

Physician Compensation

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We drew straws to see who would write a paper on physician compensation and I lost. That's why I'm here today. Physician compensation is a subject no one seems to want to know about, and so there's not much research into it. And, when one does research the subject, no one wants to hear what you have to say.

That's because people respect doctors and do not want to think anything about them. For one thing, I would not ever be here today if it were not for the skilled hands of a surgeon. A year ago, without any significant warning, I suffered a gall bladder attack and was admitted to the emergency room of the hospital. My gall bladder, as I later learned, was gangrenous and contained a gall stone the size of a duck egg. I was suffering from a very high temperature. After a successful surgery I am completely recovered.

But there's another side of the story. I have a relative whose doctor told her that she had gall stones and should have her gall bladder removed. She dutifully arranged to have surgery. When it was over she learned that she had a single gall stone the size of a grain of sand. Clearly, in retrospect, there was no need for surgery.

By almost every measure physician pay is high and rising. If one looks back across the broad span of 46 years, for example, the share of total expenditures spent on physician and clinical services, as measured in the Center for Medicare and Medicaid Services, has risen from 19.4 to 21.2 percent of total health care expenditures, even as spending on health care itself has grown faster than the economy. What this means is that the gap between what physicians earn and what the average American earns has widened considerably over time and that physician compensation and clinical services are a major driver of the increase in health care costs.

One can get a sharper picture of what these changes represent by setting 1960 spending levels at 100 and adding accumulated percentage increases since then. Using this approach, spending on physician and clinical services rose from 100 to 7,866 by 2005, compared to a rise from 100 to 7,219 for national health care expenditures. Both far outpaced the overall growth of the economy from 100 to 2,366.

The share of the national economy devoted to health care spending rose from 5.2 percent in 1960 to 16 percent in 2005. For physician and clinical services, the share rose from 1.0 percent to 3.4 percent. If present trends continue, the level of spending on physician and clinical services could be as high as total health care spending as a share of the economy in 1960.

International comparisons also add perspective. Primary care or generalist physician in the United States earn on average \$173,000 a year on 4.2 times GDP per capita. In OECD countries, generalists earn roughly half as much on average \$94,000, based on purchase parity dollars. Specialist physicians in the United States earn on average \$274,000 a year or 6.5 times GDP per capita. In OECD countries, specialists earn on average less than half that at \$129,000 or 4 times GDP per capita. So even adjusted for higher wealth and earnings in the United States, the gap between what physicians earn here and elsewhere in the develop countries is large, as is the gap between physician earnings and average American pay.

Since the United States spends twice the level of OECD countries on health care and by most measures without improved health outcomes, some health economists argue that half the spending in the United States represents waste and overutilization. Physicians have control over the largest category where overutilization and waste is occurring, it is claimed. By one calculation, physicians control 83 percent of total national health care expenditures. For 2007, that represents \$1,885 billion of a projected \$2,262 billion in spending.

To the extent doctors earn additional money for their decisions, they can drive the overall growth in total spending more than any other factor. According to a calculation by McKinsey Global Institute based on OECD data, U.S. physicians have 8.9 consultations per capita, while in Europe the number of consultations is lower, ranging from 3.4 in Switzerland to 7.8 in Belgium. These numbers are driven in part by the fact the

compensation for U.S. physicians is tied to productivity more than any other factor. The Community Tracking Study Physician Survey found that 70.4 percent of physicians in group practice report productivity incentives are a factor in their compensation. By comparison, 20.3 percent report quality incentives as a factor in compensation.

Physicians can also earn additional fees by referring patients to outpatient clinics and surgery centers where they have an ownership stake. A breakdown of physician earnings shows what a powerful earning stream this can be. McKinsey calculates U.S. physicians earn \$160 billion a year in 2003, broken down as follows: \$45 billion in fee-for-service income from hospitals, with an additional \$90 billion in fee-for-service income from outpatient facilities. In addition, physicians earned \$25 billion from profits in physician-owned facilities. That number is derived by taking about one-half of the \$50 billion a year in earnings from physician-owned outpatient centers.

Recent news has highlighted the potential level of waste, as a major clinical trial found that angioplasty shows no benefit over medical therapy with prescription drugs. There are about 1.2 million angioplasties done in the United States each year and the procedure costs between \$30,000 and \$40,000. That means that \$36 Billion to \$48 billion is spent a year on angioplasties and virtually all of it is potentially classifiable as overutilization and waste.

A study by Nallamothu et al examined the data on Medicare beneficiaries from 1995 to 2003 and calculated the annual population-based rates for total revascularizations

or coronary artery bypass graft (CABG) to gauge the effect of opening a physician-owned hospital. Four years after their opening, the relative increase in adjusted was 19.2 percent for markets where new physician-owned cardiac hospitals opened, when compared to markets where new cardiac programs opened at general hospitals, where the total revascularizations rose 6.5 percent, as well as markets where there were no new programs, where revascularizations rose 7.4 percent.

Clearly, there is not a functioning free market in the medical business that works as free market theory would suggest, even for such knowledgeable and sophisticated payers as insurance companies. The arrival of physician-owned hospitals has further exaggerated the perverse incentives that exist to provide volume instead of quality care. A survey of purchasers, including insurance companies, by the Center for the Study of Health System Change, in three cities where physician-owned hospitals have been set up found that the impact of the hospitals drove up the frequency of procedures and provoked what insurers called “an arms race” in spending.

Congress is aware of some of these problems, but has not done enough. A moratorium on new physician-owned specialty hospitals than began in 2003 expired last August after several extensions. A growing number of studies have found the introduction of physician-owned hospitals drives up the number of services performed, including surgeries and, as one insurer said, provokes “an arms race” in medical spending in the communities where they exist.

Clearly there is a need for more study of the how physician compensation incentives work against the practice of good medicine and patient satisfaction, while driving up spending at unsustainable rates. As a precaution, Congress should reinstate the moratorium on new physician-owned specialty hospitals while more research is made into their effect in markets where they exist and on the overall functioning of the health care system, as well as Medicare. Finally, studies should be undertaken to see where physician compensation arrangements have worked to improve quality while keeping costs in check.