PAYING PHYSICIANS FOR THEIR PRACTICE EXPENSES
UNDER THE MEDICARE FEE SCHEDULE:
INCENTIVE AND EQUITY CONSIDERATIONS

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I. INTRODUCTION

Until 1992, the federal Medicare program paid physicians on a fee-for-service basis according to the so-called Customary, Prevailing and Reasonable (CPR) charge system. For each service they billed the Medicare program, physicians received the lowest of their "customary" charge (the median of their charges for that service during the previous year), the "prevailing" fee for the service in their pricing locality (the 75th percentile of charges billed by all physicians in the locality during the previous year), and the charge they actually billed for the service (the "reasonable" charge being the lowest of these three). Since the charges physicians billed for services contributed to establishing their own customary charges, as well as the prevailing fees in their locality, charges for services increased at different rates in different pricing localities. By the 1980s, Medicare found itself paying widely disparate fees for the same service to different physicians, without any evidence that the differences in fees were closely related to differences in quality. In addition, fees for new procedures were being set at very high and seemingly arbitrary levels, with no control mechanism available to Medicare program administrators. An increasingly large gap developed between fees for procedures and tests, on the one hand, and those for evaluation and management (EM) services (i.e., visits and consultations), on the other. This in turn gave physicians economic incentives to favor procedures and tests in their treatment decisions over more conservative -- and less costly – forms of treatment. Between 1970 and 1990, Medicare Part B expenditures (i.e., mostly physician expenditures, Part A denoting hospital expenditures) rose twenty-fold.[1]

The 1989 physician payment reform legislation (OBRA89) replaced the CPR system with a fee schedule, known as the Medicare Fee Schedule (MFS), which is intended to compensate physicians for their services in proportion to the resources they incur in providing them. It divides the fees for services into three components: one for physician work, one for malpractice premium expenses, and one for other practice expenses. The physician work component, which accounts for about half of the fee on average, is based on the Resource-Based Relative Value Scale (RBRVS), developed by William Hsiao and colleagues at the Harvard School of Public Health.The development of this scale involved surveying physicians to obtain their opinions concerning the relative amount physician work involved in providing various services. The practice and practice expense components, in contrast, are based historical charges. At the time the legislation was passed, data were not available to develop malpractice and practice expense components for all 7,000 unique services for which physicians bill Medicare.

The service-specific practice cost percentages are computed by following several steps. First, the average percentages of physicians' gross revenues which go toward practice and malpractice costs are determined, from national survey data, for each specialty. The 1992 MFS uses 1989 American Medical Association (AMA) survey data which indicate, for example, that 31.8 percent of general surgeons' gross income is absorbed by practice expenses, 7.4 percent is absorbed by professional liability insurance expense. Second, using Medicare Part B data, the number of each type of service that was performed in 1989 is determined, and the proportion of that number that each specialty accounts for is calculated. Such a calculation could indicate, for example, that general surgeons perform 83 percent of service A and obstetrician-gynecologists 17 percent.

Third, using the proportions of services that each specialty performs as weights, a weighted average practice cost percentage and a weighted average

malpractice cost percentage are computed for each service. The practice cost share for general surgeons being 31.8 percent and the one for obstetrician-gynecologists 38.0 percent, the weighted average practice cost percentage for service A PCP_A is:

$PCP_A = (0.31 \times 0.83) + (0.38 \times 0.17)$
$PCP_A = 0.32$

The weighted average malpractice cost percentage is calculated analogously, using the malpractice cost shares for the specialties involved in place of the practice cost shares.

To calculate the practice and malpractice cost components, the practice and malpractice percentages for a service are each multiplied by the 1991 national average Medicare allowed charge for the service. If the national average Medicare allowed charge for service A is $500, the practice cost component for that service is 0.32 x 500 = $160. A similar calculation would yield the malpractice cost component. The dollar amounts are then converted into RVUs through division by a conversion factor. Separate geographic adjustment factors are applied to each component, to adjust for regional differences in input prices. Then the RVUs for practice and malpractice are added to the RVUs for work, and the total RVUs for the service are converted to dollars through multiplication by the conversion factor.[2]

The result is a fee schedule that reduces the gap between fees for procedures and tests and those for EM services, but to a smaller degree than it would have had the malpractice and practice expense components been designed to reflect actual practice expenses. Historical charges for procedures and tests, as pointed out earlier, were extremely high relative to those for visits. Physicians now receive a substantially greater payment for their practice expenses per minute while doing procedures and tests than by seeing patients in their own office. The disparity is out of proportion with differences in practice expenses across specialties.[3]

The OBRA89 definition of the practice cost component, however, was not intended to be permanent. Various proposals have been made to redefine it, some based on economic theory, and others on accounting principles. The aim of this paper is to discuss these proposals, paying particular attention to the equitableness of the income redistributions they imply, and to the economic incentives they give physicians.

II. PROPOSED ALTERNATIVES TO THE CURRENT PRACTICE EXPENSE COMPONENT

The two main alternatives to the current practice expense component that economic analysis has suggested are marginal cost pricing and Ramsey pricing; application of accounting principles has led to the Physician Payment Review Commission (PPRC)'s method and the practice characteristics approach.

Marginal Cost Pricing

Marginal cost pricing requires the estimation of the long-run marginal costs of services, defined as the incremental cost of producing one more unit of a service, assuming that all inputs are variable. It is theoretically appealing to set prices according to the long run marginal cost, since this gives physicians incentives to produce at economically efficient levels.

Marginal costs estimated econometrically do not, however, account for all practice expenses. For example, Pope and Burge find that estimated marginal costs of services collectively account for 70 to 80 percent of physician practice expenses.4 If paying physicians in proportion to their total costs, not just their marginal costs, is considered a requirement for any payment reform, then

marginal cost pricing in isolation cannot be considered a viable payment mechanism.

Ramsey Pricing

If a markup over marginal costs must be paid physicians to compensate them for their fixed costs, then two different criteria can be used to determine its amount: economic efficiency, and equity. Ramsey pricing seeks to meet the criterion of economic efficiency. In its original form, applied to the pricing of goods and services sold by public utilities, Ramsey pricing sets markups over marginal costs for different groups of consumers in inverse proportion to their demand elasticities. Consumers with low elasticities of demand then face the highest prices, while those with high elasticities face the lowest. To be more precise, Ramsey prices have the effect of making quantity demanded fall by the same proportion for every group of consumers. This has the result of minimizing the deadweight loss that the markup inevitably brings about.

Transposed to the market for physician services, Ramsey pricing presupposes that physicians seek to increase their profits and that they have considerable influence over consumer demand their services.[5,6] If given the opportunity, physicians will then provide more services than is socially optimal. Here, then, Ramsey pricing is intended to influence the supply response of physicians rather than the demand response of consumers. Social welfare loss entailed by the markup is to be minimized by making the markup inversely proportional to the elasticities of supply. This makes profitable those services the volumes of which are least under physicians' control (e.g., initial visits, setting broken arms), and least profitable those services the volumes of which under their control (e.g., many tests). In this way, the overall supply response is minimized, in the sense that the total number of times services are provided as a result of the markups is minimized.[5,6]

But minimizing the supply response in this sense will not necessarily minimize social welfare loss. The social welfare loss depends additionally on two important factors: (1) the relative harm to patients of increasing the volume of one service rather than another (the marginal benefit curves of services); and (2) the relative cost (including costs not borne by the physician, such as hospital costs) of increasing the volume of one service rather than another. It follows logically that, in order for the supply elasticities to contain all the information necessary to derive optimal markups, they must: (a) reflect the slopes of the marginal benefit curves of services, and the relative costs of services; and furthermore (b) not be themselves influenced by extraneous factors (if they were, how could the supply elasticities be interpreted?) We argue below that the supply elasticities are influenced by extraneous factors, and that they are unlikely to reflect the relative costs of services, including costs not borne by the physician.

First, a number of factors other than marginal benefit to patients and costs influence the supply elasticities of services. For example, patients rather than physicians make the decision to have an initial visit; except for advertising, the physician has no influence over their number. Well-informed patients can also insist on receiving certain tests, again influencing the price elasticity of supply. Moreover, peer pressure can influence the elasticity of supply of certain services. For example, most general surgeons cannot increase the number of appendectomies they perform very much without exceeding the national average of

about 15% negatives (i.e., 15% appendectomies that turn out to have been unnecessary). Their peers in hospital review committees would notice. But there is no such external constraint on placement of a pulmonary artery catheter for pressure monitoring.

A second reason why basing the markups on the supply elasticities alone is unlikely to yield optimal prices is that supply elasticities are highly unlikely to reflect with any accuracy the total costs (including hospital costs) of additional services. Most doctors do not know the costs of the services they provide, especially costs that they do not bear themselves. How then could their supply responses reflect such information?

The conclusion is that, in order to be economically efficient in the broader sense proposed here, the markups must take into account not just the supply elasticities of services, but their marginal benefit functions and their total costs, including costs not borne by the physician. The practical difficulty of obtaining this information for 7,000 services (even allowing for considerable grouping) is obvious.

We said earlier that methods for paying physicians for their practice costs could be evaluated according to two important criteria: equity and economic efficiency. Any form of Ramsey pricing is likely to be inequitable. Ramsey pricing is likely lead to an inequitable allocation of fixed cost amounts between practices. If the pool of fixed cost dollars is distributed between all services in inverse proportion to their supply elasticities, specialties that have relatively more discretionary services will tend to receive lower payments for their services. This will mean, for example, that practice expense payments for internists will tend to be lower than for, say, specialists in nuclear medicine. Yet practice expenses for internists are often higher than those for physicians in nuclear medicine. This equity can be mitigated to some extent by adjusting the markups per service according to the levels of practice expense of the different specialties, as in the current formula, but then the relativities implied by Ramsey pricing are distorted. It is easy that the same result would hold if Ramsey prices were modified to take account of the additional information described.

The most obvious alternative is to separate the pool of practice expense dollars into specialty subpools. But where does this end? Many subspecialties (let alone broader specialty categories) have sub-subspecialties with very different practice expense patterns. Cardiology provides a good example. Some cardiologists perform only invasive services at the hospital and have minimal practice expenses. Others spend much of their time at offices outside the hospital where they must maintain larger staffs to handle scheduling, transcription, billing, etc. Much the same is true of ophthalmologists as well. One is then led to multiply distinctions among specialties. Since many physicians do not fall into any one of the subclasses thus defined, no subclassification system can ever be quite equitable. Furthermore, the result is a fee schedule that pays different amounts for the same service when provided by physicians in different specialty, subspecialty and even sub-subspecialty classifications -- violating the politically popular principle of no specialty differentials embodied in current legislation. In short, Ramsey pricing tends to be inequitable, and remedying this would likely require either specialty fee differentials, or so many adjustments to the relativities that they could be expected to lose much of their optimality properties.

The goal of marking up the fees for   services in an economically efficient way thus seems impractical. In addition, to the extent that one marks up the prices according to a Ramsey-type formula, the fee schedule is likely to become inequitable the fee schedule is likely to become inequitable.

What makes Ramsey pricing difficult to implement in a satisfactory way is having to distribute the markup among services. What if instead one were to just give physicians a lump sum to cover their fixed costs? That is the essential idea behind the practice-type method, which is one form of the practice characteristics approach, to be discussed below. We now turn to methods that originated in the application of accounting principles to the construction of a practice cost component.

The PPRC method

The PPRC approach to incorporating practice expenses into the fee schedule is based on the methods accountants use to set prices products and services. Before it can be discussed, it is necessary to explain how accountants classify costs.

Accountants classify costs according to whether they are fixed or variable, and direct or indirect. Fixed and variable costs are defined in the same way economists understand them: fixed costs (such as office rent) are incurred regardless of the quantity of services provided, over the relevant range of production volumes; variable costs are incurred every time a service is provided (X-ray film is used up each time a chest X-ray is taken). Direct costs can feasibly be <u>physically</u> traced directly to a particular service or group of services: the cost of X-ray film is direct, but so is the cost of the X-ray machine, which can be traced to X-ray services exclusively. Thus direct costs can be either variable or fixed (the cost of the X-ray machine is fixed since it is the same regardless of how many X-rays are taken with it). Indirect costs cannot feasibly be traced in this way to specific services: for example, office rent is an indirect as well as a fixed cost. The costs of minor supplies (such as tongue depressors) are often classified as indirect because the cost of tracing them to specific services is prohibitive; they are then often variable as well. The PPRC has estimated that about 30% of physicians' costs are direct and 70% indirect.

The method that PPRC proposes is intended to serve two main objectives: (1) to be resource-based, meaning to make payments for services reflective of the costs incurred in providing them; to the extent that this goal is achieved the method should also be equitable; (2) to be incentive-neutral, meaning that it should give physicians neutral economic incentives in choosing which services to recommend to their patients.

To achieve these objectives, PPRC has proposed: (1) carefully tallying direct costs service-by-service, and incorporating the total into the fee; (2) allocating indirect costs to services on a common basis, such as physician work plus direct costs, or physician time.[7]

But allocating indirect costs across all services on a common basis such as physician time or work ignores the fact that physicians with different types of practices tend to have different indirect costs. Consider for example the effect of allocating indirect costs on the basis of time. This has the result of giving

all physicians who spend, say, 45 hours a week in direct patient care exactly the same amount to cover their indirect expenses. Yet office-based practices tend to incur higher indirect costs than hospital-based practices.*

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*Although we do not offer any empirical evidence to support this assertion, we gained this definite impression from conversations with physicians and practice managers representing 40 medical practices in seven surgical and non-surgical specialties. These conversations were conducted during the summer of 1993.

<u>Other approaches</u>

The methods considered so far presuppose that costs must be attributed to individual services. The intent of the 1989 physician payment reform legislation was to make the fee schedule resource-based -- reflective of resources expended in providing services. But, as we have seen, indirect costs by definition cannot be traced to individual services. They are not driven by the particular mix of services provided so much as by broader characteristics of practices, such as the extent to which they are office-based.

In order to gain a better understanding of the factors driving the indirect costs of physician practices, we met, during the summer of 1993, with physicians and practice managers representing 40 practices encompassing six specialties: general and family practice, internal medicine, cardiology, general surgery, thoracic surgery, and ophthalmology. These specialties were chosen because of their economic importance to the Medicare program and their clinical representativeness. We engaged the physicians and practice managers in conversations about the nature of their practice expenses, and the factors that cause these expenses to vary across practices. In spite of considerable variation in practice arrangements, we found that a fairly clear logic underlies the way in which practice expenses arise.

Specifically, we found that, in virtually every practice, practice expenses arise from the performance of some combination of the following functions: (1) billable ancillary services (e.g. tests and procedures); (2) direct patient care incident to the visit (e.g., escorting patients to waiting rooms, taking histories); (3) obtaining authorizations for procedures; (4) medical record-keeping; (5) billing; (6) collection; (7) bookkeeping; (8) management and coordination; (9) maintaining the physical plant. Indeed virtually all practice expenses can be distributed among these functions in a fairly logical way.[8]

From our observations we also noted that the costs associated with each of the functions appear to be influenced by specific characteristics of practices, such as practice size and service mix. We found linkages between specific characteristics of practices and each of the nine practice functions. For example, management and coordination costs appear to be largely driven by the size of the practice (the number of physicians), its maturity, whether it is a faculty practice, and the mix of services it provides. Table 1 lists the characteristics of practices that our conversations suggest are associated with each practice function.

Table 1. Hypothesized characteristics of practices
driving physician practice expenses,
by practice function

Function	Hypothesized Cost Drivers
Billable Ancillary Services	- Ancillary services provided
Direct Patient Care Incident to Visit	- Service mix - MD time spent in office- based E/M - % new patients - Practice age or maturity
Authorization	- Service mix - Payer mix
Medical Records	- Specialty/Service mix - Degree of Automation - % New Patients - Number of Patients
Billing	- Number of units billed - Payer mix
Collection	- Number of units billed - Payer mix - Percent claims taken on assignment
Bookkeeping	- Size of Practice - Service Mix
Management & Coordination	- Size of Practice - Maturity of Practice - Faculty Practice - Service Mix
Physical plant	- Number of sites - Number of square feet - Number of MDs - Location - Service Mix - Practice age or maturity

Thus it appears reasonable to treat indirect costs not as an undifferentiated mass, but as the sum of distinct elements that each assume a greater or lesser importance depending on the characteristics of the practice, which include, for every function, some aspect of the services provided.

There are at least two possible ways of using these insights in the formulation of a payment system. The first is to escape the constraint that indirect costs be allocated to individual services, and instead allocate them to practices as a whole. Practices could be paid a lump sum to cover their fixed costs, and marginal cost for individual services. Economists will recognize this as two-part pricing, but we refer to it as the "practice-type" method. Alternatively, we can abandon the goal of incentive-neutrality set forth by PPRC and seek instead to construct a fee schedule that results in practices being paid for their indirect costs an amount corresponding as closely as possible to those indirect costs. For reasons that will become clearer below, we refer to this approach as the "service-class" method. The central goal of both the practice-type and the service-class methods is to make payment as resource-based as possible, and therefore as equitable as possible to physicians in different types of practices.

In order to make payment more equitable, it is useful to take into account the characteristics of practices in setting payment amounts. This is done very naturally with the practice-type method: the lump sum amount is set according to relevant characteristics of the practices, such as the extent to which they are hospital-based. It can also be done with the service-class method, by using characteristics of practices as payment modifiers. The service-class method can also be implemented without practice characteristics payment modifiers. It then gains in administrative simplicity, though presumably at some loss in accuracy.

The practice-type method

Under the practice-type method, practices would receive a lump sum(on a monthly or quarterly basis) to cover their indirect expenses (i.e., those expenses, such as rent, that cannot be traced to specific service codes). The amount of the lump would be based on characteristics of the practice that help predict its level of indirect expenses, as indicated above, and on the Medicare volume of the practice.

The practice-type method is highly attractive from the points of view of both economic and accounting theory. By making it possible to pay physicians for additional services at marginal costs, it neatly solves the problem Ramsey pricing addresses: it removes altogether the incentive for overprovision of services, at least from the point of view of the practice cost component. It also makes eminent sense from an accounting point of view: indirect costs are generated at the level of the practice as a whole, and it is entirely meaningful to trace them to a practice rather individual services.

The practice-type method is also clearly incentive-neutral in the sense that the PPRC method seeks to be incentive-neutral: it gives physicians no economic incentive to choose one service over another. In addition, by making part of the physician's income in effect a salary, it reduces the incentive to over-utilization inherent to fee-for-service practice. Interestingly, at the same time it offers the potential for introducing a new kind of economic incentive: the

incentive for physicians to change their type of practice. The practice-type method could be used, for example, to encourage practices of efficient size.

Besides being economically efficient, the practice-type method has the potential to be singularly equitable. By basing the lump sum payment on relevant characteristics of practices, payments to practices can be made to correspond fairly closely to their actual indirect expenses, or at least to what those indirect expenses would be if the practice operated at a pre-established level of efficiency.

Paying physicians on such a basis would, however, mark a radical departure from the current system. At least two practical problems are likely to arise: (1) ensuring that physicians do not misreport the characteristics of their practices; and (2) prorating lump-sum payments to practices in proportion to their Medicare volume. We offer suggestions on both problems.

Several of the characteristics that we believe might be used as a basis for payment could be verified from other sources: (1) the degree to which the practice is office-based should be largely verifiable from the distribution of service codes among the claims submitted; (2) the number of physicians in the practice should be verifiable once all physicians have Unique Provider Identification Numbers (UPINs), if in addition they also must report themselves belonging to one practice; this information would be recorded on every claim submitted for payment; (3) the types of services the practice provides will be identifiable from the distribution codes among submitted claims; (4) the geographic location of the practice already serves as a factor in payment and would to do so.

Since most practices treat patients insured by payers other than Medicare, Medicare should only be expected to pay a portion of the expected level of practice expenses of each practice. This portion should, presumably, be related to the extent to which the practice serves Medicare as opposed to other patients. The principle we propose can be expressed as, if the physicians in the practice spend half their patient care time treating Medicare patients, Medicare should pay half of their practice expenses. American Medical Association (AMA) data provide us with estimates of average patient care time by specialty; and the Resource-Based Relative Value Scale (RBRVS) study also provides us with estimates of the average time required to provide services at the service code level. It is therefore possible to sum the average time required to provide the services billed for under Medicare, and divide that by the total amount of time estimated to be spent in patient care by the physicians in the practice, based on AMA data.

An example. Consider an ophthalmologist practicing solo. She is expected to spend, say, 2,000 hours per year in direct patient care on average, and is projected to have yearly practice expenses of $200,000. Now suppose she bills for a particular service with an estimated time of one hour (estimated using the RBRVS study). As long as the time required to provide the services she has billed Medicare for so far add up to less than 2,000 hours, she is paid two amounts for practice expenses with each claim submitted: a service-specific amount to cover the direct costs of that service, say $20, and a fraction of $200,000 corresponding to the fraction of her annual practice time the service takes -- in this example, $200,000/2000 = $100/hour. Thus the practice cost component of the fee is $120. But if she has already exceeded the 2,000 hours for Medicare, she

would be paid only the direct cost component -- $20. At that point her practice has already been paid $200,000 to cover its indirect costs.

Our conclusion is that the practice-type method <u>could</u> be implemented. It would give physicians desirable economic incentives; and it would also be equitable. But it would present the Health Care Financing Administration with considerable administrative challenges. The service-class method, discussed next, may strike a useful compromise.

The-service-class method

Under the service-class method, indirect costs are allocated groups of services associated with similar expected practices expenses, which we call service classes. More specifically the method involves: (1) dividing indirect costs into the nine practice function cost categories enumerated earlier; and (2) allocating each of the practice function costs to groups of services, in a manner dictated by the individual logic driving each practice function cost. From the standpoint of implementation, physicians would simply be paid under a different fee schedule than the current one. Characteristics of the practice such as those listed in Table 1 might or might not serve as payment modifiers. The objective in any case is to define the practice cost component in such a way that the total amount a practice ultimately receives for its indirect expenses corresponds as closely as possible to its actual payment.

The service-class method in effect assigns to every service (based on the class of services it belongs to) its estimated average cost. This average cost may be made conditional on the characteristics of the practice, increasing the accuracy of total indirect cost payments to practices, or it may not.

Clearly the method is equitable: given the constraint that payment must be made through the existing billing system (which disallows the practice-type method) it is about as equitable as possible, the more so the more relevant practice characteristics are taken into account. But it appears to be economically inefficient. Would it not encourage overprovision of services?

Undoubtedly average cost pricing does encourage overprovision of services in a way that marginal cost pricing (such as is obtained with the practice-type method) does not. But it is important to recognize that efficiency in the delivery of physician services involves not just an overall limitation of the number of services provided, but an appropriate mix of services. Medical care that relies on EM services is cheaper than care that resorts to tests and procedures, and clearly preferable when the outcomes the same. Increasing fees for EM services relative to those for procedures and tests will tend to increase the proportion of EM services in the mix, and conversely.

Given this, average cost pricing may be expected to increase efficiency relative to the current fee schedule if it increases fees for EM services and decreases them for procedures and tests. Whether it would do so is an empirical question. It seems likely
that it would, however, given the much higher payments for practice expenses that hospital-based physicians now enjoy, relative to office-based physicians, and the fact that hospital-based physicians generally do not need to incur expenses as large as those of office-based physicians

III. DISCUSSION: TOWARD A CHRISTIAN PERSPECTIVE ON REFORMING THE PRACTICE EXPENSE COMPONENT OF THE MEDICARE FEE SCHEDULE*

The title of this section must seem incongruous to most readers, even members of the Association of Christian Economists. We Christian economists are used to trying to identify a Christian perspective on economics as a whole, or at least on a broad top such as international trade policy, not on something as specialized as the practice expense component of the Medicare Fee Schedule. Yet this narrow issue, as must now be clear, is a microcosm of one that is central to Christian debate in economics: the relative emphases to be given to equity and economic efficiency.

The analysis presented in this paper has focused on two aspects of methods for changing the practice expense component of the Medicare Fee Schedule: their equity, and their economic efficiency. I have given an important place to equity, greater I believe than the one some other economists would have. I believe that this is an appropriate emphasis for Christian economists. But I have interpreted equity to mean, in this context, that physicians would be paid for their practice expenses an amount proportional to those actual expenses. Is that necessarily what God wants? It seems to me that in this particular case, attaining equity defined in this way would at least be a step in the right direction.

That the Scriptures reflect a concern for economic justice is hard to deny. Those who work should be paid a "fair" wage for their labors. But we cannot avoid noting that God often allows generosity or mercy to temper the norm of economic justice. For example, in the parable of the workers in the vineyard, the workers who started working near the end of the day receive the very same pay as had been promised, and is delivered, to those who started work in the morning (Mat 20:1-16). Or again, perhaps even more to the point (if Jesus' parable is meant to be taken figuratively only), through the Year of the Jubilee God appeared to want to institute a regular flow of wealth from those in an economically strong position to those in a weaker one (Lev 25:8-55). At the same time, the whole tenor of the Scriptures is opposed to the reverse kind of transfer -- to those who are in a stronger economic position taking away from the poor that which rightfully belongs to them (i.e., the poor). Any movement away from strict economic justice, it would seem, should be in the direction of greater equality.

It may seem incongruous to apply such principles to physicians. The poorest among them, with few exceptions, are well-off. No doubt God is pleased when such high earners cheerfully give substantial portions of their incomes to charity. But, given that physicians as a group <u>are</u> going to earn high incomes, why would the same principles not apply to the distribution of earnings among them?

If they do, then seeking to compensate physician's for their practice expenses in proportion to those actual expenses is at least going in the right direction. As we have argued, the current practice expense component is excessively generous for procedures and tests, at the expense of EM services. It therefore contributes to the considerable disparity in incomes between hospital-based and office-based physicians. The practice-type or service-class methods would reduce this disparity. Perhaps, ideally, the disparity would be reduced even more -- but at least the standard of payment in proportion to expenses constitutes a step in the right direction.

We now turn to the issue of economic efficiency. Many Christian economists, I believe, would incorporate economic efficiency into the broader norm of stewardship -- a wise use of the resources God has entrusted to us. Incorporated into, but not identified with. Following Goudzwaard, Wolterstorff, and others, I believe we may, as Christians, accept economic progress as good, but not as the highest good in the conduct of policy.[9,10] The welfare of people, in the Christian view, embraces more than their material welfare, and where they conflict stewardship gives precedence to equity over economic efficiency. The land was to be redistributed more equally every fifty years, even if the new farmers were less capable than the old ones.

But they need not always conflict, and perhaps they really conflict much less often than we think. Perhaps the inequities that we allow to be perpetuated slow down economic progress more than neoclassical theory allows for. In the present case, at any rate, both the practice-type method and the service-class method are compatible with economic efficiency. Here at least, equity and economic efficiency appear to go hand in hand.

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