

From the Archives:

The Resource-Based Relative Value Scale: a Threat to Private Medicine

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“To Each What She Deserves”: an Early Analysis

Would-be reformers of the Medicare payment system have resuscitated an old idea. The concept of a relative value scale, the “comparable worth” of medicine, was described and demolished in 1928 by George Bernard Shaw.

In his book *The Intelligent Woman’s Guide to Socialism, Capitalism, Sovietism, and Fascism*, Shaw deplored an economic system that rewarded prize-fighters so much more handsomely than others of presumed higher social value. “But to suppose that it could be changed by any possible calculation that an ounce of archbishop or three ounces of judge is worth a pound of prize-fighter would be sillier still.”¹

Analyzing an example involving cognitive versus procedural skills, Shaw wrote: “Well think it out. The clergyman...is able to read the New Testament in Greek; so that he can do something the blacksmith cannot do. On the other hand, the blacksmith can make a horseshoe, which the parson cannot. How many verses of the Greek Testament are worth one horseshoe? You have only to ask the silly question to see that nobody can answer it.”¹

Objective vs. Subjective Value: an Economic Analysis

The absurdity of trying to convert social value into an objective unit of measure such as ounces or horseshoes seems apparent from Shaw’s examples. The resource-based relative value scale (RBRVS) attempts to circumvent this difficulty by expressing the value of a service in objective terms related to the cost of its production.

The method used by William Hsiao and colleagues at Harvard University considers four dimensions of physician work, including the time required to perform a service, the mental effort, the degree of technical skill, and stress.² The cost of production also includes the overhead expenses such as liability insurance. Although the Harvard study has been called “a significant new source of independent information from which to design a new Medicare payment system,”³ it is based on an old idea: the **objective theory of value**, one of the fundamental tenets of Marxist economics.

This theory, which is sometimes accepted as axiomatic, was subjected to critical scrutiny in the late nineteenth century by Austrian economists Carl Menger and Eugene von Bohm-Bawerk.⁴ A simple example may serve to illustrate its fallacy:

Consider two diamonds of equal size and quality. Suppose that one was simply found by chance, with no effort or danger in its discovery, while the second one was recovered from a mine, representing a large investment by the owners, and significant danger to the workers. Although one diamond cost little or nothing, and the second was produced at enormous cost, both might be sold at the same auction for a similar price. In other words, there is no necessary connection between the value of an object and the cost of its production.⁵

In fields characterized by rapid technological advance, the fallacy of the objective theory of value is even more apparent. The theory would assign a higher value to one of the early mainframe computers, which occupied a large room, than to a far more powerful modern desk-top computer, because the former cost far more to produce. Similarly, a lengthy cataract operation performed with great intensity of effort using old techniques should be valued more highly than a modern operation with lens implantation.

The objective theory of value considers only the producer and completely neglects the consumer. Nowhere does the calculations of the “relative value” consider the most important factor: the benefit to the person who purchases the goods or services.

In contrast, the **subjective theory of economic value** proposes that the value of an object is *not* inherent in the thing itself, but exists in the mind of the person who values it.

As Bettina Bien Graves pointed out, this theory “represented a completely new, revolutionary approach to economics. For the first time, the individual actor himself became the unit with which economics was concerned. His actions, his responses..., were recognized as the key to explaining market phenomena.”⁶

The ranking of values varies with each individual, depending on personal circumstances and expectations. A person may be willing to make great sacrifices to obtain certain services, but will purchase others only if they are very cheap. For example, to one person cancer chemotherapy or surgery may seem a burden so great that the expectation of benefit may not be worth the price (either in money or suffering). To another, a small chance of cure may be worth any amount of pain and all of his worldly possessions. No third person can make a determination of the value of the service, even though its cost to the persons it may be exactly the same in the two instances.

According to the subjective theory of value, costs are basically **opportunity costs** incurred by a decision-maker, i.e. the value of the other goods or services he is willing to forgo in order to obtain

the goods or services under consideration. Such must be borne exclusively by the person making the decision; they cannot be shifted to others. Nor can they be measured by others, since subjective mental experience cannot be directly observed. (However, the subjective value is reflected in the price that an individual is willing to pay.) Further, costs are dated at the moment of the final decision or choice.⁷ A recalibration of the relative value scale every five years is far too slow to account for changes in the personal circumstances of the actors in any economic transaction.

The objective theory of value must be assumed by those who believe in central planning by omniscient planners. The subjective theory of value is espoused by those who believe in economic freedom, in the rights of individuals to engage in voluntary transactions that they perceive to be of mutual benefit.

The Harvard Study: Specific Critiques

Although the Harvard study superficially appears to be objective, with its standard deviations, equations, and lists of numerical rankings expressed to three or four significant figures, it is based on physicians' judgments, which are inherently subjective. A study garbed in the statistical trappings of science tends to be highly impressive to policymakers. However, when "judgments take the form of assigning fixed numerical weights and restrictive and arbitrary mathematical formulas to vaguely defined and unmeasurable concepts such as skill, intensity of effort, complexity, opportunity cost, and the allocation of overhead expenses, the results are castles built on sand."⁸

If judgments are made by those with a consistent preexisting bias, then the results are probably built on quicksand. The group chosen by the Health Care Financing Administration (HCFA) to do the \$2 million study had previously done work on this subject, with results that were pro-cognitive and anti-procedural with respect to fee evaluations.^{9,10} It is possible that HCFA determined in advance what it wanted, and got what it was paying for.

After obtaining a consensus from various specialists about the ranking of various procedures in order of difficulty, the researchers needed to normalize the results (i.e. rescale, compress and expand the rankings for different types of procedures so that they could be interlocked properly). The methodology to be used for this procedure was not specified. Dr. Robert Reinecke of Thomas Jefferson University Hospital thought that Hsiao's group might have withheld the details so as to prevent some specialist from jury-rigging the rankings to beat the system. However, in response to queries at an informational meeting in Dallas, Edmond Becker, Ph.D., Project Director for the Hsiao study, stated that the methodology had not been worked out, and that they planned to try different formulae until the data looked right.

This violates one of the most fundamental principles of research design, that the methodology must be specified

before the data are collected. It allows the researchers to manipulate the methodology until the data support their predetermined conclusions.¹¹

After all the sophisticated manipulations, some of the results defied common logic. For example, the same relative value was obtained for a superficial lobectomy of the parotid gland as for a pharyngolaryngectomy for cancer. The latter procedure is far more exacting and requires much more postoperative care than the former. Another result that met statistical standards of reliability but failed the common-sense test was equating the intensity per unit time spent doing a diagnostic D&C with that spent performing a vaginal hysterectomy or managing a difficult labor.¹²

Who Favors the RBRVS?

Physicians who believe that their services are undervalued, and that they would therefore benefit from the RBRVS, are more likely to support the concept. The American Society of Internal Medicine (ASIM), the American Academy of Family Physicians (AAFP), the American Society of Anesthesiologists (ASA), and the American Academy of Pediatrics have been among the biggest boosters of an RVS.

The American Association of Retired Persons (AARP) is also promoting a change in the Medicare payment system based on the RBRVS. This strange ally of the ASIM and AAFP has a different long-range objective: forcing all physicians to accept assignment. At the present time, AARP concedes that there are certain inequities in the payment system. Once these are "corrected," there is no impediment to forcing the doctors to accept a payment that is certified to be "fair."

The concept of the RBRVS has long been promoted by labor unions, directors of health and welfare funds, and Blue Cross and other third party payers, as discussed by former AAPS President Robert J. Moorhead in 1961.¹³ The RBRVS would be a means of keeping fees in line, thus helping to save actuarially unsound policies that offer first-dollar coverage.

The third parties themselves had difficulty developing an RVS for all medical procedures because of the obvious nonrelationship of so many procedures. They could not standardize the procedures when performed by more than one physician. Furthermore, they could not standardize patients. Thus, it was necessary to enlist physicians themselves to meet the "challenge" to relate, economically, all medical, surgical, x-ray, and laboratory procedures.

The American Society of Anesthesiologists set up a voluntary RVS in 1962. After it was in wide use for many years, the U.S. Department of Justice entered suit in December, 1975, charging violation of Section 1 of the Sherman Antitrust Act. In June, 1979, the suit was dismissed. Ironically, now another unit of the federal bureaucracy is on the brink of instituting a mandatory RVS!

Pitfalls in Acceptance of the RBRVS

1. **Disunity in the profession.** Pitting one group against another (the “procedural” vs the “cognitive” or “nonprocedural” specialties) is an example of the time-honored technique of divide and conquer. Furthermore, the pursuit of financial self-interest can be self-destructive in the long term. Since the actual payment to the physician will be determined by the multiplier, not exclusively by the relative value, internists may find themselves worse off than before, despite a narrower gap between themselves and “proceduralists.”
2. **Interference with the physician-patient relationship.** With the RBRVS, a collective tells every physician what his services are worth, and abolishes his right to contract with the individual patient. The RBRVS contradicts the basic principle of private medicine, that the unit of practice is the individual patient, and that the medical service is personal and unstandardized. (Note the critical difference between the RBRVS, which dictates the *worth* of a service, and an indemnity, which simply states what a particular insurer is willing to pay to its subscriber.) **The patients’ values are completely excluded from the equations.**
3. **Next step: mandatory assignment.** Acceptance of the RBRVS transfers the onus of inadequate coverage to the physician, who is easily portrayed as a capitalistic gouger.¹³ Members of the Physicians’ Payment Review Commission have acknowledged that the RBRVS was likely to be followed by a nationwide ban on balance billing. While using terms like “equity,” Congress is primarily interested in cost containment (i.e. a reduction in Medicare expenditures), which includes “controlling the inappropriate volume of care” (i.e. rationing).¹⁴ An increase in the fee could easily be offset by disallowing more services as “medically unnecessary.”
4. **Distortion in the medical marketplace.** Like all previous examples of wage and price controls, the RBRVS will predictably cause distorted market incentives, resulting in excesses and shortages. One proposed remedy is to maintain a dual system of fee schedule amounts and physicians’ charges, so that average charges can serve as a continuous monitor of how closely the fee schedule reflexes market conditions.⁸ As all centrally planned economies have discovered, price information from a free market is absolutely essential to permit rational economic calculations.

While attributing undesirable incentives in the health care system to “distortions in the price of physicians’ services” (caused by current third party payment schedules), Hsiao proposes that *his* fee schedule would serve as a corrective measure. Specifically, he suggests that central planners could use the RBRVS to encourage or discourage certain types of practice or behavior, to motivate

physicians to serve in regions or specialties with shortages, and to identify outlying charges for closer peer review.¹⁵

5. **Encouragement of dishonesty.** Under the RBRVS, the physician would benefit from practices such as removing one wart at a time and filing a separate claim for each. This is to the patient’s disadvantage and cannot be condoned. Neither can the establishment of the RVS, which precipitates this situation.¹³
6. **Irreversibility.** Like many steps on the road to collectivized medical practice, the RBRVS will be almost impossible to retract, once it is made public.

Conclusions

Because it is based on fallacious economics and flawed science, the RBRVS cannot correct inequities and distortions in the medical marketplace, but can only cause new ones. Its support is based on the politics of envy, which threatens to split the medical profession. While “proceduralists” war with each other over questions of short-term financial gain, the collectivization of medicine can proceed. The RBRVS gives would-be commissars a powerful tool for controlling physicians’ livelihoods. Its acceptance by physicians implies assent to the role of interchangeable servants of the collective, and a disavowal of responsibility to their patients as individuals.

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