

NEW PERSPECTIVES: PART II

“It’s not What You Earn but What You Keep That Counts”

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The maxim quoted as the title of this piece has been attributed to many experts on wealth, and I have chosen to resurrect it in response to a recent contribution by Robert Pear of the *New York Times*.¹ Mr. Pear cites a recent study in *Health Affairs* by Laugesen and Glied² comparing fees paid to primary care and orthopedic physicians in the United States to those paid to physicians in countries around the world. He reports that higher fees and greater physician income explain the increased spending on physicians in the United States and that cutting fees to physicians may be a way to rein in US health care costs. Put more simply, US health care costs are out of control because doctors, as service providers in a service industry, represent too much of overall health care spending. Interestingly, when comparing public payers in the United States (Medicare, Medicaid) to primary care providers in Canada, the fees are nearly identical. US physicians only earn more in fees when private payers are added to the mix. It is not immediately clear that the actions of private payers are public policy matters, as the government only has jurisdiction over public fees (which are already matched to other countries).

Laugesen and Glied also compare fees paid to primary care physicians for office visits and orthopedic surgeons for hip replacements. The primary care comparisons, which

the authors admit are apples and oranges, strike me as the more interesting of the two, as primary care is a service that generally doesn’t offer a product (like a new hip) but is connected to the indirect costs required to provide the service (rent, utilities, supplies, etc.). As such, it is not terribly shocking that the provider represents the most expensive component of the service. Furthermore, since time is very expensive in America given the huge opportunity cost of becoming a physician, that more is paid for US physician time than for physicians elsewhere is also not surprising. Interestingly enough, “In general, physician visits in the United States are somewhat longer than in most other countries.”³ The authors go on to eliminate mitigating factors such as higher practice expenses or tuition costs as possible explanations for why physician fees are higher in the United States. How they are able to ascertain practice costs is impressive given the relatively immature state of cost accounting in the US health care system.³

While reading this study, I was reminded of another *Health Affairs* article, published the month prior by Morra et al.,⁴ reporting that US physicians spend nearly four times more than Canadian physicians on interactions with payers. While the data between the two publications have been confirmed to be incompa-

table, it is most striking that US physicians, who are paid slightly higher fees, have to pay \$80,000 more per physician per year to the payment system just to receive those fees! Something is amiss.

Attempting to reconcile these two pieces of information—that US physicians are paid more but that they also pay onerous administrative costs to run their practices—makes clear some ugly truths about American health care. Simply put, medicine is not a free market and does not operate as one. While some elements of the health care system interact with the marketplace, such as the cost of physician salaries, the underlying revenue and cost structures of health care delivery systems are quite arcane. Market norms, where costs and competition matter to price, have given way to centrally planned systems, where prices are the result of consensus by wise elders (see the RUC). This results in the strange and seemingly disparate findings in the above articles.

Reducing the argument to its simplest parts: Is health care too expensive in the United States? Yes. Why? Because the quality is awful as far as we can tell. Do physicians make too much in the United States? As a group, they probably don’t—especially when compared to similarly educated people in other industries. As individuals or sub-groups, they do, as orthopedists earn three to four times more than general medicine physicians based on the results of the centrally planned system. Does the solution to the first problem of health care quality involve changing the way doctors are paid? I would say yes, although along a different dimension than either article proposes. Based on the Morra article, one could conclude that the United States could

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save \$80,000 per physician if administrative costs, which are of no benefit to patient or physician, were eliminated. Based on Laugesen and Glied, fees to doctors should be cut to make them commensurate with those paid to doctors in other countries, with the underlying assumption that lower doctor fees will result in lower health costs. This is a conclusion that I question greatly.

So which is it? Are physicians paid too much or too little? The answer is probably both—paid too much for things like ensuring certain phrases appear in a visit note and paid too little for actual patient care and care coordination. Even more importantly, how much does top line revenue matter if a significant portion of that revenue goes right back to

the payer as “interaction costs” that have no value to our patients? So it seems that how much physicians are paid is not the problem. Our payment system, made twisty and complex over years of manipulation, central planning, failed fraud prevention, and sheer bureaucratic creep, is the problem. It stands in the way of quality care and practice innovation. It is bankrupting the system and the country, and it is time for change.

References

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