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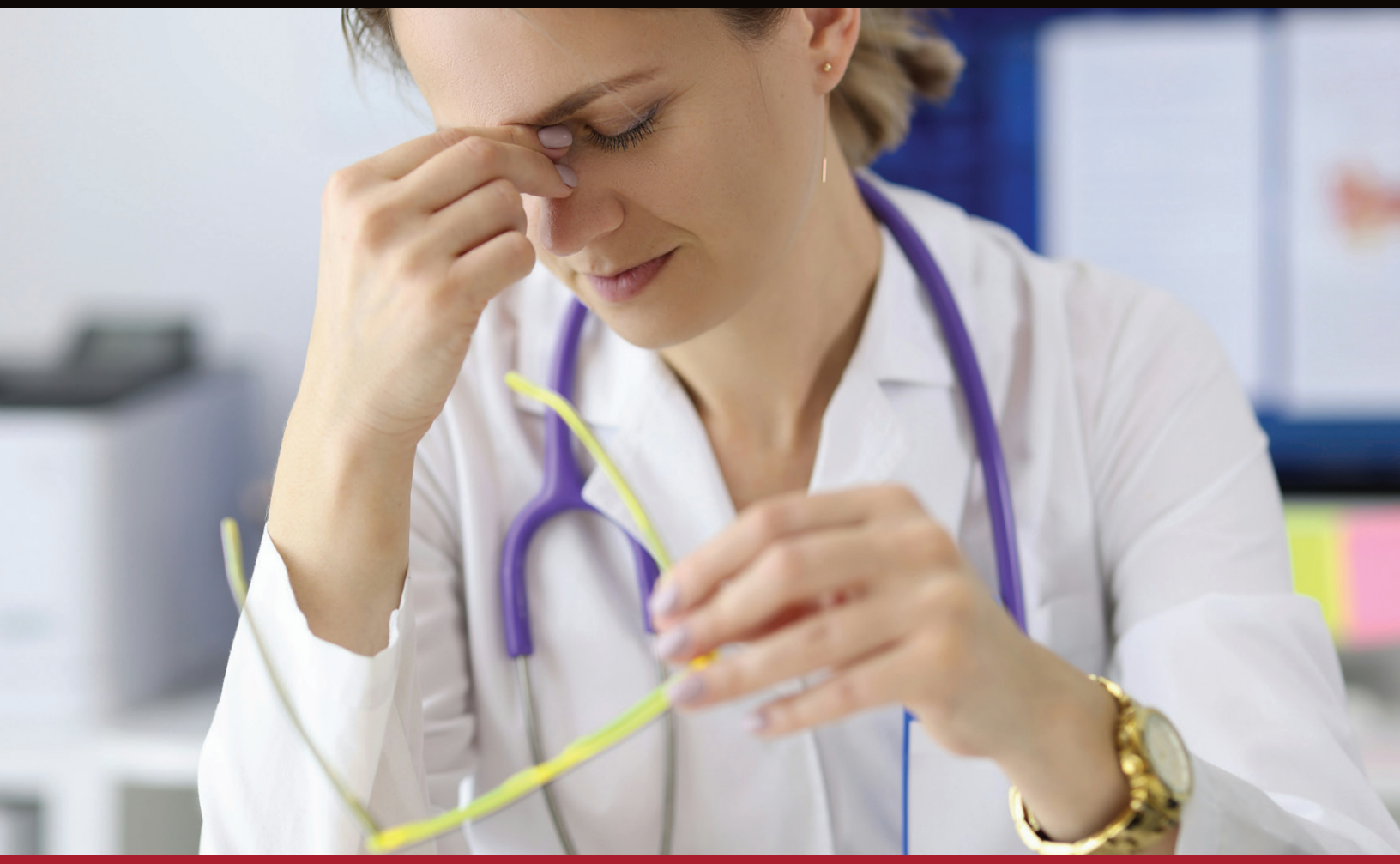
ISSUE BRIEF

Shortchanging Physicians

The mounting costs from Medicare's effective income controls on doctors

Wayne Winegarden

JULY 2024



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Introduction

Government payers cover over 40 percent of total healthcare spending in the U.S. and that share continues to rise every year. Medicare alone accounts for 21 percent. Advocates for single payer healthcare see these percentages as too small, of course, envisioning a healthcare system where the government accounts for 100 percent of total healthcare spending.

Such dreams would quickly become a nightmare. And while the adverse impacts that patients who are living in fully nationalized healthcare system provide important lessons, the crippling problems that pervade the nationalized portions of the U.S. healthcare sector are just as revealing.

Nationalizing healthcare creates adverse incentives that worsen the quality of services patients receive and, inevitably, lead to counterproductive price and income controls. One of the troubling consequences of arbitrary price and income controls is the lost access to care that inevitably follows.

When applied to the cost of medicines, the lost access is manifested as an unavailability of the latest innovative drugs that provide either better treatments or treat diseases that previously had none.[1] When applied to physicians and other medical professionals, the lost access is manifested as doctor shortages that jeopardize patients' quality of care. The doctor shortage problem is noteworthy because it is a common affliction that is reducing the quality of care across the globe.

The Growing Problem of Doctor Shortages

Canada's socialized system faces an exceptionally large doctor shortage problem. According to a 2022 *OurCare* survey, 22 percent of Canadians do not have "a family doctor or nurse practitioner" that they can consult when they need care or medical advice.[2] This problem is expected to get worse. As the *National Post* reports,

> In Ontario, more than 2.2 million people are currently without a family doctor. Another 1.7 million are looked after by a doctor who is 65 or older. The Ontario College of Family Physicians predicts more than four million Ontarians will be without a family doctor by 2026, as more doctors narrow their scope or leave their practice entirely, and fewer young medical school graduates choose to opt in. The number of grads choosing family medicine is the lowest it has been in 15 years.[3]

In Germany, which has a *mostly* socialized healthcare system, "41 percent of practicing doctors" as of 2023 "were over 60 years old, as were 28 percent of specialists. Over the next three years, an estimated 5,000 to 8,000 doctor's practices are expected to close, largely due to retirements."[4] And just like in Canada, there are insufficient domestic medical students to replace these disappearing doctors, which is why Germany is looking toward immigrants to fill the gap.

A similar story is also occurring in the U.K. According to the British Medical Association,

> In comparison to other nations, England has a very low proportion of doctors relative to the population. The average number of doctors per 1,000 people in OECD EU nations is 3.7, but England has just 2.9…
>
> England needs nearly 50,000 additional FTE doctors simply to put us on an equivalent standard with today's OECD EU average of 3.7 doctors per 1,000 people.[5]

The doctor shortages that pervade the OECD countries, including the U.S., are arising for many reasons including difficult working conditions, long hours, demographic retirements, and job dissatisfaction. However, a growing driver of these shortages is inadequate compensation, which arises because governments managing socialized healthcare systems (either fully or in part) are imposing increasingly uneconomical price controls on physicians as a means for controlling broader healthcare costs.

For instance, the British Medical Association has noted that, "while workload and waiting lists are at record highs, junior doctors' pay has been cut by more than a quarter since 2008. A crippling cost-of-living crisis, burnout and well below inflation pay rises risk driving hard working doctors out of their profession at a time when we need them more than ever."[6]

Similar underpayment trends exist in Canada and Germany. Euro News, when discussing why one in four doctors are leaving the profession, cite the experience of Dr. Peter Rott who finds the payments "unfair after so many years of training."[7]

Surveys demonstrate that this experience is typical for a German physician as only "43 percent of physicians feel they are fairly compensated," according to *Becker's ASC Review*.[8]

Discussing the low compensation for doctors in Canada, the Fraser Institute asked, "who earns more money on an hourly basis: a teacher, autoworker, or family doctor?"[9] The surprising answer "once benefits are factored in, a family doctor earns about the same as a teacher in most provinces or an autoworker. Many family doctors earn much less."[10]

Given the pervasive use of income controls in these countries, the growing doctor shortages and dissatisfaction with their jobs should not have been surprising. Basic economic theory predicts that price controls cause shortages and reduce quality. And this is exactly what has occurred in socialized healthcare systems. The result is delayed care, lower quality healthcare services, and worse healthcare outcomes.

The problems that arise due to income controls are taking root in the socialized parts of the U.S. healthcare system as well, most notably in Medicare which has been imposing the same income control policies that has led to the physician shortages that plague the nationalized healthcare systems in Canada, Germany, and the U.K.

> "Maintaining a competitive profitability profile is essential because the private sector plays the driving role developing new innovative medicines.

Underpaying Doctors Risks Provider Shortages and Lower Quality Care

Rising Medicare costs are a threat to government finances. As KFF notes, "Medicare spending (net of income from premiums and other offsetting receipts) is projected to rise from 10 percent of total federal spending in 2021 to 18 percent in 2032, and from 3.1 percent to 3.9 percent of GDP over these years, due to growing Medicare enrollment, increased use of services and intensity of care, and rising health care costs."[11]

In attempts to control these costs, Medicare administrators have been squeezing doctors' statutorily set repayment rates, driving down compensation for serving Medicare patients to uneconomical reimbursement levels (e.g. a form of price controls). As these controlled prices become more and more uneconomical, an acute doctor shortage problem for Medicare patients looms. As a March 2023 report from the Medicare Trustees warns, current

> law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term.[12]

In other words, the Medicare Trustees recognize that Medicare's income controls on doctors will cause the same doctor shortages that plague countries with fully socialized healthcare. Importantly, the problem of uneconomical income controls (what they refer to as the "cumulative gap between the price updates and physician costs") is not just a problem for tomorrow. Medicare's reimbursement data compared to inflation data demonstrate that Medicare is imposing real income losses on physicians at a time when the fear of physician shortages is growing.

Medicare sets the reimbursement rates for physicians and other providers for thousands of medical services. Figure 1 presents the percentage change in Medicare's reimbursement rates to providers compared to the percentage change in inflation as measured by the consumer price index (CPI-U). Figure 1 measures the reimbursement rates to providers based on the Average Medicare Payment Amount (Medicare Paid) and the Average Medicare Standardized Payment Amount (Medicare Standardized Amount). The Average Medicare Payment Amount is the "average amount that Medicare paid after deductible and coinsurance amounts have been deducted for the line item service."[13] The Average Medicare Standardized Payment Amount adjusts the Medicare payment to account for the "geographic differences in payment rates for individual services, such as those that account for local wages or input prices and makes Medicare payments across geographic areas comparable."[14]

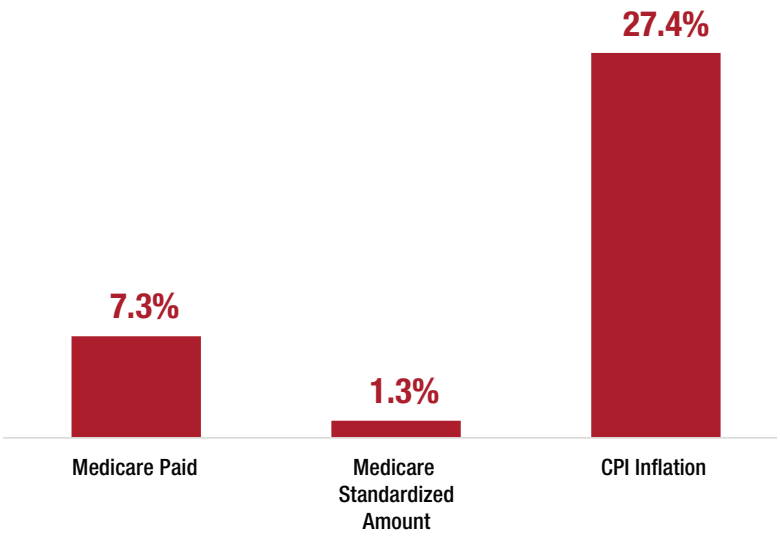
Figure 1 compares the growth in the average reimbursement rates across all the reimbursable medical services for both payment categories. As is evident from the Figure, inflation has significantly eroded provider reimbursement rates between 2013 and 2022. While average prices during the decade through 2022 grew 27.4 percent, provider reimbursement rates grew 7.3 percent based on the average Medicare payment amount or 1.3 percent based on the average Medicare standardized payment amount.

The American Medical Association examined the growth in inflation adjusted physician reimbursement rates between 2001 and 2024.[15] Consistent with these results, "adjusted for inflation in practice costs, Medicare physician payment declined 29% from 2001 to 2024."[16]

The in-depth inflation data maintained by the Bureau of Labor Statistics is also consistent with these findings. Figures 2 and 3 present the long- and short-term changes in the overall price level (i.e., inflation) compared to the changes in prices for overall healthcare goods and services and the prices at physicians' offices.

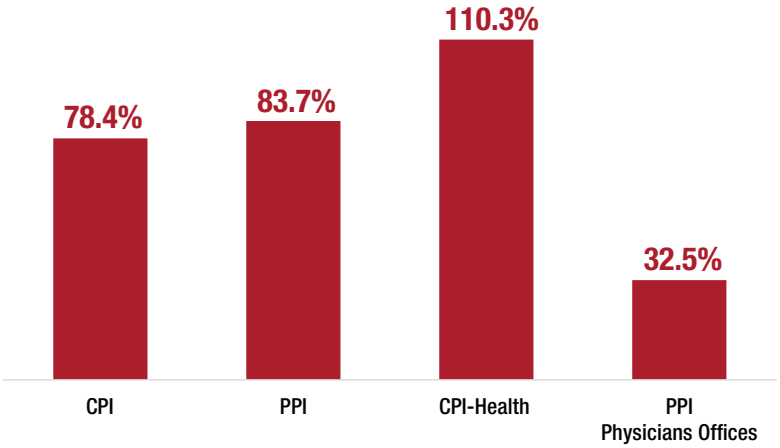
Figure 2 presents the longer-term price trends between 2001 and 2024. Over this period, the overall consumer (CPI) and producer (PPI) price levels grew 78.4 percent and 83.7 percent, respectively. While these price increases paled relative to overall growth in healthcare prices (110.3 percent), they were more than double the increases in prices at physicians' offices. These data confirm that the income pressures on physicians have been a long-standing problem.

Figure 1
Medicare Provider Reimbursement Rates Compared to Consumer Inflation (CPI-U)
2013 - 2022



Source: CMS and BLS

Figure 2
Growth in Consumer and Producer Prices Overall, Healthcare, and Physician Offices
January 2001 through April 2024

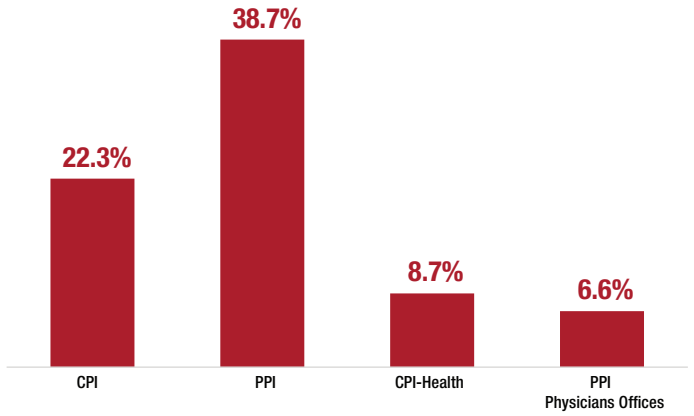


Source: CMS and BLS

Figure 3, which presents the growth in prices since 2020, confirms that these same pressures on physicians' offices continue to persist, with one important difference. While the price increases at physicians' offices (6.6 percent) since 2020 once again lagged the growth in overall consumer prices (22.3 percent) and producer prices (38.7 percent), the increases in healthcare prices (+8.7 percent) slowed significantly relative to overall inflation.

The detailed inflation data confirm that the compensation of doctors has been eroding for many years. The declining incomes and prices for medical professionals could be warranted if the demand for healthcare services was falling. Considering the aging baby boomer generation, it is infeasible that there is a declining demand for healthcare services, however. The large and growing shortages of healthcare professionals also undermines the declining demand possibility.

Figure 3
Growth in Consumer and Producer Prices Overall, Healthcare, and Physician Offices
April 2020 through April 2024



Source: BLS

According to KFF data, as of April 1, 2024, there are 74.4 million people living in primary care health professional shortage areas.[17] KFF further estimates that 12,973 practitioners are needed to eliminate this gap.[18] Rather than filling this gap, the physician shortage is projected to persist and likely worsen. According to the Association of American Medical Colleges, by 2036, the total projected shortage will likely be between 13,500 and 86,000 physicians.[19]

The combination of declining income and prices for physicians along with a large and growing shortage of doctors and other healthcare professionals provides strong evidence that current Medicare reimbursement rates are below the market value for medical providers. If not addressed, the consequences of this problem will be dire.

Less access to care reduces the quality of healthcare patients receive, increases wait times for an appointment, and ironically can even increase overall healthcare costs. Worse, these impacts will be felt more acutely by vulnerable populations. As a 2021 GoodRx analysis found, "healthcare deserts [areas where people lack access to key healthcare services] are more likely to affect those who face additional barriers to access, such as lower income, limited internet access, and lack of insurance. Together, these barriers can further widen disparities in health outcomes." Put simply, vulnerable and rural populations will bear a larger burden from the impending physician shortage than their well-insured urban counterparts.

The confluence of rising shortages in the face of government mandated declining reimbursement rates indicates that reforms are necessary to address this problem. Without reforms, the physician infrastructure will continue to deteriorate and access issues for patients will continue to worsen.

Principles for Reform

While Medicare is in desperate need of fundamental broad-based reforms, such comprehensive reforms are, to put it mildly, politically infeasible currently. Therefore, targeted reforms are a necessary stopgap measure to alleviate the problems associated with the current income controls that are imposed on doctors.

Effective reforms will achieve two goals: (1) alleviate Medicare's tightening income controls; and (2) improve the incentives to implement innovations and efficiency gains that will improve the delivery of care for patients.

To prevent the continued erosion of the real value of physician payments, physician reimbursement rates should be indexed to an appropriate cost index. For instance, Medicare maintains the Medicare Economic Index (MEI), which "is a measure of practice cost inflation that was developed in 1975 to estimate annual changes in physicians' operating costs and establish appropriate Medicare physician payment updates."[20] Just as it makes sense to index Social Security payments or income support payments to inflation, it makes sense to prevent inflation from eroding the incomes of physicians.

Insulating physician payments to inflation is insufficient, however. Medicare remains on a fiscally unsustainable path and the program does not sufficiently incentivize innovations that improve the quality of care while reducing costs. For example, the Medicare Access and CHIP Reauthorization Act of 2015 established the Merit-based Incentive Payment System (MIPS) effective January 2017. MIPS is supposed to address the problems associated with the fee-for-service model and incentivize value-based care.

The problem is that MIPS itself imposes large burdens on providers. A 2021 JAMA study found that participating in MIPS imposes an average cost burden "of $12,811 per physician" and requires "more than 200 hours per physician on MIPS-related activities."[21] Reforms to the program should focus on reducing the administrative and financial burden imposed on providers participating in the MIPS program including reducing (or eliminating) requirements that provide minimal clinical benefits to patient care but impose costly burdens on providers. The end goal should be to incentivize a more innovative/patient-driven care model.

Conclusion

Medicare's under compensation problems and its broken physician payment system have plagued physicians for many years. The large and growing physician shortage problem is an indication that these problems may be reaching crisis levels.

More broadly, Medicare's experience exemplifies the threat that a fully socialized healthcare system poses to the ability and incentive of physicians to practice medicine. Based on these experiences, adopting fully socialized healthcare in the U.S. creates troubling doctor shortages and, for those doctors still practicing, reduces their ability to provide quality healthcare services.

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About the Author

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Dr. Winegarden's columns have been published in the *Wall Street Journal, Chicago Tribune, Investor's Business Daily,* Forbes.com, and Townhall.com. He was previously economics faculty at Marymount University, has testified before the U.S. Congress, has been interviewed and quoted in such media as CNN and Bloomberg Radio, and is asked to present his research findings at policy conferences and meetings. Previously, Dr. Winegarden worked as a business economist in Hong Kong and New York City; and a policy economist for policy and trade associations in Washington D.C. Dr. Winegarden received his Ph.D. in Economics from George Mason University.

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