



## Original article

## Examining the Gap: Compensation Disparities between Male and Female Physician Assistants

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### A B S T R A C T

**Background:** Compensation disparities between men and women have been problematic for decades, and there is considerable evidence that the gap cannot be entirely explained by nongender factors. The current study examined the compensation gap in the physician assistant (PA) profession.

**Methods:** Compensation data from 2014 was collected by the American Academy of PAs in 2015. Practice variables, including experience, specialty, and hours worked, were controlled for in an ordinary least-squares sequential regression model to examine whether there remained a disparity in total compensation. In addition, the absolute disparity in compensation was compared with historical data collected by American Academy of PAs over the previous 1.5 decades.

**Results:** Without controlling for practice variables, a total compensation disparity of \$16,052 existed between men and women in the PA profession. Even after PA practice variables were controlled for, a total compensation disparity of \$9,695 remained between men and women (95% confidence interval, \$8,438–\$10,952). A 17-year trend indicates the absolute disparity between men and women has not lessened, although the disparity as a percent of male compensation has decreased in recent years.

**Conclusions:** There remain challenges to ensuring pay equality in the PA profession. Even when compensation-relevant factors such as experience, hours worked, specialty, postgraduate training, region, and call are controlled for, there is still a substantial gender disparity in PA compensation. Remedies that may address this pay inequality include raising awareness of compensation disparities, teaching effective negotiation skills, assisting employers as they develop equitable compensation plans, having less reliance on past salary in position negotiation, and professional associations advocating for policies that support equal wages and opportunities, regardless of personal characteristics.

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Despite years of progress, women continue to earn less money for the same work as men. Scholarly interest in this issue began as early as 1891 (Webb, 1891). This is not an issue confined to just the United States. The World Economic Forum predicts that overall worldwide gender pay equality will not occur until at least 2095, and ranked the United States as 65th of 142 nations in terms of wage equality for similar work, and 20th for overall gender equality (World Economic Forum, 2014). Other groups have reached similar conclusions, including the Institute for

Women's Policy Research, the U.S. Equal Employment Opportunity Commission, and the U.S. Department of Labor (Bureau of Labor Statistics [BLS], 2015; Equal Employment Opportunity Commission, n.d.; Hegewisch & Ellis, 2015).

In terms of absolute compensation of men and women in the United States, an oft-cited statistic is that women earn \$0.77 for every \$1.00 that men earn (BLS, 2011). Although this number is accurate, various factors explain a certain amount of the wage disparity (Blau & Kahn, 2006). Women often work fewer hours per week than men, have been in the workforce less time, and take more leaves of absence (Bertrand, Goldin, & Katz, 2010).

The purpose of the present research is to examine compensation of U.S.-based physician assistants (PAs) to determine whether a gender compensation disparity still exists, and whether this disparity is decreasing, increasing, or has remained stable. We build on this previous literature (e.g., Coplan, Essary,

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Viriden, Cawley, & Stoehr, 2012) by having a more complete model that controls for numerous factors that may affect compensation, such as experience, postgraduate training, hours worked, and other factors. We examine both current and historical PA compensation.

### Gender Wage Disparity among Health Care Professionals

The gender wage disparity has been examined among health care professionals. In one study, researchers examined data from the Current Population Survey (CPS) from 1987 to 2010 to estimate the gender compensation disparity for workers within health care, as well as outside health care (Seabury, Chandra, & Jena, 2013). Although the gender gap diminished over this time outside of the health care industry, it did so in only certain professions within health care. For registered nurses and pharmacists, the gap was smaller than for physicians and workers overall, and it diminished over time. For PAs, dentists, and health care executives, the gap was greater than for non-health care workers, and only diminished over time for health care executives. Although these investigators adjusted for differences in hours worked and experience, the study was limited because the CPS does not include data on specialty, practice type, and procedural volume, all of which may influence compensation.

In addition, the Seabury et al. (2013) study draws from the CPS. The CPS is robust in that it draws from a national sample, but PA data are limited to 761 PAs, with no balancing of specialty or other practice variables that are known to affect compensation. Although there was a significant gap between men and women in the PA subsample of data for the years 2006 to 2010, with men earning 29.3% more, other years within the sample did not attain significance, likely owing to the small sample size and possible variations between gender groups and specialties. One important consideration when examining the Seabury et al. (2013) data is that compensation medians, including from the period of 2006 to 2010, do not match other consumer price index-adjusted compensation medians from much larger national samples, such as the BLS and the American Academy of PAs (AAPA) Salary Surveys and Census, calling into question the conclusions regarding the size of the gender pay gap among PAs. It could be because these regression-predicted medians are computed from a small, random, but non-PA representative sample. The work by Seabury et al. (2013) was a very important first step in analyzing PA compensation trends between male and female PAs, but it is important to investigate trends in a larger sample of respondents that match the demographics of the PA profession.

### Gender Wage Disparity among PAs

As early as 1983, salary inequalities were found between men and women who were clinically practicing PAs. One researcher later postulated that the discrepancy could be related to the larger economic contribution men made to practice revenue (Oliver, Carter, & Conboy, 1984). A 1992 report indicated that salary differences between male and female PAs still existed despite comparable levels of experience and similar practice characteristics (Willis, 1992). In 2009, it was shown that, among new graduate PAs, women earned less than men, even after controlling for numerous variables, which included experience, specialty, hours worked, and hours on-call per month (Zorn, Snyder, & Satterblom, 2009). In the current study, we examine current PAs, not just new graduate PAs.

In 2012, Coplan et al. (2012) found many differences in the professional experiences of male and female PAs. Based on PA-reported compensation and benefits data from the AAPA, men had more experience in their specialty, provided more direct care to patients, and worked more hours per month on-call. Men also reported having more funding available for professional development, as well as higher total compensation, base pay, and other pay such as administrative, overtime, and on-call pay. Women reported receiving more additional sources of income over their base pay in relation to men, but total compensation was still lower than for men. This report concluded that certain salary discrepancies remain between male and female PAs regardless of specialty, experience, or other practice characteristics.

Although the Coplan et al. (2012) study provided an excellent recent overview of differences between men and women in the PA profession, it did have some limitations, including a limited scope of specialties (it examined potential differences between emergency medicine, orthopedic surgery, and family practice). In addition, the study did not examine the size of the income disparity in relation to past data, making the analysis thorough in many respects, but limited in its ability to make conclusions about all specialties in the PA profession, as well as the trajectory of the pay gap over time.

Considering the overlap of physician and PA scope of practice, the increasing proportion of female PAs in the workforce, and the relative paucity of literature regarding the influence of gender on PA practice, further study of salary disparities in the PA profession is warranted. The results could have significant implications for recruiting and retention practices, the success of female PAs in clinical practice, and the future income of female PAs. The current work aims to expand the historical overview provided by the Seabury et al. (2013) study, as well as recent studies on PA compensation disparities (Zorn et al., 2009), to determine precisely what the current state of PA compensation disparities is and how that has changed over time.

### Methods

#### *PA Compensation Disparity over Time*

Archival data from census and salary surveys on male and female PA base salary over many of the last 17 years (with the exception of 2011 and 2013) from the AAPA were examined to determine the general trajectory of base salary for men and women, as well as whether there have been any notable changes in recent years. Each year, with few exceptions, the AAPA conducts a PA Census or a Salary Survey of PAs across the United States for information regarding compensation, practice demographics, and benefits. The surveys collected base salary and bonus information as part of total compensation, in addition to gender. From those raw data, mean and median compensation of female PAs as a percentage of male PAs were calculated. These data were provided by the AAPA and collected from tens of thousands of PAs over the last 1.5 decades, from 1998 through 2015 (with the exception of 2011 and 2013). Response rates ranged from 17.9% to 44.1%, and overall margins of error were less than 1%. This study involved the secondary analysis on de-identified survey data on data that were previously collected by a private organization. Being an entirely post hoc analytical study, this study did not undergo a human subjects research review process with an institutional review board.

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