

Medical Care Prices in the United States: Private Dominion and the Relative-Value Scale

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ABSTRACT: Medical care in the US is priced by commercial forces. The forces are not free-market, but rather are controlled and owned by specific private entities. The legally-mandated method to set medical care prices (the Relative Value Scale) mandates the use of specific, privately-owned commercial billing tools. Prices, and a pricing method, ultimately direct what kinds of medical care is available in the US, and the existing structure values less-needed and inappropriate care above needed shortage care. The pricing method's origin, its designers' market biases, and its use to enforce a specific private locus of control are examined. A critical perspective on the sanctioned scale's validity, its consequences for US medical care services, and exclusive control by a specific technocratic elite are examined.

Keywords: privatization; public health; political economy; medicine

I. How is US Medical Care Priced? A Rationale for Critical Discussion

Market commerce rations United States medical care. Free-market forces purportedly deliver care in the manner of other goods and services. Indeed, existing U.S. medical pricing rests upon the promotion of private finance as the most efficient mode to deliver goods and services. In praxis, however, control of medical care pricing falls not to "free" market forces, but to governing-class interests in its commodification. This control requires mechanisms to integrate the insurance and finance industry into affiliated government agencies.

This project began as an inquiry into which structural segments and interests do indeed benefit from the current payment structure, as clinicians observe

that it does not encourage the provision of appropriate and needed medical care. Current healthcare pricing leaves necessary care unfunded, and shifts production preferentially into un-necessary medical services. The importance of different medical services simply is not reflected in their price. Procedures and imaging, for instance, are priced markedly higher than preventive primary care—despite primary services being in short supply. This reality contradicts faith in market efficiencies, for accumulated high demand and short supply have not resulted in higher prices for the primary services. This has driven a critical decline in US medical graduates willing to provide direct patient care. Current graduates preferentially seek the more

highly remunerative procedural and non-patient-care specialties (Garibaldi 2005). It has lent much to the decline of basic health care access in the United States:

Thirty minutes spent performing a... procedure often pays three times as much as a 30-minute visit with a patient with diabetes, heart failure, headache, and depression... an unsurprising result: fewer U.S. medical students are choosing primary care. [Bodenheimer 2006]

The de-valuation of preventive and primary care, as a social fact, contrasts starkly with the needs observed by citizens, physicians, and some engaged policymakers. What entities and interests, we may ask, drive a seemingly maladaptive pattern?

This is a current and pressing matter. Public awareness about how medical care is priced and paid for is lacking. Effectively, the discussion of health finance systems excludes “non-experts”—the populace who live under it. An interdisciplinary discussion is needed to open this topic to working clinicians, outside academicians, and the wider public—all effectively excluded from cognizance of the existing pricing control structures.

A critical outsider’s perspective on the payment scale, its preferential-stimuli for unneeded care, and its underlying capital presumption is here intended. An existing praxis so maladaptive, yet so pervasive, warrants exploration for its causes. Existing information on health finance is generally technical and oriented to business operations. Although health finance directly impacts the public, this discourse has been reserved for individuals with expertise validated by authority-granting institutions (e.g. universities, government, and insurance-finance industries). Most material on this topic is written for and by such sanctioned experts, pursuing career productivity within the existing payer arrangement. To my knowledge, the present critically-engaged interdisciplinary discussion, intended for non-administrative audiences, is not yet available elsewhere.

This essay explicates the government-enforced “relative value” pricing system in the United States. I discuss it as a product of cooperation between government, medical services firms, and finance-insurance enterprise. I then discuss the background

of the method’s main architects, noting the precepts beneath sanctioned experts’ pricing schemes. I discuss some limitations of this valuation method, and I suggest that its superficially technical appearance serves to exclude laypersons from a popular discourse on health finance.

I proceed from three tenets: First, the range of available medical care is a material product, dictated by the payment system. Secondly, that the US health payment system is presently maladaptive. Simply restated: the payment system determines what care is available, and the current arrangement serves identifiable controlling interests at the expense of appropriate care. Lastly, the purpose of this current paper is not theoretical exposition, but a discussion useful for further interdisciplinary pursuit, including in the area of theory, but more ambitiously to engender emancipatory goals and discourse on change strategy. This third principle may be best reflected by Zeitlin (1994:220, emphasis added):

The really important lesson to be learned from Marx and Weber is the importance of history for the understanding of society... they concerned themselves with the concrete circumstances of specific periods... *an adequate explanation of social facts requires a historical account of how the facts came to be.*

II. Relative Value: An Introduction to the US Health Payment System and its Ownership

RBRVS: The Resource-Based Relative Value Scale
US medical care is priced by an accounting system known as the Resource-Based Relative Value Scale (RBRVS). The RBRVS was developed by sanctioned experts in economics and finance, which we will discuss further below in this discussion. RBRVS was originally promoted as the solution to inappropriate distribution of high payments into less-needed services, and the underpayment of primary care services. Procedures were better-paid than needed primary care (Hsiao 1979). Rather than the most clinically-efficacious procedures, best-paying approaches were utilized preferentially. Well into the 1980’s, payment systems generated a significant number of unnecessary surgeries (Chassin 1987; Greenspan 1988).

Yet two decades after mandating use of the RBRVS, the same preferential forces persist, for the RBRVS' "relative value" of primary care remains low relative to procedures, and also low when compared to low-need elective and cosmetic types of medical services (see Goodson 2007).

Care episodes are denoted by codes from "Common Procedural Terminology" (CPT), published by the American Medical Association. The 7000-plus codes in the first edition of 1966 have expanded markedly in subsequent decades. They include surgeries and procedures, such as a vaccine injection, performing a knee replacement, or suturing a wound. "Evaluation and management" (E&M) codes from the same master list denote conventional doctor-visits. Each CPT code has an associated "relative value" calculated by RBRVS. "Relative Value" dictates dollar price.

The Mechanics of RVBRS Valuation

At first blush, the technical appearance of the RBRVS formulae intimidates many lay readers. It thus enhances a technocratic claim to privilege to make expert comment upon health pricing. The Center for Medicare Services publishes this description:

The formula for calculating 2008 physician fee schedule payment amount is as follows: 2008 Non-Facility Pricing Amount = ((Work RVU * Budget Neutrality Adjustor (0.8806)) (round product to two decimal places) * Work GPCI) + (Transitioned Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor

2008 Facility Pricing Amount = ((Work RVU * Budget Neutrality Adjustor (0.8806)) (round product to two decimal places) * Work GPCI) + (Transitioned Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor (Note: When applying the 0.8806 work adjustor to the work RVU you must round the product to two decimal places.) [Centers for Medicare Services 2008]

More simply, the formula multiplies Work, Local Costs, and a Conversion-Factor:

- A. Work: as defined by an administrative estimate:
1. Time consumed before the visit ("pre-service input")

2. Time consumed during the visit ("intra-service input")
3. Time consumed after the visit ("post-service input")
4. "Intensity of service", reckoned as the "stress" of providing a service or procedure

B. Specialty-specific practice costs

1. The "opportunity cost of training" in a specialty, as estimated from accountancy of "lost years of income" while in medical training.
2. The geographic cost of operating compared to other regions.

C. Conversion Factor (RVU to dollars): Set by Medicare in periodic updates.

The most-adjusted factor in periodic updates is the conversion factor. Center for Medicare Services (MCS, formerly the Health Finance Resource Administration) sets this dollar-RVU equivalence on the advice of the Reimbursement Update Committee, an entity which I will describe below.

Aspects of Medical Care Excluded from RVBRS and Some Limits upon RVBRS' Validity

The experts charged with the RVBRS advocated their estimates as a sufficient scoring system for the pre-, intra-, and post-service work of care in a series of technical publications. Dedicated space in the *Journal of the American Medical Association* and by the *New England Journal of Medicine* in late 1988 presented their calculation of work (and the relative values) of various care episodes. These technical articles, and the RBRVS formulae as printed above, presented the RBVRS with a face of precise econometrics. However, each element of "work" represented in RBRVS is but an actuarial approximation of socially nuanced and qualitative events, and excludes significant considerations.

First, RBVRS method necessarily ignores the bulk of qualitative interactions within medical care exchanges. Many are important to clinicians: the complex nexus of physician-patient interaction, lacking an assigned metric, is accorded no value among the "relative values" of services.

Second, the public's interest also receives no valuation: the public health impact of care, and effects upon health outcomes, are unaccounted in RBRVS.

Its designers dispensed with these considerations early, noting that “outputs of services... are enormously important to society, [but] they are very difficult to measure” (Hsiao et al 1988:2348).

Third, RBRVS necessarily reduces complex subjective experiences of medical practice to produce its metric of “service intensity.” In an early essay, the central designer of the RVBRS noted:

The service intensity for a half-hour spent by a pediatrician performing a well-baby checkup clearly can be contrasted with the same pediatrician attempting to resuscitate a newborn in the hospital. The same half-hour requires a different amount of input effort, which we define as intensity. [Hsiao 1987:360]

This definition of “intensity” was not derived from observations of real “work” taking place, nor upon any established psychometrics of human workplace “stress.” The proxy measure actually used was a survey mailed to 160 physicians, selected from the AMA’s master file. The surveys were later re-performed on sub-specialty groups. Surveyed physicians generally agreed upon how to rank the intensity of some clinical vignettes described on a telephone or written survey (Hsiao 1988:2350-52). Statistical agreement among the survey respondents was high, and the valuations surmised from the hypothetical vignettes were then judged satisfactorily reproducible by RVBRS’ designers, to estimate the values of actual work, although no actual work was studied. In commentary on their own methods, the designers noted that

There is no objective standard with which we can compare our results to ascertain how well they represent reality... we have not found a way to detect bias produced by our method... Further research studies should be conducted. [Dunn 1988:2377-78]

These “further research studies” were not conducted. Time-movement studies or more complex studies of clinical work and stress have not been substantively utilized. However, the fundamental method RVRBS utilizes today is essentially unchanged.

Ownership of the U.S. Health Payment System

The RBRVS is published by the federal government’s Center for Medicare Services, (CMS) a public agency created to pay for some of the medical care of United States citizens over age 65 (and a small range of other qualifying citizens). The CPT codes which describe care episodes, by contrast, are separate from government. The CPT list is owned privately, but using it is mandated for billing public funds using the RBRVS-scaled prices. The CPT is owned by the AMA. AMA receives over \$71 million per annum from royalties, manuals, and billing software.

Private payers generally follow the same system, which obviates the costs of developing a parallel system. Distinct to the United States, private third-party private insurance plans cover the majority of covered patients (although public dollars continue to fund the majority of actual annual medical care expenses). Clinicians submit a bill labelled with a CPT code to Medicare for each service episode. Payments from public funds are mostly processed by private intermediary billing firms. Despite being designed for Medicare operations, the mandated system for billing established the format by which private-payer insurance payments are now made, as well:

[RBRVS] was not designed as a universal system of reimbursement for the provision of services to all patient populations, including those commonly covered by state Medicaid agencies and private payers. Despite these design limitations, private payers moved rapidly to adopt this method of reimbursement. [Brill 2006]

Under its former name (Health Care Finance Administration, or HCFA), CMS mandated the use of the AMA’s CPT codes, as of 1983. An inextricable element of public health care financing is thus monopolized by a private entity, and its use is required by government mandate. HCFA also funded the creation of RBRVS, and reciprocally, the AMA voted in 1988 to endorse the RVBRS, a system which integrated smoothly with their CPT products, as the “acceptable basis for a Medicare indemnity payment system” (report AA, reference committee A, Dec 6 1988, cited in Hsiao 1989).

The AMA's CPT list still remains, officially, de-linked from Medicare's RBRVS system. In early publications, the designers of the RBRVS asserted that it "is not a set of prices but relative values that physicians and payers can use as an objective base for examining prices or establishing reimbursement" (Hsiao 1989:2329). Despite this, the AMA's web-based CPT code search provides the RVU count and a dollar-price for each CPT code. Using RBRVS requires CPT as a uniform set of descriptors to operationalize medical care into a commodity. Without CPT, RBRVS would be unusable.

Health care organizations measure "physician productivity" in Relative Value Units (RVU). The dollar-value of each Relative Value Unit (RVU) is published in periodic updates, with a direct relationship between RVU counts and the dollars represented. In 2005, a usual office visit was relatively-valued at 1.39 RVUs (each RVU then equaled \$USD 37.90). Typical primary care or hospital care physicians' contracts in 2008 aim for approximately 4,000 RVUs per annum.

The table on the next page illustrates a few examples of CPT codes with corresponding Medicare dollar-values, calculated for suburban Chicago in 2008. Primary physicians use procedure fees to offset low valuation of their main care work. Procedures do require significant skill—yet in most of the instances noted, that skill and training for the "cognitive" care is the same as for the procedures: that of a primary care physician. The calculated value-per-hour estimate is an artificial aid, presented to illuminate proportional pricing. Yet the same disproportionality characterizes real clinical scenarios: an office visit for skin rash, assessed with an empiric biopsy (CPT 11100), will remunerate about five times more per hour than a 25-minute clinical history and examination (CPT 99214).

The authors of the RBRVS were aware of this payment differential and promoted RBRVS as a solution which would

provide higher compensation for evaluation and management services relative to payment levels for invasive, laboratory, and imaging services...

Therefore, an RBRVS-based payment approach might induce physicians to shift their practice activities... inappropriate and questionable surgeries and diagnostic tests may be reduced under an RBRVS-based payment system.

Another potential impact of an RBRVS-based fee schedule might be on the specialty choices of medical graduates... [yielding] a positive effect on the accessibility, cost, and quality of health care. [Hsiao and Becker 1989:260]

It is notable that after 20 years of RBRVS, the shunting of payment preferentially to specialty procedures continues, and these positive outcomes remain unrealized. The payment calculation scheme was replaced, but control of the "relative values" of medical services remained secure.

III. The Creators of RBRVS: A Nexus of Business, Finance, and Government

One reason that RBRVS has not improved the misdistribution of medical care is that the locus of price-setting control remains unchanged from that of preceding payment arrangements. RBRVS did not change private control of price-setting. The omission reflects the privatization-economics bias of the experts who designed RBRVS.

Medicare adopted RBRVS under the Omnibus Budget Reconciliation Act of 1989, signed by the first president Bush. The individual experts tasked to design RBRVS were trained within, and allegiant to, privatization-economics and deregulation policy; they have moved between prominent roles in government, academics, and private insurance-finance industries. A brief examination of the experts' training and intellectual descent, and the sociohistorical context of RBRVS, underscores the relationships between RBRVS' official sanction and the nexus of health-services firms, insurance and finance industry, and responsible government agencies. The current text is not an exhaustive history of the participants, but to my knowledge no discussion of the sociohistorical bias of RBRVS design has been offered elsewhere previously.

RBRVS was laid out and then examined for feasibility, beginning in 1985. HCFA, seeking a

RVU and Medicare Dollar-Fees for selected E & M services and for procedures: Scaled for suburban Chicago, 2008.					
Code	Description	Work RVU	Dollar Price	Usual time needed by a primary-care physician	Dollar per hour equivalent
99407	Smoking and tobacco use cessation counseling visit; intensive.	0.5	25.16	10-20 minutes	75
96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family	0.0	41.42	30 minutes	83
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; infant, age younger than 1 year.	1.46	76.47	40-plus minutes	115
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.	2.0	129.33	40 minutes, plus documentation time and pre/post-service records time.	155
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.	2.56	123.33	50 minutes	148
99239	Hospital discharge day management; more than 30 minutes	1.9	98.17	30-plus minutes	148
11100	Skin punch Biopsy	0.81	94.30	5 minutes	1105
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	2.5	273.50	10 minutes	1608
36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	2.27	177.69	5 minutes	2090
51702	Placement of Foley Catheter (urine catheter)	0.5	94.87	10 minutes	558
32421	Thoracentesis, puncture of pleural cavity for aspiration	1.54	155.56	15-20 minutes	915
17004	Destruction (eg, freezing) of non-cancer skin lesions eg, actinic keratoses ("sun spots")	1.82	167.46	15-20 minutes	508
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	0.75	52.61	Under 5 minutes	619
20553	Injection(s); single or multiple trigger point(s), three or more muscle(s)	0.75	53.41	10 minutes	1076
36471	Injection of sclerosing solution, veins, one leg	1.6	183.79	5-10 minutes	1102
11954	Subcutaneous injection of material (eg, collagen)	1.85	166.89	N/A	N/A
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	8.12	625.17	N/A	N/A
15789	Chemical peel, facial; dermal	4.91	495.87	N/A	N/A

method to reduce money outflow, funded the economist William Hsiao's team to develop the scale. Hsiao's social context is relevant to a critical view of some assumptions beneath RBRVS. Born in China in 1936, William's family emigrated from China as the nationalist-right Kuomintang government was deposed. Hsiao's father was subsequently the capital and finance advisor to the Kuomintang's government in exile representatives at the United Nations. Hsiao first worked as an actuary at the Connecticut insurance company which became today's CIGNA. Still an actuary, he moved to the Social Security Administration (the United State's federal retirement benefit agency) in 1968, and soon became acting Chief Actuary, speaking to panels considering privatization and other methods to bolster the solvency of the Social Security public fund. Hsiao left government for economics training at Harvard, and was appointed to a professorship at the same institution in 1979. Hsiao now occupies the Kwoh-Ting Li chaired professorship at Harvard (on the strength of physics study at Cambridge, Kwoh Ting Li was the leading technocrat in Chiang's Taiwan state; as minister of finance and later of state, he oversaw the redirection of Taiwan's production from agrarianism into western import-goods, and built extensive relationships with expert economic authorities in western academia and government).

The RBRVS team's technical director on Hsiao's team, Daniel Dunn, held a faculty appointment at Harvard in the early 1980s. He is now vice president at Ingenix, a private firm selling software and consulting to "balance clinical and financial issues and most importantly, convert claims into revenue." Ingenix in turn is owned wholly by United Health Care, one of the United States' largest finance and insurance corporations. He is chairman of the National Committee for Quality Assurance to measure profits and resource efficiency of insurance and medical services industries.

Hsiao's thesis and economic thought were developed under privatization-apologist Martin Feldstein, who advised his dissertation. Feldstein headed the Council of Economic Advisers under Ronald Reagan, under whose administration HCFA funded Hsiao's

project. Feldstein advocated privatization of Social Security assets under the second Bush administration. Feldstein's other notable advisees (and his own direct advice to government) have advocated privatization of a range of public functions (advisees included James Poterba of the second president Bush's tax advisory panel, and his economic adviser Lawrence Lindsay). Feldstein continues as the George Baker Professor of Economics at Harvard, and sits on the "Group of Thirty" influential economists. He was president of the National Bureau of Economic Research, a private group formed at government request (other NBER experts included neoliberal Ludwig von Mises and Milton Friedman). He was once thought likely to become Federal Reserve Chairman but his candidacy was crippled by his role on the board of AIG, a private insurance firm which had just written down a \$2.7 billion loss, ahead of its later failure and rescue by public assets. (Hernandez 2005).

The original "Technical Consulting Groups" (TCG) used for Hsiao's project were provided to Hsiao's design team by the American Medical Association. To build the RBRVS, these TCGs' opinions were the proxy for measuring physician work. The TCGs illuminate how officially-sanctioned experts, academicians and administrators, un-representative of most US physicians, delivering only a small fraction of direct patient care in the US, exerted authority through the RBRVS:

These TCGs, made up of specialists nominated by the relevant specialty societies in a process coordinated by the AMA, were particularly important in the [RBRVS]'s inception. We reviewed the curriculum vitae of the nominees and drew up... an approximately equal mixture of academic and community-based practicing physicians...

In each specialty for which funding was available, we invited up to five physicians for the panels... [For] nonfunded specialties such as cardiology... however, we generally invited only one to three panelists...

The TCG members were the main source of substantive information on the natures of medical practice in the specialties, on the most important services, and on the typical variety of patients seen. [Hsiao et al 1988:2349]

Agencies Controlling Medical Care Prices

The American Medical Association represents a fraction of US physicians. It is often represented as a unifying umbrella organization of US physicians, but fewer than 20 per cent of US physicians are members, even when subsidized medical student memberships and retirees are included (see Peck 2007). The AMA's operating budget comes predominantly from fees, royalties and copyrights, not from membership support. The AMA operates the main panels which govern price-setting.

As a note of historical context: AMA opposed Medicare's birth in the 1950s and 1960s, and paid then-actor Ronald Reagan to record "Ronald Reagan Speaks out against Socialized Medicine." The narrative LP was intended for listening-parties called "Operation Coffee-Cup." A letter from Reagan came with the record, directed to "concerned women" assumed to be the wives of (presumably male) physicians. Current AMA integration into health finance governance is both more nuanced and more robust. It is instructive to enumerate some of the modern-day relationships between the AMA as a private, self-promoted body, and the government panels charged with setting reimbursements which determine the material impact of the "relative value" of services.

In the current era, clinicians pay to the AMA a licensing fee to use the copyrighted CPT to assess charges and billing—the AMA directly owns a required element of the payment system. In 1983, HCFA adopted a policy of exclusive use and promotion of the AMA's copyrighted CPT coding list—no alternate codes outside the AMA's copyright were to be recognized. The codes themselves are created by the AMA's 17-member CPT committee. Eleven members are appointed by the AMA. The remaining six represent: Blue Cross/Blue Shield, Centers for Medicare Services, The American Hospital Association, and the Health Insurance Association of America.

The AMA's Reimbursement Update Committee advises payment updates through the Centers for Medicare Services. The committee's mandate is to determine the "relative value" of different services. Over 90 per cent of the RUC recommendations are directly adopted by government. The RUC is com-

posed of 29 members; 23 are appointed by medical specialty societies. Nineteen appointees represent subspecialties outside of direct primary patient care (such as dermatology, plastic surgery, and anaesthesiology). The remaining four represent the declining primary care specialties, such as pediatrics, and geriatric medicine. As such, the Reimbursement Update Committee's priorities differ from the needs of the population Medicare purports to serve, for whom primary care access is in critical decline. Negative impact of the RUC's composition upon US primary care has been discussed elsewhere (Goodson 2007). Of the other six members, the composition is: a chairman appointed by the AMA, a member of the AMA's CPT panel, a representative of the American Osteopathic Association, another from the Health Care Professionals Advisory Committee, and a member of the AMA-based "Practice Expense Review Committee." No RUC panel member holds mandate or qualification to consider the impact of differential reimbursements upon the services available.

Of note, a "Payment Advisory Commission" for Medicare also exists, established in 1997 as an "independent Congressional agency" under mandate to "advise" Congress on Medicare funding (Medicare Payment Advisory Commission, 2008). "Consumers" as well as financial, medical, and other experts can be nominated publicly to the panel. It has no governing or legislative authority. "Two reports—issued in March and June each year—are the primary outlet for Commission recommendations." At the time of writing, one of the 17 panel members is a working primary-care clinician. Of citizen "consumers" among the other 16, all hold graduate degrees in law, business, or administration (among them at present are a pension fund attorney, an actuary from the exchange-traded health-finance firm Humana, several health firm executives, finance professors, government economists, and a hospital "turnaround" consultant).

The output of policy from panels responsible for the US medical finance system gives primacy not to patients' access to care, but to those institutional interests comprised in the panels' composition. These interests reify the valorization of markets and privatization which is necessary to participation in market praxis.

IV. Commodification is Incompatible with Medical Care

The existing U.S. health care payment system rests upon faith that free-market efficiencies will apply to health resources just as to other goods (whether these principles actually do adequately or equitably distribute non-medical goods and services to meet human needs is beyond the scope of this current discussion). The RBRVS exists within and reifies this market-based health-finance system: “The underlying premise [is that] prices in a well-functioning market approach resource costs” (Hsiao 1989:2328). Interestingly, the same author and lead-designer of the current payment structure noted in 1979 that “it is highly unlikely, given existing circumstances in the medical care market... that conditions for a competitive market will ever exist” (Hsiao 1979:23).

Before crafting the RBRVS into market-palatable language, the “resource-based” schema was actually itself once seen as an alternative to the unregulated free-market forces upon health-care. The notion that the market forces will approximate the resource-based estimates appears to co-opt the techniques only much later in the evolution of the RBRVS. Today, its advocates assert the indispensability of market commerce in medical care, a “well-functioning market” the same experts previously deemed non-existent.

The incongruity of free-market assumptions to medical care has been dealt with at length elsewhere, but brief review sheds critical-analytic light on the RBRVS’ role as a marketplace pricing tool. Medical care is unlike many other services and commodities. Most Americans live in communities too small to support the putative “competition” driving hypothetical market efficiencies (Kronick et al 1993). Most US citizens lack the expertise to make discriminating choices in health services, and attempts to impact medical care quality through “report-cards” for comparison-shopping have had little demonstrable effect. Multiple factors preclude effective public use of such data. Even for elective care which market-forces might conjecturally govern, publishing report-cards did not improve quality (Fung 2008). As a side-effect of one attempt, only the most affluent citizens gravitated to higher-scoring providers (Mukamel et al 2004), suggesting that less-privileged

patients could not access or act upon the scores. US citizens, overall, are actually not widely permitted to comparison-shop their health finance resources—these insurance products are instead imposed by plans selected by their employers (Commonwealth Fund, 2005). Health insurance “products” are constructed to be sold to employers, not designed to serve workers’ needs. Above all, it must be clear that “consumers” of medical interventions differ from those of other services: citizens do not shop for cars or appliances while they are sick, delirious, or bleeding.

Specialty groups maneuver annually for higher reimbursements under RBRVS, but without coherently addressing its fundamental suitability (e.g. Brill 2006). These near-horizon interests will not change the underlying flaws. RBRVS remains a fee-for-service scale, reducing medical care to commerce, and commodification intrinsically emphasizes the volume over the quality of patient care. RBRVS is a central core element of commoditized medical care. Ultimately, US medical care prices are driven not by “free” market forces, but by identifiable private bodies.

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