

Association of Directors of Geriatric Academic Programs (ADGAP)
 Longitudinal Study of Training and Practice in Geriatric Medicine

Training & Practice Update

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Financial Compensation for Geriatricians in Academic and Private Practice

Introduction

Using data from both the Association of American Medical Colleges (AAMC) report on medical school faculty salaries and the Medical Group Management Association (MGMA) survey on physician's compensation, this Update examines compensation for geriatricians in academic and private practice and compares their compensation with physicians from other specialties.

Findings

Academic Faculty

Instructors and assistant professors in geriatrics

have a considerably lower compensation than their colleagues in family practice and internal medicine, but once they become associate professors the salaries become similar. In addition, geriatric chiefs reported a median salary significantly higher than division chiefs in internal medicine or family practice. Overall, for academic physicians, geriatricians' compensation is competitive with other non-procedural specialists, but lags behind physicians in procedural practices¹ (Table 1). Table 2 presents combined median salaries of assistant, associate, and professor ranks from AY 2001-02 to AY 2002-03. During this time period, the salary of academic

Table 1. Medical School Faculty Total Compensation 2002-2003 (Median Dollars)

Practice Areas	Instructor		Assistant Professor		Associate Professor		Professor		Chief	
	Count	\$	Count	\$	Count	\$	Count	\$	Count	\$
Endocrinology	28	77,000	217	116,000	159	139,000	235	176,000	50	201,000
Family Practice	187	120,000	1,149	131,000	448	145,000	193	168,000	27	173,000
Gastroenterology	53	128,000	394	160,000	269	192,000	238	211,000	51	265,000
General Internal Medicine	570	120,000	1,537	126,000	581	148,000	396	175,000	51	190,000
Geriatrics – Internal Medicine	30	102,000	176	118,000	83	147,000	52	174,000	24	212,000
Nephrology	43	109,000	278	131,000	212	168,000	217	186,000	51	223,000
Neurology	120	88,000	771	118,000	478	145,000	487	176,000	32	169,000
Pediatrics	129	100,000	981	117,000	454	136,000	348	169,000	46	167,000
Physical Medicine & Rehabilitation	70	144,000	239	140,000	109	157,000	41	174,000	5	181,000
Psychiatry	253	121,000	1,381	125,000	689	141,000	609	174,000	75	160,000
Rheumatology	12	98,000	147	115,000	107	136,000	127	175,000	42	194,000
Urology	41	62,000	233	195,000	148	251,000	137	282,000	31	315,000

Source: AAMC Data Services.¹

Note: The reported compensation for the then 4 chairs of Departments of Geriatrics were not included in the count of chiefs of geriatrics.

Table 2. Change in Median Total Compensation by Department Faculty with MD or equivalent degree: Combined Assistant, Associate, and Professor Ranks AY 2001-2002 to AY 2002-2003

Department	Percent Change 2001-2002 to 2002-2003	2001-2002 (Median \$)	2002-2003 (Median \$)
Gastroenterology	5.7%	174,000	184,000
Psychiatry	3.0%	135,000	139,000
Neurology	2.9%	136,000	140,000
Physical Medicine & Rehabilitation	2.7%	147,000	151,000
Urology	2.2%	225,000	230,000
Family Practice	1.5%	136,000	138,000
General Internal Medicine	0%	135,000	135,000
Pediatrics	0%	128,000	128,000
Nephrology	-0.6%	159,000	158,000
Endocrinology	-0.7%	143,000	142,000
Rheumatology	-0.7%	139,000	138,000
Geriatrics – Internal Medicine	-3.0%	134,000	130,000

Note: Does not include benefits.
Source: AAMC Data Services¹

geriatricians decreased by 3%. By comparison, compensation for endocrinology, nephrology, and neurology also decreased but by less than 1%; general internal medicine remained the same; and family practice increased 1.5%. Geriatrics had the greatest percent decrease in salary (-3%) and gastroenterology had the greatest increase at 5.7%. For both years, the combined ranks salary of academic geriatricians was lower than their internal medicine and family practice colleagues, with the largest gap occurring in 2002-2003.

Private Practice Physicians

From 1999 to 2003, increases in compensation for private practicing physicians ranged from 6.8% to 32.9% (Table 3).^{2,3,4,5,6} In that same time period, salaries of private practice geriatricians increased 9.6%, going from a median salary of \$141,679 to \$155,276. However, in 2001, geriatricians' salaries increased only 0.1% from the previous year (\$151,833 versus \$151,946), and in 2002, the median salary decreased by 3.9%, going from \$151,946 to \$140,016. This resulted in geriatricians earning less in 2002 than family medicine or

internal medicine physicians. By 2003, except for family physicians, geriatricians had the lowest median salary among all physicians (Table 3). Geriatricians in private practice earned about \$25,000 more than their academic colleagues in 2003 (\$155,276 versus \$130,000) or a 19% difference.^{1,6}

Discussion

To become a geriatrician, a physician must first complete a residency program in either internal medicine or family practice, and then take additional formal training. However, there is little economic incentive to do so. In 2002, private practice geriatricians earned \$4,251 less than family physicians (\$150,267 versus \$146,016) and \$8,740 less than general internists (\$154,756 versus \$146,016).⁵ By 2003, geriatricians were earning slightly more than family physicians (\$155,276 versus \$152,478), but less than general internists (\$155,276 versus \$159,252).⁶ The narrowing of the salary gap from 2002 to 2003 between geriatricians, family physicians and general internists in private practice occurred because

Table 3. Total Annual Compensation for Private Practice Physicians 1999-2003 (Median \$ and % change)							
Practice Area	1999	2000	2001	2002	2003	% Change from 1999 to 2003	% Change from 2000 to 2003
	Median (\$)	Median (\$) (% Change 1999 to 2000)	Median (\$) (% Change 2000 to 2001)	Median (\$) (% Change 2001 to 2002)	Median (\$) (% Change 2002 to 2003)		
Rheumatology	156,521	167,199 (+6.8%)	185,262 (+10.8%)	193,410 (+4.4%)	198,991 (+2.9%)	+27.1%	+19.0%
Gastroenterology	264,500	281,308 (+6.4%)	312,074 (+10.9%)	321,023 (+2.9%)	351,614 (+9.5%)	+32.9%	+25.0%
Physical Medicine & Rehabilitation	172,311	173,643 (+0.8%)	183,957 (+5.9%)	192,490 (+4.6%)	213,362 (+10.8%)	+23.8%	+22.9%
Pediatrics	142,770	141,400 (-1.0%)	150,000 (+6.1%)	153,098 (+2.1%)	158,867 (+3.8%)	+11.3%	+12.4%
Neurology	178,197	175,143 (-1.7%)	180,325 (+3.0%)	185,666 (+3.0%)	190,973 (+2.9%)	+7.2%	+9.0%
Urology	268,825	301,772 (+12.3%)	303,433 (+0.6%)	294,337 (-3.0%)	344,038 (+16.9%)	+28.0%	+14.0%
Endocrinology	157,489	164,507 (+4.5%)	170,329 (+3.5%)	170,000 (-0.2%)	178,893 (+5.2%)	+13.6%	+8.7%
General Internal Medicine	145,375	149,009 (+2.5%)	149,020 (0.0%)	154,756 (+3.8%)	159,252 (+2.9%)	+9.5%	+6.9%
Psychiatry	151,132	152,000 (+0.6%)	154,329 (+1.5%)	159,444 (+3.3%)	161,344 (+1.2%)	+6.8%	+6.1%
Family Practice without OB	141,493	145,121 (+2.6%)	146,601 (+1.0%)	150,267 (+2.5%)	152,478 (+1.5%)	+7.8%	+5.1%
Geriatrics—Internal Medicine	141,679	151,833 (+7.2%)	151,946 (+0.1%)	146,016 (-3.9%)	155,276 (+6.3%)	+9.6%	+2.3%
Nephrology	217,726	246,580 (+13.3%)	235,357 (-4.6%)	227,385 (-3.4%)	237,659 (+4.5%)	+9.2%	-3.6%

Note: Net clinical salary (not including benefits).

The number of geriatricians participating in these MGMA surveys is small, for example in 1999 the sample size was 17 and in 2002 the sample size was 56. For the number of respondents for each cell, see Table 1.7 located at <http://www.adgapstudy.uc.edu>

Sources: MGMA^{2,3,4,5,6}

family physicians' salaries increased only 1.5% and internists' 2.9%, while geriatricians' salaries increased 6.3%.

Why is the compensation of geriatricians lower than other primary care and medical specialists? The primary reason is that geriatricians are almost entirely dependent on Medicare revenue. In 2002, Medicare reduced the average reimbursement to physicians by 5.4%.⁷ Fortunately, a 4.5% decrease that was scheduled for 2004 was replaced by a 1.5% increase in Medicare payment rates for physicians.⁸

Another reason for the lower incomes is that Medicare does not have a risk adjuster to account for the time and complexity involved with treating

a frail elderly patient. These complex patients and their families require considerable time to manage well and are common in geriatrician's practices. The small number of geriatricians in the U.S. limits the availability of expert chronic care to the oldest and most frail Americans. In 2001, there were 5.5 certified geriatricians per 10,000 population over the age of 75.⁹ In 2003, this ratio declined to 4.2 certified geriatricians per 10,000 population over the age of 75.¹⁰ Two factors account for this decline. First, geriatricians must recertify every 10 years and only about 50% of eligible geriatricians are re-certifying. Second, since 1995 the only way to become a certified geriatrician is to complete a fellowship program

in geriatrics and successfully complete the certifying exam.

In 2002 and 2003, about 300 physicians were certified in geriatrics each year. During those same two years, 25% of the available fellowship slots went unfilled. Physicians were choosing to continue their formal training in areas other than geriatrics. The result is that the current number of newly certified geriatricians and geriatricians who are re-certifying is not large enough to replace those geriatricians who are retiring or not re-certifying. As the U.S. population age 75 and over increases, the ratio of geriatricians/older Americans will decrease further.

Financial disincentives pose the largest barrier to entry into the field. In 2003, graduates of private medical schools had incurred a median debt of \$135,000, while the median amount of debt for graduates of public medical schools was \$100,000. By contrast, in 1984, private medical school students graduated with a median debt of \$27,000, and public medical school graduates had a median debt of \$22,000.¹¹ Medical students with these large debts will more likely go into practice areas with higher salaries. The characteristics of geriatricians' practices combined with low Medicare reimbursement levels for the care of the frail and complex older adult are the major causes of the limited recruitment of young physicians into geriatrics.

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