

A Thesis Presented to

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The French and Danish Perspectives on Healthcare:  
An Exploratory Study of Citizens' Attitudes

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## INTRODUCTION

I was accepted to participate in an unpaid internship in London, England, for the summer of 2011. The internship promised to provide opportunities to work in medical settings in ways that would allow me an up-close view of healthcare from the vantage point of the professionals in the system, e.g., doctors, nurses, and other healthcare professionals. I was all set to go until I got the notice that my internship had been canceled. Though it was disappointing to not be going to London to study the National Health Service I was just as excited to gain internship experience from the UK's next-door neighbor, France. My internship placement was changed from London to Avignon, France, but the content of what I was doing remained the same.

During my time in France, I was placed in three different medical settings throughout the City of Avignon. I was placed with a host family and was partnered with a representative, who worked with the internship association that was sponsoring my placement and was in charge of monitoring my stay in France. I don't speak French, and, since I had such short notice of my internship placement change, I had to learn the basics of French in order to gain anything out of my internship. I was put in an intense three-week private language training session where I learned basic French communication. Thankfully, I did have some French background from high school that became useful during this experience. Once I "passed" my language class, I was put in my first medical placement, a private osteopathic practice on the outskirts of the city. Here I spent 1 month observing and assisting with patients who came for osteopathic treatment. This was an interesting experience for me because it was an alternative form of medicine and not a typical medical setting: I gained experience in patient interaction and was able to conduct a few interviews.

My second placement was a medical laboratory that also was used as a primary care office for residents in the area. Here I aided in laboratory tests, patient charting, basic deskwork, and transporting patient samples to other laboratories in the area. I was at this placement for three weeks. Out of all three placements I was put in, this one gave me the best experience in relation to analyzing the French healthcare system. My last placement was a physical therapist's private practice that also functioned as a rehab center for the elderly. Here I aided in patient charting, care, and lessons on how to use certain physical therapy tools. I also learned a lot about types of treatment that physical therapists perform, something I never had experience with before. I spent the remainder of my time in France at this last placement.

Throughout my entire French experience I focused on finding individuals to interview that would be of value to this thesis. I gathered my interviewees from the places I worked, people I made friends with, and the associations I made from living with my host family. This internship was partially funded by an ARGUS grant from Alfred University, a Bernstein Leadership Award, and two awards from the Women's Leadership Academy from Alfred University.

Originally, Denmark was not part of my honors thesis outline; however, after studying in Copenhagen for the fall semester of 2011, that quickly changed. My studies in Denmark were focused on being immersed in the medical field, as well as learning about healthcare policies in Denmark, Sweden, and Estonia. During the semester we were exposed to various hospitals, private practices, and research facility settings throughout Denmark in order to get a well-rounded feel for how the healthcare system worked. My study abroad program also included trips to Sweden and Estonia in order to gain knowledge of other forms of healthcare in Europe and how they related to the Danish system. I also had a semester long internship with the Division of Social Medicine at the University of Copenhagen that allowed me to gain knowledge

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on how the Danish healthcare system and healthcare research was conducted. I quickly became fascinated with learning more about a system that was fully publically funded like Denmark's and started focusing on how I could incorporate this into my final thesis.

During the summer of 2012 I was accepted into an internship placement with a cardiology division at a state hospital in Copenhagen, DK. During my placement I shadowed doctors and nurses in both the emergency settings as well as patient wards throughout the cardiology section in the hospital. I spent three months in Copenhagen this summer; half of the time there was spent doing this internship placement, while the rest of the time was spent on research and personal interviews. As in France, I used the resources around me to find individuals that I would interview. Unlike France there were few language barriers since almost everyone in Copenhagen speaks fluent English.

Both of these internships in their own way have led to the thesis that I have produced. I have crafted an exploratory study of two distinct, yet similar, socialized healthcare systems that I hope gives some insight to the truth about socialized healthcare structures and leaves a take home message that causes one to reflect on our own healthcare system here in the United States.

## **The French and Danish Perspectives on Healthcare: An Exploratory Study of Citizens' Attitudes**

### **ABSTRACT**

During the summer of 2011, I studied France's healthcare system in Avignon, France, as part of an internship working in the medical field. For my research project I recruited 5 individuals who agreed to an in-depth interview about their experiences with France's healthcare system. I was located in a hospital and a clinic during my internship, and was able to find willing individuals from among the professionals with whom I worked as well as the patients attending the clinic. Although the sample was small and nonrandom, I recruited a variety of individuals with different ages, health statuses, family and social class backgrounds to ensure a kind of representativeness. The interviews took place at the convenience of the interviewees and lasted approximately 30 minutes each. The following summer, 2012, I returned to Europe, this time to work in a clinic setting in Denmark. Like the study I conducted in France, I recruited individuals for in-depth interviews about their experiences with the Danish system. I was able to interview 4 individuals. My combined sample totaled 9 individuals.

The motivation to understand European citizens' perceptions of their healthcare system came from what I've observed about Americans' opinions on the pros and cons of government-run healthcare. With the changes that were happening since the passage of the healthcare reform legislation in the U.S., my desire was to learn and experience as much as I could about other systems to expand my knowledge about healthcare programs and policies in general, as well as shed light on these timely issues through the perspective of the people using the healthcare. Through this research, I learned how the French and the Danish feel about their healthcare options and was able to compare their views to the common attitudes we may find Americans expressing about government-run healthcare. My findings concluded that French and Danish citizens are generally content with their current healthcare system, even though there are flaws, and feel that socialized medicine is a good thing, unlike the private system we have in the US, which these individuals fear.

## INTRODUCTION

As an American and a student of the American welfare system, I've come to understand that healthcare is a privilege, not a right, for Americans. Even today, the provisions in healthcare reform known as the Patient Protection and Affordable Care Act do not guarantee that the federal government will provide all the necessary healthcare a citizen might need. Americans' attitudes toward healthcare suggest that it's a privilege and should be earned through hard work and financial planning. Knowing that we are a nation that feeds off the viewpoint of "every man for himself" in terms of success and achievement in life, it is not so hard to understand why our morals and values would force us to feel the same way about healthcare. As a whole, American society is reluctant to embrace sweeping reform of healthcare because we are a nation that is hesitant to give federal government power over such matters. It is believed that by doing so our freedom of self-choice and control over our own lives would be threatened. Knowing that European systems are vastly different, I wondered what citizens in a European nation might say about their healthcare and the coverage they receive from their governments.

Government intervention takes on a special significance for Americans, as we have been described as a "reluctant welfare state," unwilling to turn over too much control to public rather than private bureaucracies (Jansson 2005). We in America have a mindset that government controlled, or socialized healthcare, would be devastating to our capitalist and individualistic society; however I feel we forget that health cannot necessarily be controlled. Dr. Joseph Slavit, an American physician for socialized healthcare, makes a point that expresses this lack of realization that dates back to the Great Depression era: "Germs and Diseases are no respecter of

contribution of class distinctions, of conditions of employment or size of income. No such considerations or limitations affect our public education system or our fire protection or any other public health service. Why must they hamper the medical care of our people?" (Slavit, 2). Should healthcare be thought of as a luxury that only the healthy and rich can afford, or rather a right of every individual regardless of external factors?

My goal was to find out what citizens say about what works, and doesn't work in relation to healthcare in their nation. I wanted to explore what "socialized medicine" looks like from the perspective of a citizen. I went to both France and Denmark with the goal of finding individuals who were willing to be interviewed about the healthcare systems that they lived with, and gauge their level of satisfaction and contentment. I wanted to discover if citizens from both countries viewed "socialized medicine" as a system they were satisfied with generally and whether there were any features they wished were different.

## LITERATURE REVIEW

A vast literature exists in multiple disciplines describing the strengths and weaknesses of various healthcare systems. In this literature we find research exploring statistical analyses of both countries' overall healthcare systems, basic country facts in relation to health and healthcare, references to satisfaction of individuals living in each country, and current reform strategies that are taking place. When looking for literature it was important to include both statistical information and individual interpretations of the current state of healthcare in both countries. The focus was to find literature that gave a broad idea of how both systems function, where they need improvement, and how they relate to both the American healthcare system and other European systems. Included in the literature are also areas that need improvement in order to show no bias or glorification of either system. By including the positives and the negatives in

this literature review of France and Denmark's healthcare systems there was little room for the reader to interpret either system as being perfect. Lastly the literature aided in making a complete and broad representation of both the healthcare systems in France and Denmark.

## THE FRENCH HEALTHCARE SYSTEM

**Structure** The French healthcare system is a public-private mixed system, which includes both a public and private sector that are responsible for the coverage of healthcare for individuals in France. The social security system, which is run much like Social Security in the United States, is the main contributor to coverage. This combination of universal or full coverage of every citizen and a public-private mixed system, in terms of financing healthcare, gives residents in France a wide range of choices when it comes to their medical care. It is believed that the "French system is like Medicare on a much larger scale" (Crook, 3).

Unlike various other socialized healthcare systems in Europe, France's system relies heavily on complementary insurance to make up the difference in coverage for citizens. Although universal medical coverage (*Couverture Medicale Universelle*) grants all citizens a basic coverage of care, many still decide to get complementary coverage in order to pay less out of pocket and get better reimbursement rates. Today, 93% of the population has complementary health coverage, in addition to the National Health Insurance with which only acute and/or chronic diseases receive full coverage with no out of pocket costs (Steffen 357). The mixed economy of welfare means that public and private healthcare structures work together. For example, 65% of all French hospitals are public and 35% are private. The ambulatory (ambulance/emergency medical transportation) system is completely separate from the public healthcare sector and is 95% private (Saint-Jean, 114). Each year Parliament approves a budget on the amount of GDP (gross domestic product) that will be used for healthcare during that year.

The average GDP spent is 10% with patient reimbursement for out of pocket healthcare. This reimbursement ranges from 80-100% of the original out of pocket expense (Saint-Jean, 114).

Decentralization is a key in the French healthcare system. Running such a large publically funded system requires the country to be divided into regions and local funds (much like municipalities) to assist in the management and coordination. A large government funded structure, with major regional support, allows for a more fluidly run system (Sandier 155). This also helps with the management of hospitals and emergency care facilities in France. An accreditation system is used in France to make sure that hospitals and clinics are fulfilling the level of quality that is expected by the government and the French residents (Durland-Zaleski, 24).

The publically funded portion of the French healthcare system is financed through taxable income from three schemes, or models (to be discussed in the next section), relating to employment and status in society. Public healthcare uses a structure that is built on the idea of cost sharing among patients, private insurances, and the national health insurance scheme. The public health insurance scheme accounts for roughly 76.6% of funding for the French healthcare system. A soft budget is set up by parliament every year and is monitored by the National Union for Health Insurance Funds (UNCAM) and the National Union of Voluntary Health Insurers (UNOCAM). These associations and fund systems are designed to incorporate all public insurance fees with private health insurers. Laws passed in 2004 also gave the UNCAM the responsibility to set up benefits packages, setting price and cost-sharing levels, as well as respectively incorporating the private and public sector together (Durand-Zaleski, 23-24).

**Coverage** All French Citizens are covered at a basic level. The National Health Insurance is in charge of regulating the coverage based on occupational status (Rodwin, 31). This system relies heavily on social security taxes that are collected from individual earnings and other taxable income of the French citizens. All contributions to the system are decided based on salary and not based on level of risk the individual may present to the health insurance system. It is illegal to demand a rate of payment based on medical conditions. Ages and degrees of health do not play a part in deciding how much an individual pays in taxes (Steffen 357).

The National Health Insurance is composed of three schemes, all of which contribute to the national healthcare costs through taxes. The first group, which is also the largest, is comprised of employees. This is called the *General Scheme* and it covers people who are employees in commerce and industry, which totals close to 84% of the populations. The *Agricultural Scheme* covers individuals who are farmers or work in the agricultural field, which includes 7% of the population. Lastly the *Scheme for the Non-Agricultural Self-Employed People* covers individuals who are self-employed or craftsmen and only totals 5% of the population. Individuals who don't fit under any of these categories are covered by other schemes (which are responsible for cover the rest of the population). These Schemes are under supervision of the Social Security Directorate of the Ministry of Health and Social Affairs, which uses decentralization tactics to better manage the taxed wages from these schemes. Throughout France there are 129 local funds who are in charge of the connection with schemes' members and control reimbursement costs; 16 regional funds that are responsible for oversight of hospitals and preventative measures; and one national fund called CNAMTS that is in charge of insurance for salaried employees and employed workers as well as agreements with health professionals (Sandier, 154-155).

Not having an income and being unemployed does not mean that healthcare coverage is not available. In recent years, France has experienced an increase in unemployment, which has led to a decrease in taxable income of affected French citizens. This understandably has created a strain on the publically funded healthcare system. Since the French fully believe that healthcare is a necessity, the government created the Universal Medical Coverage scheme (*Couverture Medicale Universelle*) that came into force in 2000. This scheme allows for free affiliation to national health insurance as well as to complementary private health insurance to anyone who is legally residing in France for more than three months. Though these individuals are associated with the public system, they do have copayments to make on visits to the doctors and certain procedures (Steffen, 357).

Children under the age of 18 are fully covered by the National Health Insurance policy for both medical and dental healthcare; however, they may have complementary insurance through their parents benefit packages. The Decentralization Act passed in 1982 gave the responsibility of caring for children to the local regions, allowing for a more local approach to child healthcare and management (Manciaux, 1038-1039).

**Satisfaction** Knowing how satisfied a population is with their general healthcare system can give valuable insight into how the system is working. Some of these gains of knowing the satisfaction rate of a population include: aid in evaluating which sectors of the population support public programs such as healthcare, understanding what political and medical systems are accepted by a population, and aiding in gaining a better understanding of the environment in which public programs function (Kikuzawa, 387). Satisfaction with the French healthcare system is moderately high with individuals often feeling as though government involvement with healthcare is expected and suitable for their society (Kikuzawa, 390). The most current recorded

satisfaction rate in France in relation to the public healthcare sector is 41-47% averaging in both the emergency care sector and the general healthcare sectors (Hurst 14). This statistic is a slightly higher than the average satisfaction rate all across the EU, which is 41.3%(Mossialos 115).

The main reasons for this satisfaction rate have been hinted to in the strengths section; however, the French also find much pride in the fact that they have a healthcare system that is based on the foundation of equality and fairness. This type of thinking can be seen from the time shortly after WWII in which the French Social Security System took on the task to “ensure that everyone should have the means required to support themselves and their family in decent conditions under all circumstances” with the main underlying moral principle of Solidarity. This still stands today heavily guarded by the citizens in France (Roth, 329). This type of cultural value leaves individuals residing in France benefiting from this healthcare system feeling a sense of unity and comfort in knowing that they will be taken care of and that they are not left to fend on their own.

***Strengths and Weaknesses*** It is no secret that French doctors get paid substantially less than doctors in the United States and, on average, get paid 1/3 of what the average American doctor makes (Duverne, 210). Since doctors’ salaries are based on a fee for service, meaning they get paid per appointment, there is a lot of abuse of the public health insurance sector. Doctors’ base salaries are so low that many feel pressured into over prescribing, requesting patients visit for consultations more often than needed, and moving closer to the private health insurance sector to make ends meet. One French doctor, Dr. Sandy Salzman, stated:

“If I have a patient with high blood pressure I might see them once every 6 months, prescribe them appropriate medicine, tell them to contact me if anything changes-but

otherwise, see you in 6 months. Sometimes I'll see other doctors patients for various reasons and I'll ask, 'How often do you see the doctor?' They'll say. 'Every month.' Every month, with no charge? So there you have a doctor who's charging the system 5 times more often than me...and it's just because he's trying to make rent!" (Lopes, 1168).

Since France runs on a fee-for-service basis in regard to medical treatment, health personnel and hospitals are reimbursed based on the procedures they perform, rather than the type of care they give or packages of care received by patients' overtime (Crook, 2).

High prescription rates piggyback on the weaknesses within the system due to treatment of doctors. Though there is a system of cost-sharing (the government pays for most of the cost of prescription drugs) individuals must pay out of pocket for a small portion of medication if they do not have private health insurance (Thomson 4-6). This has reduced the price the government must spend on prescription drugs, but it has not stopped the problem of over prescribing and over medicating. On average 90% of medical consultations end with a prescription for some sort of medication, clearly indicating that there is a problem of over prescribing in France (Steffen, 364). This not only leads to an unneeded increase in government spending on healthcare, but it also may cause problems with a population that is being over prescribed unnecessary medication.

In France citizens have free choice of who they want their primary doctor to be, even if that doctor is a specialist. During recent reforms it was pointed out that having free access to all doctors was financially draining to the public sector. It was implemented that all citizens must register with one physician as their primary care physician; however, the reform did not specify

that it could not be a specialist and therefore still allowed individuals to choose a specialist as their primary care physician. The penalty for not registering is only a minor one, with individuals not getting as big of a reimbursement if they fail to register with a physician (Steffen 369). Citizens are free to choose where they go which ultimately costs the public sector an unreasonable and unneeded amount of money.

Public Health Insurance is by far Frances' greatest strength. With the turn of the 21st century France passed a new social welfare system that covered anyone registered as a resident in France after three months on the basis of healthcare. The program called *Couverture Maladie Universelle* or universal coverage act (CMU), was created in 1998 to fill the gap of healthcare coverage that included individuals who were not part of the three-income schemes stated previously. CMU also provided registered residents, free of charge, with complementary health insurance, which was on par with what working individuals could gain through benefit packages (Steffen 367). This program is meant to be anti-discriminatory against residents that cannot contribute to the French tax system. Participation in the CMU is based on legal residence in France and the level of income of the individual. If deemed qualified for CMU then all dependent family members will also be covered (Bellanger, S24). The French system focuses on not causing a "job lock" that forces residents to obtain or hold onto jobs for fear that they will not be covered with health insurance (Crook, 4).

Since France is a mixed-system in relation to financing, residents do pay for some out of pocket contributions; however, a high rate of citizens choose to have complementary health insurance and do receive money back for their out-of-pocket expenses. Reimbursement prices are fixed by the National Health Insurance program and received by patients in a swift manner. Anybody covered under the public health insurance will get some reimbursement based on the

medication that was prescribed and/or the medical service needed. All in-hospital care and most outpatient care are fully covered (Sandier, 154-155). Most French citizens decide to get complementary health insurance in order to cover the gap between what the national health insurance covers and what they are expected to pay. Lastly anyone who is diagnosed with a chronic disease is exempt from paying any out-of-pocket fees for care and medication; the National Health Insurance covers everything (Durand-Zaleski, 24).

The infamous *Carte Vitale* is the backbone of the entire National Health Insurance. This card, which resembles the look of a bankcard, holds all the medical, insurance entitlement, and information about a patient. Patients and doctors alike use this to eliminate the redundancy of paper work and make for faster transactions for reimbursement for both patient and doctor. During the early 1990's the *Carte Vitale* was introduced to the population and soon replaced the sickness card that was formerly being used, eventually saving the government millions of dollars that was wasted on administration costs, renewing of sickness cards, and problems with reimbursements (Campbell, 1). Today this is used as the primary card for patients who seek medical care.

**Reforms** The recent economic downfall has had a considerable negative effect on the French healthcare sector. With an increase in medical costs combined with a decrease in available financial funds, the French government has been forced to go into debt, creating a deficit in order to maintain its cherished healthcare system (European Commission). Government officials have been focusing on major reforms that are intended to help the French system gain better grounds in relation to financial, medical, and socioeconomic problems in the healthcare sector.

The last few years have seen a steady rise in the consumption of medical care and goods from 1995 to present. In 1995 the GDP for healthcare was 8.2 percent compared to the 11 percent in 2006 (Organization for Economic Co-operation and Development). This increase was mainly due to the addition of sick leave for citizens, increased management expenses of the healthcare system, collective prevention programs, and increases in medical research and training. This has gained the attention of individuals in power because there is fear that this will cause an exponential increase in healthcare GDP if it is not maintained in the proper way (Steffen, 364).

The problem of overprescribing has been deemed a threat to the healthcare budget in recent years. Not only do physicians over prescribe medication, but also they enjoy prescribing non-generic brands, which ultimately cost the government a great deal (Durand-Zaleski 27). It is estimated that 90 percent of general medical consultations end in a prescription for some sort of medication (Steffen, 364). In order to counteract this, the government set up the Public Health Insurance scheme in 2009, which not only gives monetary awards to physicians that reach a targeted goal for process of care of major communicable diseases, it also gives incentives for physicians to prescribe generic drugs, and focus on preventative measures as opposed to medication. Though this was a controversial topic for physicians' unions, it was accepted by 10% of the physicians three months after implementation in France. This scheme is still implemented today (Durand-Zaleski 27).

There have been key focal points that the current government has used in order to take a look at what possible reforms must be implemented. These focal points have led to the conclusion of categories in need of more government attention in order to better the current reforms which include: universalism, regulation, and the gatekeeping scheme (Steffen, 365-269).

## THE DANISH HEALTHCARE SYSTEM

**Structure.** The Danish Healthcare system is a fully funded government public system, with options for private insurance. The system works on a structure of decentralization; In other words the burden of maintaining the system is dispersed throughout regions, much like states in the US (Vallgarda 19). This allows for smaller areas to decide, on a regulated scale, how to tax and handle the health status of that section. Currently in Denmark there are five regions and 98 municipalities that are responsible for caring for the general population. These regions take part in regulating the number of practitioners and people employed in public hospitals, determining the size and cost of the hospital activities, and controlling which treatments, aid programs, and medical technology should be bought and used. These regions do not control tax rates, but do monitor the cost of healthcare within their specific boundaries (Vrangbeak 2). This gives the regions huge control over the healthcare sector.

The main government meets with all regions and municipalities, national ministries of health, and ministries of finance to decide on a yearly “loose” budget for healthcare expenditure for the current year. This type of resource allocation takes various factors into account in order to better decide what type of budget is needed. These factors include: age distribution (demography); number of children in single parent families; number of rented flats (real estate tax income); rate of unemployment; number of uneducated individuals; number of immigrants from non-EU countries; number of elderly; and number of people living in socially deprived areas (Vallgarda 73). These factors are standard throughout all regions and municipalities; however, they obviously each have different levels of influence from different factors depending on location and associated population in Denmark. Though this meeting sets out a budget for the

year, it is not legally binding and therefore can be changed throughout the year if needed and is handled by the national parliament.

The financing of the healthcare sector is mainly taken care of through public taxes. This is regulated in the regions, with the guidelines from the government, so as to fit the financial needs of the local area. The centrally-collected tax is roughly 8% of taxable income and is set aside for health and other various needs of the region in which an individual lives. This 8% is only a portion of a Dane's income tax, the rest goes to other societal needs such as education, transportation and insurance (Vrangbaek 29-30). This tax is just a portion of the tax that is taken out of every working Dane's earnings. About 8% of the tax goes directly to healthcare. Healthcare costs account for roughly 70% of the county/regions' expenditure per year. The personal income tax, which is the centrally-collected tax of all residents in the area, covers about 82% of the county's expenditure, which still leaves a gap in coverage of needs. The government makes up the remaining with 12% in grants and real estate taxes equaling 6% (Vrangbaek 29). Parents of children under the age of 18 do not have to pay for health examinations and dental if they are using the public sector; however, if their family has private insurance then a copayment may still be demanded.

Denmark's healthcare delivery system fits into three forms: 1.) The private practitioners, which includes GP's, Specialists, dentists, etc.; 2.) The hospitals are primarily financed by the regions and are responsible for patient care; 3) The municipal health services which includes nursing homes, specialists, physiotherapists, and general local healthcare services (Vrangbaek 28-29). Denmark also focuses on maintaining a strong gatekeeper system, which limits patient interaction with expensive treatment by forcing them to see general practitioners in order to gain access to more specialized, and expensive, medical professionals.

The healthcare sector is broken down into two types of groups. The first group is represented by the public sector and the second the private insurance businesses. Group one is the most widely used (99% of the population) because it is given free of charge to the general public. For this group a resident must register with a General Practitioner within in a 10km radius, use the local hospital in the area, and in return can expect free access to general preventive, diagnostic, and curative services. This sector is mainly funded through taxes and is regulated by the local regions and municipalities. Group 2 is less common (roughly 1% of the population) and is mainly made up of the private health industry. With this group residents have access to any General Practitioner they desire; however, they must pay for all services except hospital care in public hospitals. This group also allows residents to bypass the “gatekeeper” structure by not being required to go through a GP in order to seek advice from a specialist. Normally free excess to specialists can only be attained through a referral from a GP (Vallgarda 40). There are private hospitals in which residents from group 2 can go for care, but they only account for 1% of hospitals in Denmark. The general population uses public hospitals unless they have waited longer than a month for treatment, which then entitles them to free treatment at a private hospital at the expense of the Danish Government.

Denmark believes in the use of General Practitioners as key to keeping the cost of healthcare the lowest possible, as evidenced by their strong gatekeeping scheme. Currently 23% of doctors are General Practitioners, evenly distributed throughout the regions and municipalities (Vallgarda 57). Outpatient care is a strength of the healthcare system. This not only allows for a reduced hospital stay and lower hospital bills, but it also forces residents to be accountable for their own health. There have been visible improvements in patient health since the practice of greater outpatient care (Vrangbeak 3).

Denmark also puts a strong focus on preventative care, which also reduces the cost of healthcare. Preventative measures are taken to reduce the number of communicable diseases that greatly increase healthcare expenditures in both costing the system to care for the patient but also the higher chance of losing a tax-payer due to the illness. The lower their rate of communicable diseases, the lower the burden on Danish society (Vallgarda 46).

Technology is of importance in the field of medicine. Denmark has been scrutinized for being behind in some medical advances such as certain treatments and medical equipment. In order to answer to the public, the Health and Technology Assessment (HTA) was established in 1997 with the duty to promote medical technology and make assessments of what needed to be included in the Danish healthcare system. The HTA is responsible for evaluating and analyzing medical equipment, pharmaceutical products, investigations, treatment and care procedures, and health education and promotion (Vallgarda 69).

**Coverage.** Coverage is universal; all individuals legally residing in Denmark have access to the healthcare system regardless of external factors (Vrangbeak 1). Coverage is never denied regardless of external economic or social factors. The government works off the strong moral values that economic conditions should be excluded from the picture when it comes to deciding on healthcare coverage. The liberal or socialist view that all residents should have healthcare coverage has been highly treasured and protected inside the wall of the Danish political system.

Though in general there is free access to health care there are some restrictions that apply. These include:

- Assisted Fertilization is restricted to heterosexual couples where the woman is less than 45 years old (Vallgarda 29).

- Any treatments that are considered “Alternative” are excluded from the publically financed sector, though the private sector will cover some alternative treatments (Vallgarda 29).
- Expenditure on pharmaceuticals in hospitals is 100% paid, but outpatient drugs come with a co-payment of some sort (Vallgarda 40).
- Abortions are free of charge as long as the procedure takes place during the first 12 weeks of pregnancy (Vallgarda 44).
- If you belong to group 1 you will have no access to specialists without GP approval unless you pay a fee (Vallgarda 40).
- In order to benefit from the system you must prove that you are a resident and have a CPR number (government identification number). If a resident does not have a CPR number than care will still be given but the individual will pay out-of-pocket the cost of care (Vallgarda 30).

**Satisfaction.** Satisfaction among Danes in regard to healthcare is extremely high; 89% of Danes are satisfied with their hospital stays, 92% with their GP’s, and 94% with their nurses. Currently 90% are satisfied with their healthcare system in general, which is more than residents in any other EU member state (Vallgarda 17).

Danes express high satisfaction with their GP’s and the primary care sector in general. This is due in part because more Danes continue to have the same GP over an extended period of time allowing for personal relationships to blossom. The main cause for slightly less satisfaction than in the past with hospital care is largely due to the waiting periods for emergency care (which can last over 4 hours) and surgeries, not so much with the doctors and structures of the hospitals; however, these problems have been addressed in the recent reforms (Squires 1).

Though it is a positive outcome that Danes are satisfied with the healthcare they receive, it does bring some burden to the political divisions who are responsible for regulating the system. Patients in Denmark expect a high quality of care without paying more in taxes than already is demanded which makes reform more complicated. In the future Danes' reluctance to pay higher taxes could cause a burden on the healthcare sector because it will resort to major constraints on what residents will be happy give up in order to stabilize the system. There is fear that being asked to pay higher taxes will increase individuals deciding to rely on the private sector and loosing faith in the public sector, which is the only thing that keeps the public sector in such high use. Politicians will have a vast problem on their hands with dealing with the public's opinion on what their tax dollars should be paying for (Pederson 29-30).

***Strengths/Weaknesses.*** As with any system, there are strengths and weaknesses. Denmark has maintained the same healthcare structure more or less for a century, only making minor changes to counteract the change of time. Some of the major strengths of the Danish Healthcare system include: high respect of patients by medical professionals, easy access to primary care, very effective GP sector and primary care sector in relation to the gatekeeper scheme, and high degree of patient satisfaction especially with the primary care sector. Compared to international standards, the growth rate of health expenditures is also low in Denmark showing that healthcare costs may be monitored in a way that inhibits inflation (Pedersen13-14). The main strength within the Danish system is its ability to cover all residents with legal status in the country. Since Denmark is a fully public system care is given to all that need it, regardless of income or other distinguishing factors. This has lead to an extremely high satisfaction rate in relation to healthcare coverage among the countries in the European Union (Vallgarda 17).

Some of the major weaknesses of the Danish Healthcare system include: 1.) An increase in the aging population with fewer and fewer taxpayers supporting the system; 2.) Lack of fiscal sustainability in relation to Denmark's recent struggle to financially sustain the public sector; 3) The slow introduction of new treatment options within the medical community results in a lack of modern treatments available and lowers the life expectancy; 4.) Poor communication between public and private healthcare sectors leads to a dysfunction of collaboration, which could improve treatment and care for patients (Census 13-14). Many of the weaknesses that the Danish healthcare sector experience are a kin to those faced by other European countries with socialized medicine. Nevertheless in today's financial crisis, Denmark's healthcare deficits have remained stable unlike many other EU member states (Vallgarda 33).

**Reforms.** There have been few reforms in the sector of healthcare in Denmark since the 1970's, mainly in part because the general population has been content with the decentralized structure of the system. The Danish motto in relation to healthcare is: Equal access independent of economic means. Yet this goal is likely to strain the healthcare system in years to come, requiring reform (Pedersen 29).

Reducing the number of hospitals in order to increase specialization and reducing expenditures have been the major highlights of reforms the Danish government has implemented within the last decade (Vallgarda 50-51). The goal of the government has been to make the system more efficient; however, it is tricky to do when elected officials are afraid of making changes to a system with which the majority of the population is satisfied. There is also speculation that the lack of demographic development, an aging population with a non-substantial birth rate, in Denmark will cause a catastrophic strain to the economic sector of the healthcare structure since tax payers are essential for the system to function as it currently does

(Pedersen 16). However, the growth rate of the Danish healthcare system is increasing and is expected to increase by 20-35% within the next 2 decades, but this will not fully solve the demographic gap between the working and the retired (Pedersen 24). ‘

Healthcare analysts suggest three ways to counteract the affect that this increase will cause to the healthcare sector. First, Public out-of-pocket expenditure in certain areas needs to grow. This will alleviate the burden of the government using taxes for all medical coverage by forcing patients to pay a little out-of-pocket in order for tax money to be saved for more expensive forms of medical care. Second, tax revenues have to grow faster. Increasing the tax burden is essential for collecting enough funds to cover all that medical treatment that is offered to the public sector; however, with the Danish taxes already above 40% on average this is not very welcoming to tax paying residents. It is proposed that an annual increase of  $\frac{1}{4}$  % is essential in order to start counteract the growth in deficit in Denmark’s foreseeable future. Though this tax increase will help, it will only reduce the sustainability issue from 3% of GDP to 1.7%. Lastly, increasing incentives to get complementary insurance. This will allow individuals who are capable to get private coverage become less of a burden to the public sector (Pedersen 24-25).

The French and Danish healthcare systems are similar in the fact that they offer healthcare coverage to everyone and allow for a private sector; however, they drastically differ in how they regulate their individual healthcare systems. Having diversity between these two systems proves that there is not only one-way to run a socialized healthcare system.

## DATA AND METHODS

The intent of my research was to conduct qualitative interviews with French and Danish citizens to learn about experiences and attitudes on healthcare. I recruited individuals for my

study during my internships in both France and Denmark. In France I worked at a medical laboratory where I did basic lab procedures, shadowed doctors, handled patient records, and helped transport bio-medical material from different laboratories throughout Avignon France. In Denmark, I worked at a hospital where I shadowed doctors in the emergency room and cardiology division, aided in basic patient care, and transported paperwork between doctors. During my daily interactions with doctors, nurses, and others in these settings, I listened carefully to what individuals would say about their own healthcare and the healthcare system in general. I kept careful field notes on my observations and noted what I wanted to make sure I asked about in an interview. I wanted to be able to interview individuals who would represent a variety of opinions about their system, but found out that it was harder than I thought to get a person to consent to arrange an interview. Language was a barrier in France. I didn't speak the language well enough to interview individuals who didn't speak English. In Denmark, language was less of a barrier, but I was uncomfortable approaching many of the people I worked for, worried that I was somehow inconveniencing or bothering them. I used the connections that I made with the people around me, including my host parent, who I did interview, to find participants. Fortunately my status as a student did help as well.

My sample consists of two doctors, one nurse, one high level corporate executive, one sales associate, one real estate agent, two students, and an unemployed person. The average age of my interviewees is 38 years, but really the years form a bimodal distribution-4 individuals were in their 20's; 4 more were in their 50's; and only one was in her 30's. I interviewed both men (3) and women (6) and both parents (6) and non-parents (3). All nine of these individuals, whether French or Danish citizens, benefited from their country's healthcare system. All nine in my sample were entitled to receive at

least basic healthcare for free. Some of them (5) had experience with conditions or illnesses that required more than basic treatments. None of my interviewees were in poor health. Six interviews took place in personal homes, two at a hospital, and one in a university classroom.

Below is my interview guide that I used for my interviews. I came up with these questions after completing extensive research on both the French and Danish systems in order to formulate questions that would get at both how they use the system and how they feel about it. I also used a consent form and went over it in detail with each participant prior to starting the interview (See Appendix A).

*Questions:*

1. Do you have children? If so what are their ages?
2. Are you a grandparent?
3. What's your occupation?
4. How would you describe your general health?
5. Have you had any major surgeries or health related illnesses?
6. How often do you go to see your General Practitioner?
7. Overall, how much have you used the healthcare system in the past year?
8. How much do you pay out of pocket for the healthcare you receive?
9. Do you like your GP doctor?
10. Has the healthcare you've received met your expectations?
11. If you have children/grandchildren does the health care they have received meet your expectations?
12. If you have received any special care (pregnancy, disability, etc.) how did you feel about those services?
13. What changes would you like to see with regard to:
  - Your General Practitioner?
  - Preventive health measures?
  - The hospital/ER/surgery care?
  - The system in general?
  - The way the health care system is financed?
14. Are you a health professional?
15. How much interaction do you feel you have with the healthcare in (Avignon/Copenhagen)?

16. As a person in your occupation how do you feel your role in this occupation plays into the healthcare system?
17. Are you at all familiar about different forms of health care in other countries? If so what do you know?
18. Are there any other comments that you would like to offer?

## FINDINGS

In this section, I use quotes from my interviews to illustrate citizens' perspectives and experiences. In order to protect their identities, my respondents were given pseudonyms. By way of introduction, I have listed the five French participants and the four Danish participants, along with their pseudonyms and a brief summary of some relevant personal characteristics at the beginning of the findings section for each subsample.

### *Introduction of French interviewees:*

*Yohann*, male age 23, is an unemployed French citizen with no college education. He is healthy and does not currently take any medication. He is single with no children. Yohann is generally happy with the French healthcare system.

*Lucie*, female age 27, is a real estate agent and is a French citizen. She is healthy and is six months pregnant. She currently only take prenatal medication when needed. She is married with no other children. Lucie is content with the French Healthcare system.

*Jean-Pierre*, male age 52, is a registered and practicing Osteopathic doctor and physical therapist in France. He is in good shape and does not take any regular medication, but does see the chiropractor every few months. He is married with two teenage children. Jean-Pierre is relatively content with the French Healthcare system, but does think it could use some improvements.

*Sophie*, female age 56, is a registered practicing physician in France specializing in biological analysis. She is in good health and does not take regular medication. She is married to a general practitioner and has two sons, both studying medicine at university. Sophie is generally content with the French Healthcare system.

*Edith*, female age 32, is a sales associate at a local electronic store. She is in good health and does not take regular medication. She is single with a seven-year-old son. Edith is content with the French Healthcare system.

**Structure.** The structure of the French healthcare system is a very complex one, leaving few that truly understand it without having to do some basic research; no one in the French sample offered to explain the system to me, though there were times when I asked for clarification or admitted confusion.

**Coverage.** The French Healthcare schemes are vital for regulating taxes and payments for healthcare throughout France. One of my interviewees talked about how she had to get medical care for her young son and did pay out of pocket; however, she was fully reimbursed because she was part of the *General Scheme* in France. Edith stated: “I have not had any health related issues; however, my son had to be hospitalized for bruising on his knee that required drainage when he was two. Someone came to our house to change his bandages after we left the hospital. I had to pay a bit out-of-pocket but it was so little that I don’t even remember, but I was reimbursed since I am a worker in France.”

One of my interviewees, Yohann, who was unemployed at the time of our interview, shared his experience with the universal Medical Coverage Scheme (*Couverture Medicale Universelle*) which covers individuals who are unemployed. Yohann enthusiastically explained: “I almost lost my finger when I was trying to make a bow and had to get it surgically fixed. I went to a clinic that specialized in hands. I had cut through a 3<sup>rd</sup> of the tendon and they were able to fix it completely. I had to pay a little bit out of pocket, since I’m unemployed, but it was so minor that I don’t even remember the cost.”

Many of my interviewees briefly expressed their high satisfaction with the care that their children had received. As stated in the literature review, children in France have unlimited access to the public healthcare system, but may also be covered under their parents’ complementary

insurance. All of my interviewees who had children did have complementary coverage for themselves as well as their children. When asked about how they felt about their children's medical care, all of their responses were positive. Lucie stated: "Yes, I am very pleased with how well my unborn baby has been taken care of. My prenatal care has been excellent!" Jean-Pierre: "I am very satisfied with the care that my children have received. My daughter had her appendix removed two months ago and it went very smoothly." Sophie: "Yes, but since my husband and I are doctors we are typically able to treat our own children, but when we have had to go to specialists for them, the service and care they received was excellent." Edith exclaimed: "Yes, the healthcare that my son has received has always met my expectations."

The questions that were connected to healthcare coverage resulted in positive replies from the individuals that I interviewed. My interviewees expressed an overall high level of contentment with how the French healthcare system decides how to medically cover French residents.

*Strengths/Weaknesses.* My interviewees mentioned as a weakness of the French system the lack of adequate monitoring of doctors' prescriptions and consumption of medical treatment. These were also among the most prominent weaknesses in the French healthcare system that were discussed in the literature. When interviewing my interviewees I got many responses in relation to what they felt were weaknesses in the system and most correlated with the research. There was an expression of high concern in relation to over consumption of medical treatment as well as tax money being wrongly implemented into the healthcare system. Their statements in relation to these topics were as follows: Yohann: "I would like the country to stop spending so much tax money on medications and drugs that are not needed and spend more on prevention and not just treatment. I feel that the government spends too much on new medical technology

and other forms of material things that are not completely necessary in my eyes.” Jean-Pierre offered: “There needs to be more education to explain to people that they are really paying for the healthcare through taxes and if it’s abused we pay more. We can pay less but we need to educate the French people that it is not free so it does not disappear. It’s not a simple structure and I feel that it needs to be simplified. I pay 1000 euros a month in taxes and would not complain about it if I felt that the money was being put to good use, but in my opinion it is not in relation to the healthcare structure.”

Sophie: “I feel that the money is being used in the right way, but people don’t realize the cost of the tests that they demand to have. I think that this is dangerous because someday there will not be enough money to cover costs anymore. I feel that people are abusing the system without knowing it because they don’t know the costs. I also feel that more attention and tax money should be used towards preventive treatments because in the end it will save the government more, instead of just spending so much money on unnecessary prescriptions.” Edith argued: “I feel that the government doesn’t use the tax money well. I feel that the money needs to be spent on hospitals and emergency care, but instead it is spent in ways that I don’t think is right. There is not enough staff in hospitals and I feel that the tax money should be spent on getting more health professionals in the hospital settings.”

The French Healthcare system is statistically proven to be the best in the world since the World Health Organization did a statistical test in 2000 claiming this. Though my interviewees did have much to express in relation to the weaknesses in the system, they were also quick to give their opinions on what they thought were strengths within the system. In their views, the strengths of the French system had to do with complementary care, full coverage for the chronically ill, and the famous *Carte Vitale*. Some examples of how they viewed this strength are

as follows: Yohann explained: “My mother had terminal cancer and the system took care of her. We as a family did not have to pay extra for anything. I like the fact that if you have a chronic or terminal disease you are taken care of 100% regardless of your situation.” Lucie: “Since I have complementary health insurance I pay a little upfront when I go to the doctors, but I always get reimbursed within a week. I do have the *Carte Vitale* which is the public healthcare, but I have my own extra too so I pay less out-of-pocket and can go to special clinics for my baby and me. I love having complementary coverage.”

Sophie: “The *Carte Vitale* is a good idea and is a small card that is used to keep patients records. This makes it impossible to make a mistake in the records and that we know that the patient is who they really said they were. This also allows patients not to pay in advance, although some physicians still require their patients to, but we don’t at my practice.”

**Reforms.** Reforms have always been a major component to any type of healthcare system because without them there would never be any change. As discussed in the literature review the French Healthcare system’s reforms in recent years have focused on reducing the deficit, lowering the prescription rate, reducing medical care consumption, and focusing on preventive health methods. When I asked my interviewees questions pertaining to the changes they feel need to be included in the reforms, I got a variety of answers. Their responses included offering better health education, stopping abuse of the system, reducing prescription intake, and restructuring hospitals, emergency settings, and better integration and regulation of the public-private sector. My interviewees had the following to say about their idea for reform: Yohann: “Better health education! I feel that we spend a lot of energy on sex and not other issues like smoking, hygiene, etc. I worked in the food industry for some time and was not impressed with how people did not practice good hygiene skills. In France it is normal not to use gloves when

handling food. I would also like to see more emphasis on preventive care and natural cures for health. I hate that we as a country believe in taking pills all the time.”

Yohann also had this to say in response to emergency care reform: “The ambulance services must be changed. They are separate from the hospitals. In my experience with my mother I was not impressed with how they don’t deliver good service and are paid regardless. They also have control over your ability to change ambulance services and to me this is totally unjust.” Jean-Pierre stated: “I think that we should have better preventive measures for both old and young. I feel that in my path of medicine it is vital to help patients with understanding preventive health measures. I also feel that in the French system we just give out pills and medication; this really needs to change.”

Jean-Pierre also had this to say in response to emergency/hospital care reform: “I feel that there should be more restrictions on who is allowed to go to the emergency room for free. It is abnormal for people who live on the streets to go to the hospital regularly even when they do not have any serious health problems. I think that people in this condition and in general need to be educated that these places are for physical medical problems, not emotional/mental issues. There needs to be a better separation of these medical needs.”

Sophie: “I think there is a lack of health professionals in general, but conditions of work in the ER and hospitals are not as interesting as they used to be and this makes people not interested in working there. Health professionals are paid less to work in these areas though this is where they need to be. The government makes it so there is a shortage, but there is a global lack of physicians and France is not exempt from this.”

Sophie also had this to say in regards to the healthcare system in general: “I feel that the French healthcare system was the best in the world, but is now getting into a more 2 split system. There is becoming a gap between the poor and the rich and what they are able to receive due to care. There are two: Sector 1 is linked to the S.S. and sector 2 is for people who have complementary insurance because it charges more than the prices set by S.S. I think that there is a huge gap that is slowly being created that allow people who can buy complementary healthcare to receive good care and the ones who can't don't get the same treatment.”

Edith: “I think that more people need to be working in the ER's and hospitals. I feel that people have to wait a long time and this is a known fact all over France. The countryside is the place that suffers the most because the doctors flock to the cities. I don't think it's right that anyone not be able to get adequate health attention regardless of where they live.”

Unfortunately many of my interviewees were not too familiar with the current healthcare reforms going on in France of late, but their responses on what they feel needs changing shines a light on what may need more attention. There were obvious patterns in the responses that I received, which may indicate where the French healthcare system is failing in the eyes of French residents.

**Satisfaction.** I was particularly interested in discovering my interviewees' perceptions on how well they feel that they have been treated in the French healthcare system in relation to their own medical experiences. Since the rate of satisfaction with the French healthcare system is relatively high, I concluded that investigating their feelings towards their general practitioners and medical care situations was essential.

When asked how they felt about their general practitioners and medical care the responses were all positive. For example, Yohann said: “Yes I am satisfied with the care I have gotten. I don’t feel that I have been shorthanded in any way. I like my GP very much and I have known him since I was a child. I have never felt rushed and he always takes the time to answer my questions. He has always been a fast worker but I have never felt rushed.” Lucie said: “Yes I am very pleased with how I have been cared for in France’s Healthcare system. Since I am pregnant I have a special prenatal care physician that I see. I really like her. I have never felt rushed or made a non-priority. All of the doctors that I have been to made me feel comfortable and were able to answer my questions. I also like that there are clinics set up for women and children in France and that I don’t have to pay extra for these services!”

Jean-Pierre: “Yes I have been relatively pleased with the healthcare that I have received.”  
Sophie: “The healthcare that I have received has been up to my expectations. I have never had an issue with it.”  
Edith: “The healthcare that I have gotten has always met my expectations. My doctor is very good about answering my questions and I never feel like I can’t ask him something. If I didn’t like my GP I would just change it, we are allowed to do that in France, but I have never had to do this for any reason except moving to another place.”

It was very obvious that they were all on a general scale very satisfied with both their relationships with their general practitioners and the level of medical treatment that they received. This finding parallels France’s statistics in regards to high levels of satisfaction among French residents that was discussed in the literature review.

***Introduction of Danish interviewees:***

*Camilla*, female age 21, is a student in Denmark who is studying Disaster Relief. She is single with no children and has no major medical problems or is taking any medication. Camilla is generally content with the Danish Healthcare system.

*Madsine*, female age 21, is a medical student in Denmark. She is single with no children and has only minor medical problems when she was young pertaining to her appendix. She does not take any regular medication and is generally content with the Danish Healthcare system.

*Cita*, female age 57, is a surgical nurse in Denmark. She is married with three children and 2 grandchildren. She has not had any major health problems and does not currently take regular medication. Cita is generally content with the Danish Healthcare system.

*Lars*, male age 52, is a CEO of an IT division of an insurance company in Denmark. He is married with 2 children. He has had on going problems with his back and an allergy to general anesthesia but does not take daily medication; all in all Lars is in good health. Lars is moderately content with the Danish Healthcare system, but feels there is room for improvement.

**Structure.** The structure of the Danish healthcare system is complex, yet understandable to the average citizen. When I conducted my interviews I was especially interested in learning about their knowledge of the system that they live in and depend on for their own health. I felt that understanding the level of comprehension that my interviewees had of their healthcare system was of great relevance to my research.

In general all of my interviewees had a good basic idea of how their healthcare system worked, especially the individuals who have a direct tie to the medical field. When asked about how they liked the structure of the healthcare in Denmark and if they feel that there is anything that needs changing, Camilla stated: “I don’t really think so [in relation to changes she felt needed to be conducted in the healthcare sector]. I like how it’s structured for the most part.” Cita stated: “Not in general [in relation to changes she felt needed to be conducted in the healthcare sector]. I think that we have a very good healthcare system right now. Politicians should have the courage to point out what we are going to do about certain treatments and making decisions.”

Both Cita and Camilla expressed contentment with the system. Cita expressed concern for the politicians fear of the general public, which is something discussed in the satisfaction section in the literature review. This further exemplifies the high satisfaction rate that Danes have which leads to current politicians fearing any type of healthcare reform.

Camilla and Madsine's responses expressed more detailed opinions about some changes that they felt should be incorporated into the structure of the Danish Healthcare system, though on a general scale they were still relatively content with the system. Their concerns shined a light on some of the main problems that are being handled in the recent reforms on healthcare in Denmark. For example, Camilla stated: "Even though I am pretty content with the healthcare system, I think that funding needs to be rearranged in order to get faster care in emergency settings." Madsine said: "The system could be more involved in research and be more apt to use other countries' research, especially towards vaccines. Denmark is very far behind, for example the HPV vaccine just now became free in DK for citizens." Madsine (again): "I think that treatment of rare diseases is not very good. Neurological diseases, etc. are not properly treated because Denmark doesn't have the means. The Danish healthcare system is so bad at using outside research because there is a feeling that they don't meet Danish standards; that's unfortunate. Danish standards are too high compared to the outside countries."

Madsine's points correlated with the points made about the advancements in medical technology that were described earlier in the literature review. Madsine is not alone when she suggests that there is more that the government should be doing to bring Denmark up to speed with the rest of the EU and Western countries in relation to disease treatment. The Health and Technology Assessment team in Madsine's eyes has underdeveloped its assessments in relation to what new treatments and technology may be needed in the Danish Healthcare system.

Preventive care is something that Denmark does take into consideration when it comes to structuring programs, advertising, and taxes on certain goods and materials. When asking my interviewees about their opinion on the current efforts of the healthcare system in relation to preventive methods and what they feel should be changed their responses indicated they had strong opinions. Camilla said: “I think we have some problems with the salt intake (eating habits); the only health issues that we [Danish population] care about are the ones in the media right now. Politics should focus on what are the actual health issues in Denmark and not just what people want to hear.” Madsine: “I think there could be more campaigning. The alcohol consumption that the Danes have is higher than what is recommended. This is dangerous.” Lars: “I feel that the healthcare system does a good job in moving away from tobacco. I think alcohol is advertised a lot in relation to how much you should drink until it is unhealthy. I don’t think we can do much more about it. There is a lot of tax on alcohol already, but our young people drink a lot, more than the rest of the world and we need to do something about it.” Cita: “I think there are a lot of good things being done about drinking and smoking. I do think we need to do more about obesity. I don’t agree with the surgery being done in order to reduce people’s size, like in America.”

It is clear that there are shared concerns among my interviewees. Obesity or diet and alcohol consumption were what they felt needed to be addressed. In relation to alcohol consumption, the older generation felt that this was being dealt with as best as possible which was an opposite response compared to what was concluded from one of my younger interviewees, Madsine. Diet and health were touched upon as in both the form of obesity and in daily diet, but both had the conclusion that more needed to be done to make Danes a healthier population. On a positive note tobacco use in the eyes of some my interviewees seems to be

decreasing thanks to preventive propaganda, leading to fewer individuals consuming carcinogens and other toxins that lead to costly diseases. Though the Danish healthcare system proudly states that they focus greatly on preventive measures, my respondents expressed concern over issues that are not addressed in the current programs and feel that they really should be.

**Coverage.** Coverage for healthcare is accessible by everyone who is legally residing in Denmark, regardless of tax contribution, economic status, gender, and nationality. Though Denmark runs its healthcare system in a predominately public sector, as stated in the literature review, there is a private sector as well. The balance between both of these sectors allows for coverage to be monitored, maintained, and working in a functional manner. When I conducted my interviews I was particularly interested in documenting their opinions about how the Danish healthcare system uses resources to cover residents and what type of health coverage they receive. As stated in the literature review, there are restrictions to where tax money will be spent in the healthcare sector in order to maintain fair grounds for the citizens. Lars expresses his opinion about one of these restrictions, further proving that this restriction may be accepted by Danish citizens. Lars stated: “We need to prioritize what we are going to treat and what we are not going to treat. I think that we could spend twice the amount that we currently spend if we don’t start prioritizing things. For example: Infertility should not be free, the taxes should not be used for these types of treatments.” Lars raises a relevant concern in relation to where taxes are being put to use in the healthcare sector and shows contentment in the decision of the government to restrict certain treatments from being covered under the public sector. These individuals who fall under the category of needing infertility treatment have the option to get complementary health coverage and seek medical attention at a slight out-of-pocket expense.

When asked about the need to pay out-of-pocket for treatment when they go to their doctor it was almost a joke question to all of my interviewees; to them healthcare comes out of their taxes not their personal finances. Some of my interviewees did state that they had complementary healthcare coverage to help ease the burden of expensive alternative medicine, such as chiropractic care and dentistry work. All of my interviewees were covered under group 1 in the healthcare sector, though some had complementary private insurance to supplement. According to Lars, “ I pay nothing unless it is the dentist, it is very expensive to go to the dentist. When I had a back problem, I consulted my GP and he guided me to the local hospital. I had a really good treatment though they couldn’t do the treatment in due time. I had to use my private insurance because it took too long a time to have the surgery in the public sector.”

Camilla: “I pay nothing to go to the doctors.”

Madsine: “I pay nothing when I go to the doctors. I don’t have to pay anything.”

Cita: “I don’t pay anything, unless I get a vaccine.”

When discussing out-of-pocket costs with my interviewees I was given the impression that it was an unthinkable possibility that they would be required to pay anything outside of the taxes required by law for healthcare coverage. All of my interviewees were very content with the group 1 healthcare sector and felt that having to pay extra would be unethical and against their right to be covered by the government.

**Satisfaction.** One of the most satisfying aspects of medical care for most Danes is the care they receive from their general practitioners. Since Denmark has such a high functioning gatekeeper scheme, General practitioners are among the medical professionals that most Danes come into contact with on a regular basis. All of the individuals whom I interviewed had been

with their current general practitioner for at least 3 years. When asked about their satisfaction level in relation to their general practitioner their responses were, Camilla said: “It’s been good. It’s just how I would have expected.”

Madsine: “I’ve been very satisfied with my care. All the times I was admitted (to the hospital] I was taken care of. I do think that when my appendix burst my GP should have known what it is; however, since I had stomach problems before it was not really his fault.”

Cita “I have never had any problems. My care has been good, but I sometimes (if I had a problem with emergency care) I would just go to a secretary because I work in the healthcare system and have in’s. I sometimes get past the waiting lists for care.”

Lars: “Yes so far. My GP is a very good doctor and has helped me with whatever problems I have had.”

It is obvious that my interviewees expressed a high satisfaction rate in relation to their general practitioner, further backing up the literature and statistics of Danish people’s attitudes towards the primary care sector. Madsine’s remark about doctor mistakes further expresses the Danish attitude against understanding that doctors are able to make mistakes.

***Reforms: Expressing the weaknesses in the system.*** When my interviewees were asked about the current reforms that have been going on in Denmark there was very little that they were able to provide in relation to the subject. However, they were able to give feedback on what they feel needs to be addressed in the present and future in order to protect the system. Camilla: “I would like it [public sector] to go faster, you have to wait a long time in order to get care sometimes. I think it’s an underfunding problem. I do really like the system, but I think it’s flawed in a lot of ways also. Right now we have the whole private and public problems. It means

if you are a regular person and can't afford treatment from private practice, then you must wait for the public sector. I think that people should have treatment as fast as we can get them in and not have to wait for a month guarantee in order to get treatment. This needs to change. I think that funding needs to be rearranged in order to get faster emergency care.”

Madsine: “There is a lot of waiting. Sometimes like 4 hours and it is not optimal, but I know that there is some changes being made [about this]. I don't think it's fair that people have to wait that long.

Lars “I would like centralizing of hospitals in order to allow for more efficient care. Possibly have more helicopters to transport people. There should be departments that specialize in a medical area, such as cancer. I like our system in general, but we need to think about the healthcare sector as a whole. If we want a private sector I think that it needs to be integrated in with the public sector and I feel the government has a huge role in this. We can't undermine the public sector by putting on a private sector that will only take profitable parts of the healthcare sector. This could be a problem for our society but on the other hand there is a lot of good that this type of system can do if it is integrated correctly. It is not integrated today and I am not satisfied with this. The public sector makes things difficult to perform certain treatments and I don't think this is right. From my knowledge the private sector would very much like to be integrated into the system.”

Cita: “I think that private healthcare is not old in Denmark. More and more people are getting private healthcare but I think that it is an issue. I am fearful that it will become more like an American type system. Everybody can get help now and there is no fear of helping people like there is in the U.S: it's not good to live in a system where you can't just help other people.”

There was unanimous agreement in relation to the importance of regulating the private and public sector, reducing waiting times, and maintaining the moral obligation to cover all residents regardless of their economic situation. Their responses expressed concern with the current weaknesses in the healthcare sector in relation to poor communication between the healthcare sectors and the unreasonable waiting times in the emergency wards. I think it's also important to point out that there was concern about their healthcare system becoming more "Americanized" which threatens their contentment and security in knowing that they will be covered for any medical problems that they may encounter.

*Interviewees' perspectives on other healthcare systems.* When asked about other nations' healthcare systems, my interviewees had opinions. Cita, from Denmark, wasn't too sure whether she really knew the truth about healthcare in other nations. When asked if she had an opinion, she said: "Yeah to some degree, but I don't think that anything I know is relevant. I've heard stories from people who have lived abroad, and the stories are usually horrible stories that make me really grateful for the Danish system." Her response was similar in relation to the majority of the responses that I received. Yohann, from France, had a similar response when asked about his knowledge of other systems. When he was asked if he had an opinion on the matter he stated: "I don't really know much. I know a little about how much trouble the USA is in but that's about it." There was not a single interviewee that expressed a desire for a healthcare system other than their own, indicating that there was a rate of high contentment regardless of the flaws in each system. Both the French and Danish interviewees had the same opinions in general, and many made comments about the horrific state the USA healthcare system was in.

## DISCUSSION

***Comparison of Both Systems:*** Healthcare systems are complex and expensive, filled with bureaucratic rules and regulations. Understanding and analyzing them proves to be just as complicated as the systems themselves. Through my research I tackled this challenge in a manner that allowed me to get through the “red tape” of bureaucracy and present an analysis of two distinct socialized healthcare systems. In this discussion I will highlight some of the main take away messages from my findings as well as express how the value of learning about socialized healthcare may be beneficial for America.

Problems are a major aspect of any nation’s healthcare system. As discussed in both the literature review and findings on the French and Danish systems there clearly are areas that need improvement, mostly in relation to expenditure of taxes, waiting time for medical care, preventive programs, and structure of the private-public sectors. Although the French and Danish systems are different, they both function on the basic foundation of universal coverage for citizens and therefore their structural problems rise from the same roots. Reforms in both countries have tried to address the major problems that the governments deem top priority. My findings however alluded to the idea that these reforms are not fixing what the consumers feel is necessary. My French interviewees expressed dissatisfaction with the high level of abuse of the system by individuals who do not understand the cost of their medical care and who may not need the care at all. This not only causes a potential increase in taxes, but it also wastes valuable medical care that could be used for individuals who need it. Current reforms in France are not focusing on reducing this by implementing a gatekeeper system, which would reduce the access to specialists and other forms of expensive medical care. French citizens feel a sense of entitlement to healthcare and therefore without being regulated allows overuse to occur; having a gatekeeper scheme would better manage the use of the medical sector.

Unlike in France, Denmark has a great gatekeeper system, but does not lack its share of problems. My interviewees were limited in their knowledge of current reforms that were occurring, but were able to give feedback on what they felt needed to be changed. The patterns that arose from their responses hinted to a degree of dissatisfaction with the communication between the public and private sector. Denmark currently lacks the management skills that are essential for integrating these systems which causes a lack of cooperation between the groups. Even though Denmark has full medical coverage for legal residents the increase in waiting times, restriction to alternative forms of care, limits on what is covered, and lack of ability to seek specialists independently entices individuals who can afford the private healthcare to purchase it, leaving an increasing gap between the wealthy and poor. Fears of a path towards an American form of healthcare was hinted at in my interviews with Danish citizens.

The strengths of the both the Danish and French healthcare systems by far counteract the problems. Both countries focus on a value stance that healthcare should not be restricted to the individuals who have the means to pay and make it as close to fair as possible in regards to taxes. The idea of making schemes or groups that fully cover anyone legally residing in either country is a government policy that few countries, outside ones who also have universal coverage, can proudly state. The strengths that French and Danish systems express show that a country can function under a universal healthcare system.

According to my interview data the strengths out weigh the problems. This is clear through talking to individuals who live their lives within these socialized countries. Literature can be misleading in terms of correctly analyzing whether weaknesses override success, but having personal experiences usually gives a different outcome. Yohann's personal experience with France's approach to the chronically ill patient is a prime example of this. When his mother

was ill with cancer the thought of finances was never discussed, instead the focus was entirely on the health issues that lay ahead for Yohann's mother, something that would be last on the list for an American citizen. France dismisses all policies in relation to payment when someone's health is in a crucial state, and though there are high taxes and some out-of-pocket expenses in France, these regulations never get in the way of someone getting life altering treatment. Instead of stressing about financial issues in relation to health, French citizens get the gift of spending their time and energy entirely on themselves and their family members, something that is irreplaceable.

Denmark also has a policy identical to France's in terms of the chronically ill, but likewise has its own unique evidence to prove that its strengths outweigh the weaknesses. Being predominately funded by the public sector, Danes have a strong influence over how healthcare is handled. Furthermore, Danes also express a high sense of societal commitment. Through personal interactions with Danish residents it's no secret that they are grateful for their healthcare systems, regardless of the current problems. Cita, a Danish student, expresses her feelings towards other non-universal healthcare systems by stating: "I've heard stories from people who have lived abroad, and the stories are usually horrible stories that make me really grateful for the Danish system even with its flaws." Finding statements like this from individuals who currently live in the Danish system demonstrates the low importance that the problems of the system have when compared to the overall picture. Universal healthcare does come with disadvantages, but they are minuscule in comparison to what is gained by living in a society where one knows that their health will always be taken care of.

There was also a clear relation in both countries in the responses that were gathered pertaining to opinions on other systems. Part of my research was to find out if Europeans felt

satisfied with their current healthcare systems and to discover how they felt about healthcare systems outside of the European Union, in particular the United States. Many of my respondents were not able to give knowledgeable responses on their understanding of other healthcare systems. There were many comments, however, comparing their system to the U.S. Often when interviewees would discuss problems that they would like to see fixed in their system, it resulted in expressing fear of it becoming more *Americanized*.

My findings give first hand interpretations of how both the Danish and French Healthcare systems are perceived through the individuals who use the systems routinely. These personal interviews add just that, a personal touch. Consulting literature can bring one a long way in relation to getting a feel for how something, like healthcare, works but being immersed in the culture allowed me to gain a greater comprehension of select socialized healthcare systems like the kind in place in Denmark and France.

***Feedback for the American System:*** This thesis purposefully did not detail the healthcare system in the US. My goal was to focus on two specific socialized healthcare nations so that my knowledge of what socialized healthcare meant to it's users would increase, and I would gain a fuller understanding of what it would be like to live in such a country. Socialized healthcare in general is not a perfect system, but the basic human right that every individual deserves health care is never threatened. I feel that in America we don't have this value and have pushed basic human needs onto to responsibility of the individual. Health is not always something that can be controlled, protected, and predicted which leads to a high level of uncertainty on how much we can rely that one will be healthy. How is it then that we feel that health can be controlled and that in the eyes of society should not be anyone's responsibility but the individual itself?

***Why choose qualitative field research:*** I choose to do qualitative field research because it would permit me to immerse myself in the culture that I was studying. It also allowed me to gain data from a more personal perspective than what I would have received from questionnaires or just simply a literature review. Since I was participating in internships in the medical field of both countries I felt that doing personal interviews would enhance my interpretations and findings of the attitudes of the individuals living in the healthcare systems I was interested in. My research was based on getting primary sources that could help me gain some insight into the truth about the levels of satisfaction and contentment of people who deal with socialized healthcare. I felt that qualitative field research was the obvious and best way to gain this type of data. Lastly it allowed me to build personal relationships with the people that I interacted with, giving me a deeper connection to the systems that I was studying.

***Limitations of the study:*** The limitations of my study may have affected the results. Since I was traveling to countries where English was not the first language, I had to deal with communication issues which resulted in a bias in my results. I am not a fluent French or Danish speaker so all of my interviewees had to speak fluent English, which only comes with some higher level of education. This may have excluded individuals who were less educated, older, and lacked the ability to learn English, and people who were immigrants to both countries who did not speak the national language or English. In both countries I was stationed at one location and did not travel far from my residence to find interviewees. This may have lead to a bias in my results based on location. Lastly I have a very small sample size. This may have been the greatest limitation because having such a small sample size inhibits the ability to make bold statements about either system. My sample sizes for both France and Denmark were too small to safely conclude that I have an accurate representation of either nation's attitude towards socialized healthcare.



## APPENDICES

### APPENDIX A

#### Informed consent

In order to comply with the Human Subjects Committee guidelines of conducting personal interviews, interviewees were required to sign an informed consent form. Before each interview I carefully went over the logistics of my research and emphasized that their identity would be kept confidential. Below is a copy of the consent form that I used. The consent form was changed to represent Danish healthcare before I conducted interviews in Denmark during the summer of 2012.

**June 2011**

**Dear Research Participant,**

I am an American undergraduate student at Alfred University in Alfred, NY. Currently, I am interning with the WISE ABROAD in Avignon and conducting research on attitudes toward health care among the French. I am inviting you to participate in my research, "*The French and Danish Perspective: An Exploratory Study of Attitudes*," by consenting to an interview about your health care uses and attitudes. The purpose of this research is to better understand France's current healthcare system through the eyes of the people who use the system. With the changes that are happening since the passage of the healthcare reform legislation in the U.S., I desire to learn and experience as much as I can about other systems to expand my knowledge about healthcare programs and policies in general, as well as shed light on these timely issues through the perspective of the people using the healthcare. Through this research, I will learn how the French feel about their healthcare options and compare their views to what Americans think they know about government-run health care.

This research will involve your participation in an interview with me that will take place in a location to be mutually determined. The interview should last approximately 30-45 minutes. I will ask for your permission to tape-record the interview. If you choose not to allow me to tape record the interview, I will take down your responses by hand in a notebook.

#### **Confidentiality**

*The information I gather will be kept strictly confidential. Nothing that you tell me in the interview will be shared with anybody else except my faculty advisor/sponsor of the research. In the final research paper that I produce nothing will be attributed to you by name. Each participant will receive a copy of the final research paper if so desired. Furthermore, this proposal has been*

*reviewed and approved by Alfred University's Human Subjects Research Committee, a committee whose task it is to make sure that research participants are protected from harm.*

### **Informed Consent**

- I understand that the Human Subjects Committee (HRSC) at Alfred University has approved this research for the Protection of Human Subjects in research
- I freely and voluntarily consent to participate in this study and no penalty will be implemented if participation is refused
- If I consent to this study, I may discontinue participation at any time.
- I confirm that no coercion of any kind was used in seeking my participation in this research project.
- I understand that if I have any questions about this study, I can contact the following individuals to discuss my concerns confidentially.
  - Dr. Karen Porter, Honors Thesis Advisor
    - (607)-871-2215 , [fporter@alfred.edu](mailto:fporter@alfred.edu)
    - Division of Social Sciences, Olin, Alfred University
  - Dr. Danielle D. Gagne-Chair of the Human Subjects Review Committee
    - (607)-871-2213, [hsrc@alfred.edu](mailto:hsrc@alfred.edu)
    - Division of Psychology. Science Center, Alfred University
- I certify that I have read and fully understand the purpose of this research project and its risks and benefits for me as stated above.

Print Name of Participant \_\_\_\_\_

Signature of Participant \_\_\_\_\_

Date \_\_\_\_\_

*Thank you for your time and interest in my research project.*

*Sincerely,*

*Marissa Ray, Principal Investigator [mnr1@alfred.edu](mailto:mnr1@alfred.edu)*

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