

TOWARDS A RELATIVE VALUE STUDY

A JOINT DISCUSSION PAPER PREPARED BY THE COMMONWEALTH OF HUMAN
SERVICES AND HEALTH AND THE AUSTRALIAN MEDICAL ASSOCIATION

(1) INTRODUCTION

After more than twenty years' application of the Medicare (formerly Medical) Benefits Schedule (MBS) and ten years of the universal Medicare arrangements, there is mounting pressure to re-assess the relativities, values and underlying assumptions of the MBS. The Medicare program is an essential component of the social welfare system which enables all Australians to have access to affordable, quality health care.

A Relative Value Study (RVS) of the MBS raises many complex technical and policy questions. This paper has been prepared jointly by the Commonwealth Department of Human Services and Health and the Federal Secretariat of the Australian Medical Association to promote debate and to clarify many issues associated with the development of suitable mechanisms for an across-the-board review of services, their fee relativities in the MBS.

(2) BACKGROUND

In March, 1969, the Committee of Inquiry into Health Insurance (the Nimmo Committee) recommended that a list be established of the most common fees charged for services provided by medical practitioners. This followed much dissatisfaction with the prevailing health insurance system and the failure of its benefits to keep pace with increases in medical fees. Later that month, the Federal Assembly of the AMA approved the concept of a list of "most common fees" on the understanding that it was indicative only and would not constitute a schedule of fees that individual doctors would be compelled to charge.

In July, 1969, the AMA and the Health Funds submitted to the then Minister of Health a proposal to restructure the Medical Benefits Scheme, using the results of a 1968 survey into medical fees. The intention was that benefits were to be set at a level so that patients would have their liability restricted to a set amount if the most common fees were charged.

On 1 July, 1970, the Medical Benefits Schedule (now the Medicare Benefits Schedule) came into existence, based largely on the above criteria.

A system of independent enquiries to determine periodic adjustments to overall MBS fee levels in light of inflation, changes in earnings in the community generally and other relevant factors was established in 1973 and continued until 1985. Since that time the Government has determined increases in overall MBS fees and rebates within the annual budgetary process.

Over the years, many additions and amendments have been made to the items of service listed in the MBS to reflect changes and developments in medical practice. Changes to the General Medical Services Table (except for GP and other non-referred attendance items) and to the Diagnostic Imaging Services Table, are now facilitated through the Medicare Benefits Consultative Committee (MBCC). Changes to the Pathology Services Table are facilitated through the Pathology Services Table Committee.

Under the MBCC process the Government has adopted a “cost neutral” policy in relation to reviews of parts of the MBS. That is, existing items within a section are reviewed with no change to overall expenditure on that section, so that the process is essentially one of revising descriptors and redistributing existing funds within the selected group of services in accordance with relativities determined by the medical profession. This is essentially a form of relative value study within a discrete part of the MBS with relativities determined by the professional judgement of doctors who use those items.

The Commonwealth provides additional funding for identified “new services” based on their relative value compared to existing services. The MBCC process has worked well and elicited substantial co-operation from groups within the profession when a review covers the work of a discrete group, e.g. orthopaedic surgeons, plastic surgeons but tends to fall down when more than one group is involved. This arises because under a “cost neutral” approach there must, inevitably, be shifts in funding from one group to another. The MBCC process has nevertheless resulted in significant structural improvements to the MBS in regard to procedural services. The MBCC process has not examined the items in the MBS for consultations nor has it addressed cross-sectional relativities.

There is pressure for a more fundamental reassessment of the MBS, particularly:

- i) for a process to objectively assess the relativities between the various procedural areas;
- ii) for a process to assess the structure and relativities of consultation items;
- iii) for a process for comparing the relativities between procedural and consultation items;
and
- iv) for an ongoing, fair review and update process.

This pressure for change is coming from within the medical profession and from patients who regard themselves disadvantaged in absolute and relative terms under the existing MBS structure. The concerned medical groups are those which have a high consultative work base and a low procedural or diagnostic base, e.g. some consultant physicians and GPs, or proceduralists who believe that the relativities determined in the early 1970s have always been unfavourable to their group e.g. general surgeons, and groups who believe relativities have not been adjusted to reflect greater complexities and responsibilities in their discipline e.g. anaesthetists.

Since the 1970s “common fees exercise” many factors have led to alterations in the “relative work” and relative practice costs involved in the provision of medical services. These factors range from innumerable technical developments which have affected some disciplines more than others, to changes in the costs of running a medical practice which have also affected groups differently. For example the increased costs of professional indemnity insurance and the medico-legal requirements on doctors to explain procedures in detail and the risks involved effect disciplines differently.

(3) SCOPE OF THE PROPOSED REVIEW

The overall objective of the review is to set relativities of fees for private services covered by the MBS on a consistent, fair and workable basis. The underlying emphasis is that the MBS is concerned with fees and rebates for services provided by doctors who primarily provide services to private patients which attract rebates under the Medicare benefits arrangements.

Notwithstanding this, it is recognised that there is some degree of cross-over or dependence on the structure and fees in the MBS in other arrangements such as workers compensation, public hospital arrangements e.g. for VMOs on “modified” fee-for-service payments and possibly the proposed private insurance contract option recently outlined by the Minister. The Commonwealth Government does not control those arrangements. Whether they will need to be modified following completion of the RVS is a matter for the organisations concerned and affected doctors.

(4) WHAT IS A RELATIVE VALUE STUDY?

A Relative Value Study is a process for developing a scale (or scales) of services in the Medicare Benefits Schedule according to a predetermined basis for assessing “value”. A Relative Value Scale must then be multiplied by a dollar conversion factor(s) to become a payment schedule.

There are many possible methods for constructing a Relative Value Scale across the MBS. USA and Canadian experience suggests that the best option may be a resource-based scale using a “bottom up” product costing process.

In a resource-based approach, services are ranked according to the relative costs of the resources inputs required to provide them.

Relative Value Scales could be developed in several other ways and be based on any one, or a combination, of the following “top down” processes:

- fees currently charged by doctors;
- patients' capacity or willingness-to-pay;
- doctors' assessment of the worth of a procedure;
- market-determined prices for services under perfect competition;
- outcomes such as savings or benefits to society; and
- a consensus/negotiation process.

(5) POLICY CONSIDERATIONS

Focus

Key matters to be addressed in undertaking a Relative Value Study revolve around the issues of equity and efficiency. Patients are concerned about “gaps” between fees and rebates. Most doctors would consider that equity in relation to the fees they consider as appropriate is synonymous with equity for patients in relation to their rebates. The Government expects reasonable efficiency from expenditure on health and reasonable assurance that the fees charged by doctors will not leave patients facing substantial out-of-pocket costs.

Issues/Discussion

In a well-functioning competitive market, doctors' charges would tend to reflect their relative costs (i.e. resource inputs). However, it is generally accepted that in Australia the market for medical services is imperfect. Factors such as the supply of doctors within the various disciplines, the impact of medical insurance, the capacity of patients to pay and the ability of doctors to influence the demand for their services act to distort the market and therefore influence the pricing of services.

Relative values based solely on resource inputs do not consider outputs of services by, for example, measuring health outcomes. That is, a Relative Value Study based on costed resource-inputs does not attempt to measure the social and productivity benefits of, for example, a cataract operation that saves the eyesight of a person compared with an endoscopic investigation that confirms that a patient has a duodenal ulcer. Also, a cost or resource-based Relative Value Scale does not take into account variations in the quality of the services provided nor patients' needs, demands or expectations for services or patient outcomes.

Further, unless there were regular, on-going review processes in place following the implementation of a relative value scale, distortions would again build up, especially given the rapid technological change characteristic of modern medicine.

In addressing the need for change, consideration must be given to the broader policy constraints on Governments, the profession and other groups involved in health financing. Federal Government policy supports Medicare universality as part of its “social wage”. In keeping with its responsibility for taxpayers' funds, the Government is also obliged to contain unnecessary growth under Medicare. It also seeks manageable “gaps” for people receiving private medical services. As well, the Government believes that large “gaps” threaten the viability of private health insurance and therefore indirectly place pressure on the public hospital system.

The Government believes that the MBS should contain fair fees and that these fees are what doctors in the main should charge patients:

- the objective of Medicare is to provide patients with access to necessary high quality health care at affordable cost.
- the Government is therefore concerned about out of pocket costs and it believes that is MBS fees are reasonable patients should be charged more except in justifiable circumstances, in which case claims for services of unusual length or complexity should be considered by the Medicare Benefits Advisory Committee.
- the Government does not accept the argument that market forces are working on an equal basis between doctors and patients:
 - the reality is that for doctors in an oversupply situation (e.g. GPs in metropolitan areas) they have little market power. As such, their capacity to set their own fees is illusory in many cases.
 - in areas or specialties where there is a less abundant supply the negotiating power of patients is also illusory.
- when taxpayers are funding the bulk of health services they have a right to expect services to be available at a fair price.

Concerns of the medical profession often revolve around a perception of threats to professional independence in the light of general pressure for a more efficient use of resources across the health sector.

Autonomy is perceived by doctors to be reflected in a professional working environment which allows and expects them to:

- make clinical decisions on behalf of their patients which are unfettered by bureaucratic interference or unnecessary financial constraints on their use of resources; and
- accept full responsibility for their actions and, as a quid pro quo to charge fees to their private patients which they consider to be fair and reasonable in relation to the patient's capacity to pay.

The medical profession is under increasing pressure to re-assess whether its traditional approach to the doctor/patient relationship should be modified in the light of modern community expectations of greater accountability under Medicare's universal health cover and reasonable "assurance" on fees within private health insurance arrangements. Related changes which have taken place to the health financing mechanisms since the "most common fees" were established, include paid VMO arrangements in lieu of the honorary systems in public hospitals, the different "mix" of public and private patients and technological and other changes which have greatly expanded the scope of medical science.

An open market based approach to the setting of private fees is to some extent at odds with the underlying objective of a cost or resource based relative value study which seeks a significant, tacit acceptance of administered prices as a trade off for the Government maintaining reasonable rebate levels and the maintenance of stable private health insurance premiums within a largely open ended private fee-for-service system. In the context of a market approach if the going price for a particular surgical procedure is, say, \$1,200 and a cost based relative value study indicates that the Medicare fee should be reduced from say \$900 to \$600 then the "gap" to the patient would widen. On the other hand, those specialists in relative oversupply could find themselves with no alternative but to accept prices dictated by third parties such as health funds, hospitals or both.

Significant complexities also arise from the possible introduction of "blended" payments for GP services. A shift from a universal fee-for-service based rebate system (for patients) to a

mixture of fee-for-service rebates (to patients) and fixed payments (to doctors) through Better Practice Grants would require a clear delineation of activities and costs of meaningful, focused outcomes were to be achieved. Key issues for consideration therefore, include:

- Whether it is feasible to develop workable mechanisms which achieve equity for patients in terms of the Medicare rebates they receive within a framework of market oriented fees for key procedural services;
- The extent to which the medical profession, as a whole, would be willing to accept arbitrated and/or administered prices for services as a trade off for fair and reasonable rebates across-the-board; and
- The extent to which the rebate or mixed payment mechanisms are appropriate tools to be used by the Government and the profession to influence the way doctors practice or set fees.

Summary

It would seem that unless there is a workable and agreed nexus between fees charged and rebates the outcomes of a relative value study may be meaningless in relation to some of the fees that are able to be commanded in the “market”.

In general terms, having regard to the above, the objectives of a relative value study would be to:

- develop a relative value scale of services as a basis of setting schedule fees that are fair and reasonable for work covered by those services, and which reflect the differences in cost and expertise in providing the various medical services covered by the MBS;
- encourage a level of schedule fees observance by doctors such that patients are not unduly out of pocket; and
- provide a reliable base for updating fees and reviewing of qualitative and quantitative changes such as those arising from new technology, new services, techniques, etc.

(6) EARNINGS & DISPOSABLE INCOME

General

There is not a simple linear relationship between gross earnings and disposable incomes of providers.

Practice costs vary significantly between some specialties. For example, radiology practice requires far greater capital investment and operating costs than, say, psychiatry.

The service location, both in terms of geographical location and whether the service is provided in doctors' rooms, day surgery facility or hospital, also changes the cost to income ratio. If a procedure is carried out in a hospital or a day surgery facility, costs such as prostheses and disposables can be covered in the bedday charges. However, if the same procedures are carried out in rooms these items need to be covered out of the patient charge and the Medicare rebate. The relative impact on disposable income will in turn depend on the nature of the facility, consumable and other costs that apply, and whether doctors are in a position to pass the extra costs of procedures in rooms on to their patients.

Treatment of Capital Related Costs

The different methods of handling the reimbursement of capital related costs under the Medicare arrangements also distorts the disposable incomes of providers. For example, the MBS fees covering radiotherapy services are only intended to cover the associated professional and operating costs. This is unlike the MBS fees for diagnostic services which also cover the costs of capital. The capital costs of radiotherapy services are funded through separate direct grants to providers based on actual usage and limited to the assessed useful life of the particular item of equipment.

The mixed funding approach for radiotherapy services under Medicare is aimed at avoiding the continued payment of Medicare benefits for equipment which has been fully depreciated in accordance with conventional time based amortisation of capital costs. Such an approach is seen by the Government to overcome the perverse financial incentive for providers to either

purchase older second-hand (and possibly less effective) equipment or not update equipment once it passes its useful life. This is highlighted in the case of MBS fees for Computerised Tomography (CT) where a radiologist who updates a CT scanner more regularly will get a lower disposable income (for the same volume of tests) than a radiologist who keeps a CT scanner beyond the normal depreciation period and is able to contain maintenance and other operating costs.

The long term financing of major capital equipment, its placement and replacement have important policy implications and must be considered in the appropriate context.

(7) KEY “TECHNICAL” ISSUES

Defining the “Boundaries” of Services

Before an RVS or any other major review of the Medicare Schedule could be undertaken it would be essential to first identify and define the scope and coverage of each service to be included in the Schedule. The MBS structure covering, for example, consultations and aspects of general surgery may require extensive review. Under a fee-for-service system there must be appropriate differentiation between individual services as well as a workable separation from other activities such as hospital services. The possible introduction of “blended” payments for GP services is relevant to this point.

Mechanisms to Address Change

Notwithstanding the medical profession's desire for a positive focus and objective policy platform to support private practice and on which to base an RVS, as a minimum, it would be vital to ensure that MBS mechanisms were able to be introduced which allow timely and effective addressing of:

- (i) structural and productivity changes affecting the way doctors practice or perform services;
- (ii) the introduction of new technology;
- (iii) fair treatment of consumables, capital and infrastructure costs, etc;

- (iv) cost and income adjustments in fees; and
- (v) changes from shifts in funding such as those arising from changes in the mix of services, etc.

What Inputs are Measurable within a Resource Based Relative Value Scale?

In developing the methodology on which to base an RVS it is important to identify those resource based components of fees that are able to be measured with reasonable precision and those which are not.

The components which appear to be relatively easy to measure are:

- (i) costs such as consumables that are able to be directly identified to individual services;
- (ii) identification and quantification of representative background practice costs, such as general overheads professional indemnity insurance, etc.;
- (iii) the quantification of physical units such as numbers and types of staff, technician time, floor space, etc;
- (iv) the numbers, types and replacement costs of equipment; and
- (v) representative rates of pay of staff, market rentals, etc.

Such costs are able to be standardised to ensure uniform accounting treatment across all services.

It should also be feasible to determine average professional “times”, both direct and indirect, in relation to specific services.

What is More Subjective?

The effort expended and skill required to perform a medical service are highly subjective and variable. Assessments may well differ depending on the approach by the individual doctor. There are numerous problems and difficulties in defining and estimating “work” and separating different activities. The difficulties are increased when one considers activity such as post operative care which may vary considerably depending on the condition of the patient. Also,

as outlined earlier, there may be structural differences arising from the location of the service. For example, there may be different infrastructures in public or private hospitals or between geographical locations.

In a review process the natural tendency for groups would be to attempt to define their work in ways that are advantageous or which protect their “bread and butter” activities.

Factors which are extremely difficult to measure therefore include:

- premiums for skill, intensity, including the highly controversial question of cognitive versus procedural or manual skills
- skill life
- efficiency and effectiveness
- commercial risk
- allowance for profit

(8) THE PRESSING CASE OF CONSULTATION ITEMS

General practitioners and specialists have expressed concern about existing Schedule items for consultations which have not been addressed through the MBCC process. For example, neurosurgeons point out that frequently an initial consultation by a neurosurgeon is as complex as initial consultations by consultant physicians but lower rebates are payable. Other surgeons, given the increasing complexity of their discipline, undertake prolonged consultations, whereas other specialists derive large parts of their income from short, repeat consultations. Many specialists now “subspecialise” in an area that requires considerable consultative work, e.g. gynaecologists engaged in menopause clinics. On the other hand many consultant physicians now provide substantial procedural services e.g. gastroenterologists. Various specialists, such as those engaged in rehabilitation medicine, intensive care and dialysis management believe existing “catchall” items do not adequately reflect their work.

Examples of the different mix of services provided by selected providers are illustrated in the

attached tables.

Concerns over consultations have also been raised by various organisations under the Medicare Benefits Consultative Committee process. The Government response has been two-fold:

- (i) To point out that it would be inappropriate to deal with these concerns in an ad hoc manner. If the current consultation items are in need of review, then this should be undertaken in a way that will, as far as possible, address the concerns of all groups; and
- (ii) If some complex longer consultations are not recognised in the MBS neither are a lot of shorter, less complex consultations.

The basic questions to be addressed are whether current practice is adequately encompassed by the existing consultation items and whether groups of practitioners and their patients are systematically disadvantaged, or advantaged, relative to others by the present arrangements.

Under any system despite best efforts to achieve comprehensive categorisation and detailed descriptions of services there will always be some degrees of “swings and roundabouts”. Obviously, any fundamental reassessment and adjustment of consultation items will impact on the established patterns of practice that have evolved under the current structure of the MBS. The potential to create “winners and losers” and possible discord within the profession must be overlooked. During any reassessment of consultation items difficult questions will invariably be raised such as the continued appropriateness of the Consultant Physician/Specialist distinction, time tiering, “worth” or relative effort both within consultations and between consultations, procedural and diagnostic work.

A broad review of consultations would be a major undertaking involving the deployment of substantial resources by the Government, the AMA, and other medical organisations, and have significant ramifications across the medical profession.

(9) WHAT IS ACHIEVABLE IN THE SHORT AND LONG TERMS?

Given the foregoing, an overall relative value study would not be feasible unless all parties were first satisfied that the items and descriptors in the MBS were fairly differentiated and reflected modern medical practice. This is particularly relevant in addressing the current descriptors for consultations/attendances and those areas of surgery which have not been reviewed within the normal MBCC processes.

(10) POSSIBLE PROGRAM

A program for an across the board relative value study must first address a number of basic structural issues identified above and must proceed in clearly defined and manageable steps. This process should be facilitated by a body acceptable to both the Government and the medical profession. This body would identify and prioritise the work to be undertaken, and its program would be expected to include:

- (i) Production of a detailed plan for undertaking the review, an overall timetable, including that for review and consultation with affected groups, etc. and a possible program for the implementation of any proposed changes.
- (ii) Development of management structures including budgets, suitable reporting mechanisms, evaluation of progress, etc. for the review.
- (iii) A review of all consultation and attendance items covering GP services and consultant physician/specialist services (including obstetrics and psychiatry). This work would involve major surveys across all professional groups involving detailed analyses of both direct and indirect times, intensity, etc.
- (iv) Review the relativities of procedural services, with support of relevant groups, having regard to information from various sources and the results of overseas studies such as the American RBRVS. This would require identification, separation and quantification of factors relating to time (both direct and indirect), intensity, etc.
- (v) Undertake detailed practice cost modelling on an "activity basis" to determine how direct and background practice costs are incurred in relation to the input of the doctor,

and therefore how best to provide for their recovery of fees and incorporation in scales.

- (vi) Utilisation of the costing mechanisms that are already in place, or under consideration, in relation to diagnostic imaging and pathology services.
- (vii) Identification of suitable mechanisms for ongoing review of items and structures and update processes.