Higher Physician Fees Drive Up U.S. Health Costs

The higher fees paid by insurance companies for hip replacement seem to be major contributors.

BY ALICIA AULT

FROM HEALTH AFFAIRS

Higher fees paid to physicians are a key reason for greater U.S. health care spending when compared with other nations, according to a new study.

There is also a greater pay differential between primary care and specialty care in the United States than in certain European countries, Australia, and Canada.

"Our findings as a whole suggest that the observed price differences are not entirely a consequence of differences in underlying practice costs or in the tuition costs of medical education," said Miriam J. Laugesen of Columbia University and her Columbia colleague, Sherry A. Glied, who is currently on leave at the U.S. Department of Health and Human Services (HHS).

They offered several potential reasons for U.S. physicians' greater incomes. One possibility is that physicians are reflective of a certain strata of U.S. society: those who are more highly educated and skilled and tend to be more highly paid. But higher fees paid by private insurers in general, and for hip replacement surgery in particular, seem to be major contributors as well, they concluded (Health Aff. 2011;30:9 [doi: 10.1377/hlthaff.2010.0204]).

To examine whether higher prices in the United States are responsible for the greater level of health spending in this country, the researchers analyzed fees, incomes, and spending for primary care – defined as general and family practice, internal medicine, pediatrics, and ob.gyn. – and for orthopedic surgery, specifically, hip replacement.

Data on U.S. physicians and fees were compared with similar information for Australia, Canada, France, Germany, and the United Kingdom. All of these countries continue to use some kind of fee-for-service reimbursement, which allowed for closer comparisons.

Overall, physician income was highest in the United States. Primary care physicians earned about $186,000 before taxes and after practice expenses. Australian physicians earned the least, $92,000, while primary care physicians in the United Kingdom earned close to their U.S. counterparts at $159,000.

Using the fee paid for an 11- to 15-minute office visit for an established patient, the authors determined that public payers reimbursed only $34 in Australia.

The highest rate was in the United Kingdom, at $66. In the United States, physicians received an average of $60 per visit from public payers; Canadian physicians received about $59.

The authors calculated that U.S. primary care doctors earned about one-third more than their counterparts in the other nations, primarily because they receive a greater share of their reimbursement from private insurance than do primary care physicians in the other countries.

Of the physicians studied, U.S. orthopedic surgeons were the highest earners: $442,000 after expenses and before taxes. French surgeons earned the least at $154,000, while surgeons in the United Kingdom earned $324,000.

For orthopedic surgery, the public pay rate was lowest in Canada at $652 and highest in the United States at $1,634.

The authors found that private insurance for hip replacement in the United States paid about $4,000 per procedure – more than twice as much as the private rate in any of the other countries studied.

The research "really does a nice job of just very methodically walking through the steps to show that the physician fees and incomes are much higher in the U.S. and that that's at the heart of why we spend more on physician services," Chapin White, a senior health researcher at the Center for Studying Health System Change, said in an interview.

It would be improper, however, to think that physician fees are solely to blame for higher health care spending in the United States, said Mr. White, noting that physician expenditures are a small slice of the health pie.

By detailing the difference between specialist and primary care pay in America, and the vast difference between payments for hip replacement surgery in the United States and other nations, the authors also showed a fundamental flaw in the payment system, he continued.

U.S. primary care doctors' income was only 42% of that earned by U.S. orthopedic surgeons. The authors speculated that this is because private insurers in the United States have been more successful in negotiating lower fees for primary care than for orthopedic surgery.

In Canada, France, and Germany, the pay gap was smaller: primary care physicians earned 60% of their surgery colleagues.

The pay gap between primary care and hip replacement surgery "is where the blinking red light is, that something is out of whack in the U.S.," Mr. White said.

The research also shows that "it's not at all the case that primary care is underpaid, but more that the surgeons and specialists are overpaid," he said. ■

VITALS

Major Finding: Private health insurers pay an average of $3,996 for hip replacement surgery in the United States, compared with $2,160 in the United Kingdom, $1,943 in Australia, and $1,340 in France.

Data Source: Organization for Economic Cooperation and Development, Health Data 2010.

Disclosures: The study was funded in part by grants from the Robert Wood Johnson Foundation and the Commonwealth Fund. The authors had no financial conflicts to disclose.

Factors Peg Why Only Some Docs Get Board Certified

BY MARY ANN MOON

FROM JAMA

Age at graduation, gender, race, and test scores were found to predict whether a physician would attain board certification in any of eight specialty categories, according a retrospective analysis.

"ABMS [American Board of Medical Specialties] member board certification is currently among the criteria used by HMOs, hospitals, and health insurance plans in evaluating physicians who wish to obtain privileges or join provider organizations, by medical school promotion committees in evaluating physician faculty members for promotion and tenure, and by the Accreditation Council for Graduate Medical Education as criteria for selection of physicians to serve as GME program directors and residency review committee members," according to Donna B. Jeffe, Ph.D., and Dr. Dorothy A. Andriole of Washington University, St. Louis.

"Thus, ABMS member board certification is emerging as a de facto requirement for the full participation of physicians in the U.S. health care system, and non–board-certified physicians compose an increasingly marginalized group," they noted.

To identify factors associated with achieving specialty certification, Dr. Jeffe and Dr. Andriole constructed a database with "deidentified" records for all medical students who graduated 1997-2000 and followed them for at least 8 years; a total of 42,440 graduates were included. These data were linked to testing records from the National Board of Medical Examiners as well as data from the Association of American Medical Colleges and the American Medical Association Physician Masterfile to track specialty certification.

The specialty categories included internal medicine, family medicine, pediatrics, emergency medicine, radiology, surgery (including several surgical subspecialties), ob.gyn., and a composite category comprising allergy/immunology, anesthesiology, dermatology, neurology, genetics, nuclear medicine, ophthalmology, pathology, and psychiatry.

Overall, 87.3% of the sample were board certified, the investigators said (JAMA 2011;306:961-70).

Physicians who were 28 years or older at medical school graduation were less likely to become certified, which is perhaps related to the fact that older graduates also were more likely to have failed an initial attempt at certification.

"Our findings suggest that older graduates may experience greater difficulties, regardless of specialty choice, in timely advancement along the GME continuum toward board certification," Dr. Jeffe and Dr. Andriole said.

Women physicians were less likely than men to be board certified in three specialty categories, notably in obstetrics/gynecology, which is currently the category with the largest proportion of women physicians (79%).

Members of minority groups were less likely than white physicians to be board certified in every specialty except family medicine, "raising concerns about ongoing efforts by U.S. medical schools to increase the racial/ethnic diversity of the physician workforce," they noted.

Physicians who had higher scores on Step 1 and Step 2 Clinical Knowledge tests on the U.S. Medical Licensing Examination were more likely than those with lower scores to become board certified. This finding "provides support for program directors' use of first-attempt licensing examination results among criteria for evaluating applicants in a range of specialties," the researchers said. ■

VITALS

Major Finding: Just over 87% of medical school graduates have attained specialty board certification, and factors such as their age, gender, race/ethnicity, debt, and test scores were predictors of certification.

Data Source: A retrospective cohort study of ABMS certification in 42,440 physicians who graduated from U.S. medical schools in 1997-2000 and were followed through 2009.

Disclosures: This study was supported by the National Institute of General Medical Sciences, one of the National Institutes of Health. No financial conflicts of interest were reported.

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