# 2019 REVIEW

## OF PHYSICIAN AND ADVANCED PRACTITIONER RECRUITING INCENTIVES

26TH EDITION
1994-2019

*An Overview of the Salaries, Bonuses, and Other Incentives Customarily Used to Recruit Physicians, Physician Assistants and Nurse Practitioners*

MERRITT HAWKINS
an AMN Healthcare company

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For additional information about this *Review*, please contact:


Merritt Hawkins / Corporate
8840 Cypress Waters Blvd. #300
Dallas, Texas 75019
800-876-0500
www.merritthawkins.com

Merritt Hawkins / Eastern Regional Office
100 Mansell Ct, E, Ste 500
Roswell, GA 30076
800-306-1330
www.merritthawkins.com

# Overview

Merritt Hawkins is a national healthcare search and consulting firm specializing in the recruitment of physicians in all medical specialties, physician leaders, and advanced practitioners. Now celebrating our 32nd year of service to the healthcare industry, Merritt Hawkins is a company of AMN Healthcare (NYSE: AMN), the nation's largest healthcare staffing organization and the industry innovator of healthcare workforce solutions.

This report marks Merritt Hawkins' 26th annual *Review* of the search and consulting assignments the firm conducts on behalf of its clients. Merritt Hawkins' *Review* is the longest consecutively published and most comprehensive report on physician recruiting incentives in the industry.

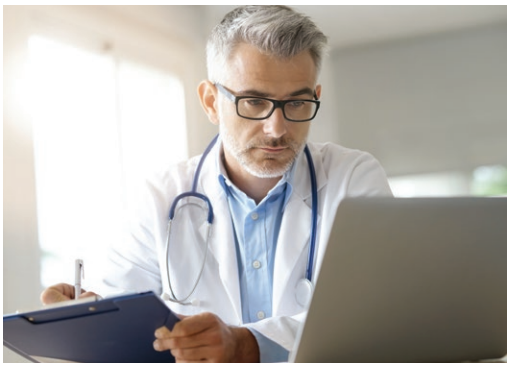
Over the past 26 years the *Review* has become a standard benchmarking resource throughout the healthcare industry used by hospitals, medical groups and other healthcare facilities to determine which incentives are customary and competitive in physician recruitment. The *Review* also has become a resource widely utilized by healthcare journalists, analysts, policy makers and others who track trends in physician supply, demand and compensation.

The *Review* is part of Merritt Hawkins' ongoing thought leadership efforts, which include surveys and white papers conducted for Merritt Hawkins' proprietary use, and surveys, white papers and analyses Merritt Hawkins has completed on behalf of prominent third parties, including **The Physicians Foundation**, the **Indian Health Service**, the **American Academy of Physicians Assistants**, **Trinity University, Texas Hospital Trustees**, the **North Texas Regional Extension Center/Office of the National Coordinator of Health Information Technology**, the **Society for Vascular Surgery**, the **Maryland State Medical Society**, the **American Academy of Surgical Administrators**, the **Association of Managers of Gynecology and Obstetrics** and **Subcommittees of the Congress of the United States**.

The 2019 *Review* is based on a sample of the 3,131 permanent physician and advanced practitioner search assignments that Merritt Hawkins and AMN Healthcare's sister physician staffing companies (Kendal & Davis and Staff Care) had ongoing or were engaged to conduct during the 12-month period from April 1, 2018, to March 31, 2019.

The intent of the *Review* is to quantify financial and other incentives offered by our clients to physician and advanced practitioner candidates during the course of recruitment. Incentives cited in the *Review* are based on contracts or incentive packages used by hospitals, medical groups and other facilities in real-world recruiting assignments.

Unlike other physician compensation surveys, Merritt Hawkins' *Review* tracks ***physician starting salaries*** and other recruiting incentives, rather than total annual physician compensation. It therefore reflects the incentives physicians are *offered* to attract them to new practice settings rather than what physicians in general may actually earn and report on their tax returns.

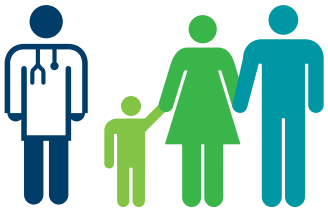


The range of incentives detailed in the *Review* may be used as benchmarks for evaluating which recruitment incentives are customary and competitive in today's physician recruiting market. In addition, the *Review* is based on a national sample of search assignments and provides an indication of which medical specialties are currently in the greatest demand as well as the types of medical settings into which physicians are being recruited.

**Following are several key findings of the *Review*.**

# Key Findings

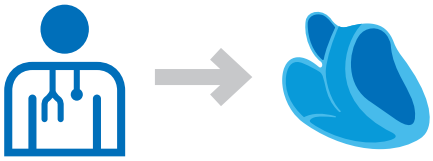
*Merritt Hawkins' 2019 Review of Physician and Advanced Practitioner Recruiting Incentives reveals a number of trends within the physician and advanced practitioner recruiting market, including:*



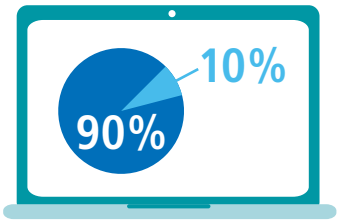
- **For the 13th consecutive year, family physicians topped the list of Merritt Hawkins' 20 most requested recruiting assignments, underscoring the continued robust demand for primary care physicians.**


- **Though primary care physicians are in strong demand, a growing volume of recruitment activity is shifting toward medical specialists. 78% of Merritt Hawkins' search assignments tracked in the 2019 Review were for medical specialists, up from 67% four years ago, a trend driven by population and physician aging.**

- **For fourth consecutive year, psychiatrists were second on the list of Merritt Hawkins' most requested recruiting assignments, reflecting a severe shortage of mental health professionals nationwide.**



- **Invasive cardiologists have the highest average starting salaries of physicians tracked in the 2019 *Review* at $648,000, followed by orthopedic surgeons at $536,000.**
- The average starting salary for family medicine physicians is $239,000, a slight decrease from $241,000 the previous year.
- The average signing bonus for physicians is $32,692.
- The use of quality/value-based physician compensation is rising. 56% of physician production bonus formulas tracked in the 2019 *Review* feature quality-based metrics, up from 42% the previous year.




- **Employment rather than independent practice remains the dominant physician recruiting model. Over 90% of Merritt Hawkins' search assignments feature employed practice settings, while less than 10% feature independent practice.**
- 66% of Merritt Hawkins' recruiting assignments tracked in the 2019 *Review* occurred in communities of 100,000 or more, a record high, further reflecting rising demand for medical specialists who tend to practice in larger communities.

Following is a breakout of the characteristics and metrics of Merritt Hawkins' 2018/19 recruiting assignments.

# Merritt Hawkins' 2019 Review of Physicians and Advanced Practitioner Recruiting Incentives: Recruiting Assignment Characteristics and Metrics

*All of the following numbers are rounded to the nearest full digit.*

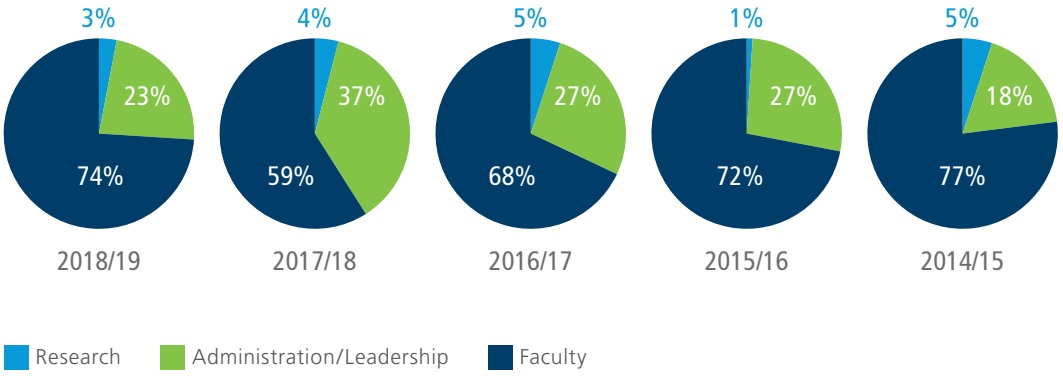
## 1 Total Number of Physician/Advanced Practitioner Search Assignments Represented

The 2019 *Review* is based on a representative sample of the 3,131 permanent physician and advanced practitioner search assignments Merritt Hawkins/AMN Healthcare's physician staffing companies had ongoing or were engaged to conduct during the 12 month period from April 1, 2018 to March 31, 2019, up from the 3,045 the previous year.

## 2 Settings of Physician Search Assignments

| | 2018/19 | 2017/18 | 2016/17 | 2015/16 | 2014/15 | 2013/14 |
|---|---|---|---|---|---|---|
| **Hospital** | 1,065 (34%) | 1,230 (40%) | 1,415 (43%) | 1,639 (49%) | 1,596 (51%) | 2,006 (64%) |
| **Group** | 877 (28%) | 798 (26%) | 886 (27%) | 628 (19%) | 625 (20%) | 401 (13%) |
| **Solo/Direct Pay/Concierge** | 31 (1%) | 45 (2%) | 34 (1%) | 181 (5%) | 125 (4%) | 17 (<1%) |
| **CHC/FQHC/IHS** | 282 (9%) | 363 (12%) | 497 (15%) | 434 (13%) | 406 (13%) | 378 (12%) |
| **Academics** | 626 (20%) | 464 (15%) | 374 (11%) | 367 (11%) | 252 (8%) | 188 (6%) |
| **Other (Urgent Care, HMO, Association, etc.)** | 250 (8%) | 145 (5%) | 81 (3%) | 93 (3%) | 92 (3%) | 30 (1%) |

**If Academics, what type of position?** *(of 626 Academic setting positions)*



## 3 States Where Search Assignments Were Conducted

Searches also conducted in the District of Columbia.

AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WA, WI, WV, WY

## 4 Number of Searches by Community Size

| | 2018/19 | 2017/18 | 2016/17 | 2015/16 | 2014/15 | 2013/14 |
|---|---|---|---|---|---|---|
| **0-25,000** | 534 (17%) | 612 (20%) | 755 (23%) | 870 (26%) | 1,184 (38%) | 1,044 (33%) |
| **25,001-100,000** | 530 (17%) | 545 (18%) | 742 (22%) | 766 (23%) | 689 (22%) | 819 (26%) |
| **100,001+** | 2,067 (66%) | 1,888 (62%) | 1,790 (55%) | 1,706 (51%) | 1,247(40%) | 1,295 (41%) |

## 5 Top 20 Most Requested Searches by Specialty

| Specialty | 2018/19 | 2017/18 | 2016/17 | 2015/16 | 2014/15 | 2013/14 |
|---|---|---|---|---|---|---|
| **Family Medicine (includes FP/OB)** | 457 | 497 | 607 | 627 | 734 | 714 |
| **Psychiatry** | 199 | 243 | 256 | 250 | 230 | 206 |
| **Nurse Practitioner** | 169 | 205 | 137 | 150 | 143 | 128 |
| **OB/GYN** | 161 | 118 | 109 | 112 | 112 | 70 |
| **Internal Medicine** | 148 | 150 | 193 | 233 | 237 | 235 |
| **Radiology** | 148 | 132 | 80 | 40 | 24 | 22 |
| **Hospitalist** | 143 | 118 | 94 | 228 | 176 | 231 |
| **Neurology** | 97 | 57 | 61 | 101 | 60 | 61 |
| **Gastroenterology** | 85 | 102 | 66 | 58 | 43 | 54 |
| **Pediatrics** | 85 | 63 | 76 | 76 | 71 | 92 |
| **Cardiology** | 84 | 61 | 62 | 33 | 36 | 32 |
| **Emergency Medicine** | 76 | 74 | 90 | 70 | 80 | 89 |
| **Orthopedic Surgery** | 73 | 85 | 61 | 81 | 106 | 58 |
| **Anesthesiology** | 70 | 40 | 43 | 28 | 16 | 14 |
| **Dermatology** | 60 | 66 | 83 | 71 | 44 | 30 |
| **Pulmonology** | 56 | 40 | 62 | 46 | 38 | 18 |
| **Urology** | 54 | 41 | 37 | 51 | 40 | 29 |
| **Hematology & Oncology** | 53 | 31 | 22 | 16 | 24 | 50 |
| **Otolaryngology** | 52 | 52 | 42 | 44 | 52 | 32 |
| **Certified Registered Nurse Anesthetists** | 47 | 23 | N/A | N/A | N/A | N/A |

## 6 Other Specialty Recruitment Assignments

- Addiction Medicine
- Addiction Psychiatry
- Adolescent Medicine
- Adult Medicine
- Adult Reconstructive Orthopedic Surgery
- Advanced Practice Midwife
- Alzheimer's and Related Dementias Neurology
- Anatomic Pathology
- Anesthesiologist Assistant
- Audiologist
- Bariatric Surgery
- Behavioral Neurology & Neuropsychiatry
- Body Imaging
- Breast Surgery
- Cardiac Anesthesiology
- Cardiology - Electrophysiology
- Cardiology - Heart Failure
- Cardiology - Interventional
- Cardiothoracic Surgery
- Child & Adolescent Psychiatry
- Child Neurology / Pediatric Neurology
- Clinical & Laboratory Immunology
- Clinical Neurophysiology / EMG
- Clinical Nurse Specialist
- Clinical Psych Nurse Specialist
- Colon & Rectal Surgery
- Cornea and Refractive Ophthalmology
- Critical Care Medicine Nurse Practitioner
- Critical Care-Intensivist Medicine
- Dentist
- Dermatopathology
- Developmental Behavioral Pediatrics
- Emergency Nurse Practitioner
- Endocrinology
- Female Pelvic Medicine and Reconstructive Surgery
- Foot and Ankle Surgery
- Forensic Pathology
- Gastroenterology
- Gastroenterology - Hepatology
- Gastroenterology - Hepatology Transplant
- General Surgery
- Geriatric Medicine
- Geriatric Psychiatry
- Geriatric Nurse Practitioner
- Gynecology
- Hand Surgery
- Headache & Neuropathic Pain Neurology
- Hematology & Oncology - Bone Marrow Transplantation
- Hospice and Palliative Medicine
- Infectious Disease
- Interventional Pain Medicine
- Laboratory Technician
- Laborist
- Mammographer
- Maternal & Fetal Medicine
- Medical Oncology
- MOHS-Micrographic Surgery
- Molecular Genetic Pathology
- Multiple Sclerosis Neurology
- Musculoskeletal Radiology
- Neonatal Nurse Practitioner
- Neonatal-Perinatal Medicine / Neonatology
- Nephrology
- Neuro-Critical Care
- Neuro-Interventional
- Neurological Surgery
- Neuromuscular Medicine
- Neuromusculoskeletal Medicine & OMM
- Neuroradiology
- Nocturnist
- Obstetrics
- Occupational Health Nurse Practitioner
- Occupational Medicine
- Oculoplastic Ophthalmology
- Ophthalmology
- Optician
- Optometrist
- Oral & Maxillofacial Surgery
- Orthopedic Spine Surgery
- Pain Medicine
- Pathology
- Pediatric Allergy/Immunology
- Pediatric Anesthesiology
- Pediatric Cardiology
- Pediatric Critical Care Medicine
- Pediatric Dentistry
- Pediatric Dermatology
- Pediatric Emergency Medicine
- Pediatric Endocrinology
- Pediatric Gastroenterology
- Pediatric Gastroenterology - Transplant Hepatology
- Pediatric Genetics
- Pediatric Hematology-Oncology
- Pediatric Hospice and Palliative Medicine
- Pediatric Hospitalist
- Pediatric Internal Medicine
- Pediatric Nephrology
- Pediatric Otolaryngology
- Pediatric Pulmonology
- Pediatric Radiology
- Pediatric Rehabilitation Medicine
- Pediatric Rheumatology
- Pediatric Surgery
- Pediatric Urology
- Pediatric Nurse Practitioner
- Physician Advisor/Utilization Review
- Physical Medicine & Rehabilitation
- Physical Therapy
- Physician Assistant
- Plastic and Reconstructive Surgery
- Podiatrist
- Psych/Mental Health Nurse Practitioner
- Psychosomatic Medicine
- Pulmonary and Sleep Medicine
- Radiation Oncology
- Registered Nurse
- Reproductive Endocrinology
- Retina Surgery
- Rheumatology
- Sleep Medicine
- Social Worker
- Sports Medicine
- Sports Medicine Orthopedic Surgery
- Surgical Critical Care (Trauma Surgery)
- Surgical Oncology
- Teleradiology
- Trauma Orthopedic Surgery
- Undersea and Hyperbaric Medicine
- Urgent Care
- Vascular & Interventional Radiology
- Vascular Surgery

## 7 Academic Titles Include:

Assistant Dean
Assistant Professor
Associate Dean
Chair
Chair of Family Medicine
Chair of Internal Medicine
Chair of Obstetrics/Gynecology
Chair of Pediatrics
Chair of Psychiatry
Chair of Surgery
Chief
Chief Executive Officer
Chief Cardiovascular Medicine
Chief Gastroenterology
Chief General Medicine
Chief Hematology and Oncology
Chief Infectious Diseases
Chief Pediatrics
Chief Pulmonology and Critical Care
Chief Rheumatology
Chief Medical Officer
Chief of Service Line
Chief Operating Officer
Chief Pediatrics: Cardiology
Chief Pediatrics: Critical Care
Chief Pediatrics: Pediatric Endocrinology
Chief Pediatrics: Pediatric Hematology/Oncology
Chief Pediatrics: Pediatric Hospital Medicine
Chief Pediatrics: Neonatal-Perinatal Medicine
Chief Pediatrics: Nephrology
Chief Pediatrics: Neurology
Chief Pediatrics: Pulmonology
Clerkship Director
Clerkship Director Dermatology
Clerkship Director Neurology
Clerkship Director Psychiatry
Clerkship Director Radiology
Dean
Director of Graduate Medical Education
Medical Director
Obstetrics & Gynecology Chair
Physician Advisor/Utilization Review
Research
Residency Program Director
Vice Chair
Vice President of Medical Affairs

## 8 Executive Titles Include:

Chief Executive Officer
Chief Experience Officer
Chief Medical Officer
Chief of Service Line
Vice President of Medical Affairs
Chief Nursing Officer
Chief Quality Officer
Director of Nursing

## 9 Income Offered to Top 20 Recruited Specialties

*(Base salary or guaranteed income only, does not include production bonus or benefits)*

| Family Medicine | Low | Average | High |
|---|---|---|---|
| 2018/19 | $130,000 | $239,000 | $400,000 |
| 2017/18 | $165,000 | $241,000 | $400,000 |
| 2016/17 | $110,000 | $231,000 | $400,000 |
| 2015/16 | $135,000 | $225,000 | $340,000 |
| 2014/15 | $112,000 | $198,000 | $330,000 |
| 2013/14 | $140,000 | $199,000 | $293,000 |

**YOY CHANGE -0.83%**

| Psychiatry | Low | Average | High |
|---|---|---|---|
| 2018/19 | $184,000 | $273,000 | $400,000 |
| 2017/18 | $200,000 | $261,220 | $465,000 |
| 2016/17 | $120,000 | $263,000 | $450,000 |
| 2015/16 | $195,000 | $250,000 | $370,000 |
| 2014/15 | $172,000 | $226,000 | $325,000 |
| 2013/14 | $150,000 | $217,000 | $350,000 |

**YOY CHANGE 4.5%**

| OB/GYN | Low | Average | High |
|---|---|---|---|
| 2018/19 | $200,000 | $318,000 | $475,000 |
| 2017/18 | $200,000 | $324,000 | $550,000 |
| 2016/17 | $175,000 | $335,000 | $700,000 |
| 2015/16 | $210,000 | $321,000 | $500,000 |
| 2014/15 | $140,000 | $276,000 | $450,000 |
| 2013/14 | $215,000 | $288,000 | $380,000 |

**YOY CHANGE -1.9%**

| Internal Medicine | Low | Average | High |
|---|---|---|---|
| 2018/19 | $180,000 | $264,000 | $500,000 |
| 2017/18 | $190,000 | $261,000 | $475,000 |
| 2016/17 | $170,000 | $257,000 | $600,000 |
| 2015/16 | $195,000 | $237,000 | $320,000 |
| 2014/15 | $100,000 | $207,000 | $260,000 |
| 2013/14 | $145,000 | $198,000 | $360,000 |

**YOY CHANGE 1.2%**

| Radiology | Low | Average | High |
|---|---|---|---|
| 2018/19 | $245,000 | $387,000 | $550,000 |
| 2018/19 (Telerad) | $320,000 | $360,000 | $400,000 |
| 2017/18 | $309,000 | $371,000 | $650,000 |
| 2017/18 (Telerad) | $350,000 | $375,000 | $500,000 |
| 2016/17 | $300,000 | $436,000 | $725,000 |
| 2016/17 (Telerad) | $400,000 | $494,000 | $600,000 |
| 2015/16 | $275,000 | $475,000 | $750,000 |
| 2014/15 | $150,000 | $400,000 | $500,000 |
| 2013/14 | $225,000 | $323,000 | $500,000 |

YOY CHANGE 4.3%

| Hospitalist | Low | Average | High |
|---|---|---|---|
| 2018/19 | $170,000 | $268,000 | $450,000 |
| 2017/18 | $215,000 | $269,000 | $365,000 |
| 2016/17 | $200,000 | $264,000 | $400,000 |
| 2015/16 | $180,000 | $249,000 | $390,000 |
| 2014/15 | $170,000 | $232,000 | $300,000 |
| 2013/14 | $145,000 | $229,000 | $350,000 |

YOY CHANGE -0.37%

| Neurology | Low | Average | High |
|---|---|---|---|
| 2018/19 | $250,000 | $317,000 | $400,000 |
| 2017/18 | $255,000 | $301,000 | $395,000 |
| 2016/17 | $220,000 | $305,000 | $400,000 |
| 2015/16 | $220,000 | $285,000 | $500,000 |
| 2014/15 | $180,000 | $277,000 | $350,000 |
| 2013/14 | $180,000 | $262,000 | $400,000 |

YOY CHANGE 5.3%

| Nurse Practitioner | Low | Average | High |
|---|---|---|---|
| 2018/19 | $90,000 | $124,000 | $200,000 |
| 2017/18 | $85,000 | $129,000 | $205,000 |
| 2016/17 | $85,000 | $123,000 | $181,000 |
| 2015/16 | $92,000 | $117,000 | $197,000 |
| 2014/15 | $78,000 | $107,000 | $129,000 |
| 2013/14 | $70,000 | $106,000 | $150,000 |

YOY CHANGE -3.8%

| Pediatrics | Low | Average | High |
|---|---|---|---|
| 2018/19 | $140,000 | $242,000 | $400,000 |
| 2017/18 | $189,000 | $230,000 | $355,000 |
| 2016/17 | $170,000 | $240,000 | $400,000 |
| 2015/16 | $165,000 | $224,000 | $308,000 |
| 2014/15 | $100,000 | $195,000 | $275,000 |
| 2013/14 | $130,000 | $188,000 | $240,000 |

YOY CHANGE 5.2%

| Gastroenterology | Low | Average | High |
|---|---|---|---|
| 2018/19 | $350,000 | $495,000 | $650,000 |
| 2017/18 | $355,000 | $487,000 | $725,000 |
| 2016/17 | $300,000 | $492,000 | $800,000 |
| 2015/16 | $300,000 | $458,000 | $600,000 |
| 2014/15 | $275,000 | $455,000 | $600,000 |
| 2013/14 | $240,000 | $454,000 | $560,000 |

YOY CHANGE 1.6%

| Cardiology (non-invasive) | Low | Average | High |
|---|---|---|---|
| 2018/19 | $325,000 | $441,000 | $620,000 |
| 2017/18 | $300,000 | $427,000 | $580,000 |
| 2016/17 | $300,000 | $428,000 | $580,000 |
| 2015/16 | $250,000 | $493,000 | $700,000 |
| 2014/15 | $200,000 | $279,000 | $400,000 |
| 2013/14 | $400,000 | $442,000 | $500,000 |

YOY CHANGE 3.3%

| Cardiology (invasive) | Low | Average | High |
|---|---|---|---|
| 2018/19 | $575,000 | $648,000 | $725,000 |
| 2017/18 | $480,000 | $590,000 | $810,000 |
| 2016/17 | $480,000 | $563,000 | $810,000 |
| 2015/16 | $475,000 | $545,000 | $700,000 |
| 2014/15 | $450,000 | $525,000 | $650,000 |
| 2013/14 | $350,000 | $454,000 | $550,000 |

YOY CHANGE 9.8%

| Emergency Medicine | Low | Average | High |
|---|---|---|---|
| 2018/19 | $240,000 | $382,000 | $415,000 |
| 2017/18 | $250,000 | $358,000 | $568,000 |
| 2016/17 | $250,000 | $349,000 | $450,000 |
| 2015/16 | $250,000 | $304,000 | $425,000 |
| 2014/15 | $300,000 | $345,000 | $434,000 |
| 2013/14 | $220,000 | $311,000 | $400,000 |

YOY CHANGE 8.5%

| Orthopedic Surgery | Low | Average | High |
|---|---|---|---|
| 2018/19 | $350,000 | $536,000 | $850,000 |
| 2017/18 | $340,000 | $533,000 | $985,000 |
| 2016/17 | $192,000 | $579,000 | $1,000,000 |
| 2015/16 | $350,000 | $521,000 | $800,000 |
| 2014/15 | $350,000 | $497,000 | $800,000 |
| 2013/14 | $350,000 | $488,000 | $700,000 |

YOY CHANGE 0.56%

| Anesthesiology | Low | Average | High |
|---|---|---|---|
| 2018/19 | $281,000 | $404,000 | $450,000 |
| 2017/18 | $325,000 | $371,000 | $540,000 |
| 2016/17 | $249,000 | $376,000 | $520,000 |
| 2015/16 | $360,000 | $397,000 | $450,000 |
| 2014/15 | $270,000 | $361,000 | $400,000 |
| 2013/14 | $350,000 | $383,000 | $475,000 |

YOY CHANGE 8.9%

| Dermatology | Low | Average | High |
|---|---|---|---|
| 2018/19 | $250,000 | $420,000 | $700,000 |
| 2017/18 | $280,000 | $425,000 | $650,000 |
| 2016/17 | $250,000 | $421,000 | $1,000,000 |
| 2015/16 | $250,000 | $444,000 | $650,000 |
| 2014/15 | $265,000 | $398,000 | $550,000 |
| 2013/14 | $235,000 | $371,000 | $425,000 |

YOY CHANGE -1.2%

| Urology | Low | Average | High |
|---|---|---|---|
| 2018/19 | $300,000 | $464,000 | $575,000 |
| 2017/18 | $290,000 | $386,000 | $700,000 |
| 2016/17 | NA | $460,000 | NA |
| 2015/16 | $325,000 | $471,000 | 625,000 |
| 2014/15 | $260,000 | $412,000 | $550,000 |
| 2013/14 | $430,000 | $504,000 | $625,000 |

YOY CHANGE 20.2%

| Pulmonology/ Critical Care | Low | Average | High |
|---|---|---|---|
| 2018/19 | $325,000 | $399,000 | $460,000 |
| 2017/18 | $355,000 | $418,000 | $725,000 |
| 2016/17 | $225,000 | $390,000 | $530,000 |
| 2015/16 | $275,000 | $380,000 | $500,000 |
| 2014/15 | $260,000 | $331,000 | $386,000 |
| 2013/14 | $230,000 | $358,000 | $425,000 |

YOY CHANGE -0.75%

| Otolaryngology | Low | Average | High |
|---|---|---|---|
| 2018/19 | $310,000 | $402,000 | $450,000 |
| 2017/18 | $325,000 | $405,000 | $600,000 |
| 2016/17 | $200,000 | $468,000 | $1,000,000 |
| 2015/16 | $305,000 | $403,000 | $700,000 |
| 2014/15 | $150,000 | $334,000 | $450,000 |
| 2013/14 | $250,000 | $372,000 | $500,000 |

YOY CHANGE -0.74%

| Hematology/ Oncology | Low | Average | High |
|---|---|---|---|
| 2018/19 | $200,000 | $393,000 | $450,000 |
| 2017/18 | N/A | $391,000 | N/A |
| 2016/17 | N/A | $388,000 | N/A |
| 2015/16 | N/A | $405,000 | N/A |
| 2014/15 | N/A | $397,000 | N/A |
| 2013/14 | N/A | $410,000 | N/A |

YOY CHANGE 0.50%

| Certified Registered Nurse Anesthetists | Low | Average | High |
|---|---|---|---|
| 2018/19 | $154,000 | $197,000 | $250,000 |
| 2017/18 | NA | $194,000 | NA |
| 2016/17 | NA | $202,000 | NA |
| 2015/16 | NA | $190,000 | NA |

YOY CHANGE 1.60%

## 10 Average Salaries for Top Five Most Requested Physician Specialties by Region 2019

| | Northeast | Midwest/ Great Plains | Southeast | Southwest | West |
|---|---|---|---|---|---|
| Family Practice | $221,000 | $227,000 | $250,000 | $235,000 | $248,000 |
| Psychiatry | $260,000 | $300,000 | $300,000 | $253,000 | $265,000 |
| OB/GYN | $265,000 | $326,000 | $325,000 | $265,000 | $327,000 |
| Internal Medicine | $218,000 | $290,000 | $295,000 | $250,000 | $259,000 |
| Radiology | $310,000 | $386,000 | $425,000 | $398,000 | $300,000 |

## 11 Average Salaries for Top Five Most Recruited Specialties by Setting

| | Academics | Community Health Center | Group | Hospital | Solo |
|---|---|---|---|---|---|
| Family Practice | $217,000 | $226,000 | $252,000 | $248,000 | $312,000 |
| Psychiatry | $233,000 | $265,000 | $286,000 | $295,000 | $280,000 |
| OBGYN | $274,000 | $250,000 | $326,000 | $356,000 | NA |
| Internal Medicine | $253,000 | $233,000 | $285,000 | $274,000 | NA |
| Radiology | $343,000 | NA | $413,000 | $388,000 | NA |

## 12 Type of Incentive Offered

| | Salary | Salary with Bonus | Income Guarantee | Other |
|---|---|---|---|---|
| 2018/19 | 867 (22%) | 2,199 (70%) | 61 (2%) | 184 (6%) |
| 2017/18 | 515 (17%) | 2,285 (75%) | 89 (3%) | 156 (5%) |
| 2016/17 | 723 (22%) | 2,359 (72%) | 12 1(4%) | 84 (2%) |
| 2015/16 | 767 (23%) | 2,512 (75%) | 32 (1%) | 31 (1%) |
| 2014/15 | 715 (23%) | 2,219 (71%) | 124 (4%) | 62 (2%) |
| 2013/14 | 633 (20%) | 2,335 (74%) | 127 (4%) | 63 (2%) |

## 13 If Salary Plus Production Bonus, on Which Types of Metrics Was the Bonus Based?

*(of 2,199 searches offering salary plus bonus, multiple responses possible).*

| | RVU Based | Net Collections | Gross Billings | Patient Encounters | Quality | Other |
|---|---|---|---|---|---|---|
| 2018/19 | 70% | 18% | 3% | 9% | 56% | 0% |
| 2017/18 | 50% | 10% | 1% | 4% | 43% | 4% |
| 2016/17 | 52% | 28% | 6% | 14% | 39% | 9% |
| 2015/16 | 58% | 22% | 2% | 8% | 32% | 8% |
| 2014/15 | 57% | 23% | 2% | 9% | 23% | 4% |
| 2013/14 | 59% | 21% | 5% | 11% | 24% | 9% |

## 14 If quality factors were included in the production bonus, about what percent of physician's total compensation determined by quality? *(Question asked for the first time in 2017/18)*

| 2018/19 | 2017/18 |
|---|---|
| 11% | 8% |

## 15 Searches Offering Relocation Allowance

| | 2018/19 | 2017/18 | 2016/17 | 2015/16 | 2014/15 | 2013/14 |
|---|---|---|---|---|---|---|
| Yes | 3,064 (98%) | 2,999 (98%) | 3,132 (95%) | 3,173 (95%) | 2,623 (84%) | 2,845 (90%) |
| No | 67 (2%) | 46 (2%) | 155 (5%) | 169 (5%) | 497 (16%) | 313 (10%) |

## 16 Amount of Relocation Allowance

*(Physicians only)*

| | Low | Average | High |
|---|---|---|---|
| 2018/19 | $2,000 | $10,393 | $30,000 |
| 2017/18 | $2,500 | $9,441 | $25,000 |
| 2016/17 | $2,500 | $10,072 | $44,000 |
| 2015/16 | $2,500 | $10,226 | $30,000 |
| 2014/15 | $2,000 | $10,292 | $50,000 |
| 2013/14 | $1,000 | $9,849 | $25,000 |

## 17 Amount of Relocation Allowance

*(NPs and PAs only)*

| | Low | Average | High |
|---|---|---|---|
| 2018/19 | $2,500 | $7,067 | $15,000 |
| 2017/18 | $1,500 | $6,250 | $25,000 |
| 2016/17 | $2,500 | $8,063 | $25,000 |
| 2015/16 | $2,500 | $8,649 | $25,000 |
| 2014/15 | $2,500 | $9,436 | $35,000 |
| 2015/16 | $3,500 | $6,904 | $10,000 |

## 18 Searches Offering Signing Bonus

| | 2018/19 | 2017/18 | 2016/17 | 2015/16 | 2014/15 | 2013/14 |
|---|---|---|---|---|---|---|
| Yes | 2,220 (71%) | 2,135 (70%) | 2,501 (76%) | 2,576 (77%) | 2,280 (73%) | 2,212 (70%) |
| No | 911 (29%) | 910 (30%) | 786 (24%) | 766 (23%) | 840 (27%) | 946 (30%) |

## 19 Amount of Signing Bonus Offered
*(Physicians only)*

| | Low | Average | High |
|---|---|---|---|
| 2018/19 | $3,000 | $32,692 | $225,000 |
| 2017/18 | $2,500 | $33,707 | $180,000 |
| 2016/17 | $2,500 | $32,636 | $275,000 |
| 2015/16 | $1,000 | $26,889 | $350,000 |
| 2014/15 | $2,500 | $26,365 | $275,000 |
| 2013/14 | $1,000 | $21,773 | $150,000 |

## 20 Amount of Signing Bonus Offered
*(NPs and PAs only)*

| | Low | Average | High |
|---|---|---|---|
| 2018/19 | $2,500 | $9,000 | $25,000 |
| 2017/18 | $5,000 | $11,944 | $30,000 |
| 2016/17 | $2,500 | $8,576 | $25,000 |
| 2015/16 | $2,500 | $10,340 | $40,000 |
| 2014/15 | $2,500 | $8,791 | $20,000 |
| 2013/14 | $1,000 | $7,786 | $20,000 |

## 21 Amount of Signing Bonus offered for Top 5 most requested specialties

| | Low | Average | High |
|---|---|---|---|
| Family Practice | $5,000 | $26,071 | $100,000 |
| Psychiatry | $5,000 | $22,955 | $70,000 |
| OBGYN | $3,000 | $30,115 | $100,000 |
| Internal Medicine | $5,000 | $29,308 | $100,000 |
| Radiology | $10,000 | $27,045 | $100,000 |

## 22 Searches Offering to Pay Continuing Medical Education (CME)

| | 2018/19 | 2017/18 | 2016/17 | 2015/16 | 2014/15 | 2013/14 |
|---|---|---|---|---|---|---|
| Yes | 3,061 (98%) | 2,984 (98%) | 3,116 (95%) | 3,243 (97%) | 2,966 (95%) | 2,875 (91%) |
| No | 70 (2%) | 61 (2%) | 171 (5%) | 99 (3%) | 154 (5%) | 283 (9%) |

## 23 Amount of CME Allowance Pay Offered
*(Physicians only)*

| | Low | Average | High |
|---|---|---|---|
| 2018/19 | $1,000 | $3,620 | $35,000 |
| 2017/18 | $250 | $3,888 | $50,000 |
| 2016/17 | $500 | $3,613 | $30,000 |
| 2015/16 | $100 | $3,633 | $35,000 |
| 2014/15 | $500 | $3,649 | $35,000 |
| 2013/14 | $1,000 | $3,515 | $54,000 |

## 24 Amount of CME Allowance Pay Offered
*(NPs and PAs only)*

| | Low | Average | High |
|---|---|---|---|
| 2018/19 | $1,000 | $2,862 | $5,000 |
| 2017/18 | $650 | $2,280 | $5,000 |
| 2016/17 | $400 | $2,126 | $5,000 |
| 2015/16 | $400 | $2,140 | $3,950 |
| 2014/15 | $1,000 | $2,241 | $5,000 |
| 2013/14 | $1,000 | $2,450 | $5,000 |

## 25 Searches Offering to Pay Additional Benefits

| | 2018/19 | 2017/18 | 2016/17 | 2015/16 | 2014/15 | 2013/14 |
|---|---|---|---|---|---|---|
| Health Insurance | 99% | 99% | 98% | 98% | 99% | 97% |
| Malpractice | 98% | 99% | 98% | 99% | 99% | 99% |
| Retirement /401K | 96% | 94% | 95% | 96% | 96% | 94% |
| Disability | 97% | 98% | 91% | 97% | 92% | 86% |
| Educational Forgiveness | 31% | 18% | 25% | 26% | 25% | 26% |

## 26 If Educational Loan Forgiveness was Offered, What Was the Term?

*(of 964 searches offering loan forgiveness)*

| | 2018/19 | 2017/18 | 2016/17 | 2015/16 | 2014/15 | 2013/14 |
|---|---|---|---|---|---|---|
| One Year | NA | 18 (3%) | 40 (5%) | 45 (5%) | 61 (8%) | 90 (11%) |
| Two Years | NA | 104 (19%) | 191 (23%) | 155 (18%) | 104 (13%) | 173 (21%) |
| Three Years Plus | NA | 425 (78%) | 592 (72%) | 671 (77%) | 619 (79%) | 557 (68%) |

## 27 If Education Loan Forgiveness Was Offered, What Was the Amount?

*(Physicians only)*

| | Low | Average | High |
|---|---|---|---|
| 2018/19 | $10,000 | $101,571 | $300,000 |
| 2017/18 | $10,000 | $82,833 | $300,000 |
| 2016/17 | $10,000 | $80,923 | $260,000 |
| 2015/16 | $10,000 | $88,068 | $300,000 |
| 2014/15 | $2,500 | $89,479 | $250,000 |
| 2013/14 | $4,000 | $77,000 | $336,000 |

## 28 If Education Loan Forgiveness Was Offered, What Was the Amount?

*(NPs and PAs only)*

| | Low | Average | High |
|---|---|---|---|
| 2018/19 | $20,000 | $61,250 | $100,000 |
| 2017/18 | $25,000 | $33,333 | $37,500 |
| 2016/17 | $35,000 | $56,442 | $100,000 |
| 2015/16 | $30,000 | $61,667 | $100,000 |
| 2014/15 | $30,000 | $54,286 | $100,000 |
| 2013/14 | $20,000 | $40,000 | $60,000 |

# Trends and Observations

*Merritt Hawkins' annual Review of Physician and Advanced Practitioner Recruiting Incentives, now in its 26th year, tracks three key physician recruiting trends, as well as various advanced practitioner recruiting trends.*

1. Based on the physician recruiting assignments Merritt Hawkins is contracted to conduct, the *Review* indicates which types of physicians are in the greatest demand and which are the most challenging to recruit.

2. The *Review* also indicates the types of practice settings into which physicians are being recruited (hospitals, medical groups, solo practice, etc.) and the types of communities that are recruiting physicians based on population size.

3. The *Review* further indicates the types of financial and other incentives that are being used to recruit physicians.

Each of these trends is discussed below, following an overview of the current healthcare market in which physician recruiting takes place.

## MARKET CONTEXT: RECENT TRENDS SHAPING PHYSICIAN SUPPLY, DEMAND AND RECRUITMENT

Merritt Hawkins' *2019 Review of Physician and Advanced Practitioner Recruiting Incentives* examines the permanent physician and advanced practitioner recruiting assignments Merritt Hawkins and AMN Healthcare's physician staffing divisions had ongoing or were engaged to conduct during the 12 month period from April 1, 2018 to March 31, 2019.

These search assignments reflect the types of physicians and advanced practitioners that hospitals, medical groups, Federally Qualified Health Centers (FQHCs), academic medical centers, government entities and other organizations are seeking nationwide. They also reflect which types of physicians may be particularly difficult to recruit, necessitating the assistance and additional resources of a physician recruiting firm.

Physician and advanced practitioner recruiting takes place in the context of the nation's vast, complex and evolving healthcare system, on which Americans now spend more than the entire economies

of all but six countries. Below is a brief look at some of the developments in healthcare that took place during the 12 months period covered by Merritt Hawkins' 2019 *Review* and how these events are likely to affect physician and advanced practitioner supply, demand and recruitment.

## HEALTHCARE: A JOBS AND SPENDING BEHEMOTH

The healthcare sector of the economy created 346,000 new jobs in 2018, up from 284,000 in 2017, an increase of 22%. This includes 219,000 jobs in ambulatory services and 107,000 jobs in hospital settings, according to Bureau of Labor Statistics (BLS). Nationwide, there are 7.6 million jobs in ambulatory services and 5.2 million hospital jobs, according to BLS, underlining the industry-wide shift from inpatient care to outpatient services.

More than 16 million people worked in healthcare jobs by the end of 2018, accounting for 11% of all jobs nationally, BLS reports. Healthcare continues to be a jobs generating behemoth, having created one in seven new jobs in 2018. Healthcare now is the number one employment sector in the U.S., after superseding retail two years ago.

This torrid pace of job creation is not expected to slacken any time soon. BLS projects that the number of healthcare jobs will grow 18% by 2026.

A robust increase in the number of healthcare jobs will be accompanied by a dramatic increase in healthcare spending. Overall, the rate of growth of healthcare spending in the U.S. was 7.3% annually from 1990 to 2007. That growth rate was deaccelerated in subsequent years through government and health industry policies, declining to 4.8% in 2016 and 3.9% in 2017, ccording to the Centers for Medicare and Medicaid Services (CMS).

However, CMS now projects that all U.S. healthcare spending will grow at a 5.5% pace from 2017 to 2027, when it will reach $5.7 trillion and account for 19.7% of GDP, up from 17.9% today. CMS projects spending on hospital services will grow from $1.3 trillion in 2018 to $1.88 trillion by 2026, an increase of 5.5% each year, driven by both increases in the average cost of inpatient stays and the growing volume and average cost of hospital outpatient visits.

Accelerated spending will include more spending on services directly or indirectly provided by or generated by physicians, creating a continued robust demand for doctors.

## THE ECONOMIC ROLE OF PHYSICIANS

According to CMS, 20% of the healthcare dollar in the U.S. is spent directly on physician services (see graph on page 17).

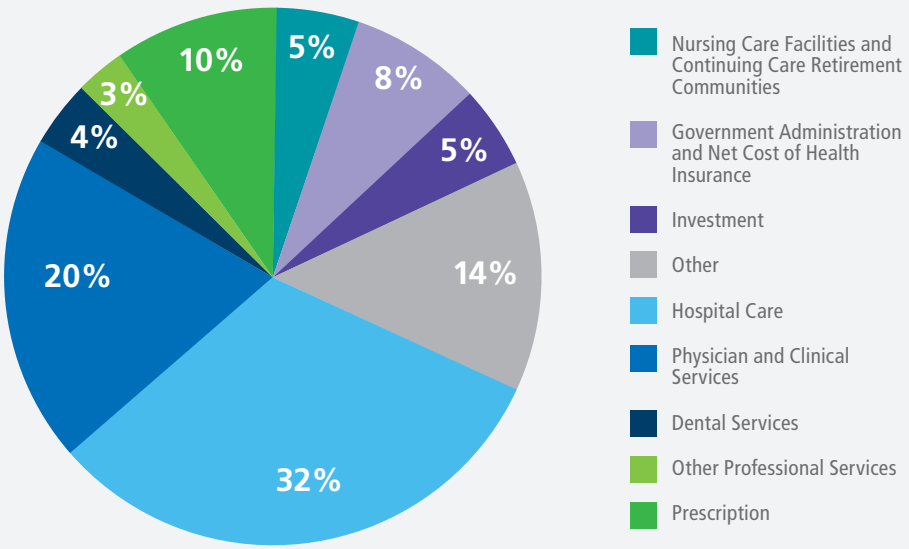
Though physicians are paid only 20 cents of every healthcare dollar, they direct where much of the remaining 80 cents are spent through hospital admissions, tests, prescriptions, treatment plans and procedures.

Merritt Hawkins' *2019 Physician Inpatient-Outpatient Revenue Survey* indicates that the average amount of annual net revenue physicians generate on behalf of their affiliated hospitals is $2.4 million, an increase of 52% over 2016. This increase is in part a reflection of population aging, which is causing a growing number of older patients to present physicians with multiple chronic ailments that often are time-consuming and expensive to treat.

Physicians do not just direct how the healthcare dollar is spent. They also create a massive amount of economic activity. According to the American Medical Association's January 2018 report *The National Economic Impact of Physicians*, the combined economic output of office-based physicians in the U.S. is $2.3 trillion, while each office-based physician generates over $3.1 million in economic output and supports an average of 17 jobs.

The economic role physicians play in healthcare is likely to keep them in high demand and ensure that they are an integral part of the growth in healthcare jobs referenced above. For additional information on this topic, see the Merritt Hawkins' white paper *The Economic Impact of Physicians*.

**THE NATION'S HEALTH DOLLAR ($3.3 TRILLION), CALENDAR YEAR 2016, WHERE IT WENT**




*Source: Centers for Medicare and Medicaid Services (CMS)*

## THE PHYSICIAN SHORTAGE ESCALATES

Ongoing trends in physician supply and demand also are likely to drive the recruitment of physicians.

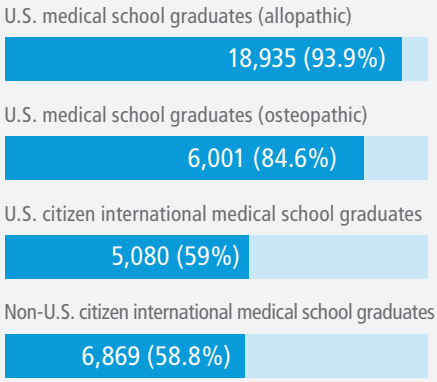
In April 2019 the Association of American Medical Colleges (AAMC) projected a shortage up to 121,900 physicians by 2032 in its periodic report The *Complexities of Physician Supply and Demand.* This is an upward revision of its 2018 report, which projected a shortage of up to 121,300 physicians by 2030.

These projections include a shortage of up to 55,200 primary care physicians and an even greater shortage of up to approximately 67,000 specialists. Among specialists, the AAMC projects a shortage of up to 23,400 surgical specialists and up to 39,100 internal medicine and other types of subspecialists.

A continuing contributor to the shortage will be a constrained supply of physicians completing their residency training, due largely to the cap Congress placed on federal funding for physician graduate medical education in 1997. From 2006 to 2016, the number of U.S. medical school graduates increased by 30% while the number of resident positions increased by only 14%, according to the AAMC's 2017 *State Physician Workforce Data Book.*

As are result, many medical graduates of U.S. and international medical schools fail to match to a residency position, as the chart below indicates.

**2019 MATCH RATES BY MEDICAL SCHOOL TYPE**




*Source: National Resident Matching Program (NRMP)*

For those who did not match, including about six percent of U.S. allopathic medical school graduates, over 15% of osteopathic graduates, and about 41% of international graduates, the path to a medical career may be blocked, inhibiting the supply of potential physicians.

To remedy the situation, a number of bills have been introduced to Congress to increase GME funding, but none have gained traction.

| STATES WITH THE HIGHEST PERCENT OF PHYSICIANS 60 OR OLDER | | STATES WITH THE LOWEST PERCENT OF PHYSICIANS 60 OR OLDER | |
|---|---|---|---|
| 1. New Mexico | 37.0% | 1. Utah | 26.0% |
| 2. Hawaii | 35.5% | 2. North Carolina | 26.6% |
| 3. New Jersey | 35.0% | 3. Minnesota | 26.7% |
| 4. Montana | 35.0% | 4. Texas | 27.2% |
| 5. Maine | 34.6% | 5. North Dakota | 27.2% |

*Source: 2017 AAMC State Physician Workforce Data Report*

## AN AGING PHYSICIAN WORKFORCE

Physician supply also is constrained by an aging physician workforce now composed of many doctors who are reaching their retirement years — a trend Merritt Hawkins refers to as the "retirement cliff." In some states, over one-third of physicians are 60 years old or older (see chart above).

Even in states with a relatively low number of aging physicians, over one quarter are 60 years old or older (see chart above).

In 2019, the Senior List released a report entitled *Digging into the Doctor Shortage* in which each state was ranked by how likely it is to experience a physician deficit. The ranking was based on the current number of physicians per capita in each state, the percent of physicians who are nearing retirement age, and the number of medical residents coming out of training (i.e., exits vs. entrants).

The chart on page 20 shows the states most likely to face a physician shortage and the states least likely to face a physician shortage based on these numbers.

## PRACTICE PATTERNS ARE REDUCING FTEs

Physician supply also is affected by prevailing physician practice patterns. Data from *A Survey of America's Physicians*, which Merritt Hawkins conducts biennially on behalf of The Physicians Foundation, indicate physicians are working fewer hours than they have in the past (see chart on page 20). Based on close to 9,000 physician responses, the *Survey of America's Physicians* is one of the largest physician surveys completed in the U.S. and has a margin of error of +/- 1.057%.

## AVERAGE PHYSICIAN WORK HOURS/WEEK

Average physician work hours tracked in the survey dropped by 2.4% from 2016 to 2018, which equates to approximately 20,000 fewer physician FTEs and millions of fewer patients seen.

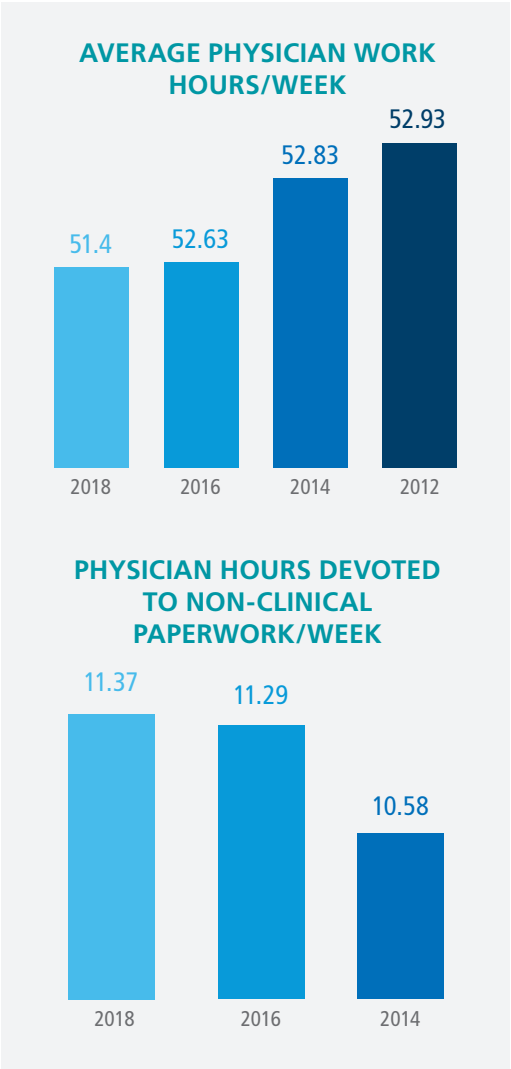
Concurrently, physicians are spending more time on non-clinical paperwork (see chart on page 20).

| STATES MOST LIKELY TO FACE A PHYSICIAN SHORTAGE | | STATES LEAST LIKELY TO FACE A PHYSICIAN SHORTAGE | |
|---|---|---|---|
| 1 | Wyoming | 1 | Massachusetts |
| 2 | Montana | 2 | Rhode Island |
| 3 | Mississippi | 3 | Ohio |
| 4 | Oklahoma | 4 | Minnesota |
| 5 | Arkansas | 5 | Delaware |

*Source: The Senior List. Digging Into the Doctor Shortage.*

The survey indicates that physicians spend 23% of their total work hours engaged in non-clinical paperwork, time equivalent to the work hours of approximately 186,000 physician FTEs. Paperwork burdens help explain why 80% of physicians responding to the *Survey of America's Physicians* indicated they currently are overworked and overextended and do not have the time to see more patients or take on new duties. Paperwork also limits the number of maladies physicians can address in one visit, thereby generating additional visits in an escalating cycle of demand.

The *Survey of America's Physicians* also indicates that physicians see fewer patients per day than they did in the past. Employed physicians see 12% fewer patients per day than independent physicians, according to the survey, while female physicians see 12% fewer patients per day than males. The growing number of both employed and female physicians in the workforce will therefore have a further inhibiting effect on total physician FTEs.




*Source: A Survey of America's Physicians. The Physicians Foundation/Merritt Hawkins. September, 2018.*

## DEMAND FOR PHYSICIANS ACCELERATING

At the same time that limited funding for physician training, an aging physician workforce, and changing physician practice patterns are combining to inhibit the supply of physicians, demand for physician services continues to accelerate.

Much of this demand is being generated by population aging. The Centers for Disease Control and Prevention (CDC) reports that patients 65 or older account for 37.4% of treatments and diagnostic tests and 34% of inpatient procedures, despite comprising only 14% of the population.

Seniors will soon represent a considerably higher percent of the population than they do today. By 2030, all U.S. Baby Boomers will be 65 or older and one in every five Americans (20%) will at retirement age and eligible for Medicare. By 2035, there will be 78 million people in the U.S. who are 65 or older while only 76.7 million will be younger than 18. For the first time in U.S. history, senior citizens will outnumber children, according to the Census Bureau. Seventy-eight million seniors, all of them with access to health insurance, will be the primary drivers of physician utilization.

Population growth will be an additional driver. From 1987 to 2010, the U.S. population grew by 28%, going from 242 million to 310 million people in 23 short years, according to the Census Bureau. By 2050, the Census Bureau projects that the U.S. population will reach 423 million with low international migration and 458 million with high international migration.

An escalating range of healthcare ailments also will drive demand for physician services. About 6 in 10 adults in America have a chronic illness such as heart disease or diabetes, according to the CDC, while 4 in 10 have more than one.

Obesity, in particular, has become a critical public health concern. A report from The Commonwealth Fund indicates that "Obesity is a grave public health threat, more serious even than the opioid epidemic. It is linked to chronic diseases including type 2 diabetes, hyperlipidemia, high blood pressure, cardiovascular disease, and cancer." *(Rising Obesity in the U.S. is a Public Health Crisis. The Commonwealth Fund. April 24, 2018)*

Societal problems such as poverty and drug abuse also are contributing to rising utilization of physician services. Drug overdose deaths in the U.S. rose from 63,632 in 2016 to 70,237 in 2017, a new record, with 47,600 overdose deaths tied to opioid use *(Washington Post. November 29, 2018)*.

Deaths from chronic pulmonary obstructive disorder (COPD), Alzheimer's, strokes and suicide also are up. The suicide rate nationally is up one third since 1999, according to the CDC, with suicide rates approximately 35% higher in rural counties than highly populated metropolitan counties.

Average life expectancy in the U.S. consequently declined in 2015, was stagnant in 2016, and declined again in 2017 – the worst such stretch in the U.S. since 1915-18 when average life expectancy was reversed as a consequence of World War I and a worldwide flu epidemic that killed 50 million people.

Rising demand for physicians is reflected in Merritt Hawkins' *2019 Survey of Final-Year Medical Residents.* Conducted every other year, this survey tracks the number of job solicitations received by physicians about to complete their training (see chart below).


*Source: Merritt Hawkins 2019 Survey of Final-Year Medical Residents.*

As these numbers indicate, 66% of 2019 final-year residents received 51 or more job solicitations during their training, while 45% received 100 or more, a clear sign that demand for physician services is outpacing the supply of new physicians.

## REDUCED ACCESS IS THE BOTTOM LINE

The bottom line of these trends for patients is reduced access to doctors. Merritt Hawkins' *Survey of Physician Appointment Wait Times* tracks how long it takes to schedule a new patient appointment in 15 large metro areas, each with a relatively high number of physicians per population. In 2017, the average physician appointment wait time was 24.1 days, up from 18.5 days in 2014, an increase of 30% over three years. The average physician appointment wait time in 15 mid-sized metropolitan areas also tracked in the survey was considerably longer at 32 days.

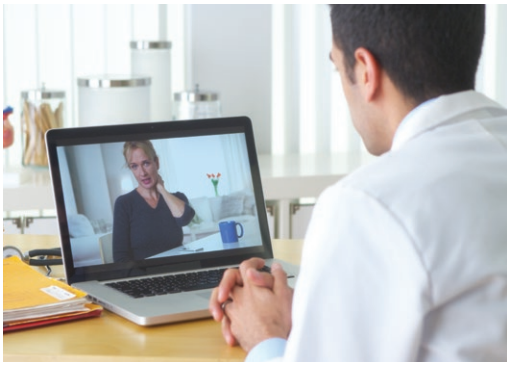
The survey does not track physician appointment wait times in rural communities, but the shortage of physicians in most rural areas is pronounced. There are more than 6,800 federally designed Healthcare Professional Shortage Areas (HPSAs) in the U.S., the majority of them in rural areas, in which 65 million people live. Texas, a largely rural state, has 35 counties with no physician, 185 with no general psychiatrist, and 147 with no ob/gyn *(The Physician Workforce in Texas. Merritt Hawkins. April, 2015)*. Other rural states have similar physician shortage patterns.

The physician shortage, and the access to care limitations it imposes, are key drivers of another trend in healthcare that also continues to accelerate – the convenient care movement.

## A MATTER OF CONVENIENCE

In May 2019, OnMed announced a virtual care concept featuring self-contained, unstaffed stations which offer video consults with providers and a built-in automated prescription drug dispensary. The units have special sanitization and air filtration systems, and are designed for maximum privacy as well as HIPAA and ADA compliance.

The stations are intended for use in hospital emergency departments, rural locations, airports, campuses and worksites. Placement of the stations will occur through contracts with health systems, employers and other organizations. The first two units were scheduled to open in April, 2019 in northern Mississippi *(HealthLeaders. March 12, 2019.)*



According to *HealthLeaders*, "Each unit includes a life sized TV screen and an ultra-high definition camera that makes it possible for doctors to look down a patient's throat or even examine a tiny skin lesion in detail. The pods also feature other advanced technology, including thermal imaging and facial recognition to provide patients with safe, private and secure consultations."

The stations have tools to measure height, weight, body mass index, blood pressure, and respiration, as well as thermal imaging to determine body temperature and diagnose infection. They are equipped to transmit results to primary care physicians and provide prescriptions to pharmacies.

Virtual care stations are the logical extension of a nationwide trend in healthcare in which convenience and patient experience are at a premium. There are now over 7,500 urgent care centers in the U.S., according to the Urgent Care Association of America, and over 3,000 primary care retail clinics. The industry is in a race to redirect how "consumers" connect with healthcare services as community-based outpatient services supplant the hospital campus/inpatient model. The chart below illustrates this trend.

### HOSPITAL ADMISSIONS AND HOSPITAL OUTPATIENT VISITS

| ALL HOSPITAL ADMISSIONS (IN THOUSANDS) | | ALL HOSPITAL OUTPATIENT VISITS (IN THOUSANDS) | |
|---|---|---|---|
| **2015** | 34,879 | **2015** | 802,680 |
| **2014** | 35,416 | **2014** | 787,422 |
| **2013** | 36,156 | **2013** | 777,961 |
| **2012** | 36,915 | **2012** | 750,408 |

*Source: American Hospital Association Annual Survey of Hospitals, Hospital Statistics. 2017*

As these numbers indicate, hospital inpatient stays are declining while hospital outpatient visits are booming.

According to a survey by Press Ganey, patient experience is five times more likely to drive consumer loyalty than is marketing *(HealthLeaders, December 28, 2018)*. One of the primary factors, if not the primary factor, determining whether patients have a positive experience is access. If patients can see a health care professional quickly they are more likely to rate their experience as positive. If they cannot, they are more likely to rate their experience as negative.

Consumer ratings are of growing importance as reimbursement is increasingly linked to quality metrics such as patient satisfaction. In addition, access, rather than price, often is the key factor over which healthcare organizations compete when seeking to increase market share.

For these reasons, a prevailing mantra among healthcare organizations today is to be "everywhere, all the time." The effort to be everywhere may include the acquisition, expansion or recruitment of physician groups by large healthcare networks, the proliferation of urgent care centers and retail clinics, telemedicine, and the virtual care kiosks referenced above.

Patient monitoring through smart phones is the latest piece of the puzzle, opening a new realm of patient touch points, particularly for millennials.

Whether virtual or brick and mortar, all of these multiplying sites of service will require additional health professionals, including primary care physicians and, in particular, advanced practice professionals such as nurse practitioners, a trend discussed later in this report. In addition, population aging virtually guarantees that hospital inpatient stays will rise again, most likely in the near future.

Access issues also are a major driver of another healthcare trend that picked up considerable momentum over the last year – the further consolidation and disruption of the healthcare industry.

## CONSOLIDATION, DISRUPTION AND A "NEW FRONT DOOR"

Over the last year and a half, the news of a proposed merger between CVS and Aetna has reverberated around the healthcare industry. CVS has over 1,100 Minute Clinics nationwide, and its proposed merger with Aetna, a $69 billion deal, opens up the possibility of expanded clinic sites and expanded service offerings, including chronic patient care for conditions such as heart disease and diabetes. The intent is to open up a "new front door" to the healthcare system, in a direct challenge to physician offices and hospitals.

Walmart's deal with Humana, the alliance between Amazon, JP Morgan and Berkshire Hathaway, now called "Haven," and the United-Davita merger also promise to reimagine and disrupt healthcare delivery, with the purpose ofenhancing quality, reducing costs and improving the patient experience.

While entities not traditionally active in healthcare are entering the industry, major healthcare organizations seek to address access, cost, quality and market share challenges through consolidation,

a trend that continued over the last year. According to *HealthLeaders'* April, 2019 *Mergers, Acquisitions and Partnerships Survey*, 73% of healthcare executives will be exploring potential M&A deals during next 12-18 months.

However, even if a new front door to health care emerges along with other potential innovations and consolidation, it is hard to envision healthcare delivery ultimately leading anywhere other than to physicians, regardless of how or where physicians may be accessed. Whether it is care coordination for older patients with multiple chronic conditions, telemedicine consultations, or a high tech procedure needed to save a life, physicians will remain indispensable care givers for a growing and aging population.

## GOVERNMENT POLICY: A CLIMATE OF UNCERTAINTY

No examination of healthcare trends is complete without a discussion of government's role in shaping the healthcare system. Republicans were unable to replace the Affordable Care Act (ACA) last year with their own healthcare law, so the ACA remains in place if not entirely intact.

Various changes to ACA policies and implementation include:

- The fine for not having healthcare insurance was lowered to zero, effectively ending the mandate that all adults have healthcare insurance.
- The sign-up period to enroll in ACA/state exchange plans was shortened from 90 days to 45 days.
- The budget for "navigator" programs making it easier to sign up for state exchanges was reduced from $62.5 million to $10 million.
- Cost sharing payments made by the federal government to insurance companies covering low income patients were cancelled.

Despite these changes, 11.8 million people signed up for coverage under the state exchanges during the 2019 ACA enrollment period, down from 12.2 million the previous year, but still a considerable number. Approximately 12 million people have health insurance through states that expanded access to Medicaid under the ACA. Insurance expansion under the ACA is another factor driving utilization of healthcare services and the increased demand for doctors

However, the future of the ACA is in doubt. In December 2018, a federal judge in Texas ruled that the ACA is unconstitutional, a matter that likely will eventually be resolved by the Supreme Court. In addition, in the last year the Trump Administration introduced cheaper, less comprehensive, short-term health insurance plans called Association Health Plans (i.e., "skinny

plans") that could further weaken the ACA. In March 2019, a federal judge blocked implementation of these plans.

Also pending is the fate of Medicaid work requirements. The Trump Administration, through CMS, gave states the authority to require Medicaid recipients to work, volunteer or obtain job training to obtain benefits. Eight states have received federal approval to implement Medicaid work requirements, but in March 2019 a federal judge blocked such plans proposed by Arkansas and Kentucky, requiring the Department of Health and Human Services (HHS) to amend how the plans are structured. Should states implement these plans they would likely reduce utilization of healthcare services and have an inhibiting effect on physician demand.


For now, key provisions of the ACA remain intact, including coverage for children up to 26, no insurance denials for preexisting conditions, comparable rates for men and women, and the requirement that companies with 50 or more people provide health insurance to their employees.

However, due in part to cancellation of the mandate, and a lack of necessary enrollment by young, healthy people in ACA plans, cost of ACA plans have on average doubled.

Increased costs and the federal policies referenced above put the ACA under a cloud. If it goes under and is not replaced, utilization of health services will likely decline and with it demand for physicians and other healthcare professionals. The fact that we are in an election cycle further complicates the picture and ensures that the topic of enhanced access to care will be front and center.

With this market context in mind, following is a discussion of various trends and findings revealed by Merritt Hawkins' *2019 Review of Physician and Advanced Practitioner Recruiting Incentives*.

## THE MARKET FOR PRIMARY CARE PHYSICIANS

### A Baker's Dozen for Family Medicine

For the thirteenth consecutive year, family medicine was Merritt Hawkins' most requested search assignment, the 2019 *Review* indicates.

Demand for primary care physicians is driven by the factors referenced above, but also by evolving delivery models that emphasize prevention, quality payments and care coordination not just for individuals but for large patient groups.

In the population health management model, for example, primary care-led teams coordinate care for defined populations, such as blocks of Medicare patients, under a global payment model where the health system (and, increasingly, its physicians) assume risk. Today the model is being implemented through a growing number of accountable care organizations (ACOs), large medical groups, hospital systems, major

employers, insurance companies and other organizations. The primary care-led team in population health management typically consists of the following (see chart below).

Primary care physicians such as family physicians top the list of most in-demand doctors in part because of their key role as "quarterbacks" of the delivery team. Through the patient management and care coordination they provide, quality goals are achieved within an environment of defined financial resources. Primary care physicians then are rewarded for the savings they realize, the quality standards they achieve and for their managerial role.

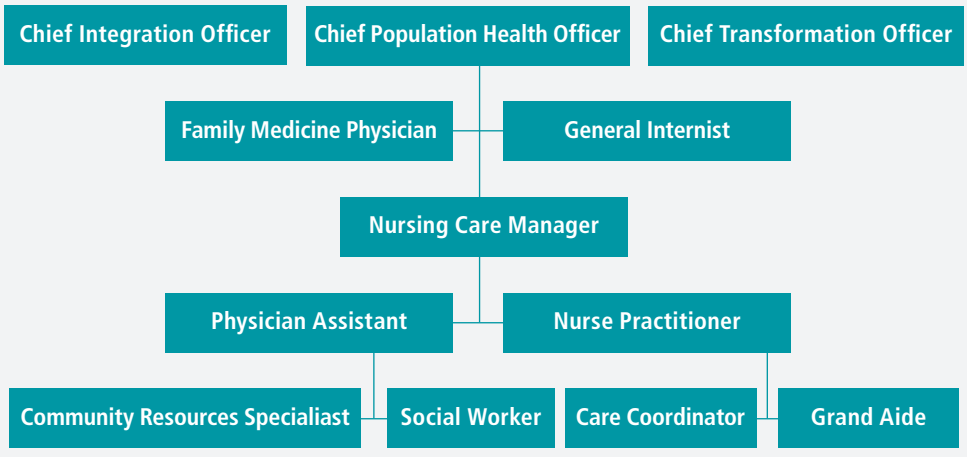
## BIGGER SYSTEMS RECRUITING FAMILY PHYSICIANS EN MASSE

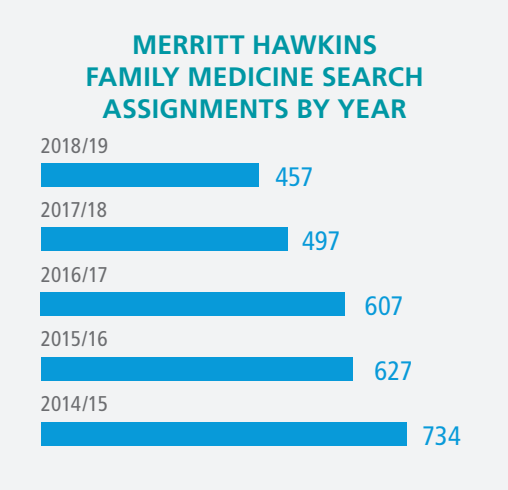
Health system consolidation is a further driver of demand for family physicians and other primary care doctors. Whereas in the past, an individual acute care facility might recruit two or three primary physicians at a time, consolidated systems may recruit 200 or more in order to create the primary care networks needed to treat large population groups and to grow market share. Instead of recruiting reactively to fill a void or to respond to demand, health systems now are recruiting proactively to meet the needs of covered lives, and, in a growing number of cases, to manage their own health plans. In some cases, large systems act as a single or primary funnel through which newly recruited physicians must pass. This can limit the number of primary care physicians being recruited, as one entity can only recruit so many physicians at a time.

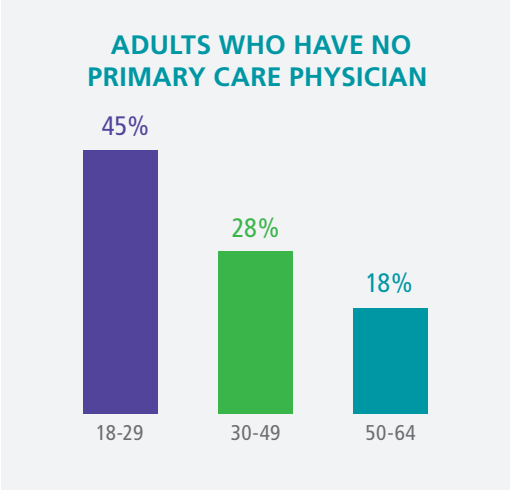
## THE PRIMARY CARE PARADIGM IS SHIFTING

Even though family medicine remained Merritt Hawkins' most requested type of search in the last year, demand for the specialty has declined. In 2014/15, Merritt

### COMPOSITION OF THE PRIMARY CARE-LED TEAM






*Source: Health Care Cost Institute/ Kaiser Health News/ Washington Post. 10/8/2018*

Hawkins conducted a record high of 734 family medicine searches. That number declined to 457 searches in 2018/19, a decrease of 38% (see chart above).

This decrease is due in part to the periodic pendulum swings that are commonly observed in physician recruiting, in which healthcare organizations will focus on particular specialties such as primary care during a given number of years. Having addressed priorities in that area, they will move on to recruiting other types of physicians for whom demand has built.

However, there appears to be a second underlying reason for the decline in demand for family physicians, which is that some patients are turning away from the primary care model. According to a November, 2018 report from the Health Care Cost Institute, visits to primary care physicians dropped by 18% between 2012 and 2016. In 2012, 51% of office visits for patients under 65 were to primary care physicians. That number declined to 43% in 2016, according to the report. Young people, in particular, appear less inclined to see a primary care physician (see chart above), and are less tied to seeing a particular provider in a particular place.

There was a corresponding 129% increase in office visits to NPs and PAs from 2012 to 2016, according to the report, underlining that the manner in which patients access the healthcare system is evolving. As referenced above, convenient care venues such as urgent care centers and retail clinics, commonly staffed by NPs and PAs, are becoming key entry points into the health system. A growing number of younger people are using these sites (as well as telemedicine) as their main source of primary care.

It should be considered, however, that though the number of searches Merritt Hawkins conducts for family physicians has declined in recent years, family physicians remain in strong demand. It is in part because they are in such strong demand, and are often difficult to access, that patients are turning toward convenient care venues.

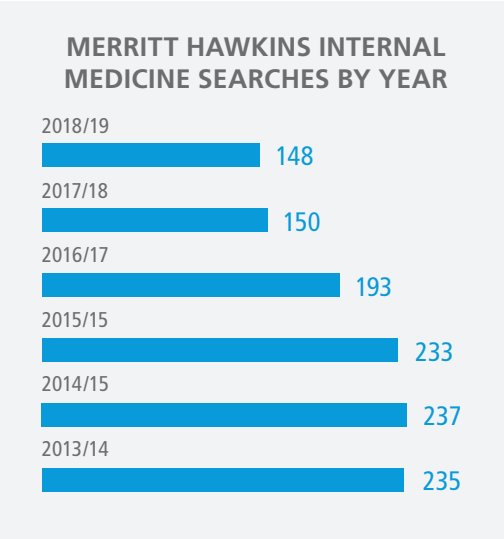
According to Merritt Hawkins' *2017 Survey of Physician Appointment Wait Times*, the average wait to schedule a new patient appointment with a family physician in 15 major metropolitan markets is 29.3 days, up from 19.5 days in 2014, a 50% increase. The average wait time to see a family physician in 15 mid-sized metro markets is considerably higher at 54.3 days, according to the survey.

Given population aging and the other trends referenced above, continued robust demand for family physicians will likely continue for the foreseeable future, even though more patients may enter the health system by first seeing other types of providers. For more information on this topic, see Merritt Hawkins' white paper *Supply, Demand and Recruiting Trends in Family Medicine*.

## INTERNAL MEDICINE FOLLOWS SUIT

The 2019 *Review* also shows that Merritt Hawkins is engaging in a still robust but diminishing number of internal medicine searches, with a 37% decline in internal medicine searches since 2013/14 (see following chart).

Despite the fact that demand for internal medicine physicians has diminished, the specialty remains difficult to recruit. Only about 10% to 12% of internal medicine residents go on to practice general internal medicine today, compared to 54% in 1998, according to the American College of Physicians (ACP). The great majority go on to subspecialize or practice inpatient medicine as hospitalists.




The supply of physicians willing to practice true inpatient/outpatient general internal medicine therefore is extremely constrained, and these types of positions remain a challenge to fill. The challenge has reached the point where services once provided by general internists are being delegated to pulmonologists, geriatricians and other specialists. For more information on this topic see the Merritt Hawkins' white paper *Supply, Demand and Recruiting Trends in Internal Medicine*.

## A PUSH FOR PEDIATRICS

The number of searches Merritt Hawkins conducted for pediatricians increased year-over-year by 35% and was the highest since 2013/14.

Demand for pediatricians is driven in part by birth rates, which have been in decline among U.S. women in the last several decades. In 1957, the U.S. averaged 123 births per 1,000 women of child bearing age. That average declined dramatically to

63 births by 2015 *(Wall Street Journal, June 17, 2015).*

Nevertheless, there are still about 4 million births in the U.S. annually, and immigration adds to the number of children in the population. Physician demographics may be an additional factor driving demand for pediatricians. Approximately 73% of pediatric residents are women, and women are coming to dominate the specialty. The *Survey of America's Physicians* cited above indicates that female physicians see 12% fewer patients than males and may be more likely to work part-time. This reduces overall FTEs in the specialty and may be one reason why demand for pediatricians remains strong. In addition, pediatric visits are almost always in person with little scope for telemedicine.

## THE MARKET FOR SPECIALISTS

Despite the common perception that physician shortages are most acute in primary care, a growing percentage of Merritt Hawkins' search assignments are for surgical, internal medicine, and diagnostic specialists.

In 2014/15, 67% of Merritt Hawkins' search assignments were for specialists, while 33% were for primary care physicians. In 2017/18, 74% of our search assignments were for specialists and 26% were for primary care physicians. The 2019 *Review* indicates that specialists now comprise 78% of our search assignments while primary care accounts for just 22%.

## DEMOGRAPHIC DESTINY

What also is notable about this trend is that emerging integrated, value-driven delivery systems are designed to emphasize prevention and to address the social determinants of health, reducing the need for costly specialist interventions. The accelerated recruitment of specialists indicates that demand for surgical and diagnostic specialists, driven largely by patient aging, is outpacing efforts to manage care and reduce specialty utilization.

It may be the case that the healthcare system cannot manage its way out of our collective demographic destiny, which will be characterized by a growing number of older patients with a growing number of healthcare needs. Organs, bones, skin and psyches eventually reach the point of obsolescence, and an increasing number of medical specialists are being recruited to address the physical and mental consequences of aging.

Primary care physicians have a key role to play in this scenario, managing the multiple chronic ailments of those who are aging in addition to younger patients subject to the interrelated pathologies created by lifestyle and social factors, such as obesity, diabetes, pulmonary disease, depression and others.

However, the 2019 *Review* suggests that the momentum in terms of demand continues to be on the side of medical specialists. For close to ten years, healthcare systems have pushed to increase their patient panels/ covered lives by acquiring or recruiting primary care physicians. They now find they must have specialists to whom primary care physicians can refer. Moreover, the reality of healthcare economics is that specialists generate the high revenue volumes on which healthcare facilities depend.

The following specialties are in particularly strong demand as evidenced by the 2019 *Review*.

## PSYCHIATRY: A PUBLIC HEALTH CRISIS

For over ten years, Merritt Hawkins has been noting in these *Reviews* the critical shortage of psychiatrists nationwide, a theme expanded upon in our white paper *Psychiatry: The Silent Shortage*.

The 2019 *Review* marks the fourth consecutive year that psychiatry has been our second most requested search, having progressively moved up from the 13th spot in 2000/2001, a reflection of continued demand for the specialty.

Today it is widely acknowledged that the shortage of mental health professionals, including psychiatrists, has developed into a public health crisis.

In March 2017, the National Council of Behavioral Health (NCBH) released a report indicating that 77% of U.S. counties are experiencing a severe shortage of psychiatrists. *(HealthLeaders, March 30, 2017)*. In Texas, Merritt Hawkins' home state, 185 out of 254 counties lack a general psychiatrist.

In some areas, primary care physicians attempt to address burgeoning demand for mental health services, but a report by the Commonwealth Fund indicates that more than 8 in 10 family doctors in the US say they are not adequately prepared to care for severely mentally ill patients. According to the report, just 16% of doctors said their offices had the capacity to care for those with serious mental illnesses, the lowest of any developed country besides Sweden *(The Hill, December 8, 2015)*.

## THE GROWTH OF PSYCHIATRIC ERs

The national crisis in behavioral health is manifesting itself most dramatically at hospital emergency rooms. The rate of ER visits involving psychoses, bipolar disorder, depression or anxiety jumped more than 50% from 2006 to 2013, according to the federal Agency for Healthcare Research and Quality. Patients who arrive at the ER for psychiatric or substance abuse disorders are more than twice as likely to be admitted to the hospital as are other patients, though approximately 80% of the time the problem can be resolved without an inpatient stay. Roughly 1 in 8 ER visits now stem from

mental illness or substance abuse disorders *(CNN.com March 21, 2019)*.

Crowding of psychiatric patients in the ER has become so prevalent that patients commonly have to wait to be admitted to a psychiatric hospital while their symptoms are exacerbated by the noise and chaos typical of hospital ERs. Hospitals around the country are therefore trying something new to address this challenge by opening emergency units specifically designed to help stabilize and treat psychiatric patients and connect them to longer- term resources and care.

Staffed by nurses, social workers and psychiatrists, psychiatric ERs are designed to treat and release psychiatric patients in 24 hours, or admit them to the hospital if need be. There are now approximately 100 psychiatric ERs around the country, and if the model proves successful, additional psychiatrists will be needed to work at these units.

## A CASE OF "RECRUITMENT FATIGUE"

As Merritt Hawkins has consistently observed in these *Reviews*, the shortage of psychiatrists is an escalating challenge of more severity than shortages faced in virtually any other specialty.

The supply of psychiatrists, already constrained, will soon diminish significantly as close to 60% of psychiatrists are 55 years old or older. With many psychiatrists aging out of the profession, and with a preference among psychiatrists for outpatient practice, it is becoming increasingly difficult to recruit to inpatient settings.

Despite these trends, the number of searches Merritt Hawkins conducted for psychiatrists declined in 2018/19 by 18% year over year. However, we do not see this decline persisting long-term.

Based on feedback we receive from clients, the declining number of psychiatry searches Merritt Hawkins saw year-over-year is likely a result of "recruitment fatigue." Healthcare organizations, unable to recruit psychiatrists, are putting resources into searches that are likely to be more productive than searches for psychiatrists often are. The decline also is a reflection of the fact that some healthcare facilities are seeking to meet behavioral health needs through the recruitment of other types of professionals, including NPs and psychologists, and have at least temporarily abandoned the idea of recruiting psychiatrists.

## OBSTETRICS/GYNECOLOGY SEES A BUMP

The number of ob/gyn searches Merritt Hawkins conducted increased by 25% year- over-year as ob/gyn moved into the third spot on our list of most requested specialties ranked by the 2019 *Review*.

As in other specialties, the supply of ob/gyns is constrained and there is a maldistribution of ob/gyns nationally.

The American Congress of Obstetricians and Gynecologists (ACOG) reports that the number of residents going into ob/gyn has remained virtually the same since 1980 at about 1,205. ACOG projects there will be 6,000 to 8,800 too few ob/gyns by 2020 as the number of women in the U.S. is expected to climb by 18% between 2010 and 2030 *(Columbus Dispatch, August 28, 2016)*. The majority of ob/gyns who are 55 or older are men. However, about 4 in 5 first year ob/gyns are women, which, as in pediatrics, reduces overall FTEs.

Nearly half the counties in the U.S. do not have a single ob/gyn, while 56% do not have a single nurse midwife, according to the American College of Nurse-Midwives. Merritt Hawkins' data indicate that there are 147 counties in Texas with no ob/gyn, a pattern evident in other states with large rural areas.

It should be noted that both male and female ob/gyns today express interest in a "controllable lifestyle" and are less inclined to be on call, giving rise to the use of "laborists" whose sole function is to attend deliveries in the hospital. In addition, a growing number of ob/gyns are entering subspecialties such as gynecologic oncology, reproductive endocrinology and infertility, reducing the number available for routine care and deliveries. While only 7% of ob/gyn residents entered a subspecialty in 2000, 19.5% did so in by 2012 *(Columbus Dispatch, August 28, 2016)*.

Merritt Hawkins' 2017 *Survey of Physician Appointment Wait Times* indicates that the average wait time for a new patient appointment with an ob/gyn in 15 major metropolitan areas is 26.4 days, up from 17.3 days in 2014, an indicator of the continued imbalance between supply and demand in the specialty.

## RADIOLOGY RESURGENCE

The 2019 *Review* reflects a continued resurgent demand for radiologists. Merritt Hawkins conducted 148 searches for radiologists in the 2019 *Review* period, an increase of 572% over 2013/14.

Though radiology topped the list of Merritt Hawkins' most requested search assignments in 2003, demand for the specialty subsequently dropped precipitously due in part to the 2007 recession and to the growing use of both domestic and offshore teleradiology services.

Renewed demand for radiologists was inevitable, however, because imaging remains central to diagnostic and procedural work in today's healthcare system, in which very little transpires without a picture. The importance of radiology is enhanced with each technological advance (including artificial intelligence) that makes imaging techniques more varied and effective.

A *Health Affairs* study projected that as the population ages, demand for radiology services will grow about 18% between 2013 and 2025 *(Radiology Business April 14, 2017)*. A study in *Mayo Clinic*

*Proceedings* ranked radiologists fifth among 23 specialties as having the highest rates of burnout *(Mayo Clinic Proceeding Dec 2015)*. While 47.7% of radiologists reported burnout in 2011, the number jumped to 61.4% in 2014. Higher rates of burnout in the specialty are attributed to increasing volumes, decreasing pay, and other factors examined in more detail in the Merritt Hawkins' white paper *Supply, Demand and Recruiting Recommendations in Radiology*.

Combine this with improvements in the economy allowing for more elective procedures and the effect of population aging on utilization, and demand for radiologists was going to rise at some point.

Rising demand for radiology also is notable as it suggests that even with the widespread use of teleradiology, which allows for the distribution of imaging studies to radiologists nationally and even internationally, healthcare facilities are again seeking the assistance of recruiting firms such as Merritt Hawkins to help them find radiologists. Demand now is at the level where facilities are seeking both more traditional, on-site radiologists and those working as teleradiologists. Teleradiology has gained momentum recently due to technological advancements that improve quality and the ability of radiologists to work remotely.

The long-term supply of radiologists will be constrained by the fact that over half of all diagnostic radiologists (53%) are 55 years old or older, compared to 42% of all physicians, and significant attrition can be expected in the specialty.

## INCREASED DEMAND FOR THE "OLOGIES"

The 2019 *Review* shows continued strong demand for internal medicine subspecialties – the so-called "ologies." Merritt Hawkins' search assignments in gastroenterology, cardiology, pulmonology, hematology/oncology and others all were up year-over-year or remained robust.

According to the Health Resources and Services Administration (HRSA) report *National and Regional Projections of Supply and Demand for Internal Medicine Subspecialty Practitioners*, December 16, 2016, a variety of internal medicine subspecialists are projected to be in short supply in 2025.

The chart on page 35 indicates HRSA's shortage projections in these subspecialties.

As these numbers indicate, a variety of internal medicine subspecialists who treat conditions often associated with aging, such as heart disease, cancer and others are projected to be in short supply by 2025, projections consistent with demand trends as indicated by Merritt Hawkins' 2019 *Review*.

## ANESTHESIOLOGY AND CRNA: A SIGN OF THE TIMES

Another clear indicator of healthcare supply, demand and utilization trends is the presence

## NATIONAL ESTIMATES OF PHYSICIAN SUPPLY, DEMAND AND DEFICITS/INTERNAL MEDICINE SUBSPECIALTIES BY 2025

| | Supply | Demand | Deficit/2025 |
|---|---|---|---|
| **Allergy and Immunology** | 4,140 | 4,620 | -480 |
| **Cardiology** | 28,560 | 35,460 | -7,080 |
| **Dermatology** | 13,100 | 13,530 | -430 |
| **Gastroenterology** | 15,540 | 17,170 | -1,630 |
| **Hematology/Oncology** | 18,100 | 19.500 | -1,400 |
| **Pulmonology** | 14,110 | 15,510 | -1,400 |

*Source: HRSA Regional Projections of Supply and Demand for Internal Medicine Subspecialty Practitioners. December, 2016.*

of both anesthesiologists and certified registered nurse anesthetists (CRNAs) on the list of Merritt Hawkins' top 20 search assignments in 2018/19. Anesthesiology was last among the top 20 in 2010/11, while CRNA was last listed in 2008/09.

Increased demand for anesthesiology services reflects the ramping up of surgical and other procedures. This includes elective procedures driven by a healthy economy and non-elective procedures driven by patient aging. Anesthesiology is a rare specialty in which non-physician clinicians are used interchangeably with physicians. A surgical NP, for instance, cannot be considered an FTE in orthopedic surgery, while a CRNA can be considered an FTE in anesthesiology. The fact that both physician and non-physician anesthesiology providers are included in Merritt Hawkins' top 20 list underlines the growing need for anesthesiology services.

## AN EVOLVING ROLE FOR HOSPITALISTS

The 2019 *Review* indicates that the number of hospitalist searches Merritt Hawkins conducted increased by 21% year-over-year. This is the second consecutive year that hospitalist searches conducted by Merritt Hawkins increased, after a sharp decline in 2016/17.

Hospitalist medicine, which got its start in 1996, has grown from a few hundred physicians 20 years ago to more than 50,000 today. Nine out of 10 hospitals of more than 200 beds now have hospitalists who provide inpatient care to patients, many of whom have complex problems *(New England Journal of Medicine, September, 15, 2016).*

Nevertheless, a heightened focus on outpatient treatment, the merger of health systems, and a growing number hospital closures, particularly in rural areas, have raised questions about the continued viability of the hospitalist role. Traditionally, the focus of hospitalists has been on reducing length of inpatient stays and transitioning patients out of the hospital, and that focus is still there.

However, emerging payment models may drive a new hospitalist role, as payment is increasingly attached to a bundle of care that extends at least 30 days from

patient discharge, and sometimes longer. Hospitalists will have to work more closely with a team of healthcare professionals beyond inpatient care to ensure patients remain healthy and are not readmitted to the hospital, acting as "outpatient intensivists." This will enhance their value as the volume of inpatient services and the number of hospitals declines.

Information technology and quality implementation roles may open for hospitalists, along with leadership roles, as hospitalists, with their clinical knowledge and familiarity with hospital operations, are uniquely positioned to help lead the transition from volume to value.

Demand for hospitalists also may be driven by periodic shifts in how these positions are staffed. Some large hospital systems have chosen to bring hospitalist staffing in-house rather than relying on contract management companies to provide this service.

For additional information on hospitalists see Merritt Hawkins' white paper *The Growing Use and Recruitment of Hospitalists.*

## EMERGENCY MEDICINE/ BURN-OUT AND TURNOVER

According to the Centers for Disease Control (CDC), annual U.S. hospital emergency department visits now stand at 136.3 million. Of these, 40.2 million are injury related and 16.2 million lead to hospital admissions *(Becker's Hospital Review, October 7, 2016).*

Over half of hospital admissions now come through the ED *(New York Times, May 20, 2013)*, illustrating that EDs can be an important loss leader for hospitals -- a compelling reason to keep EDs staffed appropriately. Eighty-four percent of ED visits are generated by patients with insurance *(Becker's Hospital Review, October 7, 2016)*, and many ED patients, both insured and uninsured, fall back on the ED when they cannot obtain convenient access to office-based physicians.

Demand for emergency medicine physicians continues to be robust for these reasons and because turnover is an ongoing staffing challenge in the specialty. The relocation/turnover rate among emergency medicine physicians is 13.3%, according to data firm SK&A's Physician Relocation Report, while a report in the *Annals of Emergency Medicine* cited in the April 5. 2019 edition of *Healthleaders* indicates that 76% of emergency medicine residents experience feelings of burnout. In addition, some healthcare systems have reached a point of critical mass where they can manage emergency medicine staffing on their own rather than outsourcing this function. These systems may be recruiting for entire emergency medicine departments, increasing demand for emergency medicine specialists.

For additional information on emergency medicine see Merritt Hawkins' white paper

*Emergency Medicine: Physicians Recruiting, Supply and Staffing Considerations in Today's Healthcare System.*

## DEMAND FOR SURGICAL SPECIALTIES STAYS STRONG

Orthopedic surgery is one of several surgical specialties where demand remains strong, the 2019 *Review* indicates. The number of searches Merritt Hawkins conducted for orthopedic surgeons in 2018/19 declined from the previous year but was up compared to two years ago.

Continued robust demand for orthopedic surgeons further illustrates how patient aging is driving the need for medical specialties. Between 2000 and 2014 the number of hip replacements in the U.S. more than doubled – from 160,282 to 371,605 annually, according to the Healthcare Cost and Utilization Project. The number of knee replacements saw even larger growth in the same period, from 274,467 to 680,886 *(Boston Globe, April 6, 2018).*

The average wait time to schedule an appointment with an orthopedic surgeon in 15 major metropolitan areas is 11.4 days for those reporting knee pain, according to Merritt Hawkins *2017 Survey of Physician Appointment Wait Times*, up from 9.9 days in 2014. In mid-sized communities, the average wait time is 15 days.

Aging baby boomers, committed to living an active lifestyle, ensure that demand for orthopedic surgeons will continue to remain strong, as will improvements in procedures that greatly reduce hospital stays and rehabilitation times.

Additional surgical specialties in robust demand include otolaryngology, dermatology, and urology.

## NOT IN THE TOP 20 BUT RISING

Demand for several specialties appears to be on the rise based on the growing number of search assignments Merritt Hawkins conducted for theses specialties in last 12 to 18 months. Though these specialties did not make the list of Merritt Hawkins' 20 most requested search assignments in 2018/19, we anticipate demand for them will grow in subsequent years from what we are seeing in the market and for other reasons cited below.

## GERIATRICS

Recent data from National Resident Matching Program show that of the 139 geriatric fellowships for 2018, just 35 were filled. By contrast, in same year, 198 of 203 cardiovascular fellowships were filled.

Comparatively low compensation, complex patients, and round the clock care required by older patients are barriers keeping medical graduates from entering this specialty, in which severe shortages are to be anticipated.

There are about 44 million Medicare beneficiaries today, a number that will rise to 79 million by 2030 *(Modern Healthcare Feb. 27, 2018.)* About 30% of those will need a geriatrician, according to the American Geriatrics Society (AGS). There currently are approximately 7,300 certified geriatricians in practice in the U.S., and the AGS projects that 30,000 will be needed by 2030.

There is little to no chance that the supply of geriatricians will meet future demand, and care coordination for many elderly patients will have to be provided by primary care physicians practicing to the top of their training.

## INFECTIOUS DISEASE

In the 1970s, advances in medicine led to the perception that infectious disease (ID) would cease to be a medical specialty in strong demand. This proved not to be the case. A rise in tuberculosis rates, the global HIV pandemic, the outbreak of Ebola in humans, and increasing Hepatitis C infection rates continue to drive demand for ID specialists.

Most often observed in settings with high poverty, mental illness, addiction, and incarceration, ID requires complex care coordination. New therapies for cancer and transplants have resulted in more immunocompromised patients with susceptibility to ID. Specialists in ID are more important than ever in addressing hospital-acquired infections. Deaths due to drug resistant pathogens are predicted to rise rapidly over the next several decades and there will be a dwindling supply of new antibiotics to address this challenge.

At same time, the number of physicians entering ID has steeply declined. Between the 2009-2010 and 2016-17 fellowship matches, the number of adult ID programs filling all their positions dropped by 41% and the number of applicants decreased by 31%. In 2015, fewer than half of US ID fellowships filled their incoming classes.

These stark supply and demand trends suggest that the looming shortage of ID specialists is a public health crisis waiting to happen.

## RHEUMATOLOGY

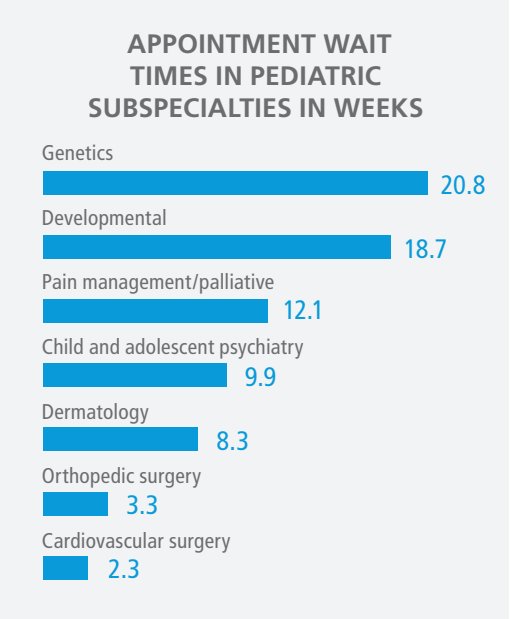
A February, 2018 study published in *Arthritis Care & Research* projects demand for rheumatologists will exceed supply by more than 100% in 2030. There are approximately 4,900 rheumatologists in patient care roles in the U.S. today and about that many more will be needed in 11 years to meet the needs of an aging population, according to the study.

## PEDIATRIC SUBSPECIALTIES

While more specialists will be needed to care for an aging population, at the other end of the age spectrum, additional pediatric subspecialists will be needed to care for children. Merritt Hawkins continues

to see a growing demand for a wide range of pediatric subspecialists, of whom there are a very limited number.

The 2017 Children's Hospital Association survey tracks appointment wait times for various types of pediatric subspecialists (see graph below).




As these numbers indicate, accessing pediatric subspecialists can take months, and wait times are not likely to improve based on the limited number of physicians being trained.

## NPs FILLING GAPS

The number of search assignments Merritt Hawkins conducted for nurse practitioners (NPs) declined year-over-year, the 2019 *Review* indicates, but was up over all other previous years as demand for NPs remains extremely robust. This decline is expected to be temporary and was in part a result of large systems acquiring NP practices in advance of recruiting new NPs to their service areas.

There are approximately 265,000 NPs practicing in the U.S. today, according to the American Association of Nurse Practitioners (AANP), 78% of them delivering primary care. There are over 120,000 PAs practicing in the U.S. today, about one-third of them in primary care and two-thirds in specialty areas, according to the American Academy of Physician Assistants (AAPA).

NPs and PAs are playing a growing role in team-based care (many were trained in this model), in some cases handling 80 percent or more of the duties physicians perform, allowing doctors to focus on the most complex patients and procedures. Their ability to educate patients, ensure patient compliance, reduce costs and enhance patient satisfaction makes them an ideal resource for value-based delivery systems operating in global payment structures.

Increasingly, NPs and PAs are viewed as appropriate leaders of the team-based care model, capable of coordinating the efforts of all members of the team, from physicians to community care coordinators. They also are being groomed for those leadership positions considered critical to the transition to quality-based care, including chief quality officer, director of population health management, and others.

PAs have prescriptive authority in all 50 states, while NPs now can practice independently of physicians in over 20 states and the District of Columbia, with scope of practice expected to expand. As referenced above, NPs and PAs provide the bulk of care at the growing number of urgent care and retail centers and also

have been a fixture at Federally Qualified Health Centers (FQHCs) for years. Their presence and role is likely to be determined on a state-by-state level, as each state has discretion to impose its own level of NP and PA management, oversight and autonomy.

A significant recruiting challenge is arising in this area as many NPs and PAs are choosing to specialize, making it more difficult to find providers to fill primary care roles.

For more information on this subject see Merritt Hawkins' white paper, *NPs and PAs: Supply, Distribution and Scope of Practice* and the survey of PA employers Merritt Hawkins conducted on behalf of the American Academy of Physician Assistants *(2016 Survey of PA Recruiting and Employment Trends).*

## WHO LEADS IN "ABSOLUTE DEMAND?"

It is to be expected that specialties that have a comparatively high number of practicing physicians, such as family medicine and internal medicine, will generate a comparatively high number of searches. But how does the picture look if specialties are ranked by number of search assignments/ job openings as a percent of all active physicians in a given specialty, or by what Merritt Hawkins calls "absolute demand?"

The chart below ranks demand for particular types of physicians in this manner.

### MERRITT HAWKINS TOP SEARCH ASSIGNMENTS AS A PERCENT OF ALL PHYSICIANS IN VARIOUS SPECIALTIES (PATIENT CARE ONLY)

| | 2018/19 |
|---|---|
| NEUROLOGY | 0.90% |
| PSYCHIATRY | 0.70% |
| GASTROENTEROLOGY | 0.70% |
| HEMATOLOGY/ONCOLOGY | 0.70% |
| DERMATOLOGY | 0.60% |
| UROLOGY | 0.60% |
| OTOLARYNGOLOGY | 0.60% |
| GERIATRICS | 0.60% |
| RHEUMATOLOGY | 0.50% |
| FAMILY MEDICINE | 0.50% |
| OBSTETRICS/GYNECOLOGY | 0.50% |
| RADIOLOGY | 0.50% |
| CARDIOLOGY | 0.50% |
| PULMONOLOGY/CRITICAL CARE | 0.50% |
| ORTHOPEDIC SURGERY | 0.40% |
| INFECTIOUS DISEASE | 0.30% |
| INTERNAL MEDICINE | 0.20% |
| EMERGENCY MEDICINE | 0.20% |
| ANESTHESIOLOGY | 0.20% |
| PEDIATRICS | 0.20% |
| CRNA | 0.10% |
| NURSE PRACTITIONER | 0.01% |

Considered this way, it can be seen that a variety of specialists are in greater demand than are primary care physicians. For example, ten specialties are ranked higher in absolute demand than are family medicine

physicians and 15 are listed ahead of internal medicine physicians.

## RECRUITMENT SETTINGS

### Types of Healthcare Facilities Currently Recruiting Physicians

Following is a review of the types of settings into which Merritt Hawkins recruited physicians during the 2018/19 *Review* period.

### Hospital Systems Reviewing Their Recruiting Needs

A variety of healthcare facilities and organizations recruit physicians today. When Merritt Hawkins was founded 32 years ago, hospitals funded the great majority of physician recruiting efforts, often on behalf of independent medical groups or solo physicians. Rather than employing newly recruited physicians, hospitals typically would provide the financial outlay to set them up in private practice.

Today, hospitals remain a major factor in physicians recruiting, but are much more likely to recruit physicians whom they employ directly or who are placed at hospital-owned medical groups than to establish them in private practice.

The 2019 *Review* indicates that 34% of Merritt Hawkins' search assignments over the last year featured a hospital setting, down from 40% the previous year and down from 51% four years ago.

Hospitals have been challenged in recent years to evolve from a transactional model based on maximizing individual patient encounters and services, to alternative models focusing on population health management and resource utilization in which reimbursement is capitated and quality-driven. They also are embracing consumer driven demand for convenience by expanding outpatient services and sites, in some cases playing catch up with retail and other settings that have been quicker to embrace the convenient care model.

After a period of intense consolidation, some systems are pausing to determine what their physician staffing needs are, whether they have service line redundancies or opportunities to gain market share. They also may be tabling some recruiting efforts as they integrate recently acquired medical groups and seek to standardize physician compensation structures.

When hospital systems resume physician recruiting after a pause, they often do so with a comprehensive goal in mind. Rather than recruiting two or three physicians, hospital systems may recruit or acquire 200 or more, at the same time building inter-professional clinical teams around them and the management to support them. As hospital systems resume recruiting on this basis, we anticipate that the number searches Merritt Hawkins conducts featuring hospital settings will increase.

For smaller, rural facilities the challenge today is to maintain a viable business model, often by affiliating with larger entities. Approximately 100 rural hospitals have closed in the last ten years, while about 700 are at high risk of closing. These facilities are seeking alternative approaches to care delivery, including the expanded use of telemedicine and advanced practitioners such as NPs and PAs. For additional information on this topic, see Merritt Hawkins' white paper *Rural Physician Recruiting Challenges and Solutions.*

## MEDICAL GROUPS ACTIVE IN PHYSICIAN SEARCH

Twenty-eight percent of Merritt Hawkins' search assignments tracked in the 2019 *Review* were conducted for medical group settings, up from 26% the previous year and up from 19% two years ago.

In some cases, large medical groups like Kaiser Permanente and Cleveland Clinic look and operate in a manner similar to that of a hospital system, employing thousands of physicians while operating both clinics and hospitals. These mega groups also may recruit multiple physicians at one time, seeking to expand service lines or shore up primary care networks. Large medical groups can be favorably positioned in today's market because they have been the first to employ extensive networks of physicians, embrace quality metrics and drive change through the development of physician executives.

However, according to the 2019 *Survey of America's Physicians*, 56% of physicians still practice in groups of 10 physician or fewer, up from 52% in 2016.

While hospital employment of physicians is becoming the prevalent model, there are still physicians who wish to remain in independent groups, some of them who have been employed by a hospital and have chosen to go back into private practice. Being relatively small and nimble, they can proceed with physician recruiting efforts without pausing to create system-wide recruiting plans. The 2019 *Review* suggests that both large and small medical groups continue to be active in physician recruiting.

## FEDERALLY QUALIFIED HEALTH CENTERS FACING BUDGET CONSTRAINTS

With over 50 years of service, Federally Qualified Health Centers (FQHCs) are one of America's healthcare success stories, supported with funding by both sides of the political aisle. FQHCs have expanded rapidly in recent years and now include approximately 1,400 centers providing services at over 9,000 sites nationwide.

Using a primary-care driven, preventive model now being adopted by other types of providers, FQHCs see over 24 million patients annually, while offering affordable, accessible care and seeing all

patients regardless of their ability to pay. ***Merritt Hawkins is proud to be the sole provider of permanent physician search services for the National Association of Community Health Centers (NACHC) and to support the vital mission of FQHCs in addressing the needs of medically underserved populations.***

The 2019 *Review* indicates that 9% of Merritt Hawkins' recruiting assignments over the last year featured FQHC settings, down from 12% the previous year and down from 15% two years ago.

FQHCs are working hard to meet their recruiting challenges, which include the following:

**FQHC Workforce Challenges**

- 95% of FQHCs have at least one clinical vacancy
- The vacancy rate for family physicians is 25%
- 69% of FQHCs are recruiting for at least one family medicine physician
- Average time to recruit a family physician is 11.4 months
- 56% of FQHCs have an opening for a behavioral health professional
- Average time to recruit a psychiatrist is 12.7 months
- 50% of FQHCs have an opening for NPs
- 56% report at least one behavioral health staff vacancy

*Source: National Association of Community Health Centers*

Limited funding (i.e., the "fiscal cliff") has reduced the ability of some FQHCs to invest in outside recruiting resources, which has in some case inhibited the number of searches Merritt Hawkins conducts for these facilities.

## ACADEMIC MEDICAL CENTERS ARE BOOSTING CLINICAL SERVICES/LEADERSHIP

Academic Medical Centers (AMCs) continue to ramp up their physician recruiting efforts, the 2019 *Review* indicates. During the 2018/19 *Review* period, 20% of Merritt Hawkins' search assignments featured academic settings, up from 15% the previous year and up from 8% in 2014/15.

Seventy-four percent of these assignments were for faculty positions, 23% were for leadership positions and 3% were for research positions.

AMCs are hospitals and health systems with a close affiliation with a medical school. AMCs feature residency and often fellowship training programs and pursue clinical research in addition to direct patient care. They also are often considered tertiary care centers, because of their ability to treat a full range of complex conditions, in many cases by providing subspecialty care.

In 2015, the latest year for which data is available, approximately 400 U.S. hospitals were affiliated with a medical school. There were 144 allopathic medical schools accredited in 2017 by the Liaison Committee on Medical Education and 35 schools of osteopathic medicine accredited by the American Osteopathic Association.

Recruitment of faculty, research and leadership positons at AMCs has increased in recent years due to the expansion of medical education in the U.S. and the continued vital role AMCs play as tertiary care centers. In 2006, the Association of American Medical Colleges (AAMC) announced the goal of increasing medical school enrollment by 30%, and that goal has been accomplished.

In addition, academic centers are typically major hubs of care in their communities, and often are contending with sharp increases in demand for services. They are seeking to significantly expand clinical capabilities and teaching capabilities simultaneously and can be overwhelmed for this reason. It can be difficult for the board and other AMC leaders to reconcile the competing agendas of the health system side of the organization with the academic side, and in some cases the distinction between academic and non-academic systems is starting to blur.

## AN EVOLVING KIND OF ACADEMIC LEADER

Over the past 24 months, Merritt Hawkins has observed several notable trends in AMC recruiting, including a significant increase in recruiting requests from osteopathic schools, which have been particularly dynamic in their expansion efforts.

Also notable is an evolution in the type of academic leaders being sought, with less emphasis placed on publication history and associated funding, and more emphasis placed on an understanding of profit/loss business dynamics, conflict resolution, interpersonal relationships and collaboration throughout the organization.

Traditionally, AMCs have sought leaders offering a "triple threat," with research, clinical and leadership skills. However, we have recently seen a transition in which some AMCs focus on recruiting "double threat" candidates while utilizing an existing leader who has strengths in one of the three areas to complement the new leader.

In addition, the average tenure of AMC Deans placed by Merritt Hawkins is a relatively short four years, as many centers are seeking a new breed of leader who can navigate the organization through transformative times.

Academic institutions also are making a concerted effort to diversify their leadership, seeking to identify and develop female and minority leaders.

## AN ACADEMIC "TALENT DRAIN"

Academic recruiting is further driven by the physician shortage, which has seen many faculty members lured to private practice by comparatively high income offers. Leaders of academic medical centers, including Chairs, Department Chiefs and others, are being targeted for leadership positions by pharmaceutical companies, private health systems, and other organizations,

contributing to a "talent drain" that has challenged some academic facilities. This challenge has become more acute as expectations for greater clinical throughput grows at AMCs while protected research time is reduced.

Combined with the need to replace an aging academic workforce, these trends have accelerated the pace of academic medical center recruitment. For more information on this topic see Merritt Hawkins' white paper *The Changing Landscape in Academic Recruiting.*

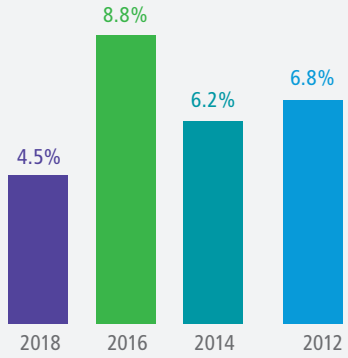
In response, Merritt Hawkins' Department of Academics has expanded its resources, forming an Academic Advisory Council of nationally prominent academic medicine leaders to help set strategic goals and to source top candidates for academic leadership positions. **The Advisory Council is composed of Tom Lawley, MD, former Dean of Emory Medical School; Philip Pizzo, MD, former Dean of Stanford Medical School; and Arthur Rubenstein, MD, former Dean of the University of Pennsylvania School of Medicine.**

## SOLO PRACTICE/DIRECT CARE REMAINS A NICHE SETTING

In 2001, 22% of Merritt Hawkins' search assignments were for solo practice settings. Since then, market forces, regulatory compliance issues, and physician practice preferences have eroded the viability of the solo physician model. Only 1% of the searches Merritt Hawkins conducted in the 2019 *Review* period were for solo settings or direct care settings, down from 2% the previous year and down from 5% in 2015/16.

The future of solo practice has been presumed to lie with the direct pay or concierge practice model in which physicians bypass third party payers and contract directly with patients. A growing number of physicians have indicated they plan to adopt this model in the next several years (see following chart):

**PHYSICIANS PLANNING TO PRACTICE CONCIERGE/DIRECT PAY IN THE NEXT THREE YEARS**




*Source: 2018 Survey of America's Physicians. The Physicians Foundation/Merritt Hawkins*

While most of the solo physician practice searches Merritt Hawkins conducted in the 2019 Review period were for direct pay/ concierge settings, this model has not yet become more than a niche. Numbers from the *2018 Survey of America's Physicians* cited above suggest physicians may be less sanguine about moving to concierge/direct pay than they once were.

## THE GREAT MAJORITY OF NEWLY RECRUITED PHYSICIANS ARE EMPLOYED

The majority of the organizations recruiting physicians today – hospitals, medical

groups, urgent care centers, FQHCs, academic centers, and others -- typically employ physicians rather than establishing them in private practices.

While it is hard to be precise given the hybrid nature of some physician contacts, the 2019 *Review* suggests that the great majority of physicians accepting new positions today – above 90% -- will practice as employees and not as independent practice owners/partners. By contrast, in 2001, this number was approximately 40%.

Physician employment may be required to implement the integration, evidence-based treatment protocols, IT standardization, global payments and other hallmarks of value-based care. In order to establish a value-based organizational culture and a uniform compensation plan for hundreds and even thousands of physicians, employment is the model of necessity if not preference. Employing physicians also can help hospitals comply with Stark and federal fraud and abuse statutes.

In addition, employment is the preferred practice model of many physicians today who do not want the attendant responsibilities, time constraints and stress of "running a business." The challenges of physician recruiting become more daunting for those facilities unable or unwilling to offer physicians employment.

Despite these trends, however, there is some evidence that the independent practice model is not moribund yet. Many respondents to the *2018 Survey of America's Physicians* expressed misgivings about the employed model, and the survey showed a growing number of doctors who practice in smaller groups of 10 doctors or less, reversing a recent trend. Employment has not proved to be a panacea for some physicians and pushback against this model could increase. Employment also has lead to increased physician turnover, a serious staffing challenge for many healthcare facilities.

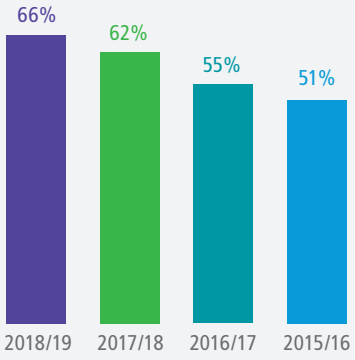
## LARGER COMMUNITIES ARE DRIVING PHYSICIAN RECRUITMENT

Physician shortages, and, by extension, physician recruiting efforts, are often thought to be concentrated in smaller communities and rural areas. Merritt Hawkins' 2019 *Review* underscores how this dynamic continues to change.

For the first 22 years Merritt Hawkins completed the *Review*, the number of search assignments we conducted in communities of 100,000 or more never exceeded 50%. That has not been the case over the last four years (see chart on page 47):

As these numbers indicate, during the 2018/19 *Review* period, two-thirds of Merritt Hawkins' search assignments (66%) were for communities of 100,000 people or more.

**PERCENT OF MERRITT HAWKINS SEARCH ASSIGNMENTS IN COMMUNITIES OF 100,000 OR MORE**




This trend further underscores how demand for medical specialists, who typically practice in larger communities, is driving a growing number of recruiting efforts. Physician shortages have by no means diminished in rural areas, but recruiting challenges and efforts have expanded into larger communities as well, particularly those seeking specialists. The consolidation of hospital systems, which often are located in larger communities, has spurred the recruitment of multiple physicians at a time, some of whom are recruited by systems based in large communities but who subsequently practice in rural areas.

Merritt Hawkins worked for clients in 48 states and the District of Columbia during the 2019 *Review* period, underlying the national presence of physician recruiting needs and challenges.

## AVERAGE STARTING SALARIES AND CONTRACT STRUCTURES

Merritt Hawkins' *Review* tracks the starting salaries being offered to recruit physicians, as well as other recruiting incentives typically offered to doctors and advanced practitioners.

Average starting salaries represent the base only and are not inclusive of bonuses or other incentives. This is in contrast to physician compensation numbers compiled by the Medical Group Management Association (MGMA), the American Medical Group Association (AMGA) and other organizations, which track overall average physician incomes, not just salaries.

Merritt Hawkins' salary ranges are therefore indicators of the financial incentives needed to attract physicians already established in a practice or those coming out of residency to a practice opportunity, rather than indicators of physician average incomes. If Merritt Hawkins' compensation numbers are equal to or exceed numbers of other surveys that track total physician earnings, that is a strong indicator that demand in those specialties is particularly high. It therefore can be useful to use Merritt Hawkins' surveys in tandem with surveys tracking total physician earnings when developing physician compensation packages.

It also should be noted that in today's market the salary amount is just one metric to consider – it also is important to consider how salaries are structured.

## SALARIES IN PRIMARY CARE STALL – THOUGH NOT IN PEDIATRICS

Salaries for primary care physicians as tracked by Merritt Hawkins' *Review* have been on an upward trajectory for years. Average salary offers made to family medicine physicians grew from $185,000 in the 2012 /13 *Review* to $231,000 in 2016/17, an increase of 25%. Similarly, average salaries for internal medicine physicians grew from $208,000 to $257,000 in the same period, an increase of 24%. Average salaries for pediatricians also grew, from $179,000 in 2012/13 to $240,000 in 2016/17, an increase of 34%.

However, the 2018 *Review* indicated a potential plateauing of starting salaries for family physicians and internal medicine physicians, with starting salaries increasing by 4% year-over-year for family physicians and by 2% for internal medicine physicians.

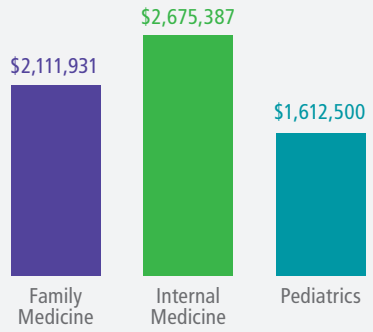
The 2019 *Review* provides a further indicator than starting salaries are in a holding pattern in these two primary care specialties. The average starting salary for family physicians as tracked in the 2019 *Review* was $239,000, an 8.3% decrease from the previous year. The average starting salary for internal medicine physicians was $264,000, an incremental 1.2% increase over the previous year.

As is referenced above, competition for primary care physicians remains robust but is not at the same level of two or three years ago as signaled by the declining number of family medicine and internal medicine searches Merritt Hawkins has conducted over the last several years. In addition, starting salaries for physicians typically have a ceiling since primary care physicians generally do not perform the high-dollar procedures on which many healthcare facilities still depend. There is not as much latitude to increase their salaries as there is in the case of some specialists, as procedures continue to be economically rewarded above consultation in today's healthcare system.

In fact, hospitals and other healthcare facilities sometimes lose money on primary care physician contracts given their current salary levels. They often more than make up for these losses, however, through the "downstream" revenue primary care physicians generate.

The economic contribution of primary care physicians to hospitals is quantified by Merritt Hawkins' *2019 Survey of Physician Inpatient/ Outpatient Revenue* (see chart below).

**AVERAGE ANNUAL NET INPATIENT/OUTPATIENT REVENUE GENERATED BY PRIMARY CARE PHYSICIANS ON BEHALF OF THEIR AFFILIATED HOSPITALS**



By contrast, both the number of searches Merritt Hawkins conducted for pediatricians and average starting salaries for pediatricians increased year-over-year. The average starting salary for pediatricians as tracked in the 2019 *Review* was $242,000, a 5.2% increase over the previous year. Pediatricians, though not procedure oriented, often are the key to capturing the loyalty of the family unit, and are valuable for that reason. In addition, given the schedule flexibility required by many pediatricians, FTEs in the specialty can be difficult to come by, putting upward pressure on salaries.

## SALARIES FOR SPECIALISTS MOSTLY UP

As referenced above, demand for specialists is being driven upward by population aging and other factors. Average salaries, however, do not always correspond to increases in demand, at least not initially, as the market needs time to adjust to changing supply and demand dynamics.

However, the chart below indicates that most specialties in Merritt Hawkins' top 20 saw year-over-year increases in starting salaries.

### SPECIALTIES SEEING YEAR-OVER-YEAR AVERAGE STARTING SALARY INCREASE/DECREASE

| | 2017/18 | 2018/19 | Increase/Decrease |
|---|---|---|---|
| **Urology** | $386,000 | $464,000 | +20.00% |
| **Cardiology (inv.)** | $590,000 | $648,000 | +9.80% |
| **Anesthesiology** | $371,000 | $404,000 | +8.90% |
| **Emergency Med** | $358,000 | $382,000 | +8.50% |
| **Neurology** | $301,000 | $317,000 | +5.30% |
| **Psychiatry** | $261,220 | $273,000 | +5.00% |
| **Radiology** | $371,000 | $387,000 | +4.30% |
| **Cardiology (non-inv)** | $427,000 | $441,000 | +3.30% |
| **Gastroenterology** | $487,000 | $495,000 | +1.60% |
| **CRNA** | $194,000 | $197,000 | +1.60% |
| **Orthopedic Surgery** | $533,000 | $536,000 | +0.56% |
| **Hematology/Oncology** | $391,000 | $393,000 | +0.50% |
| **Hospitalist** | $269,000 | $268,000 | -0.37% |
| **Dermatology** | $425,000 | $420,000 | -1.20% |
| **Ob/Gyn** | $324,000 | $318,000 | -1.90% |
| **Pulmonology** | $418,000 | $399,000 | -0.75% |
| **Otolaryngology** | $405,000 | $402,000 | -0.70% |

While some specialties saw decreases in starting salaries year-over-year, they were mostly minor, and average starting salaries in these specialties are generally consistent with where they have been over the last several years.

## SALARIES BY REGION AND TYPE OF SETTING

The 2019 *Review* breaks out for the fourth year average starting salaries by region for Merritt Hawkins' top five most requested physician specialties for which we have the most data, including family practice, psychiatry, internal medicine, ob/gyn and radiology. The 2019 *Review* indicates that physician salaries tend to be lowest in the Northeast and West and highest in the Midwest/Great Plains, Southeast, and Southwest.

The Midwest/Great Plains is generally considered to have comparatively high third party reimbursement and a comparatively large number of productive, independent physicians, factors contributing to higher salaries. Some areas of the Midwest/Great Plains are isolated and so must be highly competitive in their salary offers to attract candidates.

A high ratio of physicians per capita in the Northeast creates competition, suppressing salaries, as does a relatively high prevalence of managed care/capitated compensation plans in both the Northeast and West, while a higher ratio of fee-for-service and a lower ratio of physicians per capita create higher salaries in the Midwest, Southeast and Southwest.

The 2019 *Review* also tracks for the fourth year starting physician salaries in Merritt Hawkins' top five most recruited specialties by search setting, including hospitals, medical groups, academic centers, community health centers and solo settings. Academic institutions and community health centers typically offer less than hospitals and medical groups based on budget and policy restrictions that limit what they may be able to offer.

## PAYING PHYSICIANS FOR QUALITY/VALUE

In order to evolve away from the fee-for-volume model, ACOs, hospitals, medical groups, and other organizations are striving to create physician payment structures that reward doctors for providing value, which is measured by various metrics, including:

### Quality/Value-Based Physician Compensation Metrics

- Patient satisfaction scores
- Adherence to treatment/quality protocols,
- Reduction of hospital readmissions/errors
- Group governance participation
- Cost reduction/containment
- Appropriate coding
- Implementation/use of electronic health records

At the same time, facilities that employ physicians want to ensure that they stay productive, and "productivity" still is measured in part by what are essentially fee-for-service metrics, including relative value units (RVUs), net collections and number of patients seen.

The goal is to find the "Goldilock's zone" – physician payment models that encourage physicians to see the patients and generate the revenue that healthcare facilities still need, but that also reward doctors for adopting the behaviors and practices that will drive reimbursement in emerging value-based payment models.

## MORE PRODUCTION BONUSES TIED TO QUALITY

Merritt Hawkins' 2019 *Review* provides an indication of the extent to which physicians currently are compensated on quality metrics. Seventy percent of searches tracked in the 2019 *Review* feature a salary with a production bonus, down from 75% the previous year. The remaining 30% feature a straight salary, an income guarantee or other arrangement. The great majority of hospitals and medical groups offer physicians the salary plus production bonus formula, while FQHCs, urgent care settings and academic centers are more likely to offer straight salaries.

Of the 70% of searches offering a production bonus, 56% featured a bonus based in whole or in part on quality metrics such as patient satisfaction, adherence to treatment protocols, etc. This is up from 43% in 2018 *Review* and is the highest percent of contracts offering a quality-based production bonus that Merritt Hawkins has tracked.

## QUALITY AS A PERCENT OF TOTAL COMPENSATION INCREASES

While the 2019 *Review* indicates that quality is becoming a more common determinant of physician production bonus amounts, a question arises as to the amount of *total* physician compensation that is tied to quality.

The 2019 *Review* tracks this amount directly for the second time. In instances where the production bonus includes quality metrics, the 2019 *Review* indicates that, on average, 11% of the physician's total compensation will be determined by quality, up from 8% the previous year.

## VOLUME-BASED PRODUCTION METRICS SURGE

Relative value units (RVUs), which are a volume-based metric measuring physician work levels, were used in 70% of production bonus formulas tracked in the 2019 *Review*, up from 50% the previous year and the highest percent recorded since Merritt Hawkins began tracking production bonus formula metrics. Other volume-based metrics, such as net collections and number

of patients seen, also were used more frequently than in the previous year.

The resurgence of volume-based metrics to determine physician production bonuses underscores the priority healthcare facilities place on rewarding physicians for seeing patients and performing a high volume of work, both to meet patient need and to ensure adequate reimbursement.

The balancing act between promoting quality and ensuring volume is a difficult one, and health systems and medical groups often tinker with their physician compensation formulas, to the aggravation of many physicians. In a sign of the times, Geisinger Health System, a pioneer of quality payments, recently discontinued tying physician payments to quality and moved their physicians to a straight salary model.

## SIGNING BONUSES AND CME

Signing bonuses were offered in 71% of the recruiting assignments Merritt Hawkins conducted in the 2018/19 *Review* period, up from 70% the previous year, though down from 76% two years ago. Signing bonuses remain a standard recruiting incentive among hospitals and medical groups, though they may not be part of incentive packages offered by academic medical centers, direct pay/concierge, urgent care centers, some FQHCs, Indian Health and other settings. Recent growth in the number these types of searches conducted by Merritt Hawkins is the primary reason for the decline in percent of searches offering signing bonuses over the last several years.

Signing bonuses offered to physicians in 2018/19 averaged $32,692, down slightly from $33,707 the previous year but nevertheless the second highest average bonus amount recorded in these *Review*s. High average bonus amounts underscore the continued competitive environment in physician recruiting in which signing bonuses can be used to persuade physicians with multiple offers to make a decisive commitment.

The 2019 *Review* includes for the first time average signing bonuses for Merritt Hawkins top five most recruited physician specialties, including family medicine, psychiatry, ob/gyn, internal medicine and radiology.

Signing bonuses offered to NPs and PAs as tracked in the 2019 *Review* averaged $9,000, down from $11,944 the previous year, but up from $8,576 two years ago.

Certain other incentives, such as paid relocation, paid CME, health insurance and malpractice insurance are standard in the majority of Merritt Hawkins' physician search assignments. The average relocation allowance offered to physicians as tracked by the 2019 *Review* is $10,393, up from $9,441 the previous year, and is a number consistent with past years in which average relocation allowances have been in the $10,000 range.

The average relocation allowance offered to NPs and PAs was $7,067, up from $6,250, the previous year and down from $8,063 two years before that.

Virtually all of the incentive packages tracked by the 2019 *Review* (98%) offered a continuing medical education (CME) allowance. The average CME allowance for physicians tracked in the 2018/19 *Review* is $3,620, down slightly from $3,888 the previous year but consistent with a longstanding average in the $3,500 range. The average CME allowance for NPs and PAs in 2018/19 was $2,862, up from $2,280 the previous year and the highest average tracked in these *Reviews*.

## MEDICAL EDUCATION LOAN REPAYMENT

Thirty-one percent of Merritt Hawkins' 2018/19 search assignments featured medical education loan repayment, compared to 18% the previous year and 25% two years ago. Educational loan repayment entails payment by the recruiting hospital or other facility of the physician's medical school loans in exchange for a commitment to stay in the community for a given period of time.

The increased use of loan forgiveness as an incentive suggests more facilities are seeking to separate themselves from the competition by allaying the anxiety many physicians feel over medical school debt, which now averages $190,964, according to the Association of American Medical Colleges.

Health facilities in Health Professional Shortage Areas (HPSAs) have traditionally had the advantage of being able to recruit National Health Service Corps (NHSC) physicians, who have their educational loans offset by the government. Merritt Hawkins' 2019 *Review* indicates that a growing number of facilities not located in HPSAs also are offering loan forgiveness, raising the competitive bar.

The average amount of loan forgiveness offered to physicians was $101,571, up from $82,833 the previous year and up from $80,923 two years ago. This is the highest number recorded in the *Review* and higher than amounts typically offered to physicians through the NHSC. The average amount of loan forgiveness offered to NPs and PAs was $61,250, up from $59,860 the previous year and up from $56,442 two years ago.

Due to an omission in Merritt Hawkins' data tracking, average term of educational loan forgiveness was not recorded this year.

# Conclusion

Merritt Hawkins' *2019 Review of Physician and Advanced Practitioner Recruiting Incentives* indicates that while demand for primary care physicians remains strong, a growing level of recruitment activity is being directed toward medical specialists. This trend is being driven by both population aging and by the growing prevalence of lifestyle and socially derived medical conditions commonly treated by specialists, such as obesity, diabetes, drug addiction, mental health and others.

The crisis in mental health is underscored by the fact that for the fourth consecutive year, psychiatry ranked second among Merritt Hawkins' most requested searches, the first time it has held this ranking for such an extended period of time in the 26 years we have completed this *Review.*

The 2019 *Review* indicates that employment rather than independent practice is the standard physician practice model. Over 90% of the search assignments Merritt Hawkins conducted as tracked by the 2019 *Review* featured an employed setting, while less than 10% featured an independent practice setting.

While a growing percentage of physician recruiting contracts feature quality-based production bonuses, the 2019 *Review* indicates that physician compensation continues to be tied to relative value units (RVUs) a volume-based metric.

The 2019 Review further indicates that physician recruiting activity is increasingly prevalent in larger communities and is not confined to rural areas. Sixty-six percent of Merritt Hawkins' recruiting assignments as tracked by the 2019 Review took place communities of 100,000 or more, the highest percent in our 32-year history.

For additional information about Merritt Hawkins' thought leadership resources contact:

MERRITT HAWKINS
an AMN Healthcare company

Merritt Hawkins
8840 Cypress Waters Blvd. #300
Dallas, Texas 75019
800-876-0500
www.merritthawkins.com

Merritt Hawkins / Eastern Regional Office
100 Mansell Ct, E, Ste 500
Roswell, GA 30076
800-306-1330
www.merritthawkins.com

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*An Overview of the Salaries, Bonuses, and Other Incentives Customarily Used to Recruit Physicians, Physician Assistants and Nurse Practitioners*

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