The Better Half of the Resource-Based Relative Value Scale

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Reactions to the newly proposed resource-based relative value scale (RBRVS)[1,2] have been immediate and predictable. Those specialties that would tend to lose income under the plan (which would reward time-intensive interventions common in primary care at a higher rate, and high-technology, procedural interventions at a lower rate) are either withholding judgment or openly opposing the proposal. Those concerned with the rising cost of health care charge that the plan would redistribute physician income but would not really keep down costs.[3]

Since family medicine stands to gain a great deal financially if this plan is implemented, it is not surprising that family practice organizations have announced immediate and enthusiastic endorsement for the RBRVS, praising specifically those aspects of it that would increase family physician reimbursement.

This reaction is, I believe, a missed opportunity of major proportions.

I will suggest here that family medicine should strongly endorse one half of the RBRVS—the half that lowers the reimbursement for subspecialists and for technology-intensive procedures. We should also specifically disavow any interest in increasing our own income and reimbursements, perhaps with the exception of a small increase to remove the major financial disincentives that now discourage newly graduated medical students from seeking careers in family practice.

I will support this apparently self-destructive proposal on two counts. First, there is an important policy agenda to be pursued, which would improve the quality of health care for all Americans while placing family practice and its primary care compatriots in a new position of national leadership. Second, any group of physicians seeking to influence national health policy today is bound to fail unless it can be clearly demonstrated that group members are not lining their own pockets as a result of the policies they propose.

The social and political concern over the rising cost of health care in the United States continues. Those who attack the RBRVS because redistributing physician income does very little to slow the rising cost of medical care are basically correct. At this point there seem to be only two strategies for effectively slowing that increase. One is a set of rigid and centralized regulations, which hardly anyone wants. The other alternative is a combination of capitation and prepayment arrangements that would give providers financial incentives to control costs.

Well-run capitation systems are those that combine managerial efficiency and cost control with high levels of provider and patient satisfaction and quality of care. From the evidence available, it appears that the only way to run such a system is to have a large number of competent primary care physicians who have a relatively high level of control over case management. Family physicians, and others similarly trained, seem to be most capable of controlling medical costs and establishing the sorts of relationships with patients that the patients seek while continuing to provide a technically high quality of care overall.[4,5] At this point, no other medical specialty can muster a similar body of evidence to justify a central role in a well-run capitation system.

Moreover, there is an additional social problem of great magnitude that further challenges the goal of cost containment. The roughly 40 million Americans who currently lack any form of health insurance must be brought within the health care system and receive a guarantee of access to decent medical care.[6,7] Family medicine has up until now neglected its natural role as an advocate for this group of patients, and can no longer afford to do so. Once again, it appears that only a medical care system heavily tilted toward primary care can possibly seek to expand coverage to this group of patients while still restraining cost increases.

These observations suggest an important political

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agenda for family practice and those primary care colleagues who wish to join us in this endeavor. We must seek to influence national health policy toward extending access to care to those now uninsured, creating new capitation systems in which the primary care case manager will play a central role, and increasing the number of primary care physicians to meet the needs of these expanded systems. The question now is whether the administrators, policy makers, and politicians will pay any attention to us if we support this agenda with aggressive political action.

The evidence (overwhelming to all except those who now purport to be leaders of organized medicine in the United States) is that physicians have almost completely lost power in the American political process. The Medicare-Medicaid debate of the 1960s, when organized medicine successfully held up reform until such time as it could assure itself of windfall profits if it conceded, is a thing of the past. Virtually all of the major changes in medical policy in the 1980s, from diagnosis-related groups onward, occurred without any significant input from the medical community. While there may be many reasons for this, one reason that cannot be denied is the high level of suspicion that both politicians and the general public have of the physicians' motives. The Medicare-Medicaid story is too vivid in their recollection. The public and the politicians are simply fed up with physicians coming before them, proclaiming their altruistic concern for the public good, and then lining their pockets with profits afterwards.

Of all the medical specialties, family practice has one of the best records with which to counteract this charge against the motives of physicians seeking change. Before Medicare and Medicaid, there tended to be a much smaller gap between family physician income and subspecialist income. After their enactment, the fantastic rise in income among the highly paid specialties took off, while family practice, by contrast, tended to fall below the increase in the cost of living. The end result is the considerable gap between medicine's haves and have-nots, which the RBRVS is designed to close.[8]

If at this point, however, family practice gets behind the RBRVS simply because it will allow us to catch up with the other specialists, we stand at risk of losing the primary political leverage that we might hope for. We will be branded by the politicians (and certainly by our subspecialist colleagues) as just one more group of greedy physicians. Our claims that we stand for quality of care and access for the uninsured will inevitably be discounted or dismissed.[9]

I conclude from this reasoning that family medicine must begin to direct itself toward a unique political agenda, but that in order to do so, we must avoid the temptation of the RBRVS as now proposed. Instead, we must get behind the better half of the RBRVS. We must encourage the lowering of payment for technologically intensive services and a variety of subspecialty services, proportionate to that necessary to bring the reimbursement and the income of those physicians closer to the medical mean. We must at the same time, however, refuse any but a very modest increase in reimbursement for the services that we ourselves provide. (A sum that would allow the average family practice residency graduate to pay off the usual student loans without undue hardship would be a reasonable income increment.) It might appear that this approach would leave us in an intolerably weak position within medicine and thereby unable to carry out the agenda that I have proposed. Let me now suggest that by adopting the better half of RBRVS, we would in fact come out ahead in several ways, even if personal income is not one of them.

First, it is my assertion that family physicians will increasingly become involved with capitation and prepayment systems. As noted above, there is an acceptable model for a well-functioning system of this type, but today, unfortunately, many systems that family physicians find themselves part of do not fit this model at all. Patient and provider satisfaction is low, regulation is excessive, quality of care may suffer, and everybody except the primary care physician seems to be in charge.[10] If we look at systems to see why this is so, a recurring problem presents itself. Family physicians have relatively little power in those systems because the primary care fund that pays them and gives them the resources needed to provide in-office treatment of most common problems is such a small percentage of the total budget. And the excessive reimbursements that now go to hospital and subspecialty services are the major cause of underfunding primary care.

If the RBRVS were to be implemented in the future, the reduction of the excessive fees paid for subspecialty and high-technology services would by itself help to right this imbalance, even if family physicians did not receive a significant increase in reimbursement by procedure or by intervention. We could expect that the relative size of the primary care fund within a health maintenance organization (HMO) or a preferred provider organization (PPO) could be readjusted to allow primary physicians to take a more active case management role as well as to expand the services (such as nursing care, health education, nutrition, and social work) that are offered in our own office setting. This move would improve the quality of care, particularly preventive care, and increase patient satisfaction. If, however, reimbursement to hospitals and subspecialties continues to rise at the present rate, it will be almost impossible for even the better HMOs and PPOs to make sure that primary care as a medical activity receives its fair share of the total budget.

Second, it is certainly in our interest as family physicians to increase the number of family physicians and other primary care providers trained in the near future. Right now, one thing that clearly discourages medical students from seeking a career in primary care is that they could make so much more money by becoming a subspecialist. If this incentive were removed under the better half of the RBRVS, we could expect that one of the major factors that discourages primary care residency training will be eliminated. This will be so even if there is not a major increase in the income of primary care physicians themselves.

Third, it would be extremely difficult to sell the RBRVS as a whole within medicine itself, and the worst scenario that would arise is that of open warfare between the primary care physicians and the subspecialists, between the financial haves and have-nots. I have argued that a well-run capitated plan requires the primary care physicians to assume a major management and patient care role. It is just as obvious that any such plan also requires a full battery of subspecialty consultants who are willing to cooperate with the primary care physicians and provide high-quality care to patients when their services are truly indicated. We desperately need the help of our subspecialist colleagues to make this goal a reality. Inevitably, any version of the RBRVS will engender great suspicion and hostility among subspecialists toward family physicians. If in addition we are making a handsome profit for ourselves, the personal animosity and lack of cooperation will only be heightened. The only way we can hope to get our subspecialty colleagues to accept some version of the RBRVS with reasonable commitment to any shared goals among us is to make very clear that we are not making any windfall profit for ourselves as a result. Only in that way is there a chance of forging some sort of coalition across specialty lines in support of the RBRVS and associated reforms. No doubt many subspecialists, perhaps the majority, will look at the implications only for their own incomes and will reject the RBRVS out of hand. We could, however, hope to attract at least a few forward-looking members of each specialty as our allies, as long as we are clearly not in it for the money.

Fourth, as long as reimbursement for high-technology procedures is minimized, the RBRVS should, contrary to the charges of some of its critics, work to contain health care costs. While physicians may make a lot of money from those procedures now, that amount represents only a fraction of their true cost. The hospital and technician services and other associated fees make up a great deal of the excessive health care expenditures in the United States. If the physician reimbursement system were changed so that physicians were no longer disproportionately encouraged to perform these procedures, fewer of these procedures would be done. If physicians instead started doing more time-intensive and patient-intensive activities, their incomes might remain high, but the associated hospital, technician, and material costs would not be added. There is thus good reason to believe that the RBRVS will by itself help to keep down medical cost increases in the future.

Finally, it may simply be politically unrealistic to urge adoption of the entire RBRVS package. While the RBRVS is supposedly budget-neutral, the most recent federal efforts since its publication have been aimed at cost-cutting at the high end with no compensatory increases at the low end.[11] If family physicians willingly give up the "pay hike" under RBRVS, we may simply be giving up something we would never get anyway.

I conclude that if family physicians support the RBRVS as it now stands, and explicitly demand a bigger share of the physician income pie, we are likely to win some battles but to lose the opportunity to pursue the broader and more important political agenda in which we have a massive stake. If, on the other hand, we find a creative way to endorse what I have called the better half of the RBRVS, we have a chance to gain major political leverage.

Mark Twain said that an advantage of doing the right thing is that it will gratify some people and astonish the rest. Certainly, if a group of physicians publicly turns down an offered pay increase in order to provide what we think is the highest quality of medical care for the greatest number of people, then the body politic may be sufficiently astounded to begin to pay us some attention.

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