CONTEMPORARY PHYSICIAN COMPENSATION

[Modern Trends and Approaches]

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'There are three compensation models. Last year's which everyone hated. This year's, which nobody likes, and next year's which is the perfect answer."
George W. Shannon MD

Physician compensation is a contentious issue and often much fodder for public scrutiny. Throw modern pay for performance [P4P], and related metrics, into the mix and few situations produce the same level of emotion as doctors fighting over wages, salary and other forms of reimbursement. This situation often springs from a failure of both sides to understand mutual compensation terms-of-art when the remuneration deal was first negotiated. This physician salary and compensation information is thus offered as a reference point for further investigations.

INTRODUCTION

Almost a decade ago, *Fortune* magazine carried the headline "When Six Figured Incomes Aren't Enough. Now Doctors Want a Union." To the man in the street, it was just a matter of the rich getting richer. The sentiment was more precisely quantified, according to health economist and financial advisor Dr. David E. Marcinko MBA, in the March 31, 2005 issue of *Physician's Money Digest*, who with Editor Gregory Kelly reported that a 47-year-old doctor with $184,000 in annual income would need about $5.5 million dollars for retirement at age 65. Of course, physicians were not complaining back then under the traditional fee-for-service system; the imbroglio only began when managed care adversely impacted income and the stock market crashed in 2008.
Source: http://www.physiciansmoneydigest.net/issues/2005/92/3951

Today, the situation is vastly different as medical professionals struggle to maintain adequate income levels. Rightly or wrongly, the public has little sympathy for affluent doctors following healthcare reform. While a few specialties flourish, others, such as primary care, barely move. In the words of Atul Gawande, MD, a surgeon and author from Brigham and Women's Hospital in Boston, "Doctors quickly learn that how much they make has little to do with how good they are. It largely depends on how they handle the business side of practice." And so, it is critical to understand contemporary thoughts on physician compensation and related trends.

COMPENSATION TREND DATA SOURCES

A growing number of surveys measure physician compensation, encompassing a varying depth of analysis. Physician compensation data, divided by specialty and subspecialty, is central to a range of consulting activities including practice assessments and valuations of medical entities. It may be used as a benchmarking tool, allowing the physician executive or consultant to compare a practitioner's earnings with national and local averages.

The Medical Group Management Association's (MGMA's) annual *Physician Compensation and Production Correlations Survey* is a particularly well-known source of this data in the valuation community. Other information sources include *Merritt Hawkins and Associates;* and the annual the Health Care Group's, [www.theHealthCareGroup.com] *Goodwill Registry.* However, all sources are fluid and should be taken with a grain of statistical skepticism, and users are urged to seek out as much data as possible and assess all available information in order to determine a compensation amount that may be reasonably expected for a comparable specialty situation. And, realize that net income is defined as salary after practice expenses but before payment of personal income taxes.

Medical Student Debt Burden and Loan Defaults

Moreover, medical student debt burdens (averaging $100,000-$250,000) must now be factor into compensation models and may be economically devastating. Since inception, for example, the federal Health Education Assistance Loan (HEAL) program has squeezed significant repayment settlements from its top deadbeat doctor debtors, and excluded more than a thousand practitioners from Medicare and other federal/state programs. Historically, student loans have even been difficult to discharge through bankruptcy. Alterations to the Bankruptcy Code in late 1998 made student loans non dischargeable, unless the borrower can establish substantial hardship. Changes in 2005 made even private student loans non dischargeable; subject to modification in 2011. And, StudentLoanJustice.org, a website propelled by the current credit squeeze and abrupt economic downturn was launched by Alan Collinge of University Place WA, who runs the site.

EMPLOYED PHYSICIAN COMPENSATION MODELS

According to corporate medical recruiter Kris Barlow*,* employed physicians can select from various employment models that may include fringe benefit packages (life, health, dental, disability insurance; medical society and hospital dues, journals, vacations, auto, and CEUs, etc.) equal to 25-40% of salary.

Independent Contractor or Employee: A payer has the right to control or direct only the result of the work done by an independent contractor, and not the means or methods of accomplishing the result. By contrast, anyone who performs services for another is an employee if he or she can control what will be done and how it will be done. Thus, employed physicians are usually not compensated as independent contractors. Hiring authorities and medical professionals should be careful overusing this technique, in the office or other business. Why? The IRS has successfully attacked many companies that

tried to classify their workers as independent contractors rather than employees. The back taxes and penalties can be fierce. However, many tasks may be successfully delegated to independent contractors or consultants without fear of such characterization. For example, a company does not have to withhold payroll taxes for an independent contractor, but must file a 1099-MISC whenever payments exceed $600 a year. To distinguish between the two, there are several factors to consider. In general, the more you have control over a worker, the more the worker looks like an employee. Two brief tables below note a few of the differences:

Employee:

- Works at the medical office site of employer
- Use practice instruments or equipment
- Cannot delegate or hire others for job
- Method/timing/hours of job specified/controlled
- Expenses reimbursed
- Little invested by worker
- Payment weekly, bi-weekly or monthly
- Only works for one employer
- No risk of non-payment if poor job
- Profit/bonus limited
- No advertising
- Contract states employee relationship
- Position seems permanent
- Work done is essential to practice

Independent Contractor:

- Works off-site
- Uses own instruments and equipment
- Can hire others or delegate [outsource]
- Method/timing of job uncontrolled
- Expenses borne by worker
- More invested by worker
- Payment by the job, procedure or flat fee
- Works for several clients
- Opportunity for profit
- Advertising to general public
- Contract says independent contractor
- Position temporary
- Work done is non-core function of practice

No single one of these factors determines status. The IRS has a 20-factor test outlined in Revenue Ruling 87-41 and discussed in Publication 1976, “Independent Contractor or Employee”. When you have a relationship that is unclear, you should consult with the IRS guidelines and publications. If your intent is to hire an independent contractor physician, try to make sure the relationship has more of the factors indicative of that

status, checking the latest IRS publication for all relevant factors. Because of the large amounts at stake, you should err on the side of employee status if uncertain. You may wish consult a tax attorney or accountant as well, especially if you have multiple workers in a gray area. In addition, you can request that the IRS make a determination of worker classification by submitting Form SS-8, "Determination of Employee Work Status for Purposes of Federal Employment Taxes and Income Tax Withholding. The IRS guidelines on this topic are rather lengthy. And, $600 is still the threshold amount this year unless it is royalties ($10). Non-employee compensation, rent, royalties, prizes or awards, and services are only a few of the situations giving rise to a 1099-MISC. Doctors may also find this link of additional benefit:
Source: http://www.ehow.com/how_13664_know-issue-1099.html

New Practitioner Salaries: Published annually for new practitioners by The Health Care Group®, the *Physician Starting Salary Survey* collects and collates nationwide data on new physician employment compensation. The guide reports first, second and third year of starting physicians' salary and incentives, but with large high-low spreads. It also includes information about co-ownership provisions, benefits and restrictive covenants. The survey is categorized by specialty and results are based on information provided by medical practices, health care advisors, physicians, and health care consultants across the country. The figures represent basic elements of the bid/ask process for establishing optimal salary and benefit amounts for new physicians entering private practice. It is annually available from the Health Care Group (800.473.0030); or www.HealthCareGroup.com).

Hospital Employees: As profit generators, physicians like pathologists, invasive radiologists, anesthesiologists, emergency department doctors and hospitalists will demand and receive higher salaries.

SELF-EMPLOYED PHYSICIAN COMPENSATION MODELS

According to medical benefits consultant Eric Galtress, physicians can still seek self-employment compensation models.

- **Independent Physicians:** A self-employed physician has great freedom but less security, because relationships with an employer are defined in return for a set compensation. Typically, this option is ideal for those who desire control, don't work well in structured environments, and are committed to maximizing personal compensation.
- **Same-Specialty Group Partnerships:** A same-specialty partnership is more restrictive than independent practice, and must balance control with the security that comes from working with colleagues along a continuum-of-care. Internal competition may be fierce, but partners maintain some autonomy while reaping rewards from economies of scale. More personal time is available too, but compensation is based on individual and group performance.

NEWER DELIVERY AND COMPENSATION MODELS

Today, whether independent or employed, physicians can pursue several creative compensation models not popular a decade ago:

- **Pay-for-Performance Initiatives:** The concept of pay-for-performance (P4P) is an unproven trend, according to the Congressional Research Service, an arm of the Library of Congress. Initial studies suggested that pay-for-performance programs might change performance on quality measures that are used for the basis of bonus payments. Claims that P4P programs are cost saving in the long run are largely speculative, however, since determining whether a certain healthcare practice produces good results usually requires controlled studies rarely possible for a social policy. A recent study published in the New England Journal of Medicine found that P4P accelerated quality improvements for some conditions in the short term. However, once targets were met, the rate of quality improvement slowed, and the quality of care actually declined for other conditions which were not incentivized. (N Engl J Med. 2009 Jul 23; 361(4):368-78). Research shows there is a fundamental problem with P4P programs: They have had little to no impact on quality. Moreover, physician pay is contingent on them believing that goals are fair, measures appropriate, performance accurately tallied, and incentives worthwhile. And so, newer models of compensation are emerging like those described below:
- **Physician Quality Reporting Initiative.** The Centers for Medicare and Medicaid Services [CMS] paid out more than $40 million in monetary incentives to medical providers who reported data on quality of care delivered between July 2009 and December 2009; as part of its PQRI. Under the PQRI, healthcare providers who participated got bonuses of 1.5 percent of their total CMS payments during the reporting period. Average payments ranged from $750 for individual physicians to $5,000 for groups. One large practice received more than $200,000.
- **Direct Reimbursement Payment Model:**

- **Global Healthcare Model:** American businesses are extending their cost-cutting initiatives to include offshore employee medical benefits, and facilities like the Bumrungrad Hospital in Bangkok, Thailand (cosmetic surgery), the Apollo Hospital in New Delhi, India (cardiac and orthopedic surgery) are premier examples for surgical care. Both are internationally recognized institutions that resemble five-star hotels equipped with the latest medical technology. Countries such as Finland, England and Canada are also catering to the English-speaking crowd, while dentistry is especially popular in Mexico and Costa Rica. Although this is still considered "medical tourism," Mercer Health and Benefits was recently retained by three Fortune 500 companies interested in contracting with offshore hospitals and JCAHO has accredited 88 foreign hospitals through a joint international commission. To be sure, when India can discount costs up to 80%, the effects on domestic hospital reimbursement and physician compensation may be assumed to increase downward compensation pressures.

- **Values Based Healthcare Model:** According to Mark Fendrick, MD and Michael E. Chernew, PhD, instead of the one size fits all approach of traditional health insurance, a "clinically-sensitive" cost-sharing system that supports co-payments related to evidence-based value for targeted patients seems plausible. In this model, out-of-pocket costs are based on price and a cost/quality tradeoff in clinical circumstances: low co-payments for interventions of highest value, and higher co-payments for interventions with little proven health benefit. Smarter benefit packages are designed to combine disease management with cost sharing to address spending growth.

- **Concierge Practice Model:** The concierge practice model continues to gain in popularity. The concept of concierge medicine (CM), also known as retainer medicine, first emerged in Seattle, Washington in the 1990's. With CM, the physician charges an annual retainer fee to patients. The fee usually ranges from $1,000 to $20,000 per year, and the number of patients in a practice is usually limited to a few hundred. In return, patients receive increased levels of access and personalized care. This often includes same day appointments, extended visit times, house calls, and 24/7 access to the physician by pager and cell phone. An annual executive physical is often included, as well as an increased emphasis on preventive care. Many physicians choosing this type of practice model do so for lifestyle and control reasons, although the average income for a successful CM primary care physician is higher than that of a typical primary care physician. For more information on starting a CM practice, see http://www.modernmedicine.com/modernmedicine/article/articleDetail.jsp?id=112475.

- **Locum Tenens Practitioner Model:** Locum Tenens (LT) is an alternative to full-time employment is enjoying a comeback for most specialties. Some younger physicians enjoy the travel, while mature physicians like to practice at their leisure. Employment factors to consider include: firm reputation, malpractice insurance, credentialing, travel and relocation expenses (which are negotiable). However, a LT firm typically will not cover taxes [NALTO.org and http://www.studentdoc.com/locum-tenens.html]

Locum Tenens Specialty Compensation per 8 Hour Shift

CRNA	$750 to $900
Family Practice	$425 to $475
Internal Medicine	$425 to $500
Pediatrics	$425 to $450
OB/GYN	$650 to $825
Hospitalist	$525 to $775
General Surgeon	$70 to $775
Orthopedic Surgeon	$825 to $925
Neurosurgeon	$1,350 to $1,450

Anesthesiologist	$1,100 to $1,550
Psychiatrist	$525 to $600
Radiologist	$1,250 to $1,500
Cardiologist	$625 to $750

Source: LocumTenens.com

Other next-generation medical models may be found at the websites: InnovativeCareModels.com, MedInnovationblog.blogspot.com, SoundPractice.net, and IdealMedicalPractices.typepad.com.

INCOME OFFERED TO TOP 22 RECRUITED MEDICAL SPECIALTIES *#+
(Base salary or income guarantee only, does not include production bonus or benefits)
Low -- Average -- High

Family Practice
2008/09 $120,000 $173,000 $245,000
2007/08 $120,000 $172,000 $275,000
2006/07 $120,000 $161,000 $250,000
2005/06 $115,000 $145,000 $220,000
Family Practice with Obstetrics
2008/09 $140,000 $184,000 $275,000
2007/08 $140,000 $184,000 $275,000
2006/07 $145,000 $159,000 $200,000
2005/06 $140,000 $158,000 $180,000
Internal Medicine
2008/09 $140,000 $186,000 $300,000
2007/08 $125,000 $176,000 $330,000
2006/07 $135,000 $174,000 $275,000
2005/06 $130,000 $162,000 $250,000
Hospitalist
2008/09 $160,000 $201,000 $300,000
2007/08 $150,000 $181,000 $300,000
2006/07 $145,000 $180,000 $250,000
2005/06 $140,000 $175,000 $190,000
General Surgery
2008/09 $175,000 $321,000 $616,000
2007/08 $240,000 $321,000 $450,000
2006/07 $225,000 $301,000 $350,000
2005/06 $150,000 $272,000 $350,000
Orthopedic Surgery
2008/09 $300,000 $481,000 $1,000,000
2007/08 $250,000 $439,000 $750,000
2006/07 $250,000 $413,000 $650,000
2005/06 $250,000 $370,000 $515,000
OB/GYN

2008/09 $150,000 $266,000 $655,000
2007/08 $160,000 $255,000 $405,000
2006/07 $200,000 $247,000 $345,000
2005/06 $175,000 $234,000 $450,000

Psychiatry

2008/09 $160,000 $200,000 $300,000
2007/08 $120,000 $189,000 $230,000
2006/07 $160,000 $186,000 $230,000
2005/06 $130,000 $174,000 $230,000

Cardiology

2008/09 $180,000 $419,000 $880,000
2007/08 $250,000 $392,000 $1,000,000
2006/07 $250,000 $391,000 $500,000
2005/06 $175,000 $342,000 $500,000

Pediatrics

2008/09 $120,000 $171,000 $350,000
2007/08 $120,000 $159,000 $265,000
2006/07 $115,000 $159,000 $200,000
2005/06 $115,000 $151,000 $180,000

Neurology

2008/09 $180,000 $258,000 $375,000
2007/08 $150,000 $230,000 $325,000
2006/07 $170,000 $234,000 $275,000
2005/06 $150,000 $210,000 $250,000

Emergency Medicine

2008/09 $185,000 $244,000 $302,000
2007/08 $190,000 $240,000 $258,000
2006/07 $150,000 $239,000 $300,000
2005/06 $130,000 $210,000 $270,000

Pulmonology

2008/09 $215,000 $293,000 $400,000
2007/08 $200,000 $283,000 $525,000
2006/07 $225,000 $266,000 $350,000
2005/06 N/A N/A N/A

Urology

2008/09 $230,000 $401,000 $550,000
2007/08 $300,000 $387,000 $550,000
2006/07 $275,000 $400,000 $500,000
2005/06 $250,000 $320,000 $375,000

Gastroenterology

2008/09 $250,000 $393,000 $600,000
2007/08 $250,000 $379,000 $475,000
2006/07 $200,000 $365,000 $450,000
2005/06 $175,000 $315,000 $500,000

Radiology

2008/09 $300,000 $391,000 $500,000

2007/08 $230,000 $401,000 $750,000
2006/07 $250,000 $380,000 $500,000
2005/06 $240,000 $351,000 $500,000

Hematology/Oncology

2008/09 $250,000 $335,000 $450,000
2007/08 $225,000 $365,000 $500,000
2006/07 $300,000 $339,000 $500,000
2005/06 N/A N/A N/A

Otolaryngology

2008/09 $280,000 $377,000 $450,000
2007/08 $275,000 $362,000 $600,000
2006/07 $200,000 $312,000 $400,000
2005/06 $175,000 $272,000 $350,000

CRNA

2008/09 $125,000 $189,000 $250,000
2007/08 $155,000 $185,000 $230,000
2006/07 $130,000 $164,000 $200,000
2005/06 $87,000 $156,000 $210,000

Anesthesiology

2008/09 $250,000 $344,000 $500,000
2007/08 $250,000 $336,000 $480,000
2006/07 $220,000 $300,000 $425,000
2005/06 $275,000 $306,000 $375,000

Dermatology

2008/09 $200,000 $297,000 $400,000
2007/08 $250,000 $315,000 $400,000
2006/07 $200,000 $318,000 $400,000
2005/06 N/A N/A N/A

Phlebology +

2008/09 $175,000

Podiatry #

2008/09 $125,000

Sources:
* Merritt Hawkins and Associates
# Podiatry Management Compensation Report
+ iMBA Inc, Proprietary Compensation Statistics

And, these specialties enjoyed the biggest jumps from a year earlier: neurology, non-invasive cardiology, anesthesiology, emergency medicine and internal medicine.

Source: http://blogs.wsj.com/health/2009/06/17/how-much-do-rookie-doctors-make-the-latest-scorecard/

Most recently, a "top five" medical specialty list was developed for primary care specialties by the National Physicians Alliance (http://npalliance.org/). This initiative was

funded through the American Board of Internal Medicine [ABIM] Foundation's "Putting the Charter into Practice" grants, which fund organizations to develop initiatives to advance physician professionalism, including management of finite resources. What follows are the median (50 percent earn more, 50 percent earn less) salaries for the six highest-paying and six lowest-paying medical specialties in 2009-10:

Five Highest
Orthopedic surgeons: $580,711 to $641,728
Cardiac and thoracic surgeons: $507,143
Radiologists: $438,115 to $478,000
Radiation therapy: $413,518
Gynecological oncology: $406,000
Cardiology: $398,034

Five Lowest
Family Medicine: $197,655
Pediatrics: $202,832
Internal Medicine: $205,441
Psychiatry: $208,462
Geriatrics: $211,425
Hospitalists: $211,835

Source:
http://www.abimfoundation.org/Professionalism/Professionalism%20in%20Practice.aspx

THE EFFECT OF HEALTHCARE REFORM LEGISLATION ON PHYSICIAN COMPENSATION

With the passage of healthcare reform legislation, officially known as the Patient Protection and Affordable Care Act of 2010, many questions remain regarding its effect upon physicians' livelihood. Undoubtedly this bill moves the healthcare system several steps closer to a socialized model, but the effects on physicians' salaries and compensation models are far from clear.

One way to see the effect that this shift may have on compensation is to look to other countries. According to the CRS Report for Congress, US Health Care Spending: Comparison with Other OECD Countries (September 17, 2007, http://assets.opencrs.com/rpts/RL34175_20070917.pdf), US specialists rank near the top in compensation compared to these other countries, trailing the Netherlands and Australia. The average specialist in the US made $230,000 in this survey. The comparable salary in Canada is $161,000, $150,000 in the UK, and $253,000 in the Netherlands. Generalists in the US are at the top in terms of compensation with an average of $161,000. This compares to $107,000 in Canada, $118,000 in the UK, and $117,000 in the Netherlands.

Another indicator of physician salary trends is the change in compensation adjusted for inflation. According to the American Medical Association, the inflation-adjusted income for the average patient care physician declined from $180,930 to $168,122 from 1995 to 2003, a 7% decrease. And, the inflation adjusted decrease is more substantial given the low interest rate environment thru 2010, and going forward

	Average net income		
	1995	**2003**	**Decrease**
All patient care physicians	$180,930	$168,122	7%
Primary care physicians	$135,036	$121,262	10%
Medical specialists	$178,840	$175,011	2%
Surgical specialists	$245,162	$224,998	8%

(http://www.ama-assn.org/amednews/site/free/prsc0724.htm)

Given these trends, as well as the fact that an increasing percentage of healthcare payments are coming from dwindling government sources, it is likely that physician salaries will decline as "healthcare reform" legislation is implemented. In fact, it is likely that this trend will accelerate. A 15% to 25% inflation-adjusted decline in salaries over the next decade is a reasonable prediction.

It is also important to note that the level of student debt in the US continues to rise, while college and medical education are usually subsidized in other countries. Many foreign physicians graduate with no student loan debt. The ratio of debt level to salary in the US continues to become more onerous for new physicians.

OTHER MEDICAL PROFESSIONAL SALARIES

Dentists are Different

A 2003 Survey of Dental Practices reported net income from dentistry-related sources. Dentists differ from physicians in that 90% are in private practice. In 2002, the average practitioner's net income was $174,350. The average dental specialist's net was $291,250. These figures represent a 0.7% and a 5.8% increase over 2001, respectively. Net income rose steadily since 1986, when general dentists made an average of $69,920 and specialists an average of $97,920. But, by 2010, according to PayScale.com, the average general dentist earned $98,276 - $157,437; a decreasing trend allocated as follows.

Salary $92,689 - $147,682
Bonus $1,996 - $19,727

Profit Sharing $1,038 - $27,514

Commissions $480.74 - $32,500

Source: http://www.ada.org/prof/resources/pubs/dbguide/newdent/income.asp#private
Source: http://www.payscale.com/research/US/Job=Dentist/Salary

So Are Chiropractors

According to Salary.com, the median salary for strictly office-based chiropractors was $78,994 in 2005; while Collegegrad.com reported the median annual earnings of a salaried chiropractor as $65,330 in 2002; with the middle 50% earning between $44,140 and $102,400.

The U.S. Bureau of Labor Statistics estimated chiropractors earned an average salary of $84,020 in 2004. A Chiropractic Economics survey in 2005 suggested mean salary at $104,363. Another survey, for 2007, in *Chiropractic Economics* is available here: http://www.chiroeco.com/article/2007/Issue8/images/CES&ESurvey2007.pdf

And, a range of $44,511 - $82,826 was reported in 2010 by PayScale.com, allocated as follows:

Salary	$42,106 - $78,129
Bonus	$1,008 - $10,205
Profit Sharing	$973 - $8,139
Commission	$750 - $10,113
Total Pay	$44,511 - $82,826

Source: http://www.payscale.com/research/US/Job=Chiropractor/Salary

Podiatrist's Potential Rising

The salary range for a podiatrist, or Doctor of Podiatric Medicine, in 2006 was reported as $128,000 to $292,000 according to http://www.allied-physicians.com/salary_surveys/physician-salaries.htm.

This robust growth was likely due to expanded education, training, and general allopathic and osteopathic acceptance by the medical community, as well as by insurance companies, employers, patients and various governmental agencies and third party payers. Increased surgical sub-specialization, in-patient hospital and ambulatory out-patient surgical center activity were also positive compensation factors.

HEALTH 2.0 EXAMPLES
On Pre-Paid Cash-Based Medicine
www.NoInsuranceClub.com

Patients take out private insurance policies for catastrophic events with high-deductibles [MSA/HSAs] and to keep monthly premiums down. They also turn to Medicaid, mini retail-clinics at grocery stores/pharmacies, and emergency room visits for common illnesses. The firm connects patients with participating board certified physicians that monitor and treat preventative healthcare needs for a one-time prepaid annual membership fee. Patients receive up to 12 office visits per year, including immunizations, in-office prescriptions and additional services like blood tests. There are no deductible, no co-pays, no premiums and no surprise bills. The services offers viable alternatives to COBRA for employees laid off from work, and/or a low cost preventative care option for the self-employed.

The PROMETHEUS Payment® Model
www.prometheuspayment.org

This not-for-profit organization, formed in 2006, is developing a new provider payment model which offers a different approach to include all providers treating a patient for specified conditions. The goals of this model are to improve quality, lower administrative hassles, enhance transparency, and support a patient-centric and consumer driven environment.

A unique aspect of this model is the alignment of incentives for all parties, so that by doing the right things for patients the healthcare providers and insurers do well for themselves. One tool used to align incentives is the Potentially Avoidable Complication, or PAC. The Prometheus Payment system uses modeling programs and "Evidence-informed Case Rates" (ECRs) to predict the number of PACs likely to occur for a population of patients. The system acknowledges that some of these will occur. The physician is compensated based upon the number of PACs anticipated for the patients under care. The physician can improve the profit margin by investing in measures to avoid PACs. To the extent that the physician is successful, the compensation will exceed the baseline. In this manner, Prometheus Payment can become a "win-win-win" for patients, providers and purchasers.

THE COMPENSATION VERSUS VALUE PARADOX

Regardless of specialty, degree designation or delivery model, physician salary is traditionally inversely related to independent medical practice business value. In other words, the more a doctor takes home in compensation from his practice, the less ownership in a private practice is worth, and *vice versa*. This is the difference between a short-term and long-term compensation strategy.

ASSESSMENT

Money, received as salary in the present, can earn money over a period of time (making the amount ultimately larger than if the same initial sum were received later). Therefore, both the amount of investment return and the length of time it takes to receive that return affect the rate of return (i.e., the value of the return). This financial planning principle, known as the time-value of money (TVM), is a vital compensation issue regarding ultimate wealth accumulation.

This TVM concept, along with the Marcinko/Kelly retirement report, should serve as a wake-up call that physicians may need to cut personal consumption and professional expenses, and to save more aggressively to harvest the eventual lifestyle and retirement dream all are working toward.

CONCLUSION

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www.CashCare.us
www.CertifiedMedicalPlanner.com
www.Collegegrad.com 2010
www.HealthCapital.com
www.HealthCareFinancials.com
www.HealthCareGroup.com
www.HealthDictionarySeries.com
www.HowMuchDoc.com
www.MedicalBusinessAdvisors.com
www.MDIntellinet.com
www.PodiatryManagement.com
www.Salary.com 2010

Additional Resources

Related Medical Information Resources
SIC 8043 / NAICS 621391
Physicians

Bureau of Labor Statistics, U.S. Department of Labor
Occupational Outlook Handbook - Physicians
http://www.google.com/search?hl=en&q=occupational+outlook+handbook
This site describes the nature of the industry, working conditions, employment, occupations in the industry, training and advancement, earnings and benefits, employment outlook, and lists of organizations that provide additional information.

American Medical Group Association
Medical Group Financial Operations Survey
http://www.amga.org/ Select "Departments – Publications – Data/Statistical Publications"
The financial operations survey provides critical benchmark data on support staff salaries and benefits, staffing profiles, and other key management costs. The data is presented on

a per physician basis as well as on a per square foot basis. The summary information pages include financial profiles based on varied managed care revenue percentages and are further broken down by group type, geographic region, and group size, as well as a staffing profile by specialty.

Health Capital Consultants, LLC
Published Research Articles
www.HealthCapital.com
HCC specializes in healthcare valuation, merger & acquisition, litigation support & expert testimony, financial analysis, & related health industry economics and capital evaluation research services.

The Health Care Group
Physician Starting Salary Survey
http://www.thehealthcaregroup.com Select "Products - Annual Surveys"
The physician starting salary survey collects nationwide data on new-doctor compensation. The survey reports three initial years of salary and incentive information and includes co-ownership provisions, benefits, and restrictive covenants.

The Sherlock Company
Physician Executive Compensation Analysis
http://www.sherlockco.com Select "Analyses"
Douglas B. Sherlock, CFA, is President of Sherlock Company which assists health plans, their business partners and their investors in the treasury, control and compensation functions of healthcare finance.

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