CENTER for STUDYING HEALTH SYSTEM CHANGE

Tracking Report

ACCESS TO CARE

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Losing Ground: Physician Income, 1995-2003

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Between 1995 and 2003, average physician net income from the practice of medicine declined about 7 percent after adjusting for inflation, according to a national study from the Center for Studying Health System Change (HSC). The decline in physicians' real income stands in sharp contrast to the wage trends for other professionals who saw about a 7 percent increase after adjusting for inflation during the same period. Among different types of physicians, primary care physicians fared the worst with a 10.2 percent decline in real income between 1995 and 2003, while surgeons' real income declined by 8.2 percent. But medical specialists' real income essentially remained unchanged. Physicians reported working slightly fewer hours overall but spent more time on direct patient care. Flat or declining fees from both public and private payers appear to be a major factor underlying declining real incomes for physicians. The downward trend in real incomes since the mid-1990s likely is an important reason for growing physician unwillingness to undertake pro bono work, including charity care and volunteering to serve on hospital committees.

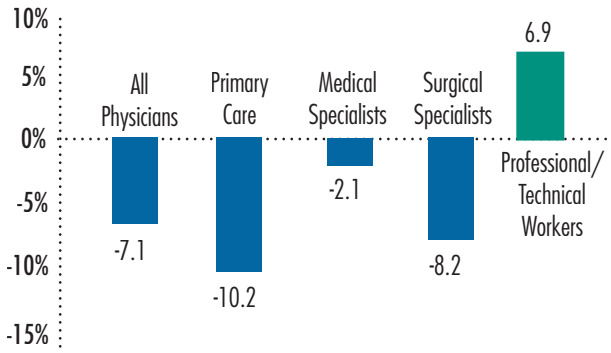
DECLINE IN PHYSICIANS' REAL INCOME CONTINUES

Between 1995 and 2003, average physician net income from the practice of medicine declined about 7 percent after adjusting for inflation, according to HSC's nationally representative 2004-05 Community Tracking Study Physician Survey (see Figure 1 and Data Source). Primary care physicians and surgeons fared the worst in keeping pace with inflation, while medical specialists fared the best.

After adjusting for inflation, medical specialists' incomes have remained virtually unchanged since the mid-1990s. In contrast, primary care physicians—already the lowest earning of all physicians—have lost substantial ground (-10.2%) to inflation since the mid-1990s. Surgical specialists also experienced a significant reduction of more than 8 percent in real incomes between 1995 and 2003.

Negative real income trends for physicians stand in stark contrast to the trends experienced by workers in professional, specialty and technical occupations.[1] Between 1995 and 2003, wages and salaries for these workers increased about 7 percent after adjusting for inflation. The divergence in income trends between physicians and other professional workers, which was especially striking in the 1995-1999 period, narrowed somewhat from 1999 to 2003, but physicians still lagged fellow professionals (see Table 1).

Figure 1: **Percent Change in Average Physician Income, Adjusted for Inflation, 1995-2003**



Note: Physician income data are based on reported net income from the practice of medicine (after expenses and before taxes). The Bureau of Labor Statistics (BLS) Employment Cost Index of wages and salaries for private sector "professional, technical and specialty" workers was used to calculate estimates for these workers. All inflation-adjusted estimates were calculated using the BLS online inflation calculator (*http://146.142.4.24/cgi-bin/cpicalc.pl*).

Source: Community Tracking Study Physician Survey

Despite the downward trend in real incomes, medicine overall remains one of the most well-paid professions in the United States: At least half of all patient care physicians earned more than $170,000 in 2003, and physician average net income was approximately $203,000. And, although surgical specialists have lost ground to inflation since the mid-1990s, they remain the highest-earning of all physicians: Their average income of $272,000 in 2003 was 29 percent higher than medical specialists and 86 percent higher than primary care physicians.

PHYSICIANS WORK FEWER HOURS BUT SPEND MORE TIME ON PATIENT CARE

While physician incomes declined in real terms between 1995 and 2003, the average number of hours worked by physicians for all medically related activities also fell slightly during this period (see Table 2). Medically related activities are defined as time spent on administrative tasks, professional activities and direct patient care but not time spent on call when not treating patients. Across all patient care physicians, the number of hours

TABLE 1: **Physicians' Net Income from Practice of Medicine, 1995, 1999 and 2003, and Percent Change, 1995-2003**

	Average Reported Net Income (Dollars)			Average Net Income, Inflation Adjusted (1995 Dollars)			Percent Change in Inflation-Adjusted Income		
	1995	1999	2003	1995	1999	2003	1995-1999	1999-2003	1995-2003
All Patient Care Physicians	180,930	186,768	202,982	180,930	170,850	168,122	-5.6*	-1.6	-7.1*
Primary Care Physicians	135,036	138,018	146,405	135,036	126,255	121,262	-6.5*	-4.0*	-10.2*
Specialists	210,225	218,819	235,820	210,225	200,169	195,320	-4.8*	-2.4	-7.1*
Medical Specialists	178,840	193,161	211,299	178,840	176,698	175,011	-1.2	-1.0	-2.1
Surgical Specialists	245,162	255,011	271,652	245,162	233,276	224,998	-4.9	-3.6	-8.2*
Private Sector Professional, Technical, Specialty Occupations	N/A	N/A	N/A	N/A	N/A	N/A	4.3	2.5	6.9

Notes: The Bureau of Labor Statistics (BLS) Employment Cost Index of wages and salaries for private sector "professional, technical and specialty" workers was used to calculate estimates for these workers. Significance tests are not available for these estimates. All inflation-adjusted estimates were calculated using the BLS online inflation calculator (http://146.142.4.24/cgi-bin/cpicalc.pl). The composition of the physician population changed between 1995 and 2003—a fact that makes some estimates of percentage changes in real income appear inconsistent (for example, estimates of income changes for all patient care physicians not falling between estimates for primary care physicians and specialists). These data patterns occur because the proportion of medical specialists steadily increased from 1995 to 2003 (32% to 38%) while the proportions of primary care physicians and surgical specialists both declined by about 3 percentage points.

* Rate of change is statistically significant at $p < .05$.
Source: Community Tracking Study Physician Survey

Data Source

This Tracking Report presents findings primarily from the HSC Community Tracking Study Physician Survey, a nationally representative telephone survey of physicians involved in direct patient care in the continental United States conducted in 1996-97, 1998-99 (results not shown for ease of presentation), 2000-01 and 2004-05. The sample of physicians was drawn from the American Medical Association and the American Osteopathic Association master files and included active, nonfederal, office- and hospital-based physicians who spent at least 20 hours a week in direct patient care. Residents and fellows were excluded. The 1996-97, 1998-99 and 2000-01 surveys each contain information on about 12,000 physicians, while the 2004-05 survey includes responses from more than 6,600 physicians. The response rates ranged from 52 percent to 65 percent.

Physicians were asked to report their incomes for the last full year prior to the initial fielding of each survey (e.g., respondents to the 1996-97 survey were asked to report their 1995 incomes). Other measures used in this report use a different, more recent time frame (e.g., physicians are asked to report the number of hours they worked in the week prior to their survey participation). For ease of presentation, all measures are reported in this tracking report as being for the years 1995, 1999 and 2003. More detailed information on survey content and methodology can be found at *www.hschange.org*.

CTSonline, a Web-based interactive system for results from the CTS Physician Survey, is available at *www.hschange.org.*

spent on medically related activities declined from 55.5 hours a week in 1995 to 53.2 hours in 2003. This pattern held true for both primary care physicians and medical specialists; only surgical specialists—who on average worked the most hours—saw no significant decline in average hours worked.

While physicians' overall work hours have declined, time spent by physicians in direct patient care has increased (see Supplemental Table 1). Patient care activities are defined as face-to-face contact with patients, patient record keeping and office work, travel time connected with seeing patients, and communication with other physicians, hospitals, pharmacies and others on a patient's behalf. The increases are generally modest in magnitude, except for surgical specialists, whose average patient care hours rose substantially—from 47.2 hours per week in 1995 to 50.1 hours in 2003. As a result of patient care hours increasing while total medically related work hours fell, physicians are now spending a significantly larger proportion of their work time caring for patients than they did in the mid-1990s—86 percent vs. 81 percent (see Supplementary Table 2).

Since the amount of time physicians spent on patient care increased between 1995 and 2003, it's unlikely that the decline in overall work hours was a major factor in declining physician incomes since revenue is more directly related to patient care. Time devoted to direct patient care increased for all types of physicians between 1995 and 1999, then leveled off or decreased slightly thereafter. This likely reflects the fact that the number of office visits grew at a robust pace in the late-1990s, but the growth rate slowed beginning in 2001.[2]

TABLE 2: **Average Hours per Week Spent on Medically Related Activities, 1995-2003**

	Average Hours per Week Spent on Medically Related Activities			Percent Change in Hours		
	1995	1999	2003	1995 to 1999	1999 to 2003	1995 to 2003
All Patient Care Physicians	55.5	54.4	53.2	-1.9*	-2.2*	-4.1*
Primary Care Physicians	53.8	52.7	51.4	-2.0*	-2.5*	-4.5*
Specialists	56.6	55.6	54.3	-1.8*	-2.3*	-4.0*
Medical Specialists	54.6	54.0	51.5	-1.0	-4.8*	-5.8*
Surgical Specialists	58.8	57.7	58.5	-1.8*	1.3	-0.6

* Rate of change is statistically significant at p <.05.
Source: Community Tracking Study Physician Survey

The decline in work hours overall and on tasks other than direct patient care may, in part, reflect changes in physician practice settings over time. Physicians have been moving from solo and small group practices into large group practices and institutional settings, such as hospitals (see Supplementary Table 3). As physicians move into larger practices where the practice can invest in more administrative staff and information technology to deal with billing and other administrative tasks, less physician time likely is required for these tasks. Another possible factor underlying decreased nonpatient care work hours is a reported pullback in unpaid activities by physicians, especially in hospitals.[3] Willingness to serve on hospital committees, for example, appears to have fallen as income pressures have increased. Volunteerism also may have declined for activities in the broader medical community, such as serving on specialty society committees.

FEES FAIL TO KEEP PACE WITH INFLATION

Flat or declining fees from both public and private payers appear to be a major factor underlying declining or stagnating real incomes for physicians. Medicare payment rate increases for physician services amounted to 13 percent from 1995 to 2003,[4] lagging substantially behind inflation, which totaled 21 percent during this eight-year period.

While Medicare fees have declined in real terms since the mid-1990s, the trend for private insurer payments to physicians has lagged even more: In 1995, commercial fees were 1.43 times Medicare fees on average; by 2003 this fee ratio had fallen to 1.23.[5] And Medicaid fees have always been much lower than Medicare fees, so despite the fact that Medicaid payment rates rose relative to Medicare and grew faster than inflation from 1998 to 2003, increased Medicaid fees would not have been enough to produce substantial income gains for most physicians.[6] One likely exception would be primary care physicians with substantial Medicaid patient panels, especially those practicing in states—such as New York and South Carolina—that started with low Medicaid fee levels and increased them the most aggressively.

VOLUME OF PHYSICIAN SERVICES INCREASES

While physician payment rates have been constrained, the volume of physician services increased substantially, largely because of the growth in the number of tests and procedures. Among Medicare beneficiaries, minor procedures grew 6 percent a year on average between 1999 and 2003.[7] This growth outpaced that of office visits (4% a year) and major procedures (3% a year). The strong growth in tests and procedures helps to explain in part why medical specialists have seen their incomes growing at a faster pace than primary care physicians, who rely more on cognitive services, such as evaluation and management of patients, to generate revenue. Among medical specialists, physicians with procedure-based practices, such as gastroenterologists or cardiologists, are better positioned to invest in specialty facilities to generate additional income than, for example, a psychiatrist, who like a primary care physician, provides cognitive-based services.[8]

Although Medicare's physician fee schedule is supposed to reflect relative physician work and practice expense and is updated periodically, the failure to identify many services for which relative values should decline because of increasing productivity has resulted in overpayments for some services, especially procedures associated with rapidly advancing technology.[9] A growing gap between costs and fees is most likely to develop for services where technological advances make physicians, staff and equipment more productive over time, enabling them to perform more procedures per day and operate at higher capacity. The upshot is that the relative rewards for evaluation and management services and other cognitive-based services, where substantial productivity gains are unlikely, are declining sharply over time. With many commercial insurers incorporating Medicare's relative value scale into their own payment schedules, the negative impact in specialties, such as primary care, for which office visits are an important revenue source, extends beyond Medicare patients.

POLICY IMPLICATIONS

The downward trend in real incomes since the mid-1990s is likely an important factor underlying reduced physician willingness to undertake pro bono work, whether providing charity care to patients who can't afford to pay[10] or volunteering for other medically related activities, such as serving on hospital committees.

Downward pressure on incomes is also likely linked to the movement of physicians away from primary care—already

lower-paying and with steeper income declines—into certain medical specialties, which offer higher compensation and have kept better pace with inflation. The composition of the physician population changed between 1995 and 2003, with the proportion of medical specialists steadily increasing from 32 percent to 38 percent, while the proportion of primary care physicians and surgical specialists each declined by about 3 percentage points. In choosing which area of medicine to specialize in, many physicians today already show preferences for medical specialties that offer more control over work hours. When these preferences are reinforced by the diverging income trends between these specialties and primary care, the result is likely to be an imbalance in the physician workforce and perhaps a future shortage of primary care physicians and other specialties that provide primarily cognitive services.

For policy makers seeking to realign the price signals sent to physicians to ensure that the nation's medical needs are met, the primary policy lever is Medicare and Medicaid payment rates. For the foreseeable future, the congressionally enacted Medicare physician payment formula will produce significant annual reductions in payment rates, unless Congress intervenes to reverse the reductions, as it has each year since 2003. Few believe that Congress should determine physician incomes, and the debate over Medicare physician payments is mostly couched in terms of beneficiary access to physician services[11] and the long-term fiscal implications of Congress continuing to reverse Medicare physician payment reductions.

For some physicians, notably some medical specialists, declining fees do not mean declining incomes because their productivity for procedures is growing rapidly, along with the volume of procedures. But for primary care physicians and other specialists who are highly dependent on office visits rather than procedures, declining fees are likely to mean declining incomes.

This points to the need for more effective updating of Medicare relative values to more closely reflect the current relative costs of different services, and policy makers are already taking steps to do so. Acknowledging the pressures faced by physicians in cognitive specialties, the Relative Value Scale Update Committee, or RUC, recently voted to increase the value of cognitive services relative to that of procedures. Moreover, the Medicare Payment Advisory Commission in March 2006 recommended that the U.S. Department of Health and Human Services establish an expert panel, including members with expertise in health economics and clinical expertise, to help identify overvalued services and review RUC recommendations.

Because many commercial insurers follow Medicare's relative value system, timely, accurate relative value updates would lead to a broader reallocation of physician resources that would have benefits beyond Medicare patients.

NOTES

1. Changes in wage/salary income for private sector "professional, specialty and technical" workers are based on the Bureau of Labor Statistics (BLS) Employment Cost Index (*http://data.bls.gov/labjava/outside.jsp?survey=ec).* Data were adjusted for inflation using the BLS online inflation calculator (*http://146.142.4.24/cgi-bin/cpicalc.pl).*

2. National Center for Health Statistics, National Ambulatory Medical Care Survey, Summaries from 1996, 2001 and 2003. Advance Data from Vital and Health Statistics, Nos. 295, 337, 365, Hyattsville, Md.

3. During HSC's 2005 site visits to 12 nationally representative communities, hospital administrators reported decreased physician willingness to serve on hospital committees. They also reported decreased physician willingness to provide emergency on-call coverage, but this is not a factor in trends on hours worked, since the questionnaire specifically directs physicians not to include time spent on call when not treating patients.

4. Medicare Payment Advisory Commission, A Data Book: Healthcare Spending and the Medicare Program (June 2005).

5. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2005).

6. Zuckerman, Steve, et al., "Changes in Medicaid Physician Fees 1998-2003: Implications for Physician Participation," *Health Affairs*, Web exclusive (June 23, 2004).

7. Medicare Payment Advisory Commission, A Data Book: Healthcare Spending and the Medicare Program (June 2005).

8. Pham, Hoangmai, H., et al., "Financial Pressures Spur Physician Entrepreneurialism," *Health Affairs*, Vol. 23, No. 2, (March/April 2004).

9. Ginsburg, Paul B. and Joy M. Grossman, "When The Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care," *Health Affairs*, Web exclusive (August 9, 2005).

10. Cunningham, Peter J. and Jessica H. May, *A Growing Hole in the Safety Net: Physician Charity Care Declines Again*, Tracking Report No. 13, Center for Studying Health System Change, Washington, D.C. (March 2006).

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LOSING GROUND: PHYSICIAN INCOME, 1995-2003
SUPPLEMENTARY TABLES

Supplementary Table 1 **Average Hours per Week Spent on Direct Patient Care, 1995-2003**

	Average Hours per Week Spent on Direct Patient Care			Percent Change		
	1995	1999	2003	1995-1999	1999-2003	1995-2003
All Patient Care Physicians	44.7	46.7	45.6	4.5*	-2.3*	2.1*
Primary Care Physicians	43.7	45.6	44.6	4.5*	-2.3*	2.1*
Specialists	45.3	47.4	46.2	4.6*	-2.6*	1.9*
Medical Specialists	43.6	45.7	43.5	4.8*	-4.8*	-0.3
Surgical Specialists	47.2	49.8	50.2	5.5*	0.7	6.2*

* Rate of change is statistically significant at p <.05.
Source: Community Tracking Study Physician Survey

Supplementary Table 2 **Hours Spent on Direct Patient Care as a Percentage of Medically Related Activity Hours, 1995-2003**

	Average Percent of Medically Related Activity Hours Spent on Direct Patient Care			Percent Change		
	1995	1999	2003	1995-1999	1999-2003	1995-2003
All Patient Care Physicians	81.0	86.4	86.3	6.6*	0.0	6.6*
Primary Care Physicians	82.1	87.2	87.5	6.3*	0.3	6.6*
Specialists	80.4	85.8	85.7	6.8*	-0.2	6.6*
Medical Specialists	80.0	85.0	85.1	6.2*	0.1	6.4*
Surgical Specialists	80.8	86.9	86.5	7.6*	-0.5	7.1*

* Rate of change is statistically significant at p <.05.
Source: Community Tracking Study Physician Survey

Supplementary Table 3 **Distribution of Patient Care Physicians by Practice Type, 1995-2003**

Practice Arrangement	1995	1999	2003
Solo or Two Physicians	40.7%	35.3%*	32.5%*
Small Group (3-10 Physicians)	18.9	20.6*	18.9
Medium Group (11-50 Physicians)	6.4	7.0	8.4*
Large Group (50+ Physicians)	2.9	2.7	4.2*
Staff/Group HMO	5.0	3.8*	4.5
Hospital-Owned, Medical School or Other	26.2	30.7*	31.4*

Note: Column percentages may not sum to 100% due to rounding.
* Difference from 1995 is statistically significant at p >.05.
Source: Community Tracking Study Physician Survey