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Updating the Fee Schedule for Physician Reimbursement: A Comparative Analysis of France, Germany, Canada, and the United States

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Based on an analysis of the fee schedule update process in France, the Federal Republic of Germany and Canada, this article draws a number of inferences and interpretations and concludes with a discussion of the major weaknesses and strengths of the United States.

This paper provides a cross-national perspective for thinking about the problem of updating a physician fee schedule under the Medicare program. It is based on an examination of the fee schedule update process in three countries that rely on fee-for-service payment to physicians under systems of national health insurance (NHI): France, the Federal Republic of Germany, and Canada. Each country represents a variation on the general model of private medical practice and public, or quasi-public, payment. All of these countries have different traditions affecting the role of government and public administration in society. But their experience, may, nevertheless, provide some insights for policy makers in the United States.

We assume that a fee schedule based on resource costs, a resource-based fee schedule (RBFS), will serve as the principal instrument for reimbursing physicians under the Medicare program. The methodological issues involved in designing a fee schedule have been amply discussed in the literature (see, e.g., Ref. 1). What remains less well-known are the practical problems of updating fee schedules under government-run or government-supervised health insurance programs.

We have relied on a review of the literature about the fee schedule update process in each country and on discussions with individuals who have either participated or studied the update process (2,3). On the basis of this examination of selected experience abroad, we examine patterns in the fee schedule update process, draw inferences and interpretations and conclude with some observations on the relative weaknesses and strengths of the United States. We begin with some background on the use of fee schedules for physician reimbursement.

FEE SCHEDULES FOR PHYSICIAN REIMBURSEMENT: GENERAL ISSUES

Fee schedules may be viewed as an instrument for purposes of managing or negotiating a "social bargain" between physicians, payers, and the patients they represent. The administratively set fee may be analyzed in relation to four elements, each of which is a potential object of negotiation in the update process.

The first element is simply the list of reimbursable procedures or codes. The existence of such a list raises the issue of how new procedures are added, obsolete ones dropped, or existing codes modified. Inclusion on this list potentially creates effective demand on the part of patients or, viewed from the supply side, a greater propensity to provide services on the part of physicians. From the perspective of physicians, for

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Abbreviations used are: RBFS, resource-based fee schedule; RVS, relative value scale; NHI, national health insurance; AIDs, association of insurance doctors.

example, the addition and valuation of a new technological procedure can either promote or slow its diffusion. From the perspective of payers, an increase in the list size could result in greater financial burdens, or no change at all, and must be weighed against the diagnostic or therapeutic efficacy of the procedure in question. In addition, changes in codes may be required for the accurate assignment of relative values.

The second element of a fee schedule is the relative value scale (RVS) which ranks the list of reimbursable procedures one against the other. A resource-based fee schedule (RBFS) represents one approach for achieving this valuation on the basis of average resource inputs, measured largely in terms of physician work effort. Other, more traditional approaches for designing an RVS have relied on historical charges or professional consensus, e.g., the California, Quebec, and French RVS. Comparison of these relative value scales reveals that there is a great deal of variation between relative values (Table 1) (4). Such variation reflects the fact that there are many other factors which enter the valuation process, for example, patient demand for services, physician willingness to provide the services, the relative power of medical specialties, and collective preferences expressed in the course of negotiations among physicians, consumers, payers, and the government. An RBFS is often viewed as a way of simplifying physician payment, making expenditures more predictable, and deriving fair prices among specialists. The criteria of "fairness," however, are remarkably elusive and agreement does not come easily.

The third element of a fee schedule is the translation of the RVS into actual fees. This may take the form of conversion factors for various categories of service or it may be expressed directly as the fee reimbursed by third-party payers.

The fourth element of a fee schedule concerns the extent to which the reimbursable fee represents "payment in full" to physicians and/or patients. Does the fee assume a level of co-insurance on the part of patients? Are physicians allowed to engage in extra-billing or are they encouraged or required to accept assignment?

Although these four elements of a fee schedule can be distinguished analytically, the final fee schedule is simultaneously an instrument for supply-side policies, demand-side policies, physicians' incomes policies, as well as price control and budget policies (Table 2).

The process of updating will need to take into account a number of factors: 1) the rate of growth of program expenditures; 2) technological change; 3) changes in physicians' costs of practice; 4) changes in beneficiaries' out-of-pocket costs; 5) changes in beneficiaries' access to services; and 6) changes in the quality of care.

These factors can appropriately be taken into account by making decisions about the following issues:

1. *Adjusting Relative Values.* Such adjustments must be made in response to technological improvements in practice or other factors which affect practice costs and relative work.
2. *Refining the Coding System.* This may refer to the addition of new codes for new medical technologies or procedures, the elimination of old ones, the bundling of several codes under one or more aggregate categories, or the modification of existing codes or their definitions to reflect accurately the work involved in performing particular procedures.
3. *Valuing New Procedures.* When new medical technologies and procedures are introduced and a decision is made to include them on the list of reimbursable codes, their values must be determined.
4. *Modifying Policy on Specialty Differentials.* In cases where services provided by different specialists under the same procedure code represent differences in work, policies on specialty differentials may have to be modified.
5. *Modifying Policy on Balance Billing.* In cases where there are problems of access to medical services, it may be necessary to encourage or even require some or all physicians to accept assignment.
6. *Adjusting Geographic Multipliers.* Such multipliers could be used to compensate for geographic differences in practice costs as well as to promote services in under-served areas.
7. *Setting Conversion Factors.* This decision, which transforms the relative value scale into a schedule of relative prices or fees, is essential for projecting medical care expenditures and physicians' incomes.

PATTERNS IN THE FEE SCHEDULE UPDATE PROCESS AND PHYSICIAN/PAYER RELATIONS

France

1. The French RVS is not a technical valuation of medical procedures based on time, complexity, intensity, and other factors. Although the values of surgical procedures are clearly a function of time, the relationship between value and time varies by medical specialty sometimes reflecting differences in intensity but often reflecting interspecialty medical politics and/or societal preferences for different branches of medicine according to their prestige.

2. The French RVS has been developed and modified largely by the medical associations and by the

Table 1

Comparison of Relative Value Scales in France, California, and Quebec

	Codes	France	California	Quebec
1	Orthopedic Treatment of a Closed Fracture Necesitating a Reduction, with or without Anesthesia			
	Clavicle	0.40	0.31	0.19
	Scapula	0.20	0.29	0.39
	Astragulus calcaneus	0.60	0.31	0.39
	Femur	1.60	0.74	0.51
	Arthroplasty of the hip	4.40	4.21	1.58
	Arthroplasty of the hip	3.60	2.10	2.37
	Osteotomy of the femur	3.00	2.00	1.84
	Syneovectomy of the hip	2.00	2.10	1.84
	elbow	1.60	1.47	1.02
	knee	1.60	1.80	1.31
2	Drainage of subdoral or hemodoral	2.40	2.94	2.85
3	External ventricles	0.80	2.94	1.05
4	Surgical treatment of the chalazion	0.30	0.12	0.11
5	Cyst of the eylids	0.80	1.05	0.41
6	Surgical removal of blockage of the tear duct	0.80	1.26	0.66
7	Graft of eyball covering	1.00	1.47	0.63
8	Excision of the wall of lacrimal sac	2.00	1.47	1.10
9	Replacement of vitreum	1.40	1.26	0.83
10	Removal of the eyeball	1.00	1.05	0.83
11	Removal with implant of the eyeball	1.40	1.26	1.09
12	Surgical treatment of the pterygion	0.80	0.63	0.41
13	Cataract	2.00	2.10	1.89
14	Iridectomie	0.80	1.05	0.86
15	Excision of bone tumor	1.20	1.26	0.54
16	Peracentesis	0.20	0.06	0.11
17	Mastoidectomy	1.50	1.26	0.97
18	Excision of turbinate bone	0.30	0.63	0.13
19	Adenoidectomy	0.40	0.29	0.17
20	Tonsilectomy	0.80	0.50	0.19
21	Parotid excision	1.60	0.63	0.84
22	Tracheotomy	1.00	0.55	0.42
23	Thyroidectomy	2.40	1.58	2.30
24	Laminectomy	2.40	3.37	2.37
25	Drainage of breast absess	0.40	0.27	0.26
26	Mastectomy	1.00	0.84	1.13
27	Benign tumor removal	0.60	0.52	1.89
28	Mastectomy w/axillary dissection	2.00	1.26	1.58
29	Thoracotomy	2.00	1.26	1.58
30	Pneumamectomy	5.00	3.15	2.89
31	Labectomy	3.60	2.73	2.52
32	Plural drainage	0.24	0.07	0.27
33	Diaphragmatic hernia	3.00	2.00	1.94
34	Congenital esophageal stenosis	5.00	3.15	3.37
35	Cardiorhaphy	4.00	2.52	1.89
36	Pericardectomy	5.00	3.58	1.84
37	By-Pass surgery 1 artery	5.00	4.00	2.85
38	Hernia repair	1.00	0.94	0.92
39	Laparotomy	1.00	1.02	1.00
40	Gastrectomy	4.00	2.94	3.07
41	Pyloraplasty	1.60	1.37	1.31
42	Segmental resection of ulcer	2.00	1.80	1.74
43	Appendectomy	1.00	1.00	1.00
44	Mackels diverticulum	1.20	1.05	1.18
45	Total colectomy	5.00	2.73	3.81
46	Partial colectomy	2.40	1.89	3.16
47	Cholecystectomy	1.20	1.26	0.92
48	Anastamosis of bile duct	3.00	1.52	3.07
49	Hemorrhoidectomy	0.60	0.50	0.35
50	Surgery for megacolon	4.00	2.73	3.16
51	Reconstruction of anal sphincter	2.00	1.05	0.92
52	Treatment of vesicocoele	2.40	2.10	1.79
53	Treatment of vaginocooele	2.40	1.52	1.47
54	Splenectomy	2.00	1.52	1.94
55	Pancreotectomy	6.00	3.58	4.60

Table 1

Continued

Codes		France	California	Quebec
56	Cysts hydatid liver	2.00	1.52	1.47
57	Kidney or liver biopsy	0.60	0.25	0.95
58	I & D for renal abscess	1.20	1.47	0.89
59	Renal stone	1.20	1.58	0.87
60	Nephrectomy	2.00	2.10	1.58
61	Nephrostomy, pylectomy	1.60	2.10	1.02
62	Rx of horseshoe kidney	2.40	2.94	2.10
63	Removal ureter	1.60	1.89	1.16
64	Ureteral exploration	2.00	2.21	1.10
65	Ureter bladder anastamosis	3.00	2.31	1.37
66	Partial bladder removal	2.40	1.89	1.31
67	Partial amputation of penis	1.20	1.05	0.52
68	I & D perineal abscess	1.00	0.84	0.25
69	Prostatectomy	2.40	2.10	1.53
70	Surgery of torsion of testicle	0.80	0.84	0.79
71	Castration	3.00	0.84	0.87
72	Excision bartholin cyst	0.80	0.50	0.27
73	Cervix excision	0.80	0.50	0.63
74	Hysterectomy	2.00	1.58	1.31
75	Myomectomy	2.00	1.47	0.79
76	Caesarion section	1.00	1.05	1.18
77	Cystoscopy	0.40	0.12	0.18
78	Laryngoscopy	0.30	0.42	0.27
79	Gastroscopy	0.60	0.42	0.26

Source: G. de Pouvourville, *Le Paiement de L'Acte Médicale: Une Comparaison Entre France, Les Etats Unis et le Quebec* (Paris : Ecole Polytechnique, Centre de Recherche Gestion, October, 1985).

Table 2

Cross-National Comparison of Fee Schedule Update Processes

	Ontario	Quebec	British Columbia	Alberta	France	Germany
Geographic multipliers	no	yes	no	no	no	slight
Balance billing	no	no	no	no	yes for second sector	no
Number of physician bargaining organizations	1	2	1	1	2	1
Medical profession independence in updating RVS	high	medium	high	high	medium	medium
Government oversight of valuing/coding new procedures	high	medium	high	high	high	high
Number of fee schedule codes	9000	4500	2400	4000	4000	2500
Expenditure caps	no	no	partial	no	no	yes
Expenditure targets	no	yes	yes	yes	no	no
Income caps	no	yes	no	no	no	no
Links between fee levels and volume	no	yes	yes	yes	no	yes

health insurance funds' physician-controllers/medical advisers. Disagreements over this process have largely been resolved among these parties. Although, in 1985, the Ministry of Social Affairs affirmed its unilateral authority to modify the RVS, it is likely to continue to rely on the recommendations of the standing commission on the RVS and all of its subcommittees. Thus, adjustments in the RVS, refinements in the coding system, and valuation of new procedures are likely to continue to result from consensual working group processes relying on few technical studies, much expert judgment and the participation of medical association representatives and health insurance physicians.

3. With the exception of fostering (ever so slightly) general practice as opposed to specialty services by adjustments in the RVS and through negotiations over the value of conversion factors (Fig. 1), the French fee schedule has rarely been used explicitly as an instrument to promote health policy objectives. First and foremost, it has served as an instrument of price policy and incomes policy for physicians. For example, from

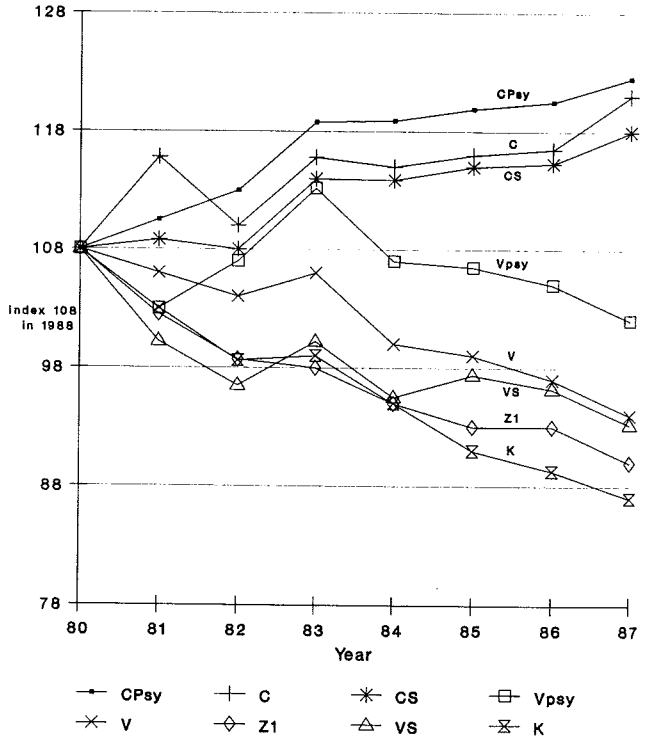

Fig. 1. The evolution of the average value of key letters in constant francs. C = consultation; CS = specialized consultation; CPsy = psychiatric consultation; V = visit; VS = specialized visit; Vpsy = psychiatric visit; K = surgical and diagnostic procedures; SPM = dental procedures; Z1 = radiological procedures. (Source: Caisse Nacionale d'Assurance Maladie des Travailleurs Salariés, 1989.)

1962-1979, the real income of general practitioners and specialists increased, respectively, at an average annual rate of 1.7% and 0.5% (5).

4. The French system of negotiating national agreements (*conventions*) every 4 or 5 years, and adjustments in conversion factors every year, has created effective working relationships, with regard to technical issues focused around the RVS, between the two major medical associations and the NHI funds. However, the issues concerning physician profiles and incomes have often resulted in acrimonious debate. What is more, in spite of the apparent two-sided nature of these negotiations, the government has had the upper hand in matters of price policy by circumscribing the terms of the agenda and often by setting unilateral constraints.

5. Since 1980, the foremost strategy for gaining the acceptance of physicians to abide by the national fees has been accomplished by allowing the emergence of a large second sector within which physicians may "extra-bill" over the amount of the nationally "negotiated" rate. In 1987, 27% of French physicians chose to join this sector. The figure is lower for general practitioners and very much higher for specialists. It is also much higher for physicians in urban areas. For example, 50% of physicians in Paris decided to join the second sector.

6. The open-ended commitment of French NHI to finance private medical practitioners, on a fee-for-service basis, according to a national fee schedule, has resulted in persistent but largely unsuccessful attempts, on the part of the NHI funds, to control the volume of medical services (6). Despite physician profiles, "selective controls," and continuing education programs to promote "*le bon usage des soins*" (appropriate use of services), there is no evidence of any trend indicating containment in the growth rate of the volume of medical services (Fig. 2; the rate goes back up in 1988).

Germany

1. There is little technical expertise used in updating the RVS in Germany. While unit costs and projected utilization of medical care are considered,

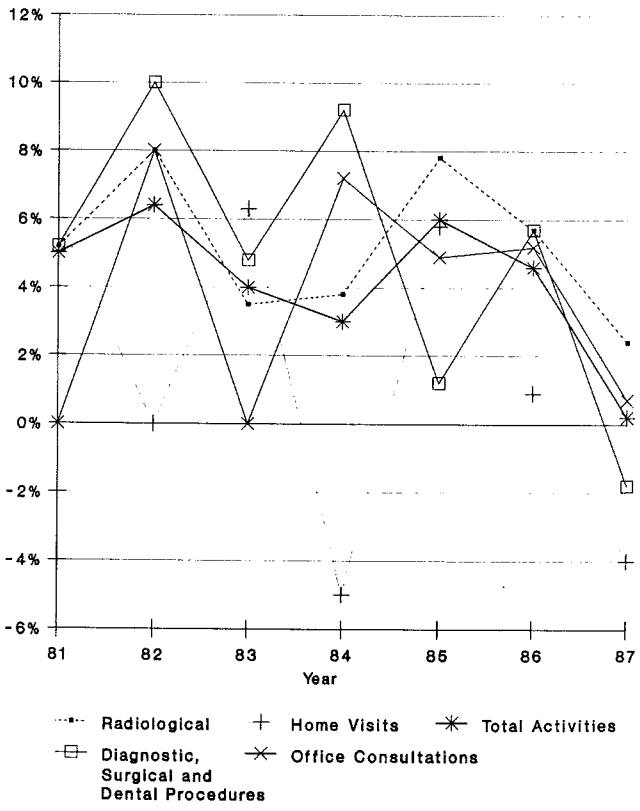

Fig. 2. The annual rate of increase in the number of procedures of office-based ambulatory care physicians. (Source: Caisse Nacionale d'Assurance Maladie des Travailleurs Salariés, 1989.)

the assigned value tends to be determined by a kind of political "give and take" between medical specialty groups. As new medical technologies emerge, their valuation is determined essentially by the politics of acceptability. This is also true of the devaluation and revaluation of old procedures.

2. Since the 1977 Cost Containment Act, a national commission known as "Concerted Action," consisting of representatives of government, unions, employers, doctors, and sick funds, has been responsible for determining the federal expenditure cap. Although Concerted Action is often presented as a nonpolemical, highly technical, negotiation process where the outcome is reached by consensus, it more closely resembles a regulatory process whose outcome is determined according to a formula that relies on measurable economic indices and projected estimates of employee wages and practice costs.

3. With the imposition of federal as well as regional expenditure caps, the German system of reimbursing ambulatory care physicians has shifted the burden of cost-control from the health insurance funds to the association of insurance doctors (AIDs). There is, consequently, little effort on the part of government and health insurance funds, either to analyze patterns of medical care utilization or to evaluate the appropriateness, let alone effectiveness, of medical care.

4. Within a system that combines regional expenditure caps with item-of-service payment to physicians on the basis of a relative value scale, the fees for services performed are automatically linked to the total volume of services provided by all physicians and are determined retrospectively. To assure receipt of their expected earnings, although rational behavior would motivate physicians to reduce, collectively, the number of their services so as to be compensated at a higher rate, individual physicians are motivated by what Brenner calls "irrational behavior patterns" (in a collective sense) to increase their volume (7).

5. The regulation of volume (or medical care utilization) has not been a priority in Germany. While the law provides for "economic monitoring boards" to review utilization, this body has merely produced profiles of physician practice patterns. There has been no collection of any case-mix data or any other information which could be helpful in assessing the uncovered patterns. Thus, it appears that economic monitoring has relied largely on deterrent effects based on fear of sanctions rather than on positive incentives to educate physicians.

6. While the expenditure cap has been successful because it derives largely from governmental regulatory authority, the actual distribution of funds by the AIDs across general practitioners and specialists has been left to the federal and regional negotiation processes over the RVS and economic monitoring. The shift from an open-ended NHI system (French-style) to one operating under an expenditure cap whereby the burden of cost-containment is passed on to physicians could, potentially, shift back some of this burden to the public in the form of decreases in access and quality of health care. However, we have no evidence on this score.

Canada

1. In most Canadian provinces, the medical profession has independence in determining the RVS component of the fee schedule. The allocation of global fee increases among specialties results from interspecialty negotiations before standing committees. Specialty groups request increases based on perceived inequities, changes in practice costs, new technologies, utilization, and malpractice premiums.

2. Fee schedules in Canada are far less detailed and complex than the Medicare fee schedule in the United States recently passed by Congress (Omnibus Budget Reconciliation Act of 1989). Past allocations of global fee increases have resulted in disproportionately high payments for procedure-based services to the detriment of cognitive services. The current trend in some Canadian provinces is toward the elaboration of more sophisticated relative value scales based on technical studies.

In British Columbia and Ontario, for example, the traditional intra-specialty "eyeball" method of revising the RVS is now being questioned. This method of allocating global fee increases on the basis of "expert opinion" about the clinical substance and relative worth of individual procedures has proven highly subjective and prone to stalemate (8).

3. While the medical profession is largely autonomous in refining the coding system in Canada, the Quebec government brings specific fee schedule codes into negotiations. By eliminating some procedures from the fee schedule and reducing the value of others, the government has been able to slow the rate of increase in the utilization of high volume medical services.

4. Although global adjustments to physician fees in Canada are negotiated between provincial governments and the medical profession, the outcomes are heavily influenced by budgetary constraints. During

periods of economic expansion, fee increases for physicians have been generous. When budgets are tight, provincial governments negotiate or impose reductions in the rate of increase in fees. When faced with sustained reductions in fees, physicians have not been able to offset income losses through increased utilization (9).

5. The Quebec government has approached expenditure control in a more draconian manner than any other Canadian province. Two distinct phases may be distinguished. From 1971 to 1977, the government limited expenditures for physician services by allowing only a 1% increase in global fees. Tight control over fees coincided with increased utilization of physician services. During the second phase of expenditure control, the government has linked fees to utilization by accepting a physician-sponsored plan to place quarterly individual income ceilings on general practitioners, a 75% fee reduction on high volume specialty procedures (following an income limit by procedure), and average annual income targets for all physicians.

6. In provinces where third-party arbitration or fact-finding is used to settle disputes between the government and medical associations (Ontario, Alberta, Manitoba, and Saskatchewan), outcomes come more slowly than in provinces where direct negotiation is used (British Columbia and Quebec). However, the ability of provincial governments to implement expenditure targets (British Columbia) or ceilings (Quebec) appears to be more related to political, social, and economic factors than to negotiating structures.

While the individual quarterly income ceilings are high enough so that physicians can, and do, earn incomes in excess of the projected average income targets, profiles of physician billing patterns are monitored to discourage large increases in services rendered by individual physicians. When a physician's activity profile is found to include services of questionable medical necessity, a peer review committee may impose sanctions whereby the physician must return a portion of the income derived from these services.

7. While provincial governments in Canada have relied on the fee schedule update process as an instrument for controlling physician expenditures largely by limiting increases in global fees, there is currently a trend for government authorities to take an interest in patterns of medical care utilization, and in some cases, to link prices and quantities (10). Such a policy of controlling both price and quantity of physicians' services is, quite bluntly, an incomes policy. It has provoked much resistance from the medical profession.

INFERENCES AND INTERPRETATIONS

1. The experience of Western Europe and Canada suggests that health systems which combine NHI 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. But no one could ever examine the evidence and conclude that this is easy. Even one of the staunchest advocates for the use of fee schedules under NHI has likened the challenge of reconciling fee-for-service payment with global expenditure control to "squaring the circle" (Ref. 11; in this paper, Robert Evans goes well beyond lamenting the difficulties to devising an ingenious scheme for linking fee adjustments to the control of volume).

2. The formal negotiating machinery in France, Germany, and Canada is actually tightly circumscribed by imposed governmental constraints. Success in achieving relative expenditure restraint for physician services—in comparison to the United States—appears to have been accomplished through the use of strong price controls, usually binding fee schedules (France); global fee adjustments, expenditure targets, and incomes policies (Canada); or direct expenditure caps (Germany).

3. The structure of physician fee negotiations in France, Germany, and Canada is largely corporatist, that is, closed to all but the principal "social partners"—physicians, government, and payers. Consumers, patients, or beneficiaries are not formally represented. In fact, parts of the negotiating process are so secretive that it is difficult, even in retrospect, to learn what transpired.

4. Compared to the United States, France, Germany, and Canada rely far less on technical studies which can provide a basis to adjust the RVS, refine the coding system, and value new procedures. Their fee schedules have been developed largely by the medical associations on the basis of "expert" judgement and a kind of political "give and take" between medical specialty groups.

5. Fee schedules in France, Canada, and Germany 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 general practitioners as well as specialists, there are still powerful financial incentives for physicians to perform ancillary services and procedures.

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" (12):

> 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.

7. Reinhardt's irony can 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 (13).

The evidence about physician fee negotiations in France, Germany, and Canada supports this hypothesis insofar as neither the health insurance funds nor the government has ever seriously challenged the legitimacy of fee-for-service medical practice 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" (10).

In Germany, since the health insurance funds simply transfer a global budget for physicians' services to associations of insurance doctors (AIDs), there is no incentive for the payer to control use of medical care. The problem of control and management is simply shifted to the AIDs.

CONCLUDING OBSERVATIONS ON THE UNITED STATES

Major Weaknesses

In comparison to France, Germany, and Canada, the United States suffers from three major weaknesses.

We have no experience in updating a national fee schedule because we have never had one.

We have never had one because we have no universal NHI Program. The absence of NHI results not only in roughly 37 million uninsured individuals; it also deprives us of the monopsony power of a sole payer with concentrated financing.

Medicare pays for the bulk of such physician services as lens extractions, hip replacements, and coronary bypass surgery. However, total revenues received by physicians for services provided to Medicare beneficiaries account for just 33% of aggregate physicians' revenues (14). Even specialists that have a large share of elderly patients, such as ophthalmologists and thoracic surgeons, receive, respectively, only 42% and 43% of their revenues from the Medicare program (15). Consequently, in contrast to France, Germany and Canada, decisions made about a Medicare fee schedule will have far weaker impact on the health care system in the United States.

Beyond Medicare's small market share, within the program itself, in 1988, only 37.3% of all physicians participated in the PAR program, i.e., agreed, in advance, to accept assignment on *all* Medicare claims (16). This figure could be increased by adding all those physicians who accept assignment on 80% or more of their claims. Moreover, it varies somewhat by specialty and even more so by geographic region. 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.

Major Strengths

The experience of France, Germany, and Canada suggests that there are also a number of relative strengths in the United States.

First, we have a health services research establishment which has produced thorough analyses of medical care utilization drawing on routinely collected data, special surveys and specialized expertise. On the basis of such information, we have developed administrative technologies for purposes of utilization review and quality assurance. Moreover, the work of William Hsiao and his colleagues at Harvard in developing a RBVS is the most sophisticated effort of this kind ever to be undertaken. In these respects, we are ahead of France, Germany, and Canada.

Second, we have more experience with a variety of different physician compensation methods than any NHI system. In addition to salary, capitation, and case-based methods of payment, there is much experimentation going on in health maintenance organiza-

tions (HMOs) organized around independent practitioner associations (IPAs) (17). 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.

Third, despite our national image of abhorring fee controls, certain health insurance programs, (for example, worker's compensation) and certain states (for example, Massachusetts) have a tradition of imposing fee schedule rates as "payment in full" for physician services (18). Also local Blue Shield Plans (originally established by the medical profession) have a history of bargaining and contracting with the medical community.

Based on a review of local interactions between physicians and health insurance organizations, Hsiao and Stevens note that in return for a role in the management of Blue Shield Plans, the "medical community is involved in organizational decisions on fee-setting, utilization review, coverage and claims adjudication" (19). This kind of capacity for fruitful interaction between physicians and administrators is a strategic base on which to build in the fee schedule update process.

Finally, the fact that there is neither a tradition nor an existing national administrative machinery, in the United States, for purposes of bargaining or negotiating fee schedules can, potentially, be turned into an immense advantage. It provides us with the power of hindsight in learning from abroad and evaluating policy options at home (20).

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