Physician Work Hours, Fees Declined in Tandem

BY MARY ANN MOON

The number of hours U.S. physicians work each week has markedly and steadily decreased during the past decade, after having remained stable during the 2 preceding decades, according to a report in JAMA.

While the study was not designed to identify why such changes have occurred, investigators did find a striking correlation between physicians' decreasing hours and decreasing fees for their services. Inflation-adjusted physician fees changed little until the mid-1990s, when they began a steady 10-year decline. "By 2006, physician fees were 25% lower than their inflation-adjusted 1995 levels," Douglas O. Staiger, Ph.D., of Dartmouth College, Hanover, N.H., and his colleagues noted.

The decrease in hours worked per week "was broad based and not concentrated among physicians with particular demographic characteristics or working in particular settings." Physicians from all demographic areas have shortened their typical workweeks from the approximately 55 hours that prevailed since 1977 to 51 hours, the investigators said.

©Udo Kroener/Fotolia.com

Physicians have shortened their typical workweeks in the last decade, unlike other professionals.

In contrast, mean weekly hours worked by other professionals such as lawyers, engineers, and registered nurses "changed very little during the past 30 years, which is consistent with national trends in mean weekly hours among all workers published by the Bureau of Labor Statistics," they said.

The researchers said they examined this issue because most studies concerning the medical workforce, as well as the policy decisions based on those studies, have assumed that hours worked by physicians have remained constant. A few recent studies have suggested that this assumption may no longer be warranted.

Dr. Staiger and his colleagues analyzed data from the Census Bureau's Current Population Survey, an annual report that obtains detailed information about employment from a nationally representative sample of adults. They examined data from the late 1970s through 2008 on all 116,733 survey subjects listed as physicians or surgeons.

Physician weekly work hours were stable during 1977-1997, ranging only from a low of 54.6 hours to a high of 55.9. Since then, however, work hours have declined steadily, and they currently total 51 hours per week.

During the same interval, mean physician fees, adjusted for inflation, decreased by 25%. "It is likely that a third factor that was associated with lower fees, such as growing managed care penetration or market competition, may have contributed to the decrease in physician hours," Dr. Staiger and his colleagues noted (JAMA 2010;303:747-53).

"Whatever the underlying cause, the decrease … raises implications for physician workforce supply and overall health care policy. A 5.7% decrease in hours worked by nonresident physicians in patient care, out of a workforce of approximately 630,000 in 2007, is equivalent to a loss of approximately 36,000 physicians from the workforce.

"Although the number of physicians has nearly doubled during the last 30 years, many workforce analysts and professional organizations are concerned about the adequacy of the size of the future physician workforce. This trend toward lower hours, if it continues, will make expanding or maintaining current levels of physician supply more difficult," they noted.

The trend also "could frustrate stated goals of health reform, which may require an expanded physician workforce to take on new roles and enhanced functions in a reformed delivery system." ■

Disclosures: *This study was supported by the National Institutes of Health. Dr. Staiger and his associates reported no financial conflicts of interest.*

MY TAKE

A Gathering Storm

This study on the decline in hours worked per week by physicians highlights a gathering storm in the field of primary care medicine. This finding comes at a time when hospitals are under increasing pressure to decrease the workload and hours worked by residents—and by extension—practicing physicians.

The other development contributing to this inclement outlook is that the health care reform legislation recently passed the U.S. Congress and signed by President Obama will soon be adding 32 million previously uninsured Americans to the national health care equation.

We therefore desperately need to ramp up our education and training of new physicians, especially those who want to practice primary care in underserved communities. However, this will take time because medical schools cannot just expand their class size without adding significant numbers of new faculty and other resources.

In the meantime, we will have to greatly expand the use of and responsibilities of allied health care professionals, such as physician's assistants and nurse midwives, to help fill the void until medical schools such as ours can greatly expand our class size. Although there is currently a shortage of allied health care professionals in the United States as well, it will nevertheless be easier to increase our output of these professionals in the short term than it will be to increase our output of physicians.

Thus, to avert this gathering storm of health care worker shortages, we must train more allied health care professionals in the short term, while in the long term we will need to significantly expand training of high-quality, committed primary care physicians.

DR. E. ALBERT REECE, PH.D., M.B.A., *who specializes in maternal-fetal medicine, is vice president for medical affairs at the University of Maryland, Baltimore, as well as the John Z. and Akiko K. Bowers Distinguished Professor and dean of its school of medicine.*

Most Practices Too Small for Performance Assessment

BY MARY ANN MOON

Most primary care practices are not large enough for significant differences in performance to be assessed using national quality and cost benchmarks, according to a report in JAMA.

Nationally, fewer than 2% of all primary care practices were able to be reliably assessed because their caseloads were too small. Even when their case loads were pooled with those of other physicians in the practice, and even if 2-3 years' worth of cases were included, the numbers were too small to reliably assess quality, according to David J. Nyweide, Ph.D., of the Centers for Medicare and Medicaid Services and his associates.

The CMS has "been overseeing a series of value-based purchasing initiatives," including pay-for-performance projects and the Physician Quality Reporting Initiative.

Dr. Nyweide and his colleagues questioned whether individual physicians see a sufficient number of patients with various disorders such that their performance can be judged against commonly used quality and cost measures.

Using national mean ambulatory Medicare spending data, the researchers calculated the caseloads that would be necessary to detect meaningful differences on each commonly used performance measure, including rates at which 66- to 69-year-old women received mammography, rates of hemoglobin A_{1c} testing for diabetics aged 65-75 years, rates of preventable hospitalizations associated with 13 specific adult conditions, and rates of hospital readmission for heart failure patients.

In all, 71,980 primary care physicians who were affiliated with 30,794 practices were included in the study. Most of the practices (61%) were solo. Caseloads ranged from a median of 170 patients for solo practitioners to 13,400 for practices with more than 50 primary care physicians.

The investigators found that "only the largest primary care physician practices, which are also the most uncommon, can be expected to have sufficient caseloads to measure significant differences in performance."

A year-long caseload of 328 women aged 66-69 years old would be needed to detect a 10% difference in the rate of mammography for that age group, and 19,069 patients would be needed to reliably detect a 10% difference in the rate of preventable hospitalizations.

Overall, fewer than 2% of the practices could be reliably compared on any of the performance measures.

Even grouping caseloads by 2-year and 3-year periods failed to amass sufficient sample sizes for reliable comparisons among practices.

"The results from this study call into question the wisdom of pay-for-performance programs and quality reporting initiatives that focus on differentiating the value of care delivered to the Medicare population by primary care physicians," Dr. Nyweide and his colleagues wrote (JAMA 2009;302:2444-50). ■

Disclosures: *None was reported.*