home infusions and other more intense prescription needs, another real issue was that the provision did not expand Medicare to nursing home services, which was of top importance to seniors looking to avoid impoverishment or the impoverishment of their spouses due to aging-related medical needs (Rice, Desmond, and Gabel 1990).

Of course, the repeal of this legislation would affect less wealthy seniors the most. Those who did not continue to benefit from employment-related health insurance were the most likely to benefit from the program (Rice, Desmond, and Gabel 1990). The resentment and indignation of those already insured individuals would later become a theme in subsequent health initiatives. As discussed above, American *longue durée* culture supports the right to be unbothered in the service of others before it supports the right to health care. By the same logic, those who were already paying for private insurance, either in part or through their employers, have often been reluctant to change health plans in any way or to pay an additional fee, premium, or tax in order to ensure more individuals.[20] The exact name or use of the funds matters little—what is important is the sentiment that those who are insured have already made their hefty contributions, and that they should not be additionally burdened or bothered in any way in order to help provide for others. As we will see in later chapters, this sentiment would resurface during Clinton's proposed health reforms, as well as during debates surrounding Obama's ACA.

As in other examples, this policy demonstrates that American *longue durée* culture does not embrace the concept of solidarity like that contained in French *longue durée* culture. Furthering this research could include investigating whether groups that have already been deemed to merit care feel unease at being asked to contribute further in order to extend care to others within their same merit group. Like discomfort at financing care for the stigmatized and the general population alike, this is reflective of Americans' preference for a freedom that does not impose any restriction on their behaviors leaving them free to pursue their goals without hindrance, as well as the preference for an individualism which does not include a relationship to

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[20] Americans are so sensitive to needing to change doctors or health plans due to new legislation that Obama addressed the issue a minimum of 37 times (Politifact n.d.).

or responsibility for the collective. Both sentiments are expressed in reactions to various policy proposals and changes, so it is reasonable to believe that both can be active at any given time. In particular, the MCCA asked a group that had been accepted as worthy of support from the "collective" and asks them to pay an additional fee to insure the rest of the group. This group would already feel that they had made their contributions to public health and well being, and their feeling would be backed up by historical policies, such as the Social Security Act, which confirmed their merit to receive support and care from public funding. By being part of this merit group, seniors may feel that they should especially not be availed upon to support others. This point could be explored further in later extensions of this research.

Price Increases Impact Policy

By the 1990s, the costs and scope of medical care were staggering. Increasingly expensive medications and procedures combined with the resulting increasing life expectancies to create true funding and finance conundrums for healthcare systems, insurers, governments, and patients alike. The result for patients can be fear, distrust, anger, financial ruin, and unnecessary mortality if they are not shielded from increasing costs. For governments, the challenge of funding medical care becomes increasingly tangled and disorienting, especially as anger from constituents grows, deficits increase, and elections near. Medical professionals are in the middle of a true storm. They are caught between the pressures of patients, insurers, and regulators. The professional pressure they experience has proven to be very disorienting. Policy makers, medical profession, and patients alike have found these situations nearly insurmountable at times. As such, they attempt to leverage *longue durée* culture as much as possible for stability and support. However, there are true limitations to how successfully this can be done.

In France, if changes are made to social security that do not reflect the solidarity of *longue durée* culture, unrest and strikes ensue. This is not to say that all budget cuts will cause strikes, but rather, cuts that go too far, are too deep, are too symbolic, or strike too deeply at the heart of *longue durée* culture will. If French administrations cut funding to social security programs, they must walk a careful line of balancing the need to preserve rights carefully and wholly while accomplishing their budgetary goals. The French passed several cost control measures in the 1990s, only a few of which caused great unrest. In 1990, to appease doctors, an agreement between private doctors and three principal health insurance bodies created policy which would support fees above the regularly set prices, at the discretion of the doctors. Several measures passed that raised prices, and in particular, hospital fees rose in 1991. Also, reimbursement rates were lowered under the Veil plan. While these changes were scarcely celebrated, they did not cause the powerful pushback that the later Juppé Plan inspired.

The 1996 Juppé Plan was intensely and uniquely unpopular because it was perceived as policing doctors too heavily (Trat 1996). The plan's main focus was controlling medical spending via price quotas, monitoring medical treatments, and evaluating results. It relied heavily on the newly established ONDAM (*Objectif national de dépenses d'assurance maladie*—National goal for health insurance spending). Doctors felt especially threatened by this reform, and made much to do about being "surveilled." An even less popular provision of the legislation, which did not pass, had proposed fining doctors for exceeding their spending limits, which had been set by a French version of DRG's. Victor Rodwin, writing for *Le Monde* aptly reflected:

> But the architects of the Plan Juppe do not dare to get beyond the administrative reflex to reinforce the control of the state. They do not recognize that, to cite Michel Crozier, you "can't change society by degree." If they had talked with people in the area, the managers of health insurance bodies, health professionals,

> and academics, the counselors of the Prime Minister would have certainly noticed that it is not enough to just adapt the health system, the role of the state must also be changed. It's not about criticizing the accrued role of the state in the financing of the health system, nor the end of the management by joint commission, nor the legitimacy of the Parliament to vote for a budget for the spending of the healthcare system. What is worrisome in the Plan Juppe is the reinforcement of an already overly centralized role of the State in the management and the regulation of the health system. It is absurd, for example, that the minister of health nominates doctors and decides their pay in public establishments. One adaptation of the role of the State consists more or less of setting hospital budgets in function of their performance and overseeing the medical results obtained by hospitals. It's the same for the mechanism of *maîtrise médicalisée.* Though it's important in France as well as elsewhere to develop best practice recommendations, it seems presumptuous, for a country that already knows the pathologies of its patients and the diagnostic tests and therapies practiced by its doctors, to apply opposable medical references (RMO) across its entire territory. (Rodwin 1996, my translation)

However, one non-health related feature of the plan also caused great pain. Retirement was made stricter: a person would have to pay into social security for 37.5-40 years before they could take a pension as opposed to simply qualifying by hitting the established retirement age (Filoche 2015). This change in social security triggered huge strikes. French culture values a focused pace of work, workers' rights, and leisure. Cultural and political evidence can be found in the fact that most Catholic holidays are bank holidays in France, many shops and industries are closed on Sundays, the entire month of August is mostly reserved for vacations, there is a two-week skiing holiday after Christmas, lunch breaks are rarely less than an hour, and the legal work week is 35 hours. This change to retirement policy would represent a grave threat to this *longue durée* cultural preference for protecting free time and preventing a culture of workaholism. Challenging a cultural trait so deeply ingrained in French common sense and *longue durée* culture could have only been met with outrage. The health reimbursement changes did not pose such a great resistance because the policy change was small enough to avoid causing mass upset. The healthcare system was not truly threatened by a few cost cutting measures the way that retirement was threatened by imposing a quota on worked years as opposed to an age. The French show solidarity in the way that they provide social programs, but also in the way that they protest changes to their system of social protections that are perceived as threatening *longue durée* culture. French strikes are infamous for mobilizing many groups across all parts of society.

Of course, not every cut or change to social security results in strikes, vitriol, and press controversy.[21] The French stand up for their social protections and support justified cost-saving measures that increase the possibility that more citizens will receive care. The negative reaction to policies such as the Juppé Plan, typified by Rodwin's article and the protests of physicians, as well as by the strikes that continued one year after the announcement (Rouard 1996) and opposition from the general public, further indicate there is a limit to what the government may regulate or impose. Controlling medical spending with quotas and fining doctors could easily compromise the quality of care that the collective population could benefit from, since the medical population could certainly be alienated or potentially too financially harmed to continue to practice. Therefore, these policies, while they may have generated some revenue or created some savings, were not seen as viable options.

A popular French health reform that would likely violate American *longue durée* culture was made in 1999. Since its introduction, the *Carte vitale* has become one of the most iconic features of French health insurance. This is a is a credit-card-sized card which has a chip and increasingly often a photo of the bearer. Since 1999, any person signed up for French health insurance possesses a *Carte vitale*, which they present each time they see a doctor, fill a prescription, go in for blood work, or check into the hospital. These cards store all of a French

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[21] Newspapers even refused to run Juppe's ads that attempted to better explain and support the plan (Biffaud 1995).

patient's medical records, eliminating the need for paper documents, repetition and redundancy of tests or procedures, and advising pharmacists, doctors, and other medical professionals of a patient's medical history. This has been one of the most successful health reforms, and has even been described as an object with a popular cult following (*Objects de légende* n.d.). In the U.S., discussions of centralized medical record keeping have been met with fear and distrust (*Fox News* 2010; Lafky and Horan 2011). In France, such fears were by contrast limited. Instead, the goals of reducing medical expenditures by reducing redundancy in paperwork, speeding reimbursements, and simplifying physician and patient workload were applauded (*La Depeche* 1998). The *Carte vitale* was a health reform that helped to make care more efficient and therefore somewhat less costly without requiring any cuts to reimbursements. This is perfectly in line with the solidarity of French *longue durée* culture. In the U.S. however, such a program triggers *longue durée* culture fears of inefficient government control over individuals.

Marketed as a strategy to provide more care to all by cutting costs, a French campaign to promote generic pharmaceuticals began in 1999 and continues today. Created during unsettled times of health care, the initial 1999 legislation gave pharmacists the ability to substitute generic medications for name brand medications without an explicit recommendation from the prescribing physician. Since the French government regulates the costs of any pharmaceutical product produced in the country, this measure did not draw a huge amount of opposition from the pharmaceutical industry, as its power was already quite limited. Instead, the strongest opposition came from consumers, who doubted that generic medications would be as effective or equally safe. The campaign surrounding a switch to generics would emphasize quality control, effectiveness, and the ability to provide more care at lower costs to more French people (Rougerie 1992).

In today's continuation of the generics campaign, the message remains the same. Consider the following two texts from the French Social Security website. First, this website features a Q&A about generic medications. The subtitle of the article reads, "Learn how generic medications participates in the financing of innovative treatments and preserves our health system" (*Ameli.fr* 2018a). Next, an article on the same website titled "Why use generic medications?" starts off with the following text: "Generic medications allow the savings of 1.6 billion Euros annually. These savings help guarantee access to therapeutic innovations, while still guaranteeing quality care. Using generic medications is economical and civic minded!" (*Ameli.fr* 2018b). These utilitarian arguments about the utility of lowering costs, where the greatest utility is defined by the ability to treat more people and provide more care, fit in perfectly with French *longue durée* culture. Here, greater solidarity, greater access to care for more people, the preservation of the health system, and the ability to support innovations are all the reasons to switch to cost-saving generic medications. These French arguments rely on deeper French ideologies of solidarity and equality to promote generic medications to spur cost savings that can be redistributed across all beneficiaries of the healthcare system. This is in stark contrast to American *longue durée* culture arguments about health care, where one of the most prominent arguments is that care is simply too expensive to extend to an increasingly large segment of the population.

Another 1990s unsettled health care times initiative was the *medecin referent*. This laid the groundwork for the 2004 legislation establishing *médecin traitant. Médecin traitant* required every person to choose a primary care doctor. A patient was free to change their primary care doctor as frequently as they wanted, but in order to benefit from the full coverage rates for specialists, prescriptions, and testing, they would need to first visit their primary care doctor. It was believed that many people were bypassing primary care in order to immediately see specialists. Sometimes patients would choose the wrong specialty, or would see specialists for issues that could be easily handled by primary care doctors. This created higher costs and placed a heavier burden on the social security budget. French commentators worried that this restriction would create a healthcare system *á deux vitesses* (a two-speed healthcare system). They worried that those who could afford to forfeit the full coverage rates would be able to see their specialists faster, meaning that their health issues would be treated more quickly, resulting in increasing health for the wealthy, and decreasing health for those with more modest means (Le Monde 2004). Consider the following viewpoint. Phillippe Fourgeaud, 38 years old, writes to *Le Parisien* to explain his opposition to the *médecin traitant* reform. He states: "No, I will not take a médecin traitant. I am capable of determining myself whether I need to consult a specialist. The patients that get sent to a specialist by their médecin traitant will have long waits. I do not want this for myself. Generally I think that this reform promotes two-speed medical care based on money" (Fourgeaud 2005).

The reaction to this policy fully demonstrates France's focus on equality. Due to the pervasiveness of this fear, the Minister of Health and Social Protection ran full page ads in newspapers with the following text in order to combat these fears. The text reads:

> Health Insurance Reforms: So that two-speed medicine never exists. The quality of our social security and the great pride of our country is that we can all be cared for in the same way. Without this reform, that accomplishment could be compromised. By making sure that everyone from health insurance managers, to health professionals, to patients, adopts new behaviors, we will not only preserve healthcare equality in our country, but we will also improve our health system. (Ministère de la santé et de la protection sociale 2004)

This response reminds us that for the French, the state must make sure that all people are able to avoid destitute need, but it must also make sure that even the lowly receive a quality of care that is dignified and worthy of both rich and poor. This equality is a deep feature of French *longue durée* culture. One of the basic premises of this culture is that all should be able to access care, but equal care, that is dignified and of high quality. All citizens merit the same care, regardless of their socio-economic status or work status. Comparing this to the U.S., where Medicaid recipients have battled for care due to the fact that their treatments will not be reimbursed at full market rates, shows just how different these approaches really are. In the U.S., merit for care is tied to type of employment, means, veteran status, and age. The American indigent receive a quality of care that is inferior to the private care that those on employer-financed plans receive. American medicine has far more extremes than just two speeds, yet no legislation aimed at reducing these inequalities has been successful enough to make a long-term reduction in health inequality. The inability of the U.S. to pass health legislation geared at systematically reducing health inequalities seven decades after World War II indicates that the country simply has different priorities informed by different *longue durée* culture. As we will see in later chapters, Americans are far more attached to the concept of choice than they are to the concept of equality, even when realistic choices often remain limited even for the insured.

Coverage for All French, Finally, and Clinton Era Failures

By far, the most symbolic French health reform of the 1990s was the 1999 CMU (*Couverture maladie universelle*—Universal Sickness Coverage), which was minister Martine Aubry's policy child. Universal medical care for all French people was a goal of French Social Security since 1945, but it was not until 1999 that it finally became a reality. This expansion covered individuals who were so poor they could not pay the *ticket moderateur* (copay), foreigners in France who were legal residents but not working, people who had exhausted their unemployment benefits, young runaways who were not yet legal adults but who could not obtain documents from their parents and could not be covered by student health insurance, and homeless people who were too far outside of the system to qualify for care.

By this time, these uninsured people numbered very few. While this legislation accomplished many things, the French press focused on its covering of complementary insurance for those making less than 3500 francs per month. This means test was likely the most controversial aspect of the plan. Aubry originally proposed a threshold of 3800 francs per month, but that number was ultimately reduced to 3500 francs per month. An article in *Le Monde* discusses this debate and Aubry's response. It states:

> The minister [Aubry] took care to point out that the policy "is not only intended for the excluded." It also applies to "salaried workers, artisans, and retailers with low revenues."... As expected, her response to the means tested limit, set to 3500 francs per month, was addressed to both the right and the left. The Green and Communist deputies… really tried to bring the means tested limit to 3800 francs. The right contests the principle of the means test, contrasting it to a personalized, degressive assistance based on revenues. (Fabre and Mandraud 1999)

Here, the financially conservative right argues and succeeds in securing a higher limit to the means test, somewhat minimizing the eligible population, which would certainly result in a cost savings. However, the right was not arguing that people of low revenues did not deserve this care. In France, the beneficiaries of social programs and welfare, including health care policies that specifically benefit the poor, are not stigmatized. Since all French people benefit from such programs, and since some programs are means tested, this is simply a normal way for the French to access services and rights. Meriting care is as simple as qualifying for French health insurance, which post-CMU is exceedingly simple for legal residents. While there was indeed some debate as to the feasibility of this last expansion, there was little outright opposition.[22] In an article covering the initial vote on the CMU by the *Administration de la Caisse nationale d'assurance-maladie des travailleurs salariés*, reports that the most common objections to come from employers, the CFDT, and insurers consisted of objections to the ability of beneficiaries to choose between social security organizations and specialized private insurances (Bezat 1999).

Additionally, some non-citizen residents of France would also become eligible for health coverage. What is truly amazing is that most articles about the CMU focused on the French people that would be able to access a complimentary health insurance as a result, as opposed to the inclusion of foreigners in legal situations. Despite the inclusion of foreigners, this legislation did not spark massive fears of immigrants. By contrast, in the U.S., potential health policies are sometimes critiqued as unfairly benefiting immigrants.

Yet again, this policy is an example of the French following through with the values of solidarity as prescribed by their constitution. The very nearly universal coverage achieved by this law and the relative lack of opposition indicates that the French truly view health care as a right, regardless of income or national origin. Following this intention is clearly an instance of returning to *longue durée* culture. This final push towards universal care was an important moment in French health policy. It represented the completion of a project that had been in the works since 1945, and one which was important enough to appear in the constitution.

The real American health drama of the 1990s was Clinton's 1993 Health Security Act and the White House Task Force on Health Reform led by Hillary Clinton. The plan set up an employer mandate, as opposed to the individual mandate that the ACA would eventually

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[22] Criticism of the plan was relatively weak, so much so that Aubry would declare that opposition to the policy deserved real debate as opposed to simple sarcasm (*Le Monde* 1999).

employ. The most frequently leveraged *longue durée* cultural concept of the Clinton plan was "Managed Competition," and it included the employer mandate, universal coverage, plans to preserve competition between insurers, and government regulations on the insurance industry. Competition and the need for competitive markets seems to be part of American *longue durée* culture. The ideological pitch and consistency of these arguments suggests that these concepts were leveraged during the unsettled times of the Clinton health care reform efforts as an attempt to find a way to orient action and decision making. Consider the following interview with Hillary Clinton. In this interview, Clinton is proposing improving Native American access to health care via her proposed reforms, only to be met with concerns about the lack of competition in rural communities. The interviewer asks, "Here in the rural areas, I'm sure you're well aware, there is very little competition in certain sectors. How is the approach going to handle that situation?" (Berry 1993). Essentially, this interviewer is concerned that the Clinton health care plan could fail to aid rural populations due to the fact that there is not sufficient competition to manage.

However, Clinton's response to this question misses the mark when it comes to effectively leveraging American *longue durée* culture. In response to the question about competition in rural areas, she states:

> So what we're looking at in rural areas is making sure that any group of physicians or any other health care providing network, whether it is organized in an urban area or whether it is supervised by the state, will have to provide services in rural areas as well as in poor urban areas. We're not going to let people only serve those patients who are affluent or who are well organized to start with. And I think you will find when we come forward with our plan that it will be a mix of the public health system where it is necessary, including using the best of the existing kind of organized networks and it will maintain a fee for service so that people will never be forced to use a doctor they do not choose to use. (Berry 1993)

Clinton's answer is as vague as it is offensive to other American *longue durée* cultural elements, namely, freedom of choice for both patient *and* physicians. While Clinton's response could potentially indicate that rural Americans would have more health care options and as a result, greater freedom of medical choice, her response clearly threatens the professional freedom of physicians. This mismatch, and similar mismatches throughout the campaign, indicate a lack of congruence between the Clinton plan, the discourse in favor of it, and American *longue durée* culture. Policy this incongruent with *longue durée* culture cannot be successful.

The American desire for competition and its inclusion in *longue durée* culture ultimately stems from beliefs about capitalism's power to keep prices low and reward those who provide the best possible products and services. Consider the following *New York Times* editorial from 1992:

> But for all their promise, H.M.O.'s have produced only modest benefits so far. That's because the current system doesn't force them to compete. That would dramatically change under managed competition once sponsors are in place… Consider Calpers, the organization providing health insurance to nearly a million California state employees. It adopted managed competition rules last year. What happened? While premiums soared everywhere else, a quarter of the H.M.O.'s with which Calpers does business maintained present premiums—or even reduced their premiums. (*New York Times* 1992)

Here, the author has only one example of managed competition in a health care context. Despite the fact that a myriad of factors could have caused, contributed to, or otherwise been a substantial factor in Calpers' maintained and lowered premiums, managed competition is quickly considered to be the reason for the favorable pricing result. This lack of true logical connection indicates that the writer was ready to be comforted by a concept within American *longue durée culture.* Defaulting to long held beliefs about the merits of competition and capitalism is a common way to leverage *longue durée* culture to navigate change.

Despite attempts to address the American need for competitive markets, the plan was attacked on several levels, and of course was finally defeated in 1994. The greatest criticisms of this plan centered around loss of medical choice, fear of poor budgeting leading to insolvency or inability to provide care, anti-socialism or anti-communism, personal attacks on Hillary Clinton as a way to discredit the proposal, objections to the potential of including birth control or abortion services, distaste for the idea of treating addicts or the mentally ill, and fears that prices to individual consumers would increase. Amazingly, many of these fears and objections were also leveraged in the Harry and Louise ads that were widely televised (Clinton Presidential Library YouTube Channel 2014), attesting to the effective cultural research that must have been conducted to inform the ads. The ads, when viewed together as they are presented on the Clinton Presidential Library YouTube channel, feel like a sizzle reel of the hardest-hitting American cultural and political fears when it comes to health care.

It is important to look beyond these iconic ads to understand fully the context of the time. Consider just a few of the objections found in the press. First, *Times-News* of Henderson North Carolina ran a story from the associated press that detailed the sorts of compromises Americans would face under the Clinton proposal. It reads,

> Under President Clinton's vision for a radically different health system, there would be no worries about losing health coverage if you were laid off or your child took seriously ill. But there's a tradeoff for that security: Most Americans would face restrictions on what doctors they could go to, and health insurance would likely become more—not less—expensive for the young... Forty-one million Americans are already enrolled in health maintenance organizations, and many others are accustomed to going to doctors their employers prefer and getting pre-approval for hospital stays. But others may chafe at such restrictions, and they will almost certainly find Clinton's promised fee-for-service option does not afford them as much freedom as they now enjoy. (*Times-News* 1993)

Here, reduced choice for anyone is simply objectionable, even if the majority would be better served if everyone would switch. Confronted with rising costs across the entire healthcare system, Americans who had secure health care clung to their individual preferences and liberties as opposed to compromising in order to extend care to their fellow citizens. This radical individualism is part of American *longue durée* culture. As such, this culture is especially leveraged in the face of turmoil, potential reform, and unsustainable costs. This time of health care crisis is marked by insecurity and uncertainty as to whether reforms will bring truly better options. For Americans who are happy enough with what they have, the ability to avoid change, maintain their strict individualism, and refrain from paying more into a system which would support others represents the most stable and least threatening way to proceed. Since solidarity is not part of American *longue durée* culture, it cannot be leveraged in the face of the uncertain times of health care.

Next, the Clinton plan brought fears of health care rationing, budgetary insolvency, and increased costs to consumers. Walter Williams, writing for *The Item* from Sumter, North Carolina writes:

> People would overuse the system and not take the preventative care means they'd otherwise employ… [Insurance companies] may raise premiums, raise co-payments, have a czar to ration services by dictating what services are reimbursable, or some combination of these options… Medical savings accounts are far superior to the Clinton crowd's agenda to socialize our medical care system. (Williams 1994)

These fears, as discussed earlier, likely stem from an American *longue durée* tradition of distrusting any redistributive state intervention as socialist. They are also in reaction to the conflict between the deep individualism of American *longue durée* culture, and the more collectivist nature of national health insurance. Williams's reaction also speaks to the belief that people will abuse the system, a belief that surfaced around Truman's efforts for national health insurance as well. Critics of these policies have a deep belief that individuals act selfishly and are not responsible citizens. There seems to be a generalized *longue durée* lack of trust that applies to the general population in a milder way, and to the indigent in an intense way. Finally, Williams believes that health insurance companies will simply respond by limiting care and raising prices. This just seems accurate and true, given the current American experience of health care.

The *Michigan Daily* reported on the financing of the Clinton Plan thusly:

> The general savings, Clinton contends, will be brought about by the decrease in paperwork and bureaucracy in addition to the increase in efficiency and competition within the system. These reservoirs of financing can best be described as fantasy, especially the latter, and exist only in government theory for the moment… Congress must take a careful look at the costs and make certain that the plan is affordable before passing any bill. Clinton owes it to the American people to develop a better financing system for this reform. (*Michigan Daily* 1993)

A response to these issues can be found in the proposals to tax tobacco products up to $2 per package as a way to pay for the health care plan. Personal responsibility and self-reliance without the need to impose upon others is a deeply embedded *longue durée* American trait. This trait shows up in this funding mechanism in that it proposes targeting individuals who are likely to have increased health problems for increased taxation. In this way, these individuals would be paying for their more expensive care as opposed to relying upon the collective. This serves American *longue durée* culture very neatly, in that it was perceived to force tobacco users to have an increased financial responsibility for health care financing due to their tobacco use to contribute at higher rates commensurate with their higher need. Consider the following newspaper article from *The Wilmington Morning Star*. The author, Peter Passell of the *New York Times* News Service states: “President Clinton is eagerly eyeing a fat new tax on cigarettes, and for reasons easy to fathom. Tobacco addicts are a proven menace to themselves and others, so why not turn that to advantage, deterring their destructive behavior with high costs and using the revenue to offset the burden smokers add to the nation’s health bill?” (Passell 1993). Here, smokers are irresponsible people impinging upon the liberties of others that would potentially share into their health care costs. By American *longue durée* culture, it is only fair for each to pay their own way, especially if poor health decisions like smoking lead to greater costs. This is not *solidarité á la francaise,* where the collective can be counted on to cover any part of the population regardless of health status.

While official objections to policy do not often simply declare that they do not care to provide for the needs of marginalized groups, a few of these objections are close enough to such a declaration. Moralizing which conditions or individuals deserve treatment does seem to be rather unique to the U.S., and has been a recurrent roadblock to health reform proposals. It has indeed been more difficult to provide care to "undeserving" populations in the U.S. than in France. Furthermore, the French celebrate social security and even the behavior changes that make it possible, while policies in the U.S. frequently die as a result of the inability inspire insured individuals to accept changes that might help others achieve coverage. The French prefer to compromise so that all can be free from want of medical care, while the U.S. prefers to leave millions uninsured in order to avoid obligating anyone to compromise.

Many proposals followed Clinton's plan, indicating consensus on the need for reform, despite an inability to find a reform method that would not alienate *longue durée* culture. None of them were successful. These included a single payer plan by McDermott and Wellstone as well as Cooper's managed competition minus the aspiration to universal coverage. These plans were attempts to bring the reform efforts more into line with specific political interests. Namely, the Cooper plan would shy away from universal coverage, which has most commonly sparked indignation across several groups.

Following these defeats, a few rather minor regulations were placed upon the health care industry. The 1996 HIPAA (Health Insurance Portability and Accountability Act) placed a few minor controls on pre-existing condition coverage denial (this issue remained serious for many

Americans until the ACA) and provided incentives for long term insurance plans. In the same year, the Mental Health Parity Act required coverage of mental health services to be on par with other coverage rates, with the exception of substance abuse issues. These regulations speak to the need to regulate the industry, but also the feebleness of American policy makers to effectuate truly necessary change in the face of interest groups, politics, and cultural obstacles. They also demonstrate the continued moralization of care and the dividing of patients into "deserving" and "undeserving" groups. Substance abuse, despite being treatable, is highly stigmatized as an issue that belongs to poor and irresponsible populations. In the U.S., the poor and needy are already stigmatized, before they are even identified as substance users or abusers. In a culture where it is already difficult to justify collective care for individuals, collective care of the stigmatized is even more challenging to establish. Substance abuse is interpreted commonly as a willful illness, making it even more difficult to justify extending state support. It is not in the same category as renal failure, despite the fact that renal failure is most often triggered by type 2 diabetes and high blood pressure, which are illness that could be arguably caused by willful lifestyle choices. The difference is that the lifestyle choices which lead to diabetes and potentially renal failure are not stigmatized. Instead, they are perhaps the most typical American lifestyle choices, which means that this group will not be stigmatized. Stigma, it seems, has saying power. The persistence of outrage over ACA plans funding birth control demonstrates the longevity of stigma, even if some of these attitudes have recently softened somewhat.[23]

There were also a few important changes to Medicaid in the aftermath of the Clinton plan. The 1996 Personal Responsibility and Work Opportunity Act disassociated the qualifying process of cash aid programs and Medicaid and let states covers families at AFDC (Aid for

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[23] Fighting about abortion has slowed many health reform plans, including the ACA (Rovner 2018).

Families with Dependent Children) rates. However, in order to finance the program and make it ideologically “easier,” it also disqualified legal immigrants from Medicaid coverage during their first five years in the country. Here legal immigrants were a pawn to *longue durée* culture, which dictates that only certain individuals within national borders merit care. These certain individuals are ideally English-speaking Americans that are not poor or unemployed. As evidenced by the powerful anti-immigrant sentiment of the Trump years, Americans are unwilling to extend their national community to include immigrants, despite the national origin story of the melting pot. Fears of immigrants as freeloaders are not uncommon, putting immigrants into a stigmatized group similar to that of Welfare Queens. Recent research points out that anti-immigrant and immigrant-as-freeloader perceptions persist despite the fact that studies show that immigrants use fewer health services than U.S. born low income households (Berlinger 2018; Roy 2011).

The Balanced Budget Act of 1997 made some provisions to slow Medicare and Medicaid spending, most of which involved reinforcing use of HMOs. The same act created S-CHIP (State Children’s Health Insurance Program), which gave states federal grants to cover poor children above the poverty line, and allowed for mandatory inscription in Medicaid managed care programs. The 1999 Ticket to Work and Work Incentives Act allowed states to cover the disabled earning up to 250% of the poverty line, but to also charge them higher income-related premiums. These changes show that coverage cannot simply be extended to stigmatized groups. Stigmatized groups can become hostages in health policy negotiations and can be used as leverage against or in the service of other stigmatized groups. The health rights of legal immigrants, who are stigmatized simply for not being originally American, needed to be traded so that more low income American families could be covered. If this sort of bargain, where one group’s health protections are traded for another’s, cannot be made, the vulnerable must simply pay more. In the above policy, the disabled but not entirely poverty stricken disabled could be assisted, but only if they were required to pay higher premiums. These targeted penalties indicated distrust, lack of solidarity, stigma, and an unwillingness, as opposed to the French willingness, to find ways to cover the entirety of the population. Clearly, *longue durée* culture dictates that health care is not at all a right in the U.S., and protecting vulnerable populations is viewed as a burden upon fellow citizen taxpayers. In the unsettled times of the health care pricing crisis, the U.S. falls back on *longue durée* culture to inform policy. This means that burdening others with increased taxes, in order to fund a right that is not established, for the benefit of stigmatized and vulnerable populations is entirely out of the question.

These programs were all a part of the Clinton welfare reforms. Welfare of most types had become unpopular. Many called for programs which would increase the responsibility and work ethic of recipients, improve employment rates of recipients, and discourage what was seen as personal dependency on welfare. Many believed that welfare recipients should be forced to "give back" if they were going to receive support. Consider the following article about a state welfare bill by Senator Bankhead that would be dependent on Federal approval, but which aimed to "slash Medicare benefits" by cutting off services after two years, albeit with increased health benefits:

> One of the pilot plans will require welfare clients to join a "workfare" program that ties benefits to getting a job. The other project stops increases welfare parents now get for having more children. "Welfare will no longer be a one-way handout. Society will assist those who are in need, but it will expect back responsible behavior," said Robert Rector, a policy analyst for The Heritage Foundation… Blackhead's plan and the other proposals each have similar incentives toward weaning welfare recipients off a government handout and to stay married. (Hollis 1993)

Furthermore, it is extremely interesting that later in the article welfare beneficiaries are referred to as "clients." The article states: "A portion of the Albright-Chestnut plan asks welfare clients if they want to join the program, but Bankhead said [his] approach is strictly mandatory" (Hollis 1993). A "client" is someone that has entered into a free but contractual agreement to receive services, most typically from a business. A person with rights is not a "client," as they are simply receiving what they are entitled to on the basis of their membership in a community or their humanity. The idea that welfare beneficiaries are "clients" reveals that American *longue durée* culture believes that welfare beneficiaries are needy by choice, that they could hypothetically choose differently, could choose a different service provider, and that they are free to end their relationship with the service provider. None of this is in fact true of indigent welfare recipients, who are in fact poor, do not have options for other service providers, must bargain or transact with something in order to obtain a service, and who arguably do not have the freedom of choices that is contained in the word "client."

Reforms proposals like this one appear to have been designed to bring the logic of welfare closer to an acceptable American vision of work ethic and independence. The Reagan "Welfare Queen" was still very top of mind, despite the political change of colors. As such, policies in this time favored "workfare" measures that required beneficiaries to find work in order to continue to receive benefits. This modification to welfare falls perfectly in line with American *longue durée* culture that specifies that the needy must not burden others, no matter the circumstances. This proposal soothes the conflict between this *longue durée* cultural tenet and the very existence of a welfare program. By requiring work and ending additional support for growing families, this proposal was able to include increased health care support, but only for those who were successful in finding work. The same article referenced above also states: "The idea behind the bill… is to limit benefits in exchange for boosting the support services and healthcare for those that can find work" (Hollis 1993). Again, we see a contractual bargaining for services for the poor that would be a simple right in France. Health rights in the U.S. cannot be simply given, they must be transacted for, and beneficiaries must be made to pay in some way if they are at all able, just as others must get an employer to pay for them, pay with military service, or pay by virtue of being old enough to have contributed into Social Security for a lifetime.

Given how deeply troubled this health care moment had become, some positive policy movement or at least agreement was needed. In an attempt to create some movement in the health policy arena, Congress debated a “Patient’s Bill of Rights,” but it was never to pass. It was modeled after the Consumer Bill of Rights, and sought to make insurance companies accountable for harms caused to patients and to guarantee emergency care regardless of ability to pay. This marks one of the more direct claims to health care as a right in the U.S. Since health care is not a right culturally accepted as a right in the U.S., it did not pass. Furthermore, this forward motion was countered by an enormous step away from measures which could help secure health care rights for working Americans in 2002, with the Medicare Prescription Drug, Improvement, and Modernization Act. This legislation created Medicare Part D, which covers pharmaceuticals for Medicare recipients. However, in a more hidden part of the legislation, it prohibited the government from negotiating prices with drug companies on behalf of Medicare patients. Given that the ability to do so is one of the most principal ways that other countries keep health care costs down, this locked the program into its pattern of exponential price increases, even if the lack of cost controls had not previously been explicitly protected. Here again, greater coverage for one group was achieved, while a great, albeit eventual, loss was incurred by other parts of the population.[24]

France continued to pass cost saving and revenue raising measures in the 2000s. The most notable of these was the 2004 reforms, which finally completely enacted and required participation in the *médecin traitant* policy. 2004 also saw the addition of a one Euro charge for each medical visit that was to be paid by the patient. This policy, which is still active, was hugely controversial. It has been criticized as unfairly burdening the poor. This also stirred fears about the development of a dangerous and unequal two-speed medical system. Consider the following text from *Le Monde*:

> For Solange Morgenstern, national secretary of the CHC, this is a "50 year step backwards... We're losing the notion of a universality that we finally accomplished with the CMU. This is a flagrant deviance from that, and could lead to privatisation for those that are able to pay." For Jean-Louis Deroussen of the CFTC, "One can't separate the French into two categories, those who can pay for a complimentary insurance and those who can't, or those who are a little sick and those who are very sick. Every French person must know they are covered." (Van Eeckhout 2002)

However, at the same time, the *Aide à l'acquisition d'une complémentaire santé* (ACS) was created. This helped individuals who did not qualify for the CMU to obtain a *mutuelle*, which would help those individuals lower their out-of-pocket costs, including the one Euro charge. This program was funded by taxes on the *mutuelles* themselves.

A New American Attempt—The Affordable Care Act

With the uninsured rate reaching 15.7% in 2007 (Quadagno 2005), individual states began new efforts to pass health reforms in the 2000s. Though federal action had proved

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[24] Additionally, we see another anti-regulatory provision here. U.S. *longue durée* culture is quite strongly against regulation of businesses.

unsuccessful time and time again, individual states had better success rates. This is likely both because there are fewer barriers to enacting policy on the state level, but also because states are more likely to have their own local *longue durée* policy cultures. Maine was the first, in 2003, with its DirigoChoice Health plan. The state expanded Medicaid, and created subsidies for individuals and small businesses to obtain health insurance. In 2006, Massachusetts passed the precursor to the Affordable Care Act. MassHealth was a universal program to get all residents of the state health insurance. The plan involved an individual mandate, as well as state plans and subsidies for health insurance. The program proved to be remarkably successful, with the number of uninsured reduced by half in just two years. Vermont was next, passing the Catamount health plan for the uninsured of the state. Also in 2006, San Francisco passed an ordinance requiring employers to spend a specified amount on health care for their employees per hour. This legislation created access to health services for all residents of the city. At the same time, California legislators attempted a universal health policy with an individual mandate based on contributions from both employers and employees, but it did not pass. San Francisco's local *longue durée* political culture is more liberal than the rest of the state. As a result, it often adopts rights expansions, environmental regulations, and social policy more quickly than the rest of the state and country (Dowd 2015).

However, the pivotal year in American health reform is clearly 2008. An election year, health reform was an important issue throughout the campaign, with both candidates drafting plans for health reform. Soon after the election, plans begin. Obama creates the Office of Health Reform to research the issue, and a plan is drafted which uses Massachusetts health care plan as a model. The first version of this plan is released as a white paper by Senator Baucus of the Senate Finance Committee.

The ACA passed in 2010, but had a long and troubled launch. It was taken to the Supreme Court over the individual mandate. Jason Riley explains the how the law has gone through the courts in the Wall Street Journal: “Last month the Justice Department reversed itself and opted to support a federal District Court ruling that the Affordable Care Act is unconstitutional. In December, Judge Reed O’Connor ruled that since ObamaCare’s individual mandate violates the Constitution, so does the rest of the law. Previously, Justice argued that only certain provisions of the law should be invalidated. Now it agrees with Judge O’Connor that the whole thing should go. The case is currently before the Fifth Circuit Court of Appeals, but chances of success are slim. Chief Justice John Roberts, who provided the fifth vote in the Supreme Court decision upholding the individual mandate in 2012, is not likely to change his mind. But even if he did, the Supreme Court has a long history of voiding certain provisions of a law without declaring the entire statute unconstitutional” (Riley 2019). The amount of turmoil described to here indicates that within this law, there is a great challenge to *longue durée* culture. Had there not been such a challenge, the law would not have been so contentious.[25] According to American *longue durée* culture, the individual mandate impinges upon the freedom of those who wish to remain uninsured. This created the largest issue for the ACA, and was the feature that was most controversial. Consider the following, from Sally Pipes of the *Washington Post*:

> Since Congress effectively ended the unpopular requirement that all Americans obtain health coverage by zeroing out the fine for noncompliance as of the first of this year, three states and the District of Columbia have enacted mandates of their own. The mandate that Massachusetts imposed in 2006 is now back in force. And at least seven other states are considering similar measures. If they succeed, one-quarter of the U.S. population will again have to choose between paying for costly insurance that’s of little value to them—and a burdensome fine. (Pipes 2019)

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[25] This contention could also indicate that *longue durée* culture is in the process of evolving or changing. That process could be examined in further research.

While Pipes is reporting on a legislative trend that could speak to the evolution of *longue durée* culture (and should be explored in further research), her phrasing of the resulting consumer decision reveals the conflict that these mandates present to *longue durée* culture. These mandates are not viewed as a vehicle for solidarity that are part of a larger and longer plan to help Americans obtain health coverage. They are seen is irritating impositions that coerce individuals into making purchases they do not want and paying fines that are inappropriate. Removing both the ACA individual mandates as a well as the Clinton employer mandates from their greater context so as to object only to the imposition indicates hyper focus on individual will, needs and decisions, to the exclusion of considerations of solidarity, greater good, health care rights, or the nation as a cohesive community.

Holman W. Jenkins, Jr. of the *Wall Street Journal* reveals other ways that the individual mandate conflicts with *longue durée* culture: “Thanks to their effective repeal of the individual mandate, nobody is forced any longer to buy ObamaCare or pay a tax penalty. ObamaCare’s user cohort now consists almost entirely of willing ‘buyers’ who receive their coverage entirely or largely at taxpayer expense. It also consists of certain users who take advantage of the coverage for pre-existing conditions and stop paying once their condition has been treated” (Jenkins 2019). It is Jenkins’s belief that the individual mandate is coercion, that subsidies exploit the taxpayers that fund them, and that those with pre-existing conditions unjustly exploit insurers by using coverage only when they need it. As demonstrated throughout this dissertation, these beliefs are consistent with American *longue durée* culture, as applied to various policies, proposals, and changes. American *longue durée* culture resists compelling individuals to make decisions that can be interpreted as more in the greater good than in the individual’s best interest. It also defaults to believing that a certain number of beneficiaries of social programs, or beneficiaries with certain traits, will exploit those programs and those who support it.

The ACA health insurance exchanges, which opened online were marked by technical problems, which would only create an even harsher environment of criticism. Criticism focused on management mistakes made by the government, issues with how the government uses contractors, and most in alignment with *longue durée* culture, suggested that the government is incompetent to handle administering such large programs. Consider the following write up in *Fox News*, which demonstrates the later spin on the situation:

> A failure of management by the Obama administration led to the disastrous rollout of the ObamaCare website and caused the government to incur tens of millions in additional costs, according to a congressional watchdog report released Wednesday. The Government Accountability Office (GAO) concluded after a months-long investigation into the rocky rollout of Healthcare.gov that the Centers for Medicare & Medicaid Services' failure to establish "effective planning or oversight practices" was to blame for the website's myriad problems after it was launched. Among the issues, investigators found that the administration kept changing the contractors' marching orders for the HealthCare.gov website, creating widespread confusion and adding tens of millions of dollars in costs. Changes were ordered seemingly willy-nilly, including 40 times when government officials did not have the initial authority to incur additional costs. (*Fox News* 2014)

This article, which cites management issues as the greatest barriers to the launch's success, suggests that the government cannot appropriately plan, budget, or oversee a large, complex project. The article suggests that if the government cannot even manage to successfully launch the ACA website, it can certainly not manage to be involved in American health care. In Chapter Four, this *longue durée* cultural belief about the inability of the government to create successful programs is further explored.

Using private insurance companies and individual mandates to provide health plans is sensible in the American context, since Americans are unlikely to feel that the government is capable of administering medical care, unlikely to risk burdening businesses with an employer mandate, and attached to both private solutions and personal choice. This means that private solutions and the individual mandate feel more in line with *longue durée* culture than other proposals and plans. This is mirrored in Alan Blinder's analysis in the *Wall Street Journal*: "Believe it or not, America may be debating ObamaCare yet again. 'Repealing but not replacing'—a terrible idea, you may remember—has come bouncing back like a bad penny. This time the effort is judicial rather than legislative, but it will run up against the same wall: The logic of American health care still pushes in the directions President Obama chose" (Blinder 2019). Blinder, an economic advisor to Clinton, reports in the same article that he had advocated for an individual mandate as opposed to Clinton's employer mandate, because it could not cover non-working Americans, and because of the burdens it would place upon small businesses.

Despite this, many critics along the way have pointed out that the coverage offered remains too expensive. Consider the following viewpoint in *Forbes*:

> The answer is that Obamacare wasn't designed to help healthy people with average incomes get health insurance. It was designed to force those people to pay more for coverage, in order to subsidize insurance for people with incomes near the poverty line, and those with chronic or costly medical conditions. But the laws' supporters and enforcers do not want you to know that, because it would violate the President's incessantly repeated promise that nothing would change for the people that Obamacare doesn't directly help. If you shop for Obamacare-based coverage without knowing if you qualify for subsidies, you might be discouraged by the law's steep costs. (Roy 2013)

Of course, the main objective of the ACA was to make health care affordable to Americans making up to 400% of the poverty line. Costs arguably remain steep for many with subsidies at the upper end of that 400%, and completely unaffordable for those who make just above that threshold. This is touted as a grand failure of the government and the legislation.

Though the debates about the ACA remain heated, the legislation passed because it was more aligned with *longue durée* American culture than the proposals that came before it. Truman preferred a national health insurance plan, while American *longue durée* culture is leery of such direct government involvement in health care. Clinton proposed an employer mandate, which would have put too much strain on businesses, and potentially too many limitations on the care that patients could choose. The ACA was thoughtfully crafted with American *longue durée culture* in mind so that it could avoid these pitfalls. The ACA gave consumers many choices of different private insurance providers, preserving the feeling of health freedom and access to private medicine. It provided individual consumers the responsibility of maintaining coverage, which speaks to American notions of self-reliance. Finally, it put fewer burdens on businesses, protecting the legislation from fears of crippling mom and pop businesses and larger industries alike. By simply being passed, the did more for the American citizenry at large than any prior health legislation. No other policy has ever managed to extend health coverage to even a small portion of the non-indigent, non-veteran, non-retired population. To do so, the ACA needed to be in tune with American *longue durée* culture.

CHAPTER FOUR:

CLASSIFICATION STRATEGIES, MERIT, AND STIGMA

Summarizing the major health policy innovations in the United States and France as I did in Chapter Two may provide an important historical understanding of how policies have evolved and when, but a look at key policies in order to examine the strategies of reform reveals the cultural work that states do in order to effect policy changes. It would be easy to believe that France and the U.S. have vastly divergent healthcare systems today because their starting points were simply too divergent. However, this chapter reveals that the ecology of institutions was similar prior to the 1940s. These similarities included the tendency to expand rights and care in a piecemeal fashion. However, once the ideologies that underpin *longue durée* culture were leveraged due to the needs of the unsettled times of the post-World War II era, these piecemeal programs coalesced into respectively French and American sets of social rights. In France, a cohesive social security system capable of providing many social rights to citizens and non-citizens alike would emerge from these programs. In the U.S., today's program remains reactive, piecemeal, and disaster-addressing as opposed to prevention-focused.

In this chapter, we see that the French and American states implicitly follow strategies of classification as they grant the right to health benefits to citizens. It is interesting to observe this, as it is also clear that policies and social programs must be resonant with culture in order to be successful long term. As states navigate policy creation, they must do so in a manner that respects culture, otherwise they are likely to provoke political pushback. A closer look at the cultural meaning of the most important policies provides insights into these phenomena. This chapter specifically identifies the differing strategies of classification as they are performed by the French and American governmental institutions. More specifically, it examines how differing notions of merit and stigma are evident in both these strategies and the resulting policies.

As we saw in the last chapter, different conceptions of social merit and stigma are central to the French and American welfare states because French and American cultures assign merit and stigma differently. This chapter demonstrates how contrasting classification and sorting strategies have been pursued by the French and American states. So, even though it would seem that these classifications might be top down or state led, governments cannot escape the need to classify and assign merit and stigma in accordance with culture. For example, in France, industrial and work-related optional benefits were converted into citizenship rights (Dumons and Pollett 2002), while in the U.S., this transition never really occurred. Instead, U.S. social policy has favored incremental social coverage increases, where coverage is extended only as extreme need is documented, and only when providing such aid avoids placing burdens upon any particular groups of citizens for the benefit of another. When the Affordable Care Act (ACA) sorted citizens into those who merit a subsidy based upon low income and those who did not, the arbitrary income thresholds and variance in coverage by state caused categorical confusion and discontent. However, the universal inclusion of French citizens classified all French as meritorious. From there, situation- or condition-specific programs were designed to meet these needs, and little social unrest occurred as these programs were created. This chapter examines other policies which highlight this phenomenon.

The Building Blocks

The largest public health system in the U.S. is undeniably the Veteran's Administration. Several aid programs for veterans were established at the start of the first World War, and those benefits were consolidated and the Veterans Bureau was created to administer those services in 1921. These benefits included disability, health insurance, and vocational retraining. Additional hospitals specifically for the treatment of veterans were built, most of which simply became VA hospitals as the administration evolved. In 1924, veterans would be treated for health issues that were not service related, and in 1928, veterans' retirement homes were opened to women and militia members (Altschuler and Blumin 2009). Despite cuts to many VA programs, veterans remain among the most meritorious and esteemed of American citizens, so it is no surprise that they were the first to be rewarded with health investments and programs. This group was deemed worthy quickly and easily, which was in keeping with prior U.S. policies for Civil War veterans (Skocpol 1992).

The Veterans Administration was created in 1930, as the Veterans Bureau was elevated to a Federal program, and pension programs as well as programs to help veterans purchase homes were federalized. At the time, the health benefits granted by the VA were the only government sponsored health benefits, federally or otherwise. They would remain the only federal health program until 1965 and the creation of Medicare. Medicare was created relatively easily, and Congress was largely in consensus as to its value (Oberlander 2003:6), since Medicare served a meritorious group. VA health care was created easily, and without much controversy. The program was not challenged on grounds of socialism or fascism, even during World War I, when such fears would have been expressed in relationship to any other federal benefits or social insurance program. Indeed, limiting the beneficiaries to veterans—a population that was truly revered at that time period—let the program exist without such challenges. As far as the American public was concerned, veterans deserved support, they merited care, and they had earned the VA, not with their indigence or need, but with their service (Skocpol 1992). These earned rights came to them at a time when social rights for citizens at large were not even on the table, yet these social rights could still be earned by veterans. These earned rights have a rather contractual basis. They are a compensatory right for service, as opposed to social rights or human rights, which are granted due to affiliation with a national or global community.

Importantly, the New Deal laid much of the framework for the welfare state in the U.S. (Marmor 2000). These depression-era policies had decidedly different goals than the post-war policies that rebuilt France and built their welfare state. Given the shape of New Deal policies, we can see that the U.S. saw the depression as a momentary financial hiccup that would only need to be temporarily soothed in order for a return to prosperity to occur. With the exception of Social Security and Unemployment Insurance, the vast majority of New Deal programs were either temporary provisions designed to be phased out, or economic regulations intended to prevent future depressions (Smith 2014). These were not programs that would sort citizens into categories of merit and stigma. Instead, they were exchanges. The poor and struggling could exchange work for benefits and funds from the government. These programs set the form of later policies, which would be created with piecemeal disaster relief in mind, provided that rights were contractual, and involved work on behalf of the beneficiary. This arrangement is in line with how veterans access health benefits, and the discourse surrounding welfare reforms such as "workfare."

Since this exchange was the culturally preferred method of poverty alleviation, few cash benefit aid programs were created, even during the depression. Instead, programs like the temporary WPA, the CWA, and FERA were all work programs designed to provide relief in the form of labor projects that would provide wages, improve infrastructure, and stimulate the economy (Smith 2014). Federal unemployment insurance, which was modeled after Ohio and Wisconsin's state unemployment insurance legislation, was created at the same time, and was also a very temporary solution to what, even at that time, was a rather chronic problem. Unemployment plans offered by individual states typically provided benefits for only three to four months. Built into Ohio and Wisconsin's legislation ere higher tax rates for employers who had a history of frequent layoffs (Hiltzik 2011). This provided incentives to business to avoid layoffs whenever possible, and discouraged employers from taking layoffs lightly in view of the new unemployment protections.

Setting up work programs did involve an inherent classification system of beneficiaries, which was eventually carried over into medical care debates. First, many of the work programs were based around manual labor and the creation or maintenance of new infrastructures. While the only economic qualification needed to benefit from these programs was unemployment, only those able-bodied enough to perform such tasks could take part. There were artistic and scientific work programs as well, distributed evenly throughout the country, but these positions were fewer in number than work programs that provided manual labor as a solution. Women would have also been excluded from a number of these manual labor-based work programs, as cultural norms and stereotypes about physical strength were limiting factors.

The work programs were on the whole well loved and well received. They were accepted as a fully American solution to unemployment and economic hardship. Since the "aid" only came as a result of legitimizing labor, these programs were not stigmatized. Recipients or their families would routinely say that they were "working for the government" when benefiting from such programs. The programs, especially those that took young men away from their homes to build parks, dams, or to do other wilderness work, were also hailed as creating important camaraderie and unifying a generation (Hiltzik 2011:162). While these programs may not have carried the prestige of high ranking public sphere jobs or gainful self-employment, they were seen as a viable and noble way to both invest in the country and in oneself.

It could be argued that that the social success of these programs created an expectation for American aid programs in the future. "Welfare" programs or proposals have often sought ways to justify aid received either by a work requirement, training, or evidence of job seeking. Even in today's economy, these requirements sort potential aid recipients into those with skills and physical capacities or lifestyles (lack of need for childcare, for example, or residing in locations with available jobs) most suited to specific types of work.

The specific nature of health care does not easily allow for an equitable distribution of medical aid based upon work status. Indeed, the precedent in the U.S. which so strongly made health care a benefit normally provided only through employers has been revealed to be exceedingly unfair, and as such the ACA seeks to address these inequities. Since people can easily be rendered unfit to work by their illness and need for health care, a work requirement or work program for health care makes little sense in any system. In the U.S., access to health care has habitually been sorted into a few categories : 1) veterans, 2) the disabled, 3) the indigent 4) the elderly, 5) poor children and 6) those with solid jobs that provide employee health care.

Though France made significant amounts of new social policy in the same period, French policy did not have a "discursive umbrella" that included depression relief or preventing future depressions since their economy had less of a boom or bust rhythm. Instead, it was designed to create a lasting safety net from the instabilities of life (Dumons and Pollet 2002). This is particularly apparent when one considers that unemployment insurance, a clear need in times of depression, was actually a rather late development in France. French unemployment insurance (*allocation chômage)* did not begin until 1958 (Galant 1955). Instead, one of the largest impetuses for the French to create social policy in this era was the Alsatian experience (Dumons and Pollet 2002). Having been annexed into Germany from 1871 to 1918, people living in this region were given Bismarkian social benefits and were vociferous about their desire to keep them. This accelerated a process of the state taking control and regulating what had previously been optional employer or industry provided benefits. However, state-managed unemployment insurance did not rattle the French psyche or culture, so this addition of a program did not create any sustained issues when it classified the unemployed as deserving of support through a difficult period.

In Paul Dutton's magisterial analysis, France pursued two concurrent strategies to universal social protection (Dutton 2002). Family welfare, which occupies a very privileged place in French policy, embraced a corporatist model, where until the state stepped in, class distinctions and employer control was preserved. For the remaining protections against illness, disability, maternity, and old age, a mutual aid model was followed. The evolution of these latter programs laid more of the groundwork for the establishment of the modern French welfare state in 1945 (Dutton 2002). Going one step further, we can see the French now view the protections provided as social citizenship rights—meaning that these employer-provided and family-protecting programs became actual citizenship rights once they were extended and guaranteed by the French state.

The most influential and most developed early French social insurance programs were based largely around families (Andersen 2015). Real discussion of rights became far more common in the unsettled times post World War II. This had a lot to do with France's perpetual fear of declining or stagnating population and the subsequent power of their natalist movement. *Allocations familiales* began in 1917 as optional employer programs, and they were made mandatory in 1932, well before the social insurance push after World War II. Interestingly, though these programs were made mandatory, employers consistently fought to retain the administration of the programs. This battle between the state and employers persisted until after the war when the legislative power of De Gaulle's right wing provisional government and the "Father of French Social Security," Pierre Laroque's dedication to a universal system of social insurance made greater, more complete social protection possible for the whole of the French population (Dutton 2002). Under this discursive umbrella, these policies were underpinned by the belief that all French citizens were meritorious of a base level of protection from social risk. The umbrella sorting of French citizens put them all into the category of meritorious. From there, need-specific programs were designed in order to fit most circumstances.

These pre-World War II *allocations familiales* did contain problematic provisions. The rights were gendered and clearly promoted traditional religious values, even though France had already taken on an official policy of secularism (*laïcité)*, or the protected separation of church and state. For example, these benefits could initially only be paid to men who were the head of their households. Not even abandoned mothers, divorced mothers, or women supporting their husbands could apply (Dutton 2002:4). In this particular instance, the French state did sort citizens into categories of merit and stigma. Unattached women and breadwinning women were both stigmatized. Male-headed households were seen as the building blocks of a solidary community whose boundaries became more inclusive after the war.

Given that the French state took over the administration of what were originally employment benefits, officializing them, and converting them into social rights expected by the

French, labor classifications are still visible in French social policy today. Industry specific programs or designations are not uncommon. Social rights were largely extended professional category by professional category, making it appear that social rights were dependent on type of employment, employment status, or industry. However, it is more accurate to simply note that since state administered social rights protections grew out of a tradition of industrial and employment sponsored work benefits, so as these rights were expanded and extended, it was logistically easiest to make expansions based upon work classifications. Here we can see just how similar the French social program starting point was to where the U.S. started. However, it has been the need for states to sort citizens and implement policies and programs that agree with culture that has created the different evolutions that we see today.

Though French social protections expanded based upon professional category, largely due to the fact that the benefits were originally work-related benefits, adding each subsequent professional category to the system of insurance bodies served eventually to remove professional distinctions and homogenize class differences through income redistribution. It seems that the industrial model of welfare state expansion was indeed eventually replaced by a mutual aid model. In the end, the merit of workers, the middle class, and the poor trumped the desires of the better off to retain larger amounts of their incomes. This is quite the opposite of the climate in the U.S., where the right to be unencumbered by the needs of others trumps health care rights for most of the population.

In France, benefits had been dependent on employment until World War II. The U.S. still has not shifted this policy. Since the ACA does not affect all citizens, the links between labor and health care and economic status remain intact. France shifted from the industrial work-based benefits framework to a mutual aid framework over time. Culturally, the industrial framework did not work, as it left too many citizens unprotected. Still, this cultural agreement took some conversation, and there were stakeholders that defended the industrial framework. The French began to make these compromises with stakeholders as early as 1928, with their first social insurance law. This law was a compromise between mutual leaders and legislators (Dutton 2002:12). The CCAF (Central committee for Family Funds, *Comité centrale des allocations familiales*), a powerful lobby that supported the pronatalist movement, found strong parliamentary support by mobilizing current social-political fears. This lobby was successful at keeping employer control of benefits, especially family benefits, until 1928. Additionally, the National Alliance for the Growth of the French Population (*Alliance nationale pour l'accroissement de la population française*) was a lobby that led a successful campaign to make it morally unacceptable to pay a single individual as much as an individual with a family. Family benefits at the time allowed for a base salary (*salaire vitale*), plus special allowances for each dependent (Dutton 2002:19). These were paid directly by the employer for as long as employers could keep control of the administration of these benefits. This effectively made the salary of workers with dependents higher than that of single workers.

These led to discussions of compulsory medical, retirement, and disability insurance on economic, labor cost, inflation, and international competition grounds (Dutton 2002:37). Legislators debated how to keep benefits and popular aspects of voluntary systems while making things compulsory. They had debates about liberty, choice, freedom, and responsibility that were superficially similar to the U.S. but contained fundamentally different premises.

The first major legislative attempt for health care in a comprehensive system of social programs including health was the Vincent Bill. The plan was funded through payroll withholding taxes, and it created a decentralized administration of benefits (Srinivas 2012:172).

The Vincent Bill took most of the power away from employers, was state subsidized, and decided the value of benefits based upon earnings. In this conception of social security, the mutual movement was first proposed as the backer of a state mandated system. Though it was supported by the Mutual Federation of Labor (*Federation mutualiste de travail*) and by other industrial workers, the insurers (*mutuelles*) did not support the plan, as it dictated a minimum organization (*caisse*) size, equalized power amongst them, and placed other regulations upon their operation (Dutton 2002:60). This was a move to become more focused on mutual aid, since it was an attempt to equalize the operations of the insurers which were providing some access to health care.

The Vincent Bill's successor, the Grinda Bill, passed in 1924. The largest debates surrounding this bill involved exactly how to integrate the existing insurers (*mutuelles*) and the state. The Grinda Bill established the mutual movement as the backer of a state mandated system of benefits (which is remarkably similar to the broad strokes aims of the ACA). This represented a strong move away from assistance aid, and a move towards insurance (Smith 2018). This bill cited employer abuses as the principal reason for wrestling power away from work related benefits plans (in the U.S., the issue has been framed in terms of high uninsured or underinsured rates). These employers could no longer be classified as worthy of administering these benefits, so that privilege was revoked. The bill also managed to appease some other large political factions—namely the pronatalists, the mutualists (since the program would be compulsory but run through the *mutuelles*, they would benefit from the higher membership), as well as the industrialists, who were promoting the scientific rationalization of labor, and held the belief that healthier, happier workers would be more productive. The Grinda Report stated:

> In every firm there are two essential factors: machines and labor. To the boss, the latter represents a capital investment that must be maintained, replaced, and

> amortized. This is one of the essential purposes of social insurance. Illness insurance will reduce morbidity and thereby reduce work interruptions that impair profits; it will also diminish incubation and convalescence periods during which the quality of work falls dramatically. Disability and retirement insurance will ease replacement of the labor force with younger, stronger workers. (Grinda 1923)

In the end, these logics add up to a culturally and practically compelling argument for these reforms, and the classification system used by the French state took a step in its evolution. Employers would no longer be seen as worthy of administering benefits. This step would be followed by steps that would continue the process of creating a welfare state based upon mutual aid, the eventual separation of merit from work status. Of course, complete separation of benefits from work status would be a larger, later, development in the evolution of French solidarity and fraternity.

These systems were more difficult to administer during the Depression and some faith in the system was lost. However, once the Depression was over, the insurance system continued to expand (Smith 2018). Since the *caisses* were the stewards of state mandated protections, they enjoyed increased legitimacy, and as more businesses complied with the requirements, increasing membership. The strategy at this point was to classify types of employers as they joined the *caisses* as opposed to classifying citizens. The state also began to classify different types of *caisses*, and which benefits were covered by which *caisses*. This was also complicated because legislation in 1922 had required family allowances and other benefits in the public works sectors and construction, so workers in these two industries already had existing *caisses* (Andersen 2015). In some cases, these *caisses* could simply be expanded to include new members, but in others the creation of new *caisses* was required. However, these classifications were based more upon the need to create order and which bodies were most qualified, or worthy, of administering health rights, than the need to decide who should benefit from care.

The state also needed to do a fair bit of regulatory work. Since there were not enough inspectors for the number of *caisses* (there were 160 inspectors to regulate and enforce practices at the over 100,000 *caisses* around the country just after the Grinda Bill was passed), *caisses* and employers were still able to manipulate the regulations to their advantage. The Grinda Bill preserved higher benefits for workers with families, which was in line with French thinking about families and about support for the birth rate. However, certain industries tended to have single, childless employees. Employers in these industries simply made new *caisses* to reduce their overall costs. This created enough issues that in 1932, a separate *caisse* for family allowances is created, which had stricter controls (Dutton 2002:129). Still, the problem of industries with lower insurance costs forming industry specific *caisses* would persist until further regulations and controls were introduced. These controls and regulations would be put into place because it was deemed that industries did not merit the right to separate themselves from the rest of the system. Again, these controls were instituted because of a decision about merit.

More *caisses* were added. Integrating the system was sometimes difficult—newer *caisses* did not have the reserves of funds that older ones did, so were sometimes less reliable. Also, contributions to the *caisses* needed to be documented in order to receive benefits. This left many low income people, temporary workers, domestic workers, and anyone who worked less regularly or seasonally out of the system. Women were disproportionately in these categories. French feminists campaigned for work benefits for French mothers and single women (Offen 1989). They could see that an employment-based system of social rights could too easily exclude workers doing jobs traditionally reserved for women, women who left the workforce in order to care for their families, and made women too dependent on the benefits of their husbands.

Feminist groups did not fight the shape of the system. Instead, they simply fought for inclusion of women into it. In other words, they fought for women to be classified differently by the state.

Agricultural workers were also completely exempt, as per legislation from 1922, until the PF (*Parti fédéraliste*) advocated for their inclusion. This shows how dependent on occupation the employment-based system was (Dutton 2002:138). In the meantime, rural *caisses* sprang up, covering risks specific to rural workers, and charging lower rates on health insurance. Agricultural workers were not stricken with the types of diseases from which industrial workers of the era suffered. This then caused agricultural workers to resist joining health insurance plans that included the rest of the population a few years later. Clearly not all French workers were quite ready for a system with complete solidarity.

By 1938, health insurance in France was fragmented, and legislators began to see state intervention as the best option. To begin regulating, the average male salary was calculated for each prefet, and child allowances were calculated according to this average. Workers received an additional 5, 10, of 15% of their salary for one, two, or three children respectively, and an additional payment for their wives if they stayed at home with the children (Dutton 2002:152). This effectively standardized the level of benefits that workers received, even if who received benefits from whom was still not regulated. However, this standardization was not without issues. Rural areas outside of Paris in the same prefect were calculated with Paris, so benefits for Paris itself were artificially low, while payments for the rural areas were artificially high.

After the war, new efforts at extending social protections resumed. However, unlike in the U.S., the conversation was not about how to relieve specific populations of their particular difficulties or how to provide relief during a period of crisis. The debate was more about how to go about extending coverage to as many people as possible. Debate about who deserved benefits was not common. The powerful French medical lobbies did not succeed in blocking the extension of coverage, because allowing them to limit the extension of a state system grounded in solidarity, fraternity, and social protection would not have resonated with French culture. Interestingly, the U.S. confronted a similar coalition of doctors, medical schools, insurers, and other stakeholders that were opposed to the establishment of national health insurance in the U.S. However, in the U.S., the claims these stakeholders made against national health insurance had success since these claims resonated culturally, especially in the post-war era. Also, in the French case, the state had already classified all French citizens as meriting health care. Health industry lobbyists would not be strong enough to influence the direction of this classification.

The team of social reformers, led by Pierre Laroque, which had spent the end of the war exiled in London, had several principal goals. They believed that insurance should protect all people from disturbances in income; that costs should be shared by the collective, meaning workers, employers, and society at large; that social security must create solidarity between the insured themselves as well as between the insured and the society; and finally that compulsory participation in the programs should be extended to every member of society (Dutton 2002:204). Clearly, these principles are more far reaching than economic relief or aid for veterans and the elderly, as in the U.S. While it might be possible to believe that Laroque simply imposed an ideology on France upon his return, the enthusiastic support that the programs received and their longevity reveal that these were not simply forced reforms. Had this been the case, the Fifth Republic, which began in 1958, would have gone back on these programs. Or, these programs would have been slowly minimized and retrenched over the many years of right-wing rule. However, these programs have actually grown stronger and more comprehensive over time, as opposed to being thrown out, minimized, or slowly eroded.

Official Launch

The ordonnance of 4/10/1945 launched France's post-war welfare state. Laroque pushed for the greatest levels of solidarity and "rationalization" imaginable. He envisioned a single national *caisse* that would cover all people and administer all of the social insurance programs. He believed in income redistribution and full employment, believing that there would surely be enough jobs if they were simply managed correctly. He also found the mutual societies fundamentally inequitable because they were not controlled by the beneficiaries. French discourse about solidarity was particularly intense during this period, both in politics and in ideology throughout the country (Jabbari 2012:26).

The process to universal health coverage in France is frequently misunderstood. The 1945 legislation provided a base from which coverage could be extended, and the intention was to extend solidarity widely (Jabbari 2012:29). Indeed, Pierre Laroque's goals for social security included administrative ease and national solidarity (Jabbari 2012:35). Laroque also shared the pro-natalists fear of demographic decline, which explains why early French healthcare policies benefited women and children (Jabbari 2012:40). However, that legislation only covered about half of the French population, since only employees in certain industries were immediately covered, or rather, required to be covered. Some salaried middle class professions (*professions liberales*) and the self-employed had led successful campaigns to be excluded from coverage on the basis that they objected to income redistribution. However, these populations were often able to gain access to coverage when they did indeed desire it, despite having escaped paying into the system. These sorts of classifications by profession or work status were about how to best administer the healthcare system, but they were also about who needed coverage first, and why.

These conversations were also about how to distribute risk and income redistribution. The French state worked to bring the most at risk populations into the health care and social security system first, then focused on bringing lower risk populations and populations with more objections into the system later. These classifications were an essential part of extending care, since it would have been logistically very difficult to cover the entire population immediately. The American state has not engaged in this level of sorting, since there are so few categories of Americans which receive total inclusion into the social security system. The French began by classifying all citizens as worthy, then creating many small categories which would help citizens access social security. In the end, this achieved a system where most citizens have a relatively similar experience and level of coverage. So, in France, one classification of merit was created, and then many classifications were created in order to create the experience of one single classification and experience.

But in the U.S., only the most worthy citizens and the most fragile citizens benefited from a classification which would place them into the healthcare system. In the U.S., labor won the largest expansions of health care at the collective bargaining table, which further confirms that the U.S. strategy for providing health care followed an industrial path. Since health insurance was an entirely privately administered benefit (with the exception of veterans), it could be extended only workplace by workplace at the bargaining table. By 1954, 12 million workers and 17 million of their dependents had gained health insurance through the bargaining efforts of unions (Dutton 2007:127). Organized labor was strong at that time (Goldfield 1987:10), but lack of federal funding for health care placed a lot of financial stress on both employees, employers, and the medical industry. These stresses and the need to find some way to fund difficult-to-insure populations would fuel the early discussions of Medicare. Here the American state had no hand in the expansion of care, and had no sorting or classifying work to do. In France, every time health coverage was expanded, the state would need to step in to sort or classify citizens in some way. In the American case, any expansion which did not involve veterans, the indigent, disabled, or elderly, has fallen largely into the hands of the private sector and employment market, greatly reducing the state's need to interact with this process, except of course for the ACA.

In the 1950s, Labor preferred the so-called Blues because they were non-profits and did community service, versus commercial insurers that they believed to be in collusion with employers (Dutton 2007:127). However, when it became clear that Blue Cross was maintaining cash reserves far larger than was legal and not making efforts to hold the cost of care down, the *New York Times* published an editorial stating that the insurer had "not given its subscribers and the public the status they should have—especially in dealing with the hospitals as to charges" (Dutton 2007:128). This relationship became hostile in 1957 when Blue Cross announced a 40% increase in premiums for hospital coverage (Rosner and Markowitz 1997:88). This started a battle between labor and health insurers over controlling access to and the cost of health care. At the same time, labor's relationship with Blue Shield, which provided surgical benefits, was also souring. Workers on over 30 Blue Shield plans were finding their surgical benefits limited to $200. Even in the fifties, this was not nearly enough to cover the cost of most medical procedures (Klein 2003:240).

It was at this point that different health plans really began to diverge across different industries and employers across the U.S. With different benefit packages being negotiated workplace by workplace, there was little consistency in what was offered to workers. Since there was no standard health care right, since health care was not a right and workers had not been classified as meriting care, this battle could only be fought in the public sphere. As this process continued, unions continued to attempt to bargain for health—by creating their own network of plans and physicians. This created even more complicated webs of memberships that could potentially provide benefits. The state was not involved in this process, so few plans were based on local conditions, negotiations between different parties in each instance, and the particularities of individual industries and populations. Workers with weaker unions found themselves with less access to health care than those with stronger unions. Again, since there was no standard health right for workers established by the state, this differentiation did not result from a merit- or stigma-based decision by the state, but upon the individual configurations of each bargaining table. There was less public outcry about these differences than would have been expected. Health insurance, at this point, was viewed as a work benefit, not a right, and not a service necessary to the proper functioning of society. As a work benefit, it remained acceptable to the American public that health benefits be negotiated with such inequity across industries and regions.

After the war, a large part of French medical policy negotiation included how to administer and who should administer health insurance. Pierre Laroque and the crafters of social security envisioned health insurance as part of the social security plan. However, the *mutuelles* and employers had previously enjoyed a large degree of control over these work benefits, and they resisted giving up this control. However, they did not retain this control. In the end, social security did become the largest health insurer, a place was reserved for both private and not-for-profit *mutuelles*, and the influence and power of both labor and employers was partially preserved. Labor kept its seat at the table since health insurance and social security funding came from payroll taxes and wage withholding. *Mutuelles* were allowed to cover the portion of health care costs that social security did not cover (Jabbari 2012:128). This gave France a healthcare system that was both public and private, as well as still tied financially to labor. One of the largest differences between the U.S. and France at this point was that the state had clearly claimed a seat at the negotiating table. In the U.S., the idea of the state administering or managing health care on behalf of the citizens had been unacceptable due to ideological conceptions of rights, and outcries against socialism, impending moral decline, and fears of losing medical choice. These objections kept Truman from advancing his national health insurance plans and kept the state almost entirely out of American health care.

Though the U.S. medical industry was publicly and politically opposed to any sort of governmental regulation of health care, there were some exceptions. However, the exceptions were never programs that would benefit the majority of Americans. The Hill Burton Act contributed between 75 and 186 million every year from 1948 until 1961 for the construction and modernization of hospital facilities (Dutton 2007:135). This was supported by the AMA (Starr 2008). This funding was culturally acceptable because it was not a “hand out” to individuals, and it posed no threat of reducing patient choice. It also did not upset the medical industry, since it did little to regulate any aspect of practicing medicine or the rates that could be charged for medical services. The Hill Burton Act required that a community demonstrate the future viability of the projects it used Hill Burton funds to support. Though any community could technically receive these funds, the poorest communities had difficulty meeting this requirement. Still, this difficulty was not enough to cause the medical profession or Americans to object to the fairness or logic of the act. Though this is an instance of state involvement in medicine, the state was not involved in sorting or classifying citizens via the Hill Burton Act. Instead, only community projects could be deemed feasible or not. While this could have had the impact of making care more or less accessible to rural Americans, that access to care was not decided based upon the merit of any individual person, but instead upon the feasibility of a building project.

The AMA and businesses were fairly successful at expanding private coverage so as to prevent any increase in popularity of the idea of public plans. Many American full-time employees had a private health insurance plan by the late 1950s. This fit with other American policies, where there was some transactional, contractual relationship between the beneficiary and the provider of the benefit. In this case, health care beneficiaries were limited to workers and their dependents. This left vulnerable groups such as the elderly, women and minorities, who very often did not work for wages, and the indigent, uninsured. And of course, workers were generally healthier and had lower health care costs than their retired parents. Health insurance companies were thus able to insure only the healthiest of the population by fostering the link between labor and health insurance. By this time, insurers had also introduced experience-ratings (Conrad 2008:325). Since health insurance was sold to individual workforces, insurers could further assess their risk in each individual industry or workplace. Insurers created entirely different plans for entirely different industries, which included different premiums and different benefits. Since the Taft-Hartley act made it impossible for unions to administer benefits for members, health insurers had an even easier time offering these plans (Dutton 2007:138). Soon, the number of different plans began to multiply, community rated plans became non-existent, and it became nearly impossible for the average American to obtain health insurance without being a member of a specific work-related community rated risk pool. When President Eisenhower signed the tax-deductibility of group health insurance plans into law, in 1954, this trend increased its pace. This instance of state intervention had the opposite impact that state interventions into health care had in France. In fact, by the late sixties, Blue Cross community-rated health plans were declining (Cunningham and Cunningham 1997). By inserting themselves into the sorting and regulatory role of the state, health insurers were able to make their own decisions about who merited care, and the political and cultural climate that rationalized health care as a work benefit supported this power grab. Of course, when health insurance companies decide who merits care without government, union, or patient group input, the decision comes down to dollars and cents, not societal contribution, citizenship, solidarity, fraternity, or social rights.

The 1960s: Solidification of State-Strengthened Cultural Priorities

As global definitions of health were expanding to include preventative care, the French continued to expand health coverage. 1961 and 1966 expansions to include agricultural workers and expansion to include ministers and "remaining populations" enabled the coverage rate for the French population to reach 96% by 1970 (Dutton 2007:146). Agricultural workers were always sort of parallel and separate to other employment sectors. Since they were more rural, obviously due to the nature of their work, they had separate *caisses* and were organized amongst themselves. Like some other groups, they had an important debate over inclusion into the country's new social insurance schema. Agricultural workers did not suffer from the same diseases that urban populations experienced. Their health needs were generally believed to be lower as a result, causing some to advocate for separate treatment by social security. However, agricultural workers were absorbed into social security as well, though their care was administered separately.

The 1978 expansion to include ministers and "remaining populations" raised several important questions. In the case of ministers, taxing their respective congregations posed some difficulties due to France's strict stance on the separation of church and state, or *laïcité.* Here we can truly see that while the goal was to have all populations covered, cultural, political, and structural barriers prevented clergy members from being absorbed as easily as other populations. The state's reliance on existing professional categories further slowed the inclusion of certain types of entrepreneurs and artists. Though the state followed these existing structures, the state did not withdraw from the role of fitting each of these populations nor from finding some way to categorize them that would fit them into social security and health insurance. The French state maintained this role as it was an important step in guaranteeing the right to health care to French citizens.

By the 1960s, the U.S. knew that it had an issue with uninsurable populations. The elderly and the poor were the most obviously uninsured and uninsurable groups. Debates about a means-tested program that would eventually become Medicaid began. Means testing was important because Americans were not ready to accept a universal or national health insurance system, and there had to be some way to justify who truly needed state care. Means testing was the only way to ensure that the middle class and slightly-less-poor would not be benefiting from Medicaid. Had those rather large groups been able to benefit from Medicaid in an ongoing manner, the program would have appeared too similar to the national health plans that Europe had begun to embrace and that the U.S. had already rejected in the late 1940s. The 1960 Kerr-Mills Bill provided the outlines for what would be Medicaid, though the program was deemed a failure (Marmor 2000:27). The Kerr-Mills bill offered only means-tested benefits and was viewed as a way to prevent the expansion of Social Security in the future by both of its sponsors. The Kerr-Mills bill was not successful in its way of managing the problem of health care for the elderly, but it did indicate important things about American *longue durée* culture as it relates to medical care. Since it was means tested, the Kerr-Mills bill sought to cover only the neediest of the elderly without extending solidarity to all of the country's elderly. The Kerr-Mills bill was a failed attempt to classify the elderly into indigent and non-indigent as a way to limit the number of Americans to whom health care would be extended.

The elderly were expensive to insure, not part of any experience rated group, and no longer had employers who would pay for their health insurance. Since they could not be attached to any other means of acquiring health care and since they were very vulnerable, the state needed to address this population directly, and could not do so with means-tested programs. It was thus the prerogative of the state to classify the elderly as meriting care, despite their inability to work or earn enough to obtain any employer sponsored plan. Even so, as solidarity is not part of American *longue durée* culture, Medicare was most often discussed as what it was not, or would not cover, as opposed to what it was or what it did not cover (Marmor 2000:152-157). Medicare was not to be "socialized" medicine like the UK's NHS, nor was it to be charity or "welfare," as all of these concepts were highly stigmatized and outside the realm leverageable of *longue durée* culture.

The AMA opposed both plans, as it had opposed any other extension of health insurance. However, with Medicaid, they were unable to find public and institutional support for their objections. Not even the American Hospital Association was willing to form a coalition with the AMA to lobby against the program (Dutton 2007:150). Americans were generally in favor of the programs. The idea that health care for the poorest could be taken advantage of certainly already existed, but limiting the program to the very poorest seemed to be a suitable enough safeguard. Most importantly, insurers believed that government support for the otherwise uninsurable would actually help the private insurance industry.

There were important distinctions between Medicare and Medicaid beneficiaries, as well as their link to work. Medicaid did not directly use work to qualify beneficiaries. However, a person needed to have contributed to Medicare for ten years in order to receive benefits. It was only through these contributions that a person could merit this sort of care. And even then, seniors paid for their medical coverage. Medicare in 1965 charged seniors premiums, especially for Part B which covered consultations, and required that patients pay 100% of their prescription drugs. Medicaid, which was means-tested, would cover seniors who could not pay Medicare fees. Medicaid reimbursed at a lower rate, meaning fewer doctors would see Medicaid patients (Terry 1991). This created a stigmatized and separate system with reduced freedom of choice for Medicaid beneficiaries.

Most importantly, the creation of Medicare and Medicaid was meant to just take care of these uninsurable, but now seen as deserving, people. It was not meant to be expanded and others were still going to be expected to access health care through the private employer provided system of private health insurance.

Paul Dutton points out how truly disastrous this proves to be when the U.S. labor market shifts away from manufacturing and into the service industry. He notes that between 1985 and 1991, for every 100 manufacturing jobs lost, 244 people lost health insurance. This was because when a worker lost a manufacturing job, their entire family often lost health insurance. Meanwhile, for every 100 new service industry jobs, only 40 people gained health insurance (Dutton 2007:155). This was because manufacturing jobs, which typically benefited from strong unions which had worked hard to win health rights for workers, were being replaced with service industry jobs. These service industry jobs were not unionized, and workers did not benefit from the collective bargaining efforts of the unions. Only a fraction of service industry jobs provided health care, and the decades of fight by labor unions for health benefits could not simply be used to protect service workers. Since the state had not stepped into this regulatory and classificatory role, when the labor market shifted, parallel protections could not be quickly won.

In 1961, a relatively small number of French citizens were uninsured, while many Americans were still uninsured. Due to the continued growth in medical technology and expenses and the economic recession of the 1970s, medical cost control became a new health policy priority in both countries. Spending on care in both countries had exploded, making them among the world leaders in health spending (Kaiser Family Foundation 2011). Both were spending roughly half of their health funding on hospital care. France began making attempts to slow "*le nomadisme medicale*" or medical nomadism, which they defined as patients' trips to multiple specialists in search of second opinions or different treatment options. This debate would continue for decades (Cleach 2013). This conversation would result in an important new classification tactic. Debates about doctors' unchecked diagnostic and treatment plans began—despite the fact that it had previously been doctors' status as independent professionals that had prevented this tendency towards multiple, potentially redundant or unneeded tests and treatments (Lucas 1971). Business interests who had previously simply been against an increase in payroll taxes now saw increased taxes as directly related to medical costs and argued for the control of such costs. Capitated as opposed to fee-for-service billing was even debated as an option to reduce unnecessary procedures. Even considering capitated payment to doctors represented a huge policy reversal, and one that would require a massive reorganization and resorting of patients and doctors. Michel Flamme, the secretary of the health planning committee, supported this option and even went so far as to propose medical review boards that would evaluate a doctor's efficacy and impose penalties for wasteful treatment plans. The proposed penalty was quite stiff—a doctor could be banned from social security, which would have meant that their patients would not be reimbursed for their consultations. The balancing compromise would have allowed physicians to adjust their fee schedules according to the wealth of their patients, or according to the complexity of their illnesses, but only when the doctor had sufficient experience. The upcharges, however, would be paid for by the *mutuelles* or the patient, not social security, making this a rather cost shifting proposal in addition to a new way of classifying patients and doctors. Here again, we see that French health policy has relied on shifting classification strategies as a means to manage health care at multiple junctures. A surprising 96% of doctors had agreed to this new convention by the end of 1974 (Dutton 2007:172).

An important omission in American health policy, which would end up greatly surprising the original sponsors and creators Medicare, was the refusal to create any sort of price conventions or assignments for medical care when Medicare was established (Mayes and Berenson 2006:17). This decision to not classify treatments into expected price categories, even when paid for by the government, would have impacts that endure to this day. Prices for medical care and services were increasing in the 60s, but not at the rates they would eventually hit, and controlling costs was not seen as vital of an issue as it is today. Since price conventions were not set, doctors started to complain that Medicare was not paying enough, so they began to charge as much as they wished, and pass the cost on to patients and their insurers. This was legal, since there were no price assignments. Soon, doctors were setting prices considerably above what Medicare would reimburse (Mayes and Berenson 2006:18). Since there were no fee schedules, many people could end up still owing a lot, and the less wealthy Medicare beneficiaries would be left to find doctors that charged at Medicare rates. Physicians could choose to be in a group that respected the assignments of Medicare and thus received preferential treatment by Medicare. If they chose not to do this, they could be penalized for raising prices, but not to such an extent that raising prices hurt their overall profit margins. The U.S. system was cementing its "*medecine a deux vitesses*," or two-speed medicine. Two pathways were emerging that offered different prices and access to care. These two pathways were accessible to patients based upon their financial resources and the types of health plans they had. These two things were largely dependent on where they had been in the workforce before retirement. Retirees of different socioeconomic status fell into different categories of care and different categories of merit and health rights depending on their work histories. While the French have done everything to avoid this situation, the U.S. has created several policies that have separated populations into such groups, even if inadvertently.

In the U.S., rising costs were also blamed equally on patients as well as doctors. Health, Education, and Welfare secretary Douglas Coleman lamented that there was no "organizational framework" which would hold physicians accountable for their treatment decisions (Dutton 2007:180). Here, Coleman is essentially complaining about the lack of classification strategy that can be used to make treatment decisions. This frustration led to the Nixon administration's promotion of HMOs. The conversation between Nixon and his aide John Ehrlichman, in which Ehrlichman states that Kaiser's HMOs were running a profit because "the less care they give them the more money they make" and "the incentives run in the right direction" and Nixon's approval (Nixon and Ehrlichman 1971). Here, we also see that classification strategies can be used to qualify more and more people for care, as has been true in most moments of the French case, or to limit treatments to small populations or disease states, as has been true in most moments of the American case.

The next biggest health care-related classification to arrive in the U.S. was Diagnostic Related Groups (DRGs). This innovation had nothing to do with extending care. Instead, it was a budgetary measure designed to manage costs. Developed in the U.S. specifically for Medicare in the early 1980s, France quickly adopted the practice. DRGs encouraged hospitals to treat patients in the most efficient way possible, because they were an intermediary between fee-for-service billing and capitated payments. They were an attempt to solve some of the Medicare billing and availability issues that arose as a result of not assigning prices to treatments and medical services. In short, the hospital would receive a set price for the treatment not of an individual, but of the individual's specific illness. If the patient recovered with less treatment than was typically assumed to be required, the hospital kept the difference. After this program proved relatively successful, a similar arrangement was made for physicians. This strategy saved so much money that Blue Cross and Blue Shield also implemented similar policies in states where negotiations with hospitals had previously been difficult (Dutton 2007:187). DRGs represented a new sorting and classification technique that proved to save money in the American healthcare system. However, this sorting technique had little to do with expanding care. It made Medicare budgets easier to deal with, but added no one to the Medicare ranks. Here, the American state was focused only on finding ways to get care to those who had been deemed to merit care.

France quickly implemented this American policy. Social security began using GHMs (*groupes homogenes de malades)* to estimate health budgets, control spending, and streamline hospital services as much as for a billing method. However, cost-saving measures in France became tied to the ability to expand care. Since the goal since 1945 had been to expand care to the entire population, and since rising costs were placing burdens upon the healthcare system, any cost-saving measure became closely tied to the goal to provide care to all. In 1998, GHMs were implemented across all medical care facilities, public and private. GHMs, along with other budgeting measures and local considerations, factor into hospital revenues and reimbursement rates. In France, creating these classifications could easily fall in line with the French *longue durée* cultural plan of extending care further, even when the discussions related to budgetary issues.

Despite French health care being far more equally distributed than American health care, inequalities have still persisted. The French would enact the CMU to finally classify all as meriting health care once and for all. By 1995, 83% of the population had obtained a supplemental insurance; however, those supplemental plans were disproportionately benefiting white collar workers. Wage earners were far less likely to benefit from a supplemental insurance, leaving those with lower means a higher cost to pay at the doctor's office. Though the finance link between health and work has remained nearly as strong in France as in the U.S., the social merit link is no longer present. Though France reacted negatively when Alain Juppe proposed alternate financing measures that would allow taxes on wealth and rents to help finance social security, the CMU was passed with its appeals to "justice" (Aubry 2003). The CMU, which was enacted under Lionel Jospin with Martine Aubry as a figurehead, covered those who were unemployed, indigent, and the few others who did not make it into any insurable categories. It guaranteed coverage to all citizens and permanent residents by 2000. This measure categorized all remaining citizens and residents as deserving of care in one movement.

Clinton's health plan, which proved a failure, ended up resulting in only a few modest gains for the poor and children. Again, American policy was ready to provide a patch work expansion for populations deemed especially needy, yet not ready to pass a general health expansion. The Health Insurance Portability Act reformed COBRA plans, which were often ultimately very pricey at a time when workers had less income (*Inc.* n.d.). This was followed by the 2003 Medicare Modernization Act, another patchwork reform that created a prescription drug benefit under Medicare. Another similarly small provision of the 2003 MMA was Health Savings Accounts (HSAs). These allowed for pretax earnings to be set aside uniquely for health care. HSAs were made available only to people with high deductible plans. That meant deductibles of $1050 for an individual or $2100 for a family (U.S. Congress 2003). They could not benefit from any plan deemed "comprehensive." These solutions still presented all of the same access problems because they did not lower the cost of care or provide funding for care. They sorted the less wealthy into a group that would benefit from a unique way to save up for medical services, but did not help mitigate costs in any other way. The lower middle class was yet again sorted into a category where they were expected to work towards all of their own goals with little actual assistance. Still, they did not merit any extra care or assistance in accessing health care in the way that veterans, the elderly, the disabled, the poor, or children have merited care.

Conclusion

In this chapter, we have seen that the French state has used classification strategies to constantly expand access to health care, while the U.S. has failed to do so. Instead, in a continuation of the piecemeal, reactive, and disaster-abatement policies, classification strategies have been used to cover only the neediest and most uninsurable populations. The differences in these two strategies diverged post World War II and created conditions that endure to this day in both nations. In the unsettled times of the post-World War II era, *longue durée* culture was leveraged, and these two classification strategies emerged as a way to create two different sets of social health care rights. France created a cohesive system of rights, despite the fact that it started out with a piecemeal approach to social rights. The U.S. continued down its piecemeal path, extending rights only on a contractual, transactional basis, much in line with New Deal policies. We have also learned that adding new classifications of health care rights beneficiaries is not beyond possibility in the U.S., since the ACA added a health rights classification that allowed for subsidies for the lower end of the middle class. However, the ACA has been challenged repeatedly, as it is not fully in harmony with the American values of individualism, self-reliance, and non-government interference in private lives. Here we see that these classification strategies, just like any state action, need to operate within the realm of *longue durée* culture in order to create unchallenged and enduring policies.

CHAPTER FIVE:

AMERICAN *LONGUE DURÉE* HEALTH CARE CULTURE ILLUSTRATED

Despite the fact that sociologists can easily detect the presence of themes repeatedly used in the service of distinctive political camps, the average American is not as likely to be able to do so. Indeed, an unmarked newspaper clipping found in the Clinton Presidential archives indicates just this. The article, titled “Confused Americans Caught in Crossfire of Healthcare Ads” asks, “What do people think when they see opposite things? ‘they throw up their hands and decide they do not know who’s telling the truth any more, and then they run for cover,’ according to Kaiser advertising exec Drew Altman, there is little question who is winning. An environment of confusion contributes to skepticism, experts say. The impulse is not to want to change when you’re confused.” The article continues on to note the great diversity of recent ads that appeared addressing health reform, including ads for health insurers, Canadian-style system advocates, National Right to Life (pro life), National Restaurant Association, and the American Hospital Association. The AARP ran ads noting that health costs would soar if reform is thwarted, while pharmaceutical companies that research would stop should reforms be passed. The AMA invoked the specter of managed care as part of the new reform, and the DNC ran ads claiming that the middle class would suffer without universal coverage. Indeed, conflicting messages have muddied American health care debates for decades, and as this this astute observer believes that notices, this has left Americans disoriented.

However, opinions on what should be done with health care are not difficult to encounter in the United States, despite conflicting messages and an opaque public discourse (Kahneman 2011:8). Behavioral science offers us several keys to understand how people make sense of confusing times, but these behavioral science tools must be combined with a robust understanding of culture in order to be explanatory. Behavior is oriented by culture, and even when we break behavior down to its most psychological impacts, culture has great impact, defining what makes individuals feel most comfortable. Behavioral science gives us insights into a number of common heuristics and biases that contribute to this tendency to favor culturally familiar claims. First, consider the power of familiarity bias. Behavioral economics states that in any ideological environment, including in ideologically charged environments, whichever claim or argument feels most emotionally or culturally familiar will quickly become the claim that a person favors. believe to be true. The renowned psychologist Daniel Kahneman examines the simplifying shortcuts of intuitive thinking that people routinely make decisions and form opinions. He describes familiarity bias as the tendency for people to like things more if they have been exposed to them repeatedly (Kahneman 2011:97-101). Interpreted culturally and psychologically, we understand that cultural common sense is extremely familiar, and thus extremely favorable. Common sense arguments, which by definition appeal to familiar cultural anchors, are thus more likely to be favored than arguments that do not appeal to cultural common sense. This suggests that especially in the midst of a disorienting debate, individuals will favor a familiar argument over a new one. This partially explains why established culture has such inertia.

Next, consider the attribute substitution heuristic. Kahneman explains that when people are presented with a very complicated question that they cannot reasonably answer with the information available to them, they instead answer a much simpler question, without realizing that they are actually answering the simpler question. For example, when faced with the question, “how should American health care be managed?” people are likely to answer a simpler question, such as “who deserves health care?” The answer to this much simpler question relies on familiar cultural narratives that the individual favors due to their familiarity (Kahneman 2011:66-67). Therefore, culture and the embedded discourses about health care color how individuals interpret complex and conflictual messages. Culture works together with human psychology and influences the behavioral economics of how individuals assign value to different ideological positions. However, it seems that individuals are just as likely to make faulty assessments of policy proposals based on culture and the biases and heuristics that help simplify the evaluative task as they are to simply run and hide from the issues, as Altman suggests.

The Enduring Puzzle of Health Care Reform

Before beginning this analysis of primary public sphere documents about American health care reform, it is worthwhile to remember that Americans have been caught up in debates about health care reform, individual mandates, business mandates, single payer health care, and private health insurance and medicine for nearly eight decades. This issue is fraught with twisted concepts, political spin, and most importantly, disagreements about what a real societal good would look like when it comes to health care. These differences, and to perhaps an even greater extent, the proliferation of advertisements and commentary about health care, has left Americans either summarily confused or caught in opinions simplified by cognitive bias and heuristics that are shaped by the most familiar cultural elements.

This confusion, and the documentation of it, has continued to characterize the American health care debate. An *NBC News* article from 2013 reported that polls indicated that approximately half of Americans remained very confused about the potential benefits, proposed changes, and general direction of health care under the Affordable Care Act (ACA) (Connor

2013). This uncertainty and lack of clarity means that the discourse that surrounds the issue is even more likely to be targeted directly to the greatest fears, values, preferences, and concerns of the American public, as this conversation is an ideological one.

It would be tempting to believe that the power of marketing undermines culture. However, just as an authoritarian regime cannot create culture to its liking despite its power, political parties crafting political discourse and marketing within a democratic society must resonate with the broadest, most common denominators of culture in order to be successful. These cultural appeals and the policies that they inform must appeal to people on opposite sides of the political divide in order to gain traction. Though it is tempting to believe that political research and marketing are tools that manipulate culture and politics, they are not. Since Berezin has showed us that even the most powerful states cannot manipulate culture, we know that American parties also cannot do this, even if they possess tools like marketing and research. Instead, political research and marketing are tools that allow parties to test their ideas for cultural resonance, which is ultimately a key to their success, but not a force powerful enough to sway culture.

With the creation of Campaigns Inc. in 1933, marketing, market research, focus groups, and the use of buzzwords, brands, and consumer-style messaging found their home in American politics (Lepore 2012). Marketing itself was new in this era, but even then, marketing would need to successfully reach the emotional and cultural realities of its targets. The first marketing focus group was carried out to research Ivory Snow soap, one of the flagship products of Procter and Gamble. The application of these marketing techniques would forever change not only the American political process and its outcomes, but also the ways that Americans speak and write about politics. Studying the cultural resonance of political messages and policy initiatives would become big business.

The very first political consulting firm would be employed successfully by the AMA both in the fight against Earl Warren's health care plan for California, and then against Truman's health plan (Lepore 2012). Campaigns Inc. learned just how powerful of a tool culture is when it is properly leveraged. They won seventy out of the seventy-five campaigns they were hired onto between 1933 and 1955. Their success relied on emotional appeals, which are largely grounded in values, thus paving the way for more carefully packaged politics that appeals to cultural standards. The field now relies on everything from focus groups, to polls, interviews, social listening, and data scraping in order to carefully craft political messages, slogans, ads, and headlines that resonate with Americans and bring them into their campaigns. Ever since, the words of political campaigns have been carefully researched, tested, and then chosen to have maximum impact, to resonate with both specific and wide audiences, and to be, essentially, effortlessly resonant, in the way of advertisement campaigns for consumer goods and services. Equally, the appeal of potential policy initiatives, plans, and platforms are tested on voters, and those that are most popular are more likely to be pursued by policy makers. This is why political discourse, regardless of the side that it supports, is such an accurate barometer of culture. Since slogans and messages are tested, only those that resonate are pitched. When messages that are less resonant are pitched, they are most likely to fail to garner the type of support that is needed to move an issue forward. Or, if they do make it into becoming actual policy, they are likely to be challenged at the first possible opportunity, much the way that the ACA has been. Even if research budgets are not equal on both sides of the political divide, both sides conduct extensive political research, including both polling and focus groups. Later in this chapter, we will look at the results from focus groups conducted by the Republican National Committee (RNC) during the Clinton administration about the health reform campaign. We will see that the appeal of this program simply could not be pitched to conservatives. Additionally, non-partisan groups such as Pew Research Center provide ongoing research into cultural and political issues that can be leveraged by any party.

In the next two chapters, I finally turn to direct media campaigns, speeches, newspaper articles, and the other primary sources which most truly inform a cultural analysis. Values as embodied in the assumptions of the public and of policy elites have proven to be central to the health debates that I analyze here. These values have been mobilized in mostly consistent manners, thus creating continuity in the assumptions present in discourse despite important changes in setting and policy. More specifically, the evidence leads me to hypothesize that France uses its republican values to justify the expansion of state-supported health care, while the U.S. uses its capitalist values to justify not doing so. In the U.S., health care is expanded only for utilitarian reasons when it is entirely out of financial reach for a specific population, while in France, health expansion was slow at only certain junctures for utilitarian or practical reasons. The fundamental differences in French and American values and orientations to utilitarianism has led to both very different policies and very different discourses. Worded in another way, the French viewed healthcare expansion as utilitarian because it would bolster solidarity, while in the U.S., the utility in providing care is only present when a population is nearly entirely cut off from care due to cost and disastrous health outcomes must be avoided.

Furthermore, I observe that in the U.S., arguments against expanding health care rights, whether they are through direct government provision or government support of private provision of those rights, remain remarkably the same over time. Meanwhile, arguments for the expansion of health care rights, while they do contain some similarities, respond much more clearly to the way that Americans experience changes in the medical industry. They also respond to the growing differences in health rights globally, as more Americans become aware that health care costs are pushed more strongly onto U.S. consumers than they are in other countries. This chapter focuses on the American case, whereas the French case will be examined in the next chapter. After a brief introduction to some of the most colorful ad campaigns, the documents in this chapter are grouped and organized thematically by cultural element. This allows the reader to truly appreciate the longevity of these elements and themes. After setting the stage by examining anti-health reform ad campaigns that contain some of the most colorful and lasting arguments used against health care reform initiatives, I explore several recurrent themes. First, I examine the notion of compulsory care, which arises early in the 1940s in reaction to discourse about Truman's national health insurance. While terminology may change over time, objections to imposed health coverage have spanned many decades. Next, I examine fears of government control of health care, another highly charged talking point that has been present in anti-healthcare expansion dialogue for decades. The proposed antidote to this, personal choice, is also examined in some detail in this chapter as a culturally grounded argument against healthcare expansion. Next, I examine arguments that purport that health policy is part of a political agenda. These arguments include health reform programs as the pathway to rationed care, and socialism, communism, and other political threats. Next, I examine discussion about the quality of care in the face of reform. These include discussions about "free" services and debates about the government's ability to provide quality care. Practical and social discourse is also present in U.S. health care debates. In this arena, I examine price concerns and accessibility, extending health care to support democracy, and health insurance as fraudulent and abusive to consumers. Finally, I examine debates about private sector solutions and medical research.

Colorful and Enduring Ads Against Health Care Reform

To begin this analysis, let us examine three amazingly powerful ad campaigns against health care reform that were representative of their times. As is was most appropriate to their eras, one is a comic book, another a television ad campaign, and the third a series of YouTube advertisements. The following ads against health reform proposals, come from three distinct presidencies: Truman, Clinton, and Obama. However, they are remarkably similar in their emotional content, emotional pitch, and the fears that they mobilize as arguments against government playing any role in the expansion of health care rights. The fictional characters, Willie, Harry, and Louise, and these two young Obamacare patients all have something in common. They are the characters created by groups opposed to health reform proposals in the U.S., and all suffer greatly, or fear they will suffer greatly, due to any government intervention into the health care space. Willie graces the pages of a 17-page full color comic book prepared by the Committee on Public Medical Education of the Baltimore City Medical Society (Harry S. Truman Archives, Papers of Harry Truman, Truman's Fight for Health Insurance, Box 2, March 1950), Harry and Louise were small screen stars thanks to a series of four television ads by political affairs and messaging firm Goddard Claussen (Goddard Claussen 1993a, 1993b, 1993c, 1993d), funded by the Health Insurance Association of America, and the Obamacare patients found their fame thanks to the conservative group Generation Opportunity (The Young Turks 2013). The three ad campaigns were among the most colorful, memorable, and impactful campaigns of their eras. Respectively, they were in reaction to Truman's health proposal, Clinton’s Health Security Act, and Obama’s ACA. The following analysis of these characters reveals some of the most effective, most readily mobilized, and most frequently utilized arguments against health care available in the American political and cultural spheres.

Willie has an average build, wears clothes just a touch too large, carries a respectable but not flashy umbrella, and wears a sensible walking hat. Willie appears to be ambiguously working or middle class, but in any case, he is not poverty-stricken, and he is not wealthy. He seems like an honest, trustworthy, hard-working fellow. Willie is drawn so that he could be appealing to both the working and middle classes. Of course, in Willie’s time, cartoons were very popular, and many newspapers dedicated entire sections to comics. *Waiting Room Willie* was clearly formulated to have mass appeal, be culturally relevant, and positioned to appeal to the media consumption trends of his time. But, just what has happened to the character Willie in 1950? First, Congress passes a National Healthcare program. Next, Willie comes down with a cold at work. But since his doctor is now obligated to see him, and medical care is free, he decides it would be a great idea to see the doctor that has been treating him for years. On his way, he notices a pain in his left side, and that he has gas. Easy fixes for the doctor, surely, and as his colleagues reminded him, his doctor now must make time to see him, especially since he pays his taxes. Unfortunately for Willie, his doctor cannot see him, because every single other person who also pays their taxes is equally full. His waiting room is full of patients, all complaining of ailments, demanding they be seen as their rights as citizens dictate, and pushing. Nurse Friendly refers him to another doctor, who she believes to be less busy, of course.

However, this Dr. Smith is equally busy. Except, he is clearly using his medical practice to facilitate the purchase of new toupees as a treatment for baldness, treating breaking fingernails, and listening to the woes of fat rich ladies. Therefore, he is too busy to see Willie.

Referred to yet another doctor, Dr. Robinson, who cannot see him, a nurse finally wraps a scarf around his neck, as he has been getting progressively sicker. Willie turns instead to Senator Bifocal, who notes that Government Medicine is not perfect yet, and gives him a cigar in the meantime.

Willie turns down an offer—whispered from out of a trash can—for a prescription and a bottle of aspirin for just $2.53. Willie exclaims that he voted for Socialist Medicine, that he would pay for his aspirin with his tax dollars. After this, Willie promptly passes out, is whisked away to the same over-busy doctor's office, while other patients declare that they will not be surrendering their place in line to Willie. Willie is treated by indifferent, dismissive, inattentive, medical staff distracted by gossip who reference their "rank," and who note with the attitude of teenagers that they cannot be fired. Doctors and nurses explain that they have waiting lists 40-60 patients deep, and that he will need separate forms for his throat and his stomach. Willie is left in the care of his elderly mother, who contacts the last remaining doctor—Dr. Rural—only to discover that he no longer practices, since he did not want his practice directed by the government.

After all of this, Willie does finally find care. His mother finds a black market doctor practicing out of an old water tower, who is a "paperhanger" by day, and a doctor by night. For the fee of $100, he tells her to give him liquids and put him to bed. A witch shows up to brew Willie a potion, cheering socialized medicine which will put her back into business, when Willie's original doctor finally shows up for a house call. He declares that he must use the kitchen table to operate on Willie, that the witch will serve as nurse, and that medicine has stepped back 50 years.

Luckily, Willie survives his kitchen table operation. But he gets to wondering. To his mother, he declares, “I’m thinkin’ about thinkin’ Mom… Thinkin’ for ourselves. Instead of lettin’ some other guy do it for us, when all he’s thinkin’ is holdin’ down a fat job with the government!” Sitting outside the locked polling place, he states, “I’m gonna be the first one in there next election day to vote for Free-Choice medicine and against compulsory federal or nationalized medicine.”

Harry and Louise are two Clinton-era middle class, white collar, responsible and concerned citizens. They dress conservatively, without any offending flair, and read newspapers at their breakfast table. Harry and Louise have a less damning, but equally troubling list of concerns about health reform (Goddard Claussen 1993a, 1993b, 1993c, 1993d). They are clearly concerned, informed, and employed citizens. They are trustworthy, and they want the best for all Americans. They both agree that health reform is necessary, but that the Health Security Act was not a good solution. Harry and Louise want “coverage we can keep even if we change or lose our jobs; coverage we can afford” and to have “everyone covered” which were indeed the most important goals of the Health Security Act (Clinton Presidential Library YouTube Channel 2014). However, they fear many aspects of this plan. Most interestingly, many of their fears are echoes of fears expressed during Truman’s discussions about National Health Insurance.

With their colleagues and families, Harry and Louise are worried about a “national limit on healthcare” and the country’s health plan “running out of money.” Running out of money or fears of financial insolvency is a common criticism of a government-supported healthcare system in the U.S., despite the fact that no one ever worries about the military running out of money. Harry and Louise lament having to choose between a few government-created health plans, and they feel that “having choices we do not like is no choice at all.” Harry and Louise are well informed, as Louise has read the plans for health reform, and Harry has called an information hotline to learn more about the issue. Surprisingly, their worries have only grown as they acquire more information. They know that the government's list of private health insurance plans might not include their favorite one. Louise is so concerned about the new proposal that she talks about the issue at work. She insists to her coworker that everyone should be covered, and that government should also let everyone pick the plan they want. Harry, Louise, and everyone they talk to is worried about health care rationing, being involved in a giant social experiment, and especially, unavailable or rationed medical services.

Though their biggest objections seem to be their fears about health care rationing and the health budget running out of money, they are also worried about not having enough different health plans to choose from. They worry that they will not like the options that they can choose from, and they fear being "forced" to buy health coverage through "new mandatory government health alliances… run by tens of thousands of bureaucrats" "so we can't choose a plan that's not on their list even if we think it's better for our employees and their families." Worried about finances for her family and her business, Louise does not believe that the legislation will save them any money, and she is against "the benefits tax" on particularly pricey health plans.

So, despite voicing that they want the exact things that the HSA sought to guarantee, they wonder "why can't Congress write a law like that." As the ads progress, Louise urges friends and coworkers to "send Congress that message." Louise knows that Congress could fix all of her worries, and Harry reassures her that "they will, if we send them that message." Action is the largest marker of citizenship in these ads. The call to action entails an engaged citizenship that defends its own best interests against the follies of government.

But Harry and Louise's fears seem almost mild compared to what Obamacare patients would be led to expect. A young woman, having recently signed up for a government health insurance plan, goes into the doctor's office for her first ever gynecological exam. As soon as her feet are in the stirrups, the doctor leaves, and her assistant materializes sneakily with a speculum. This assistant is Uncle Sam. His head is about the size of ten normal human heads, and so is his smile. A similarly excited young patient also finds that his doctor is actually a deranged Uncle Sam, and that he will be enduring a surprised colonoscopy on his first ever doctor's visit covered by his new government sponsored health plan.

The Generation Opportunity creepy Uncle Sam ads were part of a six figure anti-Obamacare campaign aimed at young people (The Young Turks 2013). The goal was to prevent signups among the young, which would forcibly derail the program, which depends on the enrollment of the relatively healthy. The two visually striking ads run with essentially only one powerful message: The government will take advantage of you in really strange ways—do not allow government influence in health care if you want to be cared for at all. These ads rely on deepening distrust of the government amongst the young, combined with fears about the "stability" of the medical profession in general. The generation which has seen jobs decline, wars extend, the home foreclosure crisis, and crushing student debt may or may not be as politically informed as other generations, but either way, their opinions are just as strong and even more partisan than prior generations. Their news sources are frequently the sorts that distil trends or ideas down into their very briefest possible word counts, leading to strong political beliefs and which may or may not be even more one sided than they used to be. Here, in this ad, there is no version of citizenship. There is simply the option to not sign up for "Obamacare." That would be the only way to "protect" oneself from the horrors of creepy Uncle Sam.

What should we make of the persistence of these very colorful, very fearful arguments against health reform? American arguments against health reform have remained somewhat similar over time, while arguments for any sort of government involvement in the provision health care of evolved. They have evolved largely in response to the ever-dramatic increase in the cost of healthcare that is passed on to Americans. Even during times of economic prosperity, such as during the Clinton administration, health care costs continued to rise and burden American families. While liberals have tried a wide variety of arguments over time, ranging from justice, to fairness, to human rights, to rights as Americans, to workers' rights, to inequalities, to simple emotional appeals, few of these arguments have gained much traction, unlike in France. In the U.S., these arguments seem to be diffused as simply emotional, and health care reform proposals are largely criticized for being unpragmatic, unaffordable, unnecessary, communist, socialist, foreign, or as potentially compromising the quality of American health care.

Interestingly, there are several common elements between these three ads. First, there is fear of the government controlling, rationing, or manipulating care. Willie is unable to visit his doctors, cannot get the medicines he needs, and needs to fight through bureaucracy. These three characters all either reveal or communicate the fear that government involvement in the health system will result in lower quality care, less reliable or lower quality care, or care that is far too difficult to access.

The anti-Obamacare ad summarizes these fears in the creepy Uncle Sam caricature. This Uncle Sam is sinister, and does not have anyone's best interest in mind. He does not inspire confidence or seem competent. He is not the type of caring doctor that would give choices and options, hear a sick patient out, or find the best solution. He is likely sadistic, and might even conduct experiments on his patients. Interestingly, Harry also frets about being used as part of some social experiment. While he does not seem to believe that he might be the unwitting participant in drug testing or bizarre surgeries, his distrust reveals that he feels the American government would manipulate him through his medical care for its own gain. These types of experimentation fears, social or otherwise, could logically have roots in the Nazi experiments. Given that many health reform criticisms default to the idea that universal coverage, comprehensive coverage, or mere government involvement is socialist, communist, or even fascist, this connection seems quite likely.

Calls to citizen engagement and participation are also common to two of these ads. At the end of Willie's struggles, he declares that he will be voting for Free Choice healthcare. Harry and Louise will be sending messages to Congress. This encouragement towards action is far stronger than the option presented in the Creepy Uncle Sam ad, where someone would really only refrain from signing up for ACA coverage, as opposed to voting or writing to Congress. Nonetheless, the first two examples of inciting engaged citizen participation are strong and important. In these two examples, there is a cultural orientation to participating in politics in very specific ways—by voting, or by writing to Congress to express disapproval. As Eckstein also points out, these actions and orientations are commonly spread through conversations, discussions, or through other sorts of movements. While the actual levels of letter writing and voting may not be as high as one might think given the recurrence of such sentiment in these campaigns, their repetition is important. Letter writing and voting are the among the most culturally top-of-mind actions taken to be part of the political process and express discontent, despite the fact that there are many other options and courses of action available.

Loss of personal choice is another theme that runs through all three campaigns. Willie cannot see the doctors he has seen for years, because they most accommodate new patients, or have simply shut down. Harry and Louise worry that the health insurance plans available to them will not be to their liking. Creepy Uncle Sam is the only health care option once patients enroll. It seems that choice has a great deal of meaning in American culture. It is highly valued, if not a value itself. This may have roots in American understandings of democracy. To vote is to choose, and the right to choose is only given to citizens. If this is the case, the loss of choice is akin to the loss of citizenship rights, or, a demotion to a lower class of citizenship. The high value of choice is pervasive across many facets of American life. Consumer goods present increasing amounts of choices, health insurance now offer a dizzying array of plans, and parents look for greater choices in schools for their children to attend through charter and private schools. Berezein (1997) explains that elements of political culture may be evident in politics as well as in non-political situations. Choice is a value that Americans do not want to see compromised. When there is a political action that may infringe upon what they perceive as their ability to choose, they become very dissatisfied and are likely to take political action standard to the American context.

Compulsory Care, Voluntary Plans, and the Individual Mandate

“Compulsory care,” one of the most common terms used in anti-health reform rhetoric in the 1940s, reflects the fear that government involvement in health rights would be a forceful, intrusive, and unwanted constant interference. While the term “compulsory care” did not have staying power, the fears associated with compulsory care have persisted. At the most basic level, the objection to compulsory plans would be simply that they are not chosen by consumers from a set of options. However, upon deeper examination, it becomes clear that there are more fears and more emotions attached to “compulsory care” than simply lack of choice. It is also important to note how, many of the images in the materials analyzed here are intensely emotional. Health care, especially in the U.S., has been a lightning rod for some very extreme sentiments. This is because they become the connection point of arguments about citizenship, rights, national ideologies and identity, and the very meaning of health. As a result, arguments are often not well-connected, emotional appeals are made without explanation, and one concept is frequently equated to another. This emotional quality was already present in the Truman era, before middle class Americans were truly suffering economically. This "running downhill" type of propaganda is very well illustrated by the following quote: "Once you have compulsory insurance, you never get rid of it. Its bureaucratic. There is a third party between the physician and the patient. It is inordinately expensive, and the expenses increase by the year… And it gives a deteriorated type of medical care. It has been called the great leveler. That is, it does not bring the poor doctor up to the level of the good one; it drags the good one down to the level of the poor one" (Harry S. Truman Archive, Ewing Papers, 1918-1947, Box 39).

The opposite of "compulsory" care was "voluntary" insurance plans. Importantly, these "voluntary" plans, as they were called in the 40s, were argued to be sufficient to secure the health needs of Americans, simply based upon the fact that increasing numbers of people had plans. Though no one could predict the exponential spike in the prices of American health care or health insurance rates, "voluntary" plans appealed to American values, especially at a time when many Americans believed that the country's success in World War II was largely due to a superior economic and political system. Many people believed that encouraging these existing economic, political, and cultural values could be extended to any sector of the economy, and to any potential societal need. As such, simply allowing "voluntary" plans to proliferate was a convincing argument to many. A speaker at the National Convention of Retail Druggists in 1949 argued: “We currently have 45 million people enrolled in voluntary plans, and feel that before long, we will have 80 million. Some of those plans are only for catastrophic illness, surgery or obstetrics. Also, 24 million people get care from the government, including veterans. They would still have to pay for the compulsory health insurance even though they did not need it. Then 5 million are indigent, and others are covered through industry health cooperatives. If you add it all up, you find that the greater part of the population will be covered by the voluntary system” (Harry S. Truman Archive, Ewing Papers, 1918-1947, Box 39). Here, the argument is as simple as the belief that the voluntary health insurance system would be enough to cover all Americans, and that some Americans, veterans namely, would be potentially covered by two systems, or worse, be paying into two systems. Interestingly, this latter point could have been an argument for a refinement of policy, but is instead used as an argument against such compulsory care. This viewpoint also does not seem to value health care as a vector of national solidarity or income redistribution. Here, health care, and the experience of or availability of a similar or even identical level of coverage for all Americans is not desired as it was in post-war France. In the U.S., healthcare expansion has rarely if ever been proposed as a service that would unite or strengthen the bonds of solidarity between Americans. Like most that have argued against the expansion of health rights, and even like some that have made attempts to expand health rights, this speaker is comfortable with having Americans fall into different health service categories based upon their status as indigent, veteran, or covered by industry or catastrophic plans.

The ACA was not carefully crafted enough to escape objections to “compulsory” care. The individual mandate feature of the legislation led to the earliest firestorms surrounding its implementation. This was despite the fact that the ACA did little to truly undermine the balance of private and public control of the American health system. In order to make extending subsidies to the lower end of the middle class, others would still need to rely on employers to access health care. The ACA meant that some Americans would have health insurance as a work benefit, others would rely on programs for veterans or the indigent, and still others would select a health plan of their own choosing either with or without access to a subsidy. Though the ACA provided tax-funded subsidies for those purchasing health insurance plans through the exchanges, the availability of these subsidies varied widely by state, since some states did not cooperate with the expansion of Medicaid required to effectively administer the ACA. These regional differences actually create even more divisions and distinctions in the types of care that Americans are able to access. Equally noteworthy is the fact that the tax penalty for failing to secure health insurance through an ACA plan is among the most hotly challenged features of the law. It was so contentious, that during Donald Trump's first week in office, he signed an executive order giving the Department of Health and Human Services the ability to and authority to roll back any part of the ACA that "would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, health care providers, health insurers, patients, recipients of health care services, purchasers of health insurance, or makers of medical devices, products, or medications" (Erb 2017). Indeed, it was the way that the ACA is administered that causes the most cultural discomfort for many Americans. Deeply opposed to government intervention and individual mandates, the right, which must also support any major plan should it prove effective and supported in the long term, needed a different solution (Gramlich 2016). Even if voters can be in favor of reforming American health care, they are unwilling to accept government mandates, regardless of their party (Pew Research Center 2012). While Trump was elected while promising a solution to the health care crisis, he did this without a stated plan. The only concrete part of this supposed plan was that a private solution free of government intervention would be sought (Ferris 2015). However, this focus on private sector provision of health care appeals to these voters.

At the time of writing this dissertation, it certainly appears that the goal of Trump health reforms would be to challenge everything from the individual mandate IRS fine for not securing health insurance, to the ban on denying coverage to those with preexisting conditions, to the state subsidies granted to those with limited means. CNN reported, “President Donald Trump on Friday called for repealing the Affordable Care Act immediately and replacing it later with another Healthcare plan if Republican senators are unable to pass their bill. ‘If Republican Senators are unable to pass what they are working on now, they should immediately REPEAL, and then REPLACE at a later date,’ tweeted Trump” (Scott 2017). The movement to repeal the ACA, which was largely inspired by popular resistance to the individual mandate and the “compulsory” nature of the act, demonstrates that a large number of Americans are resistant to imposed programs, nearly seven decades after Truman’s era. Indeed, early into the Trump presidency, the individual mandate was challenged, and the White House reported that the individual mandate may not be enforced. *Fortune* reported: “Speaking on ABC’s *This Week* program, Kellyanne Conway, counselor to the president, said President Donald Trump ‘may stop enforcing the individual mandate’” (Reuters 2017).

Resistance to “Government-Run” Programs

Results from focus groups on health care generated much of the anti-reform language during the Clinton health campaign. In 1993, the RNC spent $30,000 on just one round of many focus groups, in order to research public opinion on health policy. A report on the results of this one set of focus groups notes that “Healthcare has become a question of overcoming ‘mental blocks' and getting a handle on the most useful healthcare phrases" (Clinton Presidential Records, Healthcare Task Force, Box 7). Their research revealed that "'government-run' is a pivotal, negative term for Republicans. As such, Republicans knew that they could discredit the Clinton plan by saying that the government it is not simply 'policing the system' but rather 'running the system.' Also, focus groups were concerned that health insurance plans would "rip off" consumers. The same report also noted that "everyone knows that individual policies sound better than group policies. 'Personal' is a preferable word, overall." Republicans also learned that any new plan must provide more "personal security" than the old plan (Clinton Presidential Records, Healthcare Task Force, Box 7, HC Talk Points). Just after this, Republicans introduced Personal Medical Savings Accounts—a concept which capitalizes on its ability to maximize a feeling of personal responsibility, and potential safety from being ripped off. Also, since Personal Medical Savings Accounts shelter wages from taxes and create an impression of lower government interference, they may have been more appealing to Republican voters. Still, these accounts do nothing to shield citizens from the ever-increasing costs of medical care. They simply provide a tax shelter for funds. This would do little to truly aid a middle class family confronting an increasing cost of living, a rocky period of unemployment, or any other unexpected expense. Despite their extremely limited protections and their limited ability to expand care, Health Savings Accounts (HSAs) remain a popular feature of the American health care landscape. Discussed in 2017 as an alternate to the ACA, these plans provide no regulation of the health industry, provide no avenue for wealth redistribution, and do not help the fragile. However, these accounts have a carefully chosen name, and mobilize values of personal responsibility, self-reliance, and the absence of governmental controls or regulations. Furthermore, the cultural resonance of the logic behind these programs was tested and proven via focus groups, then their resonance was confirmed by the fact that these programs have had longevity. Programs without similar resonance, such as the ACA, have difficulty standing the test of time.

The RNC focus groups of 1993 demonstrate just how carefully language must be selected in the service of health policy campaigns. The differences between the terms "policing the system" and "running the system" are subtle, but very important. Of course, a government-run system is stronger than a government-policed system, but the differences in public response to these terms were strong enough for Republicans to base what would have been exorbitantly expensive campaigns on the differences. This language showed up in campaigns against the Clinton health plan, such as the Harry and Louise ads. Even California Insurance Commissioner John Garamendi, a Democrat, knew that he would need to choose his words carefully when discussing the employer mandate. He told attendees of town hall meetings, "We must contain the costs of the system, and we can do that with a voluntary system… We've got to change this system, or we're going to drive this nation into a very serious economic situation." Garamendi favored a plan that did not allow the government to prohibit hikes in insurance premiums the way Clinton plan did. This plan also combined workers compensation with health insurance, which was unique (Clinton Presidential Records, Healthcare Task Force Records, Kenneth Starr Press Files, Box 4). Still, this alternate plan included an employer mandate, which many Republicans considered to be dangerous "compulsory" insurance. Despite the fact that many Americans would likely benefit from increased options as a result, the pressure on employers would be enough to make plans such as this seem like a power grab by the federal government, which would ultimately eventually result in a systematic loss of choice.

Fears of this sort of power grab by the government are rather constant in the American space. Related sentiments appear in this review of Michael Moore's *Sicko*. "Many Americans have forgotten how well off they are. They complain at the slightest pain, because they're told that virtually ALL their problems can and should be taken care of by a nanny state. Most immigrants, on the other hand, know that the nanny state is a lie. They know that the more powerful a state becomes, the more liberties and choices they all lose. And that's why they flock to the U.S." (Asman 2007). Interestingly, the U.S. does not currently have many immigrants arriving from Western Europe or Canada, despite their strong "nanny state" policies! In any case, we see a few themes here. First, the idea that less care should be given so as to not encourage dependency or nannying, and the idea that Americans are likely to abuse health care if it is easy to obtain. This argument is also very clearly present in *Waiting Room Willie*, where people take advantage of free glasses, free everything, and feel they need to go to the doctor for flatulence. Next is the idea that immigrants have already experienced socialized medicine from a nanny state, and that it results in loss of freedoms. Obviously, this author is not very precise. Country of origin is not specified, which freedoms might be lost are not specified, and there is no fact-based analysis about just what sorts of issues are being experienced by these unspecified immigrants, or just which issues Americans are likely to over-treat. Instead, this author will let his readers be carried away by fears that are ideologically and culturally relevant. It is the fact that this argument resonates culturally that allows it to hit its emotional target, despite the fact that it lacks real substance. Here, we see, as Mabel Berezin (1997) describes, that culture and politics, are not separate. When political institutions, political communications, and democracy are concerned, this separation is exceptionally unlikely. Our example above demonstrates this, as the argument relies on fears that are ideologically and culturally based, and that, as a result, would be unlikely to be effective in any other political context.

Distrust of "Free" Services, which will Cause Moral Decay

While *Waiting Room Willie* is the most robust of all of the ads that I encountered during my research, its 25 illustrated pages capture several arguments that persist into today's health debates. Willie finds that he cannot get a doctor's appointment, that the care he can receive is substandard, that prescriptions for simple medications are expensive, and that government handling of health care is unwieldy, obtuse, and inherently socialist. It also argues that American society will be degraded due to increasing level of dependency on government, or "free" services. While there are certainly more arguments than these against government's involvement in the extension of health care rights, many of these arguments endure into the debate surrounding the ACA. Just like in *Waiting Room Willie*'s days, today's critics of the expansion of state-sponsored health rights often remark that people are likely to abuse, take for granted, or take advantage of any "free" health care program, simply glossing over the fact that any program paid for by tax dollars is anything but free, and could even cost us our freedom (Moffitt 2017; Reinhard 2013).[26] At the same time, they also argue that a "free" system could only be of low quality (Atlas 2017; Epstein 2017). While supporters of expanded health rights, such as Moore, will sometimes also say that health care should be "free," their arguments about free health care seem to be more focused around being free from struggle, fear, or the pain of trying to pay for

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[26] The freeloader theme has been common enough in public discourse that responses to it have been published (e.g., Graves 2018).

impossibly expensive services. Moore makes this argument by showing the ease with which English, Canadian, and French patients receive care (Moore 2007).

Loss or degradation of culture is an equally persistent theme in arguments against the expansion of American health rights. This loss is most often present in fears of freeloaders. Atul Gawande finds that many opponents of health reform believe not only that programs like Medicare and Medicaid are frequently taken advantage of by freeloaders, but also that they compromise the values of self-reliance and non-imposition. Gawande found that those he interviewed in Athens, Ohio did not object nearly as much to health rights if all could be made to contribute to the system, but that their lived experience caused them to believe that this was currently far from reality (Gawande 2017). The loss of culture is visible in Willie, decades earlier, though the loss comes not from the fact that the medicine is compulsory, but rather that it is “free.” Furthermore, “free” services, a “free lunch,” a “free ride,” or “freeloaders” are decidedly offensive to an important part of the American political value system. In France, worries about freeloaders do exist, but they are more likely to be aimed at immigrants and doctors who overbill social security than they are to be aimed at individuals (Pujadas 2007). While individuals may be the target of campaigns to slow the readiness to take paid sick days or ask for name brand prescriptions, widespread fears about perfectly average French citizens flagrantly taking advantage of the system and contributing to widespread societal decline and decay do not exist as they do in the American context. The French seem to value solidarity and access to care more than they worry about the healthcare system sparking widespread laziness; further, they do not consider their health care free, even if it is paid for by the government out of tax dollars at the point of service.

Instead, Americans historically value self-reliance, individual responsibility, and each individual's right to work harder in order to be able to buy things that they desire, as is evidenced in the "unalienable" Bill of Rights promotion of "life, liberty, and the pursuit of happiness." To those who prefer the most traditional interpretation of these values, the expansion of health care rights is offensive. To this camp, the idea that valuable services would be "free," therefore, is inherently offensive to these critics of healthcare expansion, even before the argument is extended to say that free services will cause socialism and societal decay. As George Lakoff (2006) points out, political issues are used by politicians symbolically and stand for values, represent worldviews, and are used to build trust. Health care reform seems to be most effectively leveraged as a negative value by conservatives rather than as a positive value by liberals. Only the most extreme of French viewpoints will ever point to social programs as a source of this sort of decay. In fact, even the right wing Front National does not advocate cutting social programs. Instead, they ask for ways to control budgets and limit services to French citizens as opposed to other Europeans or non-European immigrants. In the 2017 election, the newly renamed party, now called *Rassemblement National*, roughly translated as National Rally, called for a strengthened military, renewed industrial policies, and recognition and services for veterans (*Rassemblement National* 2017). They did not call for a reduction of medical services.

Today a sizeable portion of the American population believes that the poor are poor largely due to their lack of effort. According to research conducted in 2017 by the Pew Research Center, 34% of Americans believe that the poor are poor because of lack of effort, and 45% believe that the rich are wealthy because they have worked harder. Among Republicans, 56% believe that poverty is caused by lack of effort, and 66% believe that wealthy people are rich because of greater effort (Smith 2017). These numbers suggest that Americans see work as the pathway to success, but not necessarily as the pathway out of poverty. The same study reported that 53% of Americans believe that a person is poor because of situations outside of their control. Since a majority of Americans do not blame the poor for being poor, only 12% of Americans would be in favor of cutting Medicaid, while 47% reported that they would like to see funding levels remain the same (Gramlich 2017). These results combined with the analysis of rhetoric included in this dissertation suggest that though Americans want to encourage work as a pathway to success, many do not blame the poor for their poverty. Despite this, extending government support to middle class Americans, even in the form of health care subsidies, is fraught with conflictual cultural baggage. Despite the fact that healthcare expansion could help the poor and the middle class with medical costs thus reducing poverty, it is charged with symbolic values that make it a non-viable option for relief. As seen in *Waiting Room Willie*, for conservatives, expanding health care rights is too symbolic of eroding American culture and the American political system for it to gain any traction. George Lakoff (2006:78) points out that conservatives see health care as a commodity that should only be available in function of what the market would support relative to a person's wealth.

Disturbing this relationship means breaking foundational American traditions that hearken back to the Revolution, which causes ideological discomfort among conservatives and those who value these ideals. Therefore, though many Americans may say that they want Medicaid funding to remain stable, and though many believe that the poor are not at fault for their poverty, addressing issues of inequality via health policy causes cognitive dissonance powerful enough to cause inertia when it comes to voting for reforms.

To examine this cognitive dissonance, Arlie Hochschild (2016) asks what Tea Party conservatives feel about politics, and how those feelings translate into votes which run contrary to their political best interests. By interrogating what people feel, want to feel, and what they are ashamed or reluctant to feel, she investigates the relationship between emotions and politics. She finds that emotions are a key driver in American politics, trumping logical considerations of what might actually benefit individuals. This is echoed by a *Columbia Journalism Review* analysis of the first presidential debate found that it "focused more on personality than any other in U.S. history" (Rich 2016). Hochschild interprets the fact that her research subjects in Louisiana confront an opposing political view by parroting language from news outlets that share their political leaning as demonstration of the depth of media penetration and how completely it shapes worldviews, common sense, and culture. However, the worldviews of Tea Partiers far predate the existence of modern media, their messages, and their frames. This language, the symbolisms attached to issues, and even many political turns of phrase have existed for decades, and in some cases more, as the present research shows. Self-reliance, non-imposition, hard work, independence, and resistance to free services are the cultural ideals that much of our political culture is built upon. As a result, the media in these areas speak this language and mirror it back to Hochschild's subjects. It is not that Hochschild's subjects mirror the language of the media, but that the media mirrors the language of the subjects.

Still, Hochschild's investigations into the politics of Tea Partiers are valuable. She finds that for the Tea Partiers of Louisiana, it is the strong emotional perception that immigrants, African Americans, women, refugees, and the environment all receive preferential treatment, as they themselves are passed up in American politics, social policy, and moral support. For the Tea Partiers, these groups are undeserving of the amount of aid that they receive because they are perceived to not pay into the benefit system (Gawande 2017), but also because the Tea Partiers perceive that these groups are stripping them of their own positions in American society.

Because of these beliefs, they vote for candidates that seemingly respect and represent their "emotional best interest," even if their actual policies do nothing to protect them from income instability, poor health, or the environmental degradation due to deregulation that plagues their region. It would follow that it is emotional reflex of these left behind Tea Partiers to also continue to vilify minorities and find them undeserving of care, separate themselves into those who contribute to the system versus those who do not, as this allows them to maintain a moral high ground, the comfort of a scapegoat, and the illusion of a party and a plan capable of rescuing them from their plight (Gawande 2017).

Hochschild finds that her Tea Partiers are shaped by the Bible, and that their greatest values are loyalty, sacrifice, and endurance. Sacrifice and endurance easily translate to the virtue of hard work. Again, this virtuous hard work has deep roots and a long history in the American psyche, and can be found across many demographics. A great example of the longevity of this value can be found in a 1950 report from Dr. Frank Dickenson, Director of the Bureau of Medical Economic Research of the AMA (Dickenson 1950). His report, "What Health Progress Means to Me," explains the marvels of modern medicine and the fact that death is no longer the closest American fear. Dickenson states, "We know that for the price of a family movie a week, a family can enjoy a membership in Blue Cross and Blue Shield. And the people who can't afford such a membership are the people that can't afford a family movie once a week. So much for that… Today the cradle-to-grave is a scheme whereby those close to the grave would fasten themselves onto the paychecks of those closer to the cradle and ride piggy back to the grave" (Dickenson 1950). Here, Dickenson displays little care or empathy for a family which might not have the means to attend a movie a week. For him, in the post-war economy, any family that would be unable to afford such an investment in their health care is likely doing something morally wrong.

In Dickenson's view, this family would be economically irresponsible and willing to benefit from the work of others—namely, other young people who do their American duty and work hard enough, long enough, and lucratively enough. Their limited means are not interpreted as the result of other hardships or sacrifices. Their limited means do not cause him to reflect that might be local or charity aid available, or that they should be supported by some other fund, program, or support system for the poor. Of course, Medicaid had yet to be dreamed up, but for Dickenson, it's "Too Bad, So Sad!" for any poor family.

However, in the U.S., the fear of "free" and its dangers perdures for decades, as has the trivialization of health issues and the impact that health issues can have on a person's life. Simply expecting people to find money for insurance, treatments, and to manage a HSA without any guaranteed sick leave demonstrates just how small we consider these risks and tribulations to be. When Willie feels ill, his colleagues urge him to go find some "free medicine," noting that since he is a tax paying citizen, his doctor is obligated to see him. And since care is free, he suddenly realizes that he actually has more minor, laughable or even frivolous (gas), medical issues than he originally realized he had. This joking about gas may be funny, but the implication is that Willie's issues are not serious, health issues do not need to be taken seriously by the state, and all Americans should grin and bear it when they fall ill if they do not have the resources to see a doctor.

In Willie's America, when National Healthcare is passed by Congress, people on Main Street react to the announcement by planning to get new dentures, eyeglasses, and hearing aids for "free." The children look forward to free ice cream, marbles, and dolls. One woman laments the possibility of her husband’s take-home pay shrinking, which would make her family need “free treatment for acute hunger,” but enormous excitement stems from the possibility of all “free” medical treatments. This attitude is made ridiculous both by the sheer implausibility of offering “free” medical care to everyone, but also by the fervent, insistent excitement with which people react to the announcement. The man hoping for free dentures displays a set of enormous, straight teeth, while his pants sag, the man wanting eyeglasses emphasizes that these glasses will be his “extra” glasses, the bucktooth paperboy announces “Its all Free, FREE!” while waving a paper headlining “Free Medicine Socialized Medicine,” and an African American child speaking in black vernacular (how unAmerican!) wistfully wishes for an entirely free dime store. Another woman notes how great minor surgeries can be when there is “no worry about payin’ bills.” In today’s U.S., many simply refuse to believe that the country could devise a budget that would allow for all citizens to receive health care, despite the fact that this is a reality in the rest of the developed world. Most believe that these sorts of services would imply subpar care or a bankrupt nation.

These scenes in *Waiting Room Willie* are truly grotesque (Harry S. Truman Archives, Papers of Harry Truman, Truman’s Fight for Health Insurance, Box 2, March 1950). They paint a truly catastrophic picture of once proud, hardworking, ration-respecting, self-reliant, war effort-supporting Americans as suddenly lazy, pleasure seeking, and particularly quick to take advantage of any little extra comfort. They give no thought to the fact that all citizens pay taxes and are in the healthcare system together. This picture is entirely opposite from any of the most famous war effort propaganda pieces, which portray Americans as strong, self-sacrificing, hard-working, and collectively oriented in the face of adversity. Somehow, mysteriously, “free” health care rights transformed them completely. This would only be a reasonable image if a free service were able to completely rewrite a group's value system. Furthermore, such a grotesque image could only resonate to readers ready to interpret a new social right as an affront to their value system.

This contrast shows us that political messages are carefully crafted to persuade. In order to do so, current cultural elements must be leveraged. In *Waiting Room Willie*, stereotypes about black children, fears about lazy freeloaders, and dismay over the promotion of the very opposites of wartime values are all culturally informed. The logic that expanded health care could lead to moral decay only exists in the U.S. More precisely, the idea that the American work ethic could be harmed by expanded health rights is also uniquely culturally and politically American. *Waiting Room Willie* would not have been effective if it leveraged images of businesses becoming too prosperous, too monopolizing, too innovative, too futuristic, or too innovative from the outcomes of health reform. *Waiting Room Willie* could have easily argued that business interests would blast ahead in innovation and science, bringing about a scary, post-apocalyptic society where business and science is king, since Americans are now so healthy that they never take sick days. Healthy American workers benefiting business too much with their good health simply would not have been a culturally feasible argument, since Americans sympathize with business interests, see businesses as the key to the prosperity of the nation, and generally pass legislation that benefits business. Americans also value science, innovation, and research. The impact of the comic would have been lost if it had not been so carefully, and culturally, crafted.

Importance of Personal Choice

Related to the resistance and fear of compulsory programs is the fear of losing personal choice. In a print advertisement in *The Washington Times* funded by Conservative Empower

America, President Reagan's Chief Domestic Policy Advisor and Under Secretary of Education Gary Bauer links Clinton's Surgeon General Jocelyn Elders to statements legalizing drugs and gay adoption. He then proclaims, "Bill Clinton chose his doctor, now he wants to choose yours" (Clinton Presidential Records, Magaziner Files, Media Coverage, Box 2, July 10, 1993). While free choice or free access to the physician of one's choosing has never been the strongest feature of the contemporary American health system, the threat of further reduced choice has been a very powerful and effective tactic. Leveraged against any health reform proposal, single payer, private insurance based (such as the ACA), or otherwise, the threat of losing personal choice succeeds in generating resistance and great angst.

We must note that Americans have been aware of the fact that their health choices have been limited for quite some time. Democrat and California Insurance Commissioner John Garamendi went on a statewide tour talking about the proposed Clinton reforms. He conducted 20 town hall meetings that advertised a discussion that would consider and discuss "the most comprehensive reform of healthcare in history." Garamendi asked the audience, "Under your current plan, who chooses your insurance for you? 'Employer' several people obediently replied. With the Clinton plan, he replied, you could choose which HMO you wanted to belong to" (Clinton Presidential Records, Healthcare Task Force Records, Kenneth Starr Press Files, Box 4). Here, we have evidence that these Americans were aware of the lack of choices that they possessed. While it is unclear from this source whether the people Garamendi spoke to were comfortable with their employers choosing their health plans, it is relevant that they remained without choice in a system that relies upon employers to provide health care. Americans were clamoring for freedom of choice but did not accept a system where it is the government that offers choices. It seems that government involvement in the health industry represents the loss of choice to many, even when that involvement would challenge reliance on employers, lack of choice due to employer involvement in health care, or lack of health care accessibility due to lack of insurance. This could be because Americans perceive career or employment as an individual choice. Perhaps Clinton-era Americans felt that should one desire health care, all they would need to do would be to seek more gainful employment. Should these beliefs be truly uncovered, they would point to American notions of merit and stigma as a deciding factor in beliefs about health care. The argument would be that those who succeeded in finding such legitimate work had chosen their own health care by proxy of choosing their work wisely. Those who had not managed to do so would not merit a choice of provider—they would not merit health care at all.

Today, as in Clinton's era, this may be because locating a doctor that is covered by one's insurance that is also likeable, not too far away, and has openings for appointments proves to be a great stumbling block (Anderman 2016). Establishing rapport and building history with a doctor is important to many patients, and the threat of losing this relationship due to a new insurance program, a new regulation, or a new mandate is enough to turn those who have been receiving satisfactory care away from a program, even if it guarantees that it would cover more Americans. This dynamic has been made even stronger due to the fact that just enough Americans are adequately insured. The sum of Medicare recipients, Medicaid recipients, veterans on VA care, and employees with sufficient employer-funded insurance has far outnumbered the number of uninsured people for many years (U.S. Census Bureau n.d.). Many of these individuals would not approve of an expansion program were it to make their own situation more expensive, reduce their choices, or complicate their process. The individual self-concern is simply greater than concern for the greater American community. This division has likely slowed health reform progress considerably. If nothing else, it has formed the backbone of any rhetorical resistance to reform. The refrain might as well have been, "Reform might help others, but it will hurt your and your family's currently acceptable health insurance situation." It would be tempting to believe that this indicates that once a country has started down the path of employer- or employment-linked health care, that this course is difficult if not impossible to alter. This path dependent theory does not seem to be true when we examine the French case. In France, health rights began as employment rights, just like in the U.S.

The Conservative Empower America ad that chimes "Bill Clinton chose his doctor, now he wants to choose yours" is another example of political emotions linking unrelated concepts or fears together into the most perfect catastrophic potential future for one specific political demographic (Clinton Presidential Records, Magaziner Files, Media Coverage, Box 2, July 10, 1993). This sensational ad paints a wild, fear-inducing picture for American conservatives. The ad posits that legalized drugs, homosexuals raising children, and doctors chosen by Bill Clinton will come along with health care reform. In this ad, all of these potential liberal victories would essentially be won at once. Allowing health care to be dictated by the government, as the ad encourages people to imagine, would be one step forward in a zero-sum struggle between liberals and conservatives. In this context, the Clinton health care reform plan becomes part of a battleground over family values and the war on drugs. This strange coalition of issues is really a coalition of conservative values versus a coalition of liberal values, with health care reform and expansion being clearly placed within the coalition of liberal values. This division and the inability to both create a policy which could speak to the widest American common sense, combined with the inability to successfully frame the policy in a wide sense contributed to the unpopularity of this policy. Again, any successful policy must be able to appeal to the widest, not the narrowest common sense. In other words, successful policy cannot neglect the fact that there are many positions on the matrix of political culture, all of which work together to form the fabric of a political sphere. “Political culture,” according to Mabel Berezin (1997:364), is a “matrix of meanings embodied in expressive symbols, practices, and beliefs that constitute ordinary politics in a bounded collectivity.” In the U.S., the bounded collectivity of ordinary politics includes disparate views that at times may even appeal to differing common sense. However, these different common sense positions can be reconciled through careful policy creation and framing that appeal to multiple positions in the matrix of meaning.

Combining political issues is very common, with different parts of the debate showing up in just about every source. In a mostly neutral article in *USA Today* outlining arguments about the inclusion or exclusion of abortion and reproductive health care in the Clinton plan, Judi Hasson states, “We can pass a historic healthcare reform without employer mandates” (Hasson 1994). In this case, distaste for employer mandates becomes intertwined with the issue of coverage for abortion. Mandates are distasteful simply because they are compulsory—not because they have anything to do with abortion coverage, the issue at hand in the article. Again, we can see how a potential coalition of cultural values may fight for or against health reform, regardless of how essential those values are to the true heart of the health insurance debate. Effective framing and policy creation must align to create efforts that can appeal to the widest common sense, even if this involves mobilizing different frames or values in different spaces. These frames and policy positions would ideally consider other issues which are likely to be drawn into the debate.

For example, abortion and birth control are issues that have curiously noteworthy levels of staying power, impact, and weight in American politics. Their centrality to health reform debates is even more curious. Taken up as part of the religious conservative coalition of values, reproductive health and family planning is clearly a true health need, especially for the working and middle classes that are most likely to benefit from health rights expansion. Appearing again in the very first weeks of the Trump presidency, and continuing into 2018, this charged anti-health reform value issue has stood the test of time, just like many of the other most central arguments against health reform (Davis and Haberman 2018; Rovner 2018). Reformers have not found a way to frame or legislate these two issues that appeals to the widest American common sense.

Health Reform Programs as the Pathway to Rationed Care

During the course of the Clinton health campaign, Ira Magaziner, Clinton's Chief Healthcare Advisor, received over 22,000 letters offering all manner of commentary, fears, objections, approval, and experiences with the healthcare system (Clinton Presidential Records, Healthcare Task Force Records, Magaziner Files, Box 20, December 1992-October 1994, Summary of Healthcare Correspondence). Many included suggestions for what people felt would work, or have seen work, personal horror stories about medical bills or being denied care, or simple feedback about the proposal. These letters also included reflections of the ad campaigns that were so ubiquitous, editorials in newspapers or magazines, and speeches, showing just how effective messaging is to these sorts of campaigns. As a result, these letters are a very rich source of information on what the American public was absorbing from this debate, and of exactly which ideas were truly resonating with Americans. Magaziner compiled the letters, analyzed them for content, removed the names, and prepared a report in order to discuss them with the White House.

One letter from Napa, California stated: “I do not want rationed care, reduced quality of care, reduced choice of physicians. I want my regular primary care physician, my regular ophthalmologist, dermatologist, dentist, etc. I do not want to be told I’m not eligible for medical treatment because I’m too old. Just take care of the ones you are targeted to and leave the rest of us alone” (Clinton Presidential Records, Healthcare Task Force Records, Magaziner Files, Box 20, December 1992-October 1994, Summary of Healthcare Correspondence). Clearly, arguments against the Clinton health plan which posited that people would lose their choice got considerable mileage with this letter writer. Though most Americans who had insurance during the Clinton campaign had insurance chosen by their employers or were limited to doctors who worked with Medicare, their perception of losing choice may have actually meant something different. Though many Americans had health coverage that did not grant them full choice of doctors or hospitals, they still managed to find care that served their needs well enough. Likely, finding a doctor, hospital, or treatment center that would take their insurance was difficult in the first place. The thought of needing to start over with a new plan, even under legislation that mandated access to health plans for all people, did not interest them. Importantly, letters like this one were very typical. It, and other sources, indicate that Americans have been largely unwilling to make any changes in their own medical care or health insurance in order to insure a larger number of Americans. Even the hypothetical possibility of needing to change health insurance providers or doctors in order to accommodate reforms was a reason to scrap the entire Clinton health reform plan.

In France, many individuals worried that the establishment of certain policies would degrade their ability to access care. This was especially true about the *médecin traitant* (general practitioner) policy. Many feared that they would need to wait longer to see specialists, would lose their ability to easily switch primary care doctors, or that their overall cost would increase since they would need to see a general practitioner before seeing a specialist. However, the utility of reducing costs in this way was apparent. General practitioners bill less, and declaring a preferred doctor would help prevent individuals from seeking multiple second opinions. These cost saving goals were framed not in terms of the need to simply save money, but as effective strategies for making tax dollars go further, allowing for more people to receive more crucial treatments. This was framed and interpreted as the best way to maintain solidarity and fraternity across the population. In this instance, a policy created some fear about degradation of care and loss of choice, but the French complied with this policy quickly, since the correct cultural references were mobilized effectively. The policy, while it potentially threatened quality of care, could be rationalized in a way that spoke to common sense; therefore, fears of reduced access to care were easily overcome. However, in the U.S., the goal of extending care to all is not a priority, meaning that any potential degradation of care cannot be justified by the resulting ability to cover more individuals.

The American desire to be "left alone," for complete freedom of choice, or simply to be left to make decisions without any governmental mandates, guidelines, limitations, or regulations on individual behavior remains as important today as it was during Truman's presidency. This desire is justified via individual rights, freedom, freedom of choice, or rejection of socialism. This anti-ACA editorial from 2012 reads as if it could have been from 1949. Here, individual rights, choice, and governmentally pre-selected options make up what would have been called "compulsory" health insurance in the 1940s:

> What about basic individual rights? Why should I, as an individual, be forced to choose from "insurance" plans that a handful of so-called "experts" in Washington have decided that I have to purchase, regardless of my own personal preferences and desires? … President Obama is the current figurehead of a

> political culture that peddles envy, entitlement and ultimately enslavement. They treat virtually every human problem as an opportunity to grow government power and the centralized planning of healthcare by the federal government is the crown jewel of their scheme. Far from actually addressing the problems that we have with our Healthcare markets, ObamaCare will enslave us to the dictates of a small but powerful group of technocrats. (Rodriguez 2012)

This editorial also treats health reform, and more specifically any government involvement in health reform, or in any "human problem" as a plot to bring the country under the control of an increasing strong centralized government. Rodriguez's belief that health care would be the "crown jewel" of such a scheme is not new**.** It appears in historical arguments about health care reform being socialist as well. Apparently, the fear of an organized socialist takeover of the American government, with an ideological anti-freedom goal, with an eventual result enslavement of the American people at the hands of the socialist elite is still alive and well!

One could perhaps believe that health care is not a right in the U.S. simply because it has never been proposed as a right. However, this is not the case. In very isolated instances, health care has been described as a right, such as in Harris Wofford's political ad during his 1992 campaign for the Pennsylvania senate. Wofford's ad states: "If criminals have a right to a lawyer, then I think that working Americans have a right to a doctor… I'm Harris Wofford and I believe there is nothing more fundamental than the right to see a doctor when you are sick" (cited in Skocpol 1997:27). Wofford won the election, Pennsylvania itself never got its own health care plan, and neither did the U.S. Rush Limbaugh lambasted Wofford for calling health care a right (Limbaugh 2019), and Wofford's invocation of health as a right did not stick around in the American health reform discourse. It was simply too far removed from *longue durée* culture to resonate and have staying power. Even more telltale is that the Clinton campaign went on to hire Wofford's political consultant in the service of his health care plan. Clinton did not do well with Wofford's strategist, further evidence that health care is not viewed as a right in the U.S.

Socialism, Communism, and Other Political Threats

This brings us to the next uncannily recurrent theme in American health reform debates: socialism, communism, or other political threats. These arguments meant more than just a different system of government. It meant the breakdown of American work ethic, business failure, defeat in the Cold War (during the Cold War, mostly), the loss of American culture, and the degradation of communities, families, the middle class, and all pro-social values. Lack of choice and government mandates are clearly linked to this rhetoric.

For one speaker at the 1949 National Convention of Retail Druggists, the "American way of life" is largely equated with its political system. Here again, socialized medicine is a central issue which will cause all other parts of the American political system to change, resulting in economic failure, a welfare state, and in the end, a country completely unrecognizable from what it had been before.

> People that are in favor of compulsory medicine are being used by a certain group in this country which is bound and determined to change our form of government and make this a welfare state. Furthermore, they admit that the first thing they've got to do is to socialize medicine. All industries will fall after that. This is a problem where you are going to have the American way of life or whether you are going to turn the U.S. into a welfare state. (Harry S. Truman Archive, Ewing Papers, 1918-1947, Box 39)

This progressive chain that moves from compulsory medicine, to a welfare state, to socialism is rarely explained or truly connected. Facts or comparisons, historical or current, are generally entirely absent in this type of discourse. Instead, an intention to turn the U.S. socialist is somehow extrapolated from arguments about health care. During the Cold War, fears of socialism were a top national issue. The current emotional link between health care specifically and the creation of a socialist state is best explained historically. Much like in the 1940s, current arguments are also noticeably devoid of facts, history, or true political analysis, and rely largely if not solely on sensational emotional appeals and fear tactics instead. Interestingly, these arguments often leave out considerations of what Americans positively want. The discourse is an advocating against, as opposed to an advocating for. While such reductive and simplistic claims and analysis were and have not been the only type of discourse, they are certainly the most common across all eras. Simple and easy to produce, reproduce, and easy to read, internalize, and share, these types of thin discourse have likely had more impact on public opinion than any extended, analytical, or complete coverage of health policy changes. Further development of this research could focus on the differences between rhetorical strategies that focus on these positive values-based wants versus negative fears.

During the Cold War, newspaper ads, such as one run by the Cambria Sommerset Association endorsing John P. Saylor for Congress, used heavily anti-socialist rhetoric, especially when discussing health care. The text of this particular ad ran:

> Pharmaceutical freedom means more than $'s and cents. We wish to maintain the American way of life... the Voluntary way, which allows men freedom of choice... We sincerely believe in the statement of Nikoli Lenin, founder of the present Russian socialistic communism, that 'the keystone of the socialist state is socialized medicine.'... We realize that socialized medicine means enslavement… that for every benefit you receive from a socialist government you must give up an equal amount of freedom. (Harry S. Truman Archive, Oscar Ewing Papers, Box 33, National Health Insurance)

In the context of the Cold War, the fear of socialism was certainly common. This fear was intense enough that real debates were often eclipsed by this style of dogma, which is so sensational that it becomes entirely unpragmatic. Despite this unpragmatic dogma, other social programs passed during the New Deal, such as Social Security, were only infrequently challenged in this light. Health, it seems, is given a uniquely pivotal position in the furthering of a socialist agenda. Perhaps this is because medicine is a profession, as opposed to a trade.

Professions, which are generally highly respected due in part to the high level of organization and education demanded by professions, may be seen as some sort of canary in the political coal mine. Perhaps the fear is that if the professions are socialized, or even just regulated, and powerful, organized, and wealthy professional organizations cannot effectively prevent themselves from being regulated and socialized, then the trades and all other livelihoods could eventually suffer.

Furthermore, this supposed Lenin quote is first and foremost, only supposed.[27] But even more fascinating is the fact that this very quote, and the parallel to slavery, would be repeated by Ben Carson about the ACA decades later. Journalist Jonathan Weiler of the *Huffington Post* provides an analysis of Carson’s assertion that the ACA is the worst thing to happen to the U.S. since slavery, because of the fact that Lenin said that “the keystone of the socialist state is socialized medicine” (Weiler 2013). Clearly, in Carson’s assessment, socialism is as bad as slavery, and national healthcare is socialism. Weiler points out that the unsubstantiated Lenin quote first came into American politics during the AMA fight against Truman’s health plan. This “quote” was used in a 15-page pamphlet circulated by Leone Baxter and Clem Whitaker of the political consulting firm Campaigns Inc. This document was a Q&A style document titled “The Voluntary Way is the American Way.” This pamphlet included the unsubstantiated Lenin quote. The rhetoric is so similar that it is as if Carson went into the archives himself, read the Campaigns Inc. pamphlet and John Saylor’s ad, and then began speaking against the ACA. The stability of the American discourse is clear.

Weiler points out that by Carson’s logic, and by the logic of any other health reform

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[27] Journalist Jonathan Weiler (2013) notes that the Library of Congress was asked to locate this quote and could find no evidence of its veracity.

opponent who cites socialism as an objection, agreeing with any program or viewpoint that corresponds to Soviet thought would cause a person to also be socialist. Stalin banned abortion in 1936. However, today's pro-life movement is never called socialist. While it is not as simple as this, Weiler's point is useful.

Many of the letters to the White House that Ira Magaziner catalogued during the Clinton campaign simply and clearly betray the moral outrage people experience when they perceive that their political values are being challenged, especially when it comes to socialism or communism. Mrs. Nilda Z Duffek of Cupertino, California wrote on bright pink paper in a large, angry, offended-looking and scrawling hand: "Pink is for commies. I was overwhelmed by the scope of what you and other Socialists in Washington DC are planning to do to our Democracy" (Clinton Presidential Records, Healthcare Task Force Records, Magaziner Files, Box 20, December 1992-October 1994, Summary of Healthcare Correspondence). This feedback is simple, direct, and clearly names her greatest fear—that Ira Magaziner's plans for extending healthcare would bring socialism to the U.S. This letter reveals the depth of genuine emotion contained in this debate, the emotional attachment to democracy as a pillar of American existence, and the deep belief that instituting a state-led or -funded healthcare system would begin a steady slide towards a socialist system.

This sentiment was repeated in multiple letters. Dr. Yale Berry wrote to Magaziner: "Single payer system is the first step to socialized medicine." In his letter, he included a clipping from the *Journal of the American Medical Association* (JAMA) that read: "U.S. healthcare system is increasingly inefficient when compared to Canada." Instead of proposing expanding healthcare through any public option, Berry suggests: "the solution is simple. Mandate by law administrative costs of hospitals to be no more than 10 percent" (Clinton Presidential Records, Healthcare Task Force Records, Magaziner Files, Box 20, December 1992-October 1994, Summary of Healthcare Correspondence). Here, this letter writer was informed by the arguments of the AMA and his profession, which of course argued against any health reform. Canada had not yet adopted a single payer system, so the comparison to Canada means something much different than it would mean today. Yet, this letter serves as another simple and to the point example of the American belief that health care, especially single payer health care, is a gate to socialism.

The same fear of socialism spanned professions as well. A 1946 letter from O.W. Baldwin to "The Committee of Funeral Directors for the Preservation of Professional Freedom," echoes the same fear that health has a special ability to advance the socialist cause: "A determined political group is exerting great pressure to force compulsory sickness insurance on the American people. This is the first step towards the regimentation of all professions. If the government undertakes responsibility for the distribution of medical care, you can be assured that the government will also assume functions of our own profession. This means state funerals!" (Harry S. Truman Archive, Papers of Harry Truman, Truman's Fight for Health Insurance, Box 2, March 1946). Here, the fear is that when health care rights are extended through a government program, the government will absorb not only all rights, but all services and all professions, resulting in the loss of freedom. Organized professionals should be in the best possible position to fight against undesirable policy, government action, or political changes. And as a particularly influential, wealthy, and generally intellectually respected profession, doctors should be in the best of possible positions to fight against any regulation they feel to be repressive. This funeral director feared that if doctors' work were regulated, if medicine socialized, of course there will also be state funerals!

These particular arguments have had such amazing staying power, beyond their historical relevance, well after the end of the Cold War, because of the fact that, like other arguments with longevity, it is both value- and fear-based. And, similar to other post-World War II arguments and Cold War arguments, the U.S.'s position in the world economy is used to justify the value of preserving the status quo. The argument is most commonly based around the idea that other countries are not doing as well economically or militarily, as evidenced by U.S. success in war or by the continuation of immigration to the U.S. The argument is underpinned by an American conception of merit—those who work hard and do the "right" thing are successful and rewarded. By remaining morally correct, or in this case, by remaining "capitalist" as opposed to socialist, the U.S. remains economically strong. The argument implies that should the U.S. reform health care in a way which would make it all similar to another less "correct" country's system, that the desirable conditions here would simply crumble, leaving Americans in a terrible situation. This argument is nearly religious in nature, with economic collapse being the punishment for being less capitalist. While it is clear that this argument flagrantly ignores the complex issues that drive immigration, it is more meant to be a scare tactic—a warning of the consequences of veering off the "correct" path of American capitalism. This correct path is not a nanny state, which causes laziness and robs people of their freedom in exchange for substandard services. Instead, the correct path is a system where all citizens must be unwaveringly hard working and self-reliant.

Distrust in the Government's Ability to Provide Quality Care

Government involvement in health care is presumed to promote care and services of lower quality, across all of these campaigns. Throughout *Waiting Room Willie*, characters illustrate that the care they received before socialized medicine was superior (Harry S. Truman

Archives, Papers of Harry Truman, Truman's Fight for Health Insurance, Box 2, March 1950). Before beginning his quest, Willie is certain that his family doctor would take "two hours" to sort out his issues, because of their long history and doctor patient relationship, which he considers to be both important, special, and worth honoring. Of course, this is clearly the exact opposite of what Willie finds. Ambulances take two hours to show up, doctors have only three minutes for a consultation, there are no appointments to be had, and even the most compassionate of doctors simply cannot fit Willie in. Despite appeals to nurses, insistence, and his rapidly worsening sickness, Willie can do absolutely nothing to cut through the red tape that is separating him from his doctor. His doctor, of course, holds the key to Willie's treatment, recovery, and health.

A similar Americans for Prosperity from 2014 ad is less theatrical, but just as ominous, and warns of the same bleak future. Julie, a two-time cancer survivor approximately in her 60s, candidly states that "Obamacare is dangerous. It can't be implemented. Your well-being, judged by a bureaucrat in DC is devastating. I do not want my children to be a name, or a number, in a computer. They are people. Our government is not organized to take care of us… They can't. We are the best in the world. And that's what we want to keep… I have had the best care in the world, and I want the same for you" (Americans for Prosperity 2014). Again, the same argument, the argument that that any governmental interference or regulation of health care will result in entirely inaccessible systems, decision makers divorced from people and their health care, impersonal treatment, and subpar services surfaces in a new era, under a new administration, in an entirely different geopolitical climate.

In a review of *Sicko,* David Gratzer focuses on a few horror stories from other countries. His review of the film indicates not just how the film was received, but also illustrates some of the greatest and most common objections to health reform. Gratzer is horrified that a French doctor would include any Marxist sentiment while discussing the distribution of health care, and frets about cleanliness and wait times in English and Canadian hospitals.

> It's not simply that Mr. Moore is wrong. His grand tour of public healthcare systems misses the big story: While he prescribes socialism, market-oriented reforms are percolating in cities from Stockholm to Saskatoon. In France, a doctor explains the success of the health-care system with the old Marxist axiom: "You pay according to your means, and you receive according to your needs."... A relative, living in Winnipeg, nearly died of a strangulated bowel while lying on a stretcher for five hours, writhing in pain. To get the needed ultrasound, he was sent by ambulance to another hospital. Around the time Mr. Moore was putting the finishing touches on his documentary, a hospital in Sutton Coldfield announced its new money-saving linen policy: Housekeeping will no longer change the bed sheets between patients, just turn them over. (Gratzer 2007)

This lack of realism is seemingly particular to the U.S. when it comes to writing about health care. When the French compare their health care to that of other nations, they generally discuss comparative budgets and outcomes. That said, when they do happen to fear the development of *medecine a deux vitesses* (two speed medicine), they worry that their medical care will begin to develop in a way which mirrors the highly inegalitarian U.S. system (Revel 2004). Yet, their perception of U.S. health inequality is not based upon an unrealistic cultural fear. The U.S. actually does suffer from health inequality.

While Gratzer is fighting anecdotes with anecdotes, his objection to French health care clearly betrays his moral compass. To Gratzer, and to many opponents of any state regulation of health care, Marx's thought is truly the enemy. For a public obsessed with avoiding socialism well after the definitive end of the Cold War, he represents all of the anti-values of this camp. Invoking Marx is pushing the moral panic button just about as hard as it could be pushed.

Some fears about declining quality of care are less anecdotal and more theoretical. In 1993, Dr. Denise Jackson wrote, "I agree our system has to change, but I fear the pie-in-the-sky attitude of some of our politicians. Our expectations are going to have to change as our system changes. Who is going to decide when a patient has received enough care? The patient? The government? I can tell you those primary care physicians do not want to be the bad guys. Somebody has to tell the American people that they have to adjust their expectations" (Jackson 1993). Jackson's thoughts here are that there are actually not enough health resources in the U.S. Despite the facts that our health spending is much higher as a percentage of GDP than other OECD countries (OCED 2018) and we have relatively low success rates, this scarcity-based fear persists. It is assumed that some people will need to give up certain types of care in order to cover more people and that people will be unhappy about this. Judging from this sentiment, it is not in the American value system to make even small compromises in order to more evenly distribute life-saving resources.

When there is less of a fear about redistributing care or funding, there is still a blended moral-financial discomfort. "The public generally believes that more than enough money is spent—and that is why they do not want to pay still more, especially if they will receive less" (Jackson 1993). Still, though the belief that Americans would need to spend more money to provide health care to more people is likely very false, given that the experiences of other countries in reducing the cost of prescriptions, specialists, and hospitalizations. The American discomfort with paying more for others, should it really be necessary, would not fit in with Americans' individual values the way it fits with French values of solidarity.

Arguments in Favor of Extending Health Care

Arguments for the extension of government involvement in the extension of health care rights, on the other hand, evolve more steadily. But more importantly, they likely evolve more because they are not able succinctly to appeal to American values. Though they may at times discuss rights, justice, equality, or even solidarity these claims do not resonate enough for them to become constant. The arguments do not stick, and therefore new arguments are generated. In these instances, the battleground is not just the policy outcome, but the framing and ideological groundwork laid or reinforced along the way. While pundits, politicians, commentators, or journalists may use any logic, concept, or value in the service of an argument, only those that resonate can be accepted as an addition to or an alteration to common sense.

Extending Health Care as a Service or Right would Support Democracy

To counter the frequent thought that national healthcare must be socialist, pro-health arguments in the 1940s alleged that better health would create a better democracy. These arguments attempted to appeal to post-war patriotic sentiment by implying that the U.S. was great because it was healthier than other nations, but that even better health could be achieved. These arguments were not appeals to rights. Instead, they were based on security, a national sentiment of superiority, or a desire to be or remain superior, and the thought that happiness would prevent the temptation of communist promises. The following Presidential address to the 1948 Swedish Pioneer Centennial Association illustrates a few of these arguments. Truman argued:

> You can prevent communism by more and better democracy. As far as the U.S. is concerned, the menace of communism is not the activities of a few foreign agents or the political activities of a few isolated individuals. The menace of communism lies primarily in those areas of American life where the promise of democracy remains unfulfilled... If some of our people do not have proper medical care, or opportunities for good education, or adequate assistance in times of sickness, or unemployment, or old age… that is an invitation to communism… Communism succeeds only when there is weakness, misery, or despair. (Harry S. Truman Archives, Public Papers of the Presidents Online)

These arguments cater directly to the common sense that America was ahead, and should stay there.

For Oscar Ewing, health care should have been part of equality, or in other words, better democracy. He argued that healthy citizens were important to defense, and that national security was dependent on increasing equality. More importantly, Ewing argued against the misery of those without access to health care, but in order to do so, felt the need to argue the need for these equalizing services in terms of defense and stability; even when that meant including unnamed enemies. Here, he calls what we can assume to be communists, "those that would halt our social progress" (Harry S. Truman Archives, Ewing Papers, Box 42, Speeches and Articles). Here, we can see how adaptable an argument in favor of extending health care had to be. This argument needed to address the anti-healthcare arguments of the day, despite the fact that those arguments actually had little bearing on health care itself:

> We are witnessing the largest "international crisis" beyond anything that has ever been seen before. This conflict is convenient for those that would halt our social progress. Progressive social legislation such as the Fair Deal cannot progress as we pay for an enormous military… Health and education seem to me among the most basic issues we have to deal with if we are to secure anything approaching equal opportunity… The poverty and lack of opportunity in which such a situation[28] develops do not prevail in this country. Most of us, most of the time, enjoy enough of the good things of life to make us totally unsympathetic to those that wish to make drastic changes. In this fact lies our real security. It is threatened only to the extent that some of us, under some circumstances, are still deprived of basic essentials to a decent living… But still, we can't afford to neglect public health and welfare, which are equally important to the successful survival of this nation. (Harry S. Truman Archives, Ewing Papers, Box 42, Speeches and Articles)

Perhaps the most interesting thing about these arguments is that they do not address the physical or human needs of citizens, solidarity, the difficulty of obtaining such services for some,

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[28] The situation Ewing is referring to is communist infiltration of the military.

or the more holistic benefit of extending social services. Instead, the only benefit is political strength and the potential of such programs to serve an anti-communist function. They are not described as having intrinsic value in and of themselves. They are not an expression of American values or culture. They are not a responsibility to fellow citizens. While Truman and Ewing did at times argue these things, it is likely that they knew that these arguments would not be strong enough to win mass public approval. So instead, Truman and Ewing reframed the utility of these programs into terms that fit the most pressing issues of their day. The issues of Truman's time are not the same issues that we face today, and therefore, the arguments in favor of health reform have had to evolve more than the arguments against health reform, which have remained stable relative to those in favor of reform. However, in the Truman era, perhaps even more so than today, social programs that benefit the middle class, serve a redistributive function, or benefit people that are able to work simply do not fit in with the principles of Americanness. So instead, these arguments argue for the preservation of certain American values: democracy and capitalism as opposed to communism and socialism, and individualism and self-reliance as opposed to collectivism and solidarity. Making arguments that work culturally may be the only way to win political arguments.

Health Insurance as Fraudulent

Another common, but unlasting, argument in support of National Health Insurance in the 1940s was that insurance companies, hospitals, or doctors were often fraudulent, or costly to the point of being fraudulent. In essence, the fear is that medical care is a rip off or a scheme, and that government oversight or administration of health care could reduce the risks to consumers. These sentiments were less frequently captured in newspapers or advertisements, but they were nonetheless felt. They were especially present in letters to the White House. This sentiment often came out of the experience of already expensive insurance, already high medical costs that were not reimbursed by insurance, or falling upon financial hardship due to illness. Before the experience of medical debt was common, Americans experienced shock when they found themselves unable to pay for care or unable to receive care. The earliest reflections of this shock sometimes translated into accusations that some part of the medical or insurance industry was fraudulent.

John Perrault wrote both to Oscar Ewing and to *Reader's Digest* in order to communicate his thoughts about voluntary health insurance, the ethics of the medical industry, and the AMA. His language is particularly colorful and large in this letter from April 23, 1949 to Ewing:

> Its [sic] strange that the opposition to your plan isn't offering any alternatives. But certainly they must know of the harvest the GYPS IN THE INSURANCE OF HEALTH have reaped or already defrauded gullible persons of $10,000,000.00 in the last year from residents in the state of NY [sic]. Will these Defrauded people be included in the grand total by the AMA as evidence that the American people prefer insurance protection from private enterprise to the Government plan? So far it is disclosed by the N.Y. State Insurance Department that there are 521 complaints with a total of 133 companies "involved." (Harry S. Truman Archives, Ewing Papers, Box 34, National Health Insurance, July 1949)

Perrault goes on to argue that the Federal Department of Insurance should guarantee depositors so that there could be more health security. Of course he is either mistaken or imagining the possible existence of such a federal department, as most insurance regulation is carried out by state governments, but for Perrault, the federal government would have an easier time guaranteeing insurance consumers health rights than insurance companies alone would, as he sees the insurance companies themselves as corrupt or fraudulent businesses. He apparently distrusts companies more than he distrusts the government.

The April 11th, 1949 issue of *Reader's Digest* included a Letter to the Editor also from

John Perrault (Harry S. Truman Archives, Ewing Papers, Box 34, National Health Insurance). In it, he critiques a piece that defended doctors' rights to control their profession, not be overworked, and have a say in the way that medical insurance is provided, which it argues is impossible under a National Health Insurance plan. Perrault writes:

> Your recently published article "Shouldn't Doctors Have Rights Too?" infers that Oscar Ewing seeks to elevate himself as an American Hitler to destroy all individual's independence by using doctors is a subterfuge. It's a distortion to believe that so much power would ever be granted. Furthermore, the AMA admits over 20% of our population fails to find adequate medical care. To continue denying the unfortunate medical services would be a direct violation of human rights; a total indifference to the 300,000 who died for lack of adequate medical services… Doctors should feel guilty for the disparity in care… Also, laws to protect people from the prescribing of illegal drugs or operations were a necessity. (Harry S. Truman Archives, Ewing Papers, Box 34, National Health Insurance)

Perrault is offended at the conservative tendency to overlook the failings of the American system. Though his argument that the U.S. does not have accessible care does indeed resurface and intensify as the decades go by, his argument that doctors should feel responsible for this failing does not stand the test of time.

While Perrault does not directly invoke fraud in his criticisms of the medical industry, he does note that a significant part of the population does not find adequate medical care, and that this information is likely to be left out by certain interest groups while discussing a National Health Insurance plan. Perrault attacks the legitimacy of just about every aspect of the medical industry, from his interpretation of drug regulations as doctors who require regulations to prevent them from prescribing illegal drugs, to unnecessary deaths, to the impossibility of a nation being fundamentally changed or taken over via a system of medical care. Notably, he explicitly invokes health care as a human right, which is uncommon though not unheard of in arguments of this era. Through letters such as Perrault's, which was published in a major publication of the time, we know that the idea that health care could or should be a human right was already in circulation during the Truman era. The fact that this idea did not become more common is supportive of the idea that Americans simply do not understand health care to be a human right. Had this idea been more resonant, it would have been picked up and repeated by more journalists, letter writers, and speech writers, and it would have appeared more in archival materials.

While one might argue that the effort to expand health rights was underfunded relative to the effort to restrict them, and that this may be the difference in what has shown up in the archives, this explanation would be incomplete. Rights were already a concept that existed in the U.S. The claim that health could be a right would not be so far outside of the understanding of Americans that it would require a massive media effort. Had the idea been resonant at that time, simple suggestions or mentions of health care as a right in political speeches and editorials would have been enough to help the idea gather at least a grass roots following. Far greater social campaigns, such as the women's and Civil Rights movements, succeeded with no monied propaganda machines to support them at first. These ideas gathered steam because they resonated with enough people. These movements felt worth fighting for, and worth repeating to others, even without a budget. Health care as a right did not resonate in such a way.

However, the conviction that health care must be fraudulent because it is so expensive and inaccessible has had staying power and resonance. Another "medical insurance as fraud" letter came from an individual with personal experience, and less of a tendency towards the sensational. The letter writer had worked in the insurance industry and felt that it was particularly exploitative of consumers. In a letter dated April 19, 1949, Alfred Holeman explained that he had worked 40 years in accident, health, and hospital insurance "in a group similar to Blue Cross." He was critical both of insurance as an industry, as well as of the idea that the country could count on insurance plans being more widely extended as a work benefit:

> Only 20% of people have insurance through work, since employers do not want to deal with extra deductions, paperwork, and expense. In Illinois nearly all insurance companies were started on a shoestring budget by people who had no previous experience in the insurance business, but who went into the business for the purpose of making a quick killing at the expense of unsuspecting policyholders—most of them believing that the insurance laws of various states give them protection. (Harry S. Truman Archives, Papers of Harry Truman, Truman's Fight for Health Insurance, Box 2, Letters)

Holeman continues, stating that insurance companies can easily "hide behind laws" by employing "attorneys high in the ranks of the party" in order to legally exploit consumers. After citing some rather compelling figures, he claims that "the policies are hardly worth the paper they are written on… The amounts payable for medical reimbursement expense and hospital bills are not in accordance with the average cost of medical treatment and hospitalization… It is the worst racket in the country, yet people buy these policies because they think they have the protection of the state insurance department." All of this is in support of his argument that those claiming that "voluntary" insurance will expand to cover everyone are misleading the public. He notes that the 52.5 million people who are cited as having voluntary health insurance and not nearly as well covered as they believe themselves to be, but also to support the idea of a "National Health Program."

In hindsight, it is easy to see that Holeman was not wrong. "Voluntary" insurance never did expand to cover the entire American population. Employers, especially as the economy shifted into services and retail, became even less likely to provide health benefits to workers. Many insured Americans have found themselves priced out of care or in debt due to medical bills; in short, they hold insurance policies "hardly worth the paper they are printed on." However, unlike Perrault, Holeman does not reference human rights as a reason for pursuing health reform. Instead, he favors consumer protections, which seems in line with American culture and society. He recognizes that employers are more likely to seek higher profits and streamlined business operations, and that providing health plans is not likely to do either, even if health care might reduce absenteeism. As noted above, it is significant that Holeman does not mention health care as a human right, when he is clearly so critical of the health industry and promoting the accessibility of health care.

Interestingly enough, the critique that health insurance is mostly fraudulent has survived beyond the Truman era. The results of Clinton-era AARP focus groups on health insurance revealed that Americans in the 1990s were skeptical of health insurance companies. These focus group participants understood that insurance companies are very wealthy and often profit at the expense of individuals or the employers that provide health plans. One participant proclaimed, “send the FBI to investigate. I paid 800 for my little hearing aids, and we both know they do not cost that much to make” (Clinton Presidential Records, Healthcare Task Force, Magaziner Files, Box 7, AARP Focus Group Results Summary). This comment reveals deep distrust in the medical and insurance industries. However, despite this distrust, Congress has repeatedly passed up opportunities to regulate insurance companies. And despite the distrust for insurance companies, we seem to distrust the federal government even more. It seems that for Americans, there is simply no credible organization, institution, or actor we truly trust to competently manage health care without taking advantage of consumers.

The Public Agenda Foundation focus group report titled *Faulty Diagnosis* concluded that the public blamed high medical costs on the greed of the medical profession and insurance companies, echoing the fears and beliefs uncovered in the AARP focus groups. The issues were viewed as a profits problem, not a costs problem. One participant was reported as saying, “I believe in free enterprise, but there comes a point where you have to limit what they can charge”

(Clinton Presidential Records, Healthcare Task Force, Magaziner Files, Box 7, Public Agenda Focus Group Results Summary). This limiting would seemingly need to result from government-imposed limits on the health industry, even though this runs contrary to much of the rhetoric in the public sphere. The focus group participants were resistant to the idea that some limits needed to be placed on technology use. Paradoxically, and despite so much rhetorical resistance, 75% said they were in favor of "National Health Insurance," but there was no consensus about what that was or would look like. Some even believed that this would be possible without any government intervention, illustrating just how committed Americans can be to the goal of keeping the government out of health care. To further complicate the issues, 78% of 1255 people surveyed agreed with limiting the amount premiums can increase, while 45% agreed with setting prescription prices. Focus group participants also believed that the employer mandate would force small business out of business, which may have accounted for the strength of the opposition to this mandate. The report was titled *Faulty Diagnosis* because the authors believed that the focus group participants had an incorrect view of the issues plaguing American health care. they write that experts blame defensive medicine, drug and alcohol related health issues, crime, duplicated technology, and the cost of developing new technologies for the rising costs of care, none of which the public seem to perceive.

Still, despite mistrust in the 1940s and continued feelings of price gouging throughout the 1990s, the desire to maintain private sector health care is frequently voiced both in reaction to the Clinton health plan. Interestingly, participants in the Clinton-era GOP focus groups also expressed the fear that health insurance plans would rip off consumers (Clinton Presidential Records, Healthcare Task Force, Box 7, HC Talk Points). However, in this instance, consumers were afraid that it would be the government health plans that would rip off consumers. This fear would continue through the ACA era, as many Americans would find that ACA plans were still too expensive or did not offer adequate coverage for their needs. Here we observe the belief that consumers will be taken advantage of by their health insurers regardless of whether they are state-run or private. However, it seems that distrust in government health plans may be higher than distrust in private health plans. In any case, it is safe to say that faith in health insurance as an entity is low, and Americans are divided about who they can trust to provide this vital service.

Focus on Private Sector Healthcare Expansion Solutions

Once Truman's discussion about a National Health Insurance failed, subsequent conversations about any single-payer system for the U.S. were severely limited. The argument that the private sector should be responsible for providing Americans' health coverage became most popular. In the meantime, while vulnerable populations remained uninsured, government programs to insure those uninsurable through private individual plans were passed instead. Medicare insured the elderly, Medicaid offered benefits to the poor, the generosity of which is still dependent on each state, and programs for medically needy children were passed. Of course, the VA still covered veterans. By the end of the Clinton era, any sort of government assistance gaining health insurance was largely seen as for the disadvantaged, needy, poor, elderly, or the domain of veterans only.

Private insurance companies were familiar to most Americans by this point, as they were the only option for a majority of the population. Those with insurance had figured out which doctors accepted their plans, and many had reasonable benefits. Few of these people wanted to change doctors or change insurance plans, even if it meant that more people could be covered. This led to various opinions about extending health care through insurance companies, "improving the current system," or sometimes, regulating the insurance industry. While it would be tempting to believe that American health care has simply fallen into a path dependent evolution, there are few structural reasons why Medicare or Medicaid simply could not be extended to increasingly large parts of the population. However, these options, when proposed, are often met with challenges to the federal government's ability to manage such an undertaking, budget concerns, fears of lack of choice, or the old socialist standby objection.

The desire to maintain the role of the private sector in the health insurance industry is not a complete rejection of health reform efforts, nor is it a complete rejection of government regulation of the health insurance industry. Indeed, many Americans can feel comfortable with reforms as long as the private sector remains active in the health insurance space. An unattributed letter to Ira Magaziner excitedly pointed out that the health insurance alliances could be described to the American people as being "like a 'wholesale club' where name brands are grouped together and sold at the best possible price" (Clinton Presidential Records, Healthcare Task Force Records, Magaziner Files, Box 20, December 1992-October 1994, Summary of Healthcare Correspondence).

Similarly, Clinton-era AARP focus groups found that Americans were ready for a government role in health care, but that they wanted a place for the private sector to remain. They liked the ideal of improving on the existing system and felt that top priorities for reform included controlling costs and making care more available. Focus group participants reportedly liked names like "Medicard" and "Health U.S.A." but they had a deep fear of "government healthcare" and feared that politicians would run the health plan. Based upon the result of the groups, the AARP concluded that the best way to avoid that fear would be to emphasize the joint public-private nature of the plan (Clinton Presidential Records, Healthcare Task Force, Box 7, Hillary Clinton's Talking Points). Despite the conclusion of these focus groups, the Clinton plan was not able to garner sufficient public support. The joint nature of the plan did not deter the many fears about the nature of the plan, potential increased costs, and the threat of losing access to favorite physicians. Likewise, while the ACA passed, its joint nature would not be enough to eclipse outrage over the individual mandate, subsidies, or the plan's inability to quickly bring costs under control.

Preserving Standards of Medical Research

The need to promote, protect, and continue medical research and innovation is a frequent lens through which health proposals are critiqued. Arguments range from the possibility that the U.S. government would be incapable of promoting health research to the idea that cost controls would limit the profits of pharmaceutical companies to the point that they could not then invest in research. In a *New York Times* article titled, "Innovation: Medicine's Best Cost-Cutter," Michael Porter, Elizabeth Teisberg, Gregory Brown of Harvard business school, and Vector Securities posit that the Clinton health plan did not rely on technology and innovation as a cost cutting method. They also fear that "monopolistic regional purchasing agencies" would cut into profits that should be earmarked for ongoing pharmaceutical research and development. They continue, "To make matters worse, if prices are tightly controlled under reform, America's flow of innovations will trickle because the incentives needed for its huge investments will disappear… Schering-Plough spent 100 million on a plant that only treated cancer. Without massive funding, it never would have been discovered that the drug also treats 15 other illnesses" (Porter, Teisberg, and Brown 1994). For these authors, "health reform is only good if it sparks innovation." In other words, innovation and new technologies are more important than even the human impacts of extending health care to more individuals. This line of thought and concerns about innovation and research continues to be a debate today, in the ACA era, as evidenced by articles appearing in the *Los Angeles Times*, the *Wall Street Journal*, and many others (Atlas 2014; Hiltzik 2014; Gourlay 2017).

Health Care as a Right

Throughout the American health care debate, rights are invoked, interestingly enough, on both sides of the debate. However, the rights invoked are less likely to be human rights, seemingly meaning that other types of rights could be more important to Americans. In the 1940s, the AMA advocated for doctors' professional rights, and citizens argued for their right to choose voluntary health insurance over compulsory health insurance. The claimed their right to freedom from governmental interference and their own choice of doctors. During the Clinton era, the anti-reform emphasis on rights was similar. By the time Obama was in office, comparisons of the U.S. healthcare system to other countries' was more common, likely due to the influence of *Sicko,* Elizabeth Rosenthal's (2013a, 2013b, 2013c) series of articles in the *New York Times*, and other such critiques. This led to a more robust discussion of rights, since the countries we compare ourselves to the most, namely European countries and Canada, all treat health care as a fundamental citizenship right, if not a human right. As Beth Simmons argues, rights tend to extend based upon international pressures, treaties, and norms, with the extension of rights being catalyzed by their extension in neighboring countries or other member of the international community (Simmons 2009). Interestingly enough, the gradual appearance of a rights discourse in favor of health reform did not result in the disappearance of a rights discourse in arguments *against* health reform. Instead, arguments against health reform continued to claim the rights of freedom of choice, freedom from government intervention, the right to choose one's doctor or medical team, the right to not pay more for health care, or the right to not switch from some aspect of the status quo. Claims of rights seem to show up more in documents written in a more personal voice, whether they are editorials or letters, regardless of which type of rights are being claimed.

A letter to Ira Magaziner from Donald H. Hossler dated June 6, 1994 states: "Single payer is the only option that supports both Biblical and Constitutional rights. The Rights to Life, Liberty, and Pursuit of happiness. I'm writing on behalf of the 37 million without coverage. They have a RIGHT to the same coverage we receive, to the same coverage that Newt Gingrich says he pays for, and that you have." Hossler goes on to state that consumers pay these costs regardless, and it is not just the government picking up the bill. He calls for control of pharmaceutical companies, insurance companies, and a single payer system that would cover all Americans. He feels that universal coverage is a matter of "civility, fairness, and cost" (Clinton Presidential Records, Healthcare Task Force Records, Magaziner Files, Box 10).

The concept of rights is also reframed into other parallel issues, perhaps in an attempt to make the discourse more palatable to wider audiences. Senator Christopher S. Bond, a Republican from Missouri, noted during a 1994 speech in Kansas City that "some of my colleagues do not believe in universal health coverage. We've got to have universal coverage. It's a matter of human kindness and decency… I believe that all Americans should receive health insurance coverage regardless of their economic status" (Clinton Presidential Records, Healthcare Task Force Records, Magaziner Files, Box 310). Here, we see a more public—but softly inferred—claim about rights. Bond discusses this in terms of "human kindness and decency," which is really only a potential precursor to human rights. Still, even this represents a move towards a discourse about human rights (and by a politician no less) that has been very late in coming to the U.S. discourse about health care.

Price Concerns and Accessibility

Of course, price concerns develop early. One of the most common arguments in favor of the ACA and the Clinton health plan is that more and more Americans, even those with health insurance, face financial ruin due to health expenses. However, these arguments have the greatest deal of resonance on the individual level, since they are less appealing to the wider matrix of American political culture. They do not resonate with individualism, they have little to do with socialism, and they are not directly related to cries for greater personal choice. Simply finding a way to assure affordable care does not imply a public or private solution, and rights are usually considered some sort of guaranteed service regardless of means, not simply a controlled price point. Despite the fact that the cost of health care has become so steadily problematic for American families, solutions that other countries have found to limit costs, such as price setting, negotiating with pharmaceutical companies, or requiring that insurance companies be non-profit have not become widely appealing in the U.S.

However, arguments asking the government to step in to avoid health cost inflation are not new, despite the run-away medical costs that Americans have experienced over the course of the past 80 years. A text-laden two-page newspaper ad run in the late 1940s by “Mothers Against the AMA” and the CIO states the following:

> Doctor, my family needs more and better healthcare. We want to pay for it when we are best able to pay for it, in advance. But, “Voluntary” health insurance costs too much and doesn’t go far enough. It pays only 35% of the average family’s medicine bill. A National Health Insurance Fund—built up through payroll contributions by employee and employer—will spread and space the costs, pay for medical care out of earnings. That is not charity, it is not socialism, it is

> *insurance*. (Harry S. Truman Archives, Ewing Papers, Box 34, National Health Insurance, July 1949)

This ad features paragraphs of text alongside the image of a concerned mother writing a "Dear Doctor" letter while her child is ill in a four-post bed, wearing striped pajamas. The ad continues, pointing a finger at the AMA and the medical profession: "You know that the American Medical Association is spending a million dollars right now on an advertising campaign to mislead the American public. The American Medical Association is doing it with Your money, and the money of doctors like you. Why is it worth millions of dollars to keep America sick?"

This ad, which makes a lot of arguments in rapid succession, is clearly a response not only to the AMA's campaign against national healthcare, but also against the entire medical industry. Especially in the 1940s and 1950s, doctors were not an easy target. With the medical wonders of penicillin and the polio vaccine in very recent memory, medicine was a little-understood, lifesaving science undertaken by the virtuous and hardworking. The AMA campaign against national health insurance was more likely to be interpreted as professionals advocating for their careers than as a selfish industry looking out solely for its profit margins at the expense of the American public. As such, this type of argument would simply miss its mark in this era.

The ad also argues against the idea that national health insurance is socialistic by stating instead that it is insurance. While this could be considered true by many accounts, selling Americans on the idea that the government should provide one health plan for citizens despite the fact that there was a newly blossoming insurance industry offering "voluntary" plans was an equally difficult task. Only those who had already experienced deceptively low benefit levels or other insurance abuse would be likely to hear such an argument. Instead, most Americans would have likely taken the private insurance advocates at their word, observed the trend of employers offering health insurance, and waited for the expansion of "voluntary" health insurance to cover them. This was not an option in France, as the French state began quickly sorting populations into groups so that they could be most easily fit into the health insurance system. Perhaps most importantly, medical costs were not as cripplingly high as they are today. While medical care would have been too expensive for the poor and the poorest set of the middle class, most of the middle class could have afforded the types of care available, even if it did pose a budgeting hardship. And, as Dr. Dickenson argued, insurance policies could cost as little as movie tickets. Neither of those things remained true for very long. That leaves the ad with its maternal appeal only. While it presents a very idyllic mother's anguish over her child's illness, even this was unlikely to deeply stir American political values at this time. The argument was too personal for a time when families were expected to, and often capable, of providing for their own health care needs. In other words, the plight of a scared mother would not be compelling to a country that is terrified that socialism could arrive in the form of national medical care.

Perhaps the most common argument in favor of health reform of any sort is a very utilitarian one. Simply put, American health care is argued to be too expensive and inadequate. These arguments have increased in frequency and pitch as the cost of care has skyrocketed, insurance premiums have risen, and as medical technologies have developed. In contrast to French arguments about health reform which tend to focus on rights, equality, and needs, these arguments commonly simply point out the failings of the system, the impact they have on families, and the health outcomes of such failings. These utilitarian arguments are not social in nature. They simply argue that American health care is broken. The utilitarianism and prevalence of these arguments supports the idea that American values do not give health care a place in national identity, citizenship, solidarity, community, rights, or mutual aid.

In arguments for health care reform, cost is frequently framed in terms of the more favorable outcomes that other countries achieved for lower prices. Anna Bernasek writes in the *New York Times*: “The economic case for a single-payer system is surprisingly strong. Start with what we already know. Countries with single-payer systems have long records of spending less on health care than the U.S. does. The U.S. spent an average of $6,102 a person on it in 2004, according to the Organization for Economic Cooperation and Development, while Canada spent $3,165 a person, France $3,159, Australia $3,120 and Britain just $2,508” (Bernasek 2006). Bernasek goes on to point out that despite all of this health spending, U.S. life expectancy is lower in other countries, and we do more paperwork than the UK and France. Single payer health care would cost less, she concludes, and studies of other nations show that freedom to choose doctor can be preserved (Bernasek 2006). Bernasek’s concern with the freedom to choose one’s own doctor is reflective of the importance of the concept of freedom of choice for Americans.

This type of discourse is especially common in the Obama era. Since information about conditions in other countries became easier to access, more frequently reported, and shown in theatres across the country in *Sicko*, this comparison has become more common. Also, as the U.S. continues down its path of private, unregulated health care, these issues have only gotten worse, making the problem more evident, and the comparisons to other healthcare systems even more stark. Elisabeth Rosenthal wrote an eight-part series in the *New York Times* that specifically looks at how much more Americans pay than their neighbors, treatment by treatment and illness by illness (Rosenthal 2013a, Rosenthal 2013b, Rosenthal 2013c). These articles would later become a book, in which Rosenthal explains the best ways for patients and families to navigate the American health system without being left with crippling debt (Rosenthal 2017). In her book, hospitals seem like loan sharks, preying upon American families and even seizing their assets and homes. In the end, Rosenthal makes it clear that the American medical industry does not have the public’s best interests in mind and instead are only driven by corporate profits, largely since a lack of transparency and regulation has allowed such a scenario.

Of course, discussion of costs began far earlier. Clinton scheduled a speech in Greensburg, Pennsylvania where he had three people who had written about health insurance woes. One stated, “It’s a terrible feeling when you can’t provide decent medical care for your child” (Clinton Presidential Records, Healthcare Task Force Records, Kenneth Starr Press Files, Box 4, March 1993). The focus on cost during the Clinton era was often framed in terms of uninsured children. The family written about in the above article had lost their insurance when the husband lost his job. The mother had heart valve issues, and the child had been added to CHIP (Children’s Health Insurance Program), which was funded by state cigarette taxes. However, this was not a possibility in all states. Just as in the “Mothers Against the AMA” ad from the Truman era, the argument that children are deserving of care and in need of medical insurance was frequently discussed during the Clinton era. This is quite logical, since the Clinton administration did manage to pass some health reform initiatives for needy, uninsured children. Here, the article points out that care is too expensive for families, and that as a result, many families are unable to pay for their children to receive adequate medical care. This seems to garner far more support and sympathy than an able-bodied and working adult who cannot afford medical care.

Arguments for health reform hit a new pitch with Michael Moore’s *Sicko* (2007). Released shortly before Obama’s election on a platform that included health reform, the film generated 24 million dollars in box office sales within the U.S., and far more in DVD and other related sales. Moore is a controversial and highly visible voice of dissent. Criticized as being overly biased, physically off-putting, and of cherry-picking his data, he presents large liberal arguments that can be every bit as mobilizing as they are divisive. *Sicko* likely positively impacted the Obama presidential campaign, by thrusting the inadequacies and failures of the American healthcare system into the national limelight. Moore's simplest argument is one that has been used increasingly over time, especially as access to health care has deteriorated for many middle class Americans. He argues that American health care, despite what many believe, is actually far inferior to the care that citizens of other nations receive as a citizenship right. While his argument is less about considering health care a right and more about the low quality of care and the injustice of health care as a for-profit industry, his argument has informed others who argue for health care as a right in the U.S.

Moore's film places American human tragedy, corporate insurance and medical industry greed, and anti-productive policy/interest group politics at the center of his critique. He also pulls on many American values, asking why it is that 9/11 volunteers were so frequently denied care for illnesses resulting from their volunteer efforts, and challenging the idea of Americans as generous, charitable people. In doing so, Moore is exposing a misalignment between political systems and what are arguably important values. However, Moore approaches these arguments without any attempt to address the long-standing American values of self-reliance and independence. If Moore were to leverage these more conservative American political values in his argument, he could have reached a wider audience. It is very difficult for a policy to become popular if it is framed in narrow terms. As we learned from the Clinton health care focus groups, language and concepts are exceedingly important, and in order to be appealing, the description and analysis of policies must appeal to the most commonly acceptable concepts and values. Arguments must win over not just liberals or conservatives, but those in the middle, on the fence, or even opponents. This means two things. First, policies should address the most common sensibilities or common sense in ways that avoid offending central values, and second, the framing of those policies must also be in line with these sensibilities.

Many economic arguments, including Moore's, that examine the inefficiencies of the American system, the losses in productivity due to untreated illness, the cost to businesses, and the wastefulness and poor results of our healthcare system as compared to other systems could be more effective at winning over the broad audience required to cause real success. Though he does highlight the fact that medications are far, far cheaper for consumers in other countries, he fails to truly investigate why or to show how exactly other systems are lowering costs to consumers. Instead, he mostly refers to universal health care as "free" in other countries. He highlights the impact that "free" and universal health care have on the quality of life of citizens of other countries. While these quality of life arguments are compelling to American liberals who value social protection, equality, care, and human rights, it is only appealing to this one group. Insisting that anything is "free" is a surefire way to inspire the fury of American conservatives, who know that that no government service is "free." Conquering the fears of socialism, bureaucracy, state mandates, reduced choices, and low-quality care requires far more than interviewing a few happy French people with "free" medical care. Instead, an in-depth examination of how these systems work might dispel some fears, though it would of course make a less compelling box office hit. Despite the relative ineffectiveness of these sorts of arguments, which appeal to too narrow of an audience, this type of oversight is common on both sides of this debate.

Sicko argues that though many Americans do have insurance, far too many of those insured have inadequate insurance that leaves them in dire straits, unable to receive care when illness strikes, even despite their insurance. The film interviews people that found themselves in this situation, unable to care for themselves or their children, even though they or their employers had been making insurance payments. One interview showed a family whose deaf infant daughter could not get her hearing aids, and another showed a woman whose feverish daughter died in transit between hospitals because the Kaiser HMO insurance plan insisted that she be treated at their approved hospital. Wisely, the film focuses on “deserving” Americans, those who successfully raise families, hold down jobs, live within their means, are eligible for Medicare, and are generally expected to be protected from such hardship. It profiles a hardworking couple who went bankrupt, lost their home, and needed to move in with their daughter after the husband’s heart attacks and the wife’s cancer. It also profiles a 79-year-old Medicare recipient who works at a grocery store because the Medicare coverage is not sufficient to cover his and his wife’s health care. These are just a few of the stories contained within the film. However, they highlight the plight of those who are not poor enough to receive Medicaid, and thus are not stigmatized as undeserving of insurance or medical care. All of these individuals should logically receive medical care, given that they are insured. These cases mount an argument about the illogicalness, unfairness, and inhumanity of the private American medical system. These arguments are very resonant with American liberals, and while they may dishearten conservatives, especially since these profiled Americans are meritorious, upstanding, deserving citizens, they are not enough to convince conservatives that a national universal healthcare system modeled after the French, British, or Canadian system is the best solution.

The film also spends a significant amount of time exposing standard health insurance practices that were still a reality at the time, such as the lists of pre-existing conditions which would make a person uninsurable. These lists were reportedly 37 pages long, and included very standard illnesses such as diabetes, according to a health insurance sales person interviewed by

Moore. The film shows people denied for the pre-existing conditions of being just slightly too fat, just slightly too thin, or for having had a very common and very treatable yeast infection. Moore also explores the nature of for-profit medicine, interviewing Dr. Linda Pina, a medical review doctor employed by Aetna, who claims that there were bonuses for the doctors which denied the highest numbers of claims. These insurance claims were referred to as "medical losses," a rather preposterous concept for an insurance company. She testifies during a hearing that her career advanced exponentially as she denied patients payment for their care, often costing them their lives. Lee Ainer, another claims adjuster charged with thorough audits of patients' medical records with the express purpose of finding reasons to discontinue coverage or make rates prohibitively high, states: "You're not slipping through the crack, someone made that crack and swept you towards it. And the intent is to maximize profits." While these inadequacies are very important to expose, and while these inefficiencies are in fact compelling arguments for most conservatives, the human case or the rights case is simply not enough in the U.S. Furthermore, successful campaigns must appeal to both liberals and conservatives, at least partially. A successful campaign does not need to garner complete support from the party which may support it less, but it needs to be able to win over at least the centrists or at least the least polarized of potential opponents. The easiest way to do this is to appeal to more standard and long-established American values, such as independence.

Equally importantly, Moore's look into the health systems of the UK, France, and Cuba challenge the idea that American health is the best in the world, a belief that has had remarkable staying power since 1945. However, by exploring only the failures of the American system, and comparing them to only the victories of other systems, Moore presents an unbalanced case that is often "too much," and therefore potentially alienating to opponents. Leveraging only liberal arguments, and failing to address deeply embedded arguments about the value and need for hard work and independence as democratic, American values, Moore can really only speak to one side of the American political space. However, this sympathetic contingent is important and large, and those who remained on the fence about health care reform surely could have been swayed by the film. More importantly, the ills and failings of the American healthcare system have been exacerbated over time due to the rising costs of care and the impacts of recession. Americans have felt these changes, and the numbers of those who can relate to any of the situations or people profiled in the film would likely correlate with the higher levels of uninsured and underinsured Americans at the time of the release of the film.

Moore speaks with patients and doctors at French, British, and Canadian hospitals. He shows happy, debt-free doctors and patients, none of whom wait for care, and many of whom have experienced severe, debilitating illnesses, which in the American cases presented, would have resulted in financial ruin or death from lack of care. Again, the emphasis during this footage is often that these patients do not pay for their care, and that it is “free.” As we saw in *Waiting Room Willie*, the idea of “free” medical care is terrifying to many Americans. It is synonymous with social decline, socialism, laziness, dependency, bureaucracy, low quality care, populism, and over-reaching entitlement.

Moore includes an investigation into beliefs and values as related to health care in his tour of the Canadian, UK, French, and Cuban healthcare systems. He interviews Tony Benn, a former UK parliament member, who explains the post-war social climate in the UK, and notes, “If you can find money to kill people, you can find money to help people.” Benn also believes that the NHS is important enough to the British that it cannot be threatened, even by conservative governments. He notes, “Even Mrs. Thatcher said ‘The NHS is safe in our hands’—it’s as noncontroversial as votes for women." It would have been useful to his argument had Moore pointed out that Thatcher is a conservative, that conservative solutions to health care can and do exist, and that national health services generally have high approval ratings from those who live in countries with such services.

After this review of the American system, and a quick look at health abroad, Moore asks, "How did we get to the point where doctors at health insurance companies are responsible for the deaths of patients?" To answer this question, he examines a few key policy junctures that he believes have greatly shaped the American health insurance landscape. His real conclusion is that American health was for sale and has been bought by medical and insurance industry interests. He argues that American congressmen and presidents have been happy to reap the personal benefits of this sale. He plays a recorded conversation between Richard Nixon and an advisor, John Erlichman, in which Nixon approves of the idea that the HMOs created by Kaiser for profit, and with the strategy of supplying as little care as possible, as the ideal solution for American health care because they were a "private enterprise" solution where "the incentives run in the right way." The right way, of course, meant that there were incentives to provide less care. Of course, shortly thereafter, Nixon did indeed facilitate the expansion of HMOs, touting them as a plan which would guarantee Americans the "Best care in the world." The 1973 HMO Act provided several important benefits to the plans and the insurance companies which allowed the plans to expand and grow. Moore believes that the growth of HMOs was directly responsible for increasingly high rates of uninsurance, low-quality care, long waits in emergency rooms, and declining health among Americans.

Moore also believes that the Clinton Health Security Act would have been an improvement and a success for Americans, but that scare tactics and cries of "socialism" combined with the $100 million dollars spent by health care companies to campaign against the act were too strong for the program to overcome. In the end, he reports, the biggest achievement of the health insurance industry was "buying Congress," including, at a later date, Hillary Clinton, who received $854,462 in health industry contributions as New York's senator from 2005 to 2006. He shows the hypocrisy of the 2003 Medicare Prescription Drug Improvement Act. This act was touted as legislation that would help everyone look after their aging parents, for it increased the budget for Medicare prescription plans, but it prohibited cost controls. Moore argues that the fact that this legislation allowed prices to rise unchecked was an actual move away from expanded, comprehensive care, even for the seniors who the act was said to prioritize.

To close out his argument, Moore brings out the big Values and Collective Memory Guns. Switching quickly back to the UK, he compares the UK post-World War II experience to 9/11. He says, "remember how everyone felt after 9/11, all of us pulling together? I guess that's how they felt… And the first way that they decided to pull together after the war was to provide free medical care for everyone." He next interviews 9/11 volunteer firefighters, many of whom developed severe respiratory conditions, but were not on any city employee benefit plan. These were volunteers like John Graham, an EMT from New Jersey who happened to be nearby during the attacks. Though he had been volunteering for a few weeks, sifting through the rubble, he stopped volunteering on the rescue efforts when he kept being denied help with his resulting respiratory condition. "I thought we were creating value… I never thought we would do this… I never thought the U.S. would do this." Consequently, there was a 50 million dollar fund set up to help volunteer rescue workers. However, receiving this aid required spending a certain amount of time at the site, being able to prove the time spent, and filing an affidavit. Even then, medical claims were frequently denied for lacking sufficient medical evidence. Here, we see that the classification work that needed to be done in order for these volunteer rescue workers did not happen in a way that allowed the workers access to care. This case is an outlier, as we saw in the previous chapter that the U.S. has passed piecemeal health rights expansions for specific populations in need. These volunteers should have been the epitome of Americans deserving of and eligible for aid towards their health care. Veterans benefit from the VA, and though these people were not enlisted, and had not been deployed, they were doing a significant and dangerous service to the country. But instead, since they were uncovered by private insurers, and must not have been Medicaid recipients, there was no help available to them. This situation is clearly painful, and Moore likely chose to include it because it implicates not only private insurance as being inadequate to address the needs of American patients, but also the reluctance of policymakers and state governments to provide effective aid, even to those who have made significant sacrifices to the national good. It paints policymakers as cold, callous, disconnected, uncaring, and un-American. Ultimately, of course, Moore is arguing that the failure to provide health care to citizens is un-American.

The film closes with a phenomenal stunt, where Moore charters a boat, and brings the untreated 9/11 volunteers to hospitals in Cuba. He first attempts to have them treated at Guantanamo Bay, as he points out that it is U.S. soil and has top notch medical facilities. Since, of course, Moore cannot gain access to the hospital at Guantanamo, the group receives effective treatments at Cuban hospitals, fills prescriptions for fractions of their U.S. cost, and tearfully realizes that their own country has failed to care for them.

The arguments presented by Moore in *Sicko* are also not uncommon to other American arguments in favor of healthcare expansion or reform. Unlike arguments that argue against healthcare expansion that advocate for Americans “investing” in their health through white collar jobs that earn them health benefits, Moore argues that health should be part of American citizenship. By looking at the rights that citizens of other countries enjoy, he calls out the lack of rights here in the U.S. By exposing the fact that even prisoners in Guantanamo have access to health care, he points out just how underserved so many American families really are. This film, often criticized as being overly biased, polarizing, preachy, or extreme is most extreme in the fact that it does not consider or explore the meanings or the practical value of American rights. Instead of looking at the divisions between those Americans deemed deserving of health care and those who are deemed undeserving and unpacking the historical ways in which these divisions were created, he tacitly argues that all Americans should have access to health care, largely because of the fact that citizens of other nations have health rights, and as a result, access to health care. While Moore gives no reason why the U.S. should endeavor to keep pace with the rights in other countries, his implied argument is simply that since it is possible for such a wealthy and technologically advanced society to provide health rights to citizens, it should. By reporting on the pharmaceutical industry's influence in health policy, and the pharmaceutical lobby's success in passing legislation that has effectively diminished health access and health rights for Americans, while showing that Americans wish they had the health rights of other countries, Moore shows that our health system is profoundly undemocratic. Here we observe that the discourse of rights in the service of health care is now summonable in the U.S. It *is* part of the U.S. toolkit, as Swidler would term it (2001), yet it is not a tool for successful debate. This is likely because applying the rights discourse is a more recent movement, likely due to more Americans becoming aware of health care rights in other nations. This discourse may have also arrived as more and more Americans suffer the denial of health rights. Perhaps when services are denied, the feeling of deprivation in turn causes a feeling of being denied rights, especially when it is health services that are being denied.

Simply put, the idea that American medical care is too expensive and inadequate relative to the care that exists abroad is exceedingly pervasive today. The rising costs are not even justified by opponents of health reform, regardless of whether the reform proposed is universal single payer coverage, or a system of subsidies and regulations like the ACA. This utilitarian argument can be isolated from any argument about rights, merit, politics and/or how the American political system might be affected. The fact that this utilitarian argument can stand entirely on its own speaks to its strength as compared to other arguments. Through the strength of this argument, we can see that in the U.S., the impetus for health reform is more functional than ideological. A critical mass of Americans have difficulty accessing health care. This is the reason why America believes that we must find some way to reform the healthcare system. This is different in France, where health reform began in the 1940s because it was viewed as an integral part of the wellbeing of society, a central right of citizenship, and a key to solidarity, perhaps the most important of French political-cultural principles. This fundamental difference, largely issued from the cultural politics of the two countries, which are made from creation stories, values, and ethics that have formed our collective consciousnesses has shaped what citizens are willing to ask for and fight for, what they will support in the face of cuts, and what issues will drive their decisions in voting booths. As long as we can believe that our democracies are intact, and that the wants and needs of our citizens are heard and that our politicians strive to meet these goals, then we must conclude that our cultures shape our policy. However, if we believe that our democracies are merely illusions engineered to distract or enable elites to act in their own interests, then we instead know a bit more about the tools which are most easily used to manipulate the French and American citizenries.

CHAPTER SIX:

FRENCH *LONGUE DURÉE* HEALTH CARE CULTURE ILLUSTRATED

The French economy has been a bit more sluggish than that of Germany, the UK, and the United States, and the French unemployment rate is one of the higher ones in Europe. However, despite trends away from welfare programs and certain periods of welfare state retrenchment, the French have continually focused on ensuring that all of their citizens maintain access to health care. This insistence, despite these potential course-changing trends, shows just how committed the French are to promoting equality in access to health services.

This chapter examines various French news broadcasts, advertisements, newspaper articles, and other French cultural artifacts that contain health care messaging, debate, or rhetoric. These data consistently reveal that the current of French values is consistent, that these values have significant longevity, and that they clearly have major impacts on the shape of French health care. The documents that are analyzed here have been chosen to represent both left and right leaning sources and cover a relevant span of time. They showcase the collective nature of French health care, and capture a wide variety of different speakers, from the health service itself, to leading reform politicians, to print and television journalists. These documents, plus the countless others that I encountered during my archival work, paint a very different picture than what we observe in the U.S.

Like their American counterparts, French conservatives do make arguments about the unaffordability of their healthcare system or the economic impossibility of expanding the healthcare system. Like arguments against health reform in the U.S., French arguments in support of the expansion of care or government support for health care pull from a standard rhetorical set, which, often enough, utilizes historical arguments. However, unlike American conservatives, critics of increasing health rights also tend to reference some of the same arguments. The most common arguments in the French health debate are focused on rights—human rights, French rights, and European rights. Inequalities, public health, access to care, and support of the medical profession are also frequently referenced. However, interestingly enough, many of the same concepts are referenced on both sides of the debate. This gives the French debates and entirely different character. In fact, the French no longer debate who should be covered, or if there should be health coverage. Instead, they discuss how and when everyone will be covered. They also discuss how much they must budget, how they will make things affordable, and how people can be convinced to take cost-saving measures, such as taking generic medications. There is rarely, if ever, an "if" or a "why" or a "who" question to be asked, at least in terms of how wide coverage should extend for French citizens. As discussed in earlier chapters, this is because of the greater levels of societal trust. In the U.S. these questions are qualifying questions. Since health care is not a right, it must only be given to very specific people.

However, the strong support that health care receives is not extended to all potential programs, even if the French do have a strong preference for comprehensive social services. Frequent changes to the retirement age, changes and debate about the 35-hour work week, indignation over high business taxes (which support the welfare state), and business resistance to worker protections indicate that not all social programs receive nearly universal support.

To preface the rest of this chapter, and to provide an example of how the French ask "how" as opposed to "if," consider this statement from Martine Aubry, one of the authors of the *couverture maladie universelle* law of 2000, which finally extended health insurance to all people legally residing in France.

> We refuse to monetize health, instead, we are changing the behaviors of doctors, patients, pharmacists, and hospitals, but that work can't happen overnight. we have already reduced the deficit. If someone is sick, someone close to you, you would say 'we have to take care of my child, or we have to take care of my parent. All French people feel this way. So, I think that this discussion should not be about accounting, and more about what we are willing to pay. What are we willing to pay for care, for expensive diseases, for palliative care, for Alzheimer's research? 9.4% of the GDP of France is spent on healthcare. in the U.S. its 14.5%, while 40 million Americans do not have health care. So we need a real debate. (Caille 1999)

There have been recurrent proposals in the U.S. to gradually lower the age at which one qualifies for Medicare until the entire population is covered. These proposals have been usually deemed "too expensive," have been criticized as potentially taking too long to implement, or have been doubted due to distrust in the government's ability to appropriately manage such a large program. Of course, the French do worry about the deficit of the social security program, and they do discuss the overall costs of a large and heavy system, yet they not only trust the government to manage such a program—they expect it. However, Aubry's comments are representative of the discourse in that they focus on the need to produce continually better outcomes and cover more people at an ever-increasing rate. Arguing for why it might be good to have less public health insurance from a moral perspective seems to be a very American move. This uniqueness becomes even easier to see when it is contrasted to comments such as Aubry's. Furthermore, most French employers tend to support the healthcare system for two reasons. First, it keeps workers healthy, ensuring an available labor force; second, employers are also French citizens, and they have the same cultural values as the rest of society. American employers, especially smaller employers, are currently dismayed at the costs of providing health care to their workers, as the prices have risen steadily despite the Affordable Care Act (ACA). Some go so far as to claim that rising health care costs cause their businesses to be insolvent.

It is especially important to notice that while it is untrue that there are few common and powerful arguments against further healthcare expansion in France, these arguments are not value-based in France. Unlike in the U.S., there is no moral reason supplied for keeping health coverage limited. Providing health care is not presumed to encourage laziness or dependency; instead, it is a human right and the right thing to do. This argument is largely taken for granted. Instead of an argument about how healthcare expansion would cause a moral decline, a French opponent to healthcare expansion might argue that social security is already in debt or over budget, and that greater coverage is not affordable or might threaten to destabilize the economy. Or, a very left leaning critic might argue that this would not be the best way to bring real change, since it is a state-centric approach. These concepts and their presence and role in French health care debates will be examined in the following chapter.

Health Care is Part of French Patrimony

While the most colorful ads about health policy in the U.S. are undeniably ads against programs which would expand health rights, the opposite is true in France. French ads celebrate solidarity as a part of French social history, provide information on already available health services, and encourage the French to use health services responsibly for the benefit of the entire system. They announce expanding rights and pridefully preserve a heritage of French citizenship as health. Newspaper articles or editorials are more likely to decry budgetary woes, expanding health budgets and needs, or criticize any proposal which might make care less accessible to any part of the population. This chapter examines popular French ad campaigns about health insurance, the National Museum of Health Insurance in Bordeaux, editorials, and TV news coverage of policy proposals. It argues that in France, health insurance is considered to be an integral responsibility of government to citizens and society, and that positive health rights remain an important marker of French citizenship, as well as a human right that should be extended even to immigrants and refugees.

The National Museum of Health Insurance in Bordeaux is a striking monument to solidarity, health, French history, and French patrimony. While museums about medicine are not uncommon, a museum dedicated uniquely to health insurance is unique. Housed in a chateau built in 1860 at the end of the Bordeaux light rail line, the museum was first acquired by the *Caisse primaire* in 1948. It was used as a center for “rest and convalescence” for women from 1951 until 1978. The Museum has been housed in the Chateau since 1989. The Museum counts six exhibits housed in nine separate rooms, five of which capture specific historical developmental phases of the health insurance system. Additional space is allocated for temporary exhibits, education, and a small library.

The first exhibit, titled “L’*antiquite et l’entreaide”* (Antiquity and Mutuelle Aide) is an excellent example of just how human the French believe solidarity to be. The exhibit begins with a Roman tombstone from the first century. The tombstone is notable because it was the gravemarker of a 35-year-old slave. It was paid for by the deceased’s peers. The explanation of the tombstone, which is where the meaning lies for our purposes, reads: “Within primitive and ancient societies, the survival of the group depends on *mutuelle aide*. This solidarity manifests itself especially in the covering of the costs of funeral rites by the greater community. Thus, in Rome, slaves would help each other to pay decent funeral services for their loved ones. This grave marker from the first century AD bears witness of this solidarity.”

The French are fond of making arguments in favor of health solidarity that invoke old history. These are most frequently references to the beginnings of French social security in 1945, but can also be arguments that simply establish the connectedness of the present state of French solidarity to French history. The retelling and celebration of solidarity serves to keep this crucial part of French identity active and preserved in the collective memory. The reverence and state stewardship of these collective memories indicate that this is patrimony on the order of national treasure. Linking solidarity back to antiquity, as is done at the museum, argues that solidarity is even greater than Frenchness itself. It is natural, nearly sacred in its historical importance, and certainly a tradition to be proud of. Via this argument, French solidarity acquires all the weight and esteem of the ancients, making an already revered concept even more impactful. As the very first exhibit in the National Museum of Health Insurance, this demonstrates just how important the concept of solidarity is in French health care debates, but also, how important historical relevancy is to the same debates.

Another example of a direct reference to solidarity far before 1945 is in a 20-minute video produced by the CPAM of Valenciennes that explains the goals of the health insurance system. The video, produced in 1992, begins with a man confused about some of the administrative paperwork he needs to fill out. He does not understand what health insurance is, why he needs to fill out forms, how much money he will be reimbursed for his care, or why. An enthusiastic announcer jumps in to assist him, but not before giving him a brief explanation of the solidarity of the 18th century coal miners of his region. This region, according to the announcer, understands solidarity particularly well because of the labor that once drove the economy. Next, the contemporary health insurance system is situated physically—right at the heart of the city (Rougerie 1992). Though the historical solidarity link is less explicit than in the case of the Museum, the use of this historical context is significant. The history invokes heritage and tradition, uniting solidarity, health insurance, and the history of one of France's lessglamorous regions.

These sorts of historical references to French history, the history of rights institutions, and explanations of solidarity as crucial to French society are not difficult to find. They are dissimilar to discussions in the American context. As we saw in the preceding chapter, American history is not invoked as a reason to preserve or protect health rights. Rather, American values are more frequently used to justify withholding rights or slowing the expansion of health programs. These values are also less likely to be referred to as "American" and are not likely to include historical anecdotes or reflections. In not being as frequently named as "American," they are more assumed as simple, de facto, universal reality. For the French, solidarity and the importance of health rights are recognized as French realities, and while these may be viewed by many as correct or civilized values or views, they are also recognized as a unique core of their own nationhood.

A History of Solidarity with the Collective

The history of solidarity is invoked even in more conservative contexts. TF1, France's more conservative TV channel, also treats health insurance as an important manifestation of French solidarity. A 1977 news broadcast discusses social security: "All French people should be covered by social security. Since the 1945 law, we have been gradually extending coverage, as per the law. Complexity has made it take so long to get people covered. Ensuring a universal level of social protection to all of the French is the spirit of the 1974 Law to Generalize Social Security" (Collins 1977a). This is especially different from the American case, where conservative news outlets display the highest levels of societal distrust and suspicion.

Even in the more conservative media sources, such as TF1, the continuation of this legacy is considered important, and even essential to the health of the overall population. Health care is frequently discussed as a positive right that needs to be extended still further, until the true entirety of the population has health access. The same 1977 news broadcast continues: “Two percent of the population still does not belong to any obligatory health insurance program. Two million are not signed up, such as liberal professionals, which include interpreters, unmarried couples, fortune tellers, piano professors, private detectives, clergy members, students, widows, and single mothers. It also includes the elderly, and marginalized people such as prostitutes, gypsies, the homeless” (Collins 1977a). Fascinatingly, these marginalized people do not seem to be inherently distrusted simply because of their marginalization. Instead, they are simply viewed as people that have managed to still fall through the cracks, thus necessitating the creation of a new classification so that they could be covered. Following the historical reminder of the goals and the original post-war social security law, these gaps in coverage are easily recognized as undesirable and even unacceptable. The reform discussed is an extension of positive health rights—and the argument for doing so is a historically, ideologically grounded reminder that solidarity, extended to all French people, was the intention of the post-war society. But this is not the only time that the French collective is considered and becomes a character in these debates.

Collective benefits to cost saving measures, extending care, and making care accessible are argued as collective goods consistently in French discourse, by commentators across the political spectrum. In 1977, during the conservative TF1’s call-in section about budgetary constraints and reductions to the reimbursement rates on a few selected medications, who proclaimed “We can’t raise payments every year. We need to use what we have set aside for social security, and we need to use it in the best and most effective ways possible. We need everyone to be aware that health has a price, and that as individuals, we cannot abuse health care.

Otherwise, we will all collectively suffer"[29] (Collins 1977b). This type of collective discourse comes from the public, politicians, and commentators alike and is a great unifier across the French political concept sphere. The very notion of a collective requires a lower sense of individualism and higher levels of trust than what can be observed in the American context.

Another great difference between the French and the American cases is that the French had the expectation that building a health insurance system that would cover the entire nation adequately would take some time, work, and refinement. Decades would pass before the French could truly say that all French people were covered by health insurance, and it took even longer for all people in the country to be covered. In the U.S., the ACA was not given much time before conservatives declared it a failure, constitutionally challenged it, and dismantled some of its most important features. It is highly unlikely that every French politician, lawmaker, and citizen agreed with every move made along the country's path to universal health coverage. However, in all of my research, I have not come across a call to systematically repeal, dismantle, throw out, or fundamentally restructure the French healthcare system. The process of building such a system seems to be given more respect, time, and space to grow. The French expectation does not seem to have been that one legislative act would simply build a perfect, functioning, and mature system. Instead, reforms accumulated piecemeal, as problems and issues became apparent and as the medical industry evolved. I believe that this is easier for a nation that sees itself as a collective built on solidarity and fraternity and exhibits a high level of societal trust than for nation that is built on states' rights and individualism and exhibits a low level of societal trust. It is not a stretch for the French to say "we are building this together, and we will get it right eventually, even if it is not perfect for me personally right now." Americans, as we have

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seen in the reactions to the ACA, seem to expect nearly perfect outcomes for themselves as individuals immediately. The failure to provide such results has led to the rather wide belief that the act was inherently flawed beyond true repair. This American trait is proving to be a major stumbling block in health reform efforts.

However, in the U.S., many people expected that the ACA should fix all problems facing American health care access. The law sparked a storm of partisan fighting. Furthermore, in the U.S., fundamental challenges to legislated rights seem to be common. The U.S. seems unique in that Americans will fight to try to take rights away from citizens for ideological reasons, financial reasons, or, in this instance, of a lack of social trust. These sorts of challenges to already enshrined rights do not seem possible in the French political or social landscapes. As such, I have not found any calls for repealing or retrenching the availability of French health care rights.

Acceptability of Obligatory Membership

Furthermore, the idea that health insurance might be obligatory is not shocking, off putting, or taboo to the French. Though issues of patient choice or freedom do come up in their health policy debates, taking issue with being "obligated" to be insured is extremely rare. It was at one time a greater issue or sticking point, before all citizens were brought into the system, as Paul Dutton (2007) points out. Instead, the French today worry more about the uninsured, those who might struggle to pay copayments even when they are very low, or those without access or the means to purchase supplemental insurance. More emphasis is placed on the hardship of those who had been undercovered, lacking in means or in the ability to navigate the healthcare system, or on the need for solidarity and care. The value of solidarity eclipses the idea that obligatory health insurance payments might be unfair. Even more importantly, fear of an "obligatory" health insurance program makes little sense when health care is treated as a right. A right is not obligatory or enforced unfairly; instead, it is granted or provided. Access to health services in France is consistently seen as a right, even during budgetary debates. Protests over mandatory or obligatory social security payments are infrequent, and are usually are limited to the extremely wealthy. For example, a movement started in 2014 that encouraged wealthy of French people to withdraw themselves from social security in favor of enrolling in private overseas health insurance programs. While this movement did not gain much momentum, it did gain some airtime on the national news. Such a thing was made legally possible by European Union regulations stating that health insurance must be equally provided to all citizens of a European country, regardless of their means. Since not all French people currently benefit from a supplementary insurance plan, this has created some questions about how European laws and the French insurance system might interact.

This theme is common, and is repeated in many different formats. A television ad run by French Health Insurance in 1998 titled "At the Heart of Life" is yet another instance of grounding solidarity historically. It also includes a strong emphasis on solidarity and lifetime inclusion in health rights. The ad begins with footage of a woman giving birth. An announcer states "Everything was put in order so that Sebastian could be born in the best conditions. Everything is done so that each and every one of us can benefit from security. Since October 1945, with solidarity as the main impetus, social security was born. Today, the ensemble of our population is protected" (Inathèque Multimedia Archive 1998).

Here, the emphasis placed on solidarity and universal health rights in advertisements for health insurance is noteworthy. Even the existence of television ads for a social program is remarkable. In the U.S., public service announcements encouraging increased use of Medicare or Social Security, which are considered to be the most legitimate of social rights or social services, are unheard of. Recipients of aid of any sort, save Medicare and VA benefits, are shamed. In France, television ads remind the French of the history of social security, inform them of their rights and services available, and disseminate public health information. This ensures knowledge of programs and encourages a higher rate of participation. In the U.S., where participation in social programs is often heavily stigmatized, such ads would likely inspire ridicule, skepticism, and distrust of the beneficiaries of such programs. These programs and their recipients are intentionally ostracized as opposed to being normalized and accepted**.**

Non-Stigmatization of Public Programs

However, in France, ads publicizing social security health insurance benefits to normal, middle class French people are common. Though the French do sometimes run ads that show how the disadvantaged can benefit from state programs, it seems equally important that the face of health insurance and social programs be common, neutral, non-stigmatized, and generally very socially accepted person. In one ad, a pretty blonde lady is pregnant. Then of course she has a baby. She is clearly a joyful mother. The sweet female announcer states, “We really do not always want to wait for things in life. Except maybe if we are expecting. With the *Carte vitale,* you will never wait more than 5 days to be reimbursed.” The closing text reads “prevention, facilitation, financing. Health Insurance: The more one does for health, the better you feel” (Inathèque Multimedia Archive 1992).

The above ad is also interesting when you consider France’s social relationship to fertility. For the French, historically, there are few groups that are more supported than pregnant women. The pronatalism movements of the late 19th and early 20th centuries left their mark on French policy. In modern times, different family-supporting state programs have existed at various times. Since this dissertation does not focus on these policies, this is not the place to detail them extensively. However, we must note that in recent times, France has provided: up to three years of parental leave, tax cuts for each child in a family, a payment equaling the minimum wage for women with three or more children, and government-subsidized day care and child care. Given this context, this ad is not at all shocking. It reminds mothers that there is prenatal care and medical care available to them after their pregnancy. Conversely, in the U.S., health care reform plans have been hotly debated due to the fact that they include prenatal care, birth control, or abortions. In the U.S., these issues are morally charged in more ways than one. First, many on the right simply feel that birth control is amoral. Others feel that if they are not women of childbearing age, they should not be required to pay into any system that covers or supports women who face these age and sex-specific health issues. In France, it is a given that these things would be covered and that even those who are not of childbearing age would be willing to help those who are.

However, when one imagines what an American television ad for prenatal state care for mothers might look like, we can see the real difference. Such ads would draw the wrath of all of those who have so gleefully used the term “Welfare Queen” ever since the Reagan years. But there is no such equivalent in France, as a pregnant woman is not stigmatized in France simply because she accepts state health care for herself and her growing family. Instead, all pregnant women benefit from such care. It is the norm as opposed to the mark of the stigmatized poor.

The “virtuous” patient is quite a different thing in France. An article in *Humanité*, one of France’s most left newspapers, warned that the march towards a privatized social security was already underway in 2005 (*Humanité* 2005). For the French left, privatizing social security or any other social program is one of the biggest threats of globalization. In reaction to the *medicine traitant* policy change, which would require French patients to choose a primary physician, who would see them in order to refer them to any specialists, should then need specialized care. An article in *Humanité* warns that the "virtuous" patients who will actually follow the protocol of first making an appointment to see their general practitioner, then making a subsequent appointment to see a specialist, will be penalized for their virtue. They might need to wait to see a specialist. The same virtuous patients, according to the article, will be victims of a system that makes those who can pay the penalty for going directly to a specialist more attractive to doctors. The only difference between a patient who would take the time to see the general practitioner first and a patient who would go directly to a specialist would be that the direct "unvirtuous" patient would pay the doctor immediately instead of waiting for social security to pay the doctor. While this usage of the terms virtuous and unvirtuous are clearly satirical, the fact that virtue is used satirically in this context is informative. Whereas in the U.S. context, it is entirely normal that certain types of poor patients could be considered unvirtuous for seeking aid to pay medical bills, in the French context, it is the wealthy patient who does not need to wait for reimbursement, goes directly to the specialist, and pays out of their own pocket who is unvirtuous. So, in the U.S., it is the poor patient receiving aid who is unvirtuous, while in France, it is the wealthy patient that circumvents the line by paying their own bill who is unvirtuous. What a difference! In France, the person who undermines the system and the collective is the real undeserving person, while in the U.S., it is the unemployed person or the poor person who needs help from the collective who is undeserving.

There are two other ads in the same advertisement series about children discussed above.

The second ad is targeted at mothers of older children. Two adolescents eat gummy candies, watch a movie, and giggle joyfully. The same announcer states: “You always keep them from eating junk. But we can help them to keep their smile pretty longer. Health insurance offers free dental exams to those between the ages of 15 and 18.” The ad closes with the same tagline: “prevention, facilitation, financing. Health Insurance: The more one does for health, the better you feel” (Inathèque Multimedia Archive 1996). It is equally difficult to imagine an American version of this ad. Dental care for children is available through CHIP and Medicaid, but these programs are so stigmatized that an ad that simply portrays happy families benefiting from the program would not go over well. The issue would be not only that receiving any sort of welfare is inherently stigmatizing in the U.S., but furthermore, many adults and children who earn enough that they do not qualify for Medicaid or CHIP and who do not receive such care from their employer’s plans are left entirely without dental care. The French can publicize their benefits widely because they are available to just about all French people. Therefore, there are few French people who would feel bitter upon realizing that their children are not offered dental care, despite the fact that they work. In the U.S., the fact that the middle class is excluded from benefits that the poor receive make this sort of advertisement unfathomable, as it would generate anger and anxiety among the middle class.

Furthermore, these families are not shamed for relying upon the state for health care. Instead, these services are intended for all French people. As a marker of nationality and belonging to the French community, benefiting from French national healthcare could not be stigmatized, unless being French were to be stigmatized. More importantly, additional health support programs for those that are less wealthy are neither hidden, nor stigmatized. In the U.S., in addition to being stigmatized, finding information about health programs for the poor, applying for programs, and receiving benefits can be exceedingly difficult. This is partially because many of these programs are state or even county programs, and are therefore handled differently in each community. In France, such programs are now nearly completely centralized. This gives these programs the legitimacy, budgets, and communication channels of the rest of the health system. And, just like other health programs, they are equally publicized. The following ad is for a program started in 2005, which helps people afford complementary insurance. In the ad, a plainly but neatly dressed woman states, “Sometimes it’s difficult to finance a complementary insurance. When you do not make a lot of money, but you do not have access to the CMU, it’s often even more difficult. But, the *caisse* decided to help us. The amount of aid you are eligible for depends on your earnings. But, do like we did, and get more information today” (Inathèque Multimedia Archive 2005). Additionally, this ad points directly at a hole in health care and offers a very specific solution. For individuals who could not access the CMU but were still left paying out of pocket costs or attempting to purchase complementary insurance, this was a big issue.

Lifelong Solidarity

Coverage throughout many different stages of life is also part of health solidarity in France. This includes solidarity throughout different life stages as well as throughout different economic statuses. The same ad that features Sebastian and his mother, who are protected because of the solidarity of 1945, follows several other insured French people. In the health insurance office, we hear from someone traveling to Italy in a few days wondering about travel insurance, a man who is disgruntled over the level of reimbursement he receives, a student, and a newly retired woman. We see several other health insurance beneficiaries: a 35-year-old man who is being rehabilitated after a bad accident, a woman being examined for breast cancer, and a grandmother, Jacqueline, who is receiving physical therapy. We are told that thousands of files are processed every week, and that each person is reimbursed in less than one week. The filmmakers have given us a cross section or different moments in life. All of these people, despite their differences in stage of life, occupation, and means, share the same experience of receiving health care from social security. The implication is that these French people share this common bond, this experience of French solidarity throughout their lives. The announcer notes that "Everyone can enjoy a sunny day, but everyone is protected, just in case" (Inathèque Multimedia Archive 1998).

Though the focus in the first section of this video is on solidarity throughout different ages, the French also maintain solidarity throughout periods of personal economic hardship. The next scene shows a social worker traveling to a remote dwelling where a young man appears quite disheveled and impoverished. The social worker informs the man, Thibault, that he could be benefiting from health insurance if he would just update his file. The announcer notes that having access to health care will give Thibault "the desire to fight for himself." Thibault is also enrolled in a professional program designed to allow him to find an internship, a career, and the "opportunity to live better."

As evidenced by the inclusion of Thibault's retraining program in a video about health insurance, the broad range of programs administered by social security points to a broadened definition of health. In France, "health" is as social as it is physical. A variety of programs, from homeless services to programs for families with children to housing subsidies for college students, are seen as a part of holistic social health and are administered by social security. In the U.S., charities and churches fill much of this void in social services. There is no sense of the collective caring for the multi-faceted aspects of health throughout a person's evolving life conditions and situations.

French health insurance has valued expanded preventative care for a long time. Seen as a public good and as part of the positive citizenship right to health, preventative care, including curbing the overconsumption of medications, especially antibiotics, is emphasized in French health ads. An interview with Mr. Marriage, the director of the CPAM of Valenciennes states that

> Prevention is probably the most important aspect of health. However, people need to be aware of how to obtain preventative health care in order to do so. So, our goal is to make the CPAM as approachable and accessible as possible. We treat the public like clients and encourage a spirit of service among our agents… We work to increase the health capital of our region by increasing education about vaccines and other preventative care options. Teaching about these practices in schools helps people develop good habits and knowledge of health insurance for later in life. (Rougerie 1992)

Like other health services provided by health insurance, preventative services are extended to the population as a right, and with the goal of making the ensemble of the French population healthier, preserving the tradition of French solidarity, and expanding solidarity in accordance with the goals of 1945. This ever-widening, rights-extending solidarity is distinctly different than the issue or crisis-aversion focused health legislation of the U.S. Furthermore, a state program treating "the public like clients" would likely appeal to the majority of Americans, since fears of subpar, disinterested, bureaucratic state services are a top fear and objection.

Collective Strategies to Maximize Health Care for All Despite Rising Costs

Even when the French take measures to reduce the cost of their health insurance, it is done with a spirit of expanding solidarity, the inclusion of the entire population, and greater overall health. The campaign for a *matrise medicalise* is a perfect example. It included several ideas, such as using the most effective treatments, promoting preventative care, regulations on general practitioners and specialists, reducing the French tendency to overprescribe medications (especially antibiotics), and a great push towards prescribing generic medications.

One of the more publicly visible aspects of the *matrise medicalise* initiative was the push towards generic as opposed to name brand medications. Health Insurance ran several advertisements informing the French that generic medications are the same as name brand medications, TV news segments interviewed pharmacists and doctors, and newspapers ran similar informational articles. Many of these ads emphasize the collective good of individually making choices to save Health Insurance money. These arguments discuss rights, the collective good, the need to provide better care to the greatest number of people possible, and express the desire to maximize health services for the greatest number of people for the lowest possible cost. In these ads, it is not framed as a question of care simply being too expensive to afford. The attitude that there simply is not enough money to provide care to all French citizens does not fit with the goal of preserving and extending solidarity to the entire French population. Instead, the conversation is about getting French people to take measures which will make health care less expensive so that the system that supports everyone will be less burdened and more effective. There is also a great emphasis placed on the need for equality in care.

If there are moral issues surrounding providing health care, they are more likely to target the moral failing of those not doing what would be right by the collective. While trust is not so much of an issue in France, citizens are encouraged to make choices that promote the wellbeing and the solvency of the healthcare system so that all may benefit and remain healthy. One TV spot from 2002 featured a cartoon angel and devil, classically perched on a Frenchman's shoulders. The Devil tells him that he can take "The Medication" because he pays into social security, and he therefore has the right to it. The Angel counters him and says "Picture it, the generic is the same, but its more economical. Because of this, we can save millions of francs and do more research. We can improve the coverage for all of those covered by social security. I promise, when the collective saves, you benefit too" (Caille 2002). This example could not be any clearer—using generic medications is a benefit to collective society. It is a morally and economically advantageous. More research can be done and better coverage can be provided to all due to the money that will be saved. The ethics of this are tacit. Solidarity as a concept is not even named here—yet references to the collectivity make it clear that solidarity is the moral good of this decision. Saving money in order to expand rights by providing better coverage is entirely consistent with the French tradition of reaching towards greater rights in order to achieve solidarity and a better society.

A 1983 television ad encouraging voting illustrates the cohesion of these social services. French people of all ages and colors cover their eyes with their hands. The announcer states "There are things that are so important in life that we do not even see them. Like your retirement, our health insurance, and family housing. All of that is social security. Therefore, social security is our concern. So, we're going to vote, because it concerns all of us." The people then uncover their eyes, and seductively put their ballot into the voting box (Inathèque Multimedia Archive 1983). Though it is unknown why voting is made sexy in this ad, it is clear that social security is a unifying agent of solidarity, that the ensemble of social security programs is considered a package deal of solidarity, and that social security is an important piece of French participatory democracy. The wide variety of people pictured in the ad also idealizes both voting and social security as a public good intended to help all French people, regardless of age, means, or ethnicity. Social security is the solidarity between all of these people—and as it takes care of them at so many different vital phases of life, they are concerned about voting in the next election.

Even when it might be less possible to establish how social security might be reformed, official discourse about both social security and health insurance emphasizes unity. This is apparent in an ad informing the public that research was being conducted on the social security system. A great humpback whale leaps from the ocean and continues its graceful course through the water. An announcer states: “Today, the focus of our study is health. Health Insurance is at the heart of our great national inquiry. For the last six months, the Etats Generaux have been gathering women, men, and ideas. The Etats Generaux of social security—its all of us, all together.” Another ad spot for the same campaign had a similar focus. It used the exact same whale and voice over. It said: “When we abandon a great idea, it’s also a part of ourselves that disappears. Today social security needs us. We protect its future the way it protects us daily. To save a great idea: les Etats Generaux of social security. It’s all of us, all together” (Inathèque Multimedia Archive 1987).

These ads, formulated by the committee charged with studying the functioning of social security with a special emphasis of user experience, represent the public image campaign for the study. Since the study relied on interviews with citizens, requested letters, and organized round tables at libraries, the exercise was rather public. These ads encouraged a positive view of the study and encouraged participation by appealing to, yet again, solidarity through social security.

The follow-up to the Etats-Generaux was a strong emphasis on personal responsibility for medical costs. Doctors and patients alike were included in this discourse. Doctors were encouraged to curb wasteful medical practices, overuse of prescriptions, overuse of testing, unneeded home visits, and excessively long exams. Patients were encouraged to accept generic medications, comply with the general practitioner before specialist *médecin traitant* protocol, refrain from taking unneeded paid sick days, refrain from requesting house calls, and curb unneeded antibiotic use. While there was certainly backlash from both doctors and patients, the concept of *responsibilisation* was generally well-tolerated. Of course, warnings against compromising the level of care were common. And though this fear was important, the need to lower costs *for the benefit of the collective* was just as strong. This link was strong enough that this dialogue about the responsibility of the collective was hardly shocking. It was not a reach to suggest that the actions of individual patients or doctors could impact, for better or worse, the state of health in France. In the words of an individual interviewed for a 1992 television spot discussing the reforms, "You recognize the responsibility of both patients and doctors in the quest to master health care costs" (Rougerie 1992). However, this concept was actually strong enough that it was not unreasonable for even the health debt to be seen as an issue to be tackled through increased collective responsibility. The conservative former Prime Minister Alain Juppe spoke this way. His politics involved "asking the whole of society to reimburse the debt."

This dialogue about responsibility is particularly interesting when it is considered next to the CMU debates and the *médecin traitant* (general practitioner) reforms. In an effort to reduce health expenditures, this policy required a patient to specify their general practitioner. In order to see a specialist, the patient needs to first see their GP to receive a referral. The most common complaint was that this policy contributed to the oft-feared *medicine a deux vitesses,* or "two speed medicine." If a patient did not first see their GP, they would be reimbursed at a lower rate for their specialist appointment. The critique was that wealthier patients could afford to simply go directly to the specialist without first seeing the generalist. These patients would have their more serious medical needs met sooner and more easily, while patients with limited resources would need to see the GP first in order to receive the highest reimbursement possible. Those patients with lower resources would supposedly suffer health consequences since they would need to wait longer to see specialists.

The general practitioner reform was also seen as a system that would exclude the poor and the old because of its complexity. Long wait times for patients who could not afford to jump to specialists, or because fears for the health of those that could not navigate a more complicated system would contribute to the much feared two speed system. On a political talk show, Dr. Christian Lehmann stated, "I won't refuse to treat patients. I refuse to trap them into an incoherent system. I'm against the one Euro copay, because it stigmatizes the poor and the old. I do not want an American system where the poor have no access to the system, or where they have an inferior system" (Aubry 2003; Revel 2004). The pervasive fear of leaving a segment of the French population with an inferior health system is directly related to the expression of French solidarity in the health system. Also, creating policy that would marginalize a portion of the population would be a diversion from the French goal of increasing positive rights and protecting inviolable human values. Though the *médecin traitant* program was actually accepted rather quickly as an effective, fair, and useable policy, it could not be implemented without undergoing analysis for potential threats to health solidarity or as a threat to this goal of furthering social rights.

The Best Social Protection in the World: No One Left Behind

The CMU, or *couverture maladie universelle* (Universal Sickness Coverage) was the final push towards inclusion of all residents of France into the health system. It passed in 2000. Despite the fact that there were further health programs created after the passage of the CMU, most notably, the allowances for those with low income to purchase supplementary insurance, the CMU was spoken of as the final piece needed to fulfill the constitutional intention of 1945.

A political television program covering the CMU just before it passed explained the reasons for the new law. In an episode titled “Those Excluded from Health,” Bernard Kuchner, Minister of Health, states:

> Our social protection is the best in the world. But still, 12 million people do not have the means to have proper health care. Some people aren’t poor enough to get help, but not do not have the means to buy supplementary insurance. Not all homeless people currently have rights, because some never worked enough hours to qualify. So they are not covered. Africans do not understand and can’t communicate with doctors, and have cultural barriers to care. But we’re in a country where people that go to the doctor should be fully covered, this is not a thing to opt out of. (Caille 1999)

Here, Kuchner, a member of the Socialist Party, boasts that France has the best social protection in the world. In U.S., the boast is that we have the best medical care, doctors, or facilities in the world. The difference between these two boasts is that France endeavors to create solidarity, cohesion, and protection that extends to all members of its society, including homeless people and African immigrants who do not understand how the system works. Whereas immigration and a person’s lack of work history and tax payments are the biggest arguments against health expansion in the U.S., in France, they were precisely the arguments mobilized in service of expanding health coverage. These opposite logics show, yet again, that France’s solidarity is based around the good of the entire society, while in the U.S., this is not the case. In the U.S., the population is fragmented by their access to or lack of access to services. This reinforces the creation of in-groups and out-groups within the society. These groups, and the fear of being moved to an out-group, provides fuel to the divisive identity politics which are currently plaguing the country. In France, identity politics are still strong, as headscarf debates and the disadvantages minorities face are frequent topics in the French media. But in France, the focus is on including all people as the same. They call it integration, whether it relates to immigrants adopting the cultural practices of the rest of the country, or whether it involves bringing all legal residents of the country into the social security health insurance system.

Martine Aubry sums this up well in her 2003 book *L'important c'est la santé* (*Health is the Most Important*). She writes: "The left carries the values of solidarity and fraternity that are threatened today. The challenge is to continue fighting for progress, and to support our country's ambition of a collective spirit" (Aubry 2003:7). Of course, as a socialist, Aubry claims these values for her own party. However, these values can be observed across the French political spectrum. Where the French right is more likely to examine the financial and economic aspects of social security, they are unlikely to say that the programs should be retrenched, abolished, or otherwise weakened. While the right might propose regulations, procedures, or what really only ever amount to modest cuts to coverage (at least by American standards!) these cost-saving or cost-regulating measures are in the overall interest of preserving French solidarity, and respecting the goals lined out in the 1945 constitution.

Conclusion

In conclusion, it is clear that French values have influenced the shape of French social programs, notably health care. While values, preferences, and beliefs evolve over time, we can also see that they have considerable staying power. In both the American and the French case, values that have been common since at least World War II still dictate the shape of our societal commitments to one another.

We have also seen that the French created a comprehensive healthcare system by systematically extending coverage to more and more groups, while the U.S. has provided only piecemeal health solutions to groups that are very clearly suffering. This difference in approach means that the two states act in very different ways regarding health care. The French state set a specific goal that resonated with the French population, and classified and sorted citizens into coverage groups until all were covered, and their health care goal was achieved. This goal was set largely because solidarity, fraternity, and the idea that medical care is a right led to the conclusion that a society should find some way to provide care to all citizens. The French prefer a stronger state, so this responsibility naturally fell to the state.

The American state, also acting in accordance with the values of the American population, has never set a goal for how health care should look in the U.S. As evidenced by the tumultuous ACA repeal votes under the Trump administration, Americans have yet to reach a consensus on whether or not health care is a right. Since American values are more firmly grounded in independence, work, self-sufficiency, and minimal state involvement in the lives of individuals, we have had only rescue efforts for our most vulnerable populations and health care rewards for our most trusted citizens: veterans and the elderly. As a result of the same values constellation, our closest attempt at expanding health care to all, even through the private sector, has been hotly challenged at all stages.

While the French state may struggle with the ever-rising costs of health care, one thing is certain: health coverage for all is a clear and enduring priority.

CONCLUSION

To conclude, this dissertation posits that the unsettled times[30] of World War II and the Cold War led both the United States and France to create health policy programs that were deeply in line with their respective *longue durée*[31] cultures. The elements of these cultures as they relate to healthcare reform discourse were isolated via extensive discourse artifacts. These artifacts include newspaper archives, letters to the editor, TV news broadcasts, archived political speeches, advertisements and propaganda both for and against health reform initiatives, and deeper political archival documents such as reports from focus groups and plans for television programs. This conclusion provides a high-level summary of the findings contained within this dissertation, proposes future directions for ongoing research, and explores the implications and applicability of the present findings.

This dissertation is an analysis of seven decades worth of discourse. It reveals that both cultures have thematic constants that make up the bulk of this discourse. Contrasting discursive elements of French and American *longue durée* culture were identified, including differing concepts of merit and stigma, the right to be unbothered by others versus a focus on solidarity, utilitarianism via expanding versus restricting health rights, and sourcing national medical pride from quality of care versus quality of social protections. These differences were identified as principal discursive elements inspired by cultural factors that have been leveraged by political strategists, politicians, and interest groups as they debate health policy. These elements, all of

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[30] "Unsettled times" as per Ann Swidler. Most briefly, this refers to times of great change in which a society must rely on its deepest, most enduring cultural elements in order to orient itself.

[31] Throughout this dissertation, *longue durée* culture refers to the deepest, most fundamental culture of a place. It is the culture that remains relatively unchanged over several decades. It has a great role in defining political opinion and is frequently leveraged in the service of political messages and debates. Of course, it influences things other than political opinion, but political opinion is the focus here.

which have been leveraged for several decades, are derived from diverse features of French and American *longue durée* culture. Only resonant elements of culture can be successfully used to influence the shape of policy. Therefore, *longue durée* culture can be isolated via these health policy debates.

First, some of the most salient cultural differences that inform health policy debates are conceptions of merit and stigma. In France, using state-funded and administered social programs, including health insurance, is not stigmatized.[32] Instead, these programs are discussed as true citizenship rights informed by human rights. As such, all French people and individuals legally residing in the country merit medical care and access to services. There is not a contractual or transactional exchange required in order to gain access to these programs. A French person does not need to make any particular sacrifice, perform military service, or be old or poor in order to benefit. Neither the sense that the recipient of a social program is in debt to society, nor the shame that is associated with this type of debt in the United States exists.

Conversely, in the U.S., gaining access to non-stigmatized state-funded health benefits is largely a contractual or transactional arrangement. Veterans receive VA care due to the sacrifice of contractual military service. They are not stigmatized for utilizing these benefits, rather their service is celebrated.[33] Individuals over 65 benefit from Medicare. This is a transactional benefit, as they have paid for these benefits over decades of wage earning and tax payments. Old age is also typically respected, and Medicare is one of the expressions of this respect. As such,

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[32] Since the most important French social programs, including healthcare, benefit all, from the indigent to the wealthy, there is far less stigma involved in utilizing these resources. Furthermore, there are more politically resourced individuals who have a vested stake in promoting the vitality of these programs.

[33] Despite the fact that veterans' rights have been greatly reduced since the 1950's it could still be argued that their service is celebrated culturally, as well as rewarded by social programs that the rest of the population does not enjoy.

receiving these benefits is not stigmatized, and these rights are protected.[34] However, recipients of Medicaid, a program that only benefits the poor, are highly stigmatized for requiring aid. Since they do not receive medical benefits as part of a transactional exchange of value with American society, they are frequently deemed unworthy or lazy. Though many of these individuals do in fact work, they are often subject to ridicule, racialized prejudice, economic or class-based anger, angst, and resentment.[35] In France, the poor and documented immigrants are not stigmatized for relying on public services such as health insurance. Instead, they merit these services not for any reason other than belonging to the national community. There is no transaction or exchange that they must make in order to lift the stigma of receiving health benefits.

Next, in the U.S., remaining unbothered by fellow citizens in need is discussed nearly as if it were a fundamental right. Being asked to pay more taxes, change health behaviors, or adapt to new health policies so that others may also receive health benefits is usually met with many objections. These objections often are rooted in resistance to loss of personal liberties and freedoms. In France, taxes pay for a health system that covers all as part of national solidarity and identity. Behavioral change campaigns that promote the use of generic medications, relying more heavily on general practitioners, and judicious use of sick days are framed as cost-saving initiatives that individuals should take in order to benefit everyone in society. The French do not have the right to sit back, use the most expensive health care resources unnecessarily, and ignore the needs of fellow citizens. Solidarity is extended to all, but it comes with acknowledged responsibilities to the collective.

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[34] Medicare is sometimes called a “third rail” in American politics. Touching it, altering it, and certainly retrenching it results in certain difficulties for politicians who do so.

[35] Resentment and anger over social programs that benefit the poor is a frequent feature in right-leaning political commentary and satire.

Next, the U.S. and France are different in the ways that they discuss and in turn practice health care utilitarianism. In the U.S., extending health care rights, especially if these rights do not require any transactional or contractual exchange, is frequently framed as causing the moral decline of beneficiaries, political degradation, and the loss of individual freedoms due to governmental mandates. It is even more frequently argued to be far too expensive to be feasible. These programs have sparked fears of socialism, and the inevitable outcome of rationed, poorly administered care. For these reasons, it is easy for many to believe that it would not be useful or helpful to extend health care rights to Americans outside of the bounds of employment perks, veteran benefits, retirement programs, or indigent programs. The moral harms of extending such benefits, combined with cost pressures, are very often believed to outweigh the overall benefits to the society; therefore, they are not viewed as utilitarian. In France, providing access to health care is utilitarian because it is an integral part of French identity, an economic benefit to business, and a human right. Solidarity, as expressed via health care, is celebrated as a historical legacy and part of the national patrimony.[36] As such, the utility of publicly available health care is nearly undisputed in France. This fundamental difference has shaped societal priorities in fundamental ways and has ultimately shaped health care policies in both nations for decades.

Despite these differing notions of the utility of health care, both countries derive a sense of national pride from their healthcare systems. The U.S. frequently touts that it is home to the "best" care in the world and the best medical research.[37] Medical discoveries, glittery hospitals with wall to wall carpeting in the waiting rooms, innovative pharmaceutical and medical device companies, and high numbers of specialists are the pride of the U.S. healthcare system. Many

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[36] Of course, I am using 'patrimony' in the French sense of *patrimoine* here. Health insurance is a veritable monument.
[37] "Best" is often left undefined in both countries.

argue that the country would lose all of these things if health care reforms are taken too far, especially if health care rights are extended. France, on the other hand, is deeply proud of its social protections, including health care. The country boasts of having the "best" social protections in the world, very comprehensive coverage, and good health outcomes as a result. These very different points of pride indicate that French and American values are very divergent indeed.

This dissertation also revealed several non-dichotomous cultural elements in each country that strongly influence discourse and, in turn, health policy. The following paragraphs discuss these elements.

France has a strong focus on inequality and inclusion, which clearly impacts both its discourse and its health policy. The desire for equality is present in the 1945 desire to push towards a social security system that includes health care that could cover the entire French population. The 1946 constitution acknowledges that "every human being that finds themselves incapacitated to where they cannot work has the right to obtain from the collective the means of a decent existence."[38] This preoccupation with access, inclusion, and solidarity in the face of hardship shows up discursively in the discussions about *médecine à deux vitesses*[39] that have endured for decades. The French decry any policy that exacerbates or creates health inequalities. The *médecin traitant*[40] policy, which aims to minimize the cost of the system by imposing visits to generalists before seeing specialists, was critiqued in this way. Many argued that wealthy individuals could visit specialists immediately by simply paying out of pocket for their care. When health access is inequal in France, it offends *longue durée* culture because it threatens the

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[38] My translation.
[39] Two speed medicine, which is used colloquially to mean inequal access to care.
[40] General practitioner.

greater societal equality that is so central to French political identity.

The French are well-known for their focus on solidarity. French solidarity is a life-long, societal support that promises well-being, care, and protection. This concept includes medical treatment. Solidarity is invoked in celebrations of health care as national patrimony in the *Musée d'assurance maladie,* in public service announcements about how to use health insurance benefits, and in discourse supporting the expansion of health insurance programs. In the case of health insurance, invoking solidarity indicates a desire to support everyone's health via collective resources, departmental and national resources. Solidarity orients health policy, actions, and common sense about health-related priorities and societal decision making. It informs the French right to health care and places this right firmly above the right to be unbothered in the face of another's need. Solidarity is the *longue durée* cultural cornerstone that makes inclusive health insurance part of French common sense. Without this version of solidarity, the justification, desire, and action towards inclusive health policy would likely not exist. In the context of health care, French solidarity directly challenges individualism by placing social health, social cohesion, and the collective good above individual preferences.

Prévoyance[41] and personal responsibility are important health policy concepts in both countries. However, these concepts are referenced differently in these two contexts. In France, virtuous patients are those that practice *prévoyance*. These patients comply with cost-saving measures that are intended to make the healthcare system more able to serve and cover as many people as possible. In the U.S., personal responsibility has more to do with remaining personally economically stable. This means maintaining the ability to cover any and all emergencies

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[41] *Prévoyance* is most commonly translated as "prudence."

independently.[42] This prevents a person from relying on welfare programs, which in turn prevents a person from inconveniencing others with their health care needs, which, in the American context, is a violation of the right to remain inconvenienced. The different application of this concept is likely due to the presence and absence of solidarity as a central *longue durée* cultural concept. Personal responsibility practiced in the context of solidarity means using no more than what one needs from the collective. Personal responsibility practiced in the absence of solidarity means taking care to not inconvenience others with one's personal needs. In the United States, this requires maintaining very good health insurance (most commonly offered as a contractual employment benefit or via an ACA subsidized plan), self-financing medical care, or forgoing care. The first two options prove difficult for many Americans, even with the Affordable Care Act.

A Quick Note About American Arguments for Expanding Health Care

American arguments in favor of heath care expansion are far less stable than American arguments against health care expansion, which have leveraged very similar elements since the Truman era. Arguments for the expansion of healthcare rights respond more clearly to the way that Americans experience changes in the medical industry and healthcare accessibility. This discourse also responds to the growing differences in health rights globally, as more Americans become aware that they pay higher rates for health care than those in other countries. Since these arguments arise from changing American realities and new health care landscapes, few of these practical arguments are in direct alignment with *longue durée* culture. This makes it difficult for

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[42] Neal Gabler, in a viral article titled "The Secret Shame of Middle-Class Americans" published in *The Atlantic*, reports that millions of Americans that do not have an extra $400 dollars to cover an unforeseen emergency. According to Gabler, 47% of Americans fall into this category. A staggering number of them have both four-year degrees and full-time jobs. Sadly, a remarkable amount of Americans cannot cover their emergencies independently.

these arguments to be successful.

Arguments against health care expansion are so much more stable, and are more influential in terms of policy because they are more closely aligned with *longue durée* culture. In order to become politically successful, future arguments for the expansion of health care must leverage appropriate facets of *longue durée* culture as well as speak to current lived experience.

Applying Future Research to Create Health Care Change in the United States

First and foremost, there is certainly room for an even more complete understanding of how *longue durée* culture impacts health-related discourse in the U.S. Extensions to this research could include deeper dives into segmented perspectives on health care and health policy changes. Understanding the evolution of and recurrence of themes in health care debates by party, socio-economic status, ethnicity, region, gender, family/personal history, health status, or even by psychological traits could create a wealth of knowledge about these groups and their outlooks and experiences. Policy makers would do well to use this information to craft policies that are truly resonant with the *longue durée* culture of the people that would be served by such programs. These culturally informed programs would be more likely to be successful, as they would be more easily embraced. Of course, any successful program also needs to be grounded in public policy, feasibility studies, and ethnographic work as well.

Political campaigns could use these segmented understandings of *longue durée* culture to go beyond the typical message testing done via focus groups and surveys. This dissertation observes that the most effective messages are those that remain relevant for decades. Focus groups and surveys capture current thinking, and potentially only superficial feedback on current campaigns and movements. Understandings based in *longue durée* culture are far more likely to have much greater longevity, deeper resonance, and the staying power required for success. As part of the deeper reality of a group, messages crafted with *longue durée* culture in mind are less likely to be quickly abandoned for the next catch concept.

Hospital systems, insurance companies, and health startups could use these cultural insights to create new market-based or technology-based solutions to shake up the ways that health care is currently provided and medicine is practiced. In the U.S., there is a strong preference for private, industry-based solutions. However, these solutions must also be culturally relevant and appealing to consumers. Just as innovation teams in most verticals conduct cultural research prior to launching or revamping products and services, so should any player in the health care industry. Given the failure of the American government to legislate health care solutions and the preference for industry-based solutions, there is a phenomenal amount of space for health care companies, especially tech startups, to serve specific populations and need states. Understanding how culture informs beliefs about health care by patient type and community is key to success in these new ventures.

When *Longue Durée* Culture Must Adapt

Given what we know about the impacts of unsettled times, we should consider the likely occurrence of new unsettled times. Technological advancements in the form of advancing AI and robotics capabilities, quantum computing, 3D printing, gene therapy, and blockchain are likely to bring widespread change to labor markets, healthcare systems, and the demand for health care. Should advancements in automation cause vast rises in employment rates, the U.S. will be forced to reconceptualize its historical link between health care and employment or risk dealing with unprecedented uninsured rates that could potentially translate into public health crises.

If the U.S. continues to leverage its traditional *longue durée* culture in the face of the challenge of increased underemployment or unemployment, it seems most likely that it will continue down a course of piecemeal policy patches for populations as they begin to suffer the impacts of these changes, as opposed to creating a longer-term policy program to extend care to all. If the country continues to define personal responsibility in economic terms, it will see the creation of many new stigmatized groups, a continued concentration of power, and growing inequalities between rich and poor.

Stigma is most likely to occur when a minority of the population exhibits the stigmatized traits. Should these workforce changes touch larger and larger parts of the population, their condition will be seen simply as a new reality as opposed to individualized personal failings. At this point, American *longue durée* culture might be leveraged entirely differently. Personal responsibility could be redefined to fit a redefined population. Piecemeal programs could proliferate to the point where they effectively cover a majority of the population. New forms of contractual, transactional health benefits could be created and extended to many. In these scenarios, it is likely that the same elements of *longue durée* culture will remain active, however, they will be applied according to the realities that the society is confronting. This means that policies like universal basic income or Medicare for All remain just as culturally and politically challenging as they are today, even in the face of mass unemployment and growing uninsured populations. Even though these solutions could be viable ways to confront coming employment market shake ups, they are far outside of American *longue durée* culture and are unlikely to be accepted without great fear and anxiety.

The United States has long embraced the private sector, technology, and hypothetically "free market" solutions for many challenges. Allowing industry to solve social ills is seemingly in alignment with *longue durée* culture, even if it has not always been successful. As such, the private sector and health tech startups are more likely to find policy responses to ruptured labor markets and the ensuing ruptured link between employment and healthcare. Since the country takes great pride in its technological prowess and is home to many of the largest tech companies in the world, these sorts of solutions are far more likely to be in harmony with American *longue durée* culture than any new government program could ever be. While allowing private corporations to serve American health needs in the absence of a durable and effective public option certainly poses important and significant challenges, lack of longue durée culture fit would certainly not be one of those challenges.

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