The Governance Institute

BOARD BRIEFING

Why a busier physician practice can still earn less

More care and higher costs can leave less money after the bills are paid.

5–6 MINUTE READ

In This Briefing

A practice can provide more care while retaining less after expenses. Physician productivity, payments for care, and the cost of keeping services available explain different parts of that result. Community access adds another dimension to the investment.

About Board Briefings

Board Briefings offer deeper explanations of healthcare issues and their implications for governance. Each includes a practical example, authoritative sources, and key questions to support informed board discussion.

What Happened

On September 17, SullivanCotter published benchmarks showing that adult medical specialists' median compensation rose 7.2% between its annual surveys, while recorded productivity rose 2.8%. The comparison covers that specialty group, not every physician or each doctor's individual raise. (1)

For health systems employing these specialists, the comparison raises a question about the cost of providing care. More recorded work does not necessarily bring enough additional payment to cover higher compensation and the other expenses of running a practice.

The Issue, Explained

When a patient leaves an appointment, the visit is over but the financial story continues. The practice records what the doctor did, bills under the patient's coverage, and receives payment later. Salaries, nursing wages, rent, and equipment costs continue in the meantime.

Productivity describes the amount and intensity of physician work. Services receive different weights for the effort involved, so a more demanding service can count more than a simpler one. The measure is called work relative value units, or work RVUs. It records clinical activity, not revenue or improvements in health. (2)

A doctor can increase that total by providing more services or a different mix of services. Neither guarantees an equivalent rise in revenue. The amount collected depends on what was provided and what the patients' insurance arrangements pay. Similar workloads can bring different amounts of money.

Growth has costs of its own. More appointments may require another nurse, longer opening hours, or additional equipment. Any extra revenue has to cover those additions as well as higher physician pay. The practice can bring in more money and still have less left after expenses.

Some responsibilities do not appear in an appointment count. A specialist may teach, answer emergency calls, or advise colleagues treating hospitalized patients. Those commitments differ from a role devoted entirely to scheduled visits. The services and responsibilities behind the totals give a comparison its meaning.

The Issue, Explained (continued)

The timing of employment changes the picture again. A newly hired doctor receives a salary while building a patient schedule. That temporary gap is different from a long-established practice that repeatedly needs more support than planned. Combining the two in an annual average can obscure the difference.

Some support may be deliberate. Employing a specialist can keep important care nearby or make another service possible. Those benefits do not necessarily appear in the practice's own earnings. Shorter waits can be valuable even when the health system must contribute more money to achieve them.

A practice may have an agreed need for financial support and still experience a change in costs or revenue. Those circumstances can coexist. The national benchmark does not separate them for a particular practice. Its own services, payment arrangements, and expenses explain what has changed.

A Practical Example

A hypothetical practice receives $8 million a year. Physician compensation costs $5 million, and staff, space, and other expenses cost $2 million. That leaves $1 million after expenses.

The next year, recorded clinical work increases 3%. Revenue remains $8 million because the mix of services and payments changes. Physician compensation rises to $5.35 million, while other expenses remain $2 million. The practice now has $650,000 left—$350,000 less despite doing more work.

These are illustrative figures, not survey results. If waits for an important specialty also became shorter, that would be a benefit worth recognizing. It would not erase the financial change. The practice has delivered more care while leaving fewer resources available for other needs.

Governance Implications

Physician employment can serve several purposes. A group may be expected to cover its costs, support a wider clinical program, or keep a scarce specialty available locally. The expected financial result depends partly on which benefit the health system intended to provide.

When compensation or other costs rise, continuing that care may require more support. That can affect resources available for other services. Better access and financial sustainability therefore belong in the same assessment, without treating either a busy schedule or a shortfall as the whole result.

The board considers major service commitments and their affordability, while management develops employment arrangements and runs the practices. Linking the care gained with the resources required gives both a clearer basis for understanding the investment. Productivity describes the work; it does not, by itself, establish the value or cost of sustaining it.

Questions for the Board

1. **When reviewing physician investment objectives:**
   What care and access benefits was physician employment intended to provide, and what financial support was anticipated?

2. **When comparing costs and productivity:**
   How do physician responsibilities, payments received, and practice expenses explain results alongside productivity?

3. **When considering ongoing financial support:**
   What evidence shows whether the services gained and the support required remain consistent with the organization’s priorities?

Sources & Further Reading

1. SullivanCotter. Physician Compensation Growth Continues to Outpace Productivity. September 17, 2026. Specialty-group benchmarks, not individual raises or practice earnings.
2. Centers for Medicare & Medicaid Services. Physician Fee Schedule Quick Reference Search Guide. Background on physician-work measures and payment.

Board Briefings provide governance education and do not constitute legal, clinical, accounting, or investment advice.