

Trends in Physician Compensation: Growth in Workload Continues to Outpace Growth in Compensation

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Physicians in the United States in virtually all medical and surgical specialties enjoyed increases in compensation from 1998 to 1999. However, that greater pay was only possible thanks to significantly greater increases in work and production during the same time period. Thus, reversing prior year trends in which compensation levels remained relatively stable, physicians generally enjoyed increased pay in 1999, but only with considerable additional work.

These findings are based on data from the *Physician Compensation and Production Survey: 2000 Report Based on 1999 Data*,¹ conducted by the Medical Group Management Association (MGMA). Continuing a trend that started in 1998, primary care physicians as a whole enjoyed compensation increases of 3.39% in 1999. However, an 11.55% increase in production (defined as gross charges) over the previous year's levels was required for that greater pay. Primary care physicians are clearly working harder to receive their increases in compensation. In today's market, those primary care physicians that are working at the same or a slower pace than in years past will likely face stagnation or decline in their compensation levels.

Specialist physicians also enjoyed relatively healthy increases in compensation in 1999, reversing downward trends that occurred from 1995 through 1997. In 1998, specialists enjoyed a 5.22% increase in compensation, followed by a 6% increase in 1999. Specialist physicians also had to increase their productivity to achieve growth in compensation, though generally not at the same magnitude as their primary care colleagues. In 1999, specialist physician production increased 8.5% over 1998 levels.

The MGMA *Physician Compensation and Production Survey: 2000 Report Based on 1999 Data* is based on the survey responses of 1315 medical practices in the United States, representing 27,985 physicians and mid-level providers. The survey of MGMA member prac-

tices has been conducted annually since 1987. Data are reported for 97 physician subspecialties and 17 mid-level provider specialties. The report contains sections on physician compensation, benefits, and productivity, as well as summary tables for selected specialties. Data examined in this article include:

- Compensation and gross charges levels for primary care (Figure 1) and specialist physicians (Figure 2) for 1995 through 1999
- Percentage change in compensation and production levels for primary care (Figure 3) and specialist physicians (Figure 4) for 1995 through 1999
- Median compensation and production levels for selected specialties for 1999 and the 5-year trend (Table 1)
- Operating costs as a percentage of total net medical revenue for 1990 through 1999 (Figure 5). (Operating cost data was obtained from the MGMA *Cost Survey: 2000 Report based on 1999 Data*.²)
- Median compensation for selected specialties by group type (Table 2 and Figure 6)
- Compensation by geographic region of the United States (Table 3 and Figure 7)
- Compensation by years in practice (Table 4 and Figure 8)
- Compensation by specialty and gender (Table 5)
- Percentage change in mid-level provider compensation and production levels for 1995 through 1999 (Figure 9)

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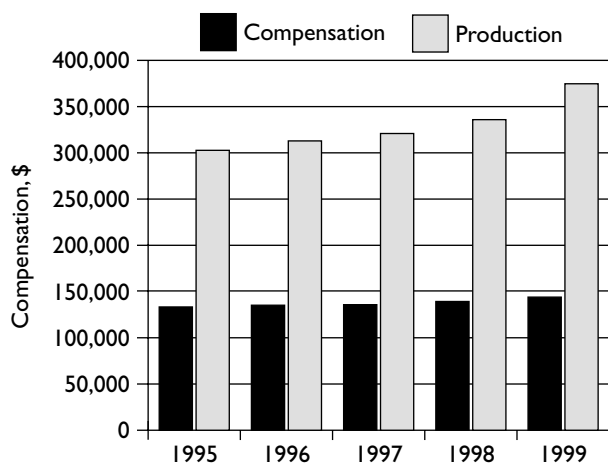


Figure 1. Median compensation and production for primary care physicians, 1995–1999. Data from MGMA Physician compensation and production survey: 2000 report based on 1999 data. Tables A and B: Median compensation and production for selected specialties, 1995–1999. Englewood (CO): Medical Group Management Association; 2000.

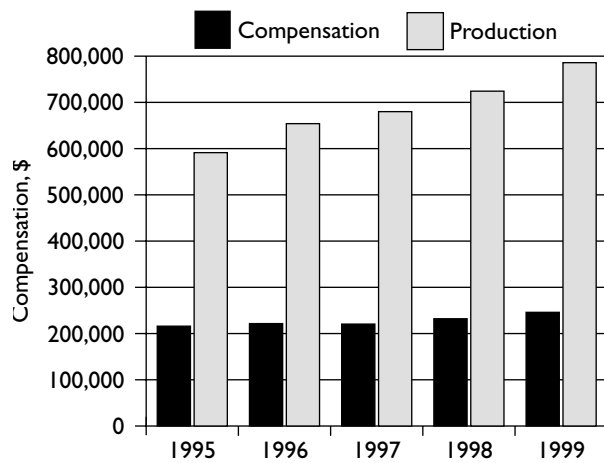


Figure 2. Median compensation and production for specialist physicians, 1995–1999. Data from MGMA Physician compensation and production survey: 2000 report based on 1999 data. Tables A and B: Median compensation and production for selected specialties, 1995–1999. Englewood (CO): Medical Group Management Association; 2000.

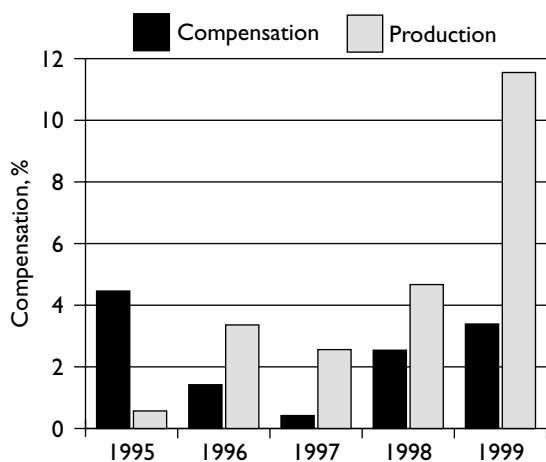


Figure 3. Percentage change in compensation and production for primary care physicians, 1995–1999. Data from MGMA Physician compensation and production survey: 2000 report based on 1999 data. Tables A and B: Median compensation and production for selected specialties, 1995–1999. Englewood (CO): Medical Group Management Association; 2000.

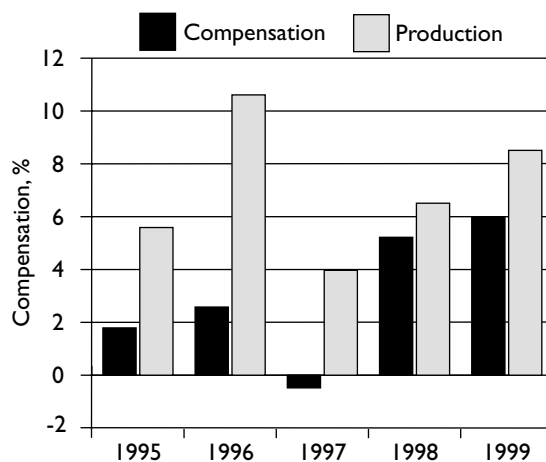


Figure 4. Percentage change in compensation and production for specialist physicians, 1995–1999. Data from MGMA Physician compensation and production survey: 2000 report based on 1999 data. Tables A and B: Median compensation and production for selected specialties, 1995–1999. Englewood (CO): Medical Group Management Association; 2000.

FIVE-YEAR TRENDS IN COMPENSATION AND PRODUCTION

Trends related to physician compensation and production levels over the 5-year period from 1995 through 1999 reveal the increased effort required to earn additional income. **Figure 1** and **Figure 2** show

median compensation and gross charges (production) levels for primary care and specialist physicians during this 5-year period. Both figures show gradual increases in compensation levels, combined with more aggressive increases in production levels. This trend is reflected in **Figure 3** and **Figure 4**, which illustrate the percentage

Table I. Median Compensation and Production for Selected Physician Specialties

	Median Compensation 1999, \$	Change in Compensation 1995–1999, %	Change in Compensation 1998–1999, %	Median Production 1999, \$	Change in Production 1995–1999, %	Change in Production 1998–1999, %
Primary care						
Family practice (without obstetrics)	141,493	9.56	2.33	370,382	24.14	15.81
Internal medicine (hospitalist)	148,846	NA	NA	299,275	NA	NA
Internal medicine (general)	145,397	4.36	3.01	369,685	23.45	12.96
Pediatric/adolescent medicine	143,011	10.79	5.93	387,583	27.92	13.02
Specialties						
Anesthesiology	244,755	1.70	–2.18	643,487	14.71	1.56
Cardiology (invasive)	340,010	0.89	–2.85	1,355,882	42.39	9.56
Cardiology (noninvasive)	278,712	16.42	–0.07	1,029,822	55.01	13.50
Dermatology	205,973	18.16	8.21	697,547	28.96	2.96
Emergency medicine	186,663	5.79	5.93	462,652	15.49	22.13
Gastroenterology	264,500	26.00	10.08	1,057,214	58.53	17.77
General surgery	236,572	9.24	4.84	927,482	39.07	10.87
Hematology/oncology	255,167	35.32	20.07	519,083	31.25	10.98
Neurology	178,197	8.46	10.96	570,370	34.20	20.04
Obstetrics/gynecology	219,029	1.87	1.26	755,331	26.73	11.95
Orthopaedic surgery	319,315	5.76	2.23	1,128,647	23.93	4.57
Psychiatry	151,903	14.66	6.42	280,793	21.60	1.97
Pulmonary medicine	192,221	12.72	4.82	544,891	22.34	0.07
Radiology (diagnostic)	315,048	27.29	15.90	1,100,000	48.57	16.24
Urology	268,825	25.94	12.01	975,872	52.65	11.79

NA = not available.

Data from MGMA Physician compensation and production survey: 2000 report based on 1999 data. Tables A and B: Median compensation and production for selected specialties, 1995–1999; Table I: Physician compensation (all specialties); Table 18: Physician gross charges (technical component excluded). Englewood (CO): Medical Group Management Association; 2000.

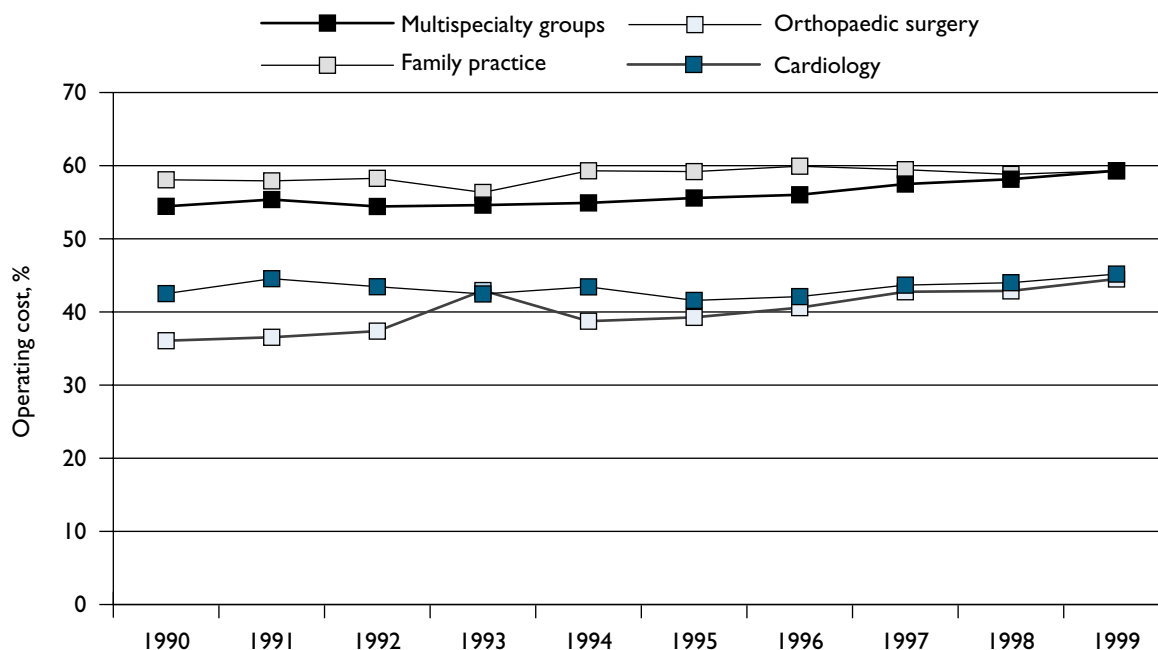


Figure 5. Operating cost as a percent of total medical revenue, 1990–1999. Data from MGMA Cost survey: 2000 report based on 1999 data. Graph 4. Englewood (CO): Medical Group Management Association; 2000.

change in primary care and specialist physician compensation and production during the same 5-year period. For primary care physicians as a whole, compensation increased from 1995 through 1999 by 7.98%, but it took a 23.78% increase in production to achieve that increase in pay. The disparity between compensation and production increases was also significant for specialists, whose 32.91% increase in production from 1995 through 1999 yielded only a 13.86% increase in compensation during the same 5-year period.

Data presented in **Table 1** reveal the same overall trends related to compensation and production levels over the 5-year period for selected medical and surgical specialties. There are several possible reasons why production consistently increases at a rate that is greater than that of compensation. These include continuing decreases in reimbursement due to managed care arrangements, continued downward pressure in governmental and private payer reimbursement rates, and increased operating costs associated with the practice infrastructure that is necessary to practice medicine in today’s increasingly complex business and regulatory environment. These factors, combined with a brisk national economy and shortages of skilled labor in many regions, have helped to further increase practice operating costs, thus placing increased pressure on the size of

the portion of the medical practice “pie” that remains for payment of physician compensation and benefits.

PRIMARY CARE PHYSICIAN COMPENSATION

Primary care physician compensation levels have generally returned to the same relationship between compensation and production that preceded the “bidding wars” that occurred in many regions during the mid-1990s for primary care physician practices. Figure 3 documents that 1995 was perhaps the final year of the primary care “buying frenzy,” in which increases in compensation levels for primary care physicians exceeded the corresponding increases in production.

Primary Care Compensation Winners and Losers

Specific changes in compensation and production for primary care physicians from 1998 to 1999 (Table 1) include:

- Family practice—median compensation in 1999 was \$141,493, reflecting a 2.3% increase over 1998 levels. During the same period, production increased 15.81%.
- Internal medicine—median compensation in 1999 was \$145,397 for general internists, up 3.01% from 1998 levels. During the same period, production in this group increased 12.96%.

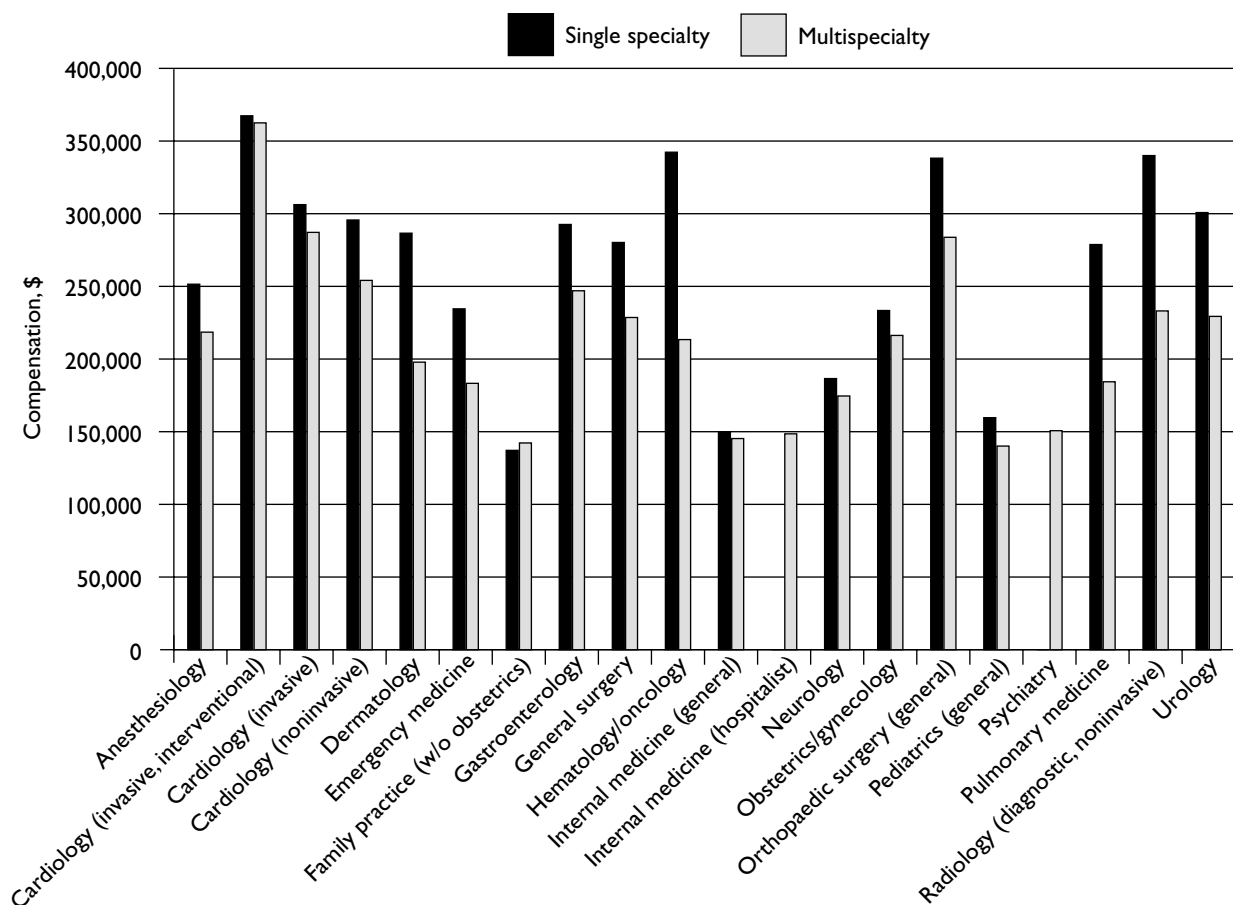


Figure 6. Median compensation by group type and physician specialty, 1999. Data from MGMA Physician compensation and production survey: 2000 report based on 1999 data. Table 2: Physician compensation by group type. Englewood (CO): Medical Group Management Association; 2000.

- Pediatrics/adolescent medicine—median compensation in 1999 was \$143,011, up 5.93% from 1998. Production increased 13.02% in this group during the same time period.

Hospitalist Compensation

The trend toward the use of hospitalist physicians that started several years ago continued unabated in 1999. These physicians generally received compensation that was slightly higher than what their counterparts in general internal medicine received (Table 1). Trend data reflecting changes in compensation and production is not yet available, reflecting the relatively newness of this specialty area. However, in 1999, median gross charges (production) for these physicians was significantly lower than the levels for general internal medicine physicians (\$299,275 versus \$370,382). This reality, combined with the slightly higher compensation levels, may indicate the

different operating costs that are associated with hospital-based versus office-based primary care physicians.

SPECIALIST PHYSICIAN COMPENSATION

Though physicians in most medical and surgical specialties also enjoyed increases in compensation levels in 1999, median levels in a few specialty areas actually decreased from 1998 to 1999 (Table 1)—particularly anesthesiology and cardiology. Compensation in most other medical and surgical specialties increased from 1998 to 1999. In virtually all specialties, production increased more than compensation. Notable exceptions to this include dermatology, hematology, pulmonary medicine, and psychiatry.

Specialty Compensation Winners and Losers

Table 1 provides compensation and production information for several medical and surgical specialties,

Table 2. Median Compensation for Selected Physician Specialties and Group Type, 1999

	Median Compensation, \$	
	Single-Specialty Groups, \$	Multi-Specialty Groups, \$
Primary care		
Family practice (without obstetrics)	137,174	142,264
Internal medicine (general)	150,000	145,295
Internal medicine (hospitalist)	*	148,530
Pediatrics (general)	159,643	140,122
Specialties		
Anesthesiology	251,500	218,504
Cardiology (invasive)	306,248	287,155
Cardiology (invasive, interventional)	367,366	362,500
Cardiology (noninvasive)	295,675	254,117
Dermatology	286,595	197,859
Emergency medicine	234,538	183,283
Gastroenterology	292,602	246,980
General surgery	280,213	228,588
Hematology/oncology	342,324	213,389
Neurology	186,560	174,578
Obstetrics/gynecology	233,397	216,246
Orthopaedic surgery (general)	338,216	283,774
Psychiatry	*	150,703
Pulmonary medicine	278,790	184,360
Radiology (diagnostic, noninvasive)	340,000	233,105
Urology	300,788	229,349

*Insufficient responses to report.

Data from MGMA Physician compensation and production survey: 2000 report based on 1999 data. Table 2: Physician compensation by group type. Englewood (CO): Medical Group Management Association; 2000.

including the following:

- Anesthesiology—median compensation in 1999 was \$244,755, reflecting a 2.18% decrease over 1998 levels. Notably, production levels for anesthesiologists during this same time period increased only 1.56%.
- Invasive and noninvasive cardiologists—these specialists also experienced stagnation in compensation levels. In 1999, median compensation for invasive cardiologists was \$340,010

(down 2.85% from 1998 levels), and \$278,712 for noninvasive cardiologists (showing virtually stable pay—a decrease of 0.07% from 1998). In both cases, however, production was increasing at a much more dramatic pace—9.56% for invasive cardiologists and 13.5% for noninvasive cardiologists.

- Dermatology—compensation levels for dermatologists outpaced their increases in production in 1998, showing an 8.21% increase in compensation based upon a 2.96% increase in production. Median compensation for dermatology physicians in 1999 was \$205,973.
- Hematology/oncology—as with dermatology, compensation levels for physicians in these specialties increased nearly 20% compared with 1998 levels, based on a 10.98% increase in production levels.
- Psychiatry—these physicians were also winners in terms of compensation, with an increase of 6.42% based on an increase in production of only 1.97%.
- Pulmonary medicine—compensation increased 4.82% compared with 1998 levels, while requiring only a 0.07% increase in production.

One reason for the relatively lower increases in physician compensation over the past several years is the generally steady increase in practice operating costs. Operating costs generally have shown consistent increases over the past 10 years, reflecting the changing business and regulatory environment of health care. **Figure 5** shows operating costs for medical group practices for multispecialty and select single-specialty groups (family practice, orthopaedic surgery, and cardiology) from 1990 to 1999 as a percentage of total net medical revenue. Although the overall trend line has a number of peaks and valleys, practice operating costs have generally increased over the past decade. And while the size of increase may not be huge (for example, a 2.7% increase in costs for single-specialty family practice groups during the period), in an age of declining reimbursement even slight increases in costs will need to be made up by increased work levels. The end result is a flattening of compensation levels despite increases in production. These trends, when taken together, illustrate the important role of physician and medical practice efficiency in determining physician compensation levels.

OTHER FACTORS INFLUENCING COMPENSATION Practice Setting

Figure 6 and **Table 2** summarize compensation levels

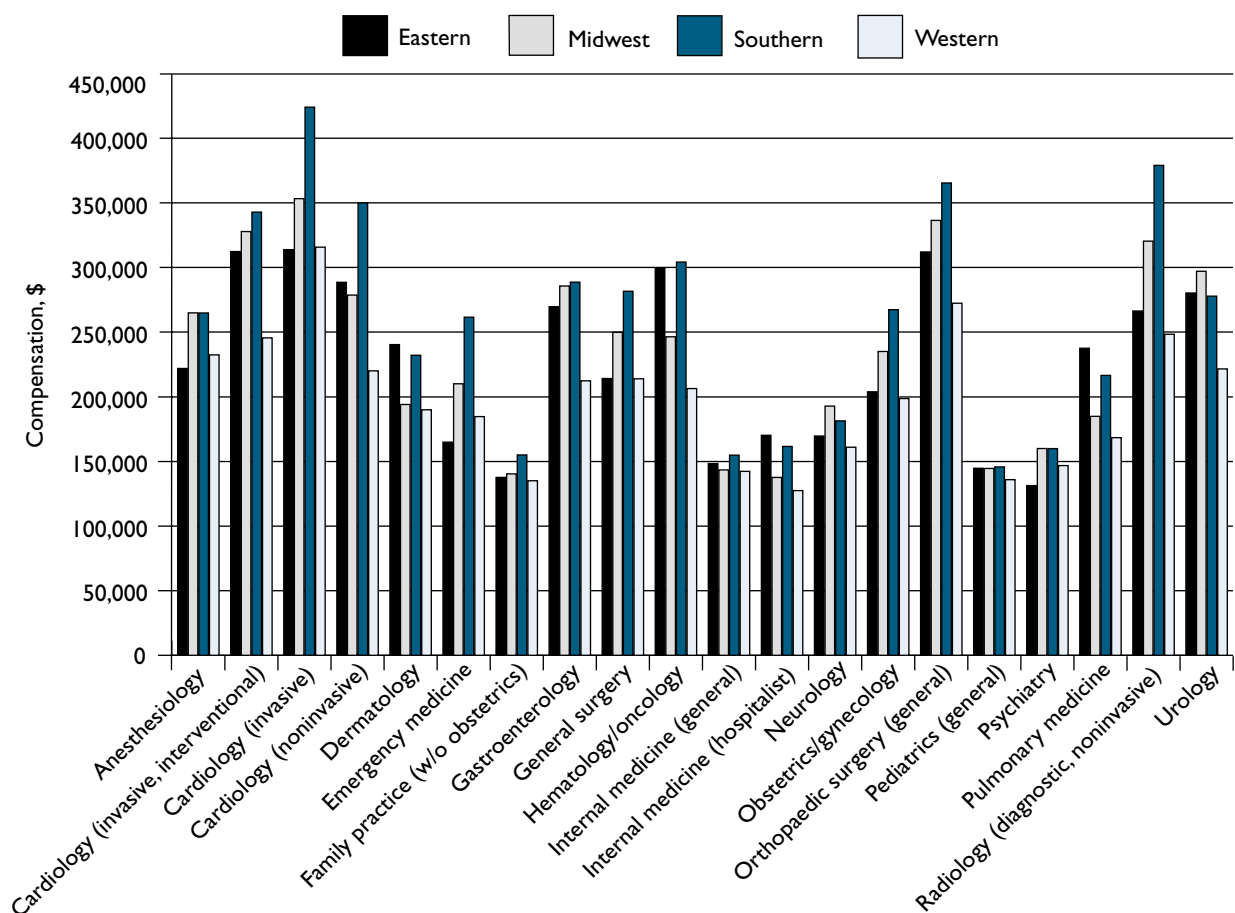


Figure 7. Median compensation by geographic region of the United States, 1999. Data from MGMA Physician compensation and production survey: 2000 report based on 1999 data. Table 3A: Physician compensation by geographic section for all practices. Englewood (CO): Medical Group Management Association; 2000.

in selected specialties for physicians in single-specialty and multispecialty groups. For the most part, specialists in single-specialty groups fared better than those in multispecialty groups. This is typically a result of many factors, including the higher operating costs associated with multispecialty enterprises, plus some spreading of practice income within a multispecialty setting among primary care and specialist physicians to promote group cohesiveness and other goals.

Of course, while physicians in single-specialty groups may garner higher wages for their efforts, physicians in multispecialty practices—particularly specialists—enjoy the built-in referrals of the multispecialty setting. Moreover, many specialists prefer multispecialty groups for various nonfinancial reasons, including enhanced contracting, access to patients, quality of care, convenience, practice culture, and other tangible and intangible benefits.

Geographic Location

As in the past, median physician compensation levels tend to be higher in the southern United States, followed by the midwestern, eastern and, finally, the western regions (Figure 7 and Table 3). This pattern generally conforms with the overall penetration of managed care throughout the United States. Physicians in the eastern and western United States have the lowest levels of compensation, primarily owing to increased managed care penetration in these regions, an overabundance of physicians in certain specialties, and relatively lower reimbursement rates. These trends might also reflect, to some degree, differences in the cost of nonphysician labor and in other operating costs in different regions of the nation.

Years of Practice

Compensation by years of practice tends to show a

Table 3. Median Compensation by Geographic Region of the United States (All Practice Types), 1999

	Median Compensation, \$			
	East	Midwest	South	West
Primary care				
Family practice (without obstetrics)	137,714	140,435	155,103	135,126
Internal medicine (general)	148,417	143,490	154,926	142,386
Internal medicine (hospitalist)	170,300	137,697	161,680	127,500
Pediatrics (general)	144,785	144,651	145,836	135,946
Specialties				
Anesthesiology	222,036	265,069	265,000	232,551
Cardiology (invasive)	312,530	328,025	343,063	245,709
Cardiology (invasive, interventional)	314,000	353,491	424,314	315,939
Cardiology (noninvasive)	288,745	278,818	350,201	220,197
Dermatology	240,521	194,174	232,259	190,062
Emergency medicine	165,000	210,188	261,715	184,784
Gastroenterology	269,843	285,864	288,854	212,478
General surgery	214,254	250,037	281,799	214,043
Hematology/oncology	300,000	246,550	304,386	206,479
Neurology	169,733	192,897	181,467	161,073
Obstetrics/gynecology	203,975	235,194	267,549	198,750
Orthopaedic surgery (general)	312,215	336,642	365,625	272,542
Psychiatry	131,362	160,068	160,000	146,869
Pulmonary medicine	237,695	184,978	216,666	168,494
Radiology (diagnostic, noninvasive)	266,518	320,600	379,236	248,527
Urology	280,464	297,265	278,018	221,686

Data from MGMA Physician compensation and production survey: 2000 report based on 1999 data. Table 3A: Physician compensation by geographic section for all practices. Englewood (CO): Medical Group Management Association; 2000.

rather steep increase after completion of the initial 1- to 2-year period of associate physician status. **Figure 8** and **Table 4** show median compensation levels in 1999 by years of practice for selected specialties. In all medical and surgical specialties, associate physicians in their first 1 to 2 years of practice received significantly lower levels of compensation than physicians with more years of experience. Moreover, although there were significant differences in the compensation received by a group's junior and most senior partners, these differences were still significantly less than those between associate and partner salaries.

Average compensation for primary care physicians in their first 1 to 2 years of practice was \$122,177. In comparison, average compensation for primary care physicians with 3 to 7 years of practice was \$141,245; 8 to 17 years of practice, \$152,162; and 18 or more

years of practice, \$160,458. Similar trends were demonstrated with specialist compensation. Average compensation for specialists with 1 to 2 years of practice in 1999 was \$178,046. This is compared to average compensation of \$239,166 for specialists with 3 to 7 years of practice, \$261,319 for specialists with 8 to 17 years of practice, and \$256,942 for those with 18 or more years of practice.

These data reflect the general life cycle of compensation levels in most groups, with physicians at the outset and in the "twilight" of their careers generally receiving lower levels of compensation. The decreases experienced by the most senior physicians are likely the result of various factors, including the addition of new and younger physicians to medical groups (thus diluting the established practices of more senior physicians) and the increased use of productivity-oriented

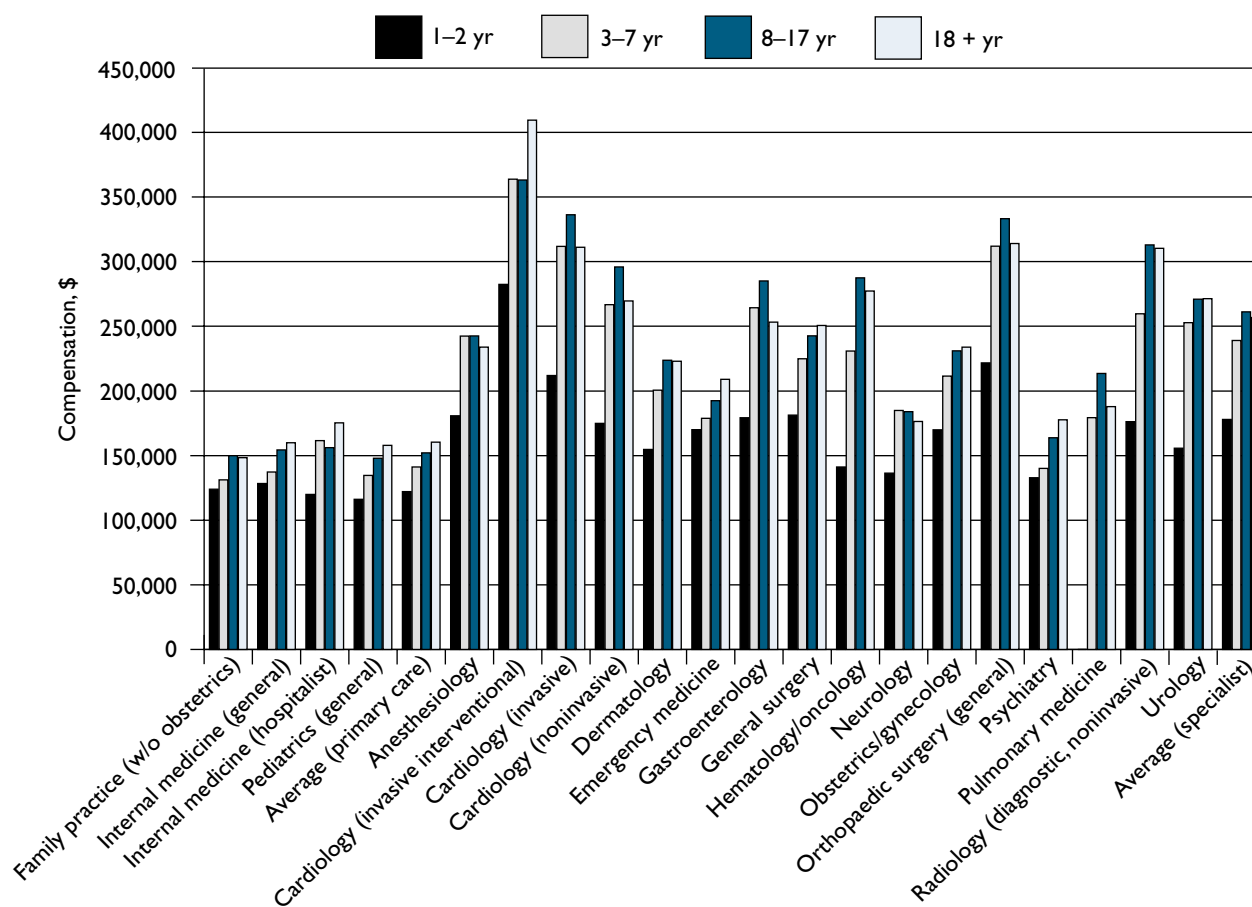


Figure 8. Median compensation by years in practice, 1999. Data from MGMA Physician compensation and production survey: 2000 report based on 1999 data. Table 7B: Physician compensation by years in specialty. Englewood (CO): Medical Group Management Association; 2000.

compensation methods in group practices. Even relatively cohesive single-specialty groups are increasingly turning to productivity-oriented compensation plans as a means of rewarding varying work levels and accommodating various income, work, and lifestyle goals of physicians at different stages of their careers.

Gender

Table 5 presents median compensation for female and male physicians in selected specialties. In 1999, male physicians made, on average, 14.7% more than their female counterparts in primary care disciplines, and 21.1% more than their female counterparts in medical and surgical specialties. This translated to an average difference in compensation of \$22,316 for primary care physicians and \$54,042 for specialists. The gender gap continues to be present even in obstetrics and gynecology, a specialty in which female physicians

are often viewed as having greater access to patients. In 1999, male ob/gyn physicians had median compensation levels of \$234,235, compared to a median of \$198,443 for female ob/gyn physicians, reflecting a difference of 15.3%.

The disparity between male and female compensation levels may result from a number of factors. Many female physicians elect to work part-time work schedules. Although such a schedule provides flexibility and more time to spend on family duties, it typically results in lower levels of production and compensation. Practice groups are increasingly turning to predominantly production-driven compensation schemes in part, as a means to accommodate differing physician preferences related to lifestyle and work levels. While such systems promote greater flexibility, physician autonomy and choice, these benefits frequently carry an associated financial cost.

Table 4. Median Compensation for Selected Physician Specialties and Years in Practice, 1999

	Median Compensation, \$			
	1–2 Years	3–7 Years	8–17 Years	18 + Years
Primary care				
Family practice (without obstetrics)	124,041	131,263	150,000	148,446
Internal medicine (general)	128,446	137,352	154,439	160,000
Internal medicine (hospitalist)	120,000	161,653	156,209	175,406
Pediatrics (general)	116,222	134,711	148,000	157,978
Average (primary care)	122,177	141,245	152,162	160,458
Specialties				
Anesthesiology	180,855	242,561	242,681	234,026
Cardiology (invasive)	212,044	312,000	336,488	311,316
Cardiology (invasive, interventional)	282,590	364,023	363,385	409,719
Cardiology (noninvasive)	175,000	266,883	296,087	269,762
Dermatology	154,820	200,699	223,858	223,090
Emergency medicine	170,119	178,912	192,547	209,099
Gastroenterology	179,352	264,500	285,242	253,365
General surgery	181,391	225,009	242,755	250,785
Hematology/oncology	141,234	230,988	287,644	277,455
Neurology	136,475	184,993	184,058	176,470
Obstetrics/gynecology	170,000	211,597	231,138	234,000
Orthopaedic surgery (general)	221,810	312,154	333,438	314,220
Psychiatry	132,906	140,149	163,868	177,758
Pulmonary medicine	*	179,419	213,643	187,967
Radiology (diagnostic, noninvasive)	176,325	259,829	313,142	310,500
Urology	155,774	252,947	271,125	271,535
Average (specialist)	178,046	239,166	261,319	256,942

*Insufficient responses to report.

Data from MGMA Physician compensation and production survey: 2000 report based on 1999 data. Table 7B: Physician compensation by years in specialty. Englewood (CO): Medical Group Management Association; 2000.

MID-LEVEL PROVIDER COMPENSATION

Mid-level providers include nurse practitioners, primary care and surgical physician assistants, certified registered nurse anesthetists, optometrists and psychologists. **Figure 9** presents mid-level provider compensation and production from 1995 through 1999. Mid-level provider compensation trends during this time period tended to mirror the basic trends experienced by primary care physicians, but with a slight 1- to 2-year delay. In 1995, primary care physicians were garnering increases in compensation that outpaced their increases in production. During that same year, mid-level providers

enjoyed only slight increases in compensation (1.39%) despite significant increases in production in comparison to prior-year levels. These trends were reversed in 1996, as primary care physicians' pay reverted to the more representative trend of production outpacing increases in compensation. Conversely, in 1996, mid-level providers enjoyed increases in compensation despite production levels that were decreased from the previous year, thus mirroring the primary care cycle but with a slight timing delay.

In 1997, however, the relationship between production and compensation levels for mid-level providers

Table 5. Median Compensation for Selected Physician Specialties and Gender

	Median Compensation, \$		Gender-Based Difference	
	Male	Female	\$	%
Primary care				
Family practice (without obstetrics)	145,779	124,610	21,169	14.5
Internal medicine (general)	150,856	130,000	20,856	13.8
Internal medicine (hospitalist)	157,000	133,745	3,255	14.8
Pediatrics (general)	150,876	126,891	23,985	15.9
Average (primary care)	151,128	128,812	22,316	14.7
Specialties				
Anesthesiology	248,709	195,991	52,718	21.2
Cardiology (invasive)	301,000	232,398	68,602	22.8
Cardiology (invasive, interventional)	380,222	301,928	78,294	20.6
Cardiology (noninvasive)	283,546	233,712	49,834	17.6
Dermatology	227,192	176,622	50,570	22.3
Emergency medicine	197,170	164,055	33,115	16.7
Gastroenterology	264,962	223,307	41,655	15.7
General Surgery	240,956	198,669	42,287	17.5
Hematology/oncology	273,300	176,100	97,200	35.6
Neurology	183,023	146,568	36,455	19.9
Obstetrics/gynecology	234,235	198,443	35,792	15.3
Orthopaedic surgery (general)	317,000	259,154	57,846	18.2
Psychiatry	153,345	146,997	6,348	4.1
Pulmonary medicine	198,652	166,186	32,466	16.3
Radiology (diagnostic, noninvasive)	310,665	217,409	93,256	30.0
Urology	271,404	183,172	88,232	32.5
Average (specialist)	255,336	201,294	54,042	21.1

Data from MGMA Physician compensation and production survey: 2000 report based on 1999 data. Table 8: Physician compensation by gender. Englewood (CO): Medical Group Management Association; 2000.

returned to the relationship more typical of other health care providers. In 1999, mid-level provider median production levels increased 3.79%, while their compensation increased 2.3%.

FUTURE TRENDS IN PHYSICIAN COMPENSATION

An assessment of historic trends reveals that physician compensation continues to rise, but only when production or work levels increase more dramatically. It is unclear how long physicians in all medical and surgical specialties will be able to sustain the double-digit increases in workload necessary to achieve single-digit increases in compensation. Although many physicians have had excess capacity and have been able to see

more patients by enhancing efficiency and working more, changes in health care and society in general may make this approach unsustainable in the long term.

Various trends will continue to place increased pressure on compensation and production levels in medical practice. These include the obvious changes in reimbursement rates and practice operating costs. In addition, changes and restructuring of health care delivery and payment systems involving public and private payers will most likely continue. Other dynamics may come into play, however. Changing population demographics will result in an increasingly elderly population, bringing greater levels of Medicare payment

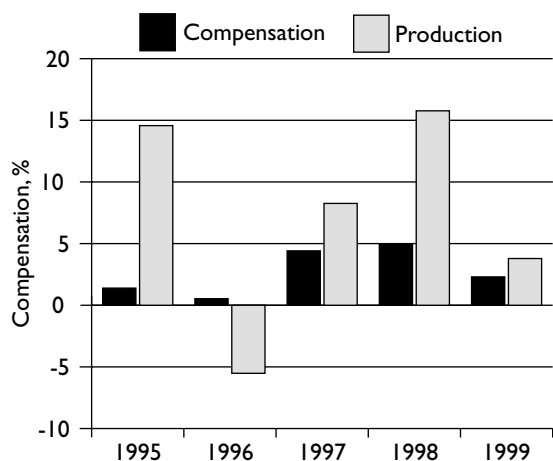


Figure 9. Percentage change in mid-level provider compensation and production, 1995–1999. Data from MGMA Physician compensation and production survey: 2000 report based on 1999 data. Tables A and B: Median compensation and production for selected specialties, 1995–1999. Englewood (CO): Medical Group Management Association; 2000.

and challenges in seeing more patients in a shorter period of time. Continued technological developments and direct marketing to consumers may result in increased consumer demand for such developments (including patient demands for the newest innovation or drug that is advertised in the media). Changes in medical education trends will result in fewer physicians being trained in some specialties, which will impose the inevitable forces of supply and demand on compensation levels. Together, these factors will continue to affect the underlying trends for physician compensation in the United States. **HP**

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2. MGMA Cost survey: 2000 report based on 1999 data. Englewood (CO): Medical Group Management Association; 2000.

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