The past several decades have seen many changes in the health-care industry, especially the manner in which it is financed. Hence, it is more important than ever for young physicians to understand how their productivity will be measured and how they will be compensated. This topic is not unique to the health-care industry. Physician-managers can learn a great deal by learning how compensation issues are handled in other service industries.

Private physicians (those who own their practices) have understood productivity and compensation very well for many years. The classic phrase, “eat what you kill”, is rather graphic but it certainly describes exactly what happens in a privately owned practice of medicine. This becomes obvious when one examines an income statement of a private practitioner. All of the bills and expenses must be paid before the physician can take a penny home.

One of the reasons it is so important for young physicians to understand concepts of productivity and compensation is that most young doctors finishing residency will have a salaried position as his or her first job. It is extremely rare today for someone to set up his or her own private practice right out of residency. This is due to the very large up-front costs required to set up and start a practice. Fortunately, today most residents have a number of options for employment -- e.g., physician-owned groups, the military, academics, etc.

So, for employed physicians, the key question is “What is a fair compensation formula?” Most models today have two major components: a fixed base-pay amount and a productivity-based amount. The productivity-based amount is variable, which means it fluctuates based on the amount of revenue brought in by the physician.

If one considers all possible compensation formulas, each one could be placed at some point on a continuum with fully fixed-pay on the extreme right end and fully variable-pay on the extreme left end. A classic example of fully fixed pay would be the compensation received on active duty in the military. At the opposite end of the spectrum, the best example of an entirely variable compensation scheme is one that is similar to private practice in which the practitioner has full equity in the business. He or she takes home only what is earned and only after all expenses are paid.

To understand the intricacies of building compensation plans and incentive formulas one needs to understand three financial concepts: operating leverage, ownership premium, and the marginal utility of money.
Operating leverage is the ratio of fixed to variable expenses for any business and can provide leverage to the bottom line of an income statement. However, it does this only with increased risk. To understand operating leverage, consider a hypothetical business that only has variable expenses. In this case any increase in revenue from one year to the next will only increase net income by the same percentage. On the other hand, if some of the business expenses are fixed, then an increase in revenue from one year to the next will increase net income by a higher percentage. It is important to understand, however, that this leverage works both ways. For a business that is heavily laden with fixed expenses, this high operating leverage will put their bottom line at greater risk during bad economic times. In general, otolaryngology practices have a high percentage of fixed expenses versus variable expenses.

Many employed physicians who have never owned their own practices don't understand why their salaries are not as high as colleagues in private practice (practice owners). Part of the answer can be found in the concept of ownership premium. The ownership premium is the additional amount of compensation that an owner gets for the risk that he or she takes on. It is related to the financial axiom of risk and reward. When a doctor has 100 percent equity in his practice, he is at full risk for both loss and gain. Employed physicians on fixed salaries do not have this risk.

The marginal utility of money is a concept concerning the value an individual places on incremental increases in his or her salary. For most individuals, a $5000 increase on a salary of $60,000 is regarded very differently than a $5000 increase on a salary of $250,000. A thorough discussion of the marginal utility of money is beyond the scope of this paper, but the concept is important to understand for those involved in crafting compensation plans and policies. Readers should consult financial and economics texts for detailed information. (See suggested reading list)

As discussed above, any compensation formula for an employed otolaryngologist will fall somewhere on the continuum between a fully fixed salary and one that is fully variable. The organization that pays fully fixed salaries takes full risk. Organizations that have plans that use some variable pay will have less risk, but some of this risk is transferred to the employee (physician). In other words, financial risk in the business of providing health-care does not go away by changing a compensation plan. It is merely shifted with more or less to the employee depending on whether the variable portion is increased or decreased.

One of the oldest and most commonly used compensation and incentive plans is the classic XYZ model. The X component represents a fixed base pay. Although it may vary from one specialty to another, it is fixed for a specified period of time, usually a fiscal year. The Y component can either be variable or fixed. It is typically a negotiated component for a specific activity. For example, it might represent a stipend for administrative duties. The Z component is entirely variable and can fluctuate during the fiscal year. It is typically the incentive component and is based on physician productivity. It is this component that often generates the most interest and perhaps controversy among employed physicians. As described below, employers must communicate the details of this component very clearly, and employees need to understand it thoroughly.

Careful thought must be put into the design of an incentive formula or “Z” component of a compensation plan. Good incentive formulas or plans have similar characteristics. The following are 10 of them:
1. To be effective, incentive payments must be a major, not a minor part of total compensation. Twenty percent of total compensation is good, while five percent or less is usually not adequate. Payoff for high performers must be substantially higher than for average performers.

2. Incentive plans must be based on objective measures of productivity and performance rather than subjective opinions.

3. Incentive plans should extend to all managers and workers, not just top executives. In other words, incentive plans should include those on the "shop floor" and not just those in the executive suite.

4. Incentive plans should be administered with scrupulous care and fairness. They must be consistent, and once established, they must be unalterable during the course of the year. Managers who change the rules in the middle of a year lose all credibility.

5. Incentives must be tightly linked to performance targets in the organizations strategic plan. Stated differently, the executive leadership of an organization should not "incentivize" one thing and hope for another.

6. Performance targets for individuals and groups must be linked to outcomes they can affect.

7. The time between performance review and payoff should be as short as possible.

8. Use of non-monetary rewards should be used as well as monetary payments.

9. Skirting the system to find ways of rewarding non-performers must be absolutely avoided. Once good excuses creep into justifying rewards for non-performers, the door is wide open for all kinds of legitimate reasons.

10. Incentive plans must be prospectively communicated (in writing) and well understood by everyone.

Comparing the productivity of an otolaryngologist to national benchmarks can be useful. Such benchmarks are available and can be purchased from companies who collect this type of data. Use of RVU’s allows one to compare his or her productivity to external otolaryngologists. However, one should be careful and understand the ramifications of using RVU’s as the only measure of productivity in an incentive plan.

Basically, RVU’s are proxies for charges. Thus, they have the same disadvantages of charges as the sole measure of productivity for an employed otolaryngologist. From the employer perspective, the total charges of two otolaryngologists say something about their productivity but does not account for their individual costs. An employer gets "more bang for the buck" from the doctor who is paid less but submits an equal amount of charges as the physician who is paid more. Even if the two physicians are paid the same salaries, one may require more resources to generate his charges than the other. Thus, cost is important and can be part of an incentive formula. From an accounting perspective, net income is the calculation that combines revenue and cost. Thus, the lower paid physician in our example above may argue that net income is the only “fair” measure of productivity for each doctor. In reality, there are other measures that are probably even more equitable.
Another way of looking at productivity is by calculating a ratio for each physician in which his charges are divided by his cost. This is provided that each doctor does not have his own fee schedule. For most groups, the fee schedule is unified since the organization does all of the contracting for the entire group. The ratio of charges to costs tells us how many dollars of charges were generated for each dollar of cost for an individual physician. Once the ratio is calculated for each physician, they can be sorted from highest two lowest. The incentive pool can then be distributed based on this ranking. As stated above in the list of principles for good incentive plans, it is important that we only include costs that the physician can have some control over. For example, in many large organizations the physician has little control over certain overhead.

Basically, there are three types of incentive plans. These are individual, group, and hybrid plans. Advantages and disadvantages exist for all three.

With respect to individual incentive plans:
1. They are highly motivating;
2. They do not compensate "dead wood";
3. However, they can cause undue competition between physicians in the same organization for the same patients;
4. And, they do not give credit to providers for "downstream revenue".

With respect to group incentive plans:
1. They promote teamwork;
2. They promote niche expertise;
3. They tend to keep referrals inside the group practice;
4. However, they have the disadvantage for an individual not to carry his or her load, i.e. "dead wood".

The hybrid incentive plan carries the advantages of both the individual and the group incentive plans.
1. They motivate individuals, but not too much to create internal competition;
2. They do not overly compensate "dead wood" when the whole group does well;
3. They promote teamwork and internal referrals;
4. They provide some credit to providers for downstream income.

The fact is there are many different formulas for calculating physician productivity and probably just as many ways to distribute incentive money once the productivity is measured. Whatever system is used, it must have integrity, and it must be administered with scrupulous care and fairness.

**ADDITIONAL READING:**


**USEFUL WEB SITES:**

http://www.investopedia.com/ (This site allows one to look up business term definitions.)

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*Posted 12/7/2001*