Pursuing Gender Equity by Paying for What Matters in Primary Care

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Female physicians earn substantially less than their male counterparts in the United States. These disparities exist across specialties and over the career course.[1] Gender-based pay disparities in medicine mirror those documented in other professions, including law and business.

The drivers of these disparities are complex. Women are relatively underrepresented in higher-paid, procedural specialties, which explains some of the pay gap among physicians in general. Women also may be more likely to cut back on hours worked during their careers or to choose positions that permit more flexibility, which contributes to gaps within individual specialties. Yet pay disparities persist even in specialties such as primary care, where, for example, female physicians generate 11% less visit revenue per year than male physicians in the same practice.[2] This disparity exists despite female and male primary care physicians (PCPs) performing generally the same roles, given the relatively low prevalence of specialization and procedural concentration in primary care. Primary care can therefore provide insights into the drivers of and potential solutions to gender-based pay disparities.

PCPs are typically compensated on the basis of the amount of revenue they generate from providing office-based care. This revenue generally comes in the form of fee-for-service (FFS) payments based on evaluation-and-management billing codes submitted to insurers. As highlighted in a recent National Academies of Sciences, Engineering, and Medicine (NASEM) report,[3] primary care compensation is largely based on a fragmented payment system that reimburses for individual services rather than whole-person care. This system creates incentives for suboptimal patterns of care delivery; as currently deployed, it also perpetuates pay disparities.

Data suggest that female PCPs spend more time with patients[2] and on electronic-messaging activities[4] than male PCPs, which results in more total and after-hours work time. Consequently, despite often working more hours per scheduled session, female physicians see, on average, fewer patients per session and therefore generate less evaluation-and-management revenue than their male colleagues. One justification for this difference could be that female physicians are simply less efficient than male physicians, which is then reflected in their pay.

But the explanation isn't so simple. To begin with, the whole-person, continuous, comprehensive care provided by PCPs seldom fits neatly into the confines of a visit,[3] particularly since care is increasingly asynchronous, provided by means of electronic messaging or phone calls. As a result, physicians perform a substantial amount of uncompensated work, often completed after hours, that is separate from revenue-generating office visits. Evidence suggests that these demands are amplified for female physicians, who receive 26% and 24% more electronic messages per month from patients and staff, respectively.[4] In addition, female physicians face different, gendered expectations during visits[2]; patients disclose more information and issues to female physicians, including more psychosocial issues, and expect more empathetic listening from them, which adds to visit time.[4] Different expectations of and demands on female physicians probably contribute to lower average productivity, as measured by number and complexity of visits, and ultimately to pay disparities.[2] Yet such care-delivery and patient-interaction patterns may also be a factor in female physicians' better performance on clinical quality metrics.[5] These aspects of performance aren't recognized in visit-based payment schemes, though some related quality measures are being incorporated into incentive programs for payers that variably filter down to primary care.

A more equitable system would fairly compensate all PCPs for providing relationship-based care while maintaining incentives related to productivity, quality, and access to care and supporting workforce well-being; it would also need to acknowledge the imperative for most organizations to maximize FFS

revenue. What will it take to create such a system?

To enhance pay equity under the existing visit-based FFS system, leaders could consider basing compensation on three major components: the synchronous and asynchronous work effort involved in taking care of a panel of patients, the value and quality of the care delivered by a PCP, and the degree and type of coordination and communication involved in care delivery (see figure). In addition to the traditional productivity measures (such as number of visits and visit complexity) assessed in an FFS system, the work effort involved in caring for a panel depends on the characteristics of the included patients, the infrastructure of the PCP's practice, and characteristics of the individual PCP (which affect the other components and wouldn't necessarily be factored into compensation).

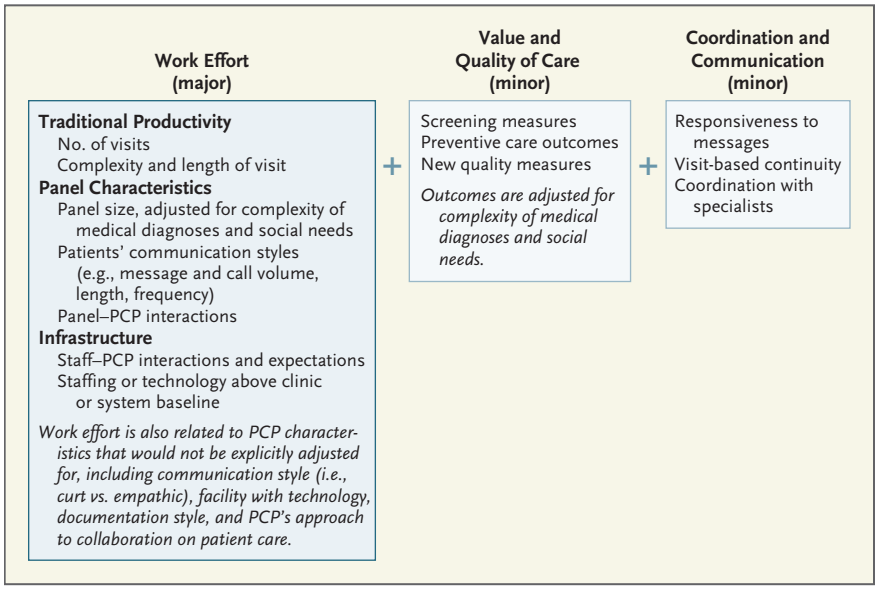
Panel characteristics that could be considered in assessing work effort include panel size, the complexity of patients' medical diagnoses and social needs, patients' communication styles and frequency, and features of patient–physician correspondence and decision making. Although measuring some components of work effort (such as number of visits, panel size, or electronic-message volume) may be straightforward, measuring others (such as aspects of patient–physician or PCP–staff interactions and expectations of staff and patients for physicians) may be more difficult, require proxy measures, or not currently be feasible.

Existing systems for assessing value and quality of care are complex and don't deliver the information that is most important to patients and clinicians while adequately considering the extent to which any measure is realistically within a physician's control. Current approaches rely on process measures, such as physicians' reviewing performance on preventive screening measures and clinical outcome measures (such as blood pressure control) for their patient panels, but some health care leaders have called for reimagining quality measurement to reduce burden and make measures more relevant for patients and clinicians. Measures that could be considered include those related to the provision of low-value or inappropriate care and those that capture the extent to which physicians consider and discuss patients' goals and preferences, for instance by means of advance care planning. Any measure that is based on outcomes should be adjusted for the complexity of patients' diagnoses and social needs to avoid penalizing PCPs who take care of sicker-than-average or marginalized patients; however, conducting such risk adjustment at the level of the individual physician can be fraught.

Finally, given the centrality of continuity and coordination to primary care delivery, PCPs could be rewarded for coordinating with specialists; seeing their patients over multiple visits, thereby supporting continuity of care; and being responsive to patients' needs. Although patient experiences and satisfaction are important, there are challenges associated with existing patient-experience measures (such as patients' tendency to provide lower ratings for female physicians than male physicians). Leaders could therefore consider rewarding physicians for excellent performance on these measures without making them central components of compensation.

Adjustment of physician compensation for nontraditional components of work effort, as well as for quality of care and degree of coordination, may require redistribution of the revenue generated under the current reimbursement system or additional funding sources. Ideally, these sources would include payments flowing to physician organizations under value-based contracts or quality-incentive programs such as the Merit-Based Incentive Payment System.

In addition, primary care payment reform could be considered through the lens of gender-based pay inequities. The NASEM report calls for a hybrid system that incorporates a fixed, prospective payment for a defined patient population over a specified period.[3] Such primary capitation frees physicians to deliver the care that is best for their patients in the most appropriate manner — asynchronously or in person — and might help address pay inequities. Like our proposed reforms under an FFS system, per-capita payments would need to be adjusted for observable features that are potentially associated with differential care demands, such as the patient panel's socioeconomic status, complexity of medical needs, and communication patterns. Although adjusting for variables such as patients' age and sex might be more straightforward, variables that are more difficult to observe, quantify, and adjust for (such as patients'



Proposed Compensation Components in an Adjusted Fee-for-Service Payment Model.
PCP denotes primary care physician.

communication styles and aspects of patient–physician interactions) remain important considerations, even under primary care capitation.

Gender-based pay disparities underscore the need to design a payment system that adequately compensates physicians for the thoughtful, relationship-based care that defines excellent primary care. A steady progression toward payment for value, potentially culminating in primary care capitation, might help reduce pay inequities among PCPs, though even capitation systems will need to account for differential demands on female and male physicians. This progression, which could reward physicians of all genders who provide thoughtful, relationship-based primary care, could have a particular effect on female physicians, whose practice patterns aren't adequately rewarded under the current payment system, and on the patients they serve.

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Toward a Stronger Post-Pandemic Nursing Workforce

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The deep effects of the Covid-19 pandemic on frontline health care providers, especially nurses, have given rise to concerns about the demands of nursing work and the appeal of nursing careers. Though these concerns have special resonance right now, this is not the first time apprehensions about the adequacy and sustainability of the U.S. nurse workforce have felt especially acute. In the mid-1990s, financial pressures in the health care industry led to changes that created stress and insecurity among hospital nurses that culminated in substantial declines in the numbers of people enrolling in and graduating from nursing education programs. By 2001, these changes had fueled a large national shortage of hospital registered nurses (RNs), estimated at 125,000 vacant positions. The American Hospital Association and the Joint Commission responded with nu-