



# Perspective

## Distributions of Industry Payments to Massachusetts Physicians

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Financial relationships between pharmaceutical manufacturers and health care professionals remain controversial. Some interactions, such as those involving research and exchange of expertise,

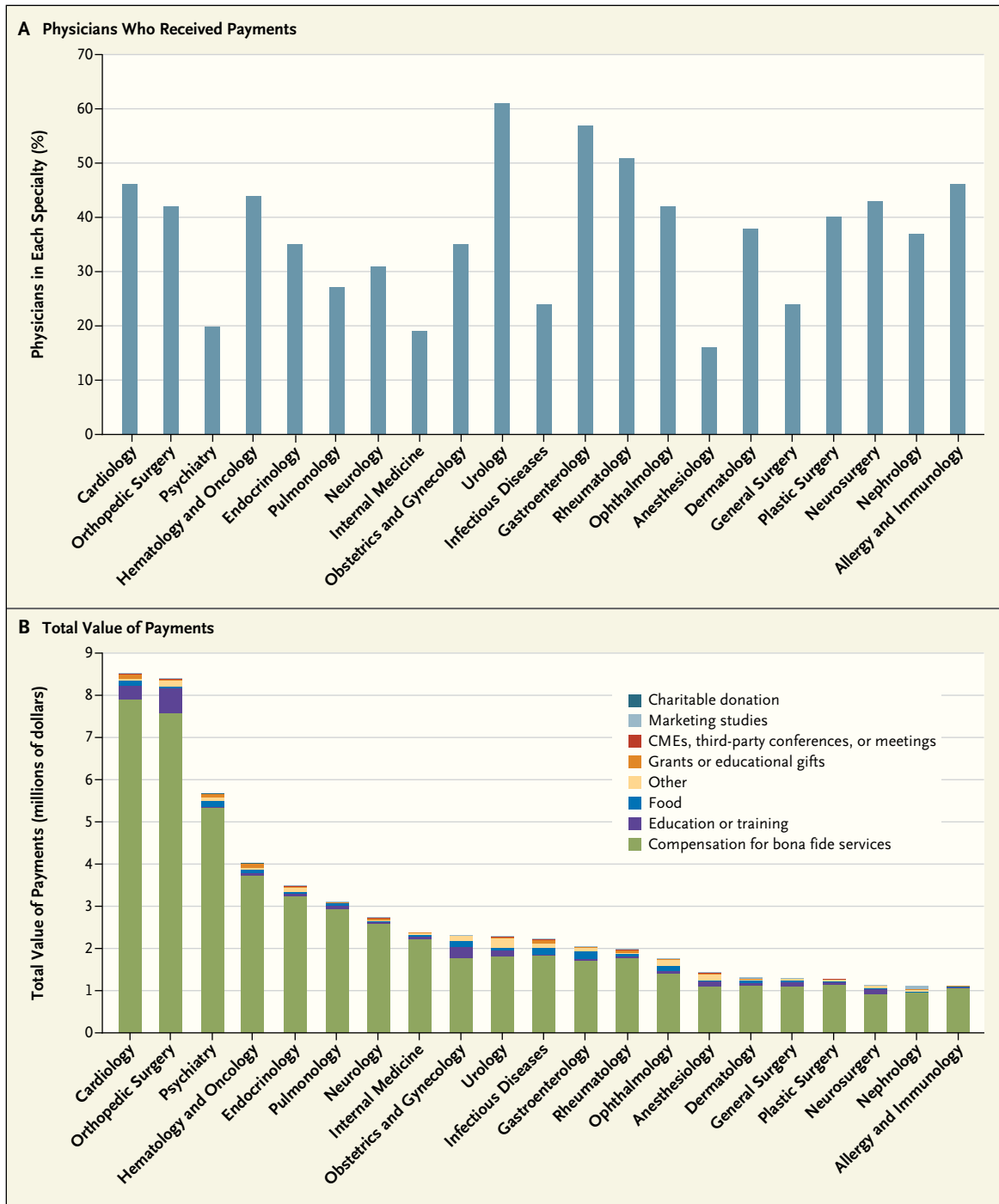
promote the development and study of new drugs; by contrast, payments in the form of meals and continuing medical education (CME) programs have been criticized for being promotional and have been linked to non-evidence-based prescribing practices. The prevalence of these relationships has been estimated from national physician surveys, which found that, across seven specialties, about 83% of physicians received gifts from industry (excluding samples) in 2004. The prevalence has decreased slightly in recent years: a 2009 survey showed that about 71% of physicians received gifts.

The numbers varied according to specialty, ranging from 62% in psychiatry to 68% in internal medicine to approximately 75% in cardiology and anesthesiology.<sup>1</sup>

In recent years, some states have implemented mandates requiring systematic public disclosure by industry of payments made to health care practitioners.<sup>2</sup> The 2009 Massachusetts Pharmaceutical and Medical Device Manufacturer Code of Conduct, for instance, required reporting of outlays with a value of at least \$50. Databases such as the resulting Massachusetts one allow direct calculation of industry payments to physicians,

comparisons with previous surveys, and evaluation of responses to trends in the marketplace.

We used Massachusetts data to characterize the distribution of payment types and the variation among medical specialties. We downloaded data from the Massachusetts Department of Health and Human Services,<sup>3</sup> which compiles information on payments of \$50 or more reported by drug and medical device companies from July 2009 through December 2011 (the most current data available) and aggregates the payments made to each physician.<sup>4</sup> The data set lists the name, address, and professional license number of each physician, the manufacturer, and the amount and purpose of the payment. The purpose is categorized by the reporting company as one of the following eight



Percentages of All Licensed Massachusetts Physicians in Each Specialty Who Received Payments (Panel A) and Total Value of Payments Received by Such Physicians, According to Specialty (Panel B), 2009–2011. Data include only those specialties registering total payments of more than \$1 million.

types, with names and descriptors set by the state: compensation for bona fide services (including consulting and participation in

speaker’s bureaus); food; grants and educational gifts; CME programs, third-party conferences, or meetings; education and train-

ing; marketing studies (payments in conjunction with research “other than genuine research”); charitable donations (excluding

free samples); or “other.” Finally, we matched each physician to a medical specialty using a publicly available data set managed by the state medical licensing board from February 2013 (historical data were not available) and compared the distributions received by various specialties.

The 30 months’ worth of data included 32,227 reported payments to 11,734 Massachusetts physicians, for a total of \$76.7 million. Of those payments, \$17.1 million occurred in the last 6 months of 2009, \$30.3 million in 2010, and \$29.3 million in 2011. In 2010, a total of 6530 physicians appeared in the database, as compared with 5921 in 2011. The average total payment per physician over the course of a year increased slightly, from \$4,637 in 2010 to \$4,944 in 2011.

The most common form of payment was food. During the 30 months, there were 14,251 payments for a total of \$2.4 million (median, \$100; interquartile range [IQR], \$69–\$164). The number of food payments shrank from 5253 in 2010 (for a total of \$858,031) to 4131 in 2011 (\$811,292). Compensation for bona fide services was the payment type with the highest value. The 8432 payments in this category accounted for \$67.3 million, or 88% of total expenditures (median, \$2,750; IQR, \$1,000–\$6,560). Such payments were made 3072 times in 2010, and the number remained stable in 2011 (2990).

When we analyzed the published Massachusetts data according to physicians’ specialty distributions, we found that 25% of currently licensed Massachusetts physicians (8439 of 33,446) received at least one payment between July 2009 and

December 2011. Primary care was among the specialties least likely to receive payments: the database contained payments to fewer nonspecialist internists (19%), pediatricians (12%), and family practitioners (21%) than urologists (61%), gastroenterologists (57%), rheumatologists (51%), and cardiologists (46%) (see graph).

The highest average per-physician amounts paid over the full 30-month period were received by orthopedic surgeons (\$18,446) and physicians in various specialties within internal medicine, including endocrinology (\$17,407), infectious diseases (\$15,922), and pulmonology (\$13,027). The distribution of types of financial relationships also varied among specialties. For example, compensation for bona fide services accounted for more than 90% of the payments for orthopedic surgeons, psychiatrists, and most internal medicine specialists, whereas general internists received larger shares of their payments in the form of food (8%) and grants or educational gifts (5%), and obstetricians received 11% of their total amounts as education or training. The prevalence of industry interactions varied widely among specialties — a finding that suggests either that industry has different incentives to engage in relationships with different types of specialists or that there are varying levels of acceptance of these interactions among practitioners in various fields.

Our analysis reveals decreases in overall payments and numbers of physicians appearing in the database between 2010 and 2011, with a slight increase in the average payment amount — when fewer physicians received

payments from drug and device companies, the remaining financial relationships became a bit more lucrative. One explanation may be that relatively high proportions of physicians in Massachusetts are affiliated with academic medical centers and health systems that now have policies preventing physicians from accepting certain types of gifts of any value; institutions that have taken such actions include Boston University School of Medicine–Boston Medical Center (2007), the University of Massachusetts (2008), Partners HealthCare (2009), Tufts University School of Medicine (2010), and Harvard Medical School (2010). In addition, starting in July 2009, state law banned many types of gifts, including most meals. Accordingly, we found a decrease in the often-criticized provision of food but no reductions in payments categorized as compensation for bona fide services, which may be promotional in nature but may also be for exchanges of scientific expertise. The gift ban was recently repealed, and “modest” industry-sponsored “meals and refreshments” are now permitted — though no restrictive definitions are attached to these terms. It is likely, therefore, that the provision of food will once again increase.

The rates were substantially lower than those reported in previous national surveys that did not distinguish among gifts according to their value.<sup>2</sup> Though these surveys are older than our data set and were derived from national samples, one explanation for the discrepancy may be that Massachusetts physicians — particularly primary care physicians — receive many gifts val-

ued at less than \$50 that are not reported to the database. However, social science research suggests that feelings of reciprocity and changes in attitudes or behavior can be induced by even small-value gifts.<sup>5</sup> The discrepancy between data sets also raises the possibility that some qualifying payments were not reported to the Massachusetts database.

The federal Physician Payment Sunshine Act will soon require manufacturers to report most payments to physicians and teaching hospitals on a national level. Recently released rules indicate the intent to create a searchable system that will include the names of drugs or devices related to the payment. Descriptors for the type of relationship will be included as well, although the ones currently used in Massachusetts are of limited value,

since the dominant category of “compensation for bona fide services” encompasses legitimate scientific as well as more controversial marketing relationships. However, many types of indirect payments, such as those made through intermediary organizations that host CME conferences, will be exempt from the national reporting requirement — which raises the possibility of some undetected payments. Nonetheless, the transparency offered by state or federal disclosure databases could be used in the future to explore relationships between financial interactions and health care outcomes or costs.

Disclosure forms provided by the authors are available with the full text of this article at [NEJM.org](http://www.nejm.org).

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