Physician Compensation in 1998: Both Specialists and Primary Care Physicians Emerge as Winners

Sue Cejka

Physicians are working harder and longer to maintain and increase their compensation. In response to 2 straight years of flat or decreased incomes caused by various market factors (eg, managed care, reimbursement rates, market competition), many physicians have learned how to maximize their incomes in highly competitive markets and managed care environments.

For the first time since 1996, both primary care physicians and specialists enjoyed an increase in compensation. Primary care physicians (family practitioners, internists, and pediatricians) whose incomes increased less than 0.5% in 1997 earned an average increase of 2.5% in 1998. Similarly, specialists who experienced income declines between 2% and 8% in 1997 experienced increases of 2% to 9% in 1998. As a whole, specialists' incomes increased 5.22% in 1998, up from 1997's decrease of 0.5%.

These observations about physician compensation are based on the annual survey, *Physician Compensation and Production Survey: 1999 Report Based on 1998 Data,*[1] conducted by Medical Group Management Association (MGMA). The survey includes compensation and production information from more than 1500 group practices and 30,000 physicians and mid-level practitioners. Compensation factors examined in this survey include compensation according to 5-year trends in charges for primary care physicians (**Figure 1**) and specialists (**Figure 2**), specialty (**Table 1**), single specialty versus multispecialty groups (**Figure 3**), specialty practice versus primary care in single and multispecialty groups (**Figures 4** and **5**), geographic region (**Table 2** and **Figure 6**), years in practice (**Figures 7** and **8**), and gender (**Table 3**).

FIVE-YEAR MARKET TRENDS

During the past 5-year period, compensation has risen more than 9% for both primary care and specialty physicians; however, gross charges for primary care and specialty physicians have vaulted 11.6% and 29.3%, respectively (Figures 1 and 2). Between 1992 and 1995, physician compensation increased at a faster rate than physician productivity. However, compensation can only increase at a faster rate than productivity for a finite period of time. The 1998 data indicate that productivity increases have caught up with and surpassed compensation increases.

Essentially, the health care marketplace is experiencing a "rightsizing" of physician compensation in that productivity continues to rise more quickly than compensation. Because today's health care environment is more complex and practices are more expensive to administer, overhead has begun to consume a greater share of the practice income. Despite contrary trends in the past, this correction should be expected, given the current influences on the health care marketplace. As this trend continues, physicians should be prepared for productivity to continue to rise at a rate faster than compensation.

Declining revenue per patient interaction (eg, office visit, procedure, follow-up)—driven not only by managed care but also by market trends, is the principle factor that affects physician compensation. Many markets are beginning to revert back to fee-for-service care. Likewise, factors that affect the physician's expense of running a practice (eg, compliance issues, Stark legislation, complex coding issues) also increase the costs of health care. As a result, physician compensation decreases, or is rightsized, because the health plans have not yet instituted concomitant premium increases. Therefore, consumers pay the same for care that costs the physician more to deliver. As costs continue to rise and compensation continues to fall, the physician is caught in the middle.

Ms. Cejka is Founder and President, Cejka & Company, St. Louis, MO.

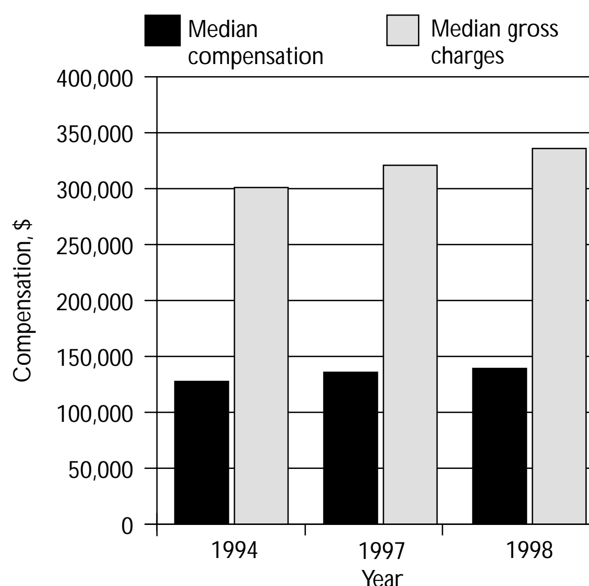

Figure 1. Median physician compensation and gross charges for primary care physicians in 1994, 1997, and 1998. Data from *MGMA 1999 Physician Compensation and Production Survey: 1999 Report Based on 1998 Data.* Sponsored by Cejka & Company, St. Louis, MO, 1999.

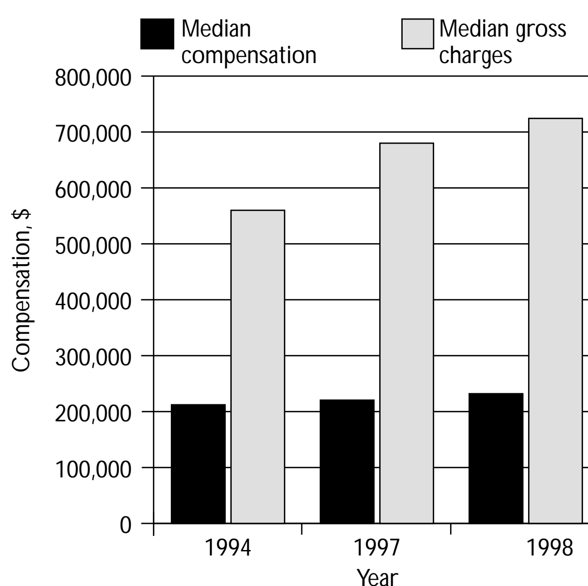

Figure 2. Median physician compensation and gross charges for specialists in 1994, 1997, and 1998. Data from *MGMA 1999 Physician Compensation and Production Survey: 1999 Report Based on 1998 Data.* Sponsored by Cejka & Company, St. Louis, MO, 1999.

In 1998, the overall increase (5.2%) of specialist compensation represents a reemergence of the specialist physician. Over the last 5 years, hospitals aggressively acquired primary care groups. In turn, primary care compensation as well as the perceived demand for primary care services became inflated. As a result, the demand for specialists decreased.

Hospitals that acquired primary care groups typically issued an annual income guarantee to group physicians regardless of the physicians' productivity level (ie, the physicians' annual compensation was independent of the number of patients the physicians saw). Therefore, physician productivity declined. Now that this strategy has been judged a failure, many single specialty groups have reemerged as leaders in the market through building strong patient bases and thus becoming extremely attractive to insurers. This development is very positive for specialists, who as a group had been unsure of their future, which now looks bright. Consequently, primary care physicians need not panic—they are still in great demand, however, the need is not as acute as it was several years ago. The demand for primary care physicians has peaked and the profession is experiencing a decrease, or rightsizing, of its compensation as well as its role in health care delivery.

PRIMARY CARE PHYSICIANS

Primary care salaries, which had been driven up between 1991 and 1995 by the hospitals' competitive bidding for primary care physicians, are now experiencing a leveling off. The 5% to 10% increases in annual compensation are a thing of the past for primary care physicians. In the future, primary care physicians can expect their compensation to increase at a rate relative to their productivity.

Compensation Winners

Top-earning primary care physicians in 1998 include the following:

- Pediatricians—rebounding from a 0.2% decrease in 1997, compensation is up 2.4% from $131,803 to $135,000
- Family practitioners—following an increase of almost 3% in 1997, compensation increased 1.7% from $136, 002 to $138,277
- Internists—after a 0.1% decrease in 1997, compensation rebounded 0.9% from $139,879 to $141,147

SPECIALISTS

The general decrease in specialist compensation in

Table 1. Median Physician Compensation According to Specialty

Specialty	1998 Median Compen-sation, $	1994 to 1998 Change in Compen-sation, %	1997 to 1998 Change in Compen-sation, %
Primary care			
Family practice	138,277	13.34	1.67
Hospitalist	159,056	*	14.43
Internal medicine	141,147	5.66	0.91
Pediatrics	135,000	6.8	2.43
Medical specialties			
Cardiology (invasive)	350,000	11.75	7.19
Cardiology (noninvasive)	278,900	22.77	7.29
Gastroenterology	240,278	19.55	5.33
Hematology/ oncology	212,516	14.57	8.95
Obstetrics/ gynecology	216,307	2.66	3
Special services			
Anesthesiology	250,200	2.29	2.57
Dermatology	193,215	17.09	9.23
Emergency medicine	176,217	−0.63	−0.64
Neurology	160,601	3.33	0.38
Psychiatry	142,736	7.38	2.69
Radiology (diagnostic)	271,828	2.79	0.38
Surgical specialties			
General surgery	225,653	12.71	0.21
Orthopedic surgery	312,356	6.97	2.41

*No data available.

Data from *MGMA 1999 Physician Compensation and Production Survey: 1999 Report Based on 1998 Data.* Sponsored by Cejka & Company, St. Louis, MO, 1999.

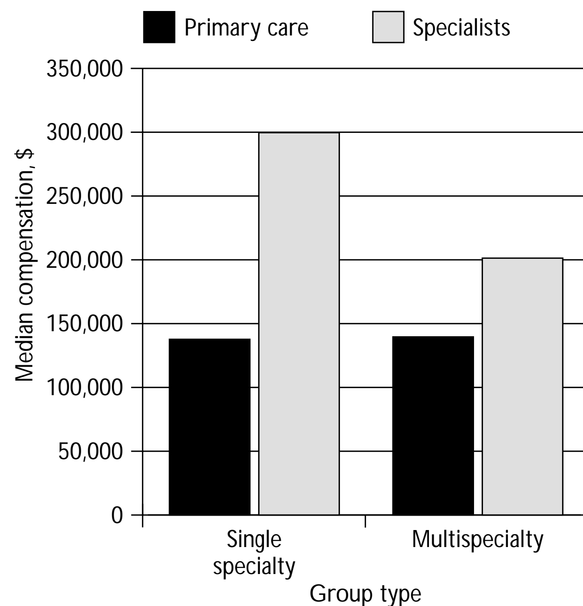

Figure 3. Median physician compensation for primary care physicians and specialists according to group type. Data from *MGMA 1999 Physician Compensation and Production Survey: 1999 Report Based on 1998 Data.* Sponsored by Cejka & Company, St. Louis, MO, 1999.

1997 and the subsequent increase in 1998 are part of a long trend (Table 1). Over the past 5 years, charges have risen 29.3%, while compensation has only risen 9.3% (Figure 2). In addition, specialists' productivity has been rising at a much greater rate than their compensation. In part, this disparity can be explained by the transfer of compensation from specialists to primary care physicians. Indeed, this transfer is evident in the relative value units schedule that has been favoring higher yearly reimbursements for primary care physicians and lower yearly reimbursements for specialists. As is true for primary care, this change can be attributed to the trend towards declining revenue per patient interaction and increasing costs associated with operating a medical practice.

In general, specialists continue to win the compensation game. Although the increase in median compensation for primary care physicians between 1994 and 1998 was slightly less than the combined increase for all specialists, in 1998 the median compensation for specialists was $231,993, whereas the median compensation for primary care physicians was significantly lower at $139,244.

Compensation Winners

Because managed care has yet to significantly affect many markets in the United States, the majority of specialty physicians are still compensated under the traditional fee-for-service plan, which results in their significantly higher incomes. Top-earning specialists in 1998 include the following:

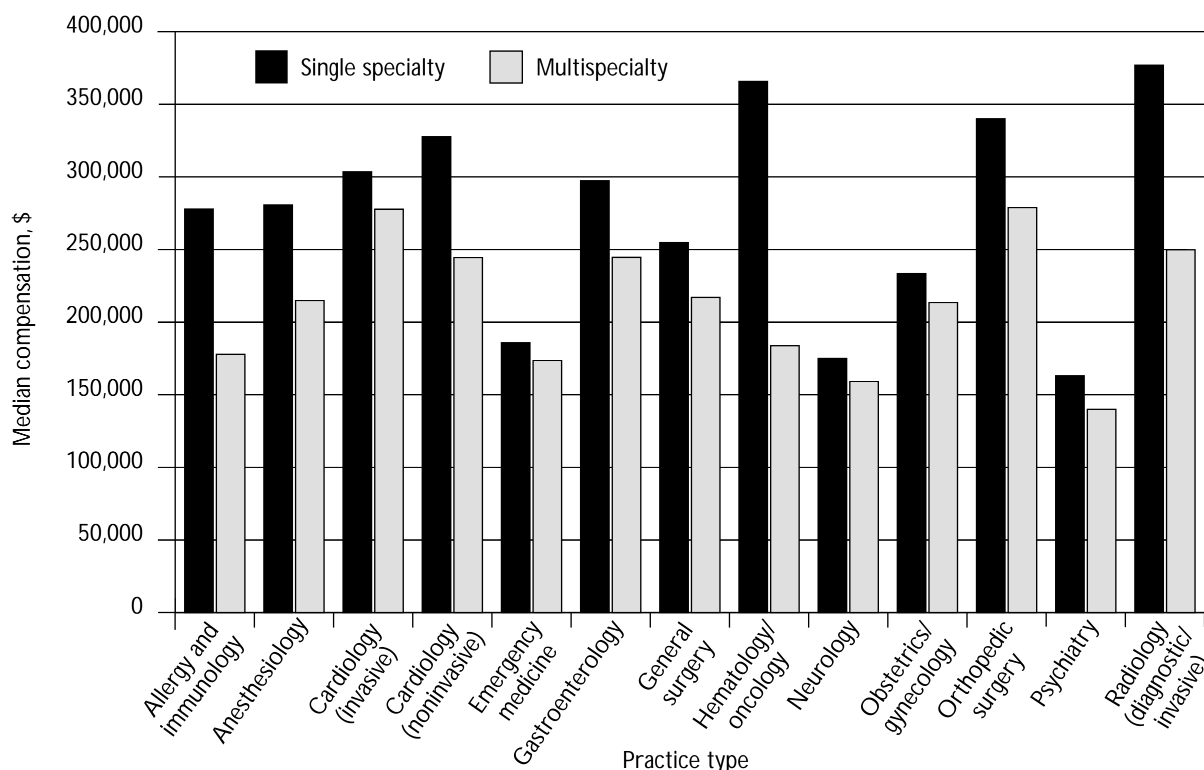

Figure 4. Median physician compensation according to practice type and group type: medical and surgical specialties. Data from *MGMA 1999 Physician Compensation and Production Survey: 1999 Report Based on 1998 Data.* Sponsored by Cejka & Company, St. Louis, MO, 1999.

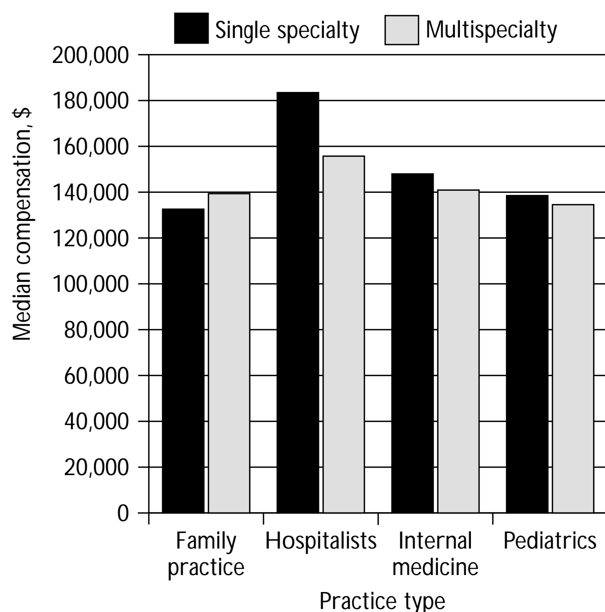

Figure 5. Median physician compensation according to practice type and group type: primary care. Data from *MGMA 1999 Physician Compensation and Production Survey: 1999 Report Based on 1998 Data.* Sponsored by Cejka & Company, St. Louis, MO, 1999.

- Anesthesiologists—following declines in both 1995 and 1996, compensation climbed 2.6% in 1997 and another 2.6% in 1998 from $243,937 to $250,200
- Invasive cardiologists—on the heels of a 7.7% decrease in 1997, compensation is up 7.19% from $326,537 to $350,000
- Noninvasive cardiologists—keeping pace with 1997's 5.19% increase, compensation rose 7.3% from $259,961 to $278,900
- Dermatologists—in the wake of a 2.68% decline in 1997, compensation is up 9.23% from $176,896 to $193,215

HOSPITALIST COMPENSATION

A new breed of specialist—the hospitalist—is gaining ground. As primary care physicians who manage inpatient care for hospitals and groups, these physicians coordinate diagnosis and treatment, ensure that patients receive optimal and cost-conscious care, and strive to discharge patients from the hospital as quickly as possible. Hospitalist compensation was surveyed for the first time in 1997 and found to be $139,000, only slightly less than the compensation of internists.

Table 2. Median Physician Compensation According to Geographic Region in the United States

Specialty	Median Compensation, $			
	East	Midwest	South	West
Allergy and immunology	205,494	200,153	303,534	167,527
Anesthesiology	236,000	311,165	305,800	229,524
Cardiology (invasive)	297,202	311,873	312,428	231,212
Cardiology (noninvasive)	262,180	289,631	340,490	206,431
Cardiovascular surgery	446,396	511,326	545,940	420,000
Emergency medicine	162,000	184,433	194,400	173,862
Family practice	130,380	135,210	155,243	133,912
General surgery	224,608	225,195	252,316	212,059
Hematology/ oncology	201,348	210,395	266,268	176,614
Hospitalist	168,525	150,000	167,295	155,720
Internal medicine	139,072	139,757	153,670	139,463
Neurology	154,978	167,966	171,000	156,159
Obstetrics/ gynecology	206,369	228,900	240,000	199,072
Orthopedic surgery	280,168	344,050	368,945	270,399
Pediatrics	129,979	136,008	137,771	134,595
Psychiatry	138,000	144,235	152,891	138,504
Radiology	220,529	323,500	298,276	234,177

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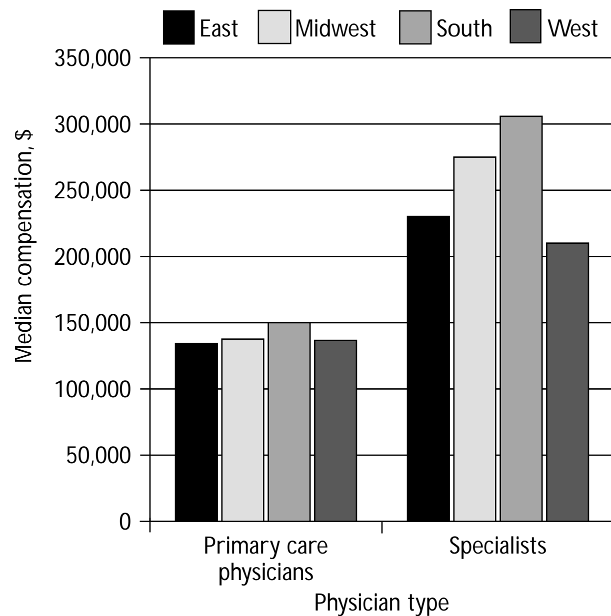

Figure 6. Median physician compensation for primary care physicians and specialists according to geographic region in the United States. Data from *MGMA 1999 Physician Compensation and Production Survey: 1999 Report Based on 1998 Data.* Sponsored by Cejka & Company, St. Louis, MO, 1999.

However, in 1998 hospitalist compensation increased 14.43% to $159,056 reflecting the specialist's pivotal role in today's delivery of in-patient care (Table 1).

Although good incentive plans for hospitalists are rare, the greatest attractions of a hospitalist career are its predictable hours and interesting work. Hospitalists who are willing to work extra hours can potentially earn up to $180,000 per year, an income they could also earn in many primary care positions.

OTHER COMPENSATION FACTORS

Single Specialty Versus Multispecialty Groups

Most physicians in the United States work in a group practice. The ease of in-house referrals, availability of new technology, "team player" atmosphere, shared call schedules, and partnership agreements are some of the advantages enjoyed by many physicians in group practice. With respect to compensation, single specialty groups have typically been more lucrative than multispecialty groups, especially for specialists (Figure 3). In some instances, the median compensation for physicians based on group type varied by as much as $10,000 to $181,000 (Figure 4).

Median compensation for specialists in single specialty groups was $299,648 versus $201,312 for specialty physicians in multispecialty practices. Primary care physicians in single specialty groups earned a median compensation of $137,716 versus $139,591 for primary care physicians in multispecialty groups (Figure 5).

Geographic Region

Geographic area has always had an impact on physician compensation (Table 2). Geographic compensation differences can be attributed to the relative costs of living in each area, the physician-to-patient ratio, the extent of physician involvement with managed care, and practice location (ie, an urban or rural area).

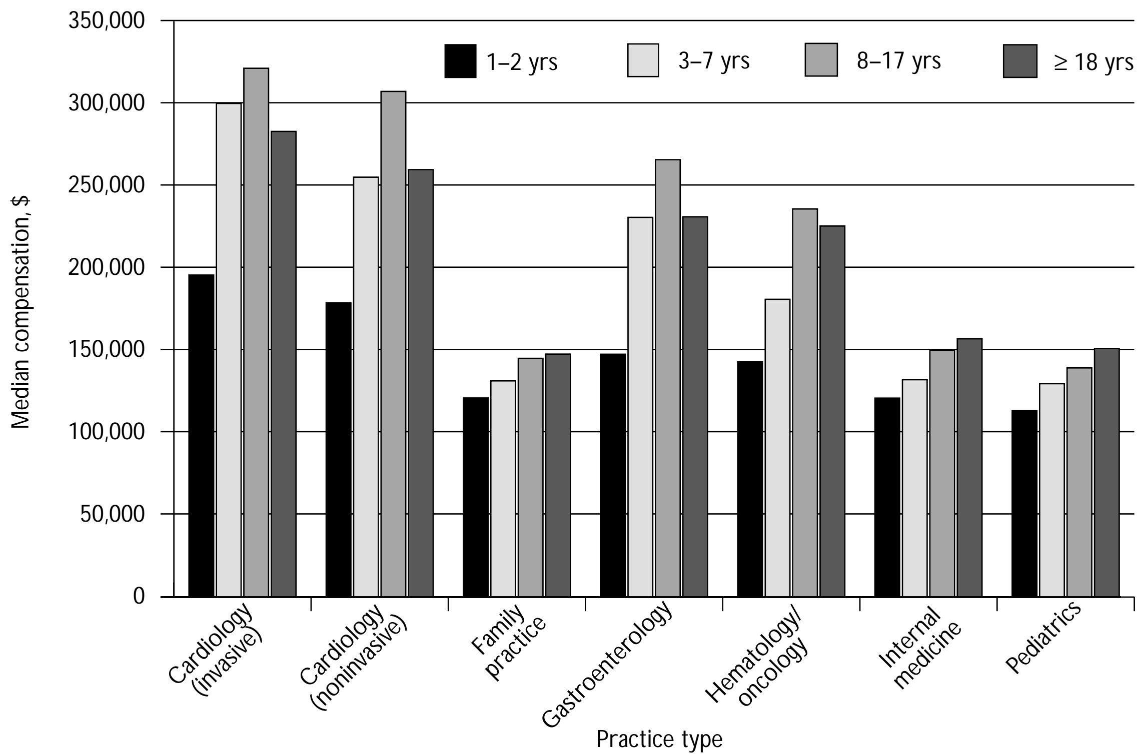

Figure 7. Median physician compensation according to years in practice: primary care and medical specialties. Data from *MGMA 1999 Physician Compensation and Production Survey: 1999 Report Based on 1998 Data*. Sponsored by Cejka & Company, St. Louis, MO, 1999.

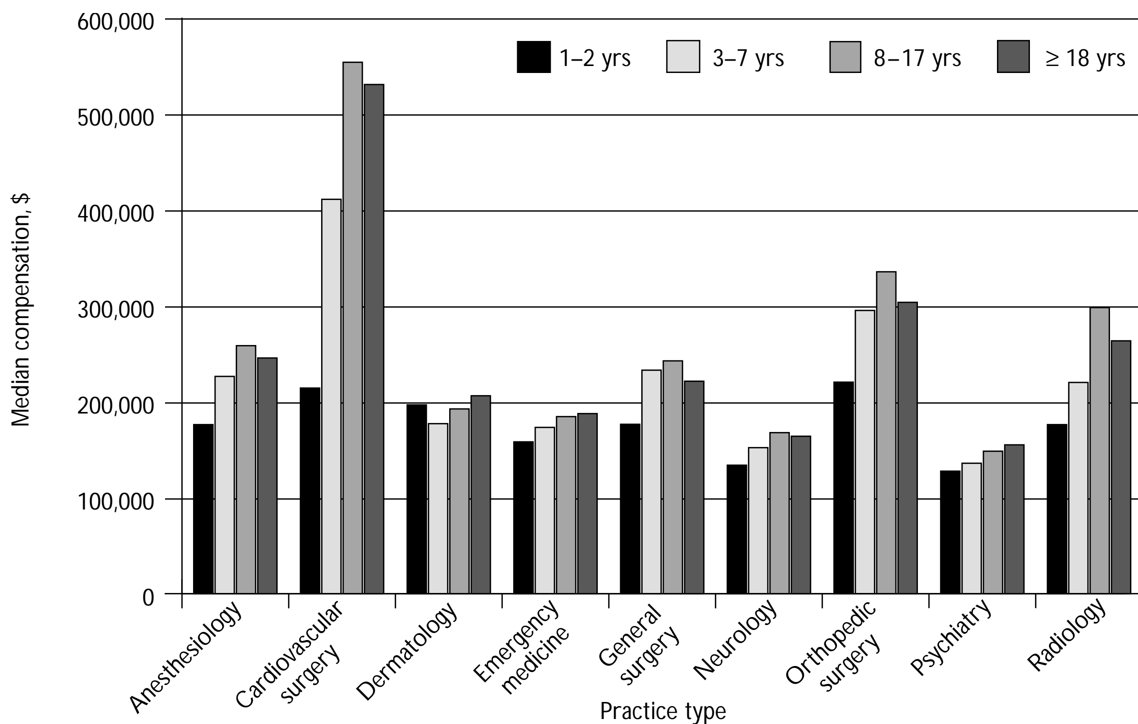

Figure 8. Median physician compensation according to years in practice: special services and surgical specialties. Data from *MGMA 1999 Physician Compensation and Production Survey: 1999 Report Based on 1998 Data*. Sponsored by Cejka & Company, St. Louis, MO, 1999.

Compensation continues to be highest in the South where primary care physicians earn $150,000 and specialists earn $305,800, followed by the Midwest, leaving the East and West in last place (Figure 6). The East and West tend to lag behind the rest of the United States in compensation rates because of the extent of physician involvement with managed care, capitation, saturation of certain physician specialties, and lower reimbursement rates.

Years of Experience

New physicians, who are undoubtedly looking forward to earning a six-figure income and paying off student loans, can expect compensation levels for the first 2 years of practice to be just under the national median (Figures 7 and 8). The median compensation for a new family practitioner is $120,891, up 0.74% from last year and only $17,386 less than the national median for all family practitioners.

Reaping the benefits of a strong market demand for their specialties, psychiatrists, hospitalists, and dermatologists experienced first-year salary increases between 7.43% and 40.72% in 1998. However, other specialties were not as lucky. Hematology/oncology physicians, noninvasive cardiologists, emergency medicine physicians, and neurologists all experienced decreases in first-year compensation. The 1998 data demonstrate that physicians with more years of experience and a strong patient base receive higher compensation when compared with younger, less experienced physicians. Specifically, physicians with experience of 8 years or more tend to earn significantly more than their colleagues with experience of 7 years or less.

The Gender Gap

In 1997 male primary care physicians earned between $20,000 and $33,000 more than female primary care physicians. Despite the growing demand for female physicians, especially female specialists in obstetrics/gynecology, the 1998 data reveal that male physicians are still earning a considerable amount more than their female counterparts (Table 3). According to the survey, the median compensation for a male specialist in obstetrics/gynecology was $227,991, compared with $194,792 for a female specialist in obstetrics/gynecology.

The disparity between male and female compensation can be attributed to differences in practice styles, not gender discrimination. Female physicians tend to spend more time with patients resulting in lower productivity. Female physicians are also more apt to work part-time, which affords them the opportunity to raise children and spend more time at home with their families.

Table 3. Gender-Based Differences in Physician Compensation

	Median Compensation, $	
Specialty	**Male**	**Female**
Primary care		
Family practice	143,061	123,546
Hospitalist	163,545	130,100
Internal medicine	147,383	125,033
Pediatrics	144,644	121,302
Medical specialties		
Cardiology (invasive)	297,239	220,000
Cardiology (noninvasive)	287,247	200,289
Gastroenterology	245,956	196,120
Hematology/oncology	225,288	175,745
Obstetrics/gynecology	227,991	194,792
Special services		
Anesthesiology	252,864	201,396
Dermatology	206,592	175,000
Emergency medicine	179,537	160,887
Neurology	162,951	140,445
Psychiatry	142,481	135,659
Radiology (diagnostic)	283,130	205,083
Surgical specialties		
Cardiovascular surgery	455,574	*
General surgery	233,144	182,668
Orthopedic surgery	308,947	209,895

*No data available

Data from *MGMA 1999 Physician Compensation and Production Survey: 1999 Report Based on 1998 Data.* Sponsored by Cejka & Company, St. Louis, MO, 1999.

COMPENSATION GROWTH FOR MID-LEVEL PROVIDERS

In light of the increasing demand for primary care physicians and the continued need to control costs, compensation for all mid-level providers, particularly physician extenders, increased 4.93% in 1998. These professionals, who in some cases deliver up to 70% of the care some primary care physicians deliver, are joining forces with primary care physicians to form health care teams composed of physicians, physician assistants, specialized nurses, social workers, nutritionists, and

public health aides. Because of continued shortages in many of these professions, median compensation levels for these professionals rose significantly in 1998:

- Nurse anesthetists—following a 5% increase in 1997, compensation is up 2.3% from $82,942 to $84,863
- Nurse practitioners—on the heels of a 3.7% increase in 1997, compensation jumped 5% from $52,788 to $55,433
- Physician assistants (surgical)—after a 6.9% increase in 1997, compensation climbed 4.4% from $67,953 to $70,950
- Physician assistants (primary care)—following a mild increase of 1.69% in 1997, compensation rebounded 7.4% from $57,200 to $61,411

In 1998, the data demonstrated an increasing trend toward the use of mid-level professionals and, in turn, a broadening of their scope of responsibilities. In markets with high levels of managed care penetration, one mid-level provider is recruited for every two physicians in primary care specialties, a dramatic increase from previous staffing levels. In addition, in many of these markets the traditional flat salary compensation for mid-level providers is being replaced with productivity-based compensation plans similar to those of physicians. This move towards productivity-based compensation undoubtedly has had an upward effect on the compensation trends for mid-level providers. This shift can only work to benefit these professionals because in past years highly productive mid-level providers were often paid fairly meager salaries relative to their productivity.

GAUGING THE FUTURE OF PHYSICIAN COMPENSATION

Physician compensation is on the rise. The 1998 data document the right-sizing of physician compensation, and compensation for primary care physicians will increase in the future because of their role in managed care. Although compensation for primary care physicians will never match that of cardiologists or cardiovascular surgeons, compensation for primary care providers will reflect the pivotal nature of their gatekeeper role in an integrated health care delivery system. Similarly, specialists have very little cause for concern. Whereas dramatic decreases in compensation and rumors of an oversupply of specialty physicians once haunted this group of professionals, specialists are more in demand than ever. **HP**

REFERENCE

1. *MGMA 1999 Physician Compensation and Production Survey: 1999 Report Based on 1998 Data.* Sponsored by Cejka & Company. St. Louis, MO, 1999.

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