

Current Issues in Physician Payment in the United States and the Republic of South Korea

Sylvia A. Law*

Abstract

This paper examines insurance payment for physician services and compares the challenges confronting Korea and the United States. In both countries health insurance generally subsidizes physician services, on the basis of fees for services provided. In the presence of widespread insurance, there is no market-based customary or prevailing fee which insurers can use to set fees. Alternative methods of setting fees are controversial. Further, fee for service payment creates incentives for unnecessary, costly, and sometimes damaging care.

The paper examines the fifty year U.S. history testing many approaches to setting fees for physician services provided to insured patients. Thus far, none has proven successful in keeping physician costs within general increases in GDP and inflation or in providing incentives for appropriate, quality care.

In the past decade, conflicts between Korean physicians and the national health insurance system have twice resulted in national physician strikes. These conflicts involve many issues, including the separating of proscribing and providing drugs and telemedicine. This paper suggests that a persistent underlying concern of Korean doctors is that fees are inadequate and force doctors to provide excessive volume of service.

Finally, the paper argues that both the United States and Korea would benefit from the adoption of alternatives to fee for service that promote more collaborative medical services.

KEY WORDS: Physician Payment, Health Insurance & Physician Payment, Telemedicine, Separation of Prescribing and Provision of Drugs, Physician Payment & the Organization of Health Care

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* Elizabeth K. Dollard Professor of Law, Medicine and Psychiatry at NYU School of Law. This paper began as a talk to students at the Law School and the School of Public Health at the National University of Seoul, April 11, 2013. Thanks to Prof. Jae-Hyup Lee, of the NUS Law School, Dean Soonman Kwon, of the NUS School of Public Health, and my research assistants, Brian Fraiser, NYU Law JD 2014 and Minju Kim, NYU Law JD 2016.

Contact: sylvia.law@aol.com, 212-998-6265

The ways in which doctors are paid is critical to all of the traditional health policy concerns of access, costs and quality. Part One (I) offers some general comments about the special characteristics of physician payment. Part Two (II) examines the history of physician payment in the U.S. and the problems it has created. Part Three (III) briefly describes current debates about physician payment in Korea. Finally, Part Four (IV) argues that approaches to physician payment should be more thoughtfully attentive to the ways in which medical work is organized. This part describes some exceptional U.S. programs that provide practical models worth emulating both in the U.S. and Korea.

The central thesis of this paper is that a mature health insurance system needs a complex process for setting physician fees. Widespread health insurance and fast developments in medical technology and treatments mean that fee for service payments invite excessive and costly services that waste insurance dollars and threaten patient well-being. Neither the U.S. nor Korea has yet developed an effective alternative to fee for service payment. The U.S. has tried several approaches, largely unsuccessfully. Both the U.S. and Korea can learn from one another.

A reader of an earlier draft of this paper suggested that “there is a difference in the systemic scale with the American health care system being private and the Korean system being public.” I disagree. Health insurance systems around the world are a mix of public and private. Brittan may be the closest to a public system in which the state owns the hospitals and most of the doctors are public employees. They avoid a lot of the problems addressed in this article. But, most countries have adopted a public/private mix to health insurance and health care. In Korea, hospitals and doctors are mostly private, as they are in the U.S. In Korea, insurance is public. In the U.S. much insurance is private, but public programs, Medicare for the aged and Medicaid for the poor, are administered by private local insurance companies. Private insurers rely on reimbursements methodologies developed in public programs. Insurers, whether public or private, confront similar issues.

I. Setting Fair Fees for Physician Services is Complex and Challenging. Both the U.S. and Korea Need Better Approaches.

For many reasons, it is difficult to apply traditional market models to determine fair and efficient compensation for medical professionals. In free market societies, most prices and compensation are determined by market transactions between a willing and informed buyer and seller. However, this model is not easily applied to medical care. Because of the large knowledge disparities between doctors and patients, arms-length negotiation is not possible. Society and the law impose fiduciary obligations on doctors who care for patients. “Let the buyer beware” may be an appropriate standard in buying a car or a computer, but it is not the right rule for doctors treating patients. Apart from the knowledge disparities, patients are often in pain and urgent need and not able to negotiate effectively. Because medical services are sometimes matters of grave necessity, rather than discretionary desire, social, political and professional norms follow their own mechanisms, irrespective of insurance to assure the availability of essential medical care or immediate ability to pay. These norms encourage sliding fees based on ability to pay and creation of charitable and public services.

The difficulty of applying market principles to the pricing of medical care is intensified by health insurance. In the past century, medicine developed a capacity to save lives and enhance function, but at a cost that no one but the extremely wealthy can afford out of pocket. Further, health problems are unpredictable; even the affluent can instantly confront medical needs too costly to pay from savings. Insurance – pooling of risk among the healthy and the sick – is, thus, essential. Most developed societies have concluded that it is wrong to allow people to die or to become unproductive because they cannot afford to buy medical care at the moment they need it.

Once a society accepts the need for health insurance, it needs to address the question of how health care providers are paid. Physician payment presents particularly difficult challenges and different nations and systems

have taken radically different approaches.¹⁾ Insurance programs, that are young and or relatively small, promise payment based on the providers' "customary charges." The assumption is that fees negotiated between paying patients and providers will set a reasonable, market-based, standard that can be adopted by the insurer. But, as insurance programs grow and everyone except the most indigent and marginalized is insured, there is no free market "customary charge" upon which the insurer can rely.

A mature health insurance system needs a sophisticated mechanism for setting and adjusting the prices that insurers pay to physicians. Fees must be sufficiently high to encourage the best and the brightest to do the hard work necessary to become a doctor and provide quality medical care. But, doctors, being humans, cannot be allowed unfettered authority to define their own values. Fees must encourage hard work and cooperation, but at the same time, not provide incentives for unnecessary or marginally necessary care that increases costs and impose burdens and risks on patients. Fees must take account of historical patterns, providing greater compensation to some specialists, while also seeking to encourage changes in physician work-force when there is an excess of some well-paid specialists and a shortage of other doctors who are less well paid. In any insurance program, fees are only paid for services that are covered by the program or policy and medically necessary. If the standards are too narrow or the review process too aggressive, patients are denied essential care. If it is too lax, doctors can make money by providing unnecessary care that is always inconvenient and sometimes dangerous to patients and always unnecessarily costly. These are difficult questions that require informed judgment of professionals, whose fees are set, and access to data that is not always available.

In addition to this complex set of issues about fees and coverage in particular cases, larger social issues need to be considered. How do physician fees in an insured system influence access to medical care? As discussed below, in both the U.S. and Korea, people in urban areas have much greater access to medical care than those in rural or smaller

1) For a good recent summary of our various systems address these issues see Miriam Laugesen & Sherry Giled, *Higher Fees Paid to US Physicians Drive Higher Spending for Physician Services Compared to Other Countries*, 30 HEALTH AFFAIRS 1647 (2011).

communities. People who need surgery are better able to find it than those who need management of complex, chronic diseases. Should insurance fees address these problems? Should physician fees, on average, compete with corporate executives, stars of rock, film and sport, or should they be double or triple the average worker?²⁾ How much do various doctors actually earn? Is that something that the agency that sets their fees should know? The general public? Finally, and perhaps most important, how does the way we pay doctors through insurance impact the organization and quality of medical care? Part 4 returns to this subject.

Apart from the substantive difficulty of determining fair fees for physicians and the broader policy questions implicated by physician payment, the political reality is that physicians, quite sensibly, favor a reimbursement system that allows them to maximize income. As Part 2 shows, in the U.S., organized medicine has resisted efforts to control and rationalize physician fees. As Part 3 shows, in Korea, doctors have also resisted governmental efforts at payment reform. Doctors are politically powerful, because most people like and trust their personal physicians.³⁾ Many other actors in health care try to be astute at protecting their self-interests. The regulators of physician payment, whether government agency or private insurer, need a sophisticated understanding of medical practice and health care organization. They also need to be politically savvy and able to communicate effectively to mobilize broad public support.

Much is at stake. Both the U.S. and Korea experience rapidly rising health care costs. In both countries, it is not clear whether the money is well spent, however. Indeed, there is much evidence that excessive medical care, driven by fee for service payment, causes serious harms. Solutions are not obvious.

2) Issues of income disparity are now hotly debated around the world. THOMAS PIKITY, *CAPITAL IN THE 21ST CENTURY* (2014).

3) David D. Kirkpatrick, *A.M.A. Endorses a Health Care Overhaul*, N.Y. TIMES, Sept. 9, 2009.

II. A brief history of physician payment in the United States

The U.S. experience is not a model for anyone to follow. T.R. Reid, in his wonderful book about health financing in developed countries tells the story of Taiwan. In the late 1980s, 60% of the population was uninsured, but political leaders recognized that the country was rich enough to address this problem. They set up a high level commission to look at what other nations had done. The commission hired Dr. William Hsiao, a preeminent health care economist from Harvard, to help them. After analyzing the system of health care financing of the U.S., the commission concluded not to follow the system, even though Taiwan, like Korea, has a close relationship with the U.S.. This shows that in relation to health care financing, the United States is a model with serious problems to be avoided.⁴⁾

Overall, U.S. health care has several distinctive features. Its spending is more than two and a half times the OECD average.⁵⁾ Per capita spending on physician services in the U.S. was \$1,599 in 2008, whereas an average was \$310 per person across all other OECD countries.⁶⁾ Further, specialists earn an average of two to four times an average salary of primary care physicians in the U.S., a differential that far surpasses that in all other developed countries.⁷⁾ This issue is related to the serious shortages in primary care physicians and an excess of specialists in the U.S.⁸⁾

All this money is not effective, as it can be shown by several statistics. Between 1960 and 2013, the life expectancy in the U.S. fell from 1.5 years above the OECD average to 1.5 years below the average,⁹⁾ while its infant mortality rates place it at 169th out of 224 nations, behind all developed

4) T.R. REID, *THE HEALING OF AMERICA* 165-175 (2009).

5) OECD HEALTH DATA 2013: HOW DOES THE UNITED STATES COMPARE (2013), www.oecd.org/health/healthdata.

6) Laugesen, *supra* note 2.

7) Elisabeth Rosenthal, *Patients' Costs Sky Rocket; Specialists' Incomes Soar*, N.Y. TIMES, Jan. 18, 2014.

8) Elayne J. Heisler, *Physician Supply & The Affordable Care Act*, Congressional Research Service, 13-14, Jan. 15, 2013, [http://op.bna.com/hl.nsf/id/myon-93zpre/\\$File/crsdoctor.pdf](http://op.bna.com/hl.nsf/id/myon-93zpre/$File/crsdoctor.pdf).

9) *Supra* note 6.

countries and even many countries that are very poor.¹⁰⁾ Korea ranks fifty places above the U.S. in infant mortality.

Even though, overall, the U.S. is a model to avoid, rather than to emulate, it is nonetheless worth to examine the U.S. system in approaching questions of physician payment. The U.S. history of health insurance is relatively long and well-studied. Because of its size and traditions of federalism and pluralism, U.S. insurers, public and private, have tried many methods for paying doctors.

In the U.S., medicine did not have much to offer until the 20th Century.¹¹⁾ Doctors and hospitals, operating within a professional and sometimes charitable frame-work, commonly varied charges in accordance with perceived ability to pay. By 1930, doctors had achieved remarkable power over the practice of medicine and powerful political authority, exercised through a disciplined local, state and national structure.¹²⁾ Also, medicine provided more useful services.

There was virtually no health insurance until the Great Depression of the 1930s. During and after the Great Depression, almost no patients were able to pay. Therefore, hospitals and doctors perceived a need for pre-paid health insurance. The form they preferred was local non-profit insurance companies, controlled by local hospitals and doctors. These organizations – the Blues – were created in every community in the US. The provider controlled Blues that paid on behalf of insured patients, on a fee for service basis pegged to the doctor's customary charges; they paid hospitals their costs, as defined by hospitals. Even though the Blue organizations were controlled by the professionals they paid, they also reflected a remarkable commitment to health care as a social good. Until the 1960s, organizations using the Blue trademark were required to offer open enrollment and community rating. Open enrollment meant that high risk people could buy Blue insurance. Community rating meant that everyone paid the same rate,

10) CIA, World Factbook (2014), <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html>. Korea ranks ahead of us at 100.

11) For analysis of the history of health insurance in the United States *see* SYLVIA A. LAW, *BLUE CROSS: WHAT WENT WRONG* (1973); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

12) PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 90-112 (1982).

whatever their risk. The Blues insisted that hospitals not charge patients more than the program paid, except for specified deductibles and co-insurance. Doctors, by contrast, insisted on their right to charge patients more than the program paid. The Blues were a bubble of local, professionally controlled collective sharing of health care risks, within a strongly market oriented economy.

In the 1950s, all of this changed. Once the Blues had demonstrated that the market for health insurance was fiscally viable, commercial insurers entered it. Medicine had more to offer, but at a high cost. Commercial insurers marketed to groups that were relatively young and healthy and aggressively denied coverage for pre-existing conditions. Within a decade, the Blues abandoned their historic commitments to open enrollment and community rating. They could not possibly compete in a market in which commercial insurers covered the young and healthy and the Blues covered the rejected.

The most identifiable victims of this change were older people. Because the elderly predictably use more health care, they could not obtain insurance. In 1965, Congress responded to a popular movement of older people, adopting Medicare to provide health insurance to the elderly. Hospitals, and most especially doctors, were strongly opposed Medicare, calling it as "socialized medicine." More concretely, they feared that a strong, centralized federal payment program could jeopardize their income. They threatened to strike by refusing to participate in the program.

In 1965, the key compromise, that later made Medicare politically feasible, guaranteed hospitals and doctors that they would continue to be paid the traditional Blue reasonable costs and customary charges for services provided to Medicare beneficiaries. It also promised both doctors and hospitals that there would be no government review of whether recommended services were medically necessary. Most importantly, it put the administration of the program in the Blue organizations controlled by hospitals and doctors.

Not surprisingly, costs soared. Medicare gave hospitals and doctors blank checks. The Blue system previously gave providers whatever they asked, but services were financed by local neighbors and family and subject to professional control. What is perhaps surprising is not that U.S. costs increased when the federal Medicare program picked up the costs for the

most expensive patients, but that they did not do so more quickly or in every place and practice. Given the blank federal check, the real puzzle is not why some doctors and hospitals charge more and do more marginally useful and risky work, but rather that many do not.¹³⁾

Since the 1970s, there have been modest state and federal public efforts to contain both doctor and hospital costs in the fee for service system.¹⁴⁾ The most significant was the introduction of Diagnostic Related Group (DRG) payments for hospital services, initially sponsored by Medicare and now adopted by most private insurers. The U.S. still confronts serious, systemic problems in relation to the quality of hospital care.¹⁵⁾ DRG payment for hospital care is an important stepping forward. Prior to DRGs, both public and private insurers paid hospitals their “reasonable costs” on a per diem basis, which created incentives to keep people in hospital longer than necessary. By contrast, DRGs pay for a sophisticatedly defined unit of care. DRGs give hospitals incentives to treat people and send them home. Length of stay and Medicare hospital costs decreased as a result, without adverse effects on patient mortality or morbidity.¹⁶⁾ The system is complex

13) In 2009, Atul Gawande studied extreme cost disparities in two demographically similar cities in Texas. Atul Gawande, *The Cost Conundrum: What a Texas town can teach us about health care*, THE NEW YORKER, June 1, 2009. One city spent twice as much per Medicare beneficiary than the other, but the people received less preventative care and were less healthy. Given the open ended check for diagnostic tests and procedures, he observes the “real puzzle” is not why the more expensive city costs more, but rather why the doctors and hospitals in the less costly city do not.

14) See e.g. Kenneth Thorpe, *Does All-Payer Rate Setting Work? The Case of the New York Prospective Hospital Reimbursement Methodology*, 12 J. HEALTH POLITICS, POLICY & L. 391 (1987) (evaluating rate setting programs in New York and other states); Eduardo Porter, *Lessons in Maryland for Costs at Hospitals*, N.Y. TIMES, Aug. 27, 2013 (describing expansion of Maryland’s successful 37 year old rate regulation program).

15) In 1999 a large, prestigious study projected that 44,000 to 98,000 people in the U.S. die each year due to systemic hospital errors and failures, and hundreds of thousands suffer avoidable injuries. INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM* (1999). It fueled a patient safety movement promoting systemic changes, reducing length of stay and hospital based infections. Lucian L. Leape & Donald M. Berwick, *Five Years After To Err is Human: What Have We Learned?*, 293 JAMA 2384 (2005). The Affordable Care Act does not directly address improvement in clinical or professional quality, but does promote pilot reforms. Barry R. Furrow, *Regulating Patient Safety: The Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1727 (2011).

16) William H. Rogers et al., *Quality of Care Before and After Implementation of the DRG-*

and informed people argue about the details. But the core DRG concept is widely accepted for hospital reimbursement, both by private insurers in the U.S. and by national health insurance programs around the world. No one has figured out how to apply the DRG concept to physician services. There are many more physicians than hospitals and many more individual transactions. The U.S. Medicare fee schedule for physicians includes 7,000 different reimbursable services. But some codes are very broad, for example, “office visit for evaluation and management” and sweep up the vast majority of services.¹⁷⁾

Despite modest regulatory efforts to control health care costs, they continued to soar. In the 1980s, a new approach emerged – managed care. The core concept of managed care makes sense, which is that people should be encouraged to enroll in organizations that will take comprehensive responsibility for medical needs for a fixed price. Managed care gets rid of the inflationary incentives of fee for service – the organization gets all of its payment up front. Managed care also encourages preventive care to avoid more costly treatment of avoidable conditions. “Managed” suggests cooperation and coordination, always good and often missing in health care. At its best, managed care provides the highest quality health care available in the US today. The question of what makes a good managed care program is addressed in Part Four, *infra*.

Managed care in the United States in 1990s was a disaster. Profit making companies sought to make money in health care. They marketed to healthy groups of young workers, and aggressively, and often deceptively, excluded coverage for costly conditions. Because U.S. doctors and hospitals were accustomed to fee for service payment, the managed care organizations of the 1980s did not control their own hospitals or hire their own doctors. Rather, they kept costs down by recruiting doctors who would take responsibility for more patients than they could possibly serve, in exchange for a fixed capitation. They recruited doctors who would

Based Prospective Payment System, 264 JAMA 1989 (2010). Some argue that Medicare DRGs controlled hospital costs by shifting them to other, less powerful, payors. See e.g. Uwe E. Reinhardt, *The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for a More Rational All-Payor System?* 30 HEALTH AFFAIRS 2125 (2011).

17) Miriam Laugesen & Sherry Giled, *Higher Fees Paid to US Physicians Drive Higher Spending for Physician Services Compared to Other Countries*, 30 HEALTH AFFAIRS 1647 (2011).

decline to refer patients for tests and services that cost money. They implemented vigorous utilization review of medical necessity, including prospective review that denied patients access to hospitals and expensive care, even when strongly recommended by their physicians. Managed care produced a temporary reduction in health care costs. But there was a huge backlash, from providers, patients and public opinion.¹⁸⁾

In 1989, Congress sought to address the problems of physician payment, through the Physician Payment Review Act, which created the Physician Payment Review Commission, charged to create a DRG like system for paying doctors.¹⁹⁾ Fees were to reflect time, mental effort and judgment, technical skill, physical effort and stress, as well a practice expenses including professional liability premiums. An overall goal was to increase the relative value of fees paid to primary care physicians, who Congress recognized were underpaid relative to specialists and in short supply. In addition, fees were supposed to control costs by tying payments to general increases in the cost of living, through a Sustainable Growth Rate Formula.

It is an understatement to say that the 1989 Act has been “an utter failure.”²⁰⁾ Physician costs have continued to increase rapidly. The payment disparities between needed primary care and excessively used interventions have gotten much worse.²¹⁾ Specialists earn two and often four times as much as primary care physicians, a differential that far surpasses all other developed countries. Income of dermatologists, gastroenterologists and oncologists rose 50 percent or more between 1995 and 2012, while those for primary care physicians rose only 10 percent.²²⁾ In the past decade, the rate of surgery has increased 400 percent in the U.S. Surgical specialists, on average, earn more than \$350,000 a year or more. In 2012, urologists had an average income over four hundred thousand dollars. Income is not closely

18) Mark A. Hall, *The Death of Managed Care: A Regulatory Autopsy*, 30 J. HEALTH POL. POL'Y & L. 427 (2005); James C. Robinson, *The End of Managed Care*, 285 JAMA 2622 (2001); SARA ROSENBAUM ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 210-218 (2012). [hereinafter ROSENBAUM].

19) ROSENBAUM, *supra* note 19, at 615-623.

20) ROSENBAUM, *supra* note 19, at 619.

21) See Rosenthal, *supra* note 8; Elisabeth Rosenthal, *The \$2.7 Trillion Medical Bill*, N.Y. TIMES, June 1, 2013.

22) Rosenthal, *supra* note 22; Laugesen, *supra* note 2.

associated with working hours. For example, while neurological surgery is highly paid, it does not demand longer than average hours. Dermatologists have high wages and low hours. Family practice doctors receive low wages, but are in the middle of the hour's rankings.²³⁾

While many factors contribute to these disparities, two are probably most important. First, in a long tradition of U.S. health care, the federal government delegated the primary responsibility for determining the details of physician fees to the American Medical Association,²⁴⁾ which in turn delegated that authority to its Relative Value Scale Update Committee, the RUC. The RUC is dominated by specialists and most of its work, conducted in secrecy, involves increasing payments for new services that specialists provide.²⁵⁾ Second, the 1989 Act requires the regulatory process to produce an aggregate payment for physician services that tracks changes in the per capita Gross Domestic Product, adjusted for increases in changes in Medicare enrollment and practice costs. The numbers are always lower than doctors believe are fair. Each year the U.S. Congress has adopted a "doctor fix" that increases Medicare payments to doctors.²⁶⁾

The Affordable Care Act (ACA) is a remarkable achievement that it makes insurance available to a much larger proportion of the U.S. population, who were previously denied insurance because they were high risk and/or could not afford to pay market rates. The Act does little to control physician costs. For the first time in its history, the American Medical Association supported national health insurance.²⁷⁾ It is not surprising that a highly contested Act to extend health insurance to millions of Americans would not also take on the question of physician payment.

23) J. Paul Leigh et al., *Annual Work Hours Across Physician Specialties*, 171 ARCH. INTERN. MED. 1211 (2011).

24) STARR, *supra* note 12, at 375-376.

25) ROSENBAUM, *supra* note 19, at 618; *see also* Ann Marie Marciarille & J. Bradford DeLong, *Bending the Health Cost Curve: The Promise and Peril of the Independent Payment Advisory Board*, 22 HEALTH MATRIX 75, 111-15 (2012).

26) ROSENBAUM, *supra* note 19 at 620; *see also* Sarah Kliff, *Doc Fix New Weapon vs. Health Reform*, POLITICO (Dec. 5, 2010, 5:09 PM), <http://www.politico.com/news/stories/1210/45976.html>; Merrill Goozner, *Medicare 'Doc Fix' Put on Life Support by AMA Lobby*, FINANCIAL TIMES, May 6, 2011, available at <http://www.kaiserhealthnews.org/Stories/2011/May/05/Fiscal-Times-Medicare-Doc-Fix.aspx?p=1>

27) David D. Kirkpatrick, *A.M.A. Endorses a Health Care Overhaul*, N.Y. TIMES, Sept. 9, 2009.

In relation to physician payment, the ACA mandated creation of an Independent Payment Advisory Board, a 15 member group of independent experts, appointed by the President, and confirmed by the Senate. If increases in Medicare costs exceed defined targets, it can recommend changes that Congress can only overrule by a super majority. No members have been nominated for this critical Board.²⁸⁾

The ACA may indirectly produce changes in physician payment. Traditionally, U.S. doctors have been solo practitioners or work in small groups.²⁹⁾ But, in recent years, many factors encourage doctors to become employees of a group. A group can provide malpractice insurance, health insurance for staff members, and colleagues.³⁰⁾ The ACA adds to these incentives for group practice by providing strong incentives for adoption of electronic patient records. It provides financial incentives for providers who can show that they comply with basic quality of care standards. These changes encourage individual physicians to join organizations, which can help to achieve these changes.³¹⁾ Demographic changes in the physician population make group practice more attractive. As more doctors, particularly women, seek to combine professional work with family life, the model of the traditional sole practitioner, available 24/7, does not meet the needs of many doctors.³²⁾

The U.S. experience in setting payment rates for doctors serving insured people offers several lessons. First, there is no magic formula. “Fee for service” is meaningless in a world in which most patients are insured.

28) Jonathan Oberlander & Marisa Morrison, *Failure to Launch? The Independent Payment Advisory Board's Uncertain Prospects*, 369 N. ENG. J. MED. 105 (2013), available at <http://www.nejm.org/doi/pdf/10.1056/NEJMp1306051>.

Ezekiel J. Emanuel and Topher Shiro, *Don't Give Up on Health Care Cost Control*, N.Y. TIMES, July 28, 2013. <http://opinionator.blogs.nytimes.com/2013/07/29/dont-give-up-on-health-care-cost-control/?src=recg>

29) Small, independent practitioners provide care for 9 out of 10 Americans. Steven Schroeder & William First, *for the National Commission on Physician Payment Reform*, 368 N. ENG. J. MED. 2029, 2030 (2013).

30) Amy Goodnough, *New Law's Demands on Doctors Have Many Seeking a Network*, N.Y. TIMES, March 12, 2014.

31) Elisabeth Rosenthal, *Apprehensive, Many Doctors Shift to Jobs With Salaries*, N.Y. TIMES, Feb. 13, 2014.

32) Garner Harris, *More Physicians Say No to Endless Workdays*, N.Y. TIMES, June 11, 2011.

DRGs for physician services or “cost based payment” are no better defined. Second, it is essential to set payment rates at a level that acknowledges the profound value of the work doctors do every day and the powerful respect it earns them from their patients. Third, any change in reimbursement policy, however dramatic, must begin with the status quo. Fourth, piece-work payment, whether fee for service or per-diems for hospital care, encourages unnecessary care that is both costly and risky for patients. Fifth, it is hard to define an alternative unit of payment for physician services. Payments for a defined care responsibility, such as managed care capitation or DRGs for an episode of hospital care, create incentives for under-service. DRGs show that it can be done, at least in carefully defined circumstances. Sixth, providers sensibly want to maximize income, and some have greater political and professional power than others. Whatever system is devised, it needs to be able to respond to legitimate complaints and, at the same time, to detect and resist predictable efforts to game the system.

III. Health Insurance in Korea and Recent Disputes about Physician Payment.

Korea faces problems very different from those confronting the United States. Between 1977 and 2000 Korea adopted a unified health insurance system for all.³³⁾ From a U.S. perspective this is stunningly impressive. The U.S. only recently joined the rest of the developed world, including Korea, in adopting national health insurance.

Not only has Korea achieved universal health insurance coverage, it has produced impressive improvements in health. From 1977 until 2003, life expectancy rose from 64.8 to 77.4 and infant mortality per 1000 live births fell from 38 to 3.8.³⁴⁾ While health care spending as a percent of gross domestic product increased, it did so at a modest rate and remains half of

33) Soonman Kwon, *Thirty years of national health insurance in South Korea: lessons for achieving universal health care coverage*, 24 HEALTH POLICY & PLANNING 63 (2009). [hereinafter Kwon, *Thirty years*.]

34) Kwon, *Thirty years*, *Id.* at 65.

the OECD average, and dramatically lower than the U.S.³⁵⁾ Since the merger of all health insurance societies in 2000, administrative costs have remained at an impressively low 4%.³⁶⁾

Despite these remarkable achievements, Korea confronts challenges. Co-payment rates range from 30% to 60% for out-patient care, the highest among the 20 OECD countries,³⁷⁾ though the rate of co-payments decreased between 1983 and 2004,³⁸⁾ and co-payments are discounted for low income people and those with chronic, catastrophic conditions.³⁹⁾ Co-payments are a regressive form of health care financing that fall more heavily on the less affluent majority. They discourage the use of beneficial, cost-effective care.⁴⁰⁾ Hospital stays are too long. A typical hospital stay in Korea is 10.6

35) In 2004 Korea spent 5.6% of its GDP on health care, an increase from 4.1% in 1985. The OECD average is 4.9%. Kwon, *Thirty years, Id.* at 66. In 2009 health care spending in Korea as a share of GDP is the third lowest in the OECD. Randall S. Jones, *Health-Care Reform in Korea*, 797 OECD Economics Department Working Papers 6, OECD Publishing (2010). [hereinafter Jones, OECD 2010].

36) Kwon, *Thirty years, supra* note 34 at 67.

37) Jones, OECD 2010, *supra* note 36 at 7.

38) Kwon, *Thirty years, supra* note 34 at 66.

39) *Id.*

40) In the 1970s, the Rand Corporation conducted a large study in which people were randomly assigned to insurance plans with varying levels of patient co-insurance and followed them for five years. Individuals assigned to plans with higher co-insurance rates used significantly less medical care, particularly for out-patient services. For the average person, lower levels of medical services did not have an adverse impact on health outcomes. However, the poor and the frail were more likely to suffer adverse health outcomes. For example, low-income, high-risk individuals saw a 14% rise in their predicted odds of death from high blood pressure under the high cost sharing plans. WILLARD MANNING ET AL., *HEALTH INSURANCE AND THE DEMAND FOR MEDICAL CARE: EVIDENCE FROM A RANDOMIZED EXPERIMENT (1988)*, available at <http://www.rand.org/content/dam/rand/pubs/reports/2005/R3476.pdf>; JONATHAN GRUBER, *THE ROLE OF CONSUMER COPAYMENTS FOR HEALTH CARE: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT AND BEYOND (2006)*, available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7566.pdf>. In 2008, in a smaller, shorter natural experiment, researchers studied the experience of 12,000 low income people in Oregon, half of whom gained Medicaid coverage through a lottery and half of whom remained uninsured. "Medicaid coverage generated no significant improvements in measured physical health outcomes in the first 2 years, but it did increase use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain." Katherine Baicker et al., *The Oregon Experiment pp Effects of Medicaid on Clinical Outcomes*, 368 N. ENG. J. MED. 1713 (2013). A systematic review of literature on cost sharing and use of prescription drugs found that "increased cost sharing is highly correlated

days, compared with an OECD average of 6.6.⁴¹⁾ Unnecessarily long hospital stays not only waste money; they are bad for patients, exposing them to hospital based infections and other adverse effects of institutionalization. Korea has an excess of hospital beds that encourages lengthy stays. The number of acute care beds in Korea is nearly double the OECD average. Further, the ratio of hospital beds to population has risen by almost 80% since 1996.⁴²⁾ Much more could be said about the impressive achievements and serious challenges of the Korean health care system, but the focus of this paper is on physician payment.

Fees for covered services are regulated and low. All providers are required to participate in the health insurance program and to serve patients insured by the program.⁴³⁾ “As fees are regulated for covered services, providers have financial incentives to provide more non-covered services, mainly new technologies.”⁴⁴⁾ For example, CT scans were not covered by the health plan until 2009 and patients paid unregulated prices, out of pocket, for these services. By 2008, Korean medical institutions had more than twice as many CT scanners, relative to population, than the OECD median.⁴⁵⁾ “With the inclusion of CT scans in the national health program, physicians moved on to MRIs, and they now have more than twice as many MRIs, relative to population, than the OECD median.”⁴⁶⁾ Until 2000, prescription drugs sold directly by doctors to patients were a particularly rich source of physician income and are discussed below.

Perhaps most important, doctors respond to low fees by increasing individual patient consultations. In 1999, Korean physicians typically recommended that a patient visit the office every two days for a minor case, for a consultation of 2 or 3 minutes.⁴⁷⁾ Between 1978 and 2009 the average

with reductions in pharmacy use, [but] the long-term consequences of benefit charges on health are still uncertain.” Dana P. Goldman et al., *Prescription Drug Cost Sharing: Associations With Medication and Medical Utilization and Spending on Health CARE*, 298 JAMA 61 (2007).

41) Jones, OECD 2010, *supra* note 36 at 10.

42) Jones, OECD 2010, *Id.* at 9.

43) Kwon, *Thirty Years*, *supra* note 34 at 69.

44) Kwon, *Thirty Years*, *Id.* at 66.

45) Jones, OECD 2010, *Id.* at 18.

46) *Id.*

47) Soonman Kwon, *Payment system reform for health care providers in Korea*, 18 HEALTH

number of visits to a physician per person rose from 3.7 per year to almost 12 per year, nearly double the OECD average.⁴⁸⁾ More superficial doctor visits are not necessarily good for patients, particularly patients who have a job, a family, a life, difficulty in travel or meeting the cost of co-payments. The typical Korean doctor provides 7,000 individual consultations each year, more than triple the OECD average.⁴⁹⁾ Overwork results in stress for doctors. From 1997 through 2000, Korea implemented DRG payments for select diagnoses at voluntarily participating hospitals.⁵⁰⁾ The pilot program reduced length of stay, antibiotic use, and costs, without negative effects on quality.⁵¹⁾ In 2002, the DRG-based payment system was officially extended, but providers remained free to decide whether to participate or to continue to receive regulated fee for service.⁵²⁾ Not surprisingly, only providers who calculate that they could gain from DRG based payments (clinics with in-patient beds) chose the DRG alternative.⁵³⁾ In 2000 and again in 2014, a substantial majority of Korean doctors went on strike for brief periods. Doctors in the United States, and in most developed nations, do not strike.⁵⁴⁾ They do not need to do so because, for complex historical reasons, their voices are heard.⁵⁵⁾ Part Two, discussing health care financing in the U.S., suggests that doctors there have too much power over health care financing. Still, doctor's voices are important in negotiating health care policy, including health care financing.

In 2000, the Korean government implemented a reform that mandated the separation of drug prescribing from dispensing.⁵⁶⁾ Traditionally, in

POLICY & PLANNING 84 (2003).

48) Jones, OECD 2010, *supra* note 36, at 11.

49) *Id.*

50) Soonman Kwon, *supra* note 48, at 87 (2003).

51) *Id.* at 88; Byongho Tchoe, *Diagnosis-Related Group-based Payment System and its Reform Plan in Korea*, 21 JAPANESE J. OF HEALTH ECONOMICS & POLICY 213, 217 (2010).

52) Byongho Tchoe, *supra* note 52, at 213-214.

53) *Id.* at 215.

54) The exceptions prove the rule. A Google search of "doctor's strikes" produces several stories about strikes in India and a story about a 1962 doctor strike in Saskatoon Province protesting the launch of the Canadian national health insurance plan.

55) STARR, *supra*, note 13.

56) Soonman Kwon, *Pharmaceutical reform and physician strikes in Korea: separation of drug prescribing and dispensing*, 57 SOC. SCIENCE & MED. 529 (2003); Soonman Kwon, *supra* note 48,

Korea and other countries of East Asia including China, Japan and Taiwan, the roles of doctors and pharmacists are not sharply differentiated.⁵⁷⁾ Pharmacists were allowed to proscribe and doctors were allowed to sell prescription drugs. As fees for medical services are strictly regulated, it became more profitable for doctors to sell drugs than to provide services. The Korean health system pays for drugs based on manufacturers wholesale prices. But drug companies sell drugs to doctors at deep discount. In some specialties, such as internal medicine, half of physician income comes from sale of pharmaceutical. Not surprisingly, Koreans consumed more drugs than people in other developed countries.⁵⁸⁾ Most distressing, prior to reform the rate of antibiotic resistance among Koreans was among the world's highest.⁵⁹⁾

In retrospect, it appears that the primary issue motivating the 2000 strike was the doctors' conviction that they are under-paid. Writing in a publication of the U.S. American Medical Journal, Korean doctor Wang Jung Lee explains that the underlying issue in the 2000 strike was that state set fees were too low. He asserts that the principle of the Korean health financing system is "low premiums, low medical consultation fees, low pay."⁶⁰⁾ Professor Soonman Kwon observes that one consequence of the 2000 strike was to push the government to abandon broader implementation of the DRG pilot program.⁶¹⁾ Physician average annual income increased sharply after the settlement of the 2000 strike, and the average annual income of pharmacists rose even more. In addition, the percentage of patients using high-priced brand name drugs, when alternatives of equal quality are available, rose from 26 percent in 2000 to 54 percent in 2001.⁶²⁾ In

57) Soonman Kwon, *supra* note 57, at 530.

58) *Id.* at 530-531. In 1996, the portion of pharmaceutical spending in health care in Korea was 31%, whereas that in OECD countries was below 20% on average. When pharmaceutical spending included physician fees for prescribing and dispensing, it amounted to as much as 40%.

59) Hak-Ju Kim & Jennifer Prath Ruger, *Pharmaceutical Reform in South Korea and the Lessons it Provides*, 27 HEALTH AFFAIRS w260, w261 (2008).

60) Wang Jung Lee, MD, *What Drove Korean Doctors into the Streets?* 6 VIRTUAL MENTOR 1 (2004).

61) Soonman Kwon, *supra* note 48.

62) Hak-Ju Kim & Jennifer Prath Ruger, *supra* note 60, at w260, w266. In 2008, the government instituted a drug formulary that lists relatively cheap alternatives of the same

broader terms, the strike reveals a conflict between civil society and the medical profession, and highlighted a need for transparency and rationality in the organization and financing of medical care.⁶³⁾

In October 2013 doctors again threatened to strike when the Korean Ministry of Health announced a bill to introduce remote diagnosis and treatment.⁶⁴⁾ In December 2013, thousands of doctors took to the streets to protest the government's plans.⁶⁵⁾ Then on March 10, thousands of doctors participated in a one-day strike to protest the policy.⁶⁶⁾ In response, the government ordered participating clinics to immediately reopen or otherwise suspend their operations for a certain period.⁶⁷⁾ Refusing to comply with the government order could lead to criminal charges.⁶⁸⁾

The use of telemedicine was introduced in 2008, in close collaboration with World Health Organization.⁶⁹⁾ It was originally introduced for use by physicians in isolated villages, who use the technology to seek consults from other doctors remotely in order to treat patients.⁷⁰⁾ The medical community and some experts are skeptical about telemedicine.⁷¹⁾ Telemedicine sometimes serves patients and sometimes does not.⁷²⁾ The

quality as brand-name drugs and penalizes doctors and patients who insist on the higher priced products, without justification. *Id.* at w267.

63) Byong-Hee Cho, *Conflicts between Civil Society and Medical Doctors Shown in the Doctors' Strike*, 1 KOREAN BIOETHICS ASSOC. 35 (2000).

64) Cho Chung-un, *S. Korea Plans to Start Telemedicine in 2015*, KOREA HERALD, Oct. 30, 2013, available at <http://www.asianewsnet.net/S-Korea-plans-to-start-telemedicine-in-2015-53428.html>.

65) Cho Chung-un, *Doctors Protest Telemedicine, For-Profit Operations*, KOREA HERALD, Dec. 19, 2013, available at <http://www.koreahearl.com/view.php?ud=2013129000671>.

66) *Doctors Go On Strike in Protest of Gov't Policy*, YONHAP NEWS, Mar. 10, 2014, <http://english.yonhapnews.co.kr/news/2014/03/10/30/0200000000AEN20140310001054315F.html>.

67) *Id.*

68) *Id.*

69) *Health Situation and Trends Assessment: Telemedicine Project in Democratic People's Republic of Korea*, WORLD HEALTH ORGANIZATION, http://www.searo.who.int/entity/health_situation_trends/topics/ehealth_dprk/en/# (noting the viability of telemedicine to increase access to the medical services, particularly in light of the fact that 80% of Korea's territory is mountainous).

70) Cho, *supra* note 66.

71) Jongyoon Moon et al., *Review on the Physician-patient Telemedicine in Legal and Social Systematic Aspect*, 21 KOREAN J. OF MEDICINE & LAW 201, 218-219 (2013).

72) Telemedicine and other forms of remote communication have improved outcomes

striking doctors also opposed government movements to encourage medical tourism and this too is controversial.⁷³⁾ Doctors in Korea have long opposed telemedicine; Song Hyung-kon, spokesman for the Korean Medical Association, said “[t]elemedicine that examines a patient without a face-to-face consultation would undermine the fundamentals of medical service.”⁷⁴⁾ KMA has also voiced concerns that telemedicine would have the effect of driving patients away from local clinics toward larger hospitals in Seoul.⁷⁵⁾

The government has stressed that the aims of the policy are to expand access to medical services, rather than to privatize the sector.⁷⁶⁾ The Ministry of Health revised its plan by banning the operation of medical institutions that specialize in telemedicine services, instead having patients receiving telemedicine services visit clinics regularly.⁷⁷⁾ However, some have suggested that pressure from Korean conglomerates like Samsung to develop the healthcare industry have been a driving force behind the policies.⁷⁸⁾ These critics have suggested that if commercial hospitals are introduced by this pressure, the government will be even less able to control fees and the costs of medical care will increase.⁷⁹⁾

From an outside perspective, it is interesting that the conflicts between the Korea health insurance authorities and physicians in 2000 and again in 2013-14 did not involve disputes about whether doctors are paid fairly or

and reduced costs for many types of patients, including those in remote intensive care units, the frail elderly, and those being treated for depression in clinics not served by a psychiatrist. See Schroeder, *supra* note 30, at 2029, 2031.

73) See e.g. Nicola S. Pocock & Kai Hong Phua, *Medical Tourism and policy implications for health systems: a conceptual framework from a comparative study of Thailand, Singapore and Malaysia*, 7 GLOBALIZATION & HEALTH 12 (2011).

74) *Id.*

75) *Id.*

76) *Id.*

77) *Id.*

78) *Id.* (noting that Samsung plans to invest 23 trillion won (approximately \$ 21.8 billion USD) in the health and medical equipment sectors by 2020). The WHO website also notes that the “[d]evelopment of a National Policy on Telemedicine and e-Health” is an activity planned for the future.

79) Elinor Lee, *Health Privatization Policies and Korean National Insurance Program*, 28 J. OF SOCIAL SCIENCE 129 (2009).

expected to work too much. It seems likely that these were the driving concerns. Organized medicine in Korea did not seek to make a public argument that they are underpaid. The government authorities did not present data that they were over compensated. I have been unable to find data on physician payment in Korea, differences among specialists or international comparisons. Certainly, doctors in Korea work long hours.⁸⁰⁾ But, it is unclear whether this is because reimbursement is too low or because they can earn more.

IV. Alternative Visions and Reality for the Organization of Medical Practice

The proceeding discussion addresses conflicts about fees between individual physicians and insurers, public and private, in the U.S. and Korea. The problems described are serious and constructive solutions not obvious. Another way to approach these questions is to ask who does a good job providing quality, reasonably cost care, and creates an environment in which doctors can find satisfying, collaborative work. Rather than imposing uniform payment policies from above, are the models on the ground that work effectively and should be encouraged?

Fee for service is not the only way to organize the financing of medical care. Some of the best of U.S. health care organizations reject fee for service, including the Mayo Clinic in Rochester, Minnesota and Miami, Kaiser Permanente of Northern California, Health Partners of Minneapolis, Group Health of Puget Sound, the Mansfield Clinic of Wisconsin, the Geisinger Health System in Danville, Pennsylvania, Intermountain Healthcare, in Salt Lake City.⁸¹⁾

What these organizations have in common is that they deliver high quality care at a relatively low cost. They are all non-profit. Fee for service is not the predominant mode of physician compensation. They facilitate cooperation amongst providers to best meet patient needs, coordinate

80) Jones OECD 2010, *supra* note 36 at 11.

81) Atul Gawande, *The Cost Conundrum: What a Texas Town Can Teach us About health care*, THE NEW YORKER, June 1, 2009.

patient care, practice evidence-based medicine, and monitor the care they provide. All rely on electronic patient data to promote these complex goals. Apart from these similarities, each has a unique individual story in terms of the way they were created and the culture that now defines the organization.⁸²⁾

The U.S. has yet another model of exemplary, low cost, high quality care. The Community Health Centers began in the 1965 when doctors working with the Civil Rights Movement to serve the massive needs of poor people in the South reached out to the new federal War on Poverty for help.⁸³⁾ Federal funding bypasses state and local governments and flows directly to nonprofit, community controlled organizations, a majority of whom must be patients of the clinics. To receive federal funds, the Centers must be located in and serve medically underserved communities, provide comprehensive primary care and adjust charges on the basis of patients' ability to pay. Their doctors are salaried and mostly primary care physicians. Health centers have been widely credited for their cost-efficiency, the quality of their primary health care, and their impact on community economic development.⁸⁴⁾ In 2008 nearly 1100 health centers operating in over 7500 locations provided care to more than 17 million patients, over 90 percent of whom were insured through the Medicaid program for the poor.⁸⁵⁾ Health centers provide excellent care to the most challenging patients at a reasonable cost. They are robust and growing. If Korea has bright spots comparable to the Mayo Clinic, Kaiser and Community Health Centers they should be nurtured, even if now modest in their scope.

Influential people in the United States now appreciate that "the level of spending on health care spending is unsustainable, that the return on investment is poor, and that the way physicians are paid drives high

82) *Id.*

83) John K. Iglehart, *Spreading the Safety Net - Obstacles to the Expansion of Community Health Centers*, 358 N. Eng. J. Med. 1321 (2008).

84) Eli Adash et al., *Health Care Reform and Primary Care: The Growing Importance of the Community Health Center*, 362 N.Eng.J.MED. 2047 (2010).

85) John K. Iglehart, *Spreading the Safety Net - Obstacles to the Expansion of Community Health Centers*, 358 N. Eng. J. Med. 1321 (2008).

medical expenditures.”⁸⁶⁾ That is the core conclusion of the National Commission on Physician Payment Reform, a group sponsored by the Society of General Internal Medicine and chaired by Steven A. Schroeder, former President of the Robert Wood Johnson Foundation and former Senator Dr. William H. First.⁸⁷⁾ The group’s first recommendation is that “Over time, payers should largely eliminate stand-alone fee-for-service payment to medical practices because of its inherent inefficiencies and problematic financial incentives.”⁸⁸⁾ As this paper suggests, there is a lot of evidence-based support for this conclusion. At the same time the Commission recognizes that fee-for-service payment is now the dominant way in which doctors are paid and it “will remain an integral part of physician payment for a long time.” These highly respected people call for radical, urgently needed, change. They were quickly supported by the American College of Physicians, CIGNA, a major profit-making health insurer, and CVS Caremark, as well as other consumer health advocates.⁸⁹⁾

86) See Schroeder, *supra* note 30, at 2029, 2031.

87) Robert Wood Johnson, *Reforming the Way Physicians Are Paid*, Jan. 10, 2014, available at <http://physicianpaymentcommission.org/>.

88) See Schroeder, *supra* note 30, at 2029, 2031.

89) Johnson, *supra* note 89.

