

Trends in Physician Compensation: Specialist Physician Growth Coupled with Primary Care Stagnation

Bruce A. Johnson, JD, MPA

Physicians in the United States in virtually all medical and surgical specialties enjoyed increases in compensation from 2000 to 2001. However, the rate of increase in overall pay levels varied considerably between primary care and specialty physicians. Overall, primary care physician pay levels remained largely stagnant with only modest increases over prior year amounts, whereas specialist physicians generally enjoyed more robust pay increases in 2001.

These findings are based on data from the *MGMA Physician Compensation and Production Survey: 2002 Report Based on 2001 Data*,¹ conducted by the Medical Group Management Association (MGMA). Continuing a trend that started in 1998, primary care physicians as a whole enjoyed a slight (1.21%) increase in compensation in 2001. However, an 11.04% increase in production (defined as gross charges) over the previous year's levels was required for that greater pay. Although some of the production increase results from yearly updates to practice fee schedules, the small increase in compensation likely results from the fact that additional professional service work can only produce a limited amount of additional revenues that can be translated into compensation.

On the other hand, specialist physicians enjoyed greater increases in compensation in 2001 in comparison to primary care physicians. In 2001, specialists enjoyed a 2.64% increase in compensation. Specialist physicians also had to increase their productivity to achieve growth in compensation, although generally not at the same magnitude as their primary care colleagues. Moreover, specialists in many medical and surgical specialties were able to garner additional revenues and compensation through the performance of ancillary and other procedures, therefore accessing additional portions of the health care revenue stream.

Trends related to physician compensation and production levels over the 3-year period from 1999

through 2001 reveal the increased effort required to earn additional income. **Figure 1** and **Figure 2** show median compensation and production levels (measured by gross charges) for primary care and specialist physicians during this 3-year period. Both graphs show gradual increases in compensation levels, combined with more aggressive increases in production levels.

The *MGMA Physician Compensation and Production Survey: 2002 Report Based on 2001 Data* is based on the survey responses of nearly 1600 medical practices in the United States, representing more than 33,000 physicians and nonphysician providers. The survey of MGMA member practices has been conducted annually since 1987. Data are reported for 108 physician subspecialties and 22 nonphysician provider specialties. The report contains sections on physician compensation, benefits and productivity, as well as summary tables for selected specialties. Data examined in this article include:

- Compensation and production levels (gross charges) for primary care (**Figure 1**) and specialist physicians (**Figure 2**) for 1999 through 2001.
- Median compensation and percentage change from prior year for selected specialties for 2001 (**Table 1** and **Table 2**)
- Median compensation for selected specialties by group type (**Table 3**)
- Compensation by geographic section (**Table 4**)
- Compensation by years in practice (**Table 5**)
- Compensation by specialty and gender (**Table 6**)

Mr. Johnson is a principal, MGMA Health Care Consulting Group, Medical Group Management Association, Englewood, CO, specializing in physician compensation system development and benchmarking; and Special Counsel, Faegre & Benson, LLP, Denver, CO.

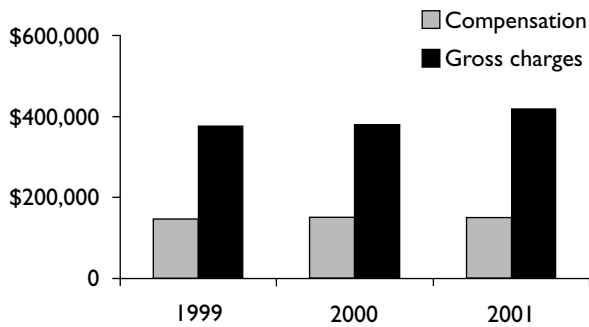


Figure 1. Median compensation and production (gross charges) for primary care physicians, 1999–2001. (Data from MGMA physician compensation and production survey: 2002 report based on 2001 data. Tables A and B: Median compensation and production for selected specialties, 1999–2001. Englewood [CO]: Medical Group Management Association; 2002. © 2002 Medical Group Management Association.)

PRIMARY CARE PHYSICIAN COMPENSATION

Primary care physician compensation levels have been generally stagnant, clearly reversing the trend of the mid-1990s, when “bidding wars” for primary care physician practices were common in many parts of the country. Despite increases in production levels from 2000, the slight increase in compensation for all primary care specialties may be due to the combination of declining reimbursement, limited additional revenue sources, and the potential that additional work can only go so far in producing additional pay.

Primary Care Compensation Winners and Losers

Specific changes in compensation and production for primary care physicians from 2000 to 2001 (Table 1) include:

- Family practice—median compensation in 2001 was \$146,601, reflecting a 1.02% increase over 2000 levels. During the same period, production increased 10.11%.
- Internal medicine (general)—median compensation in 2001 was \$149,720 for general internists, up only 0.41% from 2000 levels. During the same period, production in internal medicine as a whole increased 9.89%.
- Internal medicine (hospitalists)—median compensation in 2001 was \$156,071, representing an increase of 3.35% from 2000 levels. The data showed a 12.67% decrease in production for this group of physicians from 2000 to 2001. The causes of this decrease are not known, and it is unclear whether this represents a trend or

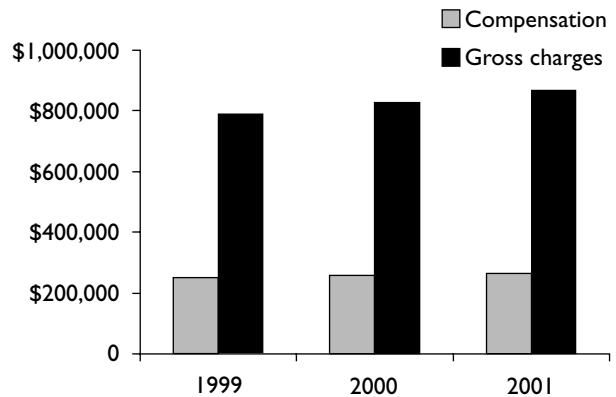


Figure 2. Median compensation and production (gross charges) for specialist physicians, 1999–2001. (Data from MGMA physician compensation and production survey: 2002 report based on 2001 data. Tables A and B: Median compensation and production for selected specialties, 1999–2001. Englewood [CO]: Medical Group Management Association; 2002. © 2002 Medical Group Management Association.)

a one-time anomaly. For example, the combined changes in hospitalist compensation and production levels may be due to an increased number of hospitalists who are employed by hospitals or health systems relative to those in physician-owned practices. The greater financial resources of hospitals may enable these organizations to place greater emphasis on providing enhanced service to patients and their families (which tends to take more time and, therefore, results in lower levels of production), whereas hospitalist physicians who are affiliated with physician-owned groups may continue to have greater production-related pressures. Findings in future years may help provide a fuller understanding of these trends.

- Pediatrics/adolescent medicine—median compensation in 2001 was \$150,222, up 6.03% from 2000, making pediatricians the only primary care specialty to emerge as a clear compensation winner. This increase was coupled with an increase in production of 9.19% during the same time period.

SPECIALIST PHYSICIAN COMPENSATION

Although physicians in medical and surgical specialties as a group enjoyed only modest increases in compensation levels in 2001, median levels in a few specialty areas increased substantially from 2000 levels. As indicated in Table 2, compensation in 5 of 17 specialties increased at double-digit levels. In 4 of the 17 specialties,

Table 1. Median Compensation and Change in Production for Selected Primary Care Physician Specialties

	Median Compensation 2001, \$	Change in Compensation 2000–2001, %	Change in Production 2000–2001, %
Family practice (without obstetrics)	146,601	1.02	10.11
Internal medicine (general)	149,720	0.41	9.89
Internal medicine (hospitalists)*	156,071	3.35	-12.67
Pediatric/adolescent medicine	150,222	6.03	9.19
All primary care	149,009	1.21	11.04

*Please refer to page 40 for a discussion of the data on hospitalists.

Data from MGMA physician compensation and production survey: 2002 report based on 2001 data. Tables A and B: Median compensation and production for selected specialties, 2000–2001 and Table 21: Physician gross charges (technical component excluded). Englewood (CO): Medical Group Management Association; 2002; and from MGMA physician compensation and production survey: 2001 report based on 2000 data. Table 15: Physician gross charges (technical component excluded). Englewood (CO): Medical Group Management Association; 2001. © 2001, 2002 Medical Group Management Association.

however, percentage increases in compensation were below the “stagnant” increases for primary care (1.21%)—although no single specialty experienced a decline in median compensation over prior year levels.

Specialty Compensation Winners and Losers

Table 2 provides compensation information for several medical and surgical specialties, including the following:

- Invasive cardiologists—these specialists experienced the highest percentage increase in compensation levels. In 2001, median compensation for invasive cardiologists was \$410,300, representing a 12.14% increase over 2000 levels.
- Noninvasive cardiologists—whereas this specialty did not enjoy the significant increases of invasive cardiologists, the median compensation level of \$320,111 nevertheless constituted a substantial 6.68% increase over 2000 levels.
- Gastroenterologists—at \$312,074, median compensation levels for gastroenterologists also showed a healthy 10.94% increase over 2000 levels.
- Ophthalmologists—with a median compensation level of \$261,012 in 2001, physicians in this specialty also saw a substantial (10.43%) increase compared with 2000 levels.
- Pulmonary medicine physicians—compensation increased 10.30% compared with 2000 levels, with median compensation equaling \$215,700.

- Otorhinolaryngologists—these physicians also enjoyed a significant 8.81% increase in compensation from 2000 to 2001, with median compensation levels in 2001 at \$256,160.
- Orthopaedic surgeons—these physicians also were winners, thanks to their 7.90% increase in compensation.
- Diagnostic radiologists—In the year 2000, this group of physicians experienced a 5% loss in median compensation, the largest loss among specialist groups that year. In 2001, however, diagnostic radiologists enjoyed an increase of 11.41%, representing the second-highest percentage increase among specialist physicians.
- Anesthesiologists—these physicians, on the other hand, had an experience that was nearly the reverse of that of diagnostic radiologists over the past 2 years. Median compensation in 2001 was \$283,655, reflecting only a slight (1.18%) increase over 2000 levels. This represents a significant change from 2000, when anesthesiologist compensation levels were 14% greater than in prior year.

The reasons for compensation differences between primary care physicians and specialists—and even among different medical and surgical subspecialties—are likely multifactorial in nature. Certainly one important reason is the different access that practice specialties have to additional revenue streams through ancillary and other health care services. For example, cardiologists increasingly operate diversified medical practice organizations that combine traditional cardiology services with

Table 2. Median Compensation for Selected Physician Specialties

	Median Compensation 2001, \$	Change in Compensation 2000–2001, %
Anesthesiology	283,655	1.18
Cardiology (invasive)	410,300	12.14
Cardiology (noninvasive)	320,111	6.68
Dermatology	215,247	0.64
Emergency medicine	210,597	6.14
Gastroenterology	312,074	10.94
Hematology/oncology	274,270	6.14
Neurology	180,325	2.96
Obstetrics/gynecology	231,000	3.49
Ophthalmology	261,012	10.43
Orthopaedic surgery	362,173	7.90
Otorhinolaryngology	256,160	8.81
Psychiatry	157,509	0.65
Pulmonary medicine	215,700	10.30
Radiology (diagnostic)	332,917	11.41
Surgery (general)	257,509	4.87
Urology	303,433	0.55
All specialties	263,254	2.64

Data from MGMA physician compensation and production survey: 2002 report based on 2001 data. Tables A and B: Median compensation and production for selected specialties, 2000–2001. Englewood (CO): Medical Group Management Association; 2002. © 2002 Medical Group Management Association.

a host of diagnostic services (eg, nuclear imaging) and, in some cases, office-based procedural services (eg, in-office catheterization). Physicians practicing in gastroenterology also commonly have access to an additional portion of the health care dollar through operation of endoscopy suites. Surgeons also increasingly supplement their professional service fees through ambulatory surgical center revenues and revenues from diagnostic and other services. Such revenues helped orthopaedic surgeons, otorhinolaryngologists, and ophthalmologists to achieve significant increases in compensation in 2001.

In addition to the greater access to these and other revenue streams, a shortage in many specialty practice areas may also be influencing compensation levels. In the mid-1990s, primary care specialties were heavily emphasized with the increased reliance on managed-care models of health care delivery. Today, the shortage of specialist physicians is resulting in increased

Table 3. Median Compensation by Group Type, 2001

	Median Compensation, \$	
	Single-Specialty Groups, \$	Multispecialty Groups, \$
All primary care	156,412	147,742
All specialties	320,146	236,934

Data provided by Medical Group Management Association, Englewood, CO, 2002. © Medical Group Management Association.

recruitment challenges and pressures for increased pay levels—particularly in multispecialty group practice settings. These supply and demand realities, as well as the reality of the competitive marketplace, continue to play an important role in determining physician compensation levels.

OTHER FACTORS INFLUENCING COMPENSATION

Practice Setting

Table 3 summarizes median compensation levels for primary care and specialists (combined) in single-specialty and multispecialty groups. Physicians in single-specialty groups fared better than those in multispecialty practice settings, with specialist physicians enjoying compensation levels in single-specialty practice settings that were more than \$80,000 higher than their multispecialty counterparts. This dramatic difference is typically the result of many factors, including the ability of single-specialty groups to develop and capitalize on additional revenue streams and the inevitable spreading of practice income within a multispecialty setting among primary care and specialist physicians to promote group cohesiveness and other goals. In multispecialty practices, ancillary service revenue streams can also be developed and captured. However, directing the revenues to the physicians who produce them is challenging, owing to internal group compensation plans and regulatory restrictions imposed by the federal Stark law (which limits physician self-referral) and other prohibitions, which commonly result in some spreading of income within the multispecialty group.

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

are viewed to be worth the additional “cost” of practicing in a multispecialty setting.

Geographic Location

As in the past, median physician compensation levels tend to be higher in the southern United States, followed by the midwestern, eastern and, finally, western regions (Table 4). This pattern generally conforms to the overall penetration of managed care throughout the United States. Physicians in the eastern and western United States have the lowest levels of compensation, primarily owing to increased managed care penetration in these regions, an overabundance of physicians in certain specialties, and relatively lower reimbursement rates. Notably, although the South is still the most lucrative area in which to practice, trends in primary care compensation are consistently stagnant across the United States. Median compensation increased only \$546 to \$160,546 in 2001 for primary care physicians in the southern United States, with nearly similar small increases in the East (with a \$792 increase to \$140,302). Compensation actually decreased in the West; the overall increase in primary care compensation was driven by a \$5,652 increase over 2000 levels in the Midwest.

Years of Practice

Compensation by years of practice tends to show a rather steep increase after completion of the initial 1- to 2-year period of associate physician status. Table 5 shows median compensation levels in 2001 by years of practice for primary care and specialist physicians. In all practice groupings, associate physicians in their first 1 to 2 years of practice received significantly lower levels of compensation than physicians with more years of experience. Moreover, although there were significant differences in the compensation received by a group’s junior and most senior partners, these differences were still significantly less than those between new physician and established physician salaries.

Average compensation for primary care physicians in their first 1 to 2 years of practice was \$126,595—representing a decrease in excess of \$3,000 per year compared with 2000 levels. In comparison, average compensation for primary care physicians with 3 to 7 years of practice was \$142,153; 8 to 17 years of practice, \$157,711; and 18 or more years of practice, \$159,948—all slightly higher than 2000 levels.

In contrast, average compensation for specialists with 1 to 2 years of practice in 2001 was \$189,824, representing an increase of more than \$3,000 per year compared with 2000 levels. This compares with average compensation of \$251,665 for specialists with 3 to

Table 4. Median Compensation by Geographic Region of the United States, 2001

	Median Compensation, \$			
	East	Midwest	South	West
All primary care	140,302	148,910	160,546	147,833
All specialties	244,668	289,949	309,291	232,269

Data provided by Medical Group Management Association, Englewood, CO, 2002. © Medical Group Management Association.

7 years of practice, \$282,598 for specialists with 8 to 17 years of practice, and \$275,445 for specialists with 18 or more years of practice. Notably, compensation for those with 8 to 17 years of practice increased more than \$25,000 over 2000 levels, and specialists with 18 or more years of experience earned approximately \$32,000 more than they did the previous year.

The trends in compensation represented by these data reflect the general life cycle of compensation levels in most groups, with physicians at the outset and in the “twilight” of their careers generally receiving lower levels of compensation.

When the changes within each category from 2000 to 2001 are compared, the increases over the previous year experienced by the most senior physicians are likely the result of various factors. These may include additional revenue streams in practices and the increased use of productivity-oriented compensation methods coupled with changing demographics and physician preferences in many medical practices. In many medical groups, differences in personal goals and values of junior and senior physicians are becoming apparent. The categories representing those physicians who have been in practice the longest (8–17 years and 18+ years) are populated largely by “baby-boom” generation physicians who are now age 43 years and older. These physicians are frequently willing to spend considerably greater time and effort in the workplace, given that many continue to function as the primary breadwinner in the family. Conversely, many younger physicians are part of 2-salary families and are more inclined to stress a more “balanced” lifestyle between work and family.

Productivity-oriented compensation plans are increasingly being employed to provide a “fair” means of rewarding varying work levels and accommodating various income, work, and lifestyle goals of physicians at different stages of their careers. The changes in compensation paid to more senior physicians over the past 2 years likely represents a combination of lifestyle preferences, work levels, and other factors.

Table 5. Median Compensation by Years in Practice, 2001

	Median Compensation, \$			
	1–2 Years	3–7 Years	8–17 Years	18+ Years
All primary care	126,595	142,153	157,711	159,948
All specialties	189,824	251,665	282,598	275,445

Data provided by Medical Group Management Association, Englewood, CO, 2002. © Medical Group Management Association.

Table 6. Median Compensation by Gender, 2001

	Median Compensation, \$		Differences	
	Male	Female	\$	%
All primary care	157,671	132,213	25,458	16.1
All specialties	280,333	205,185	75,148	26.8

Data provided by Medical Group Management Association, Englewood, CO, 2002. © Medical Group Management Association.

Gender

Table 6 presents median compensation for female and male primary care physicians and specialists. In 2001, male physicians made, on average, 16.1% more than their female counterparts in primary care disciplines and 26.8% more than their female counterparts in medical and surgical specialties. This translated to an average difference in compensation of \$25,458 for primary care physicians and \$75,148 for specialists. The gender gap continues to be present even in obstetrics and gynecology, a specialty in which female physicians are often viewed as having greater access to patients.

The disparity between male and female compensation levels may result from a number of factors. Many female physicians elect to work part-time work schedules. Although such a schedule provides flexibility and more time to spend on family duties, it typically results in lower levels of production and compensation. Part-time status is generally not viewed as an appropriate position from which to gain “partnership” status and, with it, full participation in the medical group’s ancillary revenue stream that tends to supplement professional service revenues. This is coupled with the fact that practice groups are increasingly turning to predominantly production-driven compensation schemes as a means to accommodate differing physician preferences related to lifestyle and work levels as mentioned previously. Production-driven compensation plans, flexible work schedules, and other arrangements help accommodate physician autonomy and choice; howev-

er, these benefits frequently carry an associated financial cost.

FUTURE TRENDS IN PHYSICIAN COMPENSATION

An assessment of historic trends over the past few years reveals that physician compensation levels have continued to rise, but only when production or work levels also increase more dramatically. Given the stagnation of compensation levels in primary care specialties, it may be that primary care providers are reaching the peak of their ability to sustain the double-digit increases in workload necessary to achieve single-digit increases in compensation. Many physicians have been able to see more patients by enhancing efficiency and working more, but this approach is likely to be unsustainable in the long term, in particular as professional fee reimbursement levels remain constant or decline.

For those physicians and medical practices with other sources of revenue to support provider compensation, the trends are more favorable. Specialist physicians have increased their professional service production levels over the past few years, but many medical and surgical specialties are capturing additional revenues that were previously in the domain of hospitals or other health care providers. As professional fee reimbursement declines, these specialties can nevertheless capture the technical component or other portions of the health care dollar to supplement compensation and pay practice operating costs.

A dormant national economy, ongoing cuts in reimbursement rates, increasing practice operating costs,

(continued on page 71)

(from page 44)

and the malpractice insurance “crisis” that is occurring in many regions of the country will likely influence compensation levels. The practices of the past, in which fewer physicians were trained in some specialties, combined with the inevitable forces of supply and demand, will also likely have an impact on compensation levels. Moreover, the continuing changes and attempts to restructure the health care delivery and

payment systems and other factors will continue to affect the underlying trends for physician compensation in the United States. **HP**

REFERENCE

1. MGMA physician compensation and production survey: 2002 report based on 2001 data. Englewood (CO): Medical Group Management Association; 2002.

Copyright 2003 by Turner White Communications Inc., Wayne, PA. All rights reserved.