BY LAIN CHROUST EHMANN

THE UPS AND DOWNS OF

Physician Compensation

Specialists net the biggest gains in salary surveys, while geography and payer mix also play a role. Think classic supply and demand with interference.

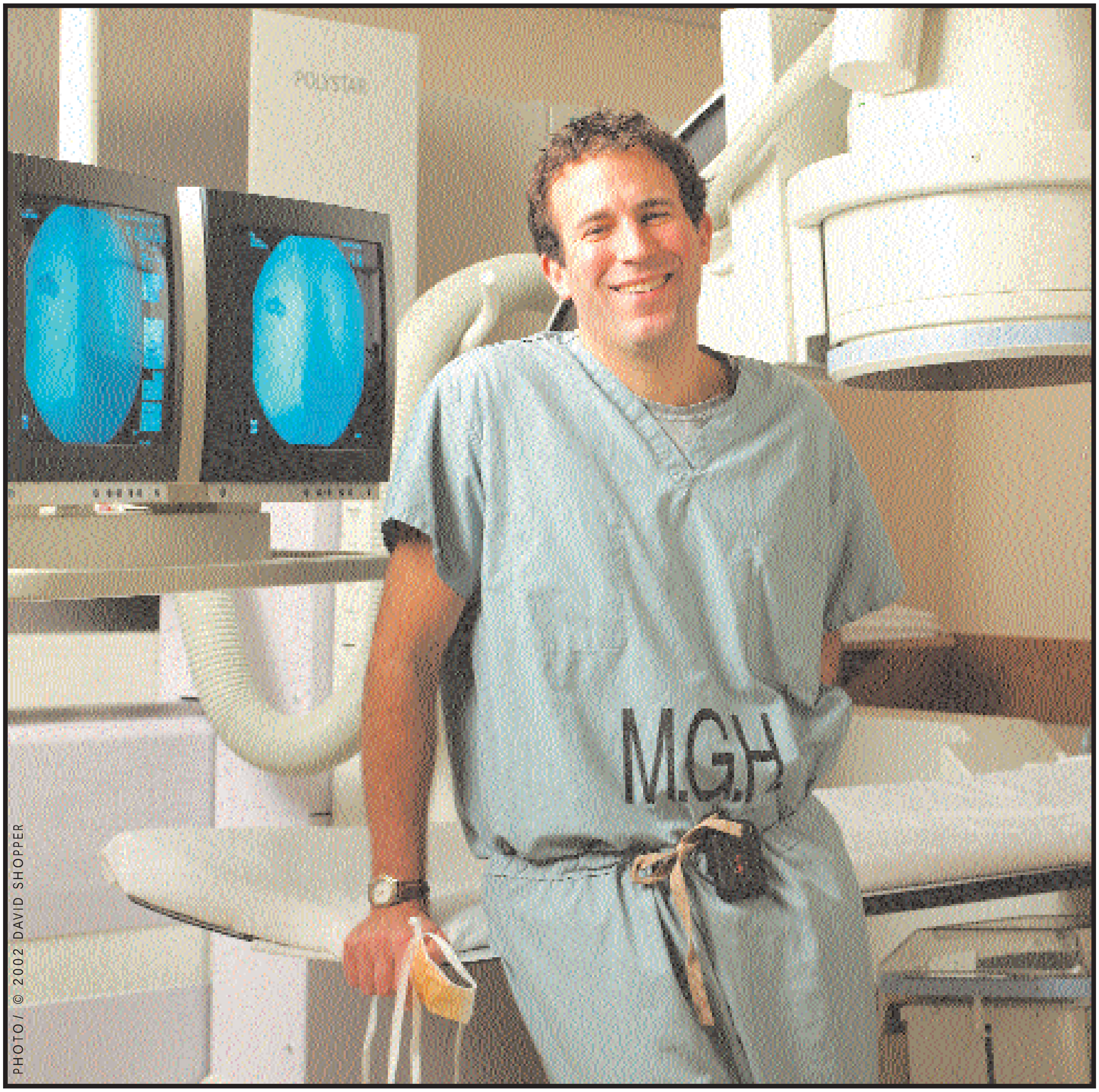
When Matt Benjamin was in medical school at Boston University in the mid-'90s, it was his interest in physics and computers, and the radiology department's involvement in the most interesting cases, that drew him to the field—not future earning potential. ◆ While his decision to "follow his bliss" seems perfectly logical, he was a rarity. Partly in response to pressure from instructors, most of the other members of BU's class of 1996 opted for primary care, recalls Benjamin, now a fellow in interventional radiology at Massachusetts General Hospital in Boston. "They were pushing everyone into primary care. They told us that primary care was where the jobs would be," he says. ◆ Though he may have originally selected radiology purely because of interest, Benjamin is now in the fortunate position of seeking a staff position in one of the most highly demanded—and lucrative—fields of medicine. "It's actually sort of ironic," he says.

2001 Review of Physician Recruitment Incentives

Income Offered to Top Ten Recruited Specialties

SPECIALTY	NO. OF SEARCHES IN 2001	2001 MEAN INCOME OFFERED	2000 MEAN INCOME OFFERED	PERCENT CHANGE
Family Practice	112	$136,000	$135,000	0.74
Ob/Gyn	87	$227,000	$225,000	0.89
Internal Medicine	136	$145,000	$139,000	4.32
Gastroenterology	84	$219,000	$204,000	7.35
Anesthesiology	127	$240,000	$222,000	8.11
Urology	52	$237,000	$215,000	10.23
Orthopedic Surgery	140	$287,000	$257,000	11.67
Cardiology	228	$267,000	$238,000	12.18
General Surgery	66	$216,000	$189,000	14.29
Radiology	233	$271,000	$225,000	20.44

Source: Merritt, Hawkins and Associates



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Ironic, indeed. Despite the best prognostications of experts in the health-care field, the future of the medical market in the United States has been difficult to predict with any real accuracy, and this difficulty is reflected in the most recent physician compensation surveys (see 2001 Review of Physician Recruitment Incentives, opposite, and Median Physician Compensation and Cash Compensation Comparisons, page 4). According to these surveys, while physicians' salaries on the national average have risen modestly, certain specialties—such as radiology—have experienced more significant increases. Likewise, some geographic regions—namely, the South—offer higher compensation to doctors than do other areas.

Explaining and predicting doctors' wages can seem as complex as a Medicare reimbursement formula, but one thing is clear: Compensation is driven by a number of factors, not the least of which is the classic concept of supply and demand.

Matt Benjamin chose to "follow his bliss" and entered a radiology residency in 1996 despite being told that primary care physicians would be more needed. Now a fellow in interventional radiology at Massachusetts General Hospital, he finds his specialty in great demand.

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When it comes to supply, specialties that have boomed in recent years—such as family practice and internal medicine—have experienced both lower increases in compensation, and lower overall compensation levels. According to Merritt, Hawkins and Associates' 2001 Review of Physician Recruitment Incentives (see 2001 Review of Physician Recruitment Incentives, page 1), the average wage offered a family practitioner in 2001, for example, was $136,000, only $1,000 more than the previous year. Likewise, the average wage offered to internists in 2001 increased less than five percent to $145,000, from $139,000 in 2000.

Meanwhile, specialties with a low supply of physicians and/or a high demand for services, have seen a dramatic increase in compensation. The Merritt, Hawkins survey shows these areas include radiology, cardiology, and orthopaedic and general surgery; the offered salaries for each increased more than 10 percent between 2000 and 2001. "There was a big void in the number of practitioners available to fill these needs," says Dustin Koger, the vice president of operations for Staff Care for Merritt, Hawkins. "The market responded."

What's hot, what's not

Medical specialties come in and out of vogue, much like everything else in our culture. "In general, we see those things cycling up and down," says American Medical Association president-elect, Yank Coble, MD. These "hot" specialties can result from a variety of sources, including emerging technologies, societal concerns, changes in managed care, and even the media.

In the early- to mid-90s, there was a strong effort to turn out more primary care physicians from medical schools. "If you were a doctor in medical school, everything you were reading was, 'be-

Continued

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WHERE HAVE ALL THE DOCTORS GONE?

Skyrocketing professional liability insurance costs. Higher costs of living. Lower reimbursement rates. Larger administrative burdens. Less time treating patients and more time pushing papers. With these kinds of burdens, is it any wonder that communities are concerned about their ability to recruit and retain physicians? "These converging factors can make it untenable for [some physicians] to continue," says American Medical Association president-elect, Yank Coble, MD.

Though statistically the number of physicians the AMA counts as "inactive" has remained fairly constant in the last 10 years (see Number of Physicians in the U.S., opposite), many states are sensing a growing tide of physician unease and dissatisfaction. "We think there's a fair level of physician attrition building, but we can't prove it," says the Pennsylvania Medical Society's Steve Foreman.

Further statistical data to support the claim that the nation may be looking at a physician shortage is available from the Massachusetts Medical Society (MMS). Though the Physician Practice Environment Index was developed in the early '90s in order to compare Massachusetts with the rest of the country, the index now provides a useful snapshot of factors such as the age of physicians, relative income, and the cost of doing business in the nation as a whole. According to the index, the number of U.S. medical school applicants is dropping, while the number of U.S. physicians older than 55 is increasing (see Physician Practice Environment, opposite).

These factors can in turn affect the public's ability to access quality health care, something that Massachusetts is well aware of, given the state's below-average compensation and above-average cost of living. "If it weren't for the fact that taking care of patients meant so much to those of us who went into medicine, I think we'd have a terrible problem with access here in Massachusetts," says MMS president Francis Rockett, MD.

The ability to get "that certain something you can't get from a paycheck," as Rockett describes it, may only go so far. If some of the other cost, reimbursement, and pay factors aren't addressed soon, the attrition problem may become more than just a gut feeling. ■

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Median Physician Compensation for 1999 and 2000, and by Geographical Region

SPECIALTY	2000	1999	CHANGE	2000 EAST	2000 NORTH	2000 SOUTH	2000 WEST
Cardiology - General	$271,001	$262,954	3.06%	$213,095	$271,001	$308,885	$283,033
Family Medicine	$144,290	$141,560	1.93%	$136,622	$141,037	$152,563	$146,367
Internal Medicine	$144,264	$142,881	0.97%	$141,200	$144,000	$153,600	$140,831
Pediatrics	$143,468	$139,307	2.99%	$139,047	$144,304	$143,651	$148,410
Psychiatry	$149,581	$144,294	3.66%	$144,606	$151,855	$155,840	$145,741
General Surgery	$244,794	$243,362	0.59%	$210,932	$261,366	$247,242	$232,112
Ob/Gyn	$228,665	$223,584	2.27%	$206,667	$235,797	$248,402	$210,634
Anesthesiology	$255,651	$238,000	7.42%	$216,270	$270,000	$257,200	$254,505
Diagnostic Radiology Interv'l	$306,000	$300,000	2.00%	$224,063	$306,000	$318,226	$311,218
Diagnostic Radiology	$262,579	$256,527	2.36%	$236,095	$268,417	$274,000	$259,493
Pathology	$211,000	$200,968	4.99%	$192,477	$228,462	$224,620	$223,700

Source: American Medical Group Association Compensation and Productivity Survey, 2001 Report Based on 2000 Data

Number of Physicians in the U.S. *Physicians Per Capita and Inactive Physicians*

YEAR	PHYSICIAN POPULATION	TOTAL POPULATION	MD/DO PER CAPITA	INACTIVE PHYSICIANS	PERCENT INACTIVE
2000	813,770	281,421,906	0.002891637	75,168	9.24
1995	720,325	270,248,003	0.002665422	72,326	10.04
1990	615,421	249,464,396	0.002466969	52,653	8.56
1985	552,716	237,923,795	0.00232308	38,646	6.99
1980	467,679	227,224,681	0.002058223	25,744	5.50

Source: American Medical Association

Cash Compensation Comparisons for 2001

Ratio to Overall Average Total Cash Compensation

SPECIALTY	RATIO	MEAN TOTAL CASH COMPENSATION FOR STAFF PHYSICIAN
Psychiatry	0.74	$141,446
Family Practice	0.77	$147,129
Pediatrics	0.78	$149,156
Internal Medicine	0.84	$161,316
Pathology	0.89	$170,566 *
Emergency Medicine	1.10	$210,995
Radiology	1.12	$229,788 **
Ob/Gyn	1.22	$233,469
Surgery	1.23	$235,213 ***
Anesthesiology	1.23	$236,075

Source: Sullivan, Cotter and Associates
**clinical pathology only **diagnostic radiology only ***general surgery only*

Physician Practice Environment

A Ten-Year Comparison

YEAR	US MED SCHOOL APPLICATIONS	PERCENT OF US PHYSICIANS OVER 55
2001	34,859	37.2
2000	37,092	36.9
1999	38,449	36.7
1998	40,998	36.1
1997	43,018	36.0
1996	46,967	35.8
1995	46,591	35.1
1994	45,364	34.5
1993	42,808	34.5
1992	37,408	34.7

Source: Massachusetts Medical Society
*estimated

come a primary care physician.' That's where the push was," says Koger. This push was intended to meet a projected huge demand for primary care practitioners supposedly arising from the "gatekeeper" model of health care—which unfortunately never materialized. By the time it was clear this model wouldn't pan out, thousands of internists and family practitioners had already entered the market.

In contrast, the relative number of specialists decreased during the same period, as Benjamin noted first-hand. Only five others from his graduating class of 200 chose radiology, for example, compared to about 25 radiologists from the previous class, Benjamin recalls, and other specialty fields experienced similar declines.

But the need for these specialties didn't drop just because the supply did. In fact, the reverse happened. As baby boomers age, they're requiring an ever-growing number of services and procedures in areas such as cardiology, radiology, anesthesiology, and orthopaedic surgery, thereby increasing both the demand for these specialists' services, and their compensation as well.

"You have a shortage of a lot of specialties," says Shawn Schwartz, the manager of the National Healthcare Consulting Practice with Minneapolis' R.S.M. McGladrey, the organization that performs the American Medical Group Association's annual compensation and productivity survey. "The demand model states that their compensation should go up, and it has." For instance, the Merritt, Hawkins survey indicates an increase of more than 20 percent in the average offered income for radiologists, from $225,000 in 2000 to $271,000 in 2001. (See 2001 Review of Physician Recruitment Incentives, page 1.)

There are other explanations for the higher wages, too. For instance, procedure-based fields such as surgery, anesthesiology, and radiology historically have been more highly compensated, says Sullivan, Cotter and Associates principal Kimberly Mobley. Coble of the AMA agrees. "There has been a long-standing trend of primary care not having quite the same compensation as procedural," he says, which may be partly because of the additional years of training needed for some specialty fields of medicine.

Trends in popular specialties and an overabundance of primary care physicians explain some of the disparity between the highs and the lows on the compensation scale. For example, ever-popular pediatrics is near the bottom of the AMGA's compensation list, with an average salary in 2000 of $143,468. (See Median Physician Compensation, page 4.) "The supply of pediatricians is good. I think pediatrics is a popular specialty to be in," explains Koger.

Psychiatry has also traditionally ranked low in compensation, says Mobley. In 2001, psychiatrists were at the bottom of Sullivan, Cotter's "Ratio of Average Total Cash Compensation" (See Cash Compensation Comparisons for 2001, page 4), with an average total cash compensation of only $141,446 for staff physicians in the field. The AMGA shows a slightly higher average salary: $149,581 in 2000, an increase of just under four percent from 1999.

Psychiatry's low pay can be explained largely by the organizations in which psychiatrists work—that is, mental health centers. Because many such centers are not-for-profits and funded totally or in part by the state and/or federal government, operating funds are tight, and center administrators are unable to pay wages on par with those for other specialties, says Merritt, Hawkins' Koger. "These aren't private sector arrangements. They have an immediate disadvantage as to what they can pay," he explains.

For the most part, these trends in relative compensation between specialties hold true across the country, according to the AMGA survey. However, there are significant regional differences when overall salary levels are compared between regions.

Biting the invisible hand

One of the founders of our free-market system, Adam Smith, coined the term, "the invisible hand." His premise is that a market left to its own devices without interference from outside forces will reach equilibrium between supply and demand independently, and will operate efficiently. However, if external influences intrude, the balance will be upset and inefficiencies would result in the form of surpluses or shortages. When it comes to the supply and demand for physicians, a major external influence is the domination of health maintenance organizations and other insurance companies.

In geographic regions where managed-care companies are strong, such as the East/Northeast and West, physicians' salaries are significantly lower in absolute terms when compared to other areas of the country. For instance, the East ranks below average in compensation for all 11 popular specialties, while the West ranks below average in 6 of the 11. (See Median Physician Compensation, page 4.)

Experts hypothesize that the strength of health insurance companies allows them to set artificially low wages via reimbursement rates. "I think a fair amount of what you're talking about here is a market story," says Steve Foreman, PhD, JD, MPA, the director of the Pennsylvania Medical Society's Health Services Research Institute. In other words, the comparative power of hospitals, physi-

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cians, and insurers in a market plays out to determine how much physicians will be reimbursed for their services, and ultimately, how much physicians will earn. "The reimbursement issue is what I see driving a lot of physician compensation today," agrees Sullivan, Cotter's Mobley.

In the Northeast, "you have insurance companies and hospitals making all the rules," explains Foreman. Foreman sees a similar situation in other areas of the Northeast, including New York, Washington, DC, and Boston. "The payers are just rugged," he says. "I think the Northeast is a tough place to practice these days."

Francis Rockett, MD, the president of the Massachusetts Medical Society, also believes the "high penetration of HMOs here in Massachusetts" is at least partly responsible for the slower increases in physicians' wages. "I'm surprised it's increasing at all," he says.

Recently one of the state's largest HMOs, Blue Cross/Blue Shield, announced it would reimburse physicians at 15 percent more than the Medicare reimbursement rate, which was just reduced 5.4 percent across the board. "It's that sort of a huge hit that the physicians have taken, and to which they have to adapt," says Rockett. Coble agrees. "Reimbursement, particularly for primary care, seems to be a problem," he says.

There are other possible contributing factors to a region's lower rate of compensation increases, including an older population of physicians who may have topped out their income and can't get much higher, as well as an economic slump, which has heavily impacted the economy in California and the rest of the West. Such downtimes also tend to hit the Northeast harder and longer than the rest of the country. "The North and South seem to be more resilient to poor economic conditions," says Schwartz.

Southern comfort

While the Northeast and West are fighting the insurance company and recessionary tides, physicians in the southern portion of the United States are experiencing relatively high wages. "One of the things that I've noticed is that in the southern region we tend to see a higher compensation in most states, at least for staff physicians, than we see in other states," says Schwartz. For instance, wages in the South outranked all other areas of the country in seven of 11 popular specialties.

Schwartz explains this difference in part by the lack of strong managed care organizations, and in part due to the fact that physicians in the South tend to be in smaller practices and in single-specialty groups.

Physicians in smaller groups may fare better economically, as many larger group practices have had financial troubles in recent years. And multi-specialty practices may see a lower average compensation, says Schwartz, because all the physicians in the group "are sharing in the compensation pie, but not necessarily contributing to it equally." In other words, the more lucrative specialists may be "contributing to the group for the benefit of primary care," he says.

What's in store?

Because of the strong factors influencing current market conditions, the following trends are likely to emerge or continue in the near future:

- **Trend towards sub-specialization.** Physicians may turn to sub-specialization in fields such as urogynecology as a way to combat slowing wage increases. "Your potential for income goes up—maybe not significantly—but it does go up," says Schwartz. He adds that increased specialization and differentiation will be an important marketing technique for doctors in an era shifting toward patient-driven physician selection.
- **Growing number of single-specialty groups and solo practitioners.** Physicians may be enticed to strike out on their own, or join single-specialty rather than multi-specialty medical groups, a trend Schwartz is seeing emerge in the North. The AMA's Coble agrees. "The trend for some time has been to consolidate into large group practices," he says. The move towards smaller practices could be due in part to the significant number of large group practices that have gone bankrupt in recent years, Coble says. However, "it's pretty early in the trend to know how significant it is."
- **Emergence of more specialists.** As medical schools urge more doctors into fields to meet current and future demand, we'll likely see a growing number of specialists, particularly in the more highly compensated fields of radiology, anesthesiology, and orthopaedics. If supply meets or exceeds demand in these fields, we could see a comparative slowing of wage increases for specialists, coupled with an increase in the wages for primary care physicians, were the market to overcorrect.
- **Increased overall demand for physicians.** As the population continues to age there will continue to be a growing demand for physicians, especially in fields related to an aging population as noted above. There could also be an overall increase in demand for medical care as the physician labor pool gets older, and more doctors reach retirement age. "You have an aging population that is getting older not only in the patients, but in the professionals providing medical care," says Merritt, Hawkins' Koger.
- **Growing attrition rates.** Because of factors like unrealistic reimbursement rates, increased professional liability costs, slowing wage growth, and administrative burdens, we may also see an increase in

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attrition rates for physicians. (See "Where Have All the Doctors Gone?" page 3.) This may result in problems with access to medical care.

While the future compensation of physicians should be quite bright due to increased demand, other factors may end up depressing wages significantly. How it all will play out is anyone's best guess. "Two opposing forces, and I wish I knew which way it was going to go," Schwartz says. However, one thing is clear, he adds; "Something's got to give." ■

California-based Lain Ehmann *covers health issues for a variety of publications.*

ABOUT THE SURVEYS

Merritt, Hawkins and Associates

2001 Review of Physician Recruitment Incentives

EIGHTH ANNUAL

Number of physician search assignments: 2,043

COMMENTS Surveys based on recruitment searches, not actual salaries paid. Based on searches in 47 states. Year-to-year data tracked although survey base fluctuates annually. MDs and DOs.

Sullivan, Cotter and Associates

2001 Physician Compensation and Productivity Survey

NINTH ANNUAL

No. of organizations surveyed: 218

Number of individuals covered: 18,300 (includes residents, physician assistants, executives, as well as physicians)

COMMENTS Surveys physician employers only. Heavily weighted toward Northeast and Midwest. Does not offer year-to-year data because base surveyed is not constant. MDs and DOs.

R.S.M. McGladrey

American Medical Group Association Compensation and Productivity Study

2001 REPORT BASED ON 2000 DATA

Number of physicians included in database: 26,981

Number of groups: 220

COMMENTS MDs and DOs.
Based on actual compensation.