

Doctors' pay

1 Mankiw's questions

Here is a post from Greg Mankiw's blog that is relevant to our reading.¹

"One can think of several reasons why physician compensation in the United States is relatively more generous than elsewhere. First, physicians in most other nations face a powerful single buyer (monopsony) for health services. As the McKinsey Global Institute and Mark Pauly have shown, market power (or regulation) translates into relatively lower prices for health services, including the services of physicians. Second, U.S. physicians must make a larger financial investment in their education than their counterparts in many other countries do; they must recover the debt they incur as part of the educational process. Third, the incomes of highly skilled health care workers—notably physicians—are determined partly with reference to the incomes that equally able and skilled professionals can earn elsewhere in the economy. Because the U.S. distribution of earned income for all occupations is wider than it is in most other OECD countries, the relatively high incomes offered skilled professionals in the United States may well have served to pull up the incomes of American physicians relative to the incomes of their peers abroad."²

Based on this reading, and in particular on the three hypotheses outlined in their last paragraph, here are some questions for class discussion:

1. On the issue of monopsony power: Explain how a large government health-care plan (a "single payer" being the extreme case) could potentially reduce the wages of healthcare workers and thereby national healthcare

¹ <http://gregmankiw.blogspot.com/2009/06/physicians-incomes-and-healthcare-costs.html>

² Uwe Reinhardt, et. al., "Cross-National Comparisons Of Health Systems Using OECD Data, 1999" *Health Affairs* 21.3 (2002).

costs. What are the similarities and differences between this solution to high healthcare costs and a targeted income tax surcharge levied only on healthcare providers (the revenue from which is rebated to all taxpayers)? Are the policies you considered above efficient, using the economist's standard definition of efficiency? Are they equitable, as judged by your own notion of fairness? In your opinion, does your analysis argue for or against a government-run healthcare plan?

2. On the issue of doctor training: Suppose that in country A physicians get free training through a taxpayer-financed educational system, while in country B physicians finance their own education and then, once trained, are paid higher fees. If country A classifies these training expenses as education rather than healthcare spending, which country would report higher healthcare costs? Is that difference in healthcare costs real or an artifact of labeling? In which country would doctors, once trained, have more incentive to work long hours? In which country would there be more doctors? Which country's system, in your judgment, is more efficient and equitable?
3. On the issue of inequality: Do you think that the provision of medical services uses more or less human capital than does the typical job in the economy? What does your answer imply about the relative price of healthcare looking across countries with varying degrees of economic inequality? In the United States, the wage gap between skilled and unskilled workers has increased substantially over the past several decades. Other things equal, what does this fact imply about the trend in the relative price of healthcare? If public policy were to try to prevent this change in the price of healthcare without addressing the underlying trend in wage inequality, what effects would the policy have?

2 A few facts

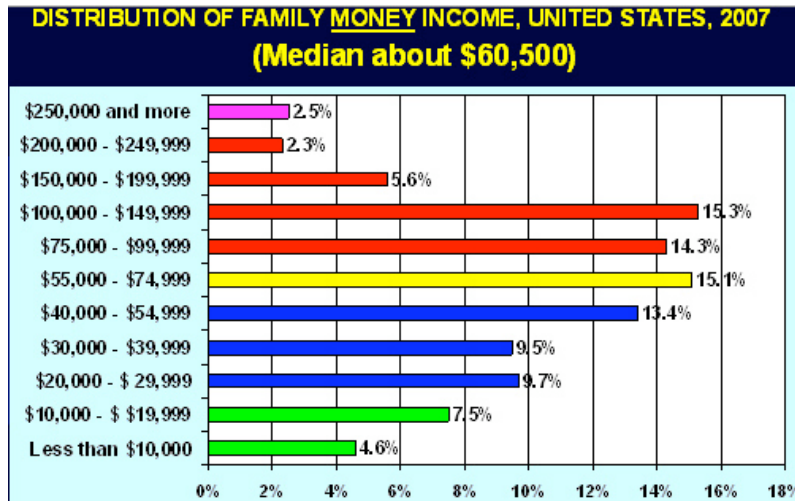
“There are a number of sources on physician income All of them suggest that the median annual net income of radiologists and of cardiologists (around \$400,000) is more than twice that of family practitioners, internists and pediatricians (less than \$200,000). The median is a statistic such that half of physicians earn as much as the median or more, and the other half as much or less. So even if Medicare cut fees of radiologists and cardiologists by 21 percent, the income of these specialists would still exceed that of their colleagues in primary care by 60 percent or more.³

“Suppose we say ... that the income physicians earn after practice expenses, working full time caring for patients, should put them somewhere into the top fifth percentile of the nation’s distribution of income (meaning 95 percent of families would have a lower annual income). What income level might we then be talking about? ... It turns out that an annual income of \$250,000 or so would comfortably meet the fifth percentile threshold. Many primary-care physicians — especially pediatricians — are considerably below that threshold. Physicians who derive a substantial part of their incomes from procedures — such as tests or imaging — are situated much above the threshold. They are comfortably in the top second percentile of the income distribution.”⁴

³ Uwe Reinhardt, “‘Rationing’ Doctors’ Pay,” *New York Times* Economix Blog, July 10, 2009.

⁴ Uwe Reinhardt, “What Is a ‘Just’ Physician’s Income?” *New York Times* Economix Blog, July 17, 2009.

Income distribution



Source: U.S. Bureau of the Census, 2009 Annual Social and Economic Supplement, Table FIN-07