and look for ways to decrease it. Compulsive attention to it, however, is often a sign that more important aspects of the practice are being neglected.

Consider revenue, for example. More often than not, it is better to increase gross receipts than to decrease overhead. As a famous businessman once told me, "Your ability to cut costs is limited, but your ability to increase revenue is unlimited."

Negotiate better contracts with third-party payers. Improve collections, possibly with the credit card system I've discussed in several recent columns. Learn to code better and train your staff to do so as well. Use your time more efficiently. Don't worry so much about overhead. Would you rather keep 60% of $800,000 or 40% of $2 million?

I recently spoke with a prominent cosmetic dermatologist in New York City whose spa was bringing in a steady $1 million per year in revenue, but with 80% overhead. He was talking about closing it down because the overhead was too high! He didn't understand that his spa was making him money, regardless of the overhead percentage. By closing the spa, he would have traded a tidy profit of 20 cents on the dollar for zero cents on the dollar.

That's why you have to be careful when using percentage as a yardstick of your overhead. Overhead percentage doesn't reflect overhead; it reflects the ratio of overhead to revenue. Without looking at the numbers themselves, both revenue and overhead, you can get a distorted view.

Let's compare two hypothetical dermatology practices: One is primarily medical and the other is surgical. The medical practice has an overhead percentage of 60% and the surgical practice 40%, but in real dollars, their overheads are exactly the same. How can that be? Is one more efficient than the other? No, the difference is in total revenue; the surgical practice generates substantially higher gross receipts than does the medical practice. When the revenue goes up, the overhead percentage drops, even though the overhead in real dollars is the same. Once again, would you rather keep 60% of $800,000 or 40% of $2 million?

Don't get me wrong. Overhead is not something you should ignore, but neither should you obsess over it on a regular basis. You would be far better off seeing patients with that time. The incremental cost of seeing an additional patient is almost zero, and the revenue is almost pure profit, since you've already paid your overhead.

Concentrate on finding new ways to increase revenue or expand your practice, and your overhead will take care of itself. ■

DR. EASTERN *practices dermatology and dermatologic surgery in Belleville, N.J. To respond to this column, write Dr. Eastern at our editorial offices or e-mail him at sknews@elsevier.com.*

MedPAC Looks At Hospitalists' Recent Growth

WASHINGTON — The explosive growth of hospitalists has caught the notice of the Medicare Payment Advisory Commission, which advises Congress on cost, quality, and access issues affecting the federal health program.

The number of hospitalists has nearly doubled in the last 5 years and will rise to 24,000 in 2008, according to information presented by MedPAC staff at a recent meeting. Citing figures from the Society for Hospital Medicine, the staff said that 40% of Medicare beneficiaries will receive care from a hospitalist by 2010, which is double the current number.

The MedPAC staff and some of the commissioners expressed concern that the explosion of hospitalist care could increase Medicare's overall spending. According to the staff, hospitalists are usually compensated through a combination of fixed salary and volume-based bonus incentives.

Those volume-based incentives may be driving hospitalists to admit and consult more often, said Zach Gaumer, a MedPAC staff member—and currently, he continued, Medicare's payment system rewards volume, not quality and efficiency.

Hospitalists have shown that they can "create measurable efficiency gains," he said, citing a study that showed that patients treated by hospitalists had a shorter length of stay and lower costs than those who were looked after by a general internist or family physician (N. Engl. J. Med. 2007;357:2589-600). There seemed to be no impact, however, on mortality or readmissions, said Mr. Gaumer.

The consistent presence of a hospitalist, however, may improve patient safety and lead to quicker adoption of process-improvement initiatives, he added.

On balance, the collaboration between hospitals and physicians can be a plus for providers and patients, said MedPAC staff member Ann Mutti.

The commission should aim for Medicare incentives that encourage appropriate care and the right mix of care, she said.

—Alicia Ault