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The Politics Of Paying American Physicians

by William A. Glaser

Paying the doctor is inherently political. Both the larger national politics of public expenditure and the narrower politics among the factions of the medical profession are involved in working out the inherent conflicts of interest between payers and the medical profession and among the medical specialties. Fee schedules were common in every country before statutory health insurance, written by medical associations or insurance carriers. To settle conflicts of interest, standing negotiating machinery is created. Usually the medical associations and health insurance carriers negotiate a contract for several years at a time, defining the rights and obligations of doctors. They create a joint committee to monitor and update the fee schedule. Every year they also negotiate the financial value of the fee schedule, following cost containment guidelines from government.

Before enactment of its statutory health insurance systems—Medicare and Medicaid—the United States had many fee schedules. These included the California Relative Value Studies (CRVS) and the New York Blue Shield Schedule of Allowances. Every other country has incorporated such an existing fee schedule into its statutory health insurance as a matter of course. The United States did not, and Medicare has had constant trouble ever since.

Medicare’s Payment Methods

Instead of adopting—or even reinventing—a fee schedule, the Americans developed the customary, prevailing, and reasonable charge (CPR) system (also known as the usual, customary, and reasonable charge method, or UCR). This formula-based reimbursement is unique to the
United States, troublesome, and incomprehensible. It aims to achieve two contradictory goals: (1) to limit doctors’ fees within the fiscal capacity of an organized and tax-supported insurance scheme; and (2) to allow each doctor to continue his or her unique pattern of charging, without the standardization of a fee schedule.

Intended to maximize professional freedom and minimize conflicts with government, CPR instead has had the opposite effect. First, for each patient visit, all doctors submit claims to Medicare with the charges they would like to collect. They are not paid those charges currently; rather, each doctor has a profile of median charges (called “customary” or “usual” charges) for all procedures, generated by computer from the claims submitted last year. A “prevailing charge” is calculated each year for each procedure, by computer screening among all individual doctors’ “customary” charges in a particular region. Medicare pays the doctor the actual charge on the current bill, the customary charge over the past year, or the local medical profession’s “prevailing” charge over the past year, whichever is lowest. Patients are expected to pay part of the bill but never know their liability in advance. Often doctors do not know what they will be paid.

To be successful, a reimbursement method must be stable, simple, widely understood, and accepted as legitimate by all. Disputes should focus on real conflicts, such as amounts of money. However, the CPR method itself has invited trouble, has interfered with cost containment, and has been inimical to clear-cut decision making.

Reworking physician payment. Throughout Medicare’s history, doctors were free to accept the Medicare fee as full payment (assignment of claims) or to bill the patient to make up the difference (balance billing); individual doctors need not follow any standard rules. The Medicare payment method became increasingly contentious over time, as the government tried to limit costs by means of economic indexes, and as it tried to protect the patient from excessive balance billing by means of a bewildering mixture of inducements and price ceilings. By the early 1980s) everyone agreed that a change was necessary. But the inevitable fallback—adopting an existing fee schedule—was no longer available. Health policy had come to be dominated by neoclassical welfare economists who favored pure competitive markets in all sectors. These economists and antitrust lawyers pursued medical associations and insurance companies; fee schedules could no longer be published; and the staffs that had written them were dismantled.

At present, the health services literature is full of news and commentaries about the reform of American physician reimbursement. This Commentary looks at the events of the late 1980s in light of European
and Canadian experiences in managing physicians’ pay. These countries have been settling the same problems for decades, more decisively and at lower costs in money and trouble than has been true in the United States. I present highlights, since space forbids a full examination.4

**U.S. difficulties.** The reform and management of physician reimbursement is made unduly difficult in the United States for several reasons. While parliamentary systems require consensus between executive and legislative branches, America’s separation of powers is vulnerable to dissension and deadlock, even in the face of serious problems. The American executive and legislative branches have long been diametrically opposed. The White House, the U.S. Department of Health and Human Services (HHS), and the Health Care Financing Administration (HCFA) have been led by devotees of free competition in physician services, including Medicare. They have hoped that Medicare beneficiaries and other citizens would join health maintenance organizations (HMOs) and that the market would become a mosaic of HMOs and individual patient/doctor transactions. They have opposed fee schedules and limits on balance billing as standardized and anticompetitive bureaucratic regulations. Congress, on the other hand, has been left to devise its own solutions, implementing the normal methods of paying doctors under third-party systems—as filtered through the policy-making style of U.S. health services analysis. However, policy analysis in health care finance has specialized in technical economics rather than in the construction of politically feasible structures, and the deadlocked and nervous legislators have had little guidance.

Many current issues in U.S. physician reimbursement have been dragging on for years without clear-cut resolution and will probably persist into the future. The policy overload in Congress and in the media will probably remain. Congress likely will enact physician reimbursement laws in 1989 and each year thereafter—but the practical results will probably be amorphous. In contrast, the pattern in Europe and Canada is to create a stable structure by act of the legislature and to set up a negotiating system among the interested private parties and administrative officials. The problem then is off the national agenda and can be administered more harmoniously and less expensively.

Physician payment reform requires national political leadership and a recognition that the solution has long existed. In the overstudied and overdocumented field of health care finance, legal and administrative mechanisms could have been drafted and introduced quickly during the mid-1980s when everyone realized reform was urgent. Instead, a self-defeating pattern of debate and delay began. Several years were wasted in study commissions and research projects to study all the policy options.
Congress created the Physician Payment Review Commission (PPRC) in 1985 to recommend reforms for Medicare physician reimbursement and commissioned a research project to develop a relative value scale (RVS) as the best basis for a new payment system. From one perspective, new research was not needed at all, since any available fee schedule could have been adopted and amended at once—such as the California Relative Value Studies, any of the eleven used in Canada’s provinces, or any of those used in Europe. A crude charge-based fee schedule could have been created from the prevailing charges in the HCFA computers. A new research project might have been valuable, had it designed, explained, and demonstrated alternative types of fee schedules. The Americans did none of these.

The Fallacy Of A Single Neutral Solution

Instead of realizing that paying the doctor is an inherently political process, Americans are so devoted to the mirage of formula systems of reimbursement that they are now trying to replace an unworkable old one (CPR) with a new one. A research team at the Harvard School of Public Health was given a large grant in 1985 to devise a resource-based RVS for enactment by Congress a few years later. Fearful that Washington would enact a completely unacceptable reimbursement method for doctors—such as diagnosis-related groups (DRGs) for all physician services—the American Medical Association (AMA) and several specialty societies agreed to supply expert advice to the Harvard research staff. Thereby the medical profession could press for an acceptable form of the universal and familiar reimbursement method, that is, fee-for-service by means of fee schedules.5

The American enterprise was foredoomed, in part because it failed to unify the medical profession. The Harvard team had been designing relative value scales for a decade, attempting to reward work and other inputs of resources, and correcting biases from historical charges. The researchers confronted the same difficulties as did reformers in other countries: it is easy to measure time for each procedure, but it is very hard to measure complexity and difficulty of procedures independently of their time. The usual result, a fee schedule based on this approach, raises fees and incomes for internists, reduces the advantages of surgeons, and thus is resisted by the powerful surgeons. The Harvard team expended much ingenuity and effort, but produced a relative value scale that revolved around time in a 1979 research project.6 A similar relative value scale was part of a proposed Medicaid fee schedule the Harvard team developed for the Commonwealth of Massachusetts in 1984.7 The
Massachusetts Medical Society warned the country that the Harvard team’s work would harm the interests of the surgical specialties. The American College of Surgeons (ACS) refused to cooperate with the Harvard project and created a rival research staff to develop its own fee schedule and reimbursement policy. Instead of trying to compromise and shape a single product–as in other countries–the two efforts proceeded as rivals. It would have been scientifically interesting and would have provided all factions of the medical profession with options, if the Harvard team had designed several different fee schedules, based on different assumptions. Instead, the Harvard team tried to perfect its methodology, identifying the dimensions of complexity (judgment, skill, physical effort, and stress due to risk), inferring the roles of each of these in dozens of procedures from interviews with doctors, and inferring the relative weight of each of these dimensions for each procedure among the dimensions and vis-à-vis time by means of psychometric methods. But the effects on individual fees and on comparative specialists’ incomes still benefited cognitive over surgical specialties. (One might also debate the methodology on scientific grounds, but that issue is too complex for this short article.)

The judgmental and political nature of the weights. A fee schedule is never calculated only from the amounts of time, difficulty, and practice costs of each procedure. Since individual fees determine income, each specialty presses for weights that will increase its own income. In Europe, every medical association has some type of committee on tariffs, wherein the representatives of the different specialties recommend alterations in the relative weights in the main clinical fee schedules and alterations in the conversion factors for the special nonclinical fee schedules. The lower-paid clinical specialties argue for improvements; the better-paid specialties favor the status quo. After the specialties develop a consensus, the medical profession’s negotiators present their recommendations to the negotiators from the health insurance carriers in their joint committee that manages the fee schedule.

The Americans are now trying to construct their RVS by means of a formula weighting the inputs for each procedure, that is, the time, practice costs consumed, difficulty, and skill. As the basis for the calculations, accurate data must be collected from many physicians about each variable. The Harvard team used a telephone interview survey of small samples of physicians to gather their judgments on the relative amount of work required for different procedures. Then Harvard’s team had the data and conclusions evaluated by committees of medical specialists. Experience in the writing of fee schedules and in surveys of physicians abroad and in the United States shows that it is impossible to accumulate
complete and reliable data to construct a stable measure of relative “resource-based” weights among procedures, for several reasons: (1) doctors have low response rates on surveys; (2) they answer surveys impatiently, whereas this subject requires prolonged reflection; (3) comparing acts by difficulty and gaining accurate information about costs of practice require prolonged face-to-face interviews, not telephone interviews; (4) doctors do not like to report their costs of practice, particularly to strangers by telephone; (5) doctors cooperate better if they are paid fees for their time and effort; and (6) thousands of procedures are involved, far beyond the scope of surveys.  

Even if the facts could be recorded, they do not automatically produce a relative value scale. The different variables must be weighted and combined. This is a judgmental and controversial step. Defining the “difficulty” and “skill” required for even the same procedure is a judgment. Each specialty tries to define all procedures—even those performed primarily by other specialties—in a self-serving manner. Setting the weight of input variables also is disputed among the specialties. The cognitive specialties weight time more heavily; the surgical specialties weight difficulty and skill more heavily.

In foreign systems, the monitors of fee schedules do not expect to define or measure all the input variables exactly. They assume that income targets govern the relative weights of procedures, and they know that a fee schedule is always under revision. The entire process is flexible. Some research is done by economists and statisticians employed by the different factions concerning input variables, but ultimately the weights are produced by common sense, debate, and compromise.

When the Harvard team unveiled its RVS in 1988, Washington policy makers and the professional community of health economists commended its general approach but questioned details. But instead of abandoning the effort as misconceived and impossible, Washington defined the difficulty as imperfect methodology and insufficient data. The timetable was extended; new research grants were made to the Harvard team and others to continue, improve, and expand this same approach. Congress and the nation were assured that a scientifically designed resource-based RVS would be “phased in” during the 1990s and would be fully in place after 1993. Meanwhile, in the real world of physician reimbursement, the discredited and unworkable CPR was left in place for years to come, in view of the constant slippage in the timetable.

The Political Struggle Over Relative Incomes

In every country, the enactment of statutory health insurance arouses
the medical profession’s anxiety about government dictation. Government and insurance carriers usually appease doctors by adopting preexisting fee schedules and their weights. Payments first follow historical charges, thereby continuing the income difference between the surgical and cognitive specialties.

After several years, invidious comparisons within the medical profession lead to special fee schedules for the nonclinical specialties and revision of the weights for the main clinical schedule. The incomes of radiologists and laboratory physicians rapidly increase during the early years of statutory health insurance, so that they move ahead of surgeons and other clinicians. During the annual negotiations with health insurance carriers, the medical association asks for higher fees for clinicians, carriers say they cannot afford such extra payments, clinicians fear that nonclinicians will obtain an increasing share of the limited total, and the medical association must resolve the situation.

Revising the shares becomes an important function of the internal–and secret–negotiations within the medical association. At first, nonclinicians are forced to accept lower unit fees, so their incomes will remain closer to those of the surgical specialties. Then internists, psychiatrists, and general practitioners object to their wide distance from the surgical specialists. Again, health insurance carriers are asked to supply more money, they refuse, and the medical association must devise a solution. Each year, the cognitive specialties and general practitioners get larger increases in their unit fees than the surgical specialties obtain, and gradually the gap narrows.

Professional politics requires that no specialty suffer a cut in income, and certainly not the powerful surgeons. Any such victim would protest, create public embarrassment, and cause internal antagonisms in a profession that is supposed to be solidary. Politics also requires that no rivalries become public, that all complaints and settlements be private, and that settlements evolve over years.

Foreign experience demonstrates the prudence of enacting an insurance and reimbursement plan first–even if the medical profession must be appeased–and resolving the explosive matter of relative incomes later. The persons who decide the structure of the larger financing system (government officials, economists, and other lay persons) differ from those who settle the internal rivalries within the medical profession. The Harvard team–consisting of clinicians, psychologists, statisticians, and survey experts with whom the government contracted–audaciously tried to settle both issues.

By itself, the restructuring of the fee schedule need not invite resistance. In foreign countries, changes are phased in over many years, and
the surgical specialties never suffer sudden reductions in income. Or, if quicker action is desired, new money is added to medical insurance, so the cognitive specialties and general practitioners get higher incomes while the surgical specialties rise only slightly. But the watchword of Washington during the 1980s was “budget neutrality;” any restructuring of a program must result in no higher total costs.

Instead of moving cautiously, the Harvard team brandished its red flag at the bull. When releasing its full report, the Harvard team released a table to the press showing a simulation of the reshuffling effect of their RVS on physician incomes. This table appeared unwisely in the Harvard team’s first publication, was repeatedly publicized in the coverage by the medical and popular press, and has hung over the policy debate ever since. In every other country, income targets dominate the construction and reforms of the fee schedule. The U.S. specialties’ perceptions of the Harvard team’s work is determined by the predicted incomes, not by the formulae and calculation of weights from inputs prized by the researchers.

The staff of the PPRC then tried to dampen the fire by arguing that the true income differences would be narrower, but they could do so only by “correcting” the Harvard methods and running a new simulation. This inadvertently demonstrated that no single “rational” formula exists, that no adequate database can be obtained, and that no single “objective” income distribution can be fixed. In a political field, methods are not allowed to determine outcomes, but desired outcomes determine the selection of methods.

Instead of working out a consensus in private—as in every European country, in Canada, and even in the California Medical Association’s management of its CRVS—the factions in the U.S. medical profession accepted Washington’s invitation to feud in public. As part of its initial examination of the Harvard proposal in November 1988, the PPRC heard the AMA leadership and the principal specialists’ associations in a long and confusing day of testimony. The associations again presented their rival views in hearings before congressional committees during 1989. This experience stiffened the rival positions. The long-hidden rivalry between the AMA and the ACS reopened in an exchange of sharp letters. Several specialty associations, such as the American College of Radiology and the American Society of Anesthesiologists, negotiated their own fee schedules and reimbursement policies with Medicare.

All this jeopardized the possibility of eventually enacting any kind of new payment system for Medicare, since the different factions made contradictory demands on a Congress that shrank from making clear-cut, difficult choices about any topic. Congress itself tried to defuse the problem during the forthcoming transition period by steadily increasing
payment to cognitive procedures each year relative to the technical procedures, a method common abroad. Several resolutions debated in Congress in late 1989 proposed to freeze the CPR prevailing charges for all except primary care procedures. By the time the fee schedule might be implemented in the 1990s, the gap in fees and incomes between the surgical and cognitive specialties would be narrower. However, a short-run danger might be a reduction in voluntary assignment for the frozen procedures, reversing a laboriously achieved upward trend in assignment.

Assignment Of Claims

In every country, assignment of claims at some time becomes the most explosive issue between public authorities and the medical profession. Doctors oppose dictation by lay persons and prefer to retain freedom in charging. But patients, already burdened with Social Security taxes, want their money’s worth. The political Left opposes profiteering from a social program by an elite profession. Under service benefits systems (where carriers pay doctors directly), the fights occur at the time the program is enacted (as in Belgium and Quebec). When the method is a reimbursed system (where patients pay doctors and are reimbursed by carriers), the inevitable showdown occurs years later (as in France and Ontario).

Divided over the structure of the fee schedule, American doctors—like those elsewhere—were united in opposing universal mandatory assignment. However, if doctors could charge what they liked, every fee schedule was meaningless. Congress in 1984 persuaded doctors to accept assignment by offering carrots (but no sticks), such as large increases in their fees. At first, this method foundered on the internal divisions within the U.S. government; the executive branch froze all Medicare fees, to control its budget, thereby eliminating Congress’s carrot. But eventually the “participating physician” arrangement was implemented. Congress then enacted not a penalty over the nonparticipating doctors but a restraint: a nonparticipating doctor could bill no more than 125 percent over the CPR prevailing charge (the maximum allowable actual charge, or MAAC).

The priority of the PPRC in 1989 was to enact a fee schedule. Recommending universal and compulsory assignment would have united the entire medical profession, the executive branch of the government, and many members of Congress against the entire effort. While the Association of American Retired Persons (AARP) strongly favored assignment to save pocket cash for the elderly, the general public understood remarkably little about the esoteric subject and could not be mobilized. Mandatory assignment aroused one of the few divided votes in the PPRC’s deliberations. The swing voters personally preferred man-
andatory assignment, but thought it more prudent to concentrate on congressional enactment of the fee schedule. They also feared a mass withdrawal of doctors from Medicare, in the unlikely event of actual enactment of mandatory assignment. So, the PPRC recommended and Congress in late 1989 will probably reenact the past policies under new forms, that is, rewards for “participating physicians” and a limit on extra charges in unassigned claims.¹⁵

Perhaps another country would have adopted the same result. Belgium’s Cabinets have always been too weak to impose mandatory assignment on the entire medical profession. After two decades of mandatory assignment, during the 1980s France allowed doctors (chiefly the high-status urban specialists) to opt out and balance bill. However, the dispute abroad is usually fought out by itself, without being mixed into other important issues. The president or prime minister leads public policy, not a study commission. Doctors who opt out forgo advantages and suffer sanctions. Where balance billing exists abroad, it involves fewer doctors, fewer claims, and less out-of-pocket cash.

During the maneuvering for special deals in the United States, some factions in the medical profession offered conditional assignment if the rest of their scheme was adopted by Medicare. For example, a Conjoint Council on Surgical Services uniting all the surgical specialties recommended introducing a two-class method into the Medicare law: surgical specialists would accept assignment for all patients below a certain income level but would continue to balance bill patients above it. The council offered the scheme along with its proposal for a new Medicare fee schedule calculated from the surgical specialists’ customary charges. Such class-based assignments and balance billing had disappeared from Blue Shield and the few European statutory insurance systems that had ever allowed it (several cantons in Switzerland). Patients had complained about discrimination in a social program supported by everyone’s taxes; doctors and insurance carriers did not want to investigate every person’s income; and patients could hide unearned income. The surgeons’ proposal was yet another barrier to devising a single clear-cut policy.

**Expenditure Targets And Caps**

When Medicare was enacted in 1965, its Part B (physician payment) contained no administrative structure and no cost controls. Part B drifted for decades, partly because Washington was preoccupied with hospital reimbursement under Part A; partly because Medicare needed the voluntary cooperation of all doctors; and partly because strong cost containment controls would have triggered protests by the medical profession.
and a difficult struggle in Congress over amending the law. But cost containment could not be postponed forever; three-quarters of the official reimbursement (not counting balance billing) was covered by general tax revenue, and by the late 1980s, the Treasury was paying over $20 billion per year—14 percent of the government’s annual deficit.

In late 1988, leaders of the House of Representatives—then followed by many other Washington policymakers—called for something even stricter than “budget neutrality,” that is, an “expenditure cap” impervious to unpredictable increases in utilization, particularly a larger number of diagnostic tests. The PPRC recommended the adoption of “caps” or “targets” in its 1989 annual report to Congress. Policymakers had heard that Canadian provinces used fixed-budget methods, freezes, and occasional reductions in total costs in paying doctors. They heard also that German doctors at times have been paid by provincewide fixed totals, so that unit fees are prorated downward if excessive utilization threatens a deficit. Members of Congress and others visited Canada and recommended emulation in the reform of Medicare physician reimbursement. 16

An “expenditure cap” fixes total spending for the year. If utilization increases, either fees for each service or salaries are reduced, so that total spending is not exceeded, or facilities are closed or services limited. Such strict limits have been used in many publicly financed health services abroad and in some U.S. state Medicaid programs.

The PPRC recommended and Congress is expected to enact “expenditure targets” in late 1989. The government each year would predict its expected total expenditure for physician services for the year; if the total was exceeded (because of higher-than-predicted utilization, service intensity, or upcoding), the money would be recaptured next year by a compensating reduction in the expected increase in the conversion factor. The medical profession would have a collective incentive not to overutilize services. Government can plan and control increases in total expenditure.

While expenditure controls are common abroad, the only remarkable feature of the U.S. action is the long delay. Particularly when public revenue is at stake, strict expenditure caps are installed early, since government cannot allow health providers to drain the national budget. Statutory health insurance administered by nonprofit sickness funds and financed by Social Security payroll taxes usually contains flexible expenditure targets.

Yet there is no assurance that expenditure targets ever will be implemented, despite the apparently unavoidable need for them in the United States. What Congress likely will enact in late 1989 are instructions to HCFA, which—as under many other congressional instructions—may lead HCFA to second-guess and not implement them strictly. As in all
Medicare reimbursement and many other domestic policies, Congress retains the power to enact the conversion factor itself every year, and it may back away to appease doctors’ complaints.

Proposals for aggregate expenditure controls have complicated the political environment for reforming physicians’ pay in the United States in 1989 by straining the coalition necessary to enact reform. All factions in the medical profession are willing to adopt a fee schedule, and agreement might be brokered over the structure. If policymakers are wedded to the Harvard RVS, even that might be enacted with cognitive specialists, general practitioners, and some individual surgeons alone. But proposals for an expenditure cap—and even for more flexible targets—arouse strong and united opposition from the medical associations whose participation is crucial to the adoption of fee schedules. Total expenditure limits—particularly if strict—may be opposed by Medicare’s principal backer and the medical associations’ principal adversary, AARP. AARP fears that an expenditure cap with mandatory assignment will result in doctors’ mass refusal to take Medicare patients, as is the case under Medicaid’s expenditure caps. AARP fears that an expenditure cap without mandatory assignment will result in massive cost shifting to patients that will dwarf current levels of balance billing.

For its part, the AMA launched a passionate public advertising campaign in 1989 to mobilize and unify the otherwise divided medical profession. It condemned “targets” but actually described and denounced fixed “caps” and “rationing,” which were not incorporated in the pending legislation. What the AMA was protesting was government dictation, anathema to medical professions in all countries. In contrast to this uproar in the United States during 1989, in France the medical associations and sickness funds negotiated the identical type of expenditure target and calmly included it in the 1989 edition of their five-year contract. (Under European statutory health insurance, government participates in target setting, since it must forecast the expected yield from payroll taxes and Treasury subsidies. But government does not dictate, and the result is an agreement negotiated among the medical profession, the several sickness funds, and the principal government ministries.17)

In 1989, the political discord over expenditure targets extended to the two committees of the House of Representatives that were supposed to be designing physician reimbursement reform together—the Committee on Ways and Means and the Committee on Energy and Commerce. Ways and Means initiated the idea and reported to the House floor a bill that included the expenditure targets; Energy and Commerce feared side-effects and reported a bill that excluded them.

A dogmatic attachment to budget neutrality and short-run expendi-
ture limits contradicts realistic methods of altering the relative incomes of specialties. If cognitive specialists and general practitioners are to enjoy higher unit fees and higher incomes, and if powerful surgical specialists are not to face reductions and veto the enterprise, much new money must be added. If budget neutrality is the overriding aim, any new reimbursement method will be accepted by the medical profession only if it continues the status quo—for example, a Medicare fee schedule constructed from CPR prevailing charges. If doctors are persuaded or forced to accept universal assignment, they will require the solace of money. Every significant reform in health service financing abroad has cost more than expected during the first years. If the United States is serious about reforming the payment of doctors under Medicare, it must be ready to pay for it. The price would have been lower in 1965; it will become steadily higher in the future if the system continues to drift.

**Proposed Action**

**What other counties do.** When statutory health insurance is first enacted, all European countries adopt existing fee schedules to get the system started with minimum disruption, and standing negotiating machinery is created between the medical associations and the insurance carriers. Since paying doctors is one of the most important and potentially tumultuous issues in domestic affairs, the president (or prime minister), the minister of social affairs, and (often) the entire cabinet are fully informed and lead any big reforms. Economists and statisticians are called upon by the competing sides to provide briefing papers, and sometimes they meet among themselves to negotiate a set of agreed facts, but they are never authorized to design a single neutral solution. The decisions are political solutions of conflicts of interest, and neither the government nor competing interest groups commission technically elegant and expensive research.

Europe has simplified the task of paying doctors by making all decisions universal and standardized. Every country with statutory health insurance has an all-payer system that covers nearly the entire population and all providers. In contrast, U.S health care financing and physician reimbursement are fragmented between the public and private sectors.

**What the United States should do now,** In 1989, the PPRC recommended and Congress considered a large package of changes. Instead of trying to solve everything at once and deciding nothing, the United States needs to set priorities. First, the United States can create and adopt a fee schedule for Medicare at once. Models already exist, and Americans know how to write them. Ideas from the Harvard RBRVS can be used in
the design. But decisions should no longer be delayed with excuses about needing more “precise” and more “equitable” measures of this or that. The Harvard project has primarily provided the partisan case for reducing certain types of procedures and increasing others, but the arguments could be (and in fact were) made earlier. The fee schedule finally adopted will result from political log rolling rather than from econometric wizardry, so that inevitable outcome should be brought about now.

The creation, monitoring, and updating of such a fee schedule will require the full participation—and even the leadership—of the medical profession. Once the medical profession is expected to participate in the key decisions, the self-governing and negotiating machinery springs up, as it has in every other country. (In fact, the United States now has more professional associations and more organizational skills than other countries did upon enactment of statutory health insurance.) Possible negotiation options are: (1) all internal decision making and external negotiation through the AMA and its state societies; (2) joint committees of the AMA and specialty societies; (3) a permanent confederation combining the AMA and specialty societies, such as the one created in Holland; and (4) economic representatives who specialize in contracts and reimbursement alone, as in France, Belgium, and Quebec. Various combinations of national and state-level negotiations are possible.19

On the Medicare side, HCFA could negotiate as the payer in all matters involving fee schedules, conversion factors, and rules of practice. This role would resemble that of CNAMTS, the large Medicare-like trust fund in France. The American system would work better, however, if HCFA had decision-making responsibility and was not overruled unilaterally by the Office of Management and Budget (OMB) according to the latter’s own ideology.

Negotiated agreements would go to Congress for pro forma review and approval. The PPRC and the immense amount of research it generates would become unnecessary. Congress would be relieved of the constant detail and endless political contention of Medicare; its oversight and legislation could be reserved for large issues; and its overloaded tax-writing committees could concentrate on taxation.20

Health care policymakers and the congressional committees involved with Medicare are so accustomed to their constant and enervating struggles that they cannot envisage anything else. They dismiss negotiated decision making as a “foreign idea,” incompatible with the American style. But it has already been used for several years in other sectors of U.S. public policy, such as environmental protection, occupational safety, aviation, and nuclear regulation. It is not merely American, it is bipartisan; it is sponsored in Congress by both conservatives and liberals.
At the same time the House of Representatives has been discussing an eventual resolution of Medicare Part B, the Senate Governmental Affairs Committee and the House Judiciary Committee have been marking up the Negotiated Rulemaking Act of 1989, which would create guidelines for such decision-making methods throughout the national government. Even without the law, HCFA could set up at once and Congress could accept negotiating machinery for Medicare Part B.21

Once the fee schedule and the negotiating machinery are in place, levels of costs must be addressed. Annual expenditure targets would be one of the topics regularly discussed between HCFA and the medical associations, with guidelines from OMB. No doubt disputes over levels of targets and over recovery of deficits will arise, as they do in every country. However, doctors in all countries are more cooperative if they participate in target setting and if they are not subject to unilateral government dictation. Utilization control and other devices to stay within targets are managed by the negotiating machinery.22

Other issues such as the incorporation of practice guidelines into the reimbursement system are for the future. Also, if many doctors refuse assignment and balance bill patients, mandatory assignment might have to be imposed. That is the sort of issue that deadlocks negotiators and must be decided by presidents and legislatures. Perhaps in the interim, the issue can be dampened: ordinary doctors may cooperate more with a system that the medical associations help manage, and the negotiators may devise small compromises that reduce strains on patients.

What the United States should do in the long run. The United States has had no health care financing policy for a decade. In turn, the paralysis in health policy has been part of a larger crisis of decision making in U.S. domestic affairs.

No country can function without executive leadership in the creation, enactment, and implementation of policy. The only significant Medicare reform—changes in hospital reimbursement—occurred during a brief moment of executive leadership. Otherwise, presidents, HHS secretaries, and HCFA administrators have primarily passed the buck to Congress, which is too overloaded and too divided to create policies. Several presidents and HHS secretaries have understood neither Medicare nor the larger field of U.S. health care financing—a vacuum inconceivable in any other Western government. If paying the doctor and reorganizing U.S. health care finance are. ultimately political decisions, they can be settled only by a more knowledgeable and effective political leadership than America produces nowadays.

Creating and implementing a reimbursement system requires strategic thinking about how to organize and manage a country. This requires a per-
spective in scope and number of variables beyond the individual transaction between an abstract buyer and seller. Such new perspectives on reform therefore require not only new policy chinking but new policy thinkers.

Part of the reform of policy analysis is an understanding of what America can learn from all other developed countries. Favorite clichés of current US. health policy discourse are that “no country can copy another,” “the United States is unique,” “America is more pluralistic than other countries,” and so on. But this reflects the microeconomic and noninstitutional bias in current U.S. health policy analysis. The attitude flies in the face of experience. The United States has shared problems and settings with all other developed countries; some of the principal reforms in U.S. health care and social policy have been either inspired generally or copied literally from abroad, such as the teaching hospital, the Flexner reform of medical education, the HMO, and the entire Social Security system. While health policymakers in one part of Washington declare that they have nothing to learn from Europe, the Social Security Administration elsewhere in town has long maintained an Office of International Policy and a Comparative Studies staff to collect and assimilate foreign experiences. Important sectors of the U.S. economy weakened by foreign competition—such as automobiles and electronics—try to save themselves by emulating foreign (particularly Japanese) management and production methods and by creating joint ventures. Even the Treasury Department studies foreign experience in particular tax devices (such as the value added tax) and in tax collection.23

Finally, another long-run reform that the United States should not continue to avoid is enactment of a genuine comprehensive health insurance system. Medicare can be patched temporarily by the methods described in this article, but a Medicare-only method of paying doctors is unstable. While such a comprehensive system cannot be enacted now because of the weaknesses in political leadership and policy imagination, only a genuine statutory health insurance system would solve the persistent American problems of coverage, access, and cost containment.24

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NOTES


18. In a short journal article, I must simplify. The many qualifications and details about statutory health insurance appear in my books, cited in notes 4, 16, and 17. The payment of doctors and the making of decisions in national health services (such as Britain and Sweden) and in publicly financed arrangements (such as Canada) differ, will never have statutory parallels in the United States, and therefore carry fewer relevant lessons for American policymakers. I describe them in other chapters of the aforementioned books.

19. I have described various American scenarios in Glaser, *Health Insurance Bargaining*, chap. 5. The AMA has published much about negotiating methods.

20. In contrast to my scenario, the PPRC denies that any negotiating system is feasible, either to create or to update a reimbursement system. It envisages continuation of the status quo, wherein it hears all interest groups and experts, conducts its own research, issues large research and consulting grants, and recommends what Congress should do every year. Congress continues to decide all details annually. PPRC, 1989 *Annual Report to Congress*, 174–176.


22. This would not be the AMA’s first experience in setting expenditure targets. It was a member of a consortium of providers and insurance associations in the late 1970s (the Voluntary Effort to Contain Health Care Costs), which set annual national goals and urged local providers to economize accordingly. The targets were never enforceable and lapsed after the election of 1980.
