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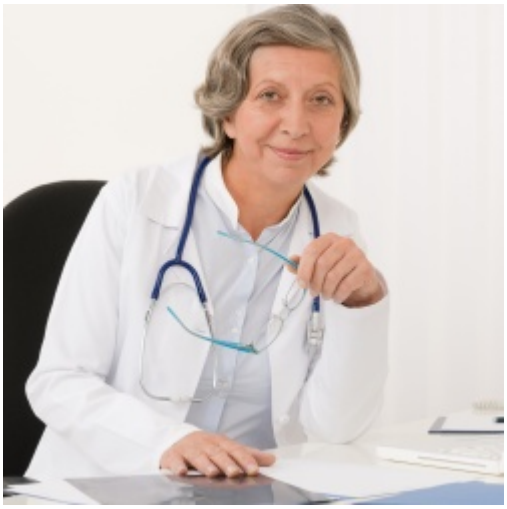
The Gender Disparity of Physician Income has a Market Solution

By Chuck Dinerstein — October 3, 2017



There is a gender pay gap in medicine. I've written about it previously [1] saying the differences are more related to hours worked, measured in relative value units (RVU) or because of contractual arrangements. The New York Times discusses the problem here [2]. But payers, Medicare, and insurance companies are gender neutral, women and men receive the same money for an appendectomy or a complex medical visit. I want to share an interesting paper entitled, A Most Egalitarian Profession: Pharmacy and the evolution of a Family Friendly Occupation [3] by Claudia Goldin and Lawrence Katz that focuses an economic lens on gender-related income disparity. Now the advantage of economic analysis is that it follows the Benjamins, it doesn't employ cultural explanations. Of course, the disadvantage of economic studies is that some of the passion surrounding the issue is lost, reducing their impact. But before launching into their findings let me share what is a typical scenario in the doctoring business.

Consider a group practice with physician partners. As the founder and managing partner, I get a bit more because I took risks in developing the practice and I spend time doing the management issues, I receive a bonus for my efforts, let us call it an 'agency or ownership bonus.' Now, one of my partners is a real "rainmaker," bringing in lots of patients because of their personality. They get a bit of a bonus in that role, too. Other partners in the practice want time away for other activities that are important to them, activities that do not generate income or even goodwill for the practice. Their time away puts a time burden on others, so we pay them a bit less and shift those savings to increase the salary of partners that have the additional time burden. This particular benefit, termed temporal flexibility - is the ability to control your hours and in today's work environment it is significant. I think there is reasonable evidence to suggest that women find it more important than men. I understand that this is a generalization, but it is true nonetheless and does not reflect on

professionalism or dedication, it is not pejorative, it is a choice women are making. Perhaps it is a choice more men should make, but I digress.

Goldin and Katz found that pharmacists with respect to gender-based income were the most egalitarian. Men and women made virtually the same amount of money, and this was in a setting where the amenity of temporal flexibility has no financial penalty. In understanding why they identified three trends in the pharmacy workforce that has resulted in a family friendly occupation where women were not penalized for work hour flexibility. Those trends were

- The replacement of independent pharmacies with corporate or large-scale employers
- The advancement of information systems that allows the individual knowledge a pharmacist might have of their patient to be available to a wider team
- The standardization of medications reducing the need for bespoke formulations.

In considering them in turn, the shift from independent pharmacies to a hospital or corporate employment eliminated the “ownership bonus” that comes from taking risks, of owning the business and the extra hours involved in management. As a result, payment is linked directly to effort. Income scales linearly, the more hours worked, the greater the income.

> *“The gender earnings gap for pharmacists principally reflects differences in hours worked by male and female pharmacists. … Owners and managers earn more primarily because they work more hours. The number of hours worked is decisive for almost all differences in pharmacy earnings.”*

Removing the management bonus reduces some gender disparity, but the reason that there was no penalty for temporal flexibility lies in the two other trends, the increasing commonality of information through computer systems making “handoffs” between pharmacists easier; and the standardization of medications, reducing the variability in the product supplied. These two trends made pharmacists’ efforts increasingly similar and equal substitutes. There were no “rainmakers” here. One pharmacist was pretty much the same as another leading to other additional consequences. First, experience does not entitle you to more money; a fact the authors also found to be true for pharmacists. Second, the cost of temporal flexibility decreases dramatically. “Thus, the part-time wage penalty for pharmacists shrunk and essentially disappeared for female pharmacists during the past 3 decades.” Third, disparities in the ratio of men to women pharmacists disappeared along with it as more women chose pharmacy as a career. As the authors explain

> *“Workers sort across occupations and firms because of differences in their preferences for workplace amenities that enable career-family balance. Occupations with a lower cost of workplace flexibility will be demanded relatively more by workers, such as women, who disproportionately value it.”*

Through the economists' lens, this is a supply and demand problem concerning the amenity of temporal flexibility. They concluded

> *"… that increased substitutability among pharmacists is a large part of the reason for these changes. Pharmacists are better able to hand off clients because of uniform training, standardization of products, and extensive use of information technology. The growth of large pharmacy chains, mail-order pharmacies, and hospitals, and the related decline of independent pharmacies has reduced the premium to ownership. The fraction of pharmacists who work low hours increased and the hourly earnings of female relative to male pharmacists rose. All of these factors led to the creation of a more family-friendly pharmacy profession."*

And they draw one further conclusion that I believe as a free-market kind of guy, is important to share.

> *"In sum, the position of pharmacist is probably the most egalitarian of all professions in the United States today. The facts we have presented concerning changes in the pharmacy profession are more consistent with the labor market effects of changes in technology and in the structure of the industry. They are less consistent with those stemming solely from an increase in the demand for family-friendly workplace amenities. The changes, moreover, do not appear to have resulted from legislation, anti-discrimination policies, licensing requirements, or regulations specific to the pharmacy profession. Rather, a host of structural changes outside the realm of the labor market increased the demand for pharmacists and re-organized work in ways that have made pharmacy a more family-friendly and female-friendly profession." [Italics added]*

I would argue that these same forces are at work in medicine. This year, for the first time, half of the physician workforce was employed by corporations and were not independent practices. Substitution of one physician in practice for another is common and appears to be well accepted, at least by doctors. [1] Electronic health records and practice guidelines reduce the variability in physician effort. Doctors are becoming through these market forces more substitutable for one another. Now at least in my mind, the equality of substitution of one physician for another will never be as equal as it is for pharmacists simply because of the decisions we are entrusted to consider and the relationships they create. Patients with chronic illness, patients undergoing major surgery will still have relationships with their doctor for which there is no natural substitute. In those instances, a disparity of income may continue, not because of gender, but by the old heuristic of a good physician, ability, affability, and availability. I would suggest that the greatest equality in gender income will be seen first in those medical specialties that have less of a long-term relationship with patients, where employment and substitution are easier, e.g., hospitalists or

radiologists. It would be an interesting study to look at these specialties to confirm or refute the hypothesis that Goldin and Katz have so eloquently put forward. It might allow the marketplace to effect change rather than more regulation with unintended, unforeseen consequences.

[1] A Google Scholar search found no study of how patients felt about seeing another member of the practice rather than “their” primary physician. Circumstantial evidence for the growing substitutability of doctors is found in the large coverage groups formed to deal with nighttime and weekend issues. Another example would be the ‘acceptance’ of mothers to have someone other than “their” obstetrician assist at delivery. On the other hand, patients do seem bothered that they do not have a single lead physician when hospitalized.

Links

[1] https://www.acsh.org/news/2017/04/26/gender-disparity-physician-income-new-straw-man-rises-11191
[2] https://mobile.nytimes.com/2016/03/20/upshot/as-women-take-over-a-male-dominated-field-the-pay-drops.html
[3] https://scholar.harvard.edu/files/lkatz/files/jole_gk_pharm_published.pdf