

The Physician's Role in Rising Health Care Costs

Perspectives on the High and Rising Cost of Physician Compensation

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June 4, 2007

## Executive Summary

By almost every measure, compensation for American physicians is high and rising; and, in view of the growing burden of health care costs to society, a subject of legitimate inquiry. To get a better perspective, one can look at the long-term trends in physician compensation and compare U.S. compensation with physician pay in other developed nations. For example, if one looks back across the broad span of 46 years, spending on physician and clinical services, as measured by 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.

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 generalists in the United States earn on average \$173,000 a year or 4.2 times gross domestic product (GDP) per capita. In other countries of the Organization for Economic Cooperation and Development (OECD), generalists earn roughly half as much – or \$94,000 on average – based on purchase power parity dollars. Specialists in the United States earn on average \$274,000 a year or 6.5 times GDP per capita. In other 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 developed world is large, as is the gap between physician earnings and average American earnings.

While medical students spend more time and money to become physicians, their earnings as a medical doctor more than makes up for the cost of their education when compared to other professions and to international benchmarks. Similarly, while U.S. physicians also have to pay malpractice insurance because of the more litigious environment in the United States, which then drives up medical malpractice insurance, the data on physician average earnings already takes that into account as an administrative expense. Even so, the impact can adversely impact physician incomes in some of the most litigious states in some disciplines, such as obstetrics and gynecology (OB-GYN).

A growing shortage of doctors has driven up demand for both generalists and primary care physicians, and medical schools are scrambling to keep up as the population expands and ages, increasing demand for doctors, which in turn further drives up physician earnings. So, expect to see physician compensation to continue to rise faster than the GDP per capita.

Since the United States spends on health care twice the level of the average for other countries in the OECD – and by many measures without improved health outcomes – some health economists argue that as much as half the spending in the United States represents waste and overutilization. Physician decisions directly affect the overall utilization of health care services. By one calculation, physicians receive or control 87 percent of total national expenditures for personal health care. For 2007, that total spending on personal health care represents \$1,885 billion or 83 percent of a projected \$2,262 billion in health care expenditures.

To the extent doctors earn additional money based on their decisions that impact overall health care spending, one can reasonably conclude that the fee-for-service business model that governs physician practice drives the overall growth in total spending far beyond just any increase in physician compensation that comes as a result of medical decisions made by physicians. Indeed, the fee-for-service business model creates strong incentives for physicians to see more patients and provide more services in order to increase income. The extent of additional effort put forth by U.S. physicians as compared to other nations can be seen in the data. According to a calculation by McKinsey Global Institute, based on OECD data, even though the United States has fewer physicians per capita, 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.

Surveys of physicians confirm that productivity, usually tied to the fee-for-service structure, is the largest factor in compensation. For example, 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. A growing number of physicians recognize publicly that productivity-based incentives are working to raise costs, generate overutilization, and unnecessarily drive up health care, and have called for reforms.

The fee-for-service model for physician compensation – tied to an elastic supply of patients whose services are covered by Medicare or who are covered by an employer-sponsored health care plan – creates a situation where the normal economic rules of markets do not apply. The “invisible hand” Adam Smith<sup>1</sup> described as directing free

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<sup>1</sup> “[E]very individual necessarily labours to render the annual revenue of the society as great as he can. He generally, indeed, neither intends to promote the public interest, nor knows how much he is promoting it. By preferring the support of domestic to that of foreign industry, he intends only his own security; and by directing that industry in such a manner as its produce may be of the greatest value, he intends only his own gain, and he is in this, as in many other cases, led by **an invisible hand** to promote an end which was no part of his intention. Nor is it always the worse for the society that it was no part of it. By pursuing his own interest he frequently promotes that of the society more effectually than when he really intends to promote

markets for the public interest is mostly absent from the much of the U.S. health care system,<sup>2</sup> especially physician compensation and the medical decisions physicians make regarding patients, despite the overall excellence of the U.S. health care system and the medical innovations it can boast. For instance, fee-for-service compensation does not promote the public interest outcome of an efficient use of medical services, based on true medical need, patient health and satisfaction. Instead, the fee-for-service model can work to promote the use of unneeded services and tests, prodded additionally by the litigious environment that surrounds health care in the United States. Even sophisticated market players like insurance companies say they are often unable to significantly offset the effect on health care spending of the incentives found in the fee-for-service business model of physician practice.

Government regulation and controls have also been unable to make much of a dent on the incentives that govern fee-for-service. Indeed, a series of efforts over decades to target and contain Medicare spending on physician fees have failed, including the most recent targeting system in place for only a decade. That was the conclusion of the Medicare Payment Advisory Commission (MedPAC) in its latest report in March on the Sustained Growth Rate (SGR) expenditure targeting system that was adopted in 1997. Indeed, MedPAC concluded that the SGR spending targets for specific fees perversely drive up volume, pushing up overall spending faster than gains in per capita GDP.

The perverse incentives of a productivity-based fee-for-service business model for U.S. medicine are strengthened by the fact that 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. The McKinsey Global Institute calculates U.S. physicians earned \$160 billion a year in 2003, segmented 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 calculated by taking about one-half of the \$50 billion a year in earnings from physician-owned outpatient centers. (Physician ownership is usually around 50 percent.)

MedPAC has found that physician-owned hospitals cherry pick the most profitable patients (usually younger and in better health) and focus on areas of medical practice that offer higher profits. This often leaves community hospitals with less profitable patients and reduced opportunities to earn higher fees. This, in turn, adds to the overall cost of the health care system, as community hospitals scramble to offset lost business by charging higher fees in other areas.

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it. I have never known much good done by those who affected to trade for the public good.” This passage is from Adam Smith’s *An Inquiry Into the Nature and Causes of the Wealth of Nations*, 1776

<sup>2</sup> To be sure, the health care market in the United States drives innovation in health care, such as new procedures, new instruments and technology, as well as new drug therapies. But, even where there are market economy successes such as the pharmaceutical industry, price controls overseas drive up the costs of drugs in the United States, as the cost of new drug development falls disproportionately on American health consumers.

The spread of physician-owned hospitals in recent years has further strengthened incentives to provide a greater volume of health care. A survey of purchasers, including insurance companies, by the Center for Studying 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 expensive procedures, such as artery by-pass operations. The introduction of new physician-owned hospitals, in fact, sparked what insurers called “an arms race” in health care spending as physicians increased referrals for medical procedures. Congress in 2003 demonstrated some concern about the negative consequences of having physicians own specialty hospitals and put in place a moratorium on new ones. That moratorium, however, expired in August 2006.

The voices for reform are growing among physicians, too, who see the need to temper the incentives for productivity and to put in place incentives to control costs, improve health outcomes, and increase patient satisfaction.

## **Recommendations**

In view of the negative impact of the fee-for-service structure, there is obviously more work to be done to rethink and reform the system beyond all the approaches that have been tried in the past. The following items are suggested as a starting point:

### Recommendations for Research:

- More research should be undertaken to better understand how physician fee-for-service compensation incentives work to increase unnecessary health care spending and how the impact of such incentives can be moderated and tempered while at the same time improving health outcomes.
- Studies should be undertaken to see where physician compensation arrangements have worked to improve quality and patient satisfaction while keeping costs in check and see how those successful models could be put into practice elsewhere.

### Recommendations for Policy:

- Congress should reinstate the moratorium on new physician-owned specialty hospitals while more research is made into their effect in health care and overutilization.
- Policymakers in Washington and leaders within the health care system should give more consideration to reforms and arrangements that are likely to increase the role of quality care, patient satisfaction, and the efficient use of resources as components of physician compensation.

## Introduction

It is no secret that physician compensation is high and headed higher. Few would deny that something needs to be done to rein in this rate of growth – else the cost of government spending on health care is going to grow even faster than expected and place an even greater burden on workers and the productive capacity of the economy. The purpose of this paper is to get several perspectives on the trends affecting physician compensation and put the matter into a broader context. Further, this paper will look at how decisions by physicians impact overall costs and how those decisions can be influenced by fee-for-service compensation incentives. This, in turn, drives up productivity and the growth in physician services. Finally, the paper will show how new developments are providing even more economic incentives for physicians to perform more tests and procedures that may be necessary for improved health outcomes while adding to the forces that are driving up health care costs to unsustainable levels.

## The Long Term Perspective

The federal government has since 1960 tracked overall health care expenses in the United States and each year has published data breaking down those costs into the largest expenditure categories. The Centers for Medicare and Medicaid Services has available data for those broad categories covering 46 years, effectively covering health care spending since the creation of Medicare. One of the broad categories that CMS tracks is “Physicians and Clinical Services.” While this is an imperfect measure of physician compensation, since it is a broader measure than simple physician compensation, it is the best and most comprehensive measure available that uses the extensive data collected by the government by survey and census. It includes not only the revenues spent by Medicare, but also spending on health care by private insurers, and other payers, including individual and family out-of-pocket payments. It covers primary care physicians, as well as specialists, and both salaried and self-employed physicians.

If one just takes the starting point and the ending point, one can determine the trends from the broadest perspective of 46 years. In 1960, for example, the United States spent \$27.534 billion on health care. Out of that total, \$5.354 billion was spent on physician and clinical services.<sup>3</sup> That represented 19.40 percent of total health care spending.<sup>4</sup> In 2005 – the latest year for which data is available – the United States spent \$1,988 billion on health care and \$421 billion on physician and clinical services.<sup>5</sup> That represented 21.20 percent of total health care spending. Thus, while health care spending was increasing faster than overall inflation and faster than gains in productivity, spending

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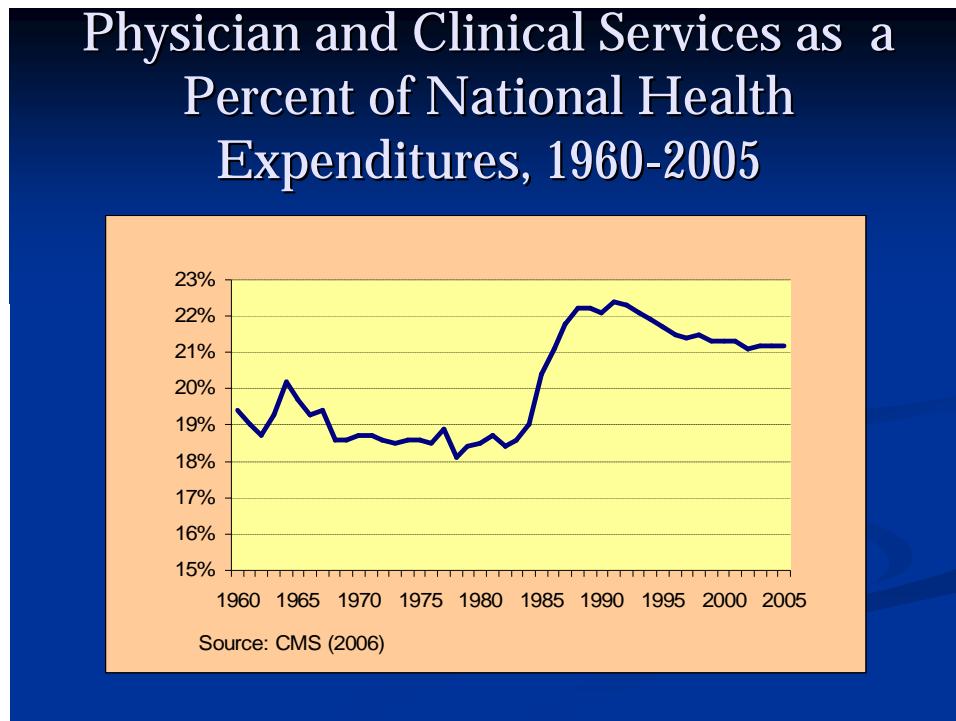
<sup>3</sup> Centers for Medicare and Medicaid Services, National Compensation Health Data, 1960-2005. link to Excel spread sheet with historic data can be found here: [http://www.cms.hhs.gov/NationalHealthExpendData/02\\_NationalHealthAccountsHistorical.asp#TopOfPage](http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage)

<sup>4</sup> Calculation made using total spending from CMS dated cited above.

<sup>5</sup> CMS, Ibid.

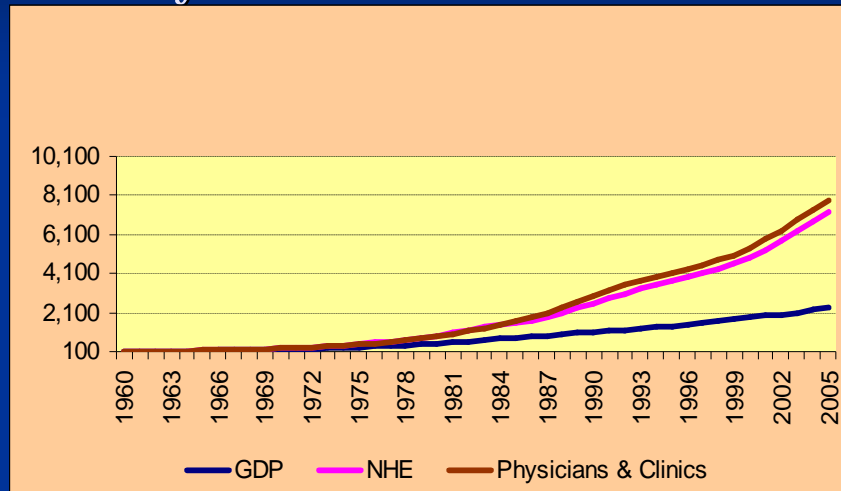
for physicians and clinical services rose so much faster, it increased its share of larger overall health care pie by 1.80 percentage points.

In the intervening years, the share of health care spending represented by physician and clinical services spending declined in years immediately after 1960 before rising to 20.20 percent in 1964. By 1968, the share had fallen back below 19 percent and remained at a level of 18.5, give or take a few tenths, until 1983 – the longest period of stability for this segment of health care spending. Beginning in 1984, however, physician expenditures as a share of total health spending began to rise, peaking at 22.4 percent in 1991. Costs fell back below 22 percent in 1994 and slowly declined as a percentage of total health care expenditures until reaching 21.10 percent in 2001. Since then expenditures, as measured by share, have risen, but remain relatively flat from 2003 to 2005. However, new developments in physician compensation hide some of the additional income since it comes in the form of returns on equity in physician-owned clinics and physician-owned specialty hospitals.



Another way to measure growth in expenditures is to set 100 as a baseline for spending in 1960 and then add to that base the accumulated growth since that time. Using this approach, spending on physician and clinical services grew from 100 to 7,866 by 2005, compared to 7,219 for national health care expenditures. Both far outpaced the rise of the overall output 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, it rose from 1.0 percent to 3.4 percent. If present trends continue, the level of spending on physician and clinical services could soon be as high as total health care spending as a share of the economy in 1960.

## Growth in GDP, NHE and Spending on Physicians & Clinics, 1960-2005



### International Comparisons

An international comparison of physician compensation finds that U.S. physicians have annual earnings at levels much higher than those of other developed nations, even adjusting for the higher wealth and greater productivity gains in the United States. The average income for U.S. salaried generalists (primary care physicians) is \$134,600 and for self-employed physicians is \$154,200.<sup>6</sup> These averages are 3.81 and 4.36 times the gross domestic product per capita.<sup>7</sup> The average income for U.S. salaried specialists is \$170,300 and for self-employed specialists it is \$229,500.<sup>8</sup> These averages are 4.82 and 6.49 times gross domestic product per capita.

The OECD data sets on physician remuneration for OECD countries are incomplete and represent selected countries and different types of sampling by those countries. For the United States, the data is based on a single year, 2001, and a single survey<sup>9</sup> by the American Medical Association. The AMA survey was recommended to the OECD by the researchers at the National Center for Health Statistics, the organization that advised the OECD on health statistics to be used in OECD reports, according to

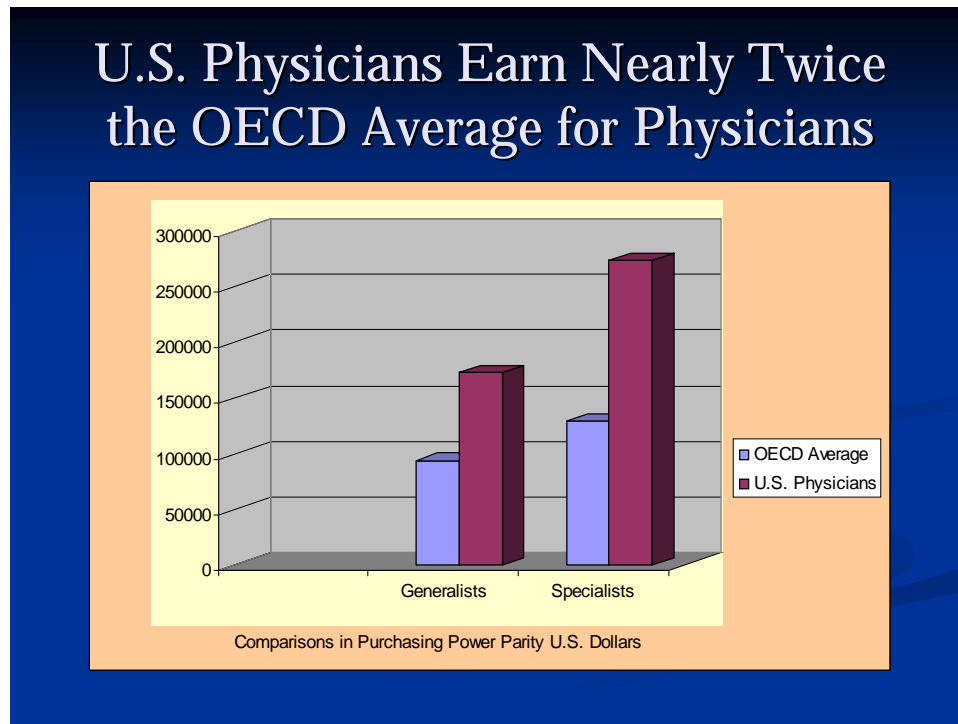
<sup>6</sup> Organization for Economic Cooperation and Development, *OECD Health Data 2006 Statistics and Indicators for 30 Countries* (Paris: OECD, October 2006). Table for general practitioners: <http://www.ecosante.org/OCDEENG/71.html>.

<sup>7</sup> Ibid.

<sup>8</sup> Ibid. Table for specialists: <http://www.ecosante.org/OCDEENG/72.html>.

<sup>9</sup> *2001 Patient Care Physician Survey, Physician Socioeconomic Statistics*. (Chicago: American Medical Association, 2003).

Gaetan Lafortune,<sup>10</sup> one of the authors of the data book containing the comparisons on physician remuneration. The AMA/OECD data are cited in a study<sup>11</sup> released early this year by McKinsey Global Institute.



The McKinsey Global Institute study put together a composite number for U.S. generalists at \$173,000 and U.S. specialists at \$274,000,<sup>12</sup> blending salaried and self-employed physicians together in each of the two categories.<sup>13</sup> Then, the McKinsey Global

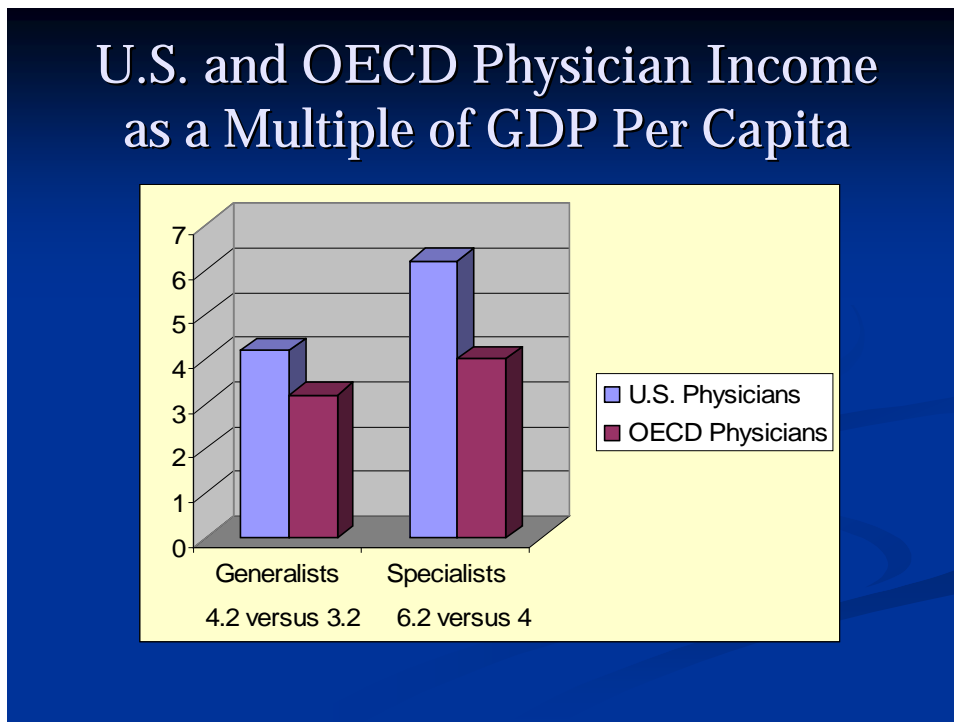
<sup>10</sup> Email correspondence received from Gaetan Lafortune on March 7, 2007.

<sup>11</sup> Carlos Angrisano, Diana Farrell, Bob Kocher, Martha Laboissiere, Sara Parker, Accounting for the Cost of Health Care in the United States (San Francisco: McKinsey Global Institute, January 2007).

<sup>12</sup> Angrisano et al, Exhibit 35, p. 54

<sup>13</sup> In response to an inquiry, Angrisano et al authors Robert Kocher, Sara Parker and Martha Laboissiere explained June 1, 2007, how the McKinsey Global Institute arrived at its numbers for physician salaries for U.S. generalists and specialists. Their explanation follows. The OECD Health Database does not have comparable raw dollar values for physician salaries between major countries for a single year, but rather the ratio of physician salaries to GDP per capita for 2003 only. The McKinsey Global Institute calculated its average U.S. salary for specialists (\$274,000) and generalists (\$173,000) for 2005 by starting first with the 2003 OECD ratio of physician salary to the 2005 GDP per capita on a US\$ purchasing power parity from the International Monetary Fund. The physician ratios have remained fairly static over time, so the authors felt comfortable with using the 2003 ratio on 2005 data. For specialists, the ratio was 6.63. If you multiply 6.63 times the U.S. GDP per capita in 2005, which is \$41,399, one arrives at a total of \$274,475. For generalists, the ratio is 4.18, which gives a predicted salary of \$173,048. These numbers are higher than the OECD raw numbers – generalist salaries and generalist self-employed and specialist salaries and specialist self-employed – from 2001 (based on the American Medical Association survey). If one calculated physician salaries using the GDP per capita in 2003 (and not 2005), U.S. physician specialist salaries would be \$249,673, \$20,173 higher than the raw income data for self-employed specialists from 2001. It would be \$157,410 for all generalists, \$3,210 higher than the self-employed salary from the 2001. The discrepancies between the raw numbers and the ratio-based numbers are all found within the OECD Health Database. They are probably explained by different definitions of salary. As a double check to its numbers, McKinsey

Institute study calculated numbers for 12 other OECD countries<sup>14</sup>, based on surveys done within those nations. The authors blended an average from the number of salaried and self-employed workers for OECD, using the data available from several countries for 2003 and comparing that with U.S. data from 2001. The found that the average OECD salary for generalists was \$94,000 and the average for specialists was \$129,000.<sup>15</sup> The dollar numbers represent the conversion of compensation from various national currencies to purchase power parity U.S. dollars. These pay levels represent 3.2 times per capita GDP for generalists and 4 times per capita GDP for specialists. The U.S. compensation levels, however, represent 4.2 times GDP per capita for generalists and 6.5 times per capita GDP for specialists.



This comparison shows that even when one compensates for the fact that U.S. incomes for all workers are significantly higher than those of the rest of the OECD, when measured in purchase power parity U.S. dollars, the compensation of U.S. physicians is still higher on a per capita GDP basis. This also suggests that even compensating for the fact that wealthier societies are going to spend more on health care, which is perhaps the

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Global Institute examined the data from the Occupational Employment Survey data from the U.S. Bureau of Labor Statistics and calculated employment-weighted salaries using occupation-level employment and salary data. Using this approach for 2005, Angrisano et al calculated an average \$268,000 for specialists (\$6,000 lower than its estimated calculated by the ratio approach) and \$167,000 for generalists (also \$6,000 lower). In summary, two independent calculations of incomes are fairly close, while the raw numbers are clearly too low.

<sup>14</sup> Netherlands, Belgium, Canada, France, Switzerland, New Zealand, Portugal, Denmark, Germany, Finland, Sweden, and Norway. There were no data separately for generalists in New Zealand and Norway.

<sup>15</sup> Angrisano et al, Exhibit 35, p. 54.

ultimate luxury, that compensation levels of U.S. physicians are still higher than any theoretical wealth effect might suggest.

The impact of higher U.S. physician compensation on overall health care spending compared to other OECD countries does not appear to be affected by the share U.S. physicians who are specialists. That's because the United States does not, in fact, have a higher level of specialists than do other OECD countries. Indeed the mix in the United States, 64 percent to 35 percent, was the same distribution found in the other OECD countries in the comparison. McKinsey Global Institute relied on the 2001 AMA survey numbers for the distribution of 434,000 specialists and 244,000 generalists in the United States. Using the numbers and averages in the McKinsey Global Institute study, one can estimate that the total amount spent on physician salaries in the United States as follows: \$118.916 billion for specialists and \$42.212 billion for generalists, or \$160.828 billion for all physicians combined. By McKinsey Global Institute's calculations, the higher physician pay as a share of GDP per capita adds an additional \$58 billion to the annual costs of health care in the United States.<sup>16</sup>

### **Higher Liability and Education Costs**

There are two important areas where U.S. physicians face higher costs than do physicians in other OECD countries and which require some scrutiny. One is the cost of liability insurance for malpractice and the other is the high cost of a medical school education. In many OECD countries the cost of medical school is paid by the government, while no other OECD country has the level of litigiousness that is prevalent in the United States.

The McKinsey Global Institute calculates that U.S. physicians pay an average of \$27,500 a year in malpractice insurance. With an estimated 700,000 doctors in practice, this amounts to about \$20 billion in insurance costs.<sup>17</sup> The higher overall U.S. average compensation for all types of physicians is based on income after paying for malpractice and all other expenses. So, the higher malpractice insurance has already been taken into account and, thus, the averages remain as they are. There is, of course, a higher cost for medical care as a result. Indeed, the additional cost to medical care posed by the litigious environment found in the United States and reflected in insurance premiums includes an estimated \$28 billion in defensive medicine through excess tests and procedures, according to the Office of Management and Budget.<sup>18</sup> If one adds the cost of defensive medicine to the cost of malpractice insurance, one arrives at an estimate of \$48 billion in additional costs to the U.S. health care system that can be attributed to the litigious environment in the United States.

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<sup>16</sup> Agrisano et al, p. 52.

<sup>17</sup> Agrisano et al, p. 18.

<sup>18</sup> Office of Management and Budget, Statement of Administration Policy on H.R. 5 – Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2005 (Rep. Gingrey (R) GA and Smith (R) TX), July 28, 2005. Statement can be found at <http://www.whitehouse.gov/omb/legislative/sap/109-1/hr5sap-h.pdf>.

The high cost of malpractice insurance does have an effect on the income of some groups of doctors where the fee-for-service reimbursement is not sufficient to offset the higher costs of medical malpractice associated with their practice. Obstetrics and gynecology (OB-GYN) physicians are one of the groups hardest hit with high malpractice insurance costs and who are also sometimes unable to recover those costs sufficiently from fees. Insurance is regulated and priced on a state basis and variations in state laws and demographics can lead to sharply higher liability premiums in some states. For example, medical malpractice crisis states such as Nevada, Pennsylvania, and Florida had malpractice premiums for OB-GYN physicians ranging from just under \$70,000 to \$135,000 in 2002, while non-crisis states had premiums ranging from \$25,000 to \$50,000, according to a study by the Robert Wood Johnson Foundation.<sup>19</sup> Thus, it is fair to say that for some physicians, medical malpractice insurance can significantly reduce their net compensation.

If one looks at the cost and length of study required to become a physician, one finds that once employed, physicians are better placed to pay off their educational debts than other professionals, according to the McKinsey Global Institute.<sup>20</sup> For example, a law degree requires eight years counting an undergraduate degree and law school, and law school graduates have \$96,000 in debt while the average annual lifetime earnings of an attorney is \$96,000. On the other hand, primary care physicians have 8 years of education and 3 plus years of residency and have a lifetime average annual earnings of \$167,000 and \$137,000 in debt. Thus, the average annual earnings are higher than the debt accumulated for a medical education. Physician specialists, who have 4 to 8 years of residency on top of their 8 years of education, can be expected to have a lifetime average annual earnings of \$268,000, a sum far above their average debt of \$137,000.<sup>21</sup>

### **The Outlook for Physician Earnings**

Physician recruiters operate on the forefront of the trends that affect physician compensation, and physician recruitment itself is a big business. Merritt, Hawkins & Associates of Irving, Texas, is one of the major recruiters and does periodic surveys of physician recruitment incentives, as well as surveys of career opportunities, financial goals and practice projections of primary care physicians. In a survey of 2,840 physicians between April 1, 2005 and March 31, 2006, the recruiting firm asked physicians about their recruitment offers. The average offer for internal medicine was \$162,000, with a low of \$130,000 and a high of \$250,000. For specialists, however, the offers were much higher. Radiologists, for example, were offered an average of \$351,000, with a low of \$240,000 and a high of \$500,000. Orthopedic surgeons topped the charts with an average offer of \$370,000, with a low of \$250,000 and a high of \$515,000. Not surprisingly, cardiologists received offers among the highest, with an average of \$342,000, a low of \$175,000, and a high of \$500,000. Gastroenterologists also garnered some of the highest

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<sup>19</sup> Michelle M. Mello, "Understanding Medical Malpractice: A Primer," Research Synthesis Report No. 8, Robert Wood Johnson Foundation, January 2006, p. 3.

<sup>20</sup> Agrisano et al, p. 52 and Exhibit 38, p. 55.

<sup>21</sup> Ibid.

pay offers: an average of \$315,000, with a low of \$175,000 and a high of \$500,000. Average offers topped \$300,000 for urologists and anesthesiologists.

While the compensation offers for specialists are shockingly high for those who are unfamiliar with what physicians make today, the real news is that there is growing demand for primary care physicians and income offers are rising for them, while the level of income offered specialists is flat at the current high levels, according to Merritt, Hawkins & Associates. In this regard, the recruiting firm noted in its report on recruitment offers, it's a case of "déjà vu all over again," borrowing the famous line from Yogi Berra,<sup>22</sup> meaning that primary care physicians are back in strong demand again. Demand for primary care physicians, strong in the early 1990s began to plateau in 1996. The slack in demand came even as medical schools were graduating more primary care physicians in response to demand for gatekeepers for managed care. Patients, however, rebelled against managed care and this, in turn, reduced demand for primary care physicians.

The excess supply of primary care physicians dampened income offers (and incomes, for that matter). Meanwhile, students studying to become physicians began to choose medical specialties in response to a rising demand for specialists, and a new supply of specialists poured out of medical schools to meet the ever growing demand for specialists, especially between 2000 and 2005, according to Merritt Hawkins.

Now, however, demand for primary care physicians is strong and is likely to increase due a shortage of new supply of doctors who have chosen to go into primary care. Meanwhile, the demand for specialists shows no sign of weakening either. The demand for medical services is so great that "most doctors are as busy as they want to be and able to cherry pick patients. Some don't even take insurance," says Phil Miller, vice president at Merritt, Hawkins. There are other trends that point to a shortage, he says. "Doctors are refusing to cover emergency departments," he said, in a departure from past practice, where new physicians starting out volunteered to cover emergency as a way to build up their practice. Hospitals are paying orthopedic surgeons a \$1,000 a day to be on call, Miller says.

The Association of American Medical Colleges reported a 2.2 percent increase in enrollees in medical colleges last fall for a total of 17,400 medical students.<sup>23</sup> Medical schools are expanding enrollments to meet future demand, according the association's Division of Medical School Services and Studies, which annually compiles the applicant and enrollment figures. At the current growth levels, the ratio of physicians to the population will peak in 2015, according to the association. This will be one year before the first of the baby boom population turns 70. The association has recommended a 30 percent increase in total medical school enrollment over the next decade to meet the expected demand.

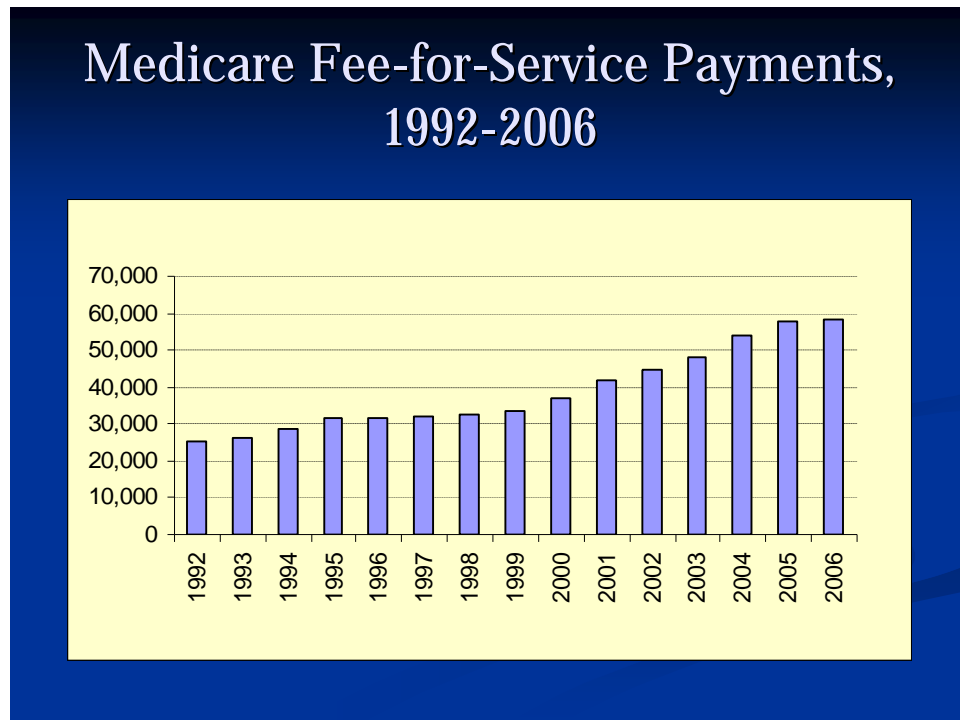
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<sup>22</sup> Merritt, Hawkins & Associates, "Summary Report: 2006 Review of Physician Recruitment Incentives" (Irving, Texas: MHA, 2006).

<sup>23</sup> *AAMC Reporter*, "Medical School Enrollment Rises," November 2206.  
<http://www.aamc.org/newsroom/reporter/nov06/enrollment.htm>

## Fee-for-Service Reimbursement Trends

The role of fee-for-service is paramount in the world of physician compensation. Not only does Medicare base its reimbursement on a detailed list of services and fees, but private insurers tend to build their fee structure on top of that and also operate on a fee-for-service basis. Thus, the trend line in fee-for-service reimbursement is a fundamental indicator of where physician compensation is headed and, ultimately, where overall medical costs are headed.



Medicare spending on physician fee-for-service reimbursement has been rising sharply since 1999, reflecting many of the factors that are driving up overall spending on physician compensation. According to the 2007 annual report of the Boards of Trustees of the Medicare trust funds, Medicare fee-for-service spending growth rates began to accelerate in 2000, rising to \$36.936 billion from \$33.348 billion in the prior year.<sup>24</sup> In 2005, the total had jumped 73 percent over the level in 1999, rising to \$57.740 billion.<sup>25</sup> In 2006, spending rose only modestly to \$58.351 billion.<sup>26</sup>

The dramatic increases in recent years in physician fee-for-service expenditures has led the Medicare Payment Advisory Commission (MedPAC) to conclude that current

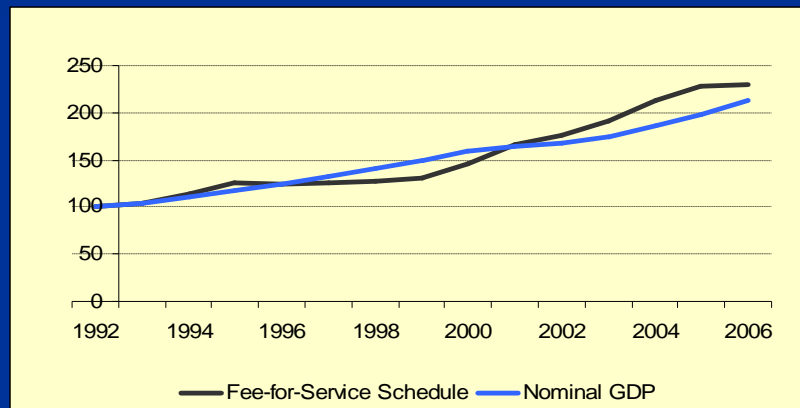
<sup>24</sup> Centers for Medicare and Medicaid Services, *2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, (Washington, D.C.: CMS, March 26, 2002), Table III.B7 – Aggregate Reimbursement Amounts on a Cash Basis, p. 121.

<sup>25</sup> Centers for Medicare and Medicaid Services, *2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, (Washington, D.C.: CMS, April 23, 2007), Table III-BY – Aggregate Reimbursement Amounts on a Cash Basis, p. 151.

<sup>26</sup> Ibid.

price targets cannot contain spending and to question whether or not any spending targets can accomplish this goal. Medicare employs an expenditure targeting system known as the Sustainable Growth Rate (SGR) system. Medicare payments for various procedures and services by doctors have long guided the price for which consumers and insurers pay for those services. SGR is tied to growth in the gross domestic product. Yet for years, physician fee-for-service spending has grown much faster than GDP, following a period in the mid 1990s when it grew slower. As the SGR began to falter, MedPAC was asked by Congress in 2005 to examine alternative mechanisms to the SGR for establishing expenditure targets.

## After Moderating in the Late 1990s Physician Fees Have Grown Faster Than Per Capita GDP



After completing its review, MedPAC's members were unable to reach consensus on an alternative expenditure target system. They did agree in their 216-page report<sup>27</sup> released in early March, however, on the need to take steps to curb rising costs. "Slowing the increase in Medicare outlays is important; indeed, it is becoming urgent," Glenn Hackbarth, Chairman of MedPAC testified before a Congressional committee in March.<sup>28</sup> While the commission agreed that SGR is not working, it could not agree on another approach to control costs. Instead, the members offered Congress two options. One recommendation is for Congress to repeal the SGR system entirely because it is so flawed it may even encourage spending rather than curtailing it. "It does little to counter the

<sup>27</sup> Medical Payment Advisory Commission, *Report to Congress: Assessing Alternatives to the Sustainable Growth Rate System* (Washington, D.C.: MedPAC, March 2007). The report is posted on the MedPAC web site: [http://www.medpac.gov/publications/generic\\_report\\_display.cfm?report\\_type\\_id=1&sid=2&subid=0](http://www.medpac.gov/publications/generic_report_display.cfm?report_type_id=1&sid=2&subid=0).

<sup>28</sup> Glenn M. Hackbarth, "Assessing Alternatives to the Sustainable Growth Rate System," testimony before the Subcommittee on Health Committee on Energy and Commerce, U.S. House of Representatives, March 6, 2007. Pdf, p. 1.

inherently inflationary nature of the fee-for-service payment,” testified Hackbarth in March.<sup>29</sup>

The second choice is to have Congress authorize the acceleration of the development and adoption of new approaches for improving incentives for physicians and other providers to furnish higher quality care at a lower cost. This would mean creating a new regime for target expenditures. The commission members who supported this approach, while admitting expenditure targets have not worked, believed that they remind Congress of the need to constantly review and assess costs in the Medicare program and, thus, may help to contain costs.

If one looks carefully at the MedPAC report, however, one can only conclude that the SGR system has been a spectacular failure, ultimately driving up medical costs instead of restraining them. The current SGR expenditure target system was adopted by Congress in the Balanced Budget Act of 1997. It replaced the volume performance standard (VPS) that linked physician fee payments to the aggregate growth in the number and mix of services. “Over time, however, the VPS began to set unrealistically stringent spending targets,” the MedPAC report concluded, and in response, Congress replaced it.<sup>30</sup>

The SGR expenditure target was created to incorporate what were thought to be the factors that affect the volume of physician services: inflation in physicians’ practice costs, changes in enrollment in fee-for-schedule Medicare, and changes in spending due to law and regulations. In addition, the SGR allows for growth above these factors based on growth in the gross domestic product per capita. This additional factor “is used as a benchmark for how much additional growth in expenditure society can afford,” the MedPAC report states. The SGR calculates how much the expenditure targets can increase each year.

For 2007 the SGR is 1.8 percent. Thus, it increases the spending target for fee-for-service from \$81.8 billion to \$83.3 billion. It is also a cumulative number based on expenditures going back to 1996. So, if expenses run ahead one year, the Centers for Medicare and Medicaid Services has to compare actual spending in the Medicare Economic Index with the targets and adjust the target each year. After 2001, however, the difference between the allowed expenditure target and actual spending went negative, meaning that there could be no increases in spending and that there should, in fact, be cuts in the fee-for-service schedule. The SGR has been negative every year since 2001. In 2006 the difference between the allowed expenditure target and the actual spending had reached \$41.9 billion. If the entire adjustment had to be made up in 2007, the target would be 25 percent below the Medicare Economic Index – or required a spending reduction of 22.9 percent.<sup>31</sup>

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<sup>29</sup> Ibid, p. 4.

<sup>30</sup> Med PAC, *Report to Congress: Assessing Alternatives to the Sustainable Growth Rate System*, p. 11.

<sup>31</sup> Ibid, p. 12.

In response to the failure of SGR to rein in overall costs, each year Congress has over-riden the necessary adjustment that would need to be made in Medicare spending. Since negative adjustments can only be made at rate of minus 5 percent a year, the Congressional Budget Office has calculated it would require 5 percent reductions in fee-for-service expenditures well into the next decade.<sup>32</sup>

### **Cost Controls on Physician Fees Generate Higher Volume**

The MedPAC report offers several hard conclusions. “The SGR has several flaws. It is inequitable, treating all providers – regardless of their behavior – and all regions of the country alike,” the MedPAC report states.<sup>33</sup> “In addition, the SGR does nothing to counter the inherently inflationary nature of FFS [for-for-service] payment. Further, in recent years volume has grown substantially, suggesting that the SGR is not an effective control.”<sup>34</sup> In other words, physicians are increasing the volume of procedures and services under the fee schedule designated by Medicare at a faster rate than all the factors Congress has determined should cover all the contingencies that one would expect to affect growth in spending on physician fees.

The volume of physician services rose 5.5 percent per beneficiary a year in 2004 and 2005. Per capita volume in imaging is the leader in volume growth, increasing 10.3 percent annually between 2000 and 2004 and 8.7 percent 2004 and 2005. There was a slower 3.8 percent growth per year for major procedures, including cardiovascular procedures, knee replacement, hip fracture replacement and others. Yet, given the cost of these procedures, this steady growth is costly. The category known as “other procedures,” which includes minor procedures, such as radiation therapy or colonoscopy, among others, rose 6.4 percent between 2004 and 2005, and 8.5 percent between 2000 and 2004.

The latest trends are nothing new to the Medicare program. A study<sup>35</sup> of Medicare spending by Thorpe and Howard found that the number of conditions treated per beneficiary rose between 1987 and 2002. By 2002, more than half of Medicare beneficiaries were being treated for five or more conditions. In 1987 only 31 percent of beneficiaries were treated for five or more conditions. Citing this study, MedPAC concluded: “It is not just the presence of these conditions that has led to the growth in volume but also more aggressive and intensive treatment of them than ever before.”<sup>36</sup>

MedPAC raised the question of whether or not the increased volume is improving the health and well being of Medicare beneficiaries and find the question difficult to

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<sup>32</sup> Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2008 to 2017* (Washington, D.C.: CBO, January 2007).

<sup>33</sup> Med PAC, *Assessing Alternatives to the Sustainable Growth Rate System*, p. 13.

<sup>34</sup> Ibid.

<sup>35</sup> Kevin E. Thorpe and David H. Howard, “The Rise in Spending among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity,” *Health Affairs Web Exclusive* (August 22, 2006):w378-w388. <http://www.healthaffairs.org>.

<sup>36</sup> Ibid, p. 17.

answer clearly one way or another. The MedPAC report cites a study<sup>37</sup> by Thorpe et al that finds that for some conditions, such as heart disease and hypertension, the cost of therapy and more intensive use of services, explain most of the spending increase. The dominant influence in growth in spending appears to be an increase in the number of people being treated for certain conditions. A study<sup>38</sup> by Cutler and McClellan found that in some cases increased spending improves health outcomes, and that the benefit of the high cost technology outweighs the cost.

MedPAC concludes that one reason that it is hard to link volume growth with improved health outcomes is that the relationship between the two depends on where patients are in terms of a curve of diminishing returns on money spent on technology. In the early stages of technology advance for a particular condition, the benefit is greatly outweighed by the cost of the procedure or treatment. Later, however, as costs of medical technologies rise, the returns in terms of benefits diminishes and the cost-benefit curve flattens. The practice of what Fuchs calls “flat-of-the-curve medicine”<sup>39</sup> is appropriately open to question as to whether or not the benefit outweighs the cost. The diminishing returns can be seen in research that has found that regions of the country where physicians and hospitals deliver many more health care services do not experience better quality of life or health outcomes. Further, patients do not report greater satisfaction with their care, according to studies by Fischer et al.<sup>40, 41</sup>

Many physicians are keenly aware that the fee-for-schedule payment system needs to be reformed to put more emphasis on quality, reducing waste, and patient satisfaction. For example, the American College of Physicians, which represents 120,000 physician and student internists, called on Congress to redesign Medicare payment policies to provide incentives for patient-centered care in a statement provided for a Congressional hearing in March 2007.<sup>42</sup> According to the American College for Physicians, internists provide care for more Medicare patients than any other medical specialty.

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<sup>37</sup> Kevin E. Thorpe, Curtis S. Florence, and Peter Joski, “Which Medical Conditions Account for the Rise in Health Care spending?” *Health Affairs Web Exclusive* (August 25):w4-437 – w4-445. <http://www.healthaffairs.org>.

<sup>38</sup> David M. Cutler and Mark McClellan, “Is Technological Change in Medicine Worth It?” *Health Affairs* 20, no. 5 (September/October, 2001): 11-29.

<sup>39</sup> Victor R. Fuchs, “Perspective: More Variation in Use of Care, More Flat-of-the-Curve Medicine,” *Health Affairs Web Exclusive* (October 7, 2004): VAR104-107. <http://www.healthaffairs.org>.

<sup>40</sup> Elliot S. Fischer, David E. Wennberg, Thérèse A. Stuckel and Daniel Gottlieb, “The Implications in the Longitudinal Efficiency of Academic Medical Centers.” *Health Affairs Web Exclusive*\_(October 7): VAR19-12. <http://www.healthaffairs.org>.

<sup>41</sup> Elliot S. Fischer, David E. Wennberg, Thérèse A. Stuckel, Daniel Gottlieb, F. L. Lucas, and Étoile L. Pinder, “The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care,” *Annals of Internal Medicine* 138, no. 4 (February 18, 2003): 288-298.

<sup>42</sup> American College of Physicians, “Options To Improve Quality And Efficiency Among Medicare Physicians,” a statement prepared for a hearing by the House Committee on Ways and Means Subcommittee on Health. <http://www.medicalnewstoday.com/medicalnews.php?newsid=70611>

The American College of Physicians supports reforms to advance what it calls the Patient-Centered Medical Home,<sup>43</sup> a model of health-care delivery it claims can improve quality, provide more efficient use of resources, reduce utilization, and promote higher patient satisfaction. This approach is also supported by the American Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association. The four professional organizations represent 333,000 physicians and medical students. These organizations, along with employers representing 50 million workers, community health organizations, are part of the Patient-Centered Primary Care Collaborative.<sup>44</sup>

## Overutilization and Waste

When one looks at how the compensation of physicians affects overall medical spending, one can not just look at total remuneration, but on the spending that occurs in conjunction with that remuneration. Indeed, the decisions doctors make decide much of the overall cost of medicine in the United States. It is appropriate, then, to ask to what extent medicine influenced by factors that affect a doctor's income increase overutilization and waste. This subject is difficult to address because one can not really determine the motivation behind a medical decision and know for sure what considerations might have been the determining factor in any given instance.

Wasteful spending is the focus of a study by Sager and Socolar<sup>45</sup>, the Directors of the Health Reform Program at Boston University School of Public Health, who evaluated the 2003 data from the Centers for Medicare and Medicaid Services on health care costs and concluded that health care costs are "soaring unsustainably." If health care spending had stayed at the 13.2 percent<sup>46</sup> of GDP level of 2000, health care would have consumed

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<sup>43</sup> According to the American College of Physicians, a Patient-Centered Health Medical home is a physician practice that has gone through a voluntary qualification process to demonstrate that it:

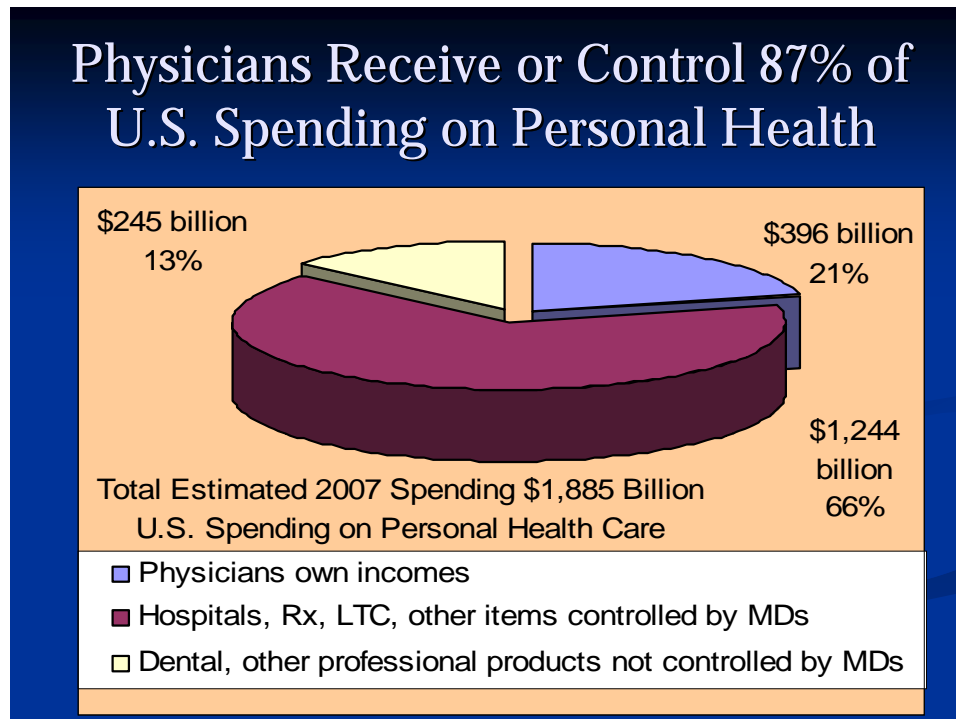
- \* Provides continuous access to a personal primary or principal care physician who accepts responsibility for treating and managing care for the whole patient through an a patient-centered medical home, rather than limiting practice to a single disease condition, organ system, or procedure,
- \* Supports the specific characteristics of care that the evidence shows result in the best possible outcomes for patients.
- \* Recognizes the importance of implementing systems-based approaches that will enable physicians and other clinicians to manage care, in partnership with their patients, and to engage in continuous quality improvement,
- \* Introduces transparency in consumer decision-making and accountability for getting better results by reporting on evidence-based quality, cost and patient experience measures of care.

<sup>44</sup> The Patient-Centered Primary Care Collaborative includes employers that collectively employ more than 50 million Americans, primary care organizations that represent the physicians that provide primary care to the vast majority of Americans, and federally-funded community health centers that provide care to millions of low-income patients. Representatives of consumer organizations have been participating in the Collaborative's ongoing discussions and are expected to endorse and join the Collaborative in the near future.

<sup>45</sup> Alan Sager and Deborah Socolar, "Health Costs Absorb One-Quarter of Economic Growth, 2000-2005" (Boston: Health Reform Program, Boston University School of Public Health), February 9, 2005,

<sup>46</sup> Health care spending in 2000 was originally reported to be 13.2 percent of GDP. Later revisions, however, raised the calculation to 13.8 percent.

\$621 billion less between 2000 and 2005, the authors found. Put another way, the rising share of GDP attributed to health care spending accounts for one-fourth of the nation's \$2,579 billion in economic growth between 2000 and 2005. Sager and Socolar contend that the costs are soaring because all attempts at health care cost control have utterly failed.



Sager and Socolar point to data, such as the OECD numbers cited earlier in this report, to argue that the United States is spending twice as much as other industrial nations, such as Canada, France, Germany, Italy, Japan and the United Kingdom. “Yet these other nations cover all their people and enjoy superior outcomes,” they write, citing OECD data on life expectancy and infant mortality rates. From these two broad observations, they argue that “some one-half of current health spending is wasted . . . [and] traditional wholesale cost controls have failed”<sup>47</sup> They also predict that “the current crop of market-oriented efforts to de-insure patients and make them pay more out-of-pocket will also fail to squeeze out meaningful shares of this waste.”<sup>48</sup> The authors make this conclusion based partly on their analysis of the 2003 health care data that also found that physicians either receive or control 87 percent of total U.S. spending on personal health, which in turn is 83 percent of total national health care expenditures reported by CMS. For 2007, spending on personal health care is projected to reach \$1,885 billion out of the \$2,262 billion. The lower number, \$1,885 billion, excludes research, construction, government public health activities, the net cost of private health insurance, and the cost of administering Medicare and Medicaid. Sager and Socolar break down total spending on personal health into three broad categories. The first is physicians’ own incomes, 21

<sup>47</sup> Ibid, p.15.

<sup>48</sup> Ibid.

percent. The next category includes hospital, prescription, long-term care, and other items controlled by MD's, 66 percent. Finally, there are dental, and other professional products not controlled by MD's, 13 percent. (See nearby chart.)

Sager and Socolar identify four types of health care waste: theft and program fraud, excess prices, administration, and unnecessary or incompetent clinical service. They contend that none of these four areas of waste will respond to either traditional wholesale cost controls or market-based controls that increase deductibles and co-pays for patients. "Caretakers have shown they can game such cost controls. If a [particular type of] cost control squeezes revenue in one way, caregivers discover ways to replace the lost money," Sager and Socolar write.<sup>49</sup> "When insurers cut prices paid for each physician visit, physicians often seek to provide more visits, thereby generating the target revenues they consider appropriate," they state. "It's helpful to appreciate how much latitude physicians have about how much care to provide." The authors cite as an example the fact that surgeons in regions with more surgeons per thousand people regularly perform more surgeries per thousand people.

Sager and Socolar suggest that policy analysts who want to improve medical care and keep costs in line need to look at the different categories and analyze them separately, as each is affected by different factors. Unnecessary and incompetent clinical service is the category where the most waste is occurring, according to the authors. Wasteful spending in this category "stems partly from lack of evidence about what care works to diagnose or treat an illness, uneven use of existing evidence, dissemination of inaccurate or misleading information by self-interested parties, incompetence or impairment of a relatively small share of caregivers, financial incentives to over- or under-serve associated with various methods of payment, excessively self-interested behavior by some caregivers, defensive medicine spurred by fear of malpractice litigation, demands by some patients for unnecessary care, and the like."<sup>50</sup>

A recently-concluded landmark clinical trial of patients with heart disease has found that most angioplasties are unnecessary. The startling results of the clinical trial by Boden et al were published in April 2007.<sup>51</sup> The team of doctors who conducted the trial – dubbed COURAGE for Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation – conducted a randomized trial of 2,287 patients with evidence of myocardial ischemia and significant coronary artery disease at 50 U.S. and Canadian centers. Between 1999 and 2004, the team assigned 1,149 patients to undergo percutaneous coronary intervention (PCI) or angioplasties<sup>52</sup> with optimal medical therapy

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<sup>49</sup> Ibid.

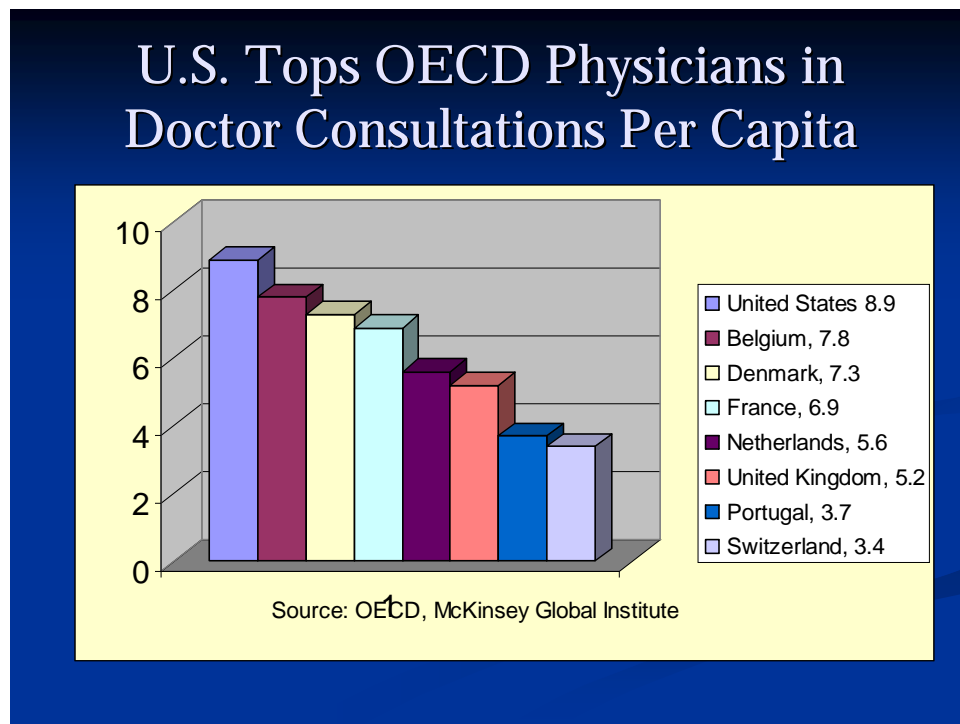
<sup>50</sup> Ibid, p. 18

<sup>51</sup> William E. Boden, Robert A. O'Rourke, Koon K. Teo, Pamela M. Hartigan, David J. Maron, William J. Kostuk, Merrill Knudtson, Marcin Dada, Paul Casperson, Crystal L. Harris, Bernard R. Chaitman, Leslee Shaw, Gilbert Gosselin, Shah Nawaz, Lawrence M. Title, Gerald Gau, Alvin S. Blaustein, David C. Booth, Eric R. Bates, John A. Spertus, Daniel S. Berman, John Mancini, William S. Weintraub, for the COURAGE Trial Research Group. "Optimal Medical Therapy with or without PCI for Stable Coronary Disease," *New England Journal of Medicine*, vol. 356 no. 15:1503-1516, April 17, 2007.

<sup>52</sup> When doctors do an angioplasty, they snake a tube through a blood vessel in the groin to a blocked heart artery. A tiny balloon is inflated to flatten the clog and a mesh scaffold stent is usually placed in the vessel.

while 1,138 patients were assigned to receive optimal medical therapy alone.<sup>53</sup> The primary outcome was death from any cause and nonfatal myocardial infarction or heart attack during a follow-up period of 2.5 to 7.0 years. When the trial was concluded, researchers reported a total of 211 primary events (death or heart attack) in the PCI. This represents a primary event rate of 19 percent. In the medical therapy only group there were 202 primary events with an event rate of 18.5 percent. So, angioplasty basically did nothing to save lives or prevent heart attacks. Even the researchers were surprised. “Few would have expected such results,” said Dr. William Boden of Buffalo Hospital in New York, the lead investigator, as a press conference called to announced the results.

There are about 1.2 million angioplasties done in the United States each year and the procedure costs between \$30,000 and \$40,000,<sup>54</sup> or \$36 billion to \$48 billion on total spending on these procedures.



## Productivity and Physician Earnings

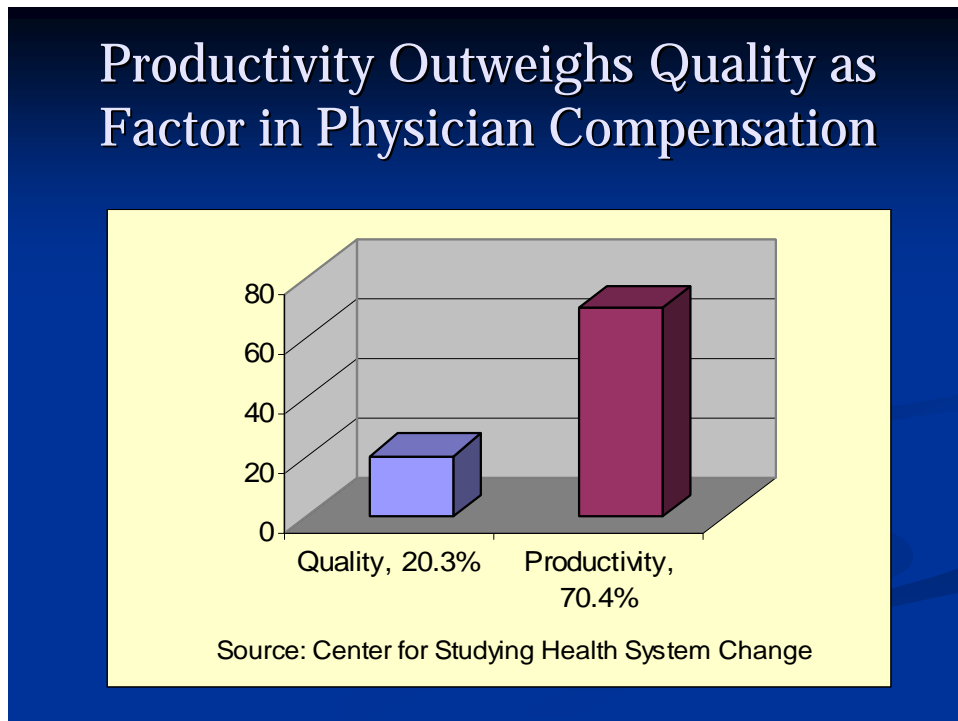
If one is looking for a link between physician decisions and physician income, the most apparent direct link is productivity-based compensation, which affects both self-

<sup>53</sup> The medical therapies included medicines to relieve chest pain and improve artery health, such as aspirin, cholesterol-lowering statins, nitrates, ACE inhibitors, beta-blockers and calcium channel blockers. All patients were also counseled on healthy lifestyles, including diet, exercise and smoking cessation.

<sup>54</sup> Associated Press, “Study: Most Angioplasties Unnecessary,” March 26, 2007. Website: <http://www.msnbc.msn.com/id/17800298>.

employed and salaried physicians.<sup>55</sup> A focus on productivity translates into physicians seeing more patients and recommending more procedures that pay them a fee. Indeed, international comparisons suggest U.S. physicians need to be more productive. There are 2.4 physicians per 1,000 population in the United States, somewhat less than the average of 3.0 physicians per capita for other OECD countries in 2004.<sup>56</sup>

According to an analysis of OECD data by the McKinsey Global Institute, the United States has a much higher rate of doctor consultations than other OECD countries.<sup>57</sup> In 2002, the consultation rate was 8.9 per capita, compared to 7.8 in Belgium, 7.3 in Denmark, 6.9 in France, 5.6 in the Netherlands, 5.2 in the United Kingdom, 3.7 percent in Portugal and 3.4 in Switzerland.



Physician compensation in the United States is, in fact, tied decidedly more to productivity than to quality in group practice,<sup>58</sup> according to the findings of national study<sup>59</sup> released in January 2007 by the Center for Studying Health System Change. About 6,600 physicians responded to the center's 2004-2005 Community Tracking Study

<sup>55</sup> Salaried physicians are affected because the organization that pays their salaries earns more in fee-for-service income, based on the productivity of its physicians. The level of salaries is set with an expectation about the level of services each physician will provide to earn that salary, even at non-profit organizations.

<sup>56</sup> *OECD Health Data 2006*

<sup>57</sup> Agrisano et al, Exhibit 39, page 56.

<sup>58</sup> The Community Tracking Study Physician Survey of 2004 and 2005 compensation did not ask full owners of solo practices about productivity.

<sup>59</sup> Findings of the Community Tracking Physician Survey of 2004 and 2005 are reported in the following: James Reschovsky and Jack Hadley, "Physician Financial Incentives: Use of Quality Incentives Inches Up, But Productivity Still Dominates," Issue Brief No. 108 (Washington, D.C.: Center for Studying Health System Change, January 2007)

Physician Survey. The survey found that 70.4 percent of physicians in group practice report that productivity incentives are a factor in their compensation. Productivity was a “very important” factor for 51.8 percent of the physicians. By comparison, 20.3 percent of the physicians in group practice reported quality as a financial incentive in their compensation. This represents a small, but significant increase over the prior physician survey of 2000-2001, which found that 17.6 percent of physicians in group practice reported that their compensation is tied to productivity incentives. “Physician practices’ heavy reliance on productivity-based compensation, which reflects the dominant fee-for-service reimbursement system used by payers, likely increases the cost of care by encouraging the provision of more services to patients,” concludes Paul S. Ginsburg, president of the Center for Studying Health System Change.<sup>60</sup>

Even without the benefit of the survey of physicians, one need only ponder the fact that physicians are compensated on a fee-for-service basis to understand why the very design of the system might tend to encourage overutilization and waste, unless there are factors affecting compensation that would help balance out the impact of the hard economic fact that more consultations, more tests and more procedures can increase a physician’s compensation. If one looks at international comparisons, U.S. physicians do more procedures, as well as more costly procedures, than are done by physicians in other countries.<sup>61, 62</sup> “The fee-for-service reimbursement system creates an incentive for physicians to see more patients,” concludes a report by the McKinsey Global Institute.<sup>63</sup> “This is magnified by physician co-ownership of [outpatient] facilities, which offers a strong incentive to self refer cases – physicians who own imaging equipment refer between two and eight times more tests than their peers without equity interest,” the report states.

Physicians in the United States who are paid on a fee-per-service basis must aggressively recruit patients, according to a study by Aaron.<sup>64</sup> The study notes that coronary artery disease causes more deaths than any other illness in both the United States and Great Britain. Yet, Aaron notes, the most common surgical treatments for heart disease – coronary bypass and angioplasty – are performed four times more often in the United States than in Great Britain.<sup>65</sup> Meanwhile, mortality rates from heart disease, once higher in the United States, are now lower than in Great Britain. In 2002, there were 515,000 coronary by-passes in the United States costing an estimated \$60,853 per patient. That accounts for \$31.3 billion in health care expenditures a year.

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<sup>60</sup> *Health & Medicine Week*, “Study: Physician Compensation Tied More to Productivity Than Quality,” published by the American Society for Quality, January 22, 2007.

<http://www.asq.org/qualitynews/qnt/execute/displaySetup?newsID=1009>

<sup>61</sup> William J. Lynk and Carina S. Longley, “The Effect of Physician-Owned Surgicenters on Hospital Outpatient Surgery,” *Health Affairs* (Millwood), 2002. 21(4): p. 215-221.

<sup>62</sup> Alain C. Enthoven and Laura A. Tollen, Competition in Health Care: It Takes Systems to Pursue Quality and Efficiency. *Health Affairs* (Millwood), 2005.

<sup>63</sup> Agrisano et al, p. 18.

<sup>64</sup> Henry J. Aaron, “Treatment of Coronary Artery Disease: What Does Rationing Do?” The Brookings Institution Policy Brief, 2005. No. 48 (December 2006)

<sup>65</sup> *Ibid*, p. 3.

Aaron explores whether or not the higher rate of coronary bypasses makes any difference to the health of Americans who receive them. One can, he notes, find clear evidence that advanced medical therapy, and particularly the coronary bypass, has contributed to the decline in mortality from coronary disease. Yet, Aaron adds, “the timing and introduction and rates of use of these therapies are poorly correlated with changes in mortality rates.” Coronary mortality rates fell faster in the United Kingdom than in the United States from 1988 to 2000, despite lower use of modern medical techniques. This “supports the view of British physicians that although Britain uses advanced technology too little, the United States may be using it too much,” Aaron writes.<sup>66</sup> “It is also consistent with findings that U.S. physicians neglect low-cost interventions, such as prescribing aspirin and beta-blockers, which can strongly influence mortality after heart attacks,” he adds.<sup>67</sup>

### **Referrals to Physician-Owned Hospitals**

In recent years a new phenomenon has strengthened and fortified the tie between physician incomes and the volume of tests, procedures and services they recommend or perform – and that is the rise of the physician-owned specialty outpatient centers and hospitals. These are hospitals often specializing in a single area, such as cardiac hospitals, and which have a large share of their equity held by the physicians who refer patients to the facility. The physician-owned hospitals generate two bills: one for physicians’ fees and the other for facility fees. The profits from the fees are shared among the physician owners. “This creates an incentive for physicians to treat patients in these locations particularly when they are co-owners and contributes to the fact the U.S. physicians’ compensation is higher than the OECD average,” according an analysis by the McKinsey Global Institute.<sup>68</sup>

The case against physician-ownership has gathered strength as more and more researchers have examined how the links may affect medical practice and costs and published their results. Mitchell examined the data from a large insurer in California to identify the level of self-referrals for advanced diagnostic imaging from 2005 billings. She found in her analysis,<sup>69</sup> which was published in April 2007, that a significant level of self-referral: 33 percent of providers who submitted bills for magnetic resonance imaging (MRI), 22 percent of those who submitted bills for computed tomography (CT) scans, and 17 percent of those who submitted bills for positron-emission tomography (PET) scans.

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<sup>66</sup> Ibid, p. 7.

<sup>67</sup> Ibid, p. 7.

<sup>68</sup> Agrisano et al, p. 51.

<sup>69</sup> Jean M. Mitchell, “The Prevalence of Physician Self-Referral Arrangements after Stark II: Evidence from Advanced Diagnostic Imaging,” Health Affairs Web Exclusive. 26.3w415.

<http://content.healthaffairs.org/cgi/content/full/hlthaff.26.3.w415v1/DC1>.

A study<sup>70</sup> by Nallamothu et al takes a look at the rate of coronary by-pass operations in a local population after a physician-owned hospital opens. The researchers examined the data on Medicare beneficiaries from 1995 to 2003 and calculated the annual population-based rates for total revascularizations, also known as coronary artery bypass graft (CABG), as well as all percutaneous coronary intervention (PCI), also known as angioplasty. Hospital referral regions were used to categorize health care markets into three types, (1) those where new cardiac hospitals opened; 13 markets, (2) new cardiac programs opened at general hospitals, 142 markets; and (3) no new programs opened, 151 markets. The researchers found that overall rates of change for total revascularization were higher in hospital referral regions after physician-owned cardiac hospitals opened when compared with regions where new cardiac programs opened at general hospitals and also higher than markets where no new programs were introduced. Four years after their opening, the relative increase was 19.2 percent for markets where new physician-owned cardiac hospitals opened, 6.5 percent for markets where new cardiac programs opened at general hospitals, and 7.4 percent for markets where there were no new programs.

The McKinsey Global Institute<sup>71</sup> has looked at how much additional cost is adding to overall health care expenditures with the growth of outpatient treatment centers, including ambulatory surgery centers, diagnostic imaging centers, drug rehabilitation clinics, dental services, mental health clinics, and non-physician offices. The McKinsey Global Institute researchers calculate that the United States spends \$1,678 per capita in outpatient care. This is \$178 billion higher than average for 13 OECD countries, based on McKinsey Global Institute's own measure known as estimated spending according to wealth or ESAW.<sup>72</sup> That is to say, the United States does not just spend more because it is wealthier, but even adjusting total spending to an wealth measure such as ESAW, the United States spends \$147 billion more than other OECD countries on outpatient surgery centers and diagnostic centers.<sup>73</sup> This additional spending represents 40 percent of the total \$371 billion excess in spending in the United States for hospital and outpatient care in the United States, taking into consideration the higher U.S. wealth effect. McKinsey Global Institute calculates that the \$224 billion in excess spending by hospital and outpatient centers combined breaks down as follows: \$100 billion in medical labor, \$75 billion in profits and \$49 billion in supplies.<sup>74</sup> Outpatient centers alone represent \$114 billion in excess spending, with \$33 billion of that on labor.<sup>75</sup>

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<sup>70</sup> Brahmajee K. Nallamothu, Mary A. M. Rogers, Michael E. Chernew, Harlan M. Krumholz, Kim A. Eagle, John D. Birkmeyer, "Opening of Specialty Cardiac Hospitals and Use of Coronary Revascularization in Medicare Beneficiaries," *Journal of the American Medical Association* vol. 297.no. 9 (March 7, 2007): 962-968.

<sup>71</sup> Agrisano et al, p. 33-44

<sup>72</sup> Agrisano et al, p. 10

<sup>73</sup> Agrisano et al, p. 33.

<sup>74</sup> Agrisano et al, p. 35.

<sup>75</sup> Global McKinsey Institute, answer to follow-up question on study, obtained by email May 1, 2007.

## Congress and Physician-Owned Specialty Hospitals

In 2003 Congress asked MedPAC to look into the impact of physician-owned heart, orthopedic and surgical specialty hospitals and imposed an 18-month moratorium on the start-up of new facilities. In March 2005 MedPAC issue its findings based on the small number of physician-owned hospitals in operation long enough to generate Medicare data. MedPAC found, as chairman Hackbarth testified, that physician-owned specialty hospitals “treat patients who are generally less severe (and hence expected to be relatively more profitable than the average) and concentrate on particular diagnosis-related groups (DRGs), some of which are relatively more profitable.”<sup>76</sup> The specialty hospitals also tend to have lower shares of Medicaid patients than community hospitals. In 2002 specialty hospitals did not have lower costs for Medicare inpatients than community hospitals, although their inpatients had shorter stays. MedPAC did not find that the specialty hospitals had an impact on the financial condition of community hospitals. MedPAC determined that the problem could be addressed by improving Medicare’s inpatient prospective payment system for acute care hospitals to reduce financial incentives for patient selection by specialty hospitals.

Similarly, Congress in 2005 asked the Secretary of Health and Human Services (through its division, the Centers for Medicare and Medicaid Services) to develop a strategic plan to address certain issues related to physician investment in specialty hospitals. The directive asked that the Secretary seek to determine whether or not there was a proportionality of investment return, whether it was, in fact, a bona fide investment. The Secretary was also to look to see whether specialty hospitals have made provisions for Medicaid patients or patients who might be thought to be Medicaid patients. Finally, the Secretary was asked to determine any appropriate enforcement, based on its charge from Congress.

The U.S. Department of Health and Human Services sent a survey to survey to two groups of hospitals to obtain the information it needed to report to Congress. These include 130 specialty hospitals<sup>77</sup> and a sample of competitor acute care general hospitals. The findings: “In summary, the data we received on physician investment have not revealed, on their face, any disproportionate or non-bona fide arrangements that require CMS to institute a drastic shift in our enforcement approach.”<sup>78</sup> HHS noted, however, that several hospitals had not responded to the survey. Under the physician self-referral statute, a physician cannot refer a Medicare patient for designated health services to an entity with which the physician, or an immediately family member, has a financial relationship, unless an exception applies. There are two exceptions, the “whole hospital” exception and the “rural provider” exception. Specialty hospitals are set up to operate under the whole hospital exception. While CMS extended the moratorium on new

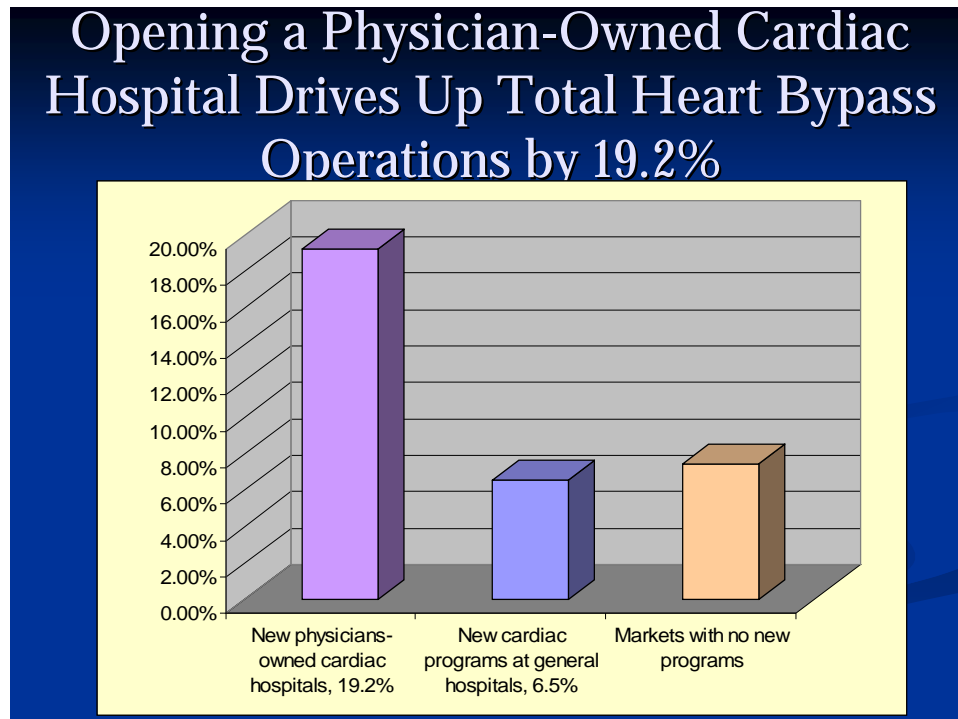
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<sup>76</sup> Glenn M. Hackbarth, “Physician-Owned Specialty Hospitals,” statement before the Finance Committee, U.S. Senate, March 8, 2005. Pdf, p. 1

<sup>77</sup> HHS began with 75 specialty hospitals identified in a prior study and added another 49 hospitals who requested an advisory opinion. In addition, HHS identified other specialty hospitals that were added to the survey.

<sup>78</sup> United States Department of Health and Human Services, “Final Report to the Congress and Strategic and Implementing Plan Required under Section 5006 of the Deficit Reduction Act of 2005.”

specialty hospitals was extended as a “suspension” and then the suspensions was extended by Congress, the prohibition on new facilities ended in August 2006.<sup>79</sup>

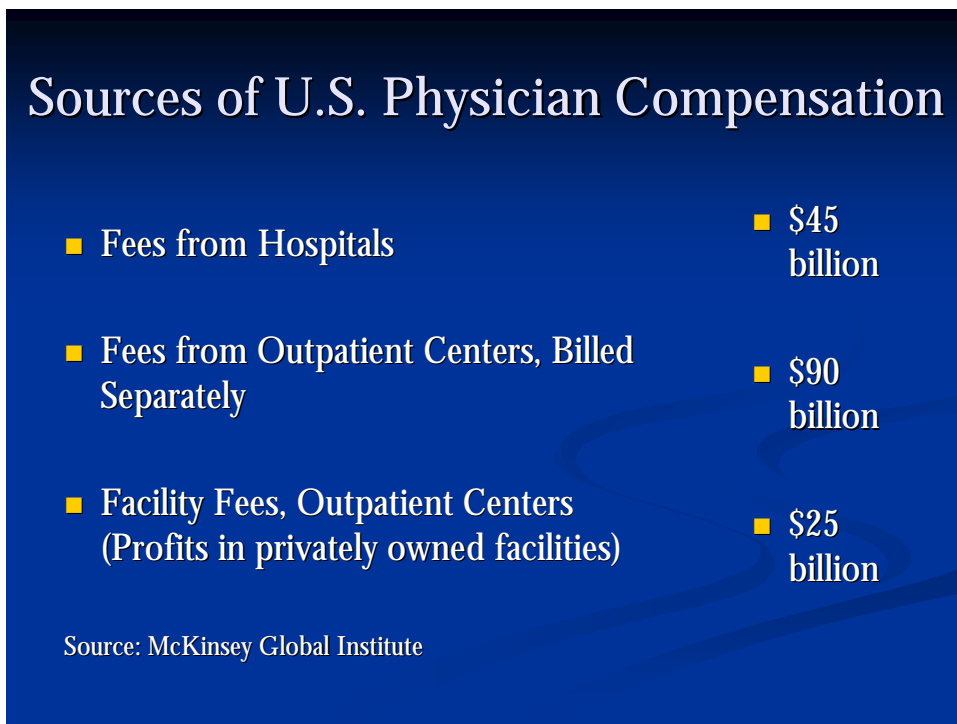


There was, to be sure, opposition to ending the prohibition of new facilities. In May 2006 the American Hospital Association called for a permanent ban on new physician-owned hospitals in a statement the Senate Finance Committee. In the statement the American Hospital Association argued that financial incentives influence physician behavior, including such adverse behavior as patient selection and steerage, service selection and increase utilization of medical services. The American Hospital Association, citing MedPAC’s findings of 2005, said that physicians who are owners of specialty hospitals self-refer the most profitable diagnoses, such as cardiac care and orthopedic surgery to their own hospitals. They also said that MedPAC data show that the number of cardiac surgeries per 1,000 Medicare beneficiaries increase when a physician-owned cardiac hospital is opened in community. The American Hospital Association also claimed that costs at physician-owned orthopedic and surgical facilities are higher. As noted, Congress did not extend the extension. Nor did it approve a ban.

The controversy over physician-owned specialty hospitals, however, has not gone away. And there are more than a few skeptics of the view by MedPAC that improving pricing accuracy would remove the incentives to self-refer and, thus, dispense with the challenges posed by physician-owned specialty hospitals. It is naïve to think that the additional financial incentives derived from ownership would not further distort the already negative cost effects associated with the fee-for-service arrangements that characterize U.S. medical practice.

<sup>79</sup> According to the public information office of the Centers for Medicare and Medicaid Services.

The McKinsey Global Institute calculates how much physicians are earnings from their financial interests and fees and profits from physician-owned facilities constitute the lion's share of physician earnings.<sup>80</sup> By McKinsey Global Institute's calculations, physicians earned \$160 billion in 2003, based on OECD data, expert interviews and analysis by the institute. McKinsey Global Institute breaks the numbers 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, including laboratory and diagnostic tests, imaging tests, outpatient procedures and physical therapy and rehabilitation. In addition, physicians earned \$25 billion from profits in physician-owned facilities. That's half the \$50 billion a year in earnings from physician-owned outpatient centers and is based on the prevalent arrangement that gives physicians about half the equity in the specialty hospitals.



Some of the opposition to a moratorium derives from a belief that new physician-owned hospitals create competition. The Center for Studying Health System Change investigated whether or not specialty hospitals promote price competition and whether or not they add unneeded capacity and increased costs while threatening the ability of general hospitals to deliver community benefits. The investigation into three markets significantly affected by specialty hospitals – Indianapolis, Little Rock and Phoenix – found that purchasers “generally believe that specialty hospitals are contributing to a medical arms race that is driving up costs without demonstrating clear quality

<sup>80</sup> Agrisano et al, Exhibit 31, p. 51.

advantages.”<sup>81</sup> Purchasers also believe that hospitals have “unfair advantages that create an unlevel playing field for hospital competition, and some suggested that certificate-of-need regulations should be used to limit the growth of hospitals.”<sup>82</sup>

The center’s study found that although prior research indicates purchasers believe specialty hospitals have lower costs,<sup>83</sup> “some purchasers believe that referring physicians, especially those with a financial interest in the specialty hospital, increase volume by inducing patient demand for elective procedures.”<sup>84</sup> The center’s issue brief on its finding quotes one Indianapolis respondent as follows: “We joke about drive-through angioplasty.” Representatives of health plans told researchers from the Center for Studying Health Care Change that they had few tools to restrain the induced utilization that physician ownership can engender at specialty hospitals. The “competition” from specialty hospitals works adversely to raise some prices at community hospitals, too, the center found. Purchasers told researchers that general hospitals responded to the loss of profitable business to the specialty hospitals by raising prices on services where there is less competition. In some cases, hospitals, instead of competing on price, are developing similar dedicated centers as “hospitals within hospitals” or even free standing facilities.

The death of a patient January 23, 2007, at a physician-owned hospital in Abilene, Texas, has become a topic in the debate over physician-owned hospitals. The patient, 44-year-old Steve Spivey, developed breathing problems during the night after spine surgery in the 14-bed physician-owned West Texas Hospital. There was no physician on duty at the time. The surgeon was called back, but the hospital was ill-equipped to handle an emergency and the hospital called 911 to have the man taken to a nearby full-service hospital.<sup>85</sup> The paramedics inserted a breathing tube in the ambulance, but a short time after he arrived at the hospital he was pronounced dead.<sup>86</sup> The Centers for Medicare and Medicaid Services wrote a letter to the specialty hospital’s CEO informing him that the facility did not meet requirements to participate in the Medicare program because of “deficiencies that represent an immediate and serious threat to patient health and safety.” The West Texas Hospital declined to comment to press inquiries at the time.

Senators Max Baucus (D-Montana), Charles Grassley (R-Iowa), and Representative Pete Stark (D-California) wrote a letter to the Acting Administrator of the Medicare program to complain and demand accountability regarding the West Texas Hospital death. “The regulatory process Congress was told was in place to prevent specialty hospitals from entering Medicare didn’t work,” Representative Stark wrote. In a

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<sup>81</sup> Robert A. Berenson, Gloria J. Bazzoli and Melanie Au, “Do Specialty Hospitals Promote Price Competition?” Issue Brief No. 103 (Washington, D.C.: Center for Studying Health System Change, January 2006), p. 1.

<sup>82</sup> Ibid.

<sup>83</sup> John K. Iglehart, “The Uncertain Future of Specialty Hospitals,” *New England Journal of Medicine*, Vol. 352 No. 14 (April 7, 2005)

<sup>84</sup> Berenson et al, p. 2.

<sup>85</sup> Reed Abelson, “Some Hospitals Call 911 to Save Their Patients,” boston.com, April 27, 2007.

[http://www.boston.com/yourlife/health/other/articles/2007/04/02/some\\_hospitals\\_call\\_911\\_to\\_save\\_their\\_patients?mode=PF](http://www.boston.com/yourlife/health/other/articles/2007/04/02/some_hospitals_call_911_to_save_their_patients?mode=PF)

<sup>86</sup> Ibid.

prepared press statement, Senator Grassley noted, “The fundamental problem with physician-owned specialty hospitals is that decision-making is more likely to be driven by financial interests rather than what is best for the patient. You see that in the cherry picking of patients and policies where emergencies are to be dealt with by calling 911 to get the local community hospital.”

The evidence is mounting that without a moratorium on new facilities, the incentives created by allowing physician-owned outpatient centers, especially specialty hospitals, will spread to more areas of the country and the new distortions in medical practice and will contribute to an increase in the overall higher medical costs that derive from the fee-for-service nature of U.S. health care system. Further, as specialty hospitals become entrenched in more and more communities, it will become more and more difficult to devise and impose appropriate reforms that affect not only specialty hospitals but also the entire medical community.

## **Conclusions**

The subject of compensation for physicians and health care workers is one that is ripe for considerable additional research. Additional insights can be obtained from further research to help the public, the medical community and policy makers better evaluate how to reform the medical system so that it will better assure quality, contain unnecessary spending and meet the genuine needs of all Americans.

Further, Congress has not sufficiently weighed the consequence of failing to reimpose a moratorium on new physician-owned specialty hospitals. The finding of a minimal impact of specialty hospitals is contradicted by a growing number of studies. It seems reasonable to assume that there are systemic distortions beyond the scope of improving fee-for-service pricing of physicians’ services.

Finally, given the systemic ramifications of the fee-for-service system that encourages volume and not quality, a few recommendations seem appropriate as a starting point to improve the functioning of the physician compensation system that governs the cost and course of so much of medical practice in the United States. Recommendations are described below.

## **Recommendations for Research:**

- More research should be undertaken to better understand how physician fee-for-service compensation incentives work to increase unnecessary health care spending and how the impact of such incentives can be moderated and tempered while at the same time improving health outcomes.
- Studies should be undertaken to see where physician compensation arrangements have worked to improve quality and patient satisfaction while keeping costs in check and see how those successful models could be put into practice elsewhere.

**Recommendations for Policy:**

- Congress should reinstate the moratorium on new physician-owned specialty hospitals while more research is made into their effect in health care and overutilization.
- Policymakers in Washington and leaders within the health care system should give more consideration to reforms and arrangements that are likely to increase the role of quality care, patient satisfaction, and the efficient use of resources as components of physician compensation.

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