Research on Compensation Equity and Transparency in the Field of Medicine

This information was presented as background during the policymaking process for ACP's position statement "Compensation Equity and Transparency in the Field of Medicine."

BACKGROUND INFORMATION

Race

Survey results from Medscape's 2017 *Physician Compensation Report* found that there were self-reported compensation discrepancies along race/ethnic lines ranging from $20,000 to $41,000.[i] On average, White physicians reported making $303,000 annually, followed by Asian physicians with $283,000, Hispanic or Latino physicians with $271,000, and Black physicians with $262,000. A 2016 study, utilizing data from 2010-2013, aligned with the results of the Medscape survey. After controlling for age, sex, race, hours worked, and state of residence, Black physicians made $194,444 annually, compared to $228,585 for White physicians – a difference of $34,141.[ii] Small sample sizes have prevented researchers from further analyzing the compensation disparity for other minority physician groups, resulting in studies that primarily focus on the Black-White disparity.

The lack of available data and research for other minority physicians demands additional attention on the issue. Non-white physicians will continue to play a substantial role in the field of medicine: the most recent AAMC data indicates that Asians make up 19.8 percent of new medical school graduates, followed by multi-racial graduates with 7.1 percent, Black with 5.7 percent, Hispanic with 4.6 percent, and other races with 1.7 percent.[iii] Moreover, numerous analyses of U.S. Census income data find a racial wage gap in the general labor market, with minority workers across the board consistently making less than their White counterparts for the same work, education, and experience.[iv,v,vi,vii,viii] Additional research is necessary to determine the scope of the racial wage gap for Latino, Asian, and other understudied groups specifically in the field of medicine.

While a plethora of research illuminates the disparity between race and earnings in the American labor market, and among physicians more specifically, very few researchers have looked at the sources of these inequities. One study finds that after controlling for physician characteristics, the racial composition of patients seen, and further the proportion of patients seen covered by Medicare or Medicaid, may account for part of the earnings gap between Black

and White physicians.[ix] Black patients make up a significantly higher proportion of patients for Black physicians vs. White physicians (45.4 percent vs. 13 percent); however, seeing more Black patients was correlated with a positive effect on income for White physicians and a negative effect for Black physicians, leading the author to conclude that wealthier Black patients – those more likely to have private, employer-provided health coverage – were more likely to seek out White physicians while poorer Black patients – those more likely covered by government health programs like Medicare or Medicaid – were more likely to seek out Black physicians, potentially as a result of residential segregation. As the publicly provided plans often reimburse physicians at a lower rate, this could account for some of the disparity in physician compensation. Others[x] have argued that an underrepresentation of minority physicians in the higher paying specialties accounts for some of the difference in compensation.[xi]

Gender

Medscape's report found that male physicians reported earning $229,000 per annum on average, compared to $197,000 for female physicians.[xii] Among internists specifically, those figures were $238,000 per annum on average for male physicians, compared to $203,000 for female physicians.[xiii] Researchers have offered many possible explanations as to why women make less than men, including choice of occupation, time taken away from work to parent, gender discrimination, and productivity levels. However, studies have found the gender compensation gap to persist even after controlling for "self-selected" factors.[xiv, xv, xvi]

Similar to the case of race, the literature supports the results of the Medscape survey. After controlling for age, sex, race, hours worked, and state of residence, female physicians made $163,244 annually, compared to $249,164 for male physicians in one study – a difference of $85,921.[xvii] Disparities in compensation begin as soon as newly trained physicians begin their career, one study found.[xviii] Researchers utilized data from New York between 1999-2008 to determine physician salary differences by gender over time. Across most specialties, female physicians had lower starting salaries and for those where they had higher starting salaries, the difference was not statistically significant. By 2008, new female physicians earned $16,819 less than new male physicians, after controlling for specialty type, hours worked, designation of hours, immigration status, age, and practice location. The authors suggested that physician practices offering greater flexibility and family-friendly policies in exchange for lower compensation may account for the gap. Another analysis of physician compensation data found that this gender compensation gap persists throughout the duration of a physician's career, peaking mid-career and gradually converging – but not completely closing – near retirement.[xix]

While the magnitude of the gap has differed marginally in research that looks at varied physician settings, one trend remains clear: a gender compensation gap persists among academic physicians, research physicians, and practicing physicians. One study of academic

medical settings found that after controlling for faculty rank, age, years since residency, specialty, NIH funding, clinical trial participation, publication count, total Medicare payments, and graduation from a medical school ranked in the top 20 by US News and World Report, female physicians made $19,878 less than male physicians ($227,783 vs. $247,661, respectively). For internal medicine physicians, this difference was $16,159 ($191,338 vs. $207,497, respectively).[xx]

Other research surveyed National Institutes of Health award recipients to determine the compensation gap for physician researchers.[xxi] Male research physicians earned roughly $200,433 annually, compared to $167,669 for female physicians—a $32,764 compensation gap. Further analysis of the data controlling for gender, age, parental status, advanced degrees, academic rank, specialty, rank of current institution, funding institution tier, publications, administrative leadership positions, work hours, and percentage of research time found that female research physicians still made $12,001 less–leaving 37.4% of the initial gender compensation gap unaccounted for.

Another study utilized Medicare payment claims data and other publicly available data to analyze disparities in compensation for practicing physicians in order to avoid instances of self-reporting bias that arise from survey methods. Before controlling for other factors, female physicians were reimbursed $34,125.68 less than male physicians. After controlling for years of experience, productivity, and hours worked, female physicians were still reimbursed $18,677.23 less than male physicians. When examined at the specialty level, female physicians in 11 of the 13 specialties received reimbursements that were statistically significantly lower than their male counterparts, including a difference of $10,850.34 for female internal medicine physicians.[xxii]

At the Intersection of Identities

While individual personal characteristics appear to have an effect on determining physician compensation, the literature also indicates that the interaction of multiple personal characteristics can have a compounding effect on compensation disparity. Among internists, White female physicians made 19 percent and Black female physicians made 29 percent less after controlling for hours worked, years of practice, practice ownership status, board certification status, IMG status, type of degree, whether located in metropolitan area, and proportion of Medicare and Medicaid patients.[xxiii] An earlier study that looked at the mean annual income of internists after accounting for similar work effort and provider and practice characteristics, found a similar trend: Black male physicians made $7,193 (4 percent) less, White females made $36,609 (19 percent) less, and Black females made $56,452 (29 percent) less than White male physicians.[xxiv]

Religion

A review of the literature reveals a lack of research or theory on the impact religious discrimination has on earnings. Pew Research has conducted surveys to gauge average household income levels of various faith groups in the United States, finding Jews, Hindus, Episcopalians, and Atheists/Agnostics near the top of earners and Baptists and Jehovah's Witnesses near the bottom.[xxv] Muslims and Catholics fall in the middle of the pack, hovering around the national average for all U.S. adults. However, these results do not control for hours work, career field, education levels, or other external factors that may affect earnings, making it impossible to draw any sort of conclusions on the impact one's religion or perceived religion may have income. Additional data would need to be collected and research conducted to examine the existence of any sort of religious wage disparities that exist in the general and physician labor markets.

Nationality

There is a gap in research which isolates one's national origin and examines its impact on compensation for both the general American workforce and the medical field. Some studies look at the immigrant wage gap in other western countries like Germany and the United Kingdom; however, there is a lack of work using data from the United States.[xxvi] The 2017 Medscape Physician Compensation report does look at reported income based on country of training, which finds that Canadian- and U.S.-trained physicians make the most ($328,000 and $301,000) while Caribbean- and Filipino-trained physicians make the least ($256,000 and $243,000).[xxvii] Despite this, it is difficult to use the country where medical school is completed as a proxy for national origin as recent numbers found that U.S.-citizen graduates of international medical schools make up 38.5 percent of international medical graduates and 13.7 percent of residency applications.[xxviii] Hence, there is inconclusive evidence whether there is systematic compensation discrimination based on national origin among physicians and further research and data collection would be necessary to determine any impacts.

Sexual Orientation

Ample research has been done on the effect of sexual orientation on compensation for the general workforce, which has found that gay men make less and lesbian women make more than their heterosexual counterparts.[xxix] A 2015 meta-analysis of 31 studies published prior to April 2012 found that while gay men earned 11 percent less than heterosexual men, lesbian women earned 9 percent more than heterosexual women.[xxx] These figures were not significantly changed by controlling for differences in occupation. The case of lesbian women earning more than heterosexual women is not as straightforward to decipher due to variance in findings among studies: studies included in the 2015 meta-analysis ranged from lesbian women

making 25 percent less to 43 percent more than heterosexual women. Despite this, lesbian women still make less than both gay and heterosexual men. Some argue that lesbian women make more than heterosexual women due to greater audacity to defy typical gender norms, including in the context of career choice.[xxxi] A later 2016 study supported these findings: of those who reported engaging in same-sex sexual behavior, gay males made 6 percent less while bisexual males made 12 percent less than heterosexual males. Similarly, of those reporting same-sex sexual partners, lesbian females earned 14 percent more while bisexual females earned 7 percent less than heterosexual females. These results account for age, education, race, number of children, marital status, geographic region, residence in a metropolitan area, year, occupation, and employment status.[xxxii]

Some have attributed this discrepancy to findings that heterosexual men have more positive attitudes towards lesbian women while having negative attitudes towards gay men, as heterosexual men are more likely to be in positions to make hiring, termination, and promotion determinations.[xxxiii] Additional explanations include gender and household dynamics among lesbian women.[xxxiv] On one hand, lesbian women may seek out higher paying jobs and invest more in human capital in order to compensate for the lack of a male wage earner in the household, as existing research shows that men make more than women after controlling for external factors. Similarly, gay men may be less worried about higher compensation knowing they have another male wage earner in their household. Another possibility is the fact that compared to heterosexual couples, same-sex couples are more likely to have both partners participating in the labor market, even with children at home.

Existing literature has not examined the effect of sexual orientation on compensation specifically for physicians, or the medical field more generally. While current research suggests compensation disparities for at least gay men among the general labor force, more research is needed to determine whether similar disparities exist among physician compensation.

Gender Identity

A lack of existing research among the general population, let alone the physician population, makes it much more difficult to determine the effect one identifying as transgender or non-binary has on compensation. One report surveyed the literature prior to 2006 and found that as many as 57 percent of transgender employees faced workplace discrimination, between 6 and 60 percent reported being unemployed, and 22 to 64 percent reported earning less than $25,000 a year.[xxxv] The latest national survey of the transgender community in 2015 found that transgender individuals were significantly more likely to make under $25,000 and significantly less likely to make more than $25,000 compared to the general population; that 16 percent are unemployed; and that 29 percent fall under the federal poverty line – twice the number compared to the general population.[xxxvi] Another study found that transgender women see

their average earnings fall by one-third after transitioning, while transgender men find their wages slightly increase after transitioning.[xxxvii] Even though the existing research does not definitively conclude wage discrepancies exist for transgender workers, it portrays unique challenges that transgender people face in the workplace, which may warrant further research. However, national Census surveys, such as the American Community Survey (ACS), Current Population Survey (CPS) and the Survey of Income and Program Participation (SIPP), among others, do not ask questions regarding gender identity, making data collection difficult.[xxxviii]

Salary Transparency

Embracing a culture of transparency in compensation through implementation of reporting procedures and other best practices have been offered as a way to reduce compensation disparities. Some argue that public disclosure of salaries would make it easier for regulators to identify and harder for employers to hide cases of discrimination. Additionally, public availability of compensation would give negotiating leverage to employees, especially those susceptible to compensation inequities; surveys have found women are less likely to negotiate then men, and that men report more successful negotiations than women.[xxxix,xl] Opponents have argued that such measures are overly burdensome and don't actually prove existence of biases. The limited research appears to support transparency as a means to reduce compensation inequities. One study examined compensation disparities in states that have passed legislation outlawing compensation secrecy in some capacity and found these states were associated with increased earnings for women relative to men and a reduction in the gender wage gap.[xli] Another found that after controlling for profit, productivity levels, and other workplace and worker characteristics, higher relative compensation was associated with employees who reported that their employers make financial data available to employees.[xlii]

Compensation transparency has been a recent focus of executive action during the last two presidential administrations. In 2015, President Obama issued an executive order requiring federal contractors to disclose compensation information for women and men. A year later, President Obama issued an executive order requiring large companies with more than 100 employees to submit an annual report on employees' compensation to the federal government which includes sex, age, and job groups—a rule which the Equal employment Opportunity Commission and the Department of Labor were to jointly implement in 2018.[xliii] However, in August 2017, the Trump Administration reversed the 2016 Obama action, over concerns that the compensation data reports "lack practical utility, are unnecessarily burdensome, and do not adequately address privacy and confidentiality issues."[xliv]

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