

WHITE PAPER

Anesthesiology Compensation:

**A Deep Dive into Market Dynamics,
Provider Complement, and
Strategic Considerations**

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Anesthesiology compensation is at an inflection point. An increasing demand for providers, rising private equity consolidation, evolving care delivery models, and shifting work expectations are reshaping how medical groups and health systems recruit, retain, and reward anesthesiologists and certified registered nurse anesthetists (CRNAs). Utilizing our unique proprietary access to one of the largest sources of national benchmarking data, we have outlined a comprehensive framework for evaluating, designing, and adjusting anesthesiology compensation programs that are both competitive and sustainable.

Current Market Environment

Anesthesiology has emerged as one of the most talked about specialties in the market. Demand continues to outpace supply, giving providers meaningful leverage and placing health systems under sustained pressure to maintain competitive total rewards offerings.

There is no shortage of headlines supported by industry surveys reflecting self-reported data. For example, in 2024 Medscape reported average compensation at \$472,000 in 2023, a 14% increase from \$405,000 the prior year.¹ By 2025, in comparison, the national AMGA Medical Group Compensation and Productivity Survey placed the median total clinical compensation (TCC) at \$536,320 in 2025, reflecting a 5.5% increase from 2024 and an average of 4.5% annual growth over the last three years. These gaps speak to mixed messages and a broader challenge in sourcing reliable compensation data with a robust sample size. Self-reported surveys capture what individuals report as earned, whereas organization-reported data reflect what organizations actually pay. This distinction matters considerably when evaluating year-over-year growth trends.

Work expectations in this specialty tend to be markedly different than other specialties,

AMGA National Compensation Survey Data: Anesthesiology			
TOTAL CLINICAL COMPENSATION			
SURVEY YEAR	N	50TH PERCENTILE	ANNUAL % CHANGE
2025	3,635	\$536,320	+5.5%
2024	3,391	\$508,406	+6.1%
2023	3,237	\$479,389	+2.0%
2022	2,754	\$470,124	+10.1%
COVID 2021	3,611	\$427,000	(8.3%)
2020	2,370	\$465,628	+6.7%

Source: AMGA National Compensation Survey. COVID-era years (2020–2022) shaded for context.

¹ Medscape. 2024. Medscape Physician Compensation Report 2024.
<https://www.medscape.com/sites/public/physician-comp/2024>

and site of service should be considered. Marit Health data indicate an average of 48 clinical hours per week and an above-average amount of paid time off (PTO) at roughly 7.5 weeks annually.² These findings match the AMGA survey data, which reflects 2,130 hours per year at median. The combination of long hours and generous PTO reflects market accommodation for a workforce that is integral to sustaining operations.

The Rise of Private Equity and Its Implications

No discussion of anesthesiology's market dynamics is complete without addressing the outsized role of private equity (PE). Significant PE consolidation across the specialty has occurred over the past decade, a trend with direct consequences for independent practices and hospital-employed groups alike. While the initial acquisition provides significant financial rewards to practice stakeholders, the long-term fallout is evident in retention and the now rising cost behind anesthesia services.

A 2020 study published in *JAMA Network* found that roughly 20% of anesthesia practices had been acquired through PE physician practice buyouts. By 2024, at least one major source had that share grow to approximately 33%.³ Dallas-based U.S. Anesthesia Partners (USAP), one of the largest PE-backed anesthesia platforms, now employs approximately 5,000 clinicians nationally. *Chicago Booth Review* published in 2025 that anesthesia prices rose 25% to 30% within two years of the uptick in PE acquisitions in the specialty.

The appeal of anesthesiology to PE investors is structural. Procedure volume has grown steadily for decades, profit margins are high, and the specialty has historically been more consolidated than others.⁴ However, the consequences for providers have been mixed. A 2021 investigation by *The Washington Post* found that USAP's physician turnover rate reached 17%, compared to an industry-wide average of roughly 7% for medical groups. In 2023, the same outlet reported that anesthesiologists at PE-backed groups were regularly expected to work 80+ hours per week, often with reduced compensation.

For medical groups and health systems competing for talent, PE's presence changes the market dynamics and increases the focus on profitability and volume. The ability to offer stable employment, reasonable workloads, and meaningful compensation, without the extractive pressures of a PE ownership model, can be a compelling differentiator in recruitment.

Anesthesiology Care Models and Coverage Complexity

Understanding compensation in anesthesiology requires a working knowledge of the care delivery models that highlights how services are billed and staffed. Three primary models are in use across the country, each with distinct implications for productivity, billing, and compensation design.

Medical Direction Model

Under the medical direction model, an anesthesiologist supervises up to four CRNAs simultaneously. Medicare splits payment and units 50/50 between the physician and the CRNA, which we do not see in other specialties with work RVUS (wRVUs). To qualify, the anesthesiologist must meet seven specific requirements including performing a pre-anesthesia examination, remaining available throughout the procedure, and

² Marit Health. 2025. <https://www.marithealth.com>

³ Private Equity's Place in Anesthesia. 2024. *Beckers ASC*.
<https://www.beckersasc.com/anesthesia/private-equitys-place-in-anesthesia/>

⁴ Private Equity Has a Grip on Anesthesiology – Here's Why. 2021. *Beckers ASC*.
<https://www.beckersasc.com/anesthesia/private-equity-has-a-grip-on-anesthesiology-heres-why/>

monitoring the patient at key clinical intervals. This model maximizes the anesthesiologist's supervisory reach while maintaining a collaborative team structure.

Medical Supervision Model

When a physician oversees more than four CRNAs or when any of the seven required steps noted above are not met, the arrangement falls into the medical supervision model. In this scenario, the anesthesiologist bills a reduced supervisory fee, typically three base units per case: a meaningful reduction in revenue relative to the direction model.

CRNA Solo "QZ" Model

In the CRNA-only or "QZ" model, the CRNA practices independently without physician direction and bills 100% of the anesthesia fee. This model is more prevalent in rural hospitals and in states that have opted out of the federal supervision requirement, a provision that now applies to a growing number of states. For organizations trying to determine how best to serve patients in these areas, the QZ model changes how they should think about hiring and paying doctors, given they have an alternative option in CRNAs.

Work Expectations and Call Structure

Work expectations are one of the most influential elements of an anesthesiology compensation arrangement. Call obligations, shift length, weekend coverage, and PTO policies all factor into a provider's assessment of the total value of an offer, and misalignment between stated and actual expectations is a leading driver of dissatisfaction and turnover.

The *AMGA 2025 Medical Group Compensation and Productivity Survey* establishes a useful baseline for anesthesiology work expectations at 2,130 hours per year at median, or 210 shifts at median, with a typical shift length of 10 hours. Again, consideration should be given to site of service (ambulatory surgical center, inpatient, etc.) and patient acuity (specialty coverage and/or trauma level).

Call participation has historically been a fundamental expectation of practicing anesthesiology, not the optional add-on that we are seeing in select contracts today. AMGA's survey data are based upon a 1.0 clinical FTE designation, which embeds a standard call rotation of one in four. In other words, compensation is inclusive of this level of call. When equal frequency of participation is not enforced, is considered "optional" and separately compensated, or is not clearly outlined in the contract, the burden of coverage resides with a smaller number of physicians. The results are disproportionate call responsibilities and participating providers seeking additional compensation.

Anecdotal sharing of compensation arrangements has led some to believe that pay for call should be above or in addition to an already competitive TCC. Marit Health survey data from September 2024 through March 2026 found that 74% of respondents carried call responsibilities, and MGMA's 2025 data report a median of 24 unpaid on-call hours per week. The takeaway for medical groups and health systems is that equitable call should be a defined condition of employment, built into work expectations from the onset. When everyone carries a fair share, the compensation benchmarks hold, the burden is manageable, and the perception of unpaid obligation largely disappears, leading to the right culture with the ability to recruit and retain.

Compensation Approaches

Three primary compensation structures are used in anesthesiology, each with distinct advantages and limitations depending on the practice setting, staffing model, and organizational goals.

Unit-Based (Productivity) Model

In the unit-based model, compensation aligns directly with clinical output as measured by American Society of Anesthesiologists (ASA) units. AMGA's longitudinal data show that median compensation per ASA unit reached \$49.05 in 2025, following an average annual growth rate of approximately 4.0% since 2019. It is pertinent for groups to consider their structure for care delivery, as we indicated earlier in this white paper. A physician operating under the medical direction model carries a risk of unsustainable compensation rates given the attribution of ASA units, which is shared as opposed to the either/or structure we see with advanced practice clinicians (APCs) and billed wRVUs.

Salary Plus Incentive Model

This model combines fixed base compensation with performance-based incentive pay tied to predetermined metrics. According to the AMGA national survey, incentive components most commonly include clinical quality and outcomes (85%), patient satisfaction (76%), citizenship behaviors (50%), and patient access (48%). This structure is well-suited to environments seeking to align physician behavior with system-level priorities and assumes a sufficient full time equivalent (FTE) complement to make equitable distribution of work feasible. The salary-based structure warrants that clarity on expected hours, inclusive of call, be set based on market data.

Shift-Based Coverage Model

The shift-based model is most common in hospital-employed and coverage-oriented settings. While intuitively straightforward, being compensated per shift as opposed to directly being paid on generated ASA units, this model requires careful alignment, as national benchmarking data on required annual shifts are limited, and coverage arrangements often do not lend themselves to a uniform shift rate across all coverage types.

Sample Impact of Compensation Under Medical Direction Model

Metric	Solo Anesthesiologist	Anesthesiologist Supervising 4 CRNAs
Rooms Covered	1	4
Cases per Day (Avg)*	4–5	16–20 (4–5 per CRNA)
Units per Case (Base + Time)*	10–11	10–11
Total Units per Day	~45–55	~180–220 (Combined)
Anesthesiologist's Billable Share	100%	50% of Rooms = 90–100 Units per Day
Annual Units (220 Workdays)	10,000–12,000	20,000–24,000
2025 AMGA Productivity Percentile	45th	90th
2025 AMGA Median Collections per ASA	\$46.23	\$46.23
Annual Billable Units	10,000	20,000
Gross Revenue	\$500K	\$1M
2025 AMGA Median Comp per ASA	\$49.05	\$49.05
Total Clinical Compensation	\$490,500	\$981,000
2025 AMGA Compensation Percentile	35th	99th

* Metrics provided by the American Anesthesiology Society.

AMGA CONSULTING FRAMEWORK

Key considerations for leaders evaluating compensation plans

1 ☐ Define the care model first

Care models are the primary driver of productivity variation in anesthesiology. A compensation plan built on unit-based benchmarks yields very different results across medical direction, medical supervision, and CRNA-only models. Ensure benchmark data reflect your specific model.

2 ☐ Use current, specialty-specific benchmarks

AMGA's National Compensation and Productivity Survey is updated annually with robust anesthesiology sample sizes. Using benchmarks more than one to two years old in this market risks misalignment.

25th %ile — \$462,602

Median — \$536,320

75th %ile — \$605,458

3 ☐ Account for total clinical compensation

Base pay alone is insufficient. Call pay, shift differentials, incentive compensation, and PTO policies all contribute meaningfully to a provider's total rewards package.

4 ☐ Anticipate private equity competition

PE-backed groups often lead with high initial base compensation. Providers may not discover workload and culture concerns until after joining. Articulate the stability, sustainability, and mission alignment of a health-system-employed model clearly in recruitment.

5 ☐ Model the financial impact of staffing decisions

Every staffing decision has a direct cost attached to it. Before making changes, build out the math.

Anesthesiology compensation is complicated and reflects a significant investment for medical groups and health systems. There are not enough providers to meet demand, private equity groups are aggressively recruiting, provider complements are shifting, and physicians know exactly what they are worth—and they have options. Organizations should proactively model compensation rates and ensure they are benchmarking all clinical compensation properly. Understanding the real cost of staffing decisions and setting clear and fair work expectations will position organizations to hire and retain providers successfully. ▲



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