

**BUSINESS**

## Primary care physicians are caught in productivity squeeze

**Costs are rising faster than income, although one survey shows some specialists may be reversing that trend.**

By [Mike Norbut](#), *AMNews* staff. Sept. 20, 2004.

Increasing costs and declining reimbursements are forcing primary care physicians to work harder for the same amount of money or simply take home less pay, according to a pair of recent surveys.

The year 2003 was the third consecutive year that increases in production outpaced increases in compensation, according to the Medical Group Management Assn.'s 2004 Physician Compensation and Production Survey.

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The current economic plight of primary care is sending shockwaves through physician offices everywhere, as clinics struggle to keep up with rising costs and try desperately to find physicians willing to put in extraordinary hours.

"I'm hearing this at every chapter I visit: 'I'm working harder, I'm putting in longer hours, I have trouble recruiting, my overhead keeps going up,'" said Mary Frank, MD, a family physician in Rohnert Park, Calif., and president-elect of the American Academy of Family Physicians. "The corollary is they're cutting back as much as they can, but that affects the customer service aspect."

According to the MGMA survey, the median compensation for all primary care physicians was \$156,902 in 2003, a 2.4% increase over the \$153,231 reported in 2002. Median gross charges, meanwhile, were \$466,283, a 6.1% increase over the 2002 total of \$439,347.

In contrast, specialists in general saw a 7.8% increase in compensation in 2003, from \$274,639 to \$296,464, but only a 4.4% increase in gross charges, from \$914,416 to \$954,239, according to the survey.

This was the first year in more than a decade that specialists saw a higher increase in compensation than in production, though the gap has been much smaller than primary care doctors have seen in recent years. It could be the beginning of a trend as well, as specialists start to capture a return on investments made a few years ago in ancillary services, said Dan Stech, MGMA's director of survey operations.

A few specialties, such as cardiology, gastroenterology and urology, have led the way in developing ancillary services, but specialists in general have more opportunities to expand their revenue than do primary care physicians, Stech said.

"I don't think it's a one-year blip" for specialists, Stech said.

Between 1999 and 2003, gross charges for primary care doctors increased 24.4%, while compensation only went up 9%. Charges for specialists also outpaced compensation increases over the last five years, though it was much more even, at 21.4% to 20.6%.

A survey published earlier this summer by the American Medical Group Assn. had similar findings. Median compensation for family physicians increased 3.7%, from \$148,992 in 2002 to \$154,463 in 2003, while median gross charges increased 11.6%, from \$439,068 to \$489,913, according to the 2004 Medical Group Compensation & Financial Survey. Internists, meanwhile, reported an 11.8% increase in gross charges, from \$419,927 to \$469,494, but only a 6.6% increase in compensation, from \$147,810 to \$157,631.

Dr. Frank said her 19-physician practice, Primary Care Associates, like many groups, pays doctors based on productivity and bases its compensation formulas on relative value units. A year ago, the group cut its RVUs in an attempt to counteract the rising costs of practicing, meaning physicians could maintain their current salaries if they found a way to be more productive.

"You can only see so many people a day," Dr. Frank said. "There's no way to mechanize this. We're not making widgets here."

Some individual specialties, of course, had similar disparities between productivity and pay. According to the MGMA survey, ob-gyn, for example, saw a five-year compensation increase of only 8.3%, while charges increased 15.5% during the same period.

However, the trend in primary care of working harder to maintain a pay level, or even watching compensation decline despite efforts to cut costs and see more patients, is disturbing to physicians and other experts connected to the field.

The fear that young physicians may choose a specialty based on financial viability is one that pervades the health care community, said William F. Jessee, MD, president and CEO of MGMA.

"We're going to need more, not fewer, primary care physicians in the future," said Stephen Montamat, MD, an internist in Boise, Idaho, and governor of the Idaho chapter of the American College of Physicians. "Solutions involve better compensation for doing cognitive skills. We don't get paid for sitting down and working out a complicated case with a patient the way you would doing a 30- or 45-minute procedure."

Rising costs, especially in the form of liability insurance premium hikes, are also taking their toll, said Donald W. Fisher, PhD, president and CEO of AMGA. In large multispecialty groups, the losses realized by primary care physicians are often subsidized by revenue earned by specialists, and even that doesn't always cover it, he said.

According to the AMGA survey, northern groups lost an average of nearly \$3,500 per physician, while southern groups made only \$570 per physician. Groups in the East and West

earned about \$2,000 and \$1,500 per physician. Losses per physician in larger groups are often covered by reserves or endowments, Dr. Fisher said.

In smaller groups, however, that cushion may not be there, and doctors have to resort to old-fashioned belt-tightening to make ends meet. Of course, practices have to hope insurers don't lower their reimbursement rates too, said Debbie Milburn, administrator for Dublin Primary Care, a seven-physician practice in Colorado Springs, Colo.

"If a doctor isn't maximizing his schedule in primary care, there's a problem," Milburn said. "But then, you reach a ceiling. You continue to lower costs or you lower physician salaries if you continue to get paid at a lower rate."

Dr. Frank said the AAFP is working on ways to help their members cope with their income issues, including offering suggestions for new revenue streams. Practices can share services like a diabetic counselor, for example, and bring in-house some tests for which they normally would refer patients to a specialist.

The AAFP also has approached the Centers for Medicare and Medicaid Services and large insurers about paying a "care management" fee to compensate doctors for the time they spend coordinating care, completing paperwork, and helping patients navigate the health care system.

Quality bonus initiatives carry promise for primary care physicians as well, but only if they're not a part of a sleight-of-hand act by insurers, Dr. Frank said.

"Our concern is, if the assumption is there's a fixed pot of money, where is [the bonus money] going to come from?" she asked. "Where is the new money?"

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## ADDITIONAL INFORMATION:

### Working even harder for the money

Primary care physicians have seen compensation gains outpaced by production for three years in a row, and the disparities in recent years have been greater than they were for specialists.

	Primary care		Specialists	
	Compensation	Production	Compensation	Production
<b>2003</b>	2.4%	6.1%	7.8%	4.4%
<b>2002</b>	2.9%	5.2%	4.3%	5.5%
<b>2001</b>	1.2%	11.0%	2.6%	5.2%
<b>2000</b>	2.3%	0.4%	4.3%	4.8%
<b>1999</b>	3.4%	11.3%	6.0%	7.7%

Source: Medical Group Management Assn.

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## Compensation vs. gross charges, 1999-2003

Primary care physicians saw gross charges increase at a much faster rate than compensation over the last five years, while many specialists did not.

Specialty	Change in compensation	Change in charges
Primary care	9.0%	24.4%
Ob-gyn	8.3%	15.5%
Invasive cardiologists	20.7%	29.2%
Hematology/oncology	23.7%	21.8%
Noninvasive cardiologists	25.4%	9.7%

Source: Medical Group Management Assn.

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