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Objective Research And Physician Payment: A Response From Harvard

by William C. Hsiao

William A. Glaser’s Commentary, “The Politics of Paying American Physicians” (Health Affairs, Fall 1989), criticizes the use of objective information in making public policy decisions. His position is summarized in his opening sentence, “Paying the doctor is inherently political.” From that starting point, he concludes that political bargaining and negotiation should decide payment method and rates, and that information and knowledge derived from projects such as the resource-based relative value scale (RBRVS) study, performed at the Harvard School of Public Health, are superfluous and wasteful.

I believe that most experts in public affairs would reject Glaser’s views as too narrow and overly reliant on political bargaining, rather than on reasoning, in public policy decision making. It is true that public policy is often decided by a political process in which organized interest groups negotiate with one another for a compromise. Nevertheless, objective information can help to narrow the different views, bringing about better political decisions more quickly. Also, agreements derived through political negotiation do not necessarily serve the general public’s interest best. Objective information obtained from studies such as the RBRVS provides a guide to a relative price structure that could enhance our nation’s welfare.

My comments here are intended to correct Glaser’s misunderstanding about the role of the RBRVS in the reform of physician payment. I also correct several factual errors in Glaser’s interpretation of the concepts and methods we used in developing the RBRVS.

The RBRVS And Physician Payment

The role of price. Price plays a vital role in medical services, determin-
ing the volume and quality of services physicians provide. Price can influence clinical decisions regarding modality of treatment, diagnostic tests, and surgical rates. The price structure also determines the income differential among specialties. Hence, in the long run, price affects how many medical students will choose to be family physicians or surgeons. Geographic price differentials also influence how many physicians will choose to practice in rural communities. Empirical studies have found that inflated prices can induce physicians to perform unnecessary tests and evaluative services and inappropriate surgery. These inappropriate services can cause harm and suffering to patients and can inflate total health care costs through unnecessary hospitalization. Exceedingly low prices, on the other hand, could lead to undersupply of services and depression of their quality.

In his Commentary, Glaser argues that the process of and participation in political negotiation is vital, and political agreement is of primary importance. He uses several European nations’ political processes as examples. He gives little consideration, however, to the price structures that have been produced from such political negotiations and whether these fees would benefit or harm all Americans. I believe the United States can do better than European nations. Political negotiation that uses empirical information can lead to decisions that are better for the public interest.

The role of the RBRVS. Glaser also misunderstands the role of the RBRVS in policy decisions on physician payment. The RBRVS study uses a rational and systematic process to derive the relative prices that would have emerged from a reasonably competitive market. Economic theory shows that competitive prices have socially desirable properties that promote efficiency and lead to optimum use of society’s scarce resources. The RBRVS study developed methods and collected data to mimic the relative prices that would have emerged if we had a perfect competitive market for physician services. The desirable properties in the RBRVS are clearly stated by the Physician Payment Review Commission (PPRC): “A resource-cost basis would reflect estimates of what relative values would be under a hypothetical market that functions perfectly. Under such a market, competition derives relative prices to reflect the relative cost of efficient producers.”

Glaser does not seem to understand this conceptual and theoretical underpinning of the RBRVS. Consequently, he criticizes the study for not employing different assumptions and alternative methods of calculations. In other words, he misinterprets the RBRVS as a set of arbitrary calculations based on subjective assumptions. That, of course, is not correct.
The role of the RBRVS is not to substitute for political negotiation; it is, rather, to provide some useful information and a common starting point to assist interested parties in reaching agreement on a set of fair and equitable fees across all medical services. Specialty groups can always argue for relative prices different from those in the RBRVS for the services they perform. In addition, the RBRVS provides a standard by which we can assess current physician charges to see how much they deviate from the competitive price.

**National differences.** The political negotiation process used in European nations may not produce similar results in the United States. In the United States, political power is decentralized, shared between the executive, legislative, and judicial branches. Unlike the European parliamentary system with its strong party discipline, the US. Congress is quite independent of the president. Congress initiates its own policies and legislation. The power and influence of organized interest groups in European nations are dwarfed by those in the United States. Furthermore, the history, politics, and power of organized medicine in the United States are very different from those of European nations. While Glaser acknowledges these differences, he nevertheless makes a leap of faith by assuming that the results produced in European nations can be produced by the dissimilar power structure in the United States.

**Specific Factual Errors**

**Physician time.** Glaser states that our 1979 initial development of an RBRVS revolved around time. On the contrary, in that study, William Stason and I clearly explained that resource cost includes two important elements: time and complexity. We tried to develop a method to measure the complexity. Our exploratory study found that the complexity for different procedures could vary at least fourfold, while holding the time constant. Therefore, it is erroneous for Glaser to say that our 1979 relative value scale revolved around time.

**Unreliability of telephone survey.** Glaser also criticizes the Harvard team's use of a telephone interview survey to collect the basic data. His belief is that we cannot collect reliable, reproducible, and valid information from physicians through a telephone survey, yet this criticism is not based on scientific evidence. Whether one can collect reliable and valid data through a telephone survey depends on the design of the questionnaire, sampling method, and execution of the survey. The reliability and validity of the survey data can be tested by statistical methods; its scientific credibility should be based on statistical results, not on beliefs. We—along with nationally recognized experts engaged by the U.S.
government, PPRC, the American Medical Association (AMA), and medical specialty organizations nationwide—have thoroughly analyzed the data collected by the Harvard team from the telephone survey. Our findings have been published in the most respected journals.² Contrary to Glaser’s belief, statistical results show that the Harvard team obtained reliable, reproducible, and valid information from the telephone survey of a randomly selected sample of physicians.

Contribution Of The RBRVS Study

The Harvard RBRVS study has produced useful information for public policy; the empirical data and knowledge gained from the study have been used in the political process for all interested parties to reach an agreement on reforming physician payment. The RBRVS is not a substitute for political negotiation. Rather, it is a starting base for discussion, through which all parties can reach agreement. More important, through a systematic and rational process, the RBRVS study has produced a set of relative values. If these relative values were used in paying physicians, they could improve medical services for all Americans. In the long run, a fee schedule based on the RBRVS can moderate medical cost inflation and help to ameliorate the uneven distribution of physicians by specialties. Simply put, the RBRVS provides a reference guide for what a set of relative prices ought to be for physician services. In the current U.S. policy-making style, the political process then determines whether these relative prices (or modified versions) will be adopted into public policy.

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