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Original article

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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,

Virden, 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.

2014 PA Compensation Model

Data for the current study were collected in early 2015 with regard to 2014 compensation. The survey was emailed to 47,387 nonretired, U.S.-based PAs. Approximately 48% were AAPA members and the others were nonmembers. A total of 8,469 PAs took the survey as a result of the email campaign, yielding a campaign response rate of 17.9%. In addition to these respondents, the AAPA also recruited 1,725 participants through social media and web channels. For the current analyses, data were included if a respondent provided compensation data in addition to all the practice variables of interest, which included gender, total compensation (base salary as well as bonus for PAs who received a bonus), whether a bonus was received, specialty, hours worked per week, hours taking call per month, years working as a PA, number of patients seen per week, and experience with postgraduate clinical training. The analysis includes data from more than 6,100 of the 108,717 certified PAs in the United States who provided data for all the compensation and practice characteristics of interest.

Although the low response rate may be of concern to some researchers, the margin of error for the analyses represents a precision not achieved by most academic survey work: this sample consists of nearly 6% of the universe of PAs in the United States, as opposed to a relatively minute sample that is used to generalize conclusions to the U.S. population in most social science work. In addition, the data were cross-checked to ascertain representativeness by using larger sources of data from close to the entire universe of all U.S. PAs. This included data from the National Commission on Certification of Physician Assistants, as well as the BLS, both of which collect compensation data on PAs across the nation. The national mean salaries reported by AAPA, National Commission on Certification of Physician Assistants, and BLS are within $1,500 of each other, a difference to be expected given differences in methodology. The similarity of AAPA's dataset with National Commission on Certification of Physician Assistants' national database of PAs (Table 1), despite small differences in variables that change year over year (i.e., specialty), suggests that nonrespondents to the AAPA Salary Survey are not dissimilar from respondents. In situations when there is a low response rate but the respondents resemble the full population, low response is not detrimental to the generalizability of findings.

Extreme univariate outliers were deleted from the sample by removing values which were implausible given minimum wage guidelines in the National Commission on Certification of Physician Assistants. For example, a salary of $3,000 for a PA who reported working for an employer 40 hours per week in a nonvolunteer role for a full year is implausible given federal minimum wage laws, so these data were coded as missing for the analysis. In addition, values more than three standard deviations from the mean were removed from the analysis. Log transformations were considered for compensation data, but this did not substantially change or improve the distributions or predictive model, so for ease of interpretation, compensation data were analyzed in dollars. Descriptive statistics were computed for both the full sample and for full-time PAs (95.8% of the sample) only. For the compensation disparity models, an ordinary least-squares sequential regression analysis was run on the full sample of PAs, with the number of hours worked and whether a bonus was received included in the model.

Table 1
Comparison of AAPA and NCCPA Demographic and Practice Characteristics

	2015 AAPA Salary Report, 2014 Data	2015 NCCPA Statistical Profile of Certified PAs, 2012–2014 Data
Demographic characteristics		
Women (%)	67.2	66.6
Men (%)	32.8	33.4
Median age (y)	37.0	38.0
Asian (%)	4.1	5.1
Black/African American (%)	2.4	3.9
American Indian or Alaska Native (%)	0.3	0.5
Native Hawaiian or Other Pacific Islander (%)	0.2	0.4
White (%)	90.0	86.8
Other (includes ">2 races"; %)	3.0	3.3
Ethnicity – Hispanic (%)	4.3	6.0
Ethnicity – non-Hispanic (%)	95.7	94.0
Practice characteristics (%)		
Family practice	17.5	19.7
Internal medicine	14.0	12.7
Pediatrics	2.9	1.8
Surgery	26.5	21.6
Emergency medicine	9.0	13.8

Abbreviations: AAPA, American Academy of PAs; NCCPA, National Commission on Certification of Physician Assistants; PA, physician assistant.

Results

PA Total Compensation Disparity over Time

Using AAPA data from 1998 to 2014, the pay disparity was calculated as a ratio of mean and median total compensation of women compared with men (Table 2). Total compensation is calculated as total income including bonus (if received). Several findings became apparent regarding the magnitude and direction of the pay disparity over time. The data presented in Table 2 are not consumer price index adjusted so as to provide raw summary statistics for examination. Compensation for women and men retain their ratio whether these adjustments are made or not.

First, the compensation disparity between men and women in the PA profession is smaller than that of all workers on average. Median compensation for women across all fields in the United States is 77% (BLS, 2011), whereas the average disparity of median male and female PA total compensation over the last 17 years is 86.8% (Table 2). Second, disparities in total compensation for the 2 most recent years available have modestly improved over past years, with compensation in 2014 amounting to a greater ratio of female-male median compensation (%) than all previous years analyzed, with the exception of 2000 (Table 2). Although these improvements in the PA pay gap are promising, when the trajectories of compensation of men and women over time for the full 17-year period are considered, the disparity, on average, is not closing. Using the period of 1998 to 2014 to develop and analyze a trend line for compensation in the PA profession, the median total compensation for male PAs increased on average $2,798 per year versus $2,412 for women, indicating that the gap is not lessening. This figure considers the trajectory over time; figures in Table 2 allow for yearly percentage increase calculations for male and female PAs. This is consistent with recent findings that indicate the gap among physicians is not closing (Lo Sasso, Richards, Chou, & Gerber, 2011). Once more data are available, future iterations of these analyses should consider the period from 2012 forward, in comparison with previous years.

Table 2
Mean and Median Total Compensation over Time for Full-Time Clinically Practicing PAs[*]

Year	N	All PAs		Male PAs		Female PAs		Disparity (Female/Male) (%)	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median
1998	15,841	64,159	62,500	68,228	67,500	59,625	57,500	87.39	85.19
1999	17,866	65,484	62,500	71,785	67,500	59,548	57,500	82.95	85.19
2000	19,135	65,791	62,500	72,418	67,500	60,064	62,500	82.94	92.59
2001	19,786	68,751	67,500	76,209	72,500	62,594	62,500	82.13	86.21
2002	19,745	70,143	67,500	77,453	72,500	64,726	62,500	83.57	86.21
2003	20,646	76,100	72,500	82,765	77,500	70,657	67,500	85.37	87.10
2004	23,494	78,280	72,500	85,513	82,500	72,715	72,500	85.03	87.88
2005	22,502	81,127	77,500	88,427	82,500	75,832	72,500	85.76	87.88
2006	23,436	84,879	82,500	93,295	87,500	78,821	77,500	84.49	88.57
2007	26,192	86,678	82,500	95,115	92,500	81,034	77,500	85.20	83.78
2008	27,568	90,284	85,888	99,179	94,813	84,584	81,490	85.28	85.95
2009	19,608	88,503	87,500	100,671	97,500	81,877	82,500	81.33	84.62
2010	19,830	93,172	90,000	103,882	100,000	86,876	85,000	83.63	85.00
2012	18,935	98,504	94,000	108,577	103,000	93,417	90,000	86.04	87.38
2014	6,164	102,854	97,000	113,231	106,000	97,839	94,000	86.41	88.68

Abbreviation: PA, physician assistant.

   [*] Data from 2011 and 2013 not available. Total compensation in these data sources is defined as total income, including base salary and bonus (if received). Data from 2014 in Table 2 are slightly different from 2014 data in Table 4 because Table 2 only reflects full-time clinically practicing PA salaries. In addition, Ns reflect the number of respondents who provided responses to the variables required to perform the analysis.

PA Compensation in 2014

Respondents to the survey were two-thirds women (67%), averaged 37.6 years of age, and predominantly Caucasian (87.1%). Of those PAs, all respondents who provided a response on all variables of interest were included in the model, making the sample 6,164 PAs. In terms of total compensation for 2014 among PAs in the United States, without controlling for any other factors, there was a disparity such that female PAs were compensated at 85.6% of the rate of male PAs ($96,898 vs. $113,157), $t(6122) = 22.03$, $p < .001$ (Table 2). A follow-up, nonparametric Mann–Whitney U test, which is less sensitive to non-normal data such as salary distributions, confirmed significant differences between the compensation distributions of male and female PAs ($U = 350.24$; $p < .001$). In terms of mean compensation, men saw more patients per week (67.29 vs. 61.96), $t(6122) = 5.30$, $p < .001$. Men also worked more hours per week (44.82 vs. 43.20), $t(6122) = 6.39$, $p < .001$, and had been PAs longer than women (11.28 years vs. 7.28 years), $t(6122) = 17.39$, $p < .001$ (see Table 3). Among both full-time and part-time PAs, men were also more likely than women to receive a bonus (58.1% vs. 52.1%; $\chi^2 = 18.02$; $p < .001$) and those bonuses were larger on average (Table 4).

Total Compensation Regression Models

Several workplace and practice variables contribute to the prediction of PA salary and compensation. Among these, years of experience, hours worked weekly, specialty, postgraduate clinical training, number of patients seen weekly, and hours taking call were all found to be significantly related to total compensation (Table 2). Sequential regression was used to determine whether the gender of a PA improved prediction of total compensation beyond these practice variables. All co-efficients are in relation to PAs in primary care. Table 5 displays the means, unstandardized regression coefficients (B), as well as R and R^2 values before and after including gender in the equation. The included regression coefficients display the relationship between variables in dollars.

PAs in each specialty area earned significantly more than PAs in primary care and, as would be expected, PAs who worked more hours per week (full-time and part-time PAs were included in the models, but hours worked were controlled for), took more hours of call, saw more patients, and/or had postgraduate training earned more on average (see unstandardized co-efficients in Table 5 for dollar amounts). The R^2 was significantly different from zero at the end of the first step of modeling, indicating that around 24% of the variance in compensation is predicted by practice characteristics.

With practice variables in the regression equation at step 1, $R^2 = 0.24$, $F_{inc}(11, 6152) = 178.87$, $p < .001$. When all variables other than gender are controlled for using hierarchical regression analysis, a disparity in total compensation still exists between male and female PAs of $9,695; the adjusted R^2 value (an indicator of goodness of fit) is 0.27, $F_{inc}(1, 6151) = 228.52$, $p < .001$. The $9,695 difference in total compensation between male and female PAs represents approximately 9.5% of the national mean total compensation. For reference, the magnitude of

Table 3
2014 Practice Characteristics for Full-Time and Part-Time PAs

Characteristic	Men	Women	All PAs	Sig.
Hours per week at PCE	44.83	43.20	43.72	<.001
Hours taking call per month	40.71	32.17	34.91	<.001
Patients per week	67.29	61.96	63.67	<.001
Postgraduate clinical training	23.3%	12.6%	16.0%	<.001
Full-time PA (≥32 h/wk)	97.2%	95.1%	95.8%	<.001

Abbreviations: PA, physician assistant; PCE, primary clinical employer.

Table 4
2014 Mean Total Compensation for Full-Time and Part-Time PAs (Not Controlling Practice Variables)

Compensation	Men ($)	Women ($)	All PAs ($)	Sig.
Salary	104,715	92,318	96,275	<.001
Bonus	14,892	8,945	11,001	<.001
Total compensation	113,157	96,898	102,115	<.001
Percent receiving bonus	58.1	52.1	54.03	<.001

Abbreviation: PA, physician assistant.

Table 5
Regression Analysis of PA Total Compensation among Full-Time and Part-Time PAs

Step	Variables	Coefficient (B)	Standard Error	R	R²
1	Specialty: Internal medicine	5,349.28	1,015.16***		
	Specialty: Pediatrics	4,964.99	2,477.94**		
	Specialty: Surgery	12,530.50	793.65***		
	Specialty: Emergency medicine	17,231.96	1,500.10***		
	Specialty: Other	9,416.58	822.43***		
	Total years working as a PA	910.64	34.91***		
	Hours worked per week for PCE	336.93	31.93***		
	Experience with postgraduate clinical training	2,028.05	803.22***		
	Hours per month taking call	18.79	3.78***		
	Receive a bonus	9,419.41	587.21***		
	Patients seen per week at PCE	58.42	8.22***	0.49	0.24***
2	Gender: Men	9,695.43	641.36***	0.52	0.27***

Abbreviations: PA, physician assistant; PCE, primary clinical employer.
After Step 2 of the ordinary least-squares sequential regression, 27% of the variance in compensation data is accounted for. **$p < .01$, ***$p < .001$.

the disparity is not trivial; it is only slightly less than the bonus a typical PA receives in a given year (Table 4).

Discussion

Longitudinal data from the last two decades illuminated the historical trends of the gender pay gap in the PA profession. A consistent compensation disparity existed; the median total compensation for female PAs has consistently been around 87% of that of male PAs over the past 17 years. Although the historical trend indicates the gap is not closing, and this is consistent just as with physician compensation (Lo Sasso et al., 2011), for the most recent 2 years for which data are available (2012 and 2014), female PAs' median and mean compensation were higher as a percentage of male PAs' median and mean compensation. A recent report on 2015 compensation and benefits data from AAPA seems to indicate that this was not an anomaly; 2015 compensation data were similar in terms of the salary disparity to 2014 and 2012 data (AAPA, 2016). It is important to continue monitoring these data in the next several years. More data are necessary to determine whether the shift in the pay gap in the past several years (2012, 2014, and 2015) is indicative that the gap is beginning to close. The past 3 years of compensation data may indicate that the gap is beginning to close; however, it may be a mere shift that lessened the disparity without an overall trend toward closing the gap.

The 2014 total compensation model confirms past research findings that there is a gender disparity in terms of PA compensation in the United States, and this is true not only for base salary as shown in previous work, but also when considering additional compensation such as bonuses. Without controlling for practice differences, female PAs are compensated $16,052 less than male PAs (Table 2). The measured variables account for more than $6,300 of the overall mean compensation. There remains almost $9,700 difference in the mean overall total compensation that can still not be explained, and future iterations of this model should examine other variables that may explain these differences, to the extent that they have been measured. The model predicts that with all other practice variables identical, male PAs will be paid $9,695 more than female PAs (Table 3). For reference, in 2014 the mean compensation was $102,081 (Table 2). These findings of absolute

compensation disparities supplement those of a large scale BLS data analysis, which found that, on average, employers report compensating female PAs at 81% of the amount of their male counterparts (BLS, 2016). As research presented in the introduction shows, similar disparities have existed across time as well as across professions.

Limitations and Future Directions

Although the sample of this study is generally representative of the universe of PAs in the United States, and salary distributions mirror those of much larger samples of PAs, this study only has an approximate 18% response rate, and that is worth noting; it does not seem that our salary data is substantially different from national databases of PA compensation despite this limitation. Like most studies that have identified significant gender differences in compensation, no post hoc analysis of compensation data can definitively attribute differences in salary to gender-based discrimination. Although studies by social psychologists show that women who have identical qualifications as men are rated as less competent and hirable (Moss-Racusin, Dovidio, Brescoll, Graham, & Handelsman, 2012), the present analysis cannot conclude with certainty that the remaining disparity is due to discrimination, because the current disparity could also be related, in part, to other unmeasured variables. Although we have included a number of variables to account for differences in practice conditions and experience, an additional variable that could be considered in future research is the degree to which individuals have taken extended leaves of absence, such as time off to care for infants or the elderly, which may affect compensation levels and may be more common in female PAs than male PAs. Future work should examine this variable in addition to the others reported on in this study.

Implications for Practice and/or Policy

The Role of the Employee

Researchers have noted that women, generally speaking, do not negotiate their salary as frequently as men (e.g., Babcock & Laschever, 2009; Small, Gelfand, Babcock, & Gettman, 2007). Leibbrandt and List (2012) conducted a large-scale field study and found that men were more likely to negotiate their salary when it is unclear if there is room for negotiation; however, when it is clear that there is room for negotiation, women were just as likely to negotiate. One way to remediate wage inequalities is for women, as well as men, to always assume that salary is negotiable unless stated otherwise. Educational programs for PAs focus on the hard skills needed to be a successful PA. Training on the soft skills—such as contracts and negotiations—would also benefit all PAs, which may set them up for a successful career. When entering into contract negotiations, it is important for candidates to be aware of salary ranges for position-based factors such as experience, location, specialty, and employer, as well as knowing the value they bring to the profession. This knowledge is particularly crucial in the PA profession, where position-specific details directly impact many facets of compensation.

The Role of the Employer

In addition to fostering an open and transparent recruitment process, employer-initiated remedies for pay inequality can take

many forms. To begin, employers may provide training to those who make hiring and compensation decisions. This training may address not only fair compensation practices, but also assigned responsibilities, performance reviews, and promotions, to name a few.

The current wage gap would be impacted if employers placed less emphasis on the past salaries of job candidates. Rather than deriving the position salary from the past salary of an applicant, employers may instill greater compensation equity by setting compensation based on the current market, as well as the job responsibilities and expectations. Given that the wage gap in the United States is well-documented, women are more likely to be disadvantaged if previous salary is a significant factor in determining the offered salary, and this may very well perpetuate and augment the wage gap.

Some employers have attempted to eliminate salary negotiation completely to avoid disproportionate effects on women. Employers should be clear whether there is room for open negotiation when offering a salary, including policies for future salary adjustments and negotiations; this may move women to closer to equal footing in terms of likelihood of negotiating a salary.

Another solution to wage disparities is for employers to provide compensation transparency; many publicly funded organizations provide a level of transparency as they seek public accountability, allowing for checks and balances against possible bias. With a profession that has more variance than similarities among individuals with the same title, it is difficult to know what skills each PA holds, and how each skill is valued by their organization. Compensation transparency may be problematic when differences in compensation between employees are known, but legitimate reasons such as skill and experience are not apparent.

Finally, some institutions, such as the U.S. federal government, use a standardized compensation structure to encourage equitable pay. Unfortunately, pay bands may limit compensation growth and offer no incentive for going above general expectations, and there may be little opportunity to recognize employees who seek additional skills. As a result, employers may retain poor- to average-performing employees and lose high-achieving ones. Although this is not used between organizations, it may be a compensation strategy that is used within organizations to ensure that there is equity within roles.

The Role of Professional Associations

Professional associations may advocate for policies that support equal wages and opportunities regardless of personal characteristics; some organizations are taking small steps to call attention to existing disparities. AAPA, for example, has adopted the following policy: "AAPA believes in gender based equity in income for PAs having comparable responsibilities within the same specialty. AAPA encourages research on gender based disparities in income." Associations may offer training and other assistance to individual members, as well as to employers. This assistance may be in the form of helping parties to understand sources of disparities and steps that can be taken to remedy them. They may even provide recognition to employers who make significant progress toward, or achieve, gender wage equity. As part of their advocacy work, associations should continue to monitor and report on the status of the gender wage disparity within the profession they represent.

Conclusion

Four male medical generalists focused on primary care started the PA profession in 1967. Although the PA profession began with a male-dominated, primary care focus, it has developed into a female-dominated profession, with PAs practicing across every medical and surgical specialty and setting. With these changes, there remains the need to ensure pay equality between female and male PAs. Even when compensation-relevant factors such as years of experience as a PA, hours worked, specialty, training, region, and call hours are controlled for, there remains a significant difference in total compensation of male and female PAs. Although the gap decreased over the last several years, compared with earlier in the 2000s and throughout the 1990s, the median compensation in the PA profession for women is still only about 86% of that of men. Employees, employers, and professional associations should consider ways to proactively eliminate disparities unrelated to experience and practice-level characteristics.

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