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Article abstract

The objective of this article is to shed light on physician satisfaction (primary care physicians and specialists) in the *Managed Care* context. Most surveys to date have brought in mixed results. The article reviews the physician's perception of cost-control mechanisms, autonomy, and the expression of physician discontent in this new era.

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Physician Satisfaction in the Managed Care Era

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ABSTRACT

The objective of this article is to shed light on physician satisfaction (primary care physicians and specialists) in the *Managed Care* context. Most surveys to date have brought in mixed results. The article reviews the physician's perception of cost-control mechanisms, autonomy, and the expression of physician discontent in this new era.

Keyword: Physician, Satisfaction, HMO, Managed Care.

RÉSUMÉ

Le but de cet article est de jeter un éclairage sur la satisfaction des médecins (généralistes ou spécialistes en premiers soins) dans le contexte du *Managed Care*. À ce jour, plusieurs enquêtes présentent des résultats hétéroclites. Cet article examine la perception du médecin devant les mécanismes de contrôle des coûts, son autonomie et l'expression de son mécontentement en cette nouvelle ère.

Mots clés : Médecin, satisfaction, HMO, Managed Care.

1. MANAGED CARE: HISTORICAL OVERVIEW

As in other Western countries, the US has faced an increase in health expenditure since WWII. This increase arose from techno-

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logical progress in medicine and an aging population. At the beginning of the 1970s, the Nixon Administration tried to contain the increase in health care costs with the adoption of a law, referred to as the *Health Maintenance Organizations Act* (1973) (HMO Act), amended in 1976, and the *Public Health Act* in California. This project has even more ancient roots: the first recorded form of health care program in US can be traced to early 1798. Several East Coast shipping companies developed prepaid services for their maritime workers (Liberman & Rotarius, 1999). With the HMO Act of 1973, certain advantages such as subsidies, or the obligation for every company with more than 25 employees to offer HMO coverage as an alternative to a fee-for-service (FFS) insurer, were granted to HMOs. Coverage included consultations with general practitioners and specialists, diagnoses, hospitalizations and certain services at the discretion of the HMO (Redin, 1989). HMOs offered services to any given group in exchange for a fixed sum paid in advance (i.e. capitation contract).

At that time, the main proponents of the Act were the US Government and private employers. Managed Care organizations' cost reduction strategies rapidly garnered attention from politicians and, later, from employers who decided to turn to these companies to manage their employee health expenditure. Patients who were concerned by economic downturns in the late 1960s and early 1970s also viewed the lower premiums as attractive. However, physicians and sociologists opposed HMOs because they were concerned that such organizations would provide less than optimal healthcare in order to contain costs.

Various organizations such as universities (Pearson et al. 1975) and major companies, e.g. Ford (Shelton, 1979), General Mills in association with other Minneapolis-based companies (Parkers, 1979), and Caterpillar (Hurst, 1980) gradually adopted these health care plans. For instance, the Dean of Harvard Medical School, Robert H. Ebert, was considering prepaid group practice in the late 1960s. In response to escalating healthcare costs, he wanted to establish an efficient and accessible delivery system as well as an effective research and teaching institution. The end product was Harvard Community Health Plan (HCHP), which was the largest Health Maintenance Organization in the New England region in the 1990s (Dorsey, 1995).

The Carter Administration also supported HMOs (Falkson, 1979). However, there were only 280 HMOs in 1983, the largest being Kaiser Permanente (4.6 million members). They aimed to reduce health care costs by one quarter to one third (Sloan, 1979).

There was also a repeal of the medical advertising ban in the late 1980s and this further promoted medical health care consumerism. At the end of the 1980s, HMOs offered differentiated care according to financial means of the insured. There were also non-profit and for-profit HMOs. The latter were often Independent Practice Associations (IPA), or Network HMOs, that offered higher returns on investment, and urged practitioners to keep a strict control on health care expenses. HMOs experienced steady growth in the 1990s. However, proponents of Managed Care must admit the major focus of Managed Care organizations shifted from quality, to cost of care. Costs reached a plateau in the early 1990s after a strong skid in the 1980s. Indeed, the percentage of health care expenditure in the GNP was only 13.6% in 1995, against 13.4% in 1992, 12.1% in 1990, 10.2% in 1985, 8.9% in 1980, and 7.1% in 1970. Patients have benefited from lower HMO costs and increased competition between these insurers: in the mid-90s and after a steady increase, reduced premiums attracted new clients. In 1995, the premiums increased at a lower rate than the general price index.

In the second half of the 1990s, HMOs faced criticism from consumer associations. Worse, these organizations experienced weaker bargaining power, as big firms joined one another to negotiate cheaper health coverage for their employees. Despite the HMO ability to master the growth of health care costs, their reputation was soiled by adverse selection (exclusion of patients with a higher risk of being ill), lower quality of care for vulnerable patients, and limited access to care. The number of people without health coverage was still high: 44 million individuals in 1999, which is 16% of the American population. These criticisms have weakened the legitimacy of Managed Care organizations and dampened efforts to impose Managed Care-based health systems in Europe and Asia. To make matters worse, HMOs were not supported by physicians: professional satisfaction of practitioners has deteriorated in the Managed Care setting.

2. PRACTICE CHARACTERISTICS IN HMOS

Physicians who are paid on the FFS basis experience minimal review of their clinical decisions by health insurance plans. A patient's clinical interest in receiving as much care as possible and the physician's financial interest are also closely aligned because of the intrinsic nature of the FFS payment. Conversely, Managed Care organizations use management tools to monitor care and control

costs. These include restricted networks of care providers, utilization review programs that reexamine care to ensure its necessity and appropriateness, and gatekeeping physicians who decide if a patient either needs to consult a specialist, or requires additional and more specialized care. HMOs have also tried to shorten hospital stay as this was a major source of costs (Miller & Luft, 1994).

Managed Care organizations also fund medical procedures prescribed by physicians, a process that works rather well for simple procedures, but not so easily for more complex or sophisticated, thus more expensive, ones (i.e. physicians or nurses must contact the Managed Care organization to convince its medical director to agree on financing such medical acts). The HMO may disapprove certain types of care if it deems them too expensive or experimental. If that is the case, the patient will not get a refund and he will have to pay for part or all of it with his own money. Obtaining such approval requires physicians to fill in administrative forms. Thus, Managed Care may mean more administrative duties for physicians and their employees. However, this widespread belief has not been confirmed by surveys (Remler, 2000).

Other cost-control mechanisms include a withholding contract. This means a partial transfer of the financial risk to the care provider. The HMO retains a fraction of payments for the care provided over a defined period. At the end of this period, there are comparisons with regard to an established cap. If expenses are lower than the cap, the sum that was withheld is returned to the care provider.

3. WHY IS PHYSICIAN SATISFACTION IMPORTANT?

Physicians might be more effective in their work if they are professionally satisfied (Linn et al., 1985). There are health and financial benefits to be expected: higher physician and patient satisfaction is associated with a greater percentage of patients experiencing continuity of care, lower patient no-show rates, more efficient use of ancillary staff in providing direct patient care, and more reasonable charges for routine follow-up visits. In addition, satisfied physicians have a higher propensity to involve patients in diagnostic and treatment decisions (Kaplan et al., 1996). This, in turn, increases treatment compliance, and patients report greater satisfaction when treated by satisfied physicians. There is a positive relation between burnout and suboptimal care (as reported by physicians) (see Shanafelt et

al., 2002), physician satisfaction and patient compliance (DiMatteo et al., 1993), test ordering (Schmoldt et al., 1994), and prescribing habits (Melville, 1980).

From the HMO view, when physicians are satisfied, they are significantly more likely to stay in a given practice, thereby lowering costs associated with high turnover. The estimated institutional-level cost to employees to recruit and replace a primary care physician ranges from $240,000 to $265,000 (Buchbinder et al., 1999). Finally, satisfied patients are less likely to quit their insurer, which then lowers the insurer administrative costs.

4. MEDICINE, PROFESSIONAL SATISFACTION AND MANAGED CARE

Early studies on the issue of satisfaction reported positive results. The first investigation (Schulz et al., 1997) in Wisconsin compared the satisfaction between 1986 to 1993 of HMO physicians, to that of physicians who remained in the traditional system with FFS payment: in 1993, nearly two thirds of HMO physicians were satisfied with their medical practice in this setting and general practitioners were more satisfied than specialists. Freedom (regarding prescriptions, treatment selection, etc.) and salary were strong drivers of satisfaction. HMO physician satisfaction remained stable between 1986 and 1993, while physicians who stayed in the traditional regime with FFS payment reported higher dissatisfaction. Similar results were noted in other medical professions: an investigation (Freeborn & Hooker, 1995) on 5,000 non-physician employees in a Managed Care setting reported high rates of job satisfaction resulting from greater responsibilities, teamwork, job security, supervision, and diversity at work. On the other hand, they were less satisfied with their workload and career opportunities. Chemical dependency counselors reported the highest satisfaction and optometrists the lowest. Consultations in the HMO setting offer more prevention and better treatment planning (Callahan & Bertakis, 1993).

The life of HMO physicians in the Managed Care setting has gained stability and there are several underlying causes. Firstly, starting costs for a new practice are high (about $50,000), and since most physicians start their career with heavy debts ($80,000 on average), they are reluctant to further increase their debt by starting their own individual practice. Furthermore, Managed Care organizations offer physicians a network of practitioners that allows the physician to

offer a wider range of medical services to his patients. Finally, working hours within the HMO setting are lower and practitioners do not receive emergency calls (other HMO-employed practitioners replace them when they are off-duty). HMOs have isolated their physicians from the external regulatory climate, thus allowing them to concentrate on patients (Stamps, 1995). HMO physicians, who otherwise could not dedicate enough time to their family, appreciated these changes. Finally, as many physicians were underemployed in the early 1990s, they could hardly refuse employment in Managed Care organizations. Consequently, affiliation with Managed Care plans grew steadily. Indeed, currently, most physicians have various non-exclusive arrangements with multiple plans. Also, the job market had an oversupply of specialists. Academic medical centers and teaching hospitals aggravated that problem by providing incentives to attract medical students who would then serve as resident physicians that worked long hours with lower salaries to control costs (McEldowney & Berry, 1995). A study in 1991 showed that over a 20 year period, the number of generalists dropped from 40 percent to less than one third (Kindig et al., 1993). Surveys of the medical school classes of 1992 also indicated that less than fifteen percent wanted a generalist track career (Kindig et al., 1993).

However, more recent investigations have outlined growing discontent among practitioners. As Managed Care reaches maturity, physician satisfaction deteriorates. A study (Ahern, 1993) by the Florida Physician Association reported that HMO physicians were less satisfied with their incomes, with patient consultation times, specialist referrals, practice freedom and quality of care, than those in the FFS regime. Even more recent studies have confirmed this discontent (see Linzer et al., 2000). A doubling of the average HMO penetration was associated with a 20 percent greater likelihood of dissatisfaction (Hadley & Mitchell, 1997).

Even though Managed Care is less marked in rural areas compared with urban areas, physicians in rural zones were also dissatisfied (Wenworth, 1998). Although two-thirds of practitioners said that time spent with patients did not decrease, 67% said that their Managed Care organization could not meet their patient's needs. In another survey (Feldman et al., 1998), the majority of physicians thought that quality of care was jeopardized by shorter hospital stays and gatekeeping. Women, who increasingly embrace a medical career more often than men[1], were even more critical of Managed Care. Reforms were ardently desired by physicians in Washington State (Malter et al., 1994): 80% yearned for a revision of the current

health care system and 40% supported a single payer regime (like in Canada)[2].

The same criticisms can be found among the non-physician medical professions: in a large group-model HMO, physician assistants (PAs), and nurse practitioners (NPs) were more likely to experience stress than primary care physicians, and were also significantly less satisfied than physicians regarding income and fringe benefits (Freeborn et al., 2002). Worse, HMOs have replaced experienced nurses with low-skilled nurses (i.e. nurse aids), because their skills and the associated costs are lower. Nurses were affected by downsizing in United States and Canada (Armstrong Stassen, 1996) and, because of this decline in numbers, they now care for a higher number of patients (Armstrong Stassen, 1996). However, this may be harmful to patients and may be the reason why care providers in California are massively recruiting nurses after dismissing many of them a few years ago.

There are non-managed care related factors such as age (younger physicians tend to be less satisfied) (Kravitz et al., 1990), and gender (McMurray, 2000) that also affect satisfaction. Also, the surveys must be put in perspective: societal changes which include expanding malpractice claims, growing consumerism, and an erosion of trust, have changed the relationship between patient and physician. Thus, medicine has lost much of its status as a profession.

5. THE LOST AUTONOMY

Historically, physicians benefited from substantial autonomy and social prestige for providing a complex and indispensable service. Independence was a prime facet of their work, to the point that many considered themselves entrepreneurs. Autonomy is defined by the Society of General Internal Medicine (SGIM) as "independence of action", including the ability to treat patients according to the best clinical judgment. Autonomy was a major characteristic of the physician profession versus other professions, and a strong predictor of the physician's well-being, whichever organization they work for. Managed Care has a major effect on physician satisfaction through its impact on professional autonomy. HMOs expect physicians to comply with medical guidelines, to use expensive or sophisticated procedures with parsimony and to enforce generic or therapeutic substitution, as well as prescribe only those drugs that are listed on a formulary. Physicians with high Managed Care revenues were more

likely to report lower levels of clinical freedom than physicians with low Managed Care revenues (Stoddard et al., 2001). Physicians working with Managed Care plans who reported that Managed Care plans influenced their practice "a lot" were more likely to be dissatisfied (Landon et al., 2002). HMO restrictions on choice of hospitals were sources of dissatisfaction (Landon et al., 2002). Lack of influence on daily work and work processes were often deemed dissatisfactory (Arnetz, 1997). Threats to physician autonomy, to their ability to manage their day-to-day patient interactions and their time (Linzer et al., 2000) were strongly associated with lowered satisfaction. Family physicians employed in an HMO also felt that their professional autonomy and control was lost (Gask, 2004). Physicians who do not subordinate their clinical judgment to that of non-physicians were more satisfied (Warren et al., 1998), as are physicians who are the most capable of maintaining some control over their professional lives (Dunstone & Reames, 2001). Eroding professional autonomy resulted in an even greater negative impact on physician satisfaction than revenue decline (Stoddard et al., 2001). Physicians participating in Medicaid Managed Care plans expressed similar concerns (Gazewood et al., 2000). Not surprisingly, when asked about specific aspects of care, FFS medicine was rated better than Managed Care in terms of minimizing ethical conflicts and the quality of the doctor-patient relationship. Managed Care also reduced the time available for research and teaching (Simon et al., 1999).

6. STATUS

Physician status also influences professional satisfaction. Physicians who are salaried employees of a staff- or group-model HMO reported the highest satisfaction with Managed Care, followed by physicians with an exclusive contract and those with multiple contracts (LePore & Tooker, 2000). However, employee status in a large medical group with a large physician workforce is associated with lower satisfaction: large medical practices may be more likely to impose bureaucratic controls, thereby limiting physician autonomy, leading to a degradation of satisfaction (Grembowski et al., 2003). This is an incentive to lower HMO size and scale. However, being HMO-employed does not invariably mean lower decision-making autonomy (Linzer et al., 2000).

7. COMPENSATION

Apart from medical practice size, reimbursement mechanisms are a factor. Physician satisfaction in more organized settings is also clearly related to the efficiency with which patients can be seen (Linn et al., 1985). Adequacy of reimbursement was a clear predictor of overall satisfaction, and satisfaction with Managed Care (Landon et al., 2002). Capitation contracts have led to a degradation of their professional satisfaction (Tyrance et al., 1999), and quality of the relationship with their patients. The latter is important: HMO must not jeopardize physician interpersonal skills: research indicates that patient compliance, health outcomes, perception of physician competence, and malpractice suits are closely related to physician's interpersonal skills (Dugdale et al., 1999). Primary care physicians from the "no-claims" group (fewer than two lifetime malpractice claims) had longer routine visits (Levinson et al., 1997). Fee-For-Service is still, by far, preferred as a mode of payment, though experience with capitation contracts was associated with improved satisfaction (Nadler et al., 1999). Those paid by capitation were more likely to report pressure to limit referrals and see more patients (Keating et al., 2004). FFS patients had higher levels of trust toward their physicians than those treated by salaried, capitated, or FFS Managed Care physicians (Kao et al., 1998).

8. TREATMENT GUIDELINES ARE PREFERRED OVER FINANCIAL INCENTIVES

Physicians are generally supportive of formulary policies: the formulary has little impact on physician freedom of prescription (De Maria, 1994), and for that reason, has not raised objections from physicians. Physicians remain agreeable to the formulary provided access to nonformulary drugs and timely approval of requests for nonformulary medications are preserved (Glassman et al., 2004). It is not the only cost control mechanism that physicians support. According to the Center for Studying Health System Change (HSC), most physicians believe the impact of practice guidelines, patient satisfaction surveys, and practice profiling on quality and efficiency has been positive (Reed et al., 2003). However, financial incentives offered to physicians to reduce services (which consequently lowers costs) has a strong negative impact on satisfaction (Hadley & Mitchell, 2002). For that reason, physician practices have progressively dropped direct financial incentives to monitor prescriptions.

Instead, they prefer treatment guidelines and other care-monitoring practices commonly associated with Managed Care (Strunk & Reschovsky, 2002). For instance, non-financial control mechanisms, such as peer influence and education, are more effective in influencing clinical behavior than more coercive devices such as rules or financial incentives. Health care plans that use these non-financial mechanisms are also better evaluated by physicians (Williams et al., 1999).

9. THE DISCONTENT OF SPECIALISTS

Specialists were more worried than general practitioners. According to Reschovsky et al., 2001, specialists were generally 50% more likely to express concerns about their ability to provide quality care than primary care physicians. As HMOs rely essentially on primary care providers, underemployment affected medical specialties such as electrophysiology (Cannom & Ruggio, 1996), cardiology, and radiology. Fresh medical graduates have reported difficulty in finding jobs, unsatisfactory compensation levels, and low job satisfaction (Kimball, 2003). Two surveys, one in cardiology, the other in radiology, outline these worries. The first inquiry (DeMaria, 1994) assessed cardiologist's perception of Managed Care. A questionnaire was sent to 4,557 physicians who were members of the American College of Cardiology (1993). Among 1961 respondents, 76% had at least one agreement with a Managed Care organization, be it an HMO or a PPO (Preferred Provider Organization). Those who chose to have no link with these organizations did so for fear of a degradation in the quality of care[3]. More than half indicated that gatekeeping was inadequate for cardiac emergencies. Another study (Deitch, 1997) on radiologists in the Managed Care setting reported a lower interest in their profession. However, more encouraging results were observed in dermatology and psychiatry, due to, among other things, better professional demographics, shifting health care systems, and the changing scope of practice (Kimball, 2003). In a survey on dermatologists by Weinberg and Engasser (1996), 70% of physician activity concerned benign or routine health problems. Most dermatologists (88%) were satisfied with medical practice, while 78% favored direct access to the patient, and 60% wanted closer links with nurses and general practitioners. GPs are unlikely to be good substitutes for dermatologists. For health care plans, substituting dermatologists with general practitioners was a way to achieve savings. However, general practitioners would have to first deepen their training in dermatology so that this substitution would not jeopardize patient health. Finally, psychia-

trists displayed high professional satisfaction. According to a survey on 400 physicians of the American Academy of Physical Medicine and Rehabilitation, 75% were very satisfied (De Lisa, 1997).

10. WORKLOAD, PRODUCTIVITY AND ITS IMPACT ON PATIENT/PHYSICIAN RELATION

The nature of contractual arrangements with insurers is at fault: capitated Managed Care provides incentives to care for the greatest number of patients because revenues do not depend on the number of consultations but the patient pool size or volume. Discounted FFS arrangements prompt physicians to see more patients because reimbursements are lower for each of them. In both cases, there will be less time available for each patient. Another indirect consequence of physician-HMO contractual agreements is cost-shifting: rates of increase in physician income have barely kept pace with inflation over the years. Rising practice expenses (particularly in primary care specialties) meant that physician net income has become squeezed by the flat reimbursement rates, which triggered cost-shifting strategies: physicians compensate for the low-level of repayments that affect Managed Care patients by increasing consumption of hospital care (exams, consultations) in other patient categories (e.g. FFS patients) (Van Horn et al., 1997).

Increasing administrative requirements for health care delivery (e.g. service and authorization requests, utilization review processes) encroach on physician time spent with patients. In the Managed Care setting, time spent with each individual patient was less (Burdi & Baker, 1999; Linzer et al., 2000), though it is still higher in the US than in other countries. General practitioners in Great Britain spend between five and eight minutes in an average office visit, while US physicians spend between 10 to 20 minutes or more (Dugdale et al., 1999). Mechanic (1975) found that 32 patients were seen per day both in nonprepaid and prepaid practices. However, general practitioners in prepaid settings reported seeing patients 40 hours per week, while the nonprepaid physicians reported seeing patients 49 hours per week. In the first setting (prepaid practice), physicians responded to increased patient demand and expectations by processing patients more quickly, whereas prepaid physicians responded by working longer hours. Patients may also feel that shorter consultation duration may indicate lower quality of care, though adequacy and appropriateness of care, in addition to time spent with the physician, are also

relevant to quality. A recent review of the relationship between visit length and various outcomes sends a cautionary note. It concluded that "visit rates above 3 to 4 per hour may lead to suboptimal visit content, decreased patient satisfaction, increased patient turnover, or inappropriate prescribing" (Dugdale et al., 1999). With an average slot of five to eight minutes per patient, there is not enough time for routine consultations (Stirling, 2001; Carr-Hill, 1998).

From the patient's perspective, shorter visit times might be perceived to be associated with poorer quality of care received. While public confidence in physicians remains high, Pescosolido et al. (2001) have outlined mostly negative sentiments over a 20 year period. The influence of health plans, particularly the HMO plan, on medical decision-making is a source of concern for patients, though many may not even know they are covered by an HMO. More than 40% of privately insured Americans believe medical practice is strongly influenced by health plan rules (Reed & Trude, 2002). Health plans limit access to care (Cykert et al., 1997) and, consequently, diminish patient trust in their physicians: among people in fair or poor health, the trust in their physicians has not increased (Reed, Trude, 2002). In the relationship between physicians and their patients, a study (Levison et al., 1993) on 1,076 physicians lists the difficulties that appear in the physician-patient relationship. Some are: lack of confidence, difficulties in understanding patient's need, improper compliance to medical treatment and unrealistic expectations from patients. According to that same survey, HMO physicians were more often confronted with these problems than non-HMO physicians.

11. THE 'DOUBLE-AGENT' ROLE OF PHYSICIANS

Although medicine relies on a tacit agreement between a physician and his patient to determine the optimal treatment, contract clauses between a physician and an HMO can dissuade physicians from giving the patient the care he needs. Worse, risk-sharing contracts prompt physicians to play the role of a "double agent", as they must manage both the HMO purse with parsimony while being the patient's best advocate. Many feel a sense of frustration in performing their job because of this (Quaye, 2001).

The patient is vulnerable because he is in a situation of information asymmetry and is ignorant of the contract that binds the physician to the HMO (i.e. the limitations the contract entails such as spending caps on treatments and financial incentives that may lead the physi-

cian to prefer one treatment over another, though the selected treatment may not be the most effective). An illustration is the gag rule. It became the symbol of Managed Care organizations meddling in the patient-physician relationship. The gag rule, quite common in the end of 1990s, prohibited the practitioner from revealing to the patient the HMO contract terms (financial clauses) that bind him, or to discuss the available treatments with his patient. This constituted a threat to public trust in the medical profession. It has, as a result, been abandoned in nearly every American state.

There has been some progress since the end of the 1990s. Freedom to choose a family physician has become an important concern for HMOs because from the patient's point of view, it is the primary criterion when choosing a health care plan. The lack of choice explains, at least in part, the failure of the Clinton health care reform in the early 1990s. HMOs are aware that patients favor health plans that allow them to choose a care provider from a large pool of providers or even outside the HMO network of providers. Physicians support that trend: the American College of Surgeons (ACS) launched a national campaign to protect the right of the patient to choose his specialist. The ACS opposes gatekeeping, which has a significant negative impact on satisfaction (Sturm, 2002). Some Managed Care organizations have already suppressed it, thereby offering faster and easier access to medical specialties. At the end of 1999, United Health Group (Minnesota) decided to leave decisions on appropriate treatment to the physician, on the basis that control of the medical activity was more expensive than savings resulting from treatment denials. This decision was supported by the American Medical Association. Finally, physicians can be more involved in the evaluation of health plans, as evaluation tools are more widespread and refined. These evaluations may be useful to consumers and purchasers of health care (Borowsky et al., 1997), as practitioners will highlight strengths and weaknesses in comparative health plans, thus enabling physicians to be more selective. In addition, the technology (e.g. ordering tests on-line) should free up more time for consultations.

12. JOB INSTABILITY

There was also increased job instability among physicians. HMOs have squeezed care provider's revenues and consequently, hospitals must retain a pool of full fee-paying patients in order to secure an income. To do this, they must attract and retain the best

physicians. For that reason, physician turnover is on the rise and, consequently, patients often switch hospitals to follow their physicians. This ensures treatment continuity, but in relocating, the physician may be accused of diverting patients (hospitals generally operate on the mandate that patients belong to it, not to the physician). Also, HMOs rarely provide financial support for research activities. In the end, a physician who resigns means not only a loss of patients for the hospital, but worse, a transfer of research funds that particularly affects hospitals already suffering from lower sources of revenues (for instance, hospitals that provide care to the deprived). Partial blame can be assigned to foundations and other providers of research funds, as they award research grants to individual physicians, rather than to research institutions.

13. PHYSICIAN REACTIONS

Physician antipathy toward Managed Care is strong. As a sign of their discontent, HMO physicians are more likely to intend to leave their practices than physicians in other practice settings (Linzer et al., 2000). Physicians who do not accept the HMO mandate on close monitoring on care delivery can choose to practice in states where HMO penetration is less marked. Other physician groups have adopted radical strategies to shun Managed Care: a group of general practitioners set up a medical practice in Englewood (Colorado) that refused HMO payment. However this movement is not popular, as practitioners who have just graduated (e.g. heavy debt, no regular flow of patients) can hardly earn a living without Managed Care patients. Other groups of physicians have created discount networks that offer care at lower costs, targeting patients who are dissatisfied with their current health plans (Volz, 1999). Others resort to grouped negotiations to strengthen their bargaining power against Managed Care organizations. This angered the authorities, however, as such movements may implicitly pave the way for collusive price agreements during medical fee negotiations. There have been very few occurrences of strikes: medical residents in city of New York went on strike more than 10 years ago, which obliged NY State to adopt a law to improve their working conditions. Managed Care is also a predictor of physician support for unionization (Collier et al., 2001). According to the National Labor Relations Act, physician trade unions are legal, as long as physicians are employees. Conversely, trade unions are not legal when physicians are individual entrepreneurs (i.e. they run an independent practice). HMO reaction toward

physician unionization is based on contract interpretation: HMOs often contend that physicians are not their employees but contracting parties. As such, they remain independent, which, from the HMO view, negates their rights to unionization. Nevertheless, physicians have increasingly joined trade unions. Some of them (e.g. Machinist Union) did not even have an original branch in medicine. This is a rare example of an alliance between providers of a service (physicians) and consumers of that same service (as the insured are the union members). At first the American Medical Association (AMA), which enrolled nearly half of the 740,000 US physicians, tried to dissuade them from integrating traditional labor-unions, as these may press them to defend the interests of non-medical professions. Later, the AMA continued to oppose strikes, but encouraged collective negotiations. Managed Care also led state-level medical societies to go beyond their traditional role of disseminating progress and ethics within the medical profession. They chose to defend physician interests in this new Managed Care environment by providing advice on the management of physician practices with the creation of Management Organizations Services (MSO). In addition, these organizations extended their range of services to offer collection of medical data, lead satisfaction surveys, and help in the design of new laws.

14. CONCLUSION

Managed Care had considerable impact on physician job satisfaction regarding quality of care, relationship with patients, autonomy and satisfaction with practice settings. Few practitioners consider that Managed Care led to a mere change in medical practice, and most retain strong hostility toward Managed Care. These hostilities have encouraged practitioners to resign from Managed Care organizations. Currently, however, freedom for referrals is higher: pressured by employers, many health plans now offer the possibility of consulting a physician outside the HMO network. It is also easier for the insured to leave their health care plan. Recommendations to improve physician satisfaction include benchmarking quality practices, implementing continuous quality programs, emphasis on accountability in medical outcome rather than procedures, good compensation, and opportunities for career advancement. One way to relieve physicians in their work would consist in using physician assistants to perform routine test and provide info on drugs side effects and treatment compliance. In addition, any organization should provide physicians with

the opportunity to influence their work environment, preserve decision-making power, and freedom to organize one's schedule. Finally, improving organizational design, employee development schemes and the company culture could improve physician satisfaction. If these and other recommendations for improvement are ignored, then the continued erosion of physician satisfaction could have significant implications for the quality of the workforce attracted to medicine as a career.

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Notes

1. In 1975, 9.1% of physicians were women. This figure jumped to 20.7% in 1995. This percentage will rise as nearly half of the medical students who joined the labor market in the last 5 years are women. Source: www.gendercenter.org.

2. In that case then, the government is the main source of funding. In Canada for instance, funds originate from the provinces and employer contribution to health care financing is low.

3. This reason was cited by 51% of physicians who refused to join an HMO and by 41% of those who did not wish to join a PPO.