The Relative Value Study and your Professional Future

National Association of Practising Psychiatrists
25 August 1998

Dear Colleague

Background

The Relative Value Study (RVS) like the Integrated Mental Health Services Project (IMHSP) requires your careful consideration as it may alter the very fabric of our profession and medicine as a whole.

The Federal Department of Health set up the Medicare Schedule Review Task Force in 1994 for the purpose of co-ordinating the RVS, in consultation with the AMA and craft groups. The RVS would replace the Medicare Benefit Schedule. Under Dr Michael Wooldridge this Task Force is now known as the Medicare Schedule Review Board and we should note that he is determined that it provide a "meaningful outcome" (what?).

Stage 1 of this process has already been determined, despite the view of some participants that they held "serious misgivings about the purpose of the RVS".

All future consultations will be classified on a scale of 1 to 8, determined by indicative time for consultations. The time classifications are 5, 10, 15, 20, 30, 45, 60 and 75 minutes. The consultation time allowed will depend on a predetermined set of clinical complexities as stipulated by the Medicare Schedule Review Board.

The Medicare Schedule Review Board is awaiting consultants' reports in the areas of Doctors Incomes VS Other Professionals, Background Practice Costs and Professional Relativities.

Our Concerns

NAPP believes that once implemented, the RVS will offer a convenient vehicle for Government managerialists to downsize mental health and general health expenditure by altering the proposed formula (see page 4). An unknowing public would be told it had happened "in consultation with the profession".

Our position is mindful of overseas concerns with similar systems. We are aware of growing dissent and of the view (in effect) that "by agreeing to administer health care cuts we abandon our duty to safeguard the health of the people" (Rosenthal S.; Trauma & Illness; Vol 3: 2; May 1998).

The US Experience

The US experience has been that this has led to marked increases in the burden of documentation (see proposed descriptors viz: every item depends on records). In turn this has led to fears of physicians being audited and prosecuted for breaches of coding

("upcoding") and some have resorted to "downcoding" to avoid litigation and accusations of fraud. (Psychiatrists here need only recall the discriminatory Item 319, with its threats of prosecution and monitoring written into the Medicare Benefits Review Schedule to understand the need for critical examination of the RVS.)

Once the RVS is introduced, it paves the way for cheaper alternatives (a view recently put by Whiteford H; Australasian Psychiatry; vol 6:3: June 1998: p 116) thus undermining and de-skilling the profession. The seriousness of this should not be underestimated as it involves a fundamental shift away from skill to time management only.

Psychiatrists should take careful note that psychiatrists will be particularly vulnerable as the differential between new and existing patients will mean the end of effective integrated psychiatric treatment; group/family psychiatric treatment is not included in descriptors to date and practice costs in the formula may well become an issue of contention.

The Threat

a. The RVS will attack the specifically integrative work psychiatrists do by defining what is consultative and what is procedural, and separating new from existing patients.

b. The existence of descriptors in psychiatry makes it easy in the future to legislate to cut them out (NB: "..the legal expression of those principles may result in the use of different and more precise language" I McNeil, Chairman, Medicare Schedule Review Board, 1996) - Budget 1996 was such a case and should be resisted in its new guise.

c. The burden of documentation will rise dramatically, affecting all medical Practitioners but especially affecting psychiatrists. Confidentiality will suffer and the intrusion of auditing will undermine therapeutic relationships.

d. Legal problems will abound with auditing, if for any reason, justified or unjustified, records can be shown not to match the codes billed. Compliance costs will be considerable.

e. The formula attacks the notion of funding based on skilled quality medicine (social benefits and cost-effectiveness are intentionally excluded from the calculations).

f. More than the above, there is a far more sinister consequence of the RVS which I would suggest has already manifested itself in the group processes of RVS meetings viz: the effect of the idea of "limited resources" perpetuated in the RVS is to stimulate craft groups to compete and vie with each other over who has the most costly practice, the greatest expertise, or the most "sweat factor" (see formula) - all with an eye on the formula, to get more resources and maintain funding at the expense of our fellow practitioners! Once divided, we'll be easily taken over - and it seems to me this is the agenda.

We need to decide as a profession whether we want to continue to be committed to such a process. We should encourage debate now, before implementation. Silence can only become a collusion with the "divide and rule" agenda of the managerialists.

What to do

1. Encourage non members to join NAPP. An application form is attached. Only a united voice can oppose the Government's negative agenda. NAPP will help you see the differing perspectives and focus on the issues.

2. Write, demand answers and express your concerns to those organisations who you pay to protect your professional interests and who are currently negotiating this on your behalf.

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Yours Faithfully

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25 August 1998

This formula and more information on the Relative Value Study can be found at the Medicare Schedule Review Task Force Website: http://www.msrtf.gov.au (link now expired Aug 2001)

GENERAL FORMULA FOR COSTING MEDICAL FEES

Fee	**= [Professional Component] + [Practice Cost Component]**
F	= [RVUs/s x Ep] + [DCs + ORp/s + PIp/s + WCp]

RVUs/s	= Relative Value Units assigned to each item of service. RVUs are a function of total professional time (T1/s and T2/s) and relative service intensity or effort (Is). Intensity of a service (Is) is a function of relative complexity (Cs) and risk or "sweat" (Ss).
T1/s	= Average efficient direct (face to face) service time by doctor.
T2/s	= Average efficient indirect (non face to face) service time by doctor.
Cs	=Relative complexity factor for that service.
Ss	=Relative risk or "sweat" factor for that service.
Ep	=Standard or base earning rate per RVU for that specialty or class of practitioner taking into account the human capital investment, including training, duration of professional working life etc. that is relevant to that specialty or class.
DCs	=Direct costs such as direct staff (technicians etc.), consumables, dedicated facilities etc. attributable to that service and based on reasonably efficient practice.
ORp/s	=General overhead recovery attributable to that specialty/service/episode or mixture-based on the financial modelling of reasonably efficient practice.
PIp/s	=Professional indemnity recovery attributable to that specialty/ service or activity.
WCp	=Allowance for working capital based on representative cost/ billing/ payment cycle and levels of debtors and creditors.

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