



AMA POLICY RESEARCH PERSPECTIVES

Physician compensation methods: Although salary-based models dominate, productivity-based models remain prominent

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Executive summary

This American Medical Association Policy Research Perspective analyzes trends in physician compensation methods from 2014 to 2024 using novel data from the AMA Physician Practice Benchmark Survey. The findings reveal a marked shift toward blended compensation models, with a growing prevalence of salary, productivity and bonuses in physician compensation structures.

In 2024, 70.5% of physicians received compensation from salary (up 9 percentage points since 2014), 55.0% from productivity (up 2 percentage points), and 39.0% from bonuses (up 9 percentage points). Blended compensation methods have become dominant with 60.8% of physicians receiving compensation from more than one method compared to 51.0% in 2014. Over the decade, there has been a decline in the proportion of physicians paid solely based on productivity (down 5 percentage points) or practice financial performance (down 4 percentage points), and an increase of over 10 percentage points in those primarily compensated by salary, often with bonuses and/or productivity as secondary components. On average, salary was 58.2% of physician compensation and productivity was still significant at 28.1%.

The analysis also highlights differences across employment status, gender, specialty and practice type. Owners received less salary-based and more productivity-based or financial performance-based compensation than employed physicians in 2024, though salary shares increased for both groups from 2014 to 2024. In 2024, female physicians had a larger share of compensation from salary-based models than male physicians while male physicians had a greater share of compensation from productivity-based models. Across specialties, salary-based compensation dominated, though surgical specialists relied more on productivity-based models. Physicians who worked in hospitals or multispecialty practices tended to have higher salary shares than those in single-specialty practices.

Overall, physician compensation models have become increasingly blended, balancing financial stability with incentives for productivity, and reflecting broader changes in employment practices and organizational structures in health care over the past decade. Unlike much of the other work in this space, this AMA Policy Research Perspective delivers unique, nationally representative estimates of multiple compensation methods and provides a clearer understanding of the underlying factors that influence physician income.

Introduction

Using 2014–2024 data from the American Medical Association Physician Practice Benchmark Survey, this study examines trends in methods used to compensate physicians—such as salary, productivity and bonuses—as well as differences in compensation methods across physician characteristics. Existing work on this topic consists of quantitative reports that often lack representative data and are characterized solely by estimates of compensation *levels* (dollar values) and qualitative discussions of salary and productivity models. In contrast, analysis of AMA Physician Practice Benchmark Survey data provides unique, nationally representative estimates of both the prevalence and income shares of key compensation methods. This allows for a clearer understanding of the underlying factors that influence physician income and the relative impact of each method. This report also assesses differences across employment status (owner or employed physician), gender, specialty and practice type.

In 2024, 70.5% of physicians received at least some compensation from salary (up 9 percentage points from 2014), 55.0% from productivity (up 2 percentage

points), and 39.0% from bonuses (up 9 percentage points). As a result of these trends, physicians are increasingly paid by a blend of methods—60.8% of physicians received compensation from more than one method in 2024 compared to only 51.0% in 2014.

During this 10-year period there were sharp declines in the percentage of physicians who received all their compensation from productivity (a decrease of 5 percentage points) and practice financial performance (a decrease of 4 percentage points) and a shift toward physicians receiving most of compensation based on salary (an increase of more than 10 percentage points) with bonuses and/or productivity playing a role in the remainder. On average, salary dominates the compensation stream with 58.2% of physician compensation based on this method although productivity remains prominent at 28.1%. Although changes in the physician population (see Kane, 2025) may influence these trends, the data show many of these patterns are consistent across physician employment status, specialty and practice type.

Data and methodology

The AMA Physician Practice Benchmark Survey is conducted on a biennial basis to collect nationally representative data on U.S. physicians who provide patient care. There were 3,500 respondents per year in 2014–2022 and 5,000 respondents in 2024. Physicians are screened to ensure they provided at least 20 hours of patient care a week, completed residency, and were not employed by the federal government at the time of the survey.¹ The survey collected detailed information about practice characteristics of physicians, including methods used to compensate physicians.

Physicians, excluding solo practitioners, were asked, “Through which of the following methods do you currently receive compensation from your practice? Please select all that apply.” The following options were provided:

- Compensation based on your personal productivity
- Compensation based on your practice’s financial performance
- Base salary
- Bonus (based on factors other than your personal productivity or your practice’s financial performance)
- Other (please specify)

For the methods that physicians selected, they were asked “Please provide your best estimates of the percentages of your income that are provided through these methods. They should sum to 100 percent.”

Physicians in solo practice are excluded from the analysis for this report because their compensation is inherently tied to practice financial performance and productivity; the term “physician” in this report refers only to non-solo practitioners.

1. A description of survey methodology can be found in Kane (2025).

Results

Prevalence of compensation methods

In 2024, 70.5% of physicians indicated they received a salary, making it the most prevalent compensation method ([Exhibit 1](#)).² Still, most physicians (55.0%) indicated their productivity factored into their compensation. Thirty-nine percent and 27.9% of physicians had bonuses and practice financial performance, respectively, playing a role in their compensation. Only 3.2% indicated that another method contributed to their income, suggesting that the four previously mentioned methods constitute a nearly exhaustive list. Since physicians can be compensated through multiple methods, the prevalence across these methods sums to more than 100%.

From 2014 to 2024, most methods increased in prevalence with salary and bonuses both increasing by 9 percentage points and productivity increasing by 2 percentage points. Compensation based on practice financial performance was the only method during this period to decrease in prevalence and that was by 4 percentage points. The growth across most methods suggests that physicians are increasingly compensated through multiple methods. In fact, 60.8% of physicians were compensated with two or more methods in 2024 compared to only 51.0% in 2014—a difference of 10 percentage points ([Exhibit 2](#)).

The decline in compensation based on a *single* method from 49.0% to 39.2% was due primarily to a decline in physicians being solely compensated based on productivity (a decrease of 5 percentage points), practice financial performance (a decrease of 4 percentage points) and, more modestly, salary (a decrease of 2 percentage points). Physicians compensated by *two* methods increased from 29.6% to 34.3%, driven by an increase of 3 percentage points in both the salary and productivity combination and the salary and bonus combination. Physicians compensated by *three or more* methods increased from 21.5% to 26.6%, primarily due to compensation structures that incorporated salary, productivity and bonuses together, an approach which increased by

60.8% of physicians were compensated with two or more methods in 2024 compared to only 51.0% in 2014—a difference of 10 percentage points.

almost 5 percentage points. As such, practices are increasingly compensating physicians using a blend of methods, with salary being a common component, often paired with a bonus and/or productivity.

To understand the prominence of these combinations in physician income, [Exhibit 3](#) distributes physicians into mutually exclusive categories based on whether *all* their compensation (“100%”) or more than half but not all their compensation (“51%–99%”) came from salary, productivity or practice financial performance. [Exhibit 3](#) shows that the percentage of physicians receiving most (but not all) their compensation from salary increased by nearly 10 percentage points, up from 32.2% in 2014 to 43.2% in 2024. In fact, the percentage of physicians who received most (but not all) their compensation from salary and also received a bonus increased by 9 percentage points, moving from 19.7% in 2014 to 28.8% in 2024.³ Similarly, the percentage of physicians who received most (but not all) their compensation from salary and also received a productivity component increased 7 percentage points, from 17.5% in 2014 to 24.8% in 2024.⁴ This suggests that the increasing prevalence of salary combined with productivity and/or bonuses (discussed in [Exhibit 2](#)) occurred with *salary being the primary component of physician income*. In contrast, the percentage of physicians receiving most (but not all) their compensation from productivity remained stable (9.9% of physicians in 2014 compared to 10.6% in 2024). All other combinations were less common and are aggregated into the other category, which remained stable over this period.

2. Physicians who received a salary were asked about the methods used to determine their salary. The most frequently cited factors were physician specialty (mentioned by 66.4% of salaried physicians) and time worked in the practice (47.3%).

3. Data are not shown in graphic and are available upon request.

4. Data are not shown in graphic and are available upon request.

Average compensation shares

Whether a particular compensation method is used provides valuable insight, and understanding the extent to which it is part of physician income offers a more comprehensive view of its prominence. This section assesses compensation shares—that is, on average, the percentage of physician income based on each method. This data is further decomposed by physician employment status, gender, specialty, and practice type to explore differences across physician and practice characteristics and assess how shifts in the physician population related to these factors may have influenced the overall trend.

Ten-year trend

Exhibit 4 shows that although the average compensation shares have shifted between 2014 and 2024, the rank order of the methods is consistent (i.e., salary is always the highest, followed by productivity). In 2024, an average of 58.2% of physician compensation was from salary—that is, for every \$100 of income the average physician received, nearly \$60 came from a salary. This reflects an increase of 8 percentage points from 2014 (50.1%), which is consistent with earlier findings that showed both a growing prevalence of salary-based compensation (Exhibit 1) and an increase in physicians receiving the majority of their compensation from salary (Exhibit 3). On average, 4.4% of compensation came from bonuses in 2024, similar to 3.8% in 2014. Although bonuses are increasingly being used in combination with salary (discussed earlier), they remain a small component of the overall compensation structure.

The average compensation share for practice financial performance declined from 11.8% in 2014 to 7.0% in 2024, consistent with the declines in the prevalence of this method (Exhibit 1) and percentage of physicians receiving all their income from this method (Exhibits 2 and 3). For productivity, Exhibit 4 shows that the average compensation share declined from 32.6% to 28.0%, albeit the fact that its prevalence increased (Exhibit 1). This is because the decline in receiving all compensation from this method was only partially offset by an increasing use of productivity in combination with other methods, namely salary (see Exhibit 3). Thus, productivity still accounted for over one-quarter of physician income in 2024.

It is notable that variable compensation methods (productivity and practice financial performance) make up nearly one-quarter of compensation for employed physicians and suggests that employed physicians are not entirely insulated from factors like RVUs and practice financial incentives.

Differences across employment status

Physicians in the AMA Physician Practice Benchmark Survey indicated whether they were employed by their practice (employee) or had an ownership stake in their practice (owner). In 2024, 69.5% of compensation came from salary for employees—this was twice the share for owners (i.e., 35.0%; see Exhibit 5). Still, it is interesting that for owners, one-third of their income was salary-based. In contrast, 40.8% of compensation came from productivity for owners, almost twice the share for employees (21.9%). Perhaps even more striking, 18.2% of compensation came from practice financial performance for owners, compared to only 2.5% for employees. It is notable that variable compensation methods (productivity and practice financial performance) make up nearly one-quarter of compensation for employed physicians and suggests that employed physicians are not entirely insulated from factors like RVUs and practice financial incentives.

Although the growth of physician employees in the population (Kane, 2025) is a factor in the increasing dominance of salary-based compensation, the average compensation share from salary increased both for owners (4 percentage points) and employees (3 percentage points; see Exhibit 5). In addition, there was a corresponding decline in the share of compensation from variable methods (productivity and practice financial performance) both for owners (a decrease of 5 percentage points for the two

Female physicians compared to male physicians had a higher share of income based on salary and a lower share of income based on productivity and practice financial performance.

methods combined) and employees (a decrease of 4 percentage points). Thus, the shift in physician employment status was not the sole driver of changes in the average compensation shares for all physicians.

Employed physicians may work at a practice wholly owned by other physicians (private practice), at a practice owned by a hospital or health system (hospital-owned practice), or directly for a hospital. Roughly 68% of compensation was from salary for physicians employed by practices, regardless of whether it was a private practice or hospital-owned practice, compared to 76% for physicians directly employed by a hospital.⁵ This suggests whether a physician is employed in a private practice or hospital-owned practice is not a factor in their compensation structure. However, whether the physician is employed by a practice (private or hospital-owned) compared to being employed directly by a hospital plays a more significant role. This latter point, which suggests there are differences in practice type (i.e., practice vs. hospital), is discussed further in the “Differences across practice types” section of this report.

Differences across gender

New to this year’s biennial report, [Exhibit 6](#) presents differences in average compensation shares for male and female physicians. There are several confounders to consider, notably age (there are more older male than female physicians), specialization (specialty selection differs between male and female physicians) and, related to both of these, employment status (older physicians and physicians in certain specialties

are more likely to have an ownership stake in their practice). As such, [Exhibit 6](#) differentiates gender by physician employment status, the most significant factor (once accounting for employment status, differences in age and specialty are smaller).

Female physicians compared to male physicians had a higher share of income based on salary and a lower share of income based on productivity and practice financial performance. The salary share for female owners was greater than that of male owners by 10 percentage points, while the shares for productivity and practice financial performance were lower among female owners than male owners by 8 percentage points and 2 percentage points, respectively. There were smaller differences for employed physicians. Female employees had only a slightly higher share of income based on salary (a difference of 4 percentage points) and a proportionally lower share of income based on productivity (a difference of 4 percentage points) compared to their male counterparts.

Differences across physician specialty

On average, more than half of compensation was based on salary for nearly all specialties ([Exhibit 7](#)). Only ophthalmologists (35.3%), orthopedic surgeons (36.0%), and other surgical subspecialists (45.6%) were exceptions. These three specialties also had the largest average productivity shares—57.1% for ophthalmologists, 52.6% for orthopedic surgeons and 40.7% for surgical subspecialists—while the productivity shares for remaining specialties were below 30%. Generally, the average share from practice financial performance was below 10% while the salary and productivity shares combined made up roughly 80%–90% of physician income for all specialties. Radiologists were the only exception with 17.8% of their income based on practice financial performance. Differences across specialties in employment status (i.e., owner vs. employed physicians) may contribute to these distinctions. Specialties with the highest percentage of owners (i.e., ophthalmologists, orthopedic surgeons, surgical subspecialists, anesthesiologists and radiologists) also had the highest average share from either productivity or practice financial performance.⁶

5. Data are not shown in graphic and are available upon request.

6. The author’s analysis of 2024 data from the AMA Physician Practice Benchmark Survey on physician specialty and employment status is not shown in the graphic and is available upon request.

Differences across practice types

Exhibit 8 shows that physicians who are employed by or contract with hospitals, compared to those in group practices (single or multispecialty) had by far the largest average share of compensation from salary (74.7%) and the lowest shares from productivity (15.0%) and practice financial performance (2.5%). These differences may relate to physician employment status (discussed earlier) since hospital physicians are all employees whereas physicians in group practices include both owners and employed physicians (Kane, 2025). Still, there were differences within group practices (i.e., multispecialty compared to single specialty). The average salary share was

10 percentage points higher for physicians in multispecialty compared to single-specialty practices while the average productivity share and practice financial performance share were each 5 percentage points higher for physicians in single- compared to multispecialty practices. Although the specialty mix in single- compared to multispecialty practices may contribute, the data suggest differences between single- and multispecialty practices exist even within specialty (e.g., the average salary share was 10 percentage points higher for pediatricians in multispecialty practices compared to those in single-specialty practices).⁷

Conclusion

This AMA Policy Research Perspective uses novel data from the AMA Physician Practice Benchmark Survey to provide an in-depth examination into the structure of physician compensation. Different from other reports that focus solely on compensation levels (McKenna, 2025; Doximity, 2025), this report identifies the factors influencing physician compensation and uniquely provides nationally representative estimates of both the prevalence and share of each compensation method. Solo practitioners are excluded from this report.

Understanding the methods that factor into compensation is important because they may provide incentives that influence physician behavior. For example, salary-based models may be tied to stable responsibilities, bonuses may be linked to quality measures, and productivity-based models may incentivize higher output. In turn, differing incentives can lead to potential variability in compensation across physicians.

The report shows that physicians are increasingly compensated by two or more methods (51.0% in 2014 compared to 60.8% in 2024). Over this period, physicians grew less likely to be *solely* compensated based on productivity (a decrease of 5 percentage points), practice financial performance (a decrease of 4 percentage points), and, more modestly, salary (a decrease of 2 percentage points). This is consistent with other reports that suggest compensation based purely on salary or productivity is declining (Medical Group Management

The growing use of blended compensation models is driven by arrangements that combine salary with productivity and/or bonuses (an increase of 10 percentage points), with salary being the primary component of physician income.

Association, 2025). The growing use of blended compensation models is driven by arrangements that combine salary with productivity and/or bonuses (an increase of 10 percentage points), with salary being the primary component of physician income.

Although salary, on average, accounted for 58.2% of physician income, productivity was still prominent at 28.0%. There is a conceptual tradeoff between salary-based and productivity-based compensation models. Salary offers financial stability and security for physicians, typically with defined expectations regarding workload (Scott, 2024). Productivity metrics (such as RVUs) are, by contrast, considered to be objective measures of physician performance but introduce variability in compensation as payment

7. Data are not shown in graphic and are available upon request.

is linked to the quantity and complexity of care delivered, which can create both an upside and downside for physician compensation (Moore, 2002). The increasing blend of these two methods suggests that a growing number of physicians may benefit from both the stability of a salary and the potential, albeit more modest, upside of their productivity.

The data also show important differences in the use of compensation methods across physician characteristics. First, employed physicians had nearly twice the average share of compensation from salary than that of owners. Still, both owners and employed physicians saw an increase in their average salary shares from 2014 to 2024. This suggests that the rise in the average salary share for all physicians was not solely driven by the shift in the physician population away from ownership (Kane, 2025) and may instead reflect an increasing tendency among practices to use a combination of compensation methods.

Despite notable differences between owners and employed physicians, it is interesting that owners still drew a third of their income as salary. It is not uncommon in other industries for owners to draw a salary from their business, although the nature of an owner's "salary" likely differs from that of an employee. Therefore, as discussed earlier, while salary may provide financial stability and security for physicians (Scott, 2024), this assurance may not extend to those that are owners. Even more striking, a quarter of compensation for employed physicians is based on variable methods (productivity or practice financial performance), which suggests that employed physicians may not be entirely insulated from factors like RVUs and practice financial incentives.

It is worth noting that employed physicians in physician-owned and hospital-owned practices had similar compensation shares for productivity and salary. Although other research (Whaley et al., 2021b) shows that differences in compensation levels exist across practice ownership structure, the AMA Physician Practice Benchmark Survey data suggest compensation structure is influenced more by a physician's employment status (owner or employee) within the practice rather than the practice's ownership structure (physician-owned or hospital-owned) itself.

The increasing blend of these two methods suggests that a growing number of physicians may benefit from both the stability of a salary and the potential, albeit more modest, upside of their productivity.

Second, there were gender differences in compensation methods. Male compared to female physicians had a higher average share of income based on productivity (a difference of 8 percentage points for owners and 4 percentage points for employed physicians) and a lower share based on salary (a difference of 10 percentage points for owners and 4 percentage points for employed physicians). Existing research has demonstrated there are gender-based differences in physician earnings and, underlying that, access to resources and negotiation behaviors and outcomes (Whaley et al., 2021a; Bravender et al., 2020; Jena et al., 2016; Koempel et al., 2023; Holliday et al., 2014). This report does not speak to the dollar amount of income associated with each method, nor does it rule out the possibility that base salaries for male and female physicians are comparable. However, it does show that the compensation structure of male physicians offers a greater potential for higher earnings, particularly due to male physicians often having a larger productivity-based component in their income compared to their female counterparts.

Third, salary was an important driver of compensation across physician specialties. In almost all specialties, more than half of income (on average) was based on salary. Only orthopedic surgeons, ophthalmologists and physicians in other surgical subspecialties had more income based on productivity than salary. This is consistent with other reports that show surgical specialists tend to have higher median work RVUs (that quantify productivity) than other specialties (Medical Group Management Association, 2025) and primary care physicians tend to have lower shares of volume-based compensation than other physicians when it is included

in their compensation (Reid et al., 2022). This potential upside from productivity may also relate to the higher relative compensation for these specialties shown in other reports (McKenna, 2025; Doximity, 2025).

Lastly, compared to physicians in single-specialty practices, those in multispecialty practices had a higher share of income based on salary (a difference of 10 percentage points) and a lower share of income based on productivity (a difference of 5 percentage points).

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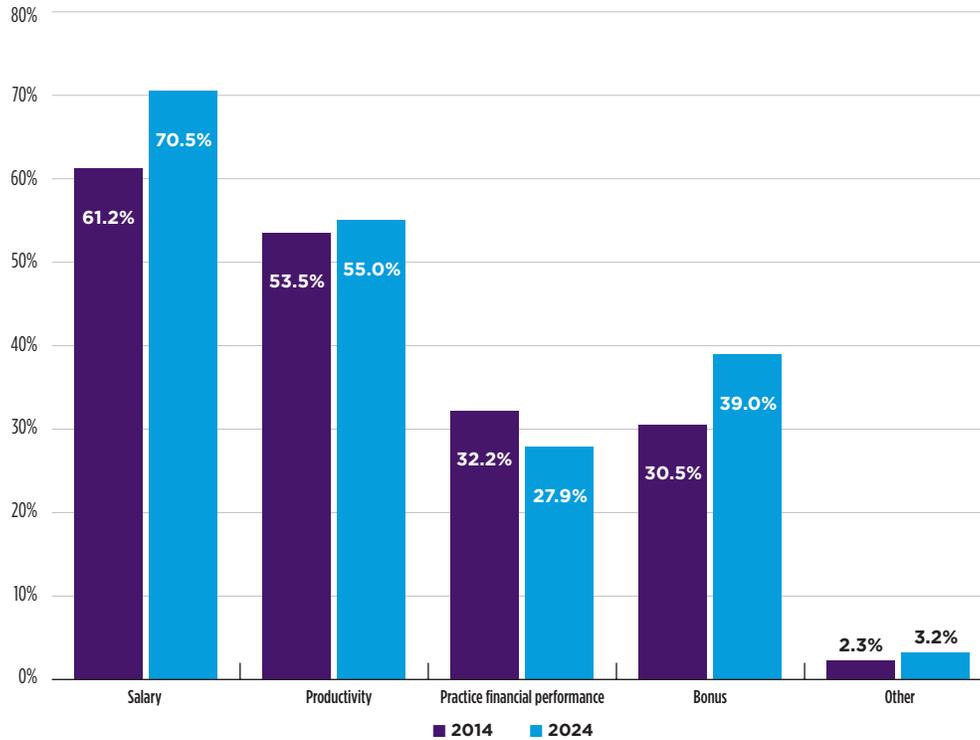
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Exhibits

Exhibit 1.

Percentage of physicians compensated by salary, productivity, practice financial performance and bonus (2014 and 2024)



Source: Based on 2014 and 2024 data from the AMA Physician Practice Benchmark Survey.

Note: Physicians in solo practices are excluded from the analysis.

Exhibit 2.

Distribution of physicians by number of compensation methods (2014 and 2024)

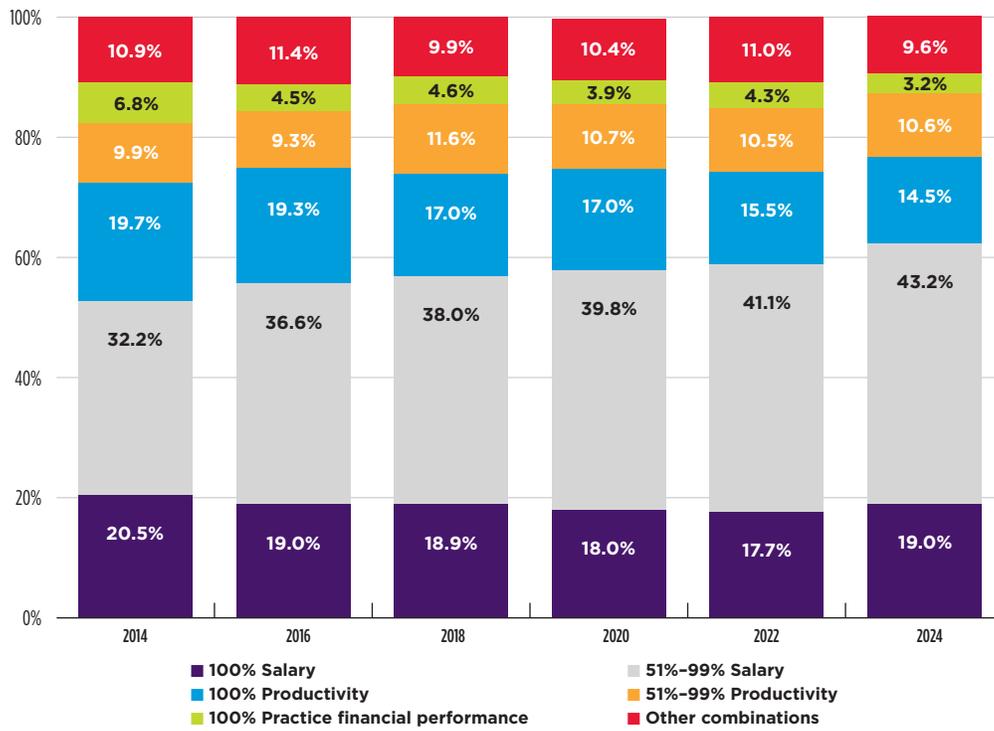
	2014	2024
1 Method	49.0%	39.2%
Salary	20.5%	19.0%
Productivity	19.7%	14.5%
Practice financial performance	6.8%	3.2%
All others	2.0%	2.5%
2 Methods	29.6%	34.3%
Salary and productivity	7.4%	10.1%
Salary and bonus	10.3%	13.4%
Productivity and practice financial performance	4.9%	3.8%
All other combinations	7.0%	7.0%
3+ Methods	21.5%	26.6%
Salary, productivity and bonus	5.0%	8.5%
Salary, productivity, practice financial performance and bonus	7.0%	8.0%
All other combinations	9.5%	10.1%
Total	100%	100%

Source: Based on 2014 and 2024 data from the AMA Physician Practice Benchmark Survey.

Notes: Physicians in solo practices are excluded from the analysis. Only combinations that had at least a 1 percentage point change are presented, the remaining are included in the "all others" or "all other combinations" categories.

Exhibit 3.

Distribution of physicians by primary compensation method (2014–2024)

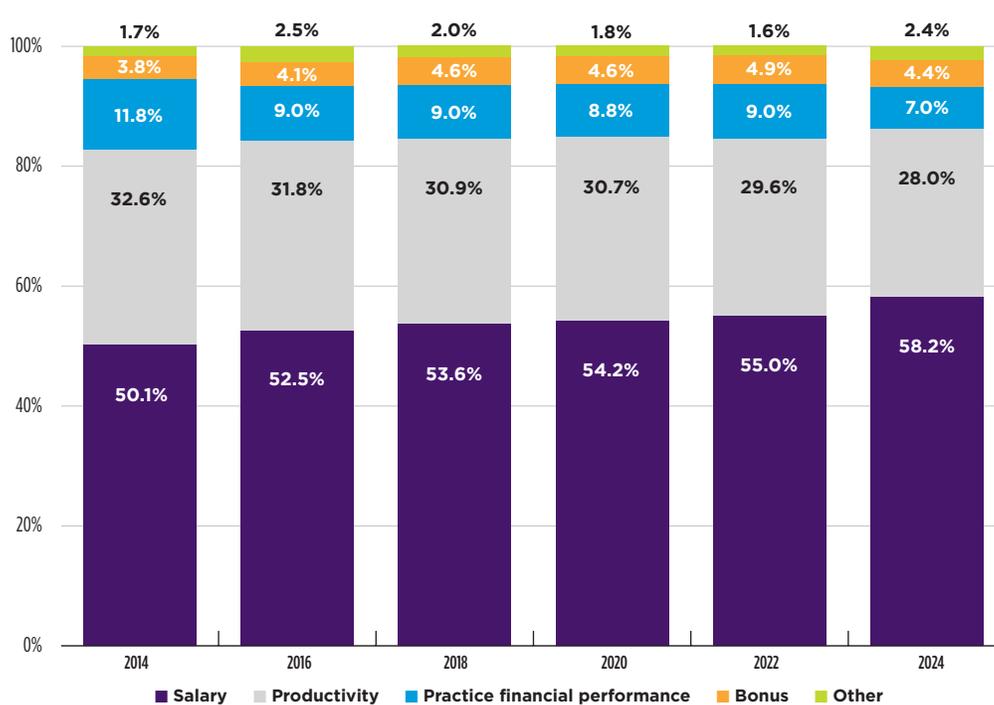


Source: Based on 2014–2024 data from the AMA Physician Practice Benchmark Survey.

Note: Physicians in solo practices are excluded from the analysis.

Exhibit 4.

Mean physician compensation shares (2014–2024)

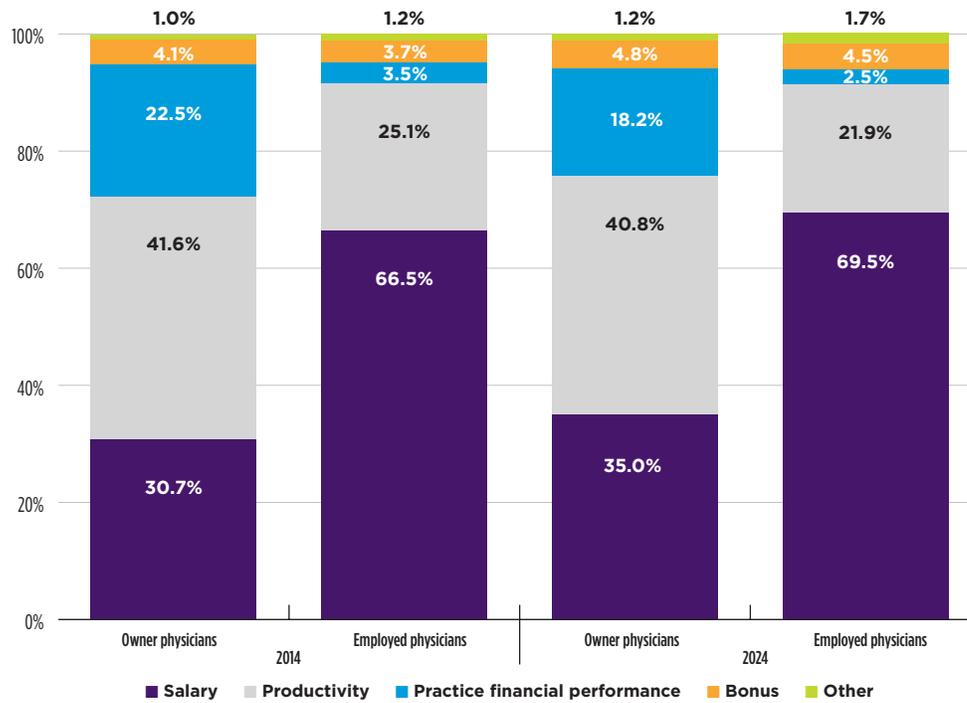


Source: Based on 2014–2024 data from the AMA Physician Practice Benchmark Survey.

Note: Physicians in solo practices are excluded from the analysis.

Exhibit 5.

Mean physician compensation shares by employment status (2014 and 2024)

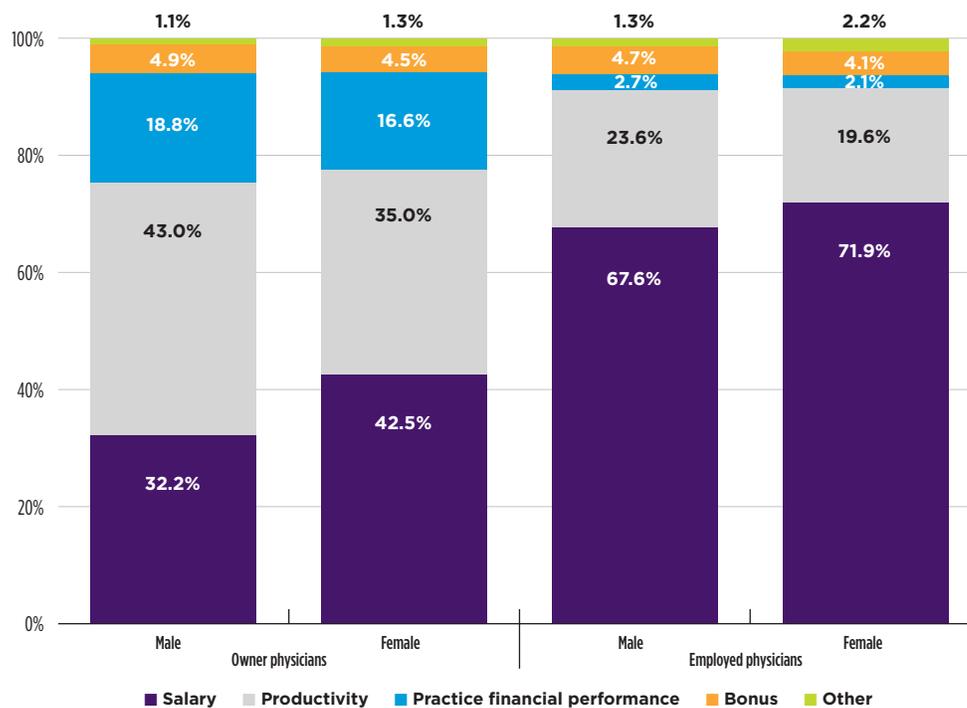


Source: Based on 2014 and 2024 data from the AMA Physician Practice Benchmark Survey.

Notes: Physicians in solo practices are excluded from the analysis. Independent contractors are not presented.

Exhibit 6.

Mean physician compensation shares by gender and employment status (2024)

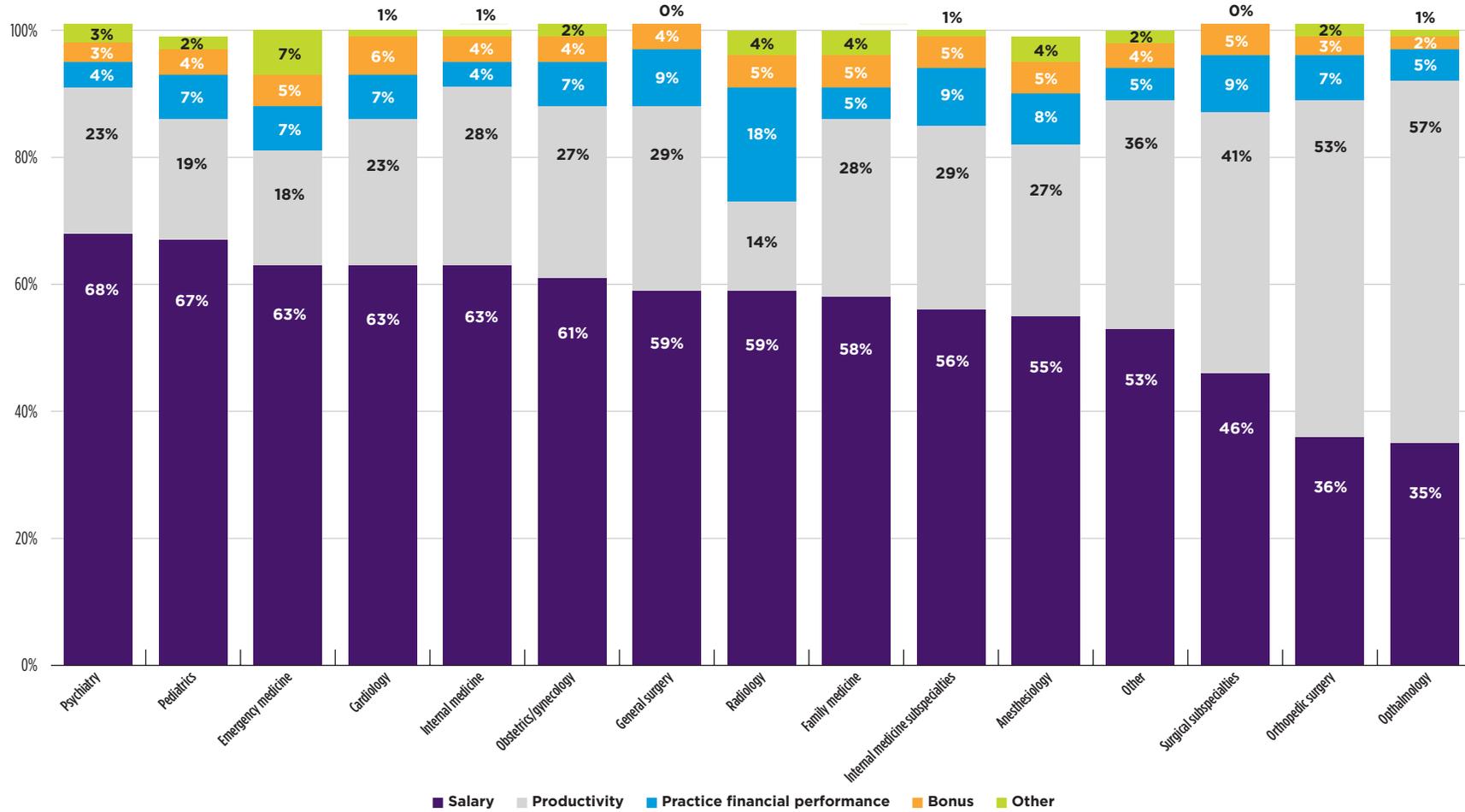


Source: Based on 2024 data from the AMA Physician Practice Benchmark Survey.

Note: Physicians in solo practices are excluded from the analysis.

Exhibit 7.

Mean physician compensation shares by specialty (2024)

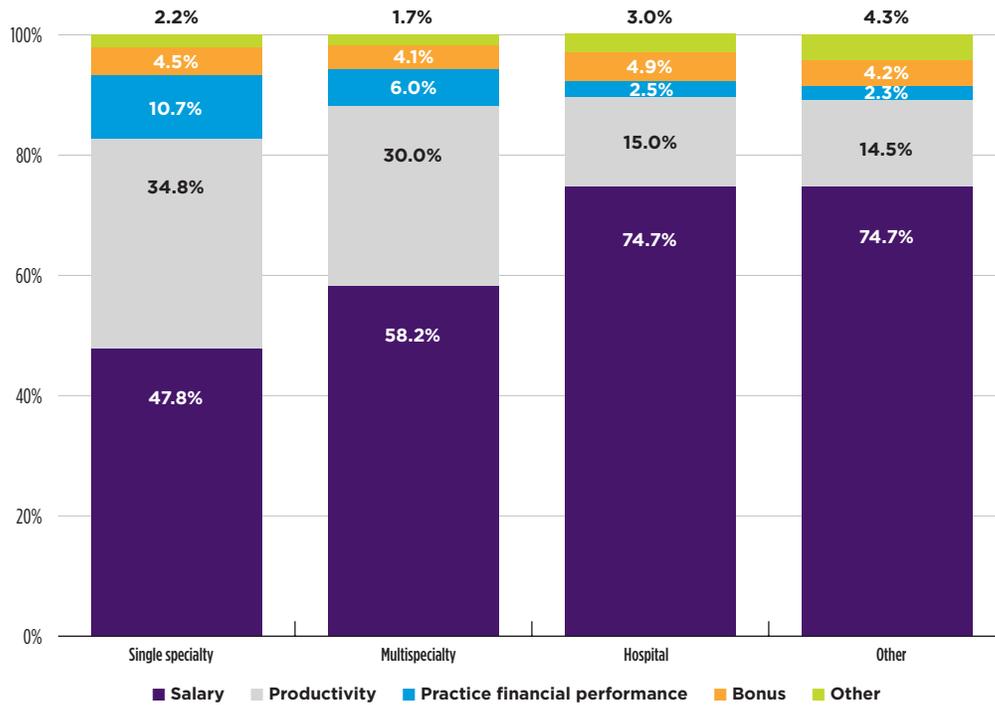


Source: Based on 2024 data from the AMA Physician Practice Benchmark Survey.

Note: Physicians in solo practices are excluded from the analysis.

Exhibit 8.

Mean physician compensation shares by practice type (2024)



Source: Based on 2024 data from the AMA Physician Practice Benchmark Survey.

Note: Physicians in solo practices are excluded from the analysis. "Hospital" includes physicians who were either employed directly by a hospital or who contracted directly with a hospital. "Other" includes physicians whose main practice was an ambulatory surgical center, urgent care facility, medical school, or some other type indicated by the survey respondents.

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