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Differential Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France

Paul V. Dutton

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builds.) Overall, this is a book to buy. Given the work's complexity, the print version might be more practical than the electronic one for some readers, but those who wish to capture and manipulate the data should check to see whether they can do so using the Kindle edition.

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Differential Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France. By Paul V. Dutton. Ithaca, N.Y.: ILR Press (an imprint of Cornell University Press), 2007. 272 pp. ISBN 978-0-8014-4512-5, $29.95 (cloth).

Why should anybody read a book that compares French and American health care? The countries are about as different as any two rich countries can be, and their health policies diverged long ago. As attendance at most international conferences shows, comparing very different health systems is an invitation to superficiality. And any competent student of comparative political science should be able to list reasons why the contrast would not work—the cases are just too different, and Dutton should compare France to Belgium, or the United States to Canada.

Dutton suggests one excellent answer: in debating health care policy, Americans, like most people, frequently cite other countries' experiences, but rarely know what they are talking about. He leads with an amusing anecdote: an American opines that France has "socialized medicine," and a horrified Frenchwoman exclaims, "Socialized medicine! That's the British!" The book certainly would straighten out that American. And if more Americans did know about other countries, they might ask themselves different questions. When some French doctors toured the United States in 1951, they were posing very good questions indeed: "How, wondered the French, could the Americans be so horrified by public health insurance but so complacent about taking money directly from insurers, a practice [the French] viewed as a slippery slope toward losing control over medical decision making?" (p. 135).

Those French doctors had a point, and what Dutton does well is show why they could see what third-party payers and managed care organizations would be doing to American medicine forty years later—and why their American hosts could not. Medical autonomy survived better in Europe than in the United States, a terrible joke on the American doctors who confused professional medical autonomy with the freedom of doctors to think of themselves as small businesses. (See also Carolyn Tuohy, *Accidental Logics*, 1999.) Anybody who still thinks that UnitedHealth or Humana promotes medical professionalism better than does a French *caisse* should read *Differential Diagnoses*. So should anyone who wants to know what else the French, or at least their questions, could teach the United States.

But there is another good reason to read this book, one that appears to emerge from Dutton's approach as well as his obvious historiographical skill. The book is not a structured comparison of the sort that political scientists tend to write, testing a hypothesis in two cases chosen for their relevance. Rather, it explores the different ways that the two countries dealt with a range of challenges, such as the role of public and private in coverage, cost containment, and international debates about the role of hospitals.

What this book might lack in political science theory it makes up in good data and a lack of preconceptions about what does and does not matter. This means that Dutton is very good at identifying important forces that are dangerously easy to write out of health politics analyses. Histories of health politics too often focus myopically on coverage, finance, and organizational structures, ignoring the intense medical and professional politics that influence any outcome. They miss the extent to which a debate about finance or legislation, for example, is shaped by inter-professional arguments or disputes about the role of hospitals, outpatient care, or doctors.

That is important. We might be interested in one slice of health policy—why the United States does not have universal coverage, say, or whether health systems are converging—but the political outcomes of interest are often shaped by the actions of people whose motivations are foreign to us and may seem inexplicable to a political scientist or political historian. Medical organizations might enter the lists for or against universal coverage or a particular reform for reasons that have little to do with the issue of interest to us. Arguably, Presidents Truman and Clinton both failed to create a system of universal coverage because their plans involved major reorganization of medical care, and made enemies of those who would not have

minded universal coverage but did fear and oppose the reorganization. We misunderstand such failures if we define the interests only in relation to the issue of universal coverage.

Studying the policies that interest us, then, requires paying attention to the agendas that interest the participants. That seems obvious, but it is not. In discussions of health financing, for example, why should we pay attention to arguments about hospital beds? Well, because those arguments between large and small hospitals, or between specialists and family doctors, shape the power and political agendas of the different players. Daniel Fox, in another landmark of comparative health history, *Health Policies, Health Politics* (1986), pointed out that the history of the organization of medicine can look very different when we take medical and health service debates seriously. Fox was concerned with identifying similar agendas in different systems; for example, he explored how hospitals came to occupy a central place in health care in the United Kingdom and the United States. Many powerful people who might have pushed U.S. universal coverage were more focused on improving health care quality and establishing a key role for hospitals (as they are now), and saw finance through that lens, as one problem on a list of others.

Dutton is charting the different ways France and the United States answer similar questions about cost containment, medical autonomy, and the role of hospitals. But thanks to his willingness to engage with the actual agendas of health care politics rather than the imposed one of universal coverage, we can see many of the same dynamics. The arguments about cost containment are often about the role of medicine, and arguments about the role of the hospital might be inspired by costs but are also about the shape of the whole health care system. They look different when we understand them that way.

So who would want to read this book? Anybody interested in a good, well-written, short history of the U.S. health care system that avoids a focus on legislative history or reductive analysis; and anybody interested in the history and politics of the French system, which is not well analyzed in English (the handful of other good treatments include another book by Dutton, his 2002 *The Origins of the French Welfare State*). Beyond that, this book would be of interest to anybody who seeks new ways to study health policy, ways that lead with the content of health debates inside and outside legislatures. Dutton does not just show how we can learn about our system by looking at the questions others (like those French doctors!) pose. He also shows us *how* we should look at any health system: by paying more attention to the full range of debates that not only define the tensions within it but also determine the ways it can be changed.

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