

Engaging physicians to transform operational and clinical performance

Health systems (and health plans) that are serious about transforming themselves must harness the energy of their physicians. To do so, they must develop a true ability to engage physicians effectively.

A confluence of events is advancing a “total cost of care” savings agenda in the US healthcare industry. Although the rate of growth in our healthcare spending has slowed in recent years, expenditures continue to rise. The United States now devotes almost 18 percent of its GDP—more than one in every six dollars earned—to healthcare.

A step change in operational and clinical performance across the healthcare value chain is needed. This transformation requires robust leadership, and much of that leadership must come from clinicians, especially physicians. Not only do physicians make many of the frontline decisions that determine the quality and efficiency of care, but they also have the technical knowledge to help make sound strategic choices about longer-term patterns of service delivery. Without physician engagement, even near-perfect execution on operational efficiency and utilization management will be insufficient to drive the necessary level of change and will never truly be sustainable. Thus, the active participation of physicians throughout the healthcare value chain, from individual practices to the national level, is mandatory for any provider or payor that wants to eliminate unnecessary costs or capture value from innovative partnerships (e.g., by reducing clinical variability and strengthening care coordination across settings).

To achieve a high level of engagement, both providers and payors must understand physicians’ attitudes about healthcare delivery and how those attitudes compare with their own goals and perspectives. To this end, McKinsey surveyed more than 1,400 US physicians from a range of geographies and specialties (including primary care, internal medicine subspecialties, and surgery) about a number of topics, such as readiness for reform, waste and inefficiency in healthcare, employment and alignment models, and financial risk sharing. We also conducted follow-up interviews with a subset of these physicians to understand underlying drivers and mind-sets. The survey builds on insights we developed leading large-scale clinical operations programs at more than 100 US hospitals; during those programs, we were able to find effective ways of engaging physicians to achieve sustainable improvements in the cost and quality of clinical care.¹

The survey enabled us to identify four key barriers to strong physician engagement in performance transformation: First, many physicians say that they feel overwhelmed and ill-equipped to implement change, and they appear to have a limited understanding of how their behavior contributes to healthcare waste and inefficiency. Second, too many providers and payors are focusing only on employment as a way to drive physician

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¹For more information about this type of program, see the accompanying article, “Clinical operations excellence: unlocking the potential within each hospital,” on p. 17.



Of course I care about costs. And I know I need to be careful about where I send my patients. I don't know a single doctor who isn't trying to figure out how to be more efficient, or how to be better coordinated for our patients. I guess I'm just not sure exactly what it is that I would change about my day-to-day work to do that.

—Primary care physician

alignment, instead of taking a holistic approach that combines multiple alignment levers. Third, too often these organizations over-weight the importance of compensation as a way to influence physician behaviors. Fourth, physicians' poor understanding of risk-based payment models, in combination with their risk aversion, is limiting the penetration of these models and their potential ability to drive higher-value care.

Health systems and health plans that want to deliver more cost-effective care must find ways to overcome these barriers. Both the survey results and our experience with clinical transformation programs suggest that many physicians are not only willing to change, but also excited at the possibility of leading transformation efforts. Providers and payors must therefore develop a true capability in physician engagement—something that is much broader than, and does not necessarily have to include, employment. They must also incorporate a wide range of levers in their

engagement strategies so that they can tailor their efforts to different types of physicians. In addition, providers and payors must think carefully about how they use risk-based models (a critical tool for aligning physician incentives with cost-reducing objectives) to encourage behavioral change.

Physician attitudes: A broad view

Our survey revealed a fundamental disconnect between what most physicians think they should be doing in light of health reform and what they have already started to do (voluntarily or in concert with a health system or health plan). For example, more than 70 percent of physicians surveyed believe that, within the next three years, they will need to make significant changes to their clinical practices. Seventy-two percent of the respondents said that, within that time frame, they are likely to make greater use of evidence-based medicine (EBM); 74 percent predicted that their tracking

EXHIBIT 1 Physicians express a strong willingness to change to remove waste from the health system

% of respondents very willing or completely willing to change their practices to affect the drivers of waste and inefficiency, by type of waste¹



¹How willing are you to make changes in your own decisions and actions or collaborate to change other physicians' practices to affect these potential factors of healthcare waste and inefficiency? (n = 1,194–1,372, depending on factors, blanks removed).

Source: 2011 McKinsey Physician Survey

and reporting of quality and outcomes metrics would increase; and 75 percent thought that their referral practices for diagnostics, specialists, and admissions would change. In addition, 77 percent of the respondents said that they expected to be involved in more aggressive cost-saving efforts, and 74 percent thought that they were likely to change the insurance types accepted by their practices.

Furthermore, 84 percent of the physicians surveyed said they are completely or very willing to make changes in their own decisions and actions, or to collaborate to change other physicians' practices, if doing so would affect at least one of ten potential sources of health-care waste and inefficiency. These sources of waste include avoidable utilization, clinical decision variability, and ineffective discharge practices (Exhibit 1).²

Despite their willingness to change and their expectation that change was imminent, few of the physicians surveyed said that they had

already made substantive modifications to their practices to prepare for the post-reform environment. Fewer than 10 percent of the respondents reported having altered their referral patterns or the insurance types they accepted. Only 17 percent had initiated cost-saving initiatives, and only about 20 percent had increased their use of EBM or their tracking of quality metrics (Exhibit 2).

Why has so little been done, if physicians understand the need to change and express a high degree of willingness to do so? Part of the answer appears to lie within physicians themselves, but the other part seems to lie with health systems and health plans—they are not engaging physicians as effectively as they could. The following four factors appear to be the key barriers to clinically led transformation.

Physicians' attitudes and capabilities

Our survey showed that there is significant room to improve physicians' perception of their own

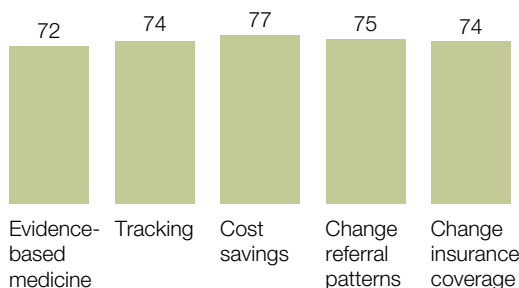


No one teaches you about cost containment; you have to figure that out for yourself when they start complaining that you are ordering too many tests or admitting too many patients. I actually think a lot of doctors would be shocked at how much it costs for them to treat a patient. We don't even look at the numbers—we're not responsible for them. It's very easy for me to order a bunch of tests if I have no idea what they cost.
—Orthopedic surgeon

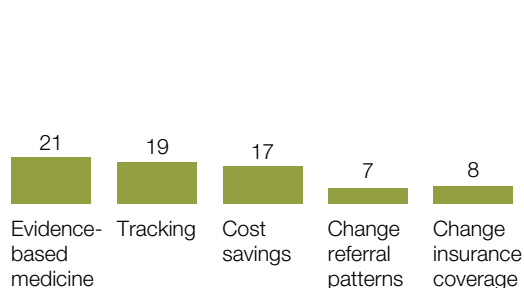
EXHIBIT 2 Although physicians recognize that change is coming, very few have taken steps yet to prepare for reform

% of respondents who said that

They are somewhat or very likely to change¹



They have already taken these measures²



¹How will your practice respond to the impact of healthcare reform? Please indicate your likelihood to prepare for healthcare reform in each of the following ways within the next three years (n = 1,402).

Source: 2011 McKinsey Physician Survey

²Follow-up interviews using controlled questioning indicated that social desirability did not appear to strongly influence the pattern of responses we observed. In other words, the physicians were not simply saying they were willing to change because they believed that that was the socially acceptable response.



For me to even consider employment, I would need to still keep some sort of control over how I spend my time, the way I see patients, how many patients I see, how many tests I order. I don't know if this would be part of the conversation or if they would even want that. That's definitely what I would want.

—Primary care physician

ability to control waste and inefficiency. For example, less than one-third of the respondents thought they had substantial control over “inappropriate venue” as a source of waste (Exhibit 3).³ Another third of the respondents felt they had only limited control over this factor. The physicians’ belief in their ability to influence other sources of waste was somewhat stronger. Nevertheless, 25 percent of the respondents thought that they had no control over clinical variability (e.g., in physician orders and pharmaceutical/medical device use), and 18 percent felt the same about avoidable utilization (such as unnecessary diagnostics and consultations).

In follow-up interviews with physicians, we explored the underlying drivers for this perceived lack of control over the sources of waste. Some physicians said that they had limited insight into how their day-to-day clinical decisions might translate into inefficiencies in care delivery, and that they had not been trained to understand the financial conse-

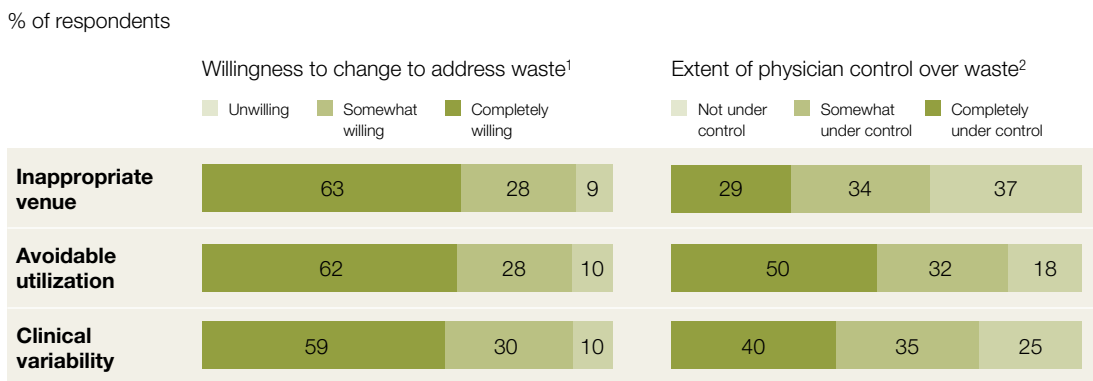
quences of their decisions for patients or the health system overall. Other physicians reported feeling ill-equipped to implement the changes they know they need to make, which often require system-level modifications.

Employment-centric approaches to physician alignment

In our experience, many health systems have used employment as their main method for increasing physician alignment, and the physicians we surveyed expect this trend to accelerate. Among the respondents, 56 percent of those not already employed by hospitals believe that they are likely to be employed or formally aligned with a hospital (for example, through a foundation model⁴ or other mechanism) within the next three years.

However, many physicians do not view employment as their preferred way of working. In fact, 47 percent of the respondents currently employed by hospitals said that they would rather be in private practice. Physician preference for other

EXHIBIT 3 **Despite their stated willingness to change, physicians do not perceive waste as being largely under their control**



³The examples we gave of inappropriate venues included avoidable emergency room utilization and unnecessary inpatient admissions.

⁴A foundation model is a corporation, usually not-for-profit, that is either a subsidiary of a hospital or an affiliate with a common parent organization. The foundation owns and operates practices, including facilities, equipment, and supplies. The foundation employs all non-physician personnel and contracts with a physician-owned entity to provide medical services for the practice.

¹What degree of control do you feel physicians as a whole have over the following factors which may contribute to healthcare waste and inefficiency? (n = 1,402).

²How willing are you to make changes in your own decisions and actions or collaborate to change other physicians’ practices to affect these potential factors of healthcare waste and inefficiency? (n = 1,402).

Source: 2011 McKinsey Physician Survey

models appears to be driven largely by their perception that compensation, clinical autonomy, and, in particular, personal autonomy are higher in a private-practice setting than in a hospital or health insurance company (Exhibit 4).

An additional problem for health systems and health plans is that physician employment does not automatically translate into engaged physicians who are aligned with the clinical and business model success of their affiliated organization. Our survey showed, for example, that employed physicians are significantly less willing to change their practices to reduce medical device use variability than are non-employed physicians in multispecialty, large group practices. This difference was particularly marked among cardiologists, a core target for physician group acquisitions in recent years: in our survey, only 63 percent of hospital-employed cardiologists expressed willingness to change medical device use, compared with 78 percent of cardiologists

in multispecialty practices. Thus, there appears to be a fundamental disconnect between the goals of a health system or plan and its often singular pursuit of employment.

Excessive focus on compensation

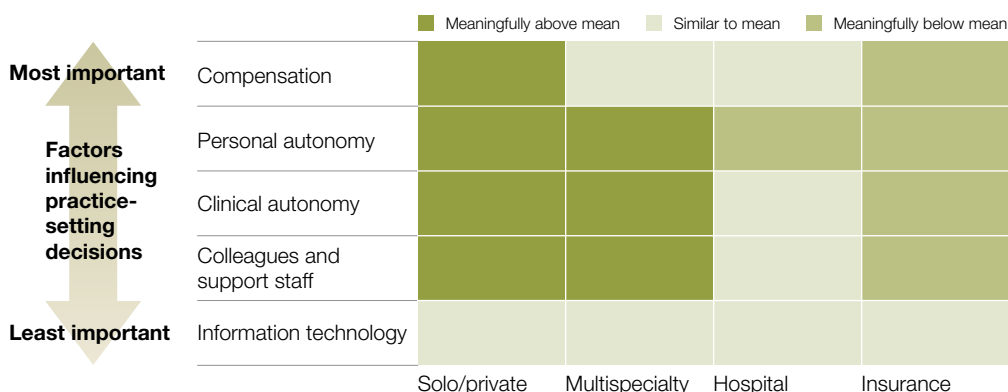
In addition to physician employment, the other element most health systems and health plans have focused on heavily to increase physician engagement is compensation. Although most physicians do rank compensation first among the factors that would influence their behavior, they do not believe it outweighs everything else. In our survey, we asked respondents to allocate 100 points among several factors that might convince them to change their practice or collaborate with others to reduce waste and inefficiency. Compensation received an aggregate score of only 29 (Exhibit 5). In other words, training and capability building, constructive feedback, effective communication, and strong role modeling by physician leaders were jointly allocated more than 70 percent of the points.



Financial incentives aren't necessarily number one and personal choice, number two. I would be willing to take less money to have more choice and more time to spend with my family.
 —Orthopedic surgeon

EXHIBIT 4 Physicians expect that they will face difficult personal and professional trade-offs when considering employment

Physician perception of practice settings^{1,2}



¹Which of the following best describes your current practice/employment? (non-hospital-employed only: n = 1,012)

²Top box summary: How much would you agree that the following dimension describes each practice?

Source: 2011 McKinsey Physician Survey



Risk sharing is the way to change the way we practice. We need to be compensated for doing the right thing, not just for seeing more patients. You have to link who is making the decisions with who has to pay. Right now, the insurance companies and hospitals are paying, but the doctors are making the decisions.

—Cardiologist

Limited penetration of risk-based payment models

Our survey suggests that risk-based payment models such as bundled payments can help drive changes in physician behavior. For

example, the respondents who said that they are already participating in risk-based models were twice as likely to report having increased their focus on EBM, performance tracking, and cost-reducing interventions than were the

EXHIBIT 5 Although compensation is the most important factor in deciding where to practice, other levers account for >70% of what influences physicians

Importance of factors when making practice employment decisions¹

Relative importance, out of 100 points

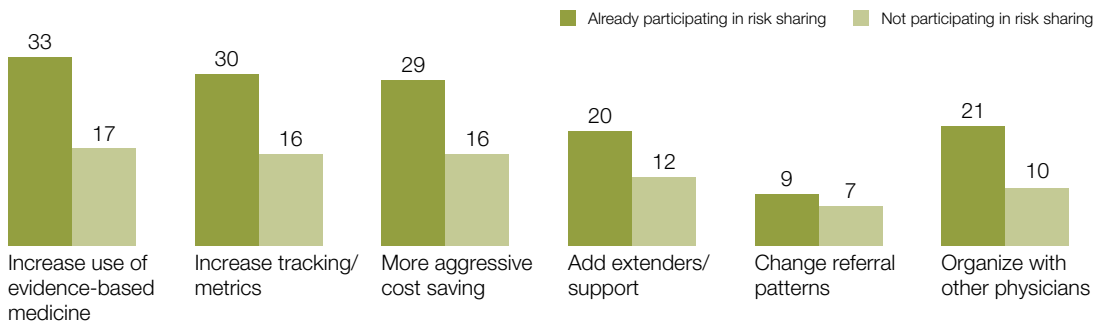
	100% = 1,402	100% = 390	100% = 1,012
IT	11	12	11
Colleagues	17	20	16
Clinical autonomy	22	21	22
Personal autonomy	24	23	24
Compensation	26	24	27
	All physicians	Hospital-employed	Non-hospital-employed

¹When making decisions on what kind of practice to be in (e.g., private practice vs. employment by a hospital or insurer), how important are each of the following elements to you? (n = 1,402, hospital-employed n = 390, non-hospital-employed n = 1,012).

Source: 2011 McKinsey Physician Survey

EXHIBIT 6 Physicians already participating in bundled payments or risk sharing arrangements are taking more steps to prepare for reform

% of respondents (excluding hospital-employed) already preparing for health reform, by preparation method^{1,2}



¹Given your level of interest, capabilities, and trends in your market, how likely are you to participate in each of these payment types in the next three years? (at risk n = 181, not at risk n = 831).

²How will your practice respond to the impact of healthcare reform? (n = 1,012).

Source: 2011 McKinsey Physician Survey

physicians not participating in such models (Exhibit 6). However, the penetration of risk-based payment models has been limited to date. Only 35 percent of the respondents who reported having been approached to partner on risk-based models said that the approaches had resulted in an agreement. The low success rate appears to be due in part to risk aversion—the proportion of approaches that resulted in an agreement drops to less than 30 percent when the physicians were exposed to downside risk.

Our survey also showed that physicians are less likely to participate in new payment models when those models are poorly understood (even if they are designed to accomplish the same goal as more conventional payment models). For example, 61 percent of the respondents said that they would be highly unlikely to participate in a novel two-sided risk model that imposes both upside and downside risk. In comparison, only 47 percent of respondents said that they would be highly

unlikely to participate in a global capitation model, even though that model presented greater risk to providers than the novel two-sided model did (Exhibit 7).

Furthermore, many current attempts to partner with physicians using risk-based payment models may be poorly targeted. In our survey, only 23 percent of the physicians whose willingness to change was above the median reported having been approached to partner on risk-based payment models, compared with 34 percent of those with below-median willingness to change. This difference was true for both upside-only and two-sided risk models.

Variability across regions and specialties

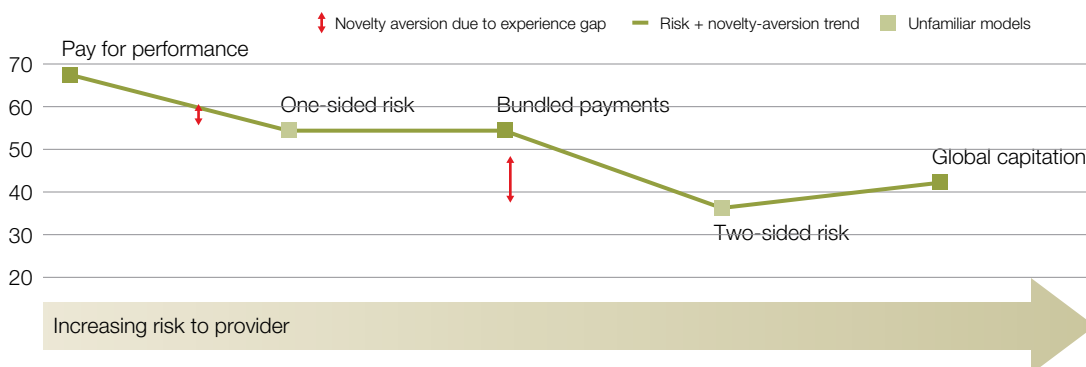
When we broke the survey data down by state, specialty, and practice setting, interesting nuances emerged. This is not surprising—physicians vary widely in their attitudes



*Why would I not want to do risk sharing?
To me it's just too confusing...30 pages of graphs and instructions and points I would lose if my patient gets admitted... I have no idea what this all means for me. If I understood it, I would be able to take a chance to do it. The problem is the unknown.*
—Primary care physician

EXHIBIT 7 After adjusting for risk, physicians are more averse to novel models than more familiar ones

% of respondents likely to participate in payment models within three years, by awareness of models¹



¹Given your level of interest, capabilities, and trends in your market, how likely are you to participate in each of these payment types in the next three years? (n = 1,402).

Source: 2011 McKinsey Physician Survey



about reform, risk, and waste reduction; in the key factors that influence their willingness to change; and in what they look for in partnerships. For example, Michigan physicians were more likely to say that they desired hospital employment than were their counterparts in other parts of the country (20 percent, versus an overall US average of 13 percent). We found similar significant geographic differences throughout the country (Exhibit 8).

There was also considerable variability among specialties. For example, cardiologists expressed more willingness to change than other specialists did, and they also had the highest level of perceived control over sources of waste. However, we found marked differences between employed and nonemployed cardiologists (Exhibit 9). Hospital-employed cardiologists identified physician leaders as the most effective way to change physician

practices, particularly around medical device use. In contrast, cardiologists who were not hospital employees thought that compensation is the most effective lever.

Strategic implications

Health systems and health plans that want to drive cost-effective care delivery must find ways to overcome the four barriers discussed above. Our survey results, follow-up interviews with physicians, and experience leading large-scale clinical transformation programs suggest that three approaches are needed to achieve that goal.

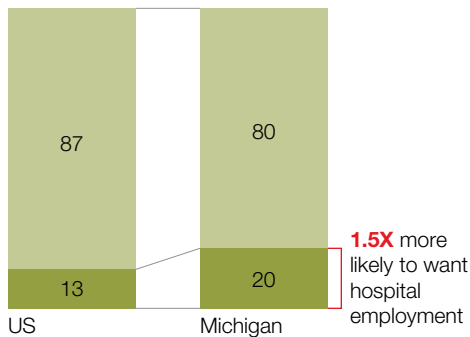
Build a true capability in physician engagement

Health systems and health plans should develop a true capability in physician engagement, which is much broader than, and does not

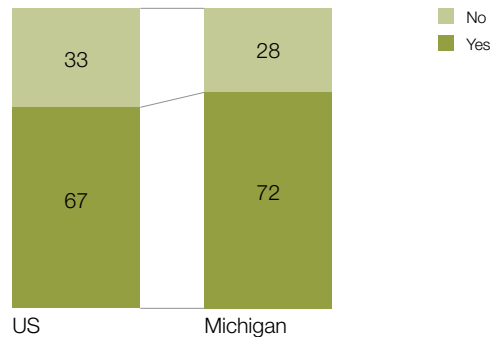
EXHIBIT 8 Michigan physicians are significantly more likely to desire hospital employment than other US physicians

Desired and expected employment structure among physicians not currently hospital employees

% of respondents who said they want to be employed by a hospital¹



% of respondents who said they think they'll be employed by a hospital in three years²



¹Summary of top rank: Regardless of what you've been doing, consider what you would most want to do and rank the following practice choices from 1 to 4, with 1 being the most appealing for you (US, n = 1,012; MI, n = 142).

²How will your practice respond to the impact of healthcare reform? (Become employed by or formally aligned [e.g., through a medical foundation] with a hospital) (US, n = 1,012; MI, n = 142).

Source: 2011 McKinsey Physician Survey

necessarily include, employment. Employing physicians is very costly, often fails to deliver the intended value, and is not crucial for achieving physician engagement. In our experience, *how* you engage physicians is more important in driving behavioral change than the contractual mechanism you put in place.

Extensive research in behavioral science suggests that four areas matter most when it comes to altering a person’s behavior.^{5,6} These areas hold as true for physicians as for everyone else.

First, people will alter their behavior only if they understand the point of the change and agree with it (at least enough to give it a try). Physicians, for example, are highly unlikely to modify their behavior unless they understand how the changes will improve the quality or cost efficiency of care. Thus,

a health system or health plan that wants to embark on a change program must develop a compelling explanation, grounded in clinical evidence, for what the proposed changes will accomplish.

Second, physicians, like other people, are more likely to change if they see people they respect adopt the new behaviors. Our survey results confirm the importance of having physician leaders who can “role model” the desired new behavior and play an active role in any change program. The successes these leaders achieve should be publicized so that their colleagues can appreciate the impact the program is producing.

Third, physicians must have the skills needed to do what is required. Both our experience and the follow-up interviews we conducted indicate that many physicians have only limited



If you make physicians leaders, there’s a lot more trust from their peers than in some executive who doesn’t have a clue what he’s talking about. You can change practices with effective leadership and communication, but that has to come from the doctors themselves.

—Vascular surgeon

EXHIBIT 9 Development of physician leaders will be especially important for influencing some groups, such as employed cardiologists

Best way to change willing physicians’ own practices or collaborate to change other physicians’ practices to affect medical device use variability^{1,2}

Relative importance out of 100 points

	100% = 27	100% = 94	100% = 390	100% = 717
Compensation	21	29	26	28
Training and resources	19	20	22	22
Physician leaders	26	20	19	18
Feedback	18	17	17	16
Communication	15	14	16	15
	Employed cardiologists	All cardiologists	All employed physicians	All physicians

¹How willing are you to make changes in your own decisions and actions or collaborate to change other physicians’ practices to affect these potential factors of healthcare waste and inefficiency?

²What is the best way to get physicians to change their decisions and actions to decrease potential healthcare waste and inefficiency?

Source: 2011 McKinsey Physician Survey

⁵Fountain T, Wilson F, Richardson B. How to change clinical behavior in primary care. *Health International*. December 2012;6-15.

⁶Lawson E, Price C. The psychology of change management. *McKinsey Quarterly*. June 2003;31-41.

About McKinsey's Physician Survey

Between June and August 2011, McKinsey conducted an online survey of more than 1,400 physicians across the United States about a number of topics, including readiness for reform, waste and inefficiency in healthcare, employment and alignment models, and financial risk sharing. In addition, we conducted follow-up interviews with a subset of these physicians to add richness to the study results and to gain greater understanding of physicians' mind-sets and the underlying factors driving their behavior.

The survey questions were developed based on insights we had gained while leading large-scale clinical operations programs in more than 100 hospitals across the country. The areas covered by the questions are listed below.

Roughly half the respondents were a representative sampling of physicians from throughout the United States. However, to better understand the differences among physicians, we over-sampled an additional 700 physicians in three regions: Dallas, Michigan (with a focus on Detroit and Lansing), and San Francisco/Sacramento.

The respondents included a wide range of specialties, including primary care (family practice, general inter-

nal medicine, and primary care-focused obstetrics and gynecology), medical specialties (hospitalists, cardiology, immunology, dermatology, endocrinology, gastroenterology, hematology/oncology, infectious disease, nephrology, neurology, pulmonary, radiation oncology, and rheumatology), and surgical specialties (general surgery, ophthalmology, orthopedic, neurological, otolaryngology, plastic, thoracic, urology, and vascular). However, we over-sampled in six specialties: family practice, internal medicine, hospitalists, cardiology, general surgery, and orthopedic surgery.

The survey consisted of 53 multiple choice or ranking questions, which covered five key areas:

1. Physician characteristics

- Demographic information: gender, region (zip-code level), years in practice following training
- Specialty (primary care, medical specialty, surgical specialty)
- Current practice setting (e.g., solo, two-person, multispecialty, hospital, insurance company)
- Ownership structure (e.g., sole proprietor, partner, employee, contract)
- Distribution of time by activity (e.g., patient care, teaching, administration) and care setting (hospital, clinic, ambulatory surgery center, etc.)

insight into how their day-to-day clinical decisions can translate into inefficiency in care delivery. Fortunately, most physicians recognize that they need help in this area—in our survey, training and resources ranked second only to compensation as a factor that would influence them to change their behavior. This provides an opportunity for health plans and health systems: these organizations could make selective, strategic

investments in capability-building programs to help physicians better understand the impact of their clinical decisions and give them the skills they need to ensure evidence-based clinical decision making.

Fourth, for a change program to take hold and be sustainable, it is crucial that surrounding structures reinforce the alterations in clinical behavior physicians are being asked to make.

2. Impact of reform

- Expected impact of reform (e.g., patient volumes, reimbursement, costs, quality, IT requirements)
- Current and planned actions to prepare for reform (e.g., use evidence-based medicine, track quality, reduce costs)
- Compensation outlook
- Current patient insurance coverage and predictions for how it will change
- Expected patient response to narrow/tiered networks

3. Attitude toward employment

- Satisfaction with current practice and most rewarding/frustrating aspects
- Ideal practice setting
- Elements important for making practice-setting decisions (e.g., compensation, autonomy, IT, colleagues)
- Alignment of each practice setting with elements important to satisfaction
- Benefits/pitfalls of being employed by an insurance company or hospital
- Approaches to changes in employment in last 12 months:
 - How often approached and by whom
 - Reasons for accepting/denying the formal agreement

4. Attitude toward waste and performance

- Importance of different sources of waste (e.g., avoidable utilization, inappropriate venue, practice variability)
- Perceived level of control and willingness to change factors influencing waste (e.g., unnecessary consults, unnecessary diagnostics, emergency department utilization, medical device variability)
- Ways to influence change (e.g., compensation, education, feedback)


5. Perceptions of risk-based and innovative models

- Familiarity with and participation in non-fee-for-service payment models (e.g., pay for performance, bundled payments, capitation, one-sided risk sharing, two-sided risk sharing)
- Approaches to changes in payment model in last 12 months:
 - How often approached and by whom
 - Reasons for accepting/denying the change to payment mechanism
- Likelihood of changing payment model in the next three years

These structures must, of course, include compensation, which most of the physicians surveyed ranked first among the factors that would influence their behavior. However, the reinforcing structures should also include information systems (such as tools to support evidence-based clinical decision making and performance transparency), aligned incentives (to encourage physicians to modify their behavior, lead

change programs, and engage other frontline clinicians more broadly), and governance arrangements (e.g., performance management frameworks).

In our experience, a change program achieves the best results when multiple levers are used to address all four of these areas simultaneously; the absence of any one of them decreases the chances of success.



If I had to design some kind of program, it would have to start with the familiar. So start with pay for performance, giving an incentive if you reach certain parameters—that's the easiest way to start. And then you can slowly start to get doctors more comfortable with more complex, risky models.

—Internist

Tailor levers to different types of physicians

Having a wide array of levers to engage physicians is crucial for a second reason: As our survey has demonstrated, individual physicians vary widely in their willingness to change, in their attitude toward employment and risk, and in what can motivate them to alter their clinical practices. Some of these variations reflect differences in geography, specialty, and practice setting—differences that should be recognized and acted upon. Health systems and health plans should take steps to understand the differences among the physicians they work with and then target the groups they want to address first. They can then tailor the levers they use with each group to increase the probability of achieving alignment.

Think strategically about how to apply risk

Finally, health systems and health plans should think strategically about how to apply risk. As our survey showed, physicians are far less likely to participate in risk-based payment models they do not understand or feel ill-equipped to manage. Thus, before a provider or payor attempts to roll out such a program broadly, it should first give physicians the training and tools they need to understand value-based models. It should then think about how it can move physicians along the risk continuum (perhaps by starting with upside-only models and then transitioning to risk-based models).

In addition, health systems and health plans should leverage their insights into physicians' attitudes so that, when they begin to roll out new risk models, they can target the physicians with a high degree of willingness

to change. This approach is likely to increase the number of formal agreements they reach, enable them to create successful change stories, and start to build momentum around the move toward value-based care delivery.



Health systems and health plans still have a long road to travel before they can effectively engage physicians to drive operational and clinical transformation and deliver the highest-value care. But the journey is essential. Although US physicians recognize the need to change and express a high willingness to do so, they do not have the capabilities today to make the required changes. Health systems and health plans have the opportunity to support and guide physicians in preparing for the future. To take advantage of this opportunity, they must understand how physicians view the world and what motivates their behavior. ○

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Displayed quotations are comments from survey respondents.

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