FROM THE EDITORS' DESK

Physician Incomes in the Twenty-first Century: Time for a New Social Contract

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Thomas Picketty's new opus, *Capital in the 21st Century*, has been acclaimed as the book most purchased (Amazon ran out of copies for a brief period in May), most talked about (The *Guardian* calls it a VIB—very important book), and least read in 2014. As a matter of editorial duty, I did read it (though admittedly not in full). The book contains huge amounts of historical data organized into a number of eyestrain-inducing tables and graphs. However, the basic idea is that over time, the return on capital investment will always exceed the rate of growth of the economy as a whole (which Picketty summarizes in the equation $r > g$). If this is true, then wealth will tend to concentrate over time, and with it political power. (Picketty views the period of rapid economic growth between World War II and the 1970s as an historical anomaly.) To avoid this plutocratic dystopia, Picketty suggests a solution that will never be implemented: a global, progressive tax on wealth. You have to admire his neo-Marxian audacity.

While Picketty's policy prescription may be dubious, his diagnosis of a withering democracy seems frighteningly plausible. But what does this have to do with physicians and specifically physicians' incomes? In 2012, health care accounted for 17 % of the \$16.4 trillion US economy. In that same year, physician and clinical services were estimated at \$566 billion—or about \$820,000 for each of 691,000 actively practicing physicians and surgeons. The Center for Medicare and Medicaid Services (CMS) estimates that growth in physician and clinical services will approach 6 % per year through 2022. Thus, in 2022 physician services will cost the country over \$1 trillion (in 2012 dollars)—about \$1.2 million for each member of the projected physician workforce of 815,000.

Of course, reimbursements for clinical services do not accrue only to doctors, nor do these figures account for practice expenses. Nevertheless, as self-declared leaders of the health care system, physicians need to take some responsibility for

managing their share of health care expenditures—what everyone else calls costs, and what we call income. This, I imagine, will require accepting both a ratcheting-down of physician incomes *on average* and a narrowing of the gap between the highest and lowest paid specialties. Depending on how this plays out, general internists, along with other specialists who trade in “evaluation and management,” could end up making about the same or somewhat more, while many procedurally oriented specialists would make somewhat less.

Based on 2007 OECD data,¹ I would suggest as a reasonable standard that physician incomes should average about five times the mean national wage—more than most lawyers, professors, engineers, and small business owners, less than many financial analysts and real estate developers. Physicians' time under this proposal would be reimbursed at roughly \$125 per hour. To allow for differences in training duration and practice intensity, some specialists could be paid up to 25 % higher and others up to 25 % lower (with additional adjustments for quality, outcomes, and efficiency). Thus, a neurosurgeon working 58 h per week (using a training/intensity multiplier arbitrarily pegged at 1.25) might make \$435,000 annually, while a general internist working 54 h per week (using a training/intensity multiplier of 0.85) would make \$275,000.² (Among the “losers”—as if anyone making more than five times a middle class wage has “lost”—would be dermatologists, who with a training/intensity index of, say, 0.95 and an average work week of 45 h, would come in at \$256,500.)

Tying physician incomes to the average industrial wage will not solve the $r > g$ national inequality problem. For one thing, most physicians don't make it into the ranks of the very rich. For another, Picketty's policy pickle is really about wealth, not income. But in an era of rising and increasingly perverse disparities between rich and poor, it would be a powerful statement for one of America's most respected professions to say: We are willing to retrench, just a little, for the sake of the medical commons. The symbolism would be important, but the benefits would be more than symbolic, as medical students experienced fewer disincentives to pursue primary care and as funds were freed up for investment in desperately needed care coordination.

Care coordination is the focus of several articles in this issue of *JGIM*. Within hospitals, Albrecht et al.³ report that more than 25 % of patients do not understand their discharge

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medication instructions and 50 % do not understand the dietary instructions. With so many patients uninformed, it is unsurprising that hospital readmission rates show few signs of decline. One answer may be interventions such as those described in the paper by Tang et al.,⁴ where nurses called recently discharged patients to probe for new problems and encourage outpatient follow-up. Although many new problems were documented and follow-up rates improved, readmission rates did not differ among patients who actually spoke with study nurses and those who did not.

Many years ago, when I was a resident moonlighting as the covering physician for an oncologist in private practice, I was given a list of a dozen specialists (one neurologist, one cardiologist, etc.) to call when needed. The paper by Mandl et al.⁵ in this issue illustrates that this model no longer holds. Using a large claims database covering more than half a million patients, the authors found a striking paucity of provider pairs caring for the same patient. As the authors themselves conclude, “Stunning variability in the constellations of providers caring for patients may challenge underlying assumptions about the current state of teamwork in healthcare.” The implications for care coordination—and the scope of investment required—are also profound.

Funding for care coordination needs to come from somewhere; as a start, incomes in the top 1 % of US wage-earners ought to be fair game. However, inducing physicians to give up a sliver of the health care expenditures pie would require a re-writing of the social contract between doctors and society. Wage targets would need to be combined with other reforms such as

guaranteed investments in care coordination, public financing of medical education, the elimination of educational debt, more transparent public support of post-graduate medical training, and fairer pay for residents, particularly at more senior levels. This is a bold gambit, though not nearly so audacious as a global tax on wealth. In an age of inequality, physician incomes are something we should start talking about.

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