Current Perspective

DAVID W. PARKE II, MD, ACADEMY CEO

How Much Is Not Enough? Part Two

In last month's column I addressed the changes in physician payment over time. While ophthalmologists' high impact, high intensity, and high overhead work is in aggregate well compensated, the reimbursement per unit of surgical service has plummeted over the years. Yet American ophthalmologists remain better off than their peers in other developed nations with average annual earnings of over $350,000—ranking ophthalmology 10th of 29 U.S. specialties.[1]

Trying to determine the "right" compensation of an ophthalmologist is a fool's errand—much as it would be for virtually any position in society. As difficult as it is to determine the "relative value" for payment of a trabeculectomy, a thoracotomy, and a hip replacement, just imagine doing that for the relative value of a teacher, an attorney, and a refractive surgeon. It leads down a rabbit hole of residency duration, intensity/complexity of procedure, impact of services, etc.

What happens if payment per unit of ophthalmologic service continues to decline in real dollars as a tactic to reduce total system health care costs? What happens when hospital payments continue to rise at a rate eight times that of physician payments? There are only a limited set of outcomes.

It is an inevitable consequence that incomes will drop if operating costs rise faster than the net of decreasing payments per service and any gains from increasing number of services or mix of services. It's just a matter of timing. That is unless or until policymakers determine that an inflection point in the cost, access, and quality equation has been reached and that payment must keep up with real practice costs.

We are already seeing the impact of stress in the system—physician burnout, practice sales to the investor community, regional access issues, and increased office throughput and less physician face time. When do diminishing margins translate into issues with access to care, innovation, acquisition of technology, and quality?

How can we stimulate a reevaluation of this down-sloping payment path at a time when physician compensation is still at the top end of the American job market? We must recognize the Washington advocacy reality. Of the nearly 90 health professional organizations whose lobbying budgets were over $200,000 in 2018, only the Academy and the American Society of Cataract and Refractive Surgery represented solely our profession.[2] Hospital lobbying expenditures were over 50 times higher than ophthalmology's combined spending!

Our best approach is going to involve politics, policy argument, and data. Congress needs to have data presented to them demonstrating the impact on health care of decades of payments that have not kept up with practice costs. And they need to understand the societal impact that could result from the loss of tens of thousands of practices and small businesses. Regulators and representatives both need to understand the limited cost savings that could be achieved from further cuts to physician payments relative to aggregate cost impacts of other interventions. And the Academy needs data as to the value and impact of ophthalmologist services. It's a combination of money, relationships, sound policy, and articulate data analytics. Finally, this is not a unique ophthalmology fix. Success requires executing this in a cohesive fashion across many specialties.

To this end, the Academy is working closely with the American College of Surgeons and other large surgery organizations to leverage our individual resources and to fund the studies necessary to better understand the economics, the value equations, and workforce issues of the surgical communities. This is essential if we are to more effectively articulate value data and policy. As my last column noted, primary care payments have gone way up at the expense of surgical specialties' payments. But rethinking payment policy should not devolve into simply interspecialty infighting.

We are also working together to explore options in areas as disparate as collective bargaining and innovative payment pathways. Ophthalmology has friends in Washington, but we must provide them with the best policy alternatives. And, as always, our best allies are our patients. Providing high quality care in an atmosphere of trust and mutual respect may be our strongest advocacy initiative.

And therein lies one of our most difficult tensions: To succeed as caring physicians, we must also succeed as businesspeople—and vice versa. When the latter is placed at risk, so also is the former.

1 www.medscape.com/slideshow/2019-compensation-overview-6011286#3
2 www.opensecrets.org/lobby/indusclient.php?id=H01&year=2018