Physician Compensation in 1997: "Rightsized" and Stagnant

Sue Cejka

The new but unpopular buzzwords *stagnation* and *rightsizing* are invading the discussion of physician compensation, and for the second consecutive year, physician compensation has remained flat. Neither primary care physicians nor specialists appear to be immune to this trend. Primary care physicians (family practitioners, internists, and pediatricians) whose incomes increased nearly 4.5% in 1995, followed by a less substantial 1.4% increase in 1996, saw an average 0.4% increase in 1997. At the same time, some specialists who experienced income boosts between 5% and 10% in 1996 experienced decreases of 2% to 8% in 1997. In contrast to primary care physicians' weak increase, the compensation of specialty physicians as a whole decreased 0.5% during 1997, a very stagnant year for physician compensation all around.

These observations about physician compensation are based on the annual survey, *Physician Compensation and Production Survey: 1998 Report Based on 1997 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**), primary care versus specialty practice 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

The most significant trend observed in physician compensation over the past 5 years is the flattening of the rate of increase in compensation. Although there is no question that physicians are working harder than ever before for their money, productivity (as measured by almost any index) and practice costs have also been increasing at virtually the same rate.

Essentially, the health care marketplace is experiencing a rightsizing of physician compensation in that productivity is now rising more quickly than is 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. For example, the health care market in Minneapolis, MN, is beginning to revert back to fee-for-service care. Health care consumers and their employers are demanding less restricted access to specialty care and other services provided by health plans. As point-of-service plans gain prominence, consumers become more willing to pay for the services they receive, and the primary care physician's role as "gate keeper" also diminishes, it is becoming more difficult for health care organizations to contain costs. 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.

There is, however, some bright news on the horizon. In markets with significant managed care penetration, health plans may soon pass along for the first time in 5 years double-digit premium increases to purchasing employers. In turn, organized physician groups will

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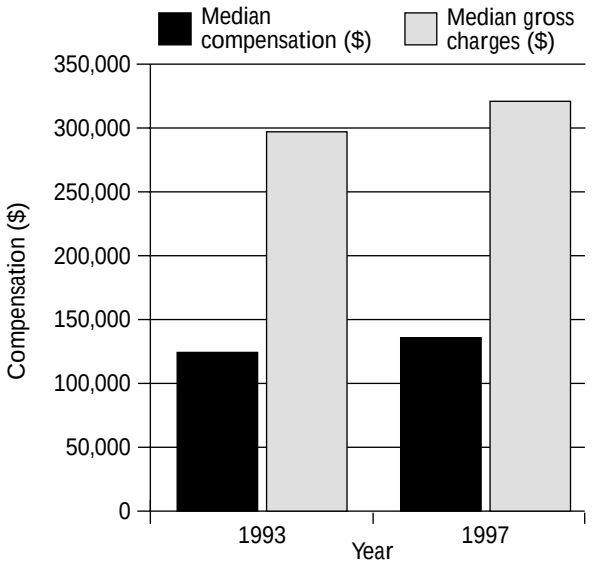

Figure 1. Median physician compensation and gross charges for primary care physicians in 1993 and 1997. Data from *MGMA 1998 Physician Compensation and Production Survey: 1998 Report Based on 1997 Data*. Sponsored by Cejka & Company, St. Louis, MO, 1998.

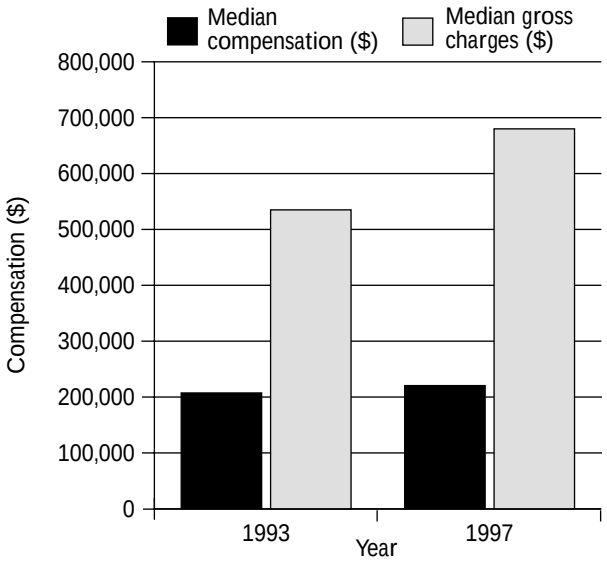

Figure 2. Median physician compensation and gross charges for specialists in 1993 and 1997. Data from *MGMA 1998 Physician Compensation and Production Survey: 1998 Report Based on 1997 Data*. Sponsored by Cejka & Company, St. Louis, MO, 1998.

stand firm in their insistence that current levels of reimbursement are unacceptable, and this premium increase will help to counteract the trend towards decreasing physician compensation.

PRIMARY CARE PHYSICIANS

In 1997 the compensation of primary care physicians increased only marginally, despite more substantial increases during the previous 5 years. From 1993 to 1997, compensation increased at a faster rate (9.3%) than charges (8%) or productivity (Figure 1). Although the marginal compensation increase in 1997 may raise concerns about future compensation increases, physicians must remember that the rate of increase in compensation can only exceed that of productivity for a finite period of time before leveling off occurs.

Family practitioners saw the most significant increase in compensation in 1997, with their income increasing 2.7% from $132,434 to $136,002. Internists and pediatricians both saw their median income decrease, 0.09% from $140,000 to $139,879 and 0.2% from $132,039 to $131,803, respectively.

SPECIALISTS

Although specialists have had an average compensation increase of 1.6% each year for the past 5 years, the general decrease in specialist compensation in 1997 is part of a long trend. Over the past 5 years, charges have risen 27%, while compensation has risen only 6% (Figure 2). In addition, specialists' productivity has been rising at a much greater rate than their compensation. In part, this can be explained by the transfer of compensation from specialists to primary care physicians. Some of this transfer, in fact, has been evidenced 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, however, specialists continue to win the compensation game. Although the increase in median compensation for primary care physicians between 1993 and 1997 was higher than the combined increase for all specialists, in 1997 the median compensation for specialists was $220,476, whereas the median compensation for primary care physicians was significantly lower at $135,791.

Compensation Winners

As 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

Table 1. Median Physician Compensation According to Specialty

Specialty	Median Compensation, 1997 ($)	Change in Compensation, 1993 to 1997 (%)	Change in Compensation, 1996 to 1997 (%)
Primary care			
Family practice	136,002	13.33	2.69
Internal medicine	139,879	8.14	-0.09
Obstetrics/ Gynecology	210,000	2.61	-3.47
Pediatrics	131,803	5.12	-0.18
Medical specialties			
Cardiology (invasive)	326,537	8.65	-7.70
Cardiology (noninvasive)	259,961	9.02	5.19
Gastroenterology	228,122	11.25	1.67
Hematology/ Oncology	195,057	6.31	2.37
Special services			
Anesthesiology	243,937	5.89	2.60
Dermatology	176,896	12.41	-2.68
Radiology (diagnostic)	262,900	2.13	-2.41
Surgical specialties			
General surgery	225,173	16.17	0.8
Orthopedic surgery	305,000	5.65	-1.76

Data from *MGMA 1998 Physician Compensation and Production Survey: 1998 Report Based on 1997 Data.* Sponsored by Cejka & Company, St. Louis, MO, 1998.

higher incomes. In 1997, specialists in hematology, gastroenterology, and general surgery experienced modest income increases (Table 1). Top-earning specialists in 1997 include the following:

- Urologists—following a 4.1% increase in 1996, their compensation climbed 3.7% from $222,236 to $230,339
- Noninvasive cardiologists—keeping pace with last year's 3.2% increase, their compensation rose 5.2% from $247,133 to $259,961
- Anesthesiologists—in the wake of a 1.2% decline in 1996, their compensation rose 2.6% from $237,749 to $243,937

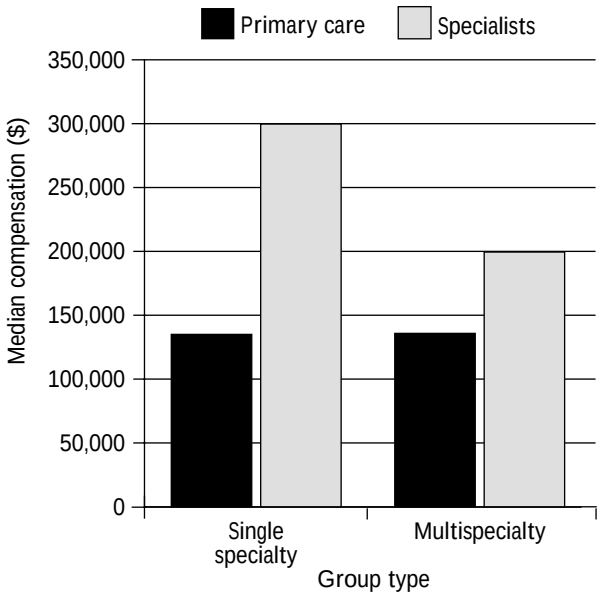

Figure 3. Median physician compensation for primary care physicians and specialists according to group type. Data from *MGMA 1998 Physician Compensation and Production Survey: 1998 Report Based on 1997 Data*. Sponsored by Cejka & Company, St. Louis, MO, 1998.

Compensation Losers

Although primary care physicians and the previously mentioned specialists experienced a modest increase or stabilization in annual income, some specialists were not as lucky. Specialists in obstetrics/gynecology and orthopedic surgery both saw their compensation decrease. Specialists who experienced the greatest income decreases in 1997 include:

- Invasive cardiologists—subsequent to a 5% increase in 1996, their compensation dropped 7.7% from $353,769 to $326,537
- Dermatologists—on the heels of a 2.7% decrease in 1996, their compensation declined 2.7% from $181,774 to $176,896
- Radiologists—following a boost of 8.9% in 1996, their compensation decreased 2.4% from $269,404 to $262,900

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

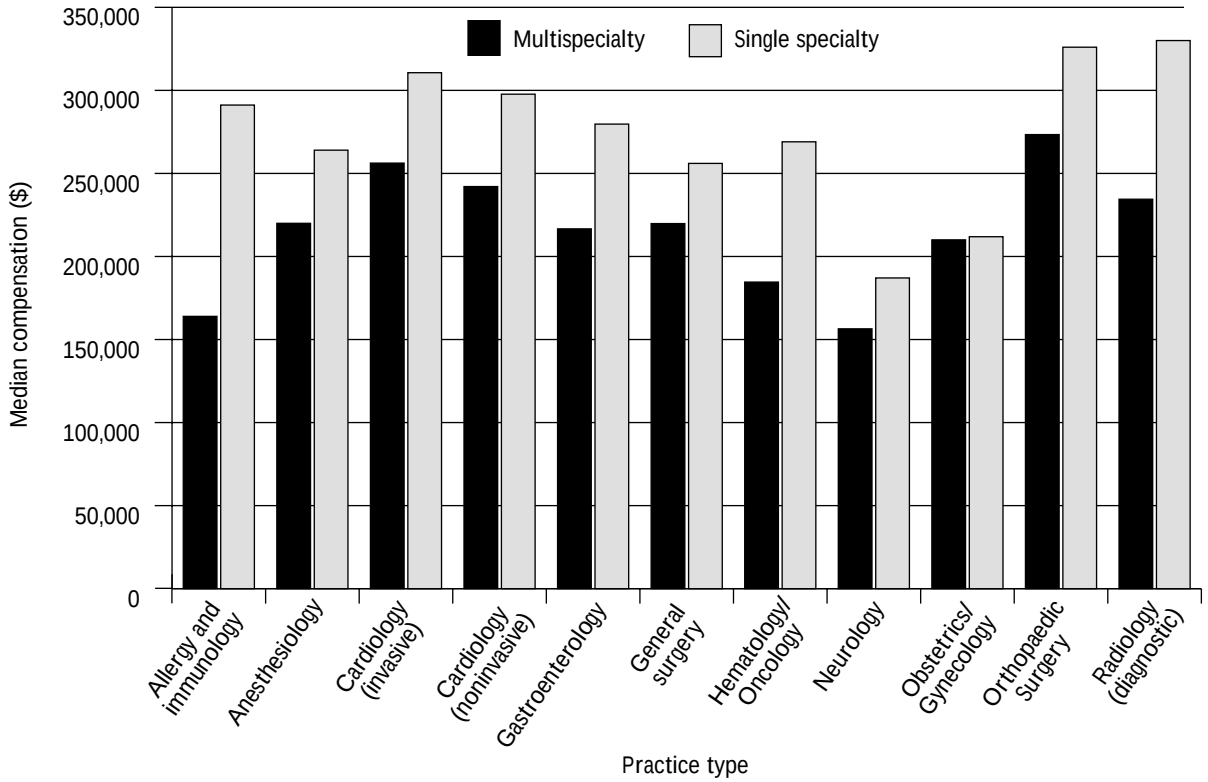

Figure 4. Median physician compensation according to practice type and group type: medical and surgical specialities. Data from *MGMA 1998 Physician Compensation and Production Survey: 1998 Report Based on 1997 Data*. Sponsored by Cejka & Company, St. Louis, MO, 1998.

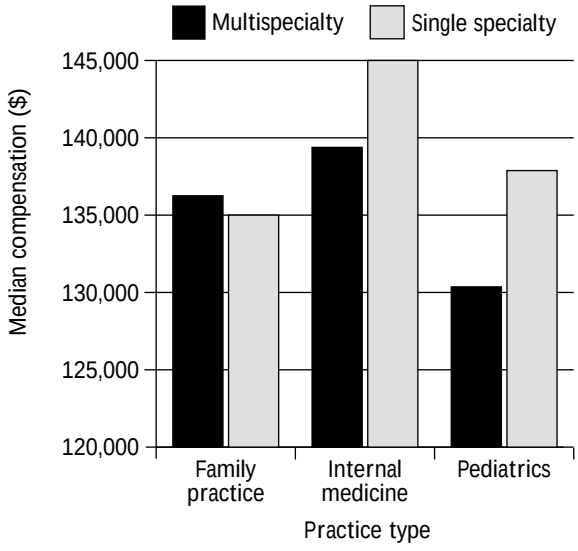

Figure 5. Median physician compensation according to practice type and group type: primary care. Data from *MGMA 1998 Physician Compensation and Production Survey: 1998 Report Based on 1997 Data*. Sponsored by Cejka & Company, St. Louis, MO, 1998.

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.

Although good incentive plans for hospitalists are rare, the greatest attractions of a hospitalist career are its predictable hours and interesting work. Physicians 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 $50,000 to $127,000 (Figure 4).

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

Specialty	Median Compensation ($)			
	East	Midwest	South	West
Allergy and immunology	189,317	180,024	211,480	151,341
Anesthesiology	217,250	252,062	295,060	219,753
Cardiology (invasive)	312,500	301,154	317,620	223,360
Cardiology (noninvasive)	245,000	309,258	300,250	198,870
Cardiovascular surgery	440,291	431,545	502,095	396,365
Family practice	126,000	135,000	155,583	129,228
General surgery	219,620	221,566	269,603	194,856
Hematology/ Oncology	180,500	195,851	250,318	172,314
Internal medicine	142,051	135,012	154,730	136,157
Neurology	150,000	168,908	176,020	152,142
Obstetrics/ Gynecology	204,096	216,985	254,649	195,878
Orthopedic surgery	301,031	327,400	326,000	259,812
Pediatrics	131,310	129,164	141,972	126,524
Radiology	249,000	330,000	276,402	225,011

Data from *MGMA 1998 Physician Compensation and Production Survey: 1998 Report Based on 1997 Data.* Sponsored by Cejka & Company, St. Louis, MO, 1998.

Median compensation for specialists in single specialty groups was $299,693 versus $199,474 for specialist physicians in multispecialty practices. For primary care physicians, compensation based on group type was nearly identical (Figure 5). Primary care physicians in single specialty groups earned a median compensation of $135,000 versus $135,791 for their colleagues in multispecialty groups.

Geographic Region

Geographic area has always had an impact on physician compensation. 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, urban or rural area).

Compensation continues to be highest in the South, where primary care physicians earn $153,100 and specialists earn $270,137, followed by the Midwest and East, leaving the West in last place (Table 2 and Figure 6).

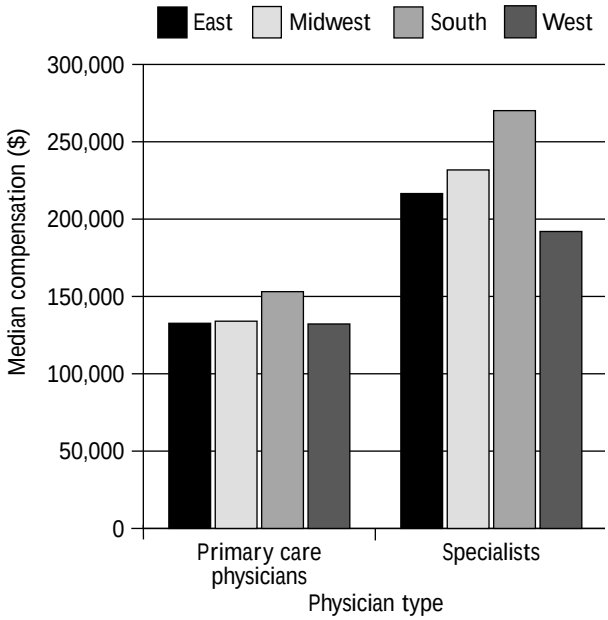

Figure 6. Median physician compensation for primary care physicians and specialists according to geographic region in the United States. Data from *MGMA 1998 Physician Compensation and Production Survey: 1998 Report Based on 1997 Data*. Sponsored by Cejka & Company, St. Louis, MO, 1998.

Years of Experience

New primary care physicians, who are undoubtedly looking forward to earning a six-figure income and paying off student loans, can expect compensation levels during their first 2 years of practice to be just under the national median. The median compensation for a new family practitioner is $120,000, up 8.9% from last year and only $16,000 less than the national median for all family practitioners (Figures 7 and 8).

During 1996, however, the median compensation for new family practitioners increased only 1%. This trend is affecting internists, whose incomes increased significantly in 1996, but increased only 0.1% 1997. In contrast, pediatricians, who have typically received mild increases in compensation, have enjoyed healthy 4.3% and 5.3% increases in compensation for the past 2 years.

This compensation trend for primary care physicians is part of the compensation pendulum: in 1996 new family practitioners' incomes slipped and the new internists saw their incomes decrease in 1997. This increase for family practitioners can be attributed to the age-diversified patient panel they serve. The practices of pediatricians and internists, in contrast, are limited

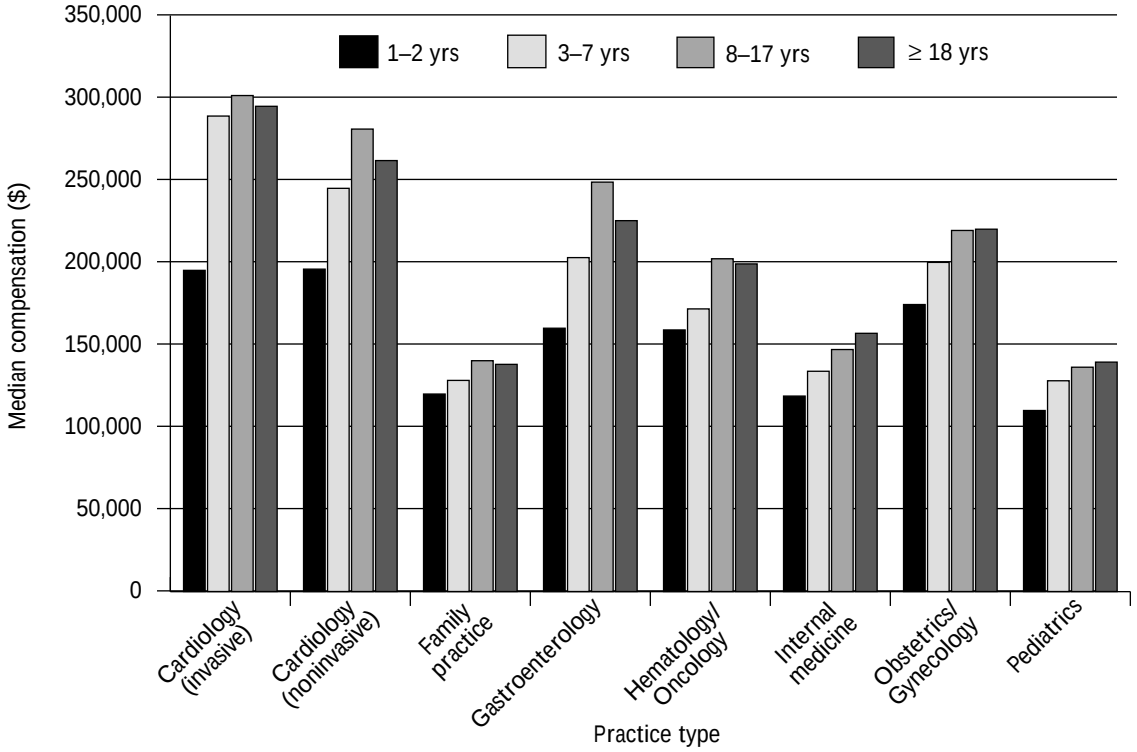

Figure 7. Median physician compensation according to years in practice: primary care and medical specialties. Data from *MGMA 1998 Physician Compensation and Production Survey: 1998 Report Based on 1997 Data*. Sponsored by Cejka & Company, St. Louis, MO, 1998.

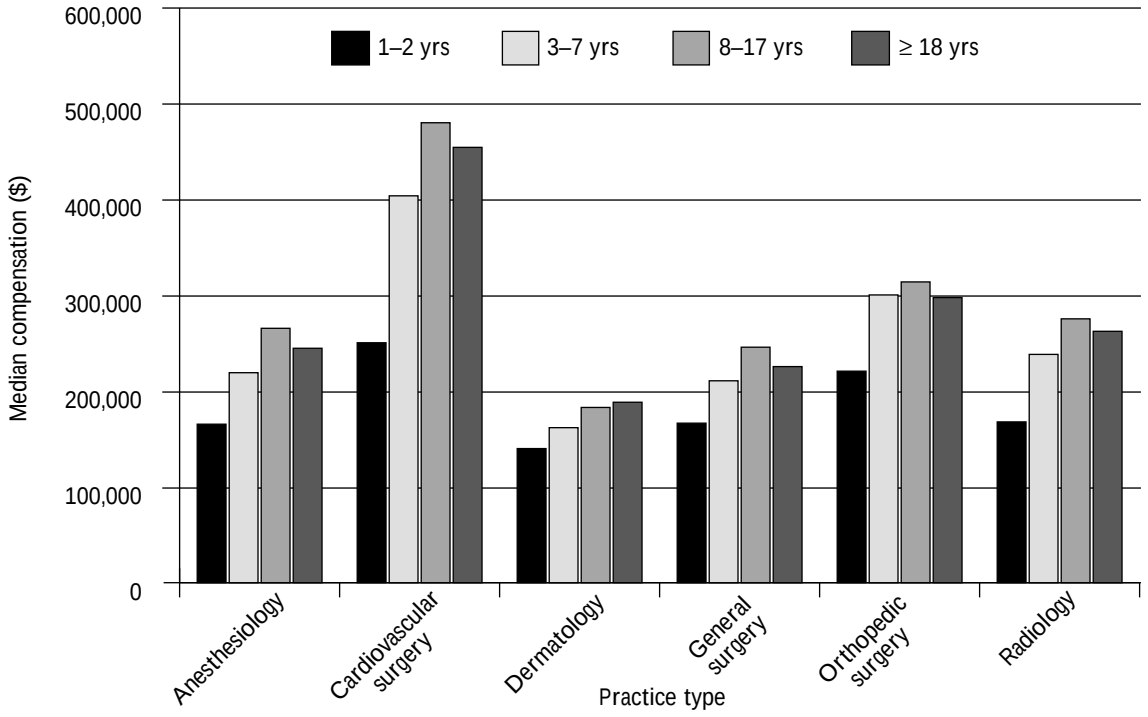

Figure 8. Median physician compensation according to years in practice: special services and surgical specialties. Data from *MGMA 1998 Physician Compensation and Production Survey: 1998 Report Based on 1997 Data*. Sponsored by Cejka & Company, St. Louis, MO, 1998.

to age-specific patient panels. As health care organizations recruit primary care physicians, the diverse patient population served by family practitioners makes these physicans more marketable, resulting in compensation boosts necessary to lure family practitioners to their practice.

The Gender Gap

In 1996 male primary care physicians earned between $20,000 and $22,000 more than female primary care physicians. Despite the growing demand for female physicians, especially female obstetricians and gynecologists, the 1997 report reveals 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 family practitioner was $138,883, compared to $118,800 for a female family practitioner. Anesthesiologists, noninvasive cardiologists, and general surgeons also experienced significant gender-related compensation differences.

Table 3. Gender-Based Differences in Physician Compensation

	Median Compensation ($)		
Specialty	**Male**	**Female**	**Difference**
Primary care			
Family practice	138,883	118,800	20,083
Internal medicine	145,315	122,601	22,714
Obstetrics/Gynecology	221,280	190,350	30,930
Pediatrics	138,174	116,331	21,843
Medical specialties			
Cardiology (invasive)	293,500	250,250	43,250
Cardiology (noninvasive)	268,405	195,892	72,513
Gastroenterology	231,300	196,329	34,971
Hematology/Oncology	200,000	155,757	44,243
Special services			
Anesthesiology	250,149	197,622	52,527
Dermatology	188,522	158,954	29,568
Radiology (diagnostic)	277,634	202,018	75,616
Surgical specialties			
Cardiovascular surgery	446,143	*	*
General surgery	230,189	177,070	53,119
Orthopedic surgery	305,297	213,704	91,593

*No data available.

Data from *MGMA 1998 Physician Compensation and Production Survey: 1998 Report Based on 1997 Data*. Sponsored by Cejka & Company, St. Louis, MO, 1998.

COMPENSATION GROWTH FOR MID-LEVEL PROVIDERS

In light of the increasing demand for primary care gate keepers, expanded roles for mid-level providers, particularly physician extenders, are on the horizon. There is an increasing trend towards the use of mid-level providers and a broadening of the scope of their training and responsibilities. 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 1997:

- Nurse anesthetists—up 5% from $79,002 to $82,942
- Nurse practitioners—up 3.7% from $50,910 to $52,788
- Physician assistants (surgical)—up 6.9% from $63,589 to $67,953

Primary care physician assistants saw the lowest compensation increase in 1997, up 1.7% from $56,249 to $57,200.

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 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

Although physician compensation has been flat for the past 2 years, the future of physician compensation is not as gloomy. The 1997 report[1] documents the right-sizing of physician compensation, and compensation for primary care physicians will increase in the future because of their role in managed care. While their compensation will never match that of cardiologists or cardiovascular surgeons, primary care physicians'

compensation will reflect the pivotal nature of the gatekeeper role in an integrated health care delivery system. As the system shifts its focus to health promotion and prevention, internists who once earned as little as $90,000 to $100,000 will have opportunities for continued increases in the future. Likewise, 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 1998 Physician Compensation and Production Survey: 1998 Report Based on 1997 Data*. Sponsored by Cejka & Company. St. Louis, MO, 1998.

NOTE

Physician compensation in 1997 for emergency medicine physicians, psychiatrists, and neurologists will be discussed in an article to be published in the February 1999 issue of *Hospital Physician*.