

Who Should Decide How Much Our Services are Worth?



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The *New York Times* published, in its edition of July 29, 2007, an article by Alex Berenson entitled “Sending Back the Doctor’s Bill.”¹ The author suggests that in considering how to fix our health care system and where to find money for the uninsured, both the liberal notion—reducing prescription drug prices and insurance company profits—and the conservative conviction—making patients pay more of their own health care costs—distract from a far bigger problem: “the relatively high salaries paid to American doctors and, even more important, the way they are compensated.”

Unfortunately, Berenson’s opening salvo, provocative though it is, appears to be fabricated from blatant distortions and untruths and reflects little understanding of the fundamental realities of what drives health care to be increasingly expensive and even unaffordable for many Americans. One would have thought that a journalist worth his salt would have delved a bit deeper into this complex issue, doing a better job of checking facts, and at least attempting to ascertain just what motivates doctors to order tests and to prescribe therapy for their patients. Sadly, beneath the sensationalistic rhetoric appears to be a rather profound lack of appreciation of what doctors are and what they do and why they do it.

The fact is that doctors are professionals who practice an ancient healing art, certainly imbued over the last hundred years with revolutionary advances in science and technology, but still largely an art more than a science. Doctors are practitioners, striving to learn and to improve what they can do for their patients. Unfortunately, about 30 years ago, health care planners began, as a construct to describe and to analyze systems of care, to call us “providers.” The reality is that doctors do not *provide* care, as if care were a commodity and doctors were tools or machines, no matter what you call us. Moreover, we have at present a health care *sector* in America, not a health care *system*. No one is in charge, and incentives, replete with examples of the unintended consequences of a complex matrix of often well-meaning legislative and regulatory tweaks, often work at cross-purposes.

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Although it is tempting to refute Berenson's text line by line, such an approach hardly seems worth the effort. Rather, it seems more appropriate to highlight (my comments in italics) some of the most glaring inaccuracies and distortions, and then to address some larger issues.

"Doctors in the United States earn two to three times as much as they do in other industrialized countries. Surveys by medical-practice management groups show that American doctors make an average of \$200,000 to \$300,000 a year. Primary care doctors and pediatricians make less, between \$125,000 and \$200,000, but in specialties like radiology, physicians can take home \$400,000 or more."

Let's face it. Hospital-based anesthesiologists serve as if they were in the infantry on the front lines of our emergency medical care system. They provide 24/7 anesthesia coverage not only for trauma and surgical patients, but also for obstetric patients. That these warriors are subject to physical, intellectual, and emotional stress, as well as long and grueling work schedules, and in addition, lend their skills and expertise to critical care units and pain management services, should be reflected in how well society values the specialty of anesthesiology.

The GAO Report issued in July 2007² "found that in 2004 average Medicare payments for a set of seven anesthesia services provided by anesthesiologists alone were 67 percent lower than average private insurance payments in 41 Medicare localities."

Moreover, it is unclear how supplementation of "generalist" income with various cosmetic procedures, or income generated by referral to self-owned labs or diagnostic facilities, or concierge-style practice innovations may cloud such comparisons. What's more, the comparison with other countries appears exaggerated.

"In Europe, however, doctors made \$60,000 to \$120,000 in 2002, according to a survey sponsored by the British government in 2004."

BBC News in November 2006³ reported that British GP average pay rose to £106,000, which is \$214,700, in 2004-2005, and that this was a 30 percent increase from the previous year because of a new contract with the National Health Service (NHS). Furthermore, this is supplemented by about 40 percent to 50 percent with work outside the NHS. Hence the comparison quoted above is false and suggests that generalists in America are grossly underpaid. Moreover, distortions in currency markets have produced a devaluation of the dollar versus the Euro in recent years.

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Therefore, without adjusting for this obvious and important issue, transatlantic comparisons across years are highly problematic.

It is important to note that in other industrialized countries (all of which are highly socialized), a much higher proportion of doctors' compensation goes back to the government via taxes. Some of that which is taken then comes back to the doctor through the many social benefits provided by the government. In contrast, American doctors must pay for many of the social services and benefits that are provided for free to doctors in these socialized countries. Examples include the costs of medical education, health insurance, pensions, and medical liability insurance, the latter sharply curtailed in Europe.

“Still, the lower salaries are a significant part of the reason that European countries spend less on health care than the United States does.”

Gross physicians' compensation in America is 20 percent of total health care expenditures, 10 percent net after overhead but before taxes. Total spending on health care is 16 percent of GNP, compared to an average of 8.3 percent in other industrialized countries. A draconian reduction of 20 percent in physician compensation would produce considerable pain and loss of practitioners, but would only reduce expenditures to 14.7 percent of GNP, surely a big number with yearly health care costs of \$2 trillion, but hardly a significant part of the big picture.

“In the United States, nearly all doctors are paid piecemeal, for each test or procedure they perform, rather than a flat salary. As a result, physicians have financial incentives to perform procedures that further drive up overall health care spending.”

It is true that there is a financial incentive to do more in a fee-for-service practice, just as in an HMO/capitated scenario there is a financial incentive to do fewer tests or procedures. Although it is unfortunate that some “proceduralists” do more largely to pad their bank accounts, the vast majority would never even consider doing so. To suggest that this is an important influence on the big picture is not to understand what motivates physicians “to do or not to do,” and is an affront to our whole history of practicing under our storied code of medical ethics. This appears to be a notion advanced by insurers and government to try to reduce their financial exposure.

The issues of self-referral by some doctors to facilities in which they have an ownership interest to capture facility fees and the magnitude of its effect

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on increased health care spending, have not been quantified, nor has organized medicine yet developed a workable approach to address this. It is generally accepted that such outpatient facilities, sporting facilities fees dramatically less than those of hospitals, certainly do save insurers and the government money. Some have resorted to trying to “capture” this type of income because they are underpaid for the work they do as doctors. However, what has come to light is that some cunning capitalists have found a way to exploit a seam in the system, and in so doing they have, perhaps inadvertently, caused all of us to be painted with a dirty brush—just as we saw vividly with “workers comp mills.” Most doctors, however, despite financial incentives, do not make these kinds of decisions based upon monetary return. There are expectations and pressures from patients to resolve issues expediently, and there are family pressures, and there is a whole legal system waiting to pounce upon any delay or “lack of completeness.”

Another aspect of doctors’ referrals to these “cheaper” facilities is that hospitals have been left with an increasingly concentrated distillate of sicker, poorer, and governmentally insured patients. At some point, does there need to be some kind of an accounting wherein the whole health care sector is obliged to participate in some way in supporting care of these kinds of patients?

Concierge medicine, the ultimate expression of this kind of business model, essentially casts to the winds of chance those patients who have less acumen and resources, or who are too sick to qualify for this refuge. It seems like a great plan for those primary care physicians and specialists who are able to embrace such a business model, but what does this do to those “left behind”?

“Doctors are paid little for routine examinations and very little for ‘cognitive services,’ such as researching different treatment options or offering advice to help patients get better without treatment.”

Really? Was it not the federal government that concocted RBRVS to enhance the value of these “cognitive services”? By the way, who made the call that anesthesiologists are not cognitive doctors, in addition to being interventionalists? Moreover, is what a neurosurgeon or thoracic surgeon or vascular surgeon does just a technical exercise? What does the common expression “He’s no rocket scientist or neurosurgeon” mean in this context?

Berenson quotes Dr. Peter B. Bach, a pulmonologist at Sloan-Kettering and former advisor to CMS: “I don’t have a view on whether doctors take home too

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much money or not enough money,” Dr. Bach said. “The problem is the way they earn their money. They have to do stuff. They have to do procedures.”

Please allow me to suggest that perhaps carefully considering what needs to get done, and then doing it, not infrequently after hours, or under conditions of physical or emotional stress, or with the operator subject to significant risks of physical injury or biohazards, qualifies for a higher rate of pay than coming in late, going home early, interviewing, thinking, ruminating, talking. It's not so much that they want to do stuff to be more highly compensated. It's just what “interventionalists” do, and there is a long history of charging extra for hazardous duty.

“Doctors are also paid whether the procedures they perform go well or badly,” Dr. Bach said, “and whether they are crucial to a patient's health or not.”

Why is it that this nouveau notion that the government and insurers—and even patients—should not pay for procedures that have complications? An adverse outcome because of malpractice or malfeasance is one thing, but an adverse outcome that is a manifestation of the laws of probability is quite another.

Professional services are in their essential nature profoundly different from the production of a commodity. They are the manifestation of judgment and experience, understood broadly but applied specifically. Medical outcomes, not unlike judicial, architectural, artistic, and every other object of professional advice and undertaking, are uncertain in any individual case; even with an appropriate process or “best practice,” they are subject to forces beyond the control of human intervention.

CMS is propagating a concept that they will no longer pay hospitals for DRGs that were not part of the admitting diagnoses: i.e., hospital-“acquired” complications—meaning, for example, sepsis that develops after surgery for a bowel obstruction or ischemia, or ARDS after a “routine” pneumonia, or a fall when an elderly patient walks to the bathroom and fractures a hip. If CMS gets away with this for hospitals, targeting doctors will not be far behind.

A corollary, or perhaps even a direct ancestor (maybe even a “pre-cog” to use the image from the film “Minority Report”) of this new CMS scheme, is the CMS Recovery Audit Contract (RAC) Initiative. Following from the Medicare Prescription Drug and Modernization Act of 2003 (MMA) and the Health Savings and Affordability Act of 2003, CMS in 2005 began a trial program (RAC) whereby it seeks to be repaid moneys paid to

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facilities and doctors for surgeries in which a CMS subcontractor determines in retrospect that the surgery was unnecessary. The demand for payment is from everyone involved, e.g., even an anesthesiologist who gave a general anesthetic for a laminectomy three years previously. This flies in the face of the old maxim: "Even if the surgery is unnecessary, the anesthesia is always necessary." This has become a real problem for hospitals (in the trial states of Calif., N.Y. and Fla.), and just recently RACs have begun to demand repayment from physicians, including anesthesiologists. The ASA has been apprised of this problem, and they are at present working with CMS to address it. However, can you even begin to imagine what CMS not paying for adverse outcomes could do in this context for hospitals teetering on the brink of insolvency? If that thought is too disturbing to hold for more than a few moments, consider what might happen when CMS refocuses its energies on physicians.

"BUT all those measures are a minor fix," said Dr. Alan Garber, a practicing internist and the director of the Center for Health Policy at Stanford University. Instead, he argues, "The United States should move toward paying doctors fixed salaries, plus bonuses based on the health of the patients they care for."

So the idea here is to pay doctors on contingency, like trial lawyers? Pay for Performance to the max, I suppose? The process of formulating measures for individual doctors is just way too unsavory for it to serve as a foundation for a new compensation scheme.

A retraction printed in the New York Times on August 12 stated that Dr. Garber's views had been misstated. What he did say was that HMOs like Kaiser do have salaried doctors, and as such represent a good model for one kind of future system, but he denied saying that all doctors should be salaried ultimately.

But Dr. Goldman of RAND said, "The whole health-care system is set up to pay for services that are rendered. . . . when the patient, and society, is interested in health."

Health is not a commodity. It is something a person can aspire to by adopting a certain lifestyle and by taking personal responsibility for getting educated. Doctors can help by illuminating the way, but they cannot make a horse drink, nor should they be held accountable for such. Doctors cannot "provide" health.

So, then, how much are the professional services of an anesthesiologist worth? In California, a general dentist in practice more than 20 years

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earns a median income of \$129,000, and some earn three times that amount. An RN may earn an annual base salary of \$60,000, but with significant overtime can easily make well over \$100,000. Market forces (insurance mix) and societal valuations (government payers) tend to create a base value, and hard work (not exactly piecework, but work hours and call slots and total days worked) adds to it. My estimate of the median hourly wage for anesthesiologists in California is \$150, and this is not time in attendance but time spent working overall.⁴

Focusing on what doctors earn is to misdirect attention away from what drives costs in the American health care sector, and for me the really big ones are non-beneficial care and egregious insurance industry profits. The insurance industry, government payers, employer groups, and patients are all desperate to limit their financial exposure. Doctors are the easiest targets because they are a diverse group, poorly organized, and barred by antitrust regulations from taking collective actions to advance or even defend their collective financial viability. Pay for Performance is a brilliant obfuscation by insurers to lead discussion away from them. Doctors must find a better way to educate our patients about who we are and what we do and why we do what we do. The simple answer is to allow doctors to earn enough to attract the best and brightest, so that they are not attracted away to business or to other more lucrative professions. Doctors did not become doctors to make a killing financially, but neither did they sign up to be harassed, insulted, and degraded by the many patients who have become unwilling even to pay a deductible for their care, no less by journalists who are clueless about “what makes Sammy run.”

Finally, Uwe E. Reinhardt, Professor of Political Economy at Princeton, in his letter of August 5, 2007,⁵ replying to this *New York Times* piece, asserts: “A more relevant benchmark would seem to be the earnings of the American talent pool from which American doctors must be recruited ...”

Indeed! It does feel a bit curious to be agreeing with an intellectual who has not appeared to be exactly simpatico with doctors, but “politics makes strange bedfellows.”

“Any college graduate bright enough to get into medical school surely would be able to get a high-paying job on Wall Street ...”

Perhaps not. Different dispositions and skill sets are needed for each.

“The obverse is not necessarily true. Against that benchmark, every American doctor can be said to be sorely underpaid ... Physicians are the central decision makers in health care ...”

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This should be true, but we appear to have arrived at a “critical inflection point” in what feels like an inertial change in American Medicine. Insurers and the government, having labored for years to interpose themselves between the patient and the physician, now are declaring that they are usurping this historical role. Physicians must find a way to take back the high ground, not just being at the table, but finding a way to change the discussion to prioritize the best interests of our patients, as we uniquely understand them, and which are also our best interests.

“A superior strategy might be to pay them very well for helping us reduce unwarranted health spending elsewhere.”

This counterintuitive and antiinstinctual approach has much appeal, and it has the advantage of paying doctors to do what is right, not paying them less to perform according to some measure—no matter how well constructed—the application of which, despite assertions to the contrary, will ultimately be to save money instead of to improve quality.

¹<<http://www.nytimes.com/2007/07/29/weekinreview/29berenson.html?ex=1188705600&en=2019b73c7e8795d8&rei=5070>>

²< <http://www.gao.gov/cgi-bin/getrpt?GAO-07-463>>

³< <http://news.bbc.co.uk/2/hi/health/6157219.stm>>

⁴ Assume that the salary range (net pre-tax after business expenses) is \$300,000 to \$400,000 per annum, hours per week are 50-70 (not just time in attendance but all work-related time), and 44-46 weeks worked. Hourly compensation on the high side would be (400,000/50x44 = \$182) and on the low side (300,000/70x46 = \$93 hourly). Average of these calculations (182+93 = 275/2 = \$137.50 per hour.

⁵<http://select.nytimes.com/gst/abstract.html?res=F40A1FFF3D5E0C768CDDA10894DF404482>

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