

# Hot commodity

Survey shows doc pay keeps climbing, but raises are moderating

By: Andis Robeznieks

Story posted: July 14, 2008 - 5:59 am EDT

According to at least one healthcare compensation expert, because of a shrinking supply of doctors and increasing demand, some physicians may soon see their services "turn into a barrel of oil," meaning they could become a commodity priced so high that healthcare organizations have to get creative in order to afford it or use less of that commodity.

Some data from *Modern Healthcare's* 2008 Physician Compensation Survey seem to fuel that contention.

Alternatives to higher physician salaries have grown to include establishing joint ventures between doctors and hospital systems, "loan forgiveness" agreements for medical-school debt, research opportunities, and payment for on-call duties and administrative services.

As healthcare becomes more volatile in terms of supply and demand, stability is also becoming a valued commodity. For hospitals, it means multiyear employment commitments that keep them off the recruiting treadmill. For physicians it can mean shift work, leaving administrative hassles to someone else and giving them more control of their daily schedules.

Although there's downward pressure on reimbursement while expenses continue to rise, of the 21 specialties tracked in the annual *Modern Healthcare* Physician Compensation Survey, 10 had salary ranges that topped the \$400,000 level at the high end. For purposes of *Modern Healthcare's* annual survey, figures are for total cash compensation, including salary, signing bonuses and other incentives.

One major difference between the 2007-08 data for this year's survey and last year's survey, however, is that compensation increases overall were not as high. Last year, three specialties registered double-digit percentage increases over the previous year: Oncology, 13.9%; pathology, 12.7%; and psychiatry, 10.9%. This year, that feat was achieved only by plastic surgeons, whose compensation grew 10.9%. The second- and third-biggest increases were pathologists at 9.2% and radiologists with 6.5%. Oncologists followed with a 6.2% increase. (In this year's survey, radiation oncology was counted as a separate specialty for the first time.)

Based on survey data, the average compensation for two specialties decreased: Psychiatry saw a decline of 5.6% and obstetrics/gynecology saw a dip of 0.6%. Several specialties saw their compensation increase by less than 2%: hospitalists, 1.9%; internists, 1.6%; noninvasive cardiologists, 1.4%; orthopedic surgeons, 1.1%; dermatologists, 0.8%; and pediatrics, 0.7%.

Kim Mobley, a Detroit-based principal with Sullivan, Cotter and Associates, says she believes

the significant drop for psychiatrists' compensation was probably a factor of the particular samples available and not necessarily market forces.

Meanwhile, Phil Villacci, a principal with Weymouth, Mass.-based healthcare consultant Beacon Partners, says there is one market force that can't be discounted. "The amount of available money is diminishing," says Villacci, who compared physician services to barrels of petroleum. "New levels of physician compensation may be unsustainable going forward."

That's where the new models of compensation come in, Villacci says. As physicians seek higher incomes-in an environment of tighter reimbursement-opportunities to enter into joint ventures, participate in research trials or receive payment for administrative services become attractive alternatives to higher salaries for hospital administrators.

For example, Villacci says an academic medical center may pay a physician an extra \$40,000 to serve as a division chief, while other organizations will now pay doctors about \$150 an hour to participate in administrative meetings.

Villacci says hospitals and systems are hiring doctors as a "defensive strategy" that includes creating stability and "professional fidelity" that leads to fewer recruitment demands while keeping patient referrals in-house.

For physicians, Villacci says hospital employment means a reduction in liability risk, workload relief and, often, unambiguous productivity-based compensation formulas that allow them to be "paid for what they do." In terms of lifestyle demands, Villacci says he knows a 48-year-old hand surgeon who, in addition to six weeks of vacation, takes every Friday off-which is the equivalent of 10 weeks of vacation-meaning he takes 16 weeks off each year.

In addition to such flexible schedules and other perks, orthopedic surgeons are receiving higher financial compensation than most of the other specialties. According to the *Modern Healthcare* survey, compensation for orthopedic surgeons is between \$372,400 and \$512,500 annually. The only specialties in the survey having compensation with higher dollar amounts at both ends of the scale are invasive cardiologists with pay ranging between \$389,000 and \$561,875, and radiologists, whose pay ranges from \$386,755 to \$600,000.

For orthopedists and invasive cardiologists, Villacci says organizations are willing to pay these physicians more because of the revenue they earn for the system. "What hospitals look at is what comes in at the bottom line," he says. "They're willing to spend the money for the return."

Despite a perceived shortage of doctors and increased demand for services in primary care, family-practice physicians, internists and pediatricians saw only modest gains in compensation. Family-practice physicians, for example, saw only a 3.2% compensation increase, which puts them 10th among the specialties for the largest average pay. Their compensation pay ranged between \$150,763 and \$204,370.

One increasingly common way of compensating family medicine specialists has been to pay off their medical-school loans in exchange for multiyear employment commitments.

"They forgive the debt if you stay in town," says Mark Smith, president of Irving, Texas-based recruiter Merritt, Hawkins & Associates. "It's a loan you don't repay financially but you repay with time."

Merritt, Hawkins' spokesman Phil Miller says loan forgiveness, pro-rated over two to three years, is easier for a hospital to manage financially, but the savings is secondary. "The main point is locking the doctor into the commitment," he says. "It really is a retention strategy."

Internists are also in short supply, Smith says. According to the *Modern Healthcare* survey, their compensation ranges from \$175,200 to \$209,845 and they saw only a 1.6% increase in average compensation. But he says the demand is there.

"We need more internists," Smith says. "With very few exceptions, there are very few easy searches."

In fact, when comparing its 2003-04 search assignments to 2006-07, Merritt, Hawkins reports a 120% increase in internist searches, and 84% and 21% increases in searches for family physicians and pediatricians, respectively.

In Merritt, Hawkins' own survey of healthcare compensation, Smith says the big news was pay indicated for certified registered nurse anesthetists, or CRNAs. While the *Modern Healthcare* survey shows anesthesiologists being paid between \$311,600 to \$446,994, the Merritt, Hawkins' survey has CRNAs earning an average of \$185,000 per year-which Smith says is almost as much as his company found for psychiatrists (\$189,000), and more than the compensation reported for family physicians (\$172,000) and pediatricians (\$159,000).

Smith says CRNAs are "beating (pediatric physicians) like a drum. In terms of real shockers out there, that was something that screamed off the pages in this general marketplace," he says. Robert Stiefel, a physician who's an expert on anesthesiologist contract development and a principal with Brentwood, Tenn.-based consultants HealthCare Performance Strategies, says compensation for both anesthesiologists and CRNAs has led to anesthesiology departments being "decoupled" from payers. He explains that anesthesia providers receive more compensation for their services than payers will reimburse, forcing hospitals to subsidize their pay by up to 50% in order to keep operating rooms operating.

Stiefel says Medicare regulations state that up to four CRNAs can practice under one supervising anesthesiologist (though, in most cases, it's usually only three). Five to eight years ago, he says that meant there'd be a team consisting of an anesthesiologist receiving \$300,000 and four CRNAs making \$100,000. But, as CRNA salaries creep up to \$200,000, he says, "the financial advantage of using CRNAs is becoming less pronounced."

Sullivan, Cotter's Mobley also says there is "a lot of market activity" for two subspecialties not specifically tracked by *Modern Healthcare*: hematology oncologists and OB/GYN subspecialists practicing high-risk maternal/fetal medicine. For the OB/GYN subspecialists in particular, she says demand and compensation are "going through the roof."

Other trends Smith notes are a decrease in openings for radiologists in general, but growing demand for radiology subspecialists such as pediatric, interventional and musculoskeletal radiology. He says this has led to fewer opportunities, but higher compensation offered for the subspecialist who meets an organization's specific needs.

Despite a perception that hospitalists are being used more and more extensively, Smith says the number of searches for hospitalists his company has been asked to conduct has leveled off. Merritt, Hawkins conducted 208 hospitalist searches in 2007 compared with 194 in 2006, Smith says. "Like radiologists, places that were once asking for three are now only asking for one," Smith says.

Merritt, Hawkins' Miller says that hospitalists are still the third-most requested search the company conducts, but the market has matured and systems are now more likely to be maintaining or expanding their hospitalist program rather than starting one from scratch.

"They're still in a growth mode, but the quantum leaps are kind of over," Miller says. Another major compensation topic is payment for on-call service. Until recently, unpaid on-call responsibility was part of having hospital privileges. For physicians, seeing new patients in emergency departments was a way to grow their practices. Lately, however, these patients are seen as unlikely to pay and more likely to sue, so physicians are more reluctant to treat them without some guarantee of payment, liability protection or reimbursement for interfering with quality of life. This practice began in rural areas, but now Smith says, it's quickly catching on in urban settings for some specialties.

"It's a topic that isn't going to go away," Smith says. Stiefel agrees. "It's becoming almost the rule and not the exception," he says, adding that the financial burden is significant.

In its response to the *Modern Healthcare* survey, the MD Network, a Dallas-based staffing firm, notes that many trends this year can be traced to the increasing number of physician-owned surgical and ancillary services such as outpatient imaging and surgery centers.

That point was echoed by Atlanta-based Pinnacle Health Group, which notes in its survey response that these facilities are having an impact most notably in states without certificate-of-need laws. They also say an increase in women's health centers has led to more demand for dermatologists, OB/GYNs and radiologists.

Carol Westfall, president of St. Louis-based Cejka Search, says that some of the hiring activity is based on hospitals' awareness of its need "to replenish an aging staff." Villacci adds that many compensation trends in the near future will be driven by two factors: a decline in the availability of primary-care services and location. Where urban physicians' compensation is dictated by fair-market value, he says, "if it's a rural area, they can ask for the moon and get it."

Dallas-based Medicus Partners backs him up in its survey response, but it also notes that-even with high compensation-it's hard to keep young docs down on the farm.

According to their data, physicians living in small towns and rural settings are 50% more likely to earn more than \$250,000. Medicus Partners says 21.4% of small-market doctors earn an annual salary of a quarter-million dollars or more compared with just 14% of their urban counterparts. Nevertheless, some 59% of the physicians they surveyed say they still prefer to practice in a major metropolitan or suburban area.