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# Perspective

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## Physician Payment Reform: Lessons From Abroad

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by Victor G. Rodwin

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William A. Glaser (“The Politics of Paying American Physicians,” *Health Affairs*, Fall 1989) argues that the design of a physician fee schedule is “inherently political” and that payment reform in the United States would be more successful if we recognize this fact and establish European- or Canadian-style negotiating machinery between the medical profession and the federal government. Glaser gives short shrift to those who do not share his views. He says that “several years were wasted in study commissions and research projects to study all policy options.” And he calls the Harvard effort to devise a resource-based relative value scale (RBRVS) “misconceived and impossible.”

Glaser is a pioneer in comparative research on health systems in Western Europe and Canada. His Commentary is refreshing because he examines the “big picture.” Glaser’s argument relies on three implicit assumptions, however. The first is that European and Canadian approaches to physician payment have no significant flaws. But they do. The second is that these approaches could have been adopted in the United States. But they weren’t, for reasons that Glaser’s own diagnosis might have led him to anticipate. The third assumption is that the United States is not “unique.” But this view is inconsistent with Glaser’s initial insistence that the United States is the only country with neither standing negotiating machinery nor an existing fee schedule to incorporate into its statutory health insurance programs. That view is also inconsistent with two of his more noteworthy ideas highlighted below.

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### Glaser’s Noteworthy Ideas

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Glaser emphasizes political obstacles in the United States to achieving

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physician payment reform. In contrast to Canadian and European parliamentary systems, which “require consensus between executive and legislative branches,” the separation of powers in the United States does leave the federal government fewer opportunities for centralizing political authority over domestic issues. Consequently, there is frequent stalemate in implementing reforms about which there is little consensus.

Glaser also argues that there is no “single neutral solution” to the problem of remunerating physicians. Yet Americans persist in seeking automatic, technical solutions to political problems; for example, scientific studies, self-regulating markets, and formulas such as diagnosis-related groups (DRGs) or those enacted by Gramm, Rudman, and Hollings. I suspect Glaser would agree with James Morone that such “policy gimmicks” reflect our distrust of politics, politicians, and government and devalue good public administration.<sup>1</sup>

Glaser notes our inadequate health insurance coverage and our failure to contain the growth of health care costs. He argues that patchwork reform of Medicare reimbursement will not solve these problems. National health insurance, he suggests, could solve both simultaneously.<sup>2</sup> Clearly, the experience of Western Europe and Canada suggests that health systems that combine universal entitlement and private, fee-for-service medical practice are able to reconcile these elements with global expenditure control—at least in comparison to the United States.<sup>3</sup>

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### An Alternative View Of Physician Payment

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I share Glaser’s commitment to the importance of learning from abroad and of devising institutions for negotiating physician fees. We differ about how well European and Canadian patterns of physician payment and negotiation work, in practice. Also, I am more sanguine than Glaser is about the Physician Payment Review Commission’s (PPRC’s) expertise and ability to translate research findings into feasible policy recommendations. In the context of the U.S. political environment and U.S. preferences for automatic solutions, PPRC Chairman Philip Lee has turned the commission into an open forum for responsible discussions between the federal government and the medical profession.

**Neglected aspects of physician/payer relations and fee schedules.** The following general patterns are based on research about physician payment in France, the Federal Republic of Germany, and Canada.<sup>4</sup> Each of these countries combines elements of private, fee-for-service medical practice with public, or quasi-public, payment. They have different traditions of government and public administration. But their experience can, nevertheless, provide important insights for U.S. policymakers.

(1) Often, what Glaser calls “standing negotiating machinery” or “political solutions of conflicts of interest” is little more than the exercise or threat of governmental regulatory authority. The establishment of physician fees is the outcome of formal negotiating structures. But the process is highly contentious and tightly circumscribed by imposed governmental constraints.

(2) The structure of physician fee negotiations is corporatist, that is, closed to all but the principal players: physicians, government, employers, and payers. Consumers, patients, or beneficiaries are not formally represented. And, parts of the negotiation process are so secretive that it is difficult, even in retrospect, to learn what transpired.

(3) There is far less reliance than in the United States on technical studies that can provide a basis to adjust the relative value scale (RVS), refine the coding system, and value new procedures. Fee schedules have been developed largely by medical associations on the basis of “expert” judgment and a kind of political “give and take” between medical specialty groups.

(4) Fee schedules tend to reward, disproportionately, procedure-based services to the detriment of cognitive services. The process of updating the RVS component of fee schedules has been slow. Although efforts have been made to increase the value of management and evaluation services of both general practitioners and specialists, physicians still have powerful financial incentives to perform ancillary services and procedures.

(5) Success in achieving relative expenditure restraint for physician services—in comparison with the United States—appears to have been accomplished through the use of strong price controls, usually binding fee schedules (France); or global fee adjustments, expenditure targets, and incomes policies (Canada); or direct expenditure caps (Germany).

(6) In contrast to the United States, France, Germany, and Canada have virtually no government or payer intrusion in clinical practice. This observation supports what may be called “Reinhardt’s irony:”

The less tightly society controls the overall capacity of its health system and the economic freedom of its providers to practice as they see fit and to price their services as they see fit, the more direct appears to be the private or public payer’s intrusion directly into the doctor-patient relationship—the less clinical freedom at the level of treatment will payers grant providers.<sup>5</sup>

(7) Reinhardt’s irony may be understood in the context of the Marmor and Thomas hypothesis that governments or payers, irrespective of the structure of bargaining or negotiating systems, prefer gaining physician concessions on amounts of payment in exchange for concessions on

methods of payment.<sup>6</sup> The evidence about physician fee negotiations supports this hypothesis insofar as neither the health insurance funds nor the government has ever seriously challenged the legitimacy of fee-for-service payment on the basis of a fee schedule. But as volume has become more of a problem, payers, while not questioning the methods of payment, are gradually extracting physician concessions on utilization control, not merely on payment levels.

(8) In France and Canada, the health insurance funds are not nearly as active as Medicare, Medicaid, and private payers in the United States in performing utilization review, quality assurance, and getting involved more generally in the reform of health care organization and finance. Nevertheless, over the past decade, French and Canadian payers have slowly become more active in managing the health care system. Although French physicians have refused the principle of expenditure targets for ambulatory care, two Canadian provinces—British Columbia and Quebec—have been leaders in what Jonathan Lomas and colleagues call “minding our Ps and Qs (prices and quantities).”<sup>7</sup>

In Germany, since the health insurance funds simply transfer a global budget for physician services to associations of insurance doctors, there is no incentive for the payer to control use of medical care. If the volume of ambulatory services increases beyond projected utilization, the reimbursement rate (price) per unit of service goes down automatically.

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## Inferences And Interpretations

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**Weaknesses of the U.S. system.** In comparison to France, Germany, and Canada, the United States suffers from two major weaknesses. First, we have no experience with a national fee schedule because we have no compulsory national health insurance program. The absence of national health insurance not only results in thirty-one to thirty-seven million uninsured, it also deprives us of the monopsony power of a sole payer. Medicare pays for the bulk of physician services such as lens extractions, hip replacements, and coronary bypass surgery. However, total revenues received by physicians for services provided to Medicare beneficiaries account for 33 percent of physicians’ aggregate revenues.<sup>8</sup> Consequently, decisions made about a Medicare fee schedule will have far weaker impact on the U.S. health care system.

Second, only 37.3 percent of physicians participate in Medicare’s participating physician program, that is, agree in advance to accept Medicare’s payment in full for *all* Medicare claims.<sup>9</sup> Thus, to the extent that there is a great deal of extra-billing in the United States—even in comparison to France—the effects of a fee schedule are severely diluted.

**Strengths of the U.S. system.** A close look at the experience of France, Germany, and Canada suggests there is much strength in the United States. First, our health services research community is outstanding. To cite just one example, the work of William C. Hsiao and his colleagues at Harvard in developing an RBRVS is the most sophisticated effort of this kind ever to be undertaken and has been a source of interest and insight to experts and policymakers in France, Germany, and Canada.

Second, the United States has more experience with a variety of different physician compensation methods than any national health insurance system. In addition to salary, capitation, and case-based methods of payment, there is much experimentation going on in health maintenance organizations (HMOs) organized around independent practice associations (IPAs).<sup>10</sup> Since the basic reform proposed by PPRC—a Medicare fee schedule within expenditure targets—resembles, in many respects, a kind of macro-IPA, the more successful and innovative IPA models should be studied carefully by PPRC. More research on controversial individual financial incentives in IPAs such as risk pools, bonuses, holdbacks, or withholds and collective incentives such as expenditure caps and practice guidelines would help design physician payment reform that builds on our strengths.

Despite the knee-jerk opposition of many American economists to the regulation of physician fees, certain health insurance programs in the United States (for example, worker's compensation) and certain states (Massachusetts) have a tradition of imposing fee schedule rates as "payment in full" for physician services.<sup>11</sup> Local Blue Shield plans (originally established by the medical profession) have a history of fee bargaining and contracting with the medical community.

**Existing components of national health insurance.** Although we lack the institutional structure of a statutory national health insurance program, we have the information systems, the specialized administrative personnel, and other components necessary to manage such a system. France, Germany, and Canada must improve their component parts; we must integrate ours. Glaser laments the absence in this country of either a tradition or an existing national administrative machinery for bargaining or negotiating a physician fee schedule. PPRC attempted to draw insights from our limitations by examining the experience of Western Europe and Canada in negotiating physician fees. Also, they reviewed the literature, called for expert testimony (including Glaser's), and conferred with officials and physician leaders abroad. In the course of its work, PPRC has been keenly conscious of its current role in orchestrating a negotiation process. What is more, PPRC has recognized its potential future role in updating a national fee schedule.

**Range of possible reforms.** It is premature to evaluate PPRC's success. But before transplanting European or Canadian mechanisms for negotiating physician fees, policy analysts would do well to rethink what is meant by negotiation and examine the range of possibilities. Deborah Stone and Mark Segal note that any system of creating or updating a fee schedule "involves negotiation at some level. The real difference among these methods is not whether they involve negotiation at all, but how *formal* and *explicit* the negotiations actually are."<sup>12</sup>

There is a wide continuum between the more formal systems in Europe and Canada and the pluralistic American system of commissioning "scientific studies" and then subjecting them to further analysis, expert opinion, and the comments of numerous interest groups. A critical policy issue for PPRC is whether standing negotiating machinery or procedures for negotiated rule making will institutionalize and strengthen cooperative interactions between Medicare program managers and physicians.

On this score, three questions merit examination: (1) Can procedural reform such as the adoption of national negotiating machinery promote social cooperation? (2) Will the creation of some variant of European and Canadian standing negotiating machinery make it possible to escape the problems of corporatist politics, which can get in the way of democracy, equality, and pluralism? (3) Is the degree of conflict between the medical profession and the state any stronger in the United States than in France, Germany, or Canada?

Differences in administrative procedure often reflect substantive differences in institutional structure and political culture. The tradition of a strong state in France, Germany, and Canada (particularly in Quebec and British Columbia) breeds a certain cooperation among powerful countervailing groups and fosters the existence of "networks and hierarchies" between these groups and the state.<sup>13</sup> Such interaction is deeply rooted in the social fabric of these nations. Procedural reform alone, without this tradition, is unlikely to promote social cooperation.

The second question concerns corporatist politics. The odds are that reliance upon a process of standing negotiating machinery or negotiated rule making will occur in "unbalanced political markets," thereby resulting in domination by concentrated industry segments.<sup>14</sup> Diffuse interests such as beneficiaries (consumers) and other potentially affected groups are disadvantaged in such circumstances. Thus, proposals to institutionalize corporatist-style negotiation may fail to correct systemic biases in favor of the powerful and wealthy.

As for the third question, it is difficult to measure degrees of conflict between the medical profession and the state. There is little, if any, evidence that there is less conflict between the medical profession and the

state in France, Germany, or Canada than in the United States. Given the working relationships in this country between local Blue Shield plans and the medical community, and between Medicare and participating physicians, it would appear possible to develop and nurture social cooperation in the course of establishing American-style patterns of negotiation.

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### Concluding Comments

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“Econometric wizardry” and more research alone will not, as Glaser suggests, result in a politically acceptable national fee schedule. But that does not preclude deep skepticism about his view that “the solution has long existed” or that fashionable administrative technologies such as negotiated decision making will resolve the issue.<sup>15</sup> There is a reasonable position between these two extremes. That middle ground includes PPRC’s commitment to technical analysis and specialized expertise, synthesis, and close monitoring of relevant research, and open consideration of explicit goals and active participation by all affected groups.

**PPRC roles.** In responding to its mandate, PPRC has actually positioned itself in three key roles.

As fact-finder, it has mustered an arsenal of intellectual capital on the topic of physician payment. This has strengthened the likelihood that PPRC’s knowledge, appropriately deployed, will wield power.

As advocate, in presenting formal testimony to congressional committees, the commissioners, their staff, and all of their constituencies, have themselves become an interest group—one charged with balancing the concerns of taxpayers, providers, and beneficiaries. In this sense, PPRC reflects what Lawrence Brown calls “technocratic corporatism.”<sup>16</sup> Its true challenge is somehow to discern the “public interest,” to square a dangling circle: the design of a reform that would encourage American physicians to pursue society’s interests as well as their own.

Finally, as umpire and mediator, PPRC has revealed yet another example of American exceptionalism in health policy.<sup>17</sup> PPRC is demonstrating—not inadvertently—that the process of inviting testimony from medical specialty societies, the AMA, and beneficiaries, and of subjecting each group to public cross-examination, is a uniquely American method of conducting national negotiations between the federal government and the medical profession.

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### NOTES

1. J. Morone, “Old Politics, New Problems: The Effect of Cost Containment Policies on the Cost of Ambulatory Medical Care in the United States,” paper prepared for the  
Downloaded from [content.healthaffairs.org](http://content.healthaffairs.org) by Health Affairs on January 9, 2014  
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International Symposium on Controlling Costs while Maintaining Health, Bonn, West Germany, 27–28 June 1988.

2. This view is consistent with the majority position expressed by those of us who participated in the Brandeis University conference, "Learning from Other Health Care Systems," summarized in this issue of *Health Affairs*.
3. Robert Evans provides theoretical support for this position in explaining how cost control should be reconciled with national health insurance by setting expenditure caps and linking physician fees with practice patterns. See R. Evans, "Squaring the Circle: Reconciling Fee For Service with Global Expenditure Controls," Discussion Paper Series, HPRU-88:8 (Vancouver: University of British Columbia, 1988).
4. V. Rodwin, H. Grable, and G. Thiel, *Updating the Fee Schedule for Physician Reimbursement: Comparative Analysis of selected Experience Abroad and of Policy Options for the United States*, prepared for the Physician Payment Review Commission, 14 February 1989. A portion of this report is forthcoming in *Quality Assurance and Utilization Review* (February 1990). This research relies on a review of the literature in each country, on my own experience in working with the former director of the French national health insurance fund (CNAMTS), and on extensive discussions with individuals in each country who have either participated in or studied the fee schedule update process.
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12. D. Stone and M. Segal, *Design of a Negotiating System for Physician Reimbursement* (Boston: Boston University Health Policy Consortium, October 1980).
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15. For a thorough critique of regulatory negotiation, see M. Rodwin, "Can Bargaining and Negotiation Change the Administrative Process?" *Environmental Impact Assessment Review* 3, no. 4 (1982).
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