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Physician employment: The path forward in the COVID-19 era

New financial pressures resulting from the COVID-19 pandemic may increase physician practice acquisition and consolidation. However, results from McKinsey physician surveys both before and during the COVID-19 pandemic suggest that these partnerships may benefit from an updated approach.

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The COVID-19 pandemic has led many providers and physicians to consider how to maintain clinical quality standards and financial stability. McKinsey launched a national survey of general and specialty physicians in 2019, which it repeated six weeks into the pandemic (Exhibit 1).[1] During the first wave of COVID-19, more than half of respondent physicians reported that they were worried about their practices closing.[2] While autonomy has remained a priority for physicians, respondents indicated that they will consider partnerships or joining a health system as a result of financial uncertainty resulting from the COVID-19 pandemic.[3]

Physician employment continues to grow, and may accelerate after COVID-19

According to an American Medical Association report, physician employment has grown 13 percent since 2012, with the percent of employed physicians surpassing their cohorts in physician-owned practices for the first time in 2018.[4] In McKinsey's 2019 survey, 79 percent of small independents, 67 percent of large independents, and 42 percent of employed physicians cited autonomy as a top factor in selecting their current practice model.[5] In the same survey, 84 percent of all independent physicians who did not proceed with an employment opportunity in previous years, and 59 percent who returned to independent practice after employment, selected autonomy as a primary influencer.[6]

Respondent physicians balance autonomy with employment

While respondent employed physicians cite autonomy as a top three factor in their current practice model decision, they were more likely than respondent independent physicians to also cite financial stability as a top factor (53 percent of employed compared with 38 percent of small independents).[7] Around 40 percent of employed physicians cited both personal and practice finances as influencers in their decision to become employed.[8]

The demand shock from COVID-19 is unprecedented, and many physician respondents believe that the resulting loss of revenue will put their practices at financial risk. Six weeks into COVID-19, 53 percent of all independent physicians reported that they were worried about their practices surviving the COVID-19 challenge.[9] Almost half of all independent physician practices said they had less than four weeks of cash on hand,[10] and 68 percent of those respondents looking

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1 In May 2019, McKinsey surveyed 1,008 primary care, cardiology, and orthopedic surgery physicians. The survey was repeated from April 27 to May 5, 2020, with 538 respondents of all specialties (including general practice/surgery, cardiology, orthopedics, dermatology, ob/gyn, oncology, ophthalmology, ENT, pediatrics, plastic surgery, behavioral health, urology, and dentistry) to see how COVID-19 had affected physicians' viewpoints. Responses of the three groups were compared based on physician practice model: employed, small independents, and large independents.

2 QFIN_ATTR1: I am concerned about my practice making it through the COVID-19 challenge. How strongly do you agree or disagree (n = 284 population [large and small independent physicians familiar with the financial position of their practice]; May 2020).

3 OFFER_SWITCH: If you were approached by a larger physician practice/provider entity regarding potentially leaving your current practice to join them, please rank (up to 5) how important the following factors would be when considering the offer overall (sum of top 3; n = 538; 59 percent ranked autonomy over personal schedule or ability to influence decision making at the practice; 78 percent ranked base salary or upside compensation; May 2020).

4 American Medical Association Policy Research Perspectives: Updated data on physician practice arrangements—for the first time, fewer physicians are owners than employees (45.9 percent in physician-owned practices and 47.4 percent employed).

5 QPA2: What are the most important reasons for your preference? Please rank up to 3 (sum of top 2; n = 1,008; May 2019).

6 QPA12: What factors influenced your decision NOT to proceed with employment? Please select all that apply (n = 131 population [currently small or large independent but approached for employment within past 5 years]); QPA10: What influenced your decision to shift from employed to independent? Please select all that apply (n = 28 population [currently small or large independent, but has been employed by a hospital or health system within past 5 years]); May 2019.

7 QPA2. No difference between employed and large independents; 52 percent rank finances.

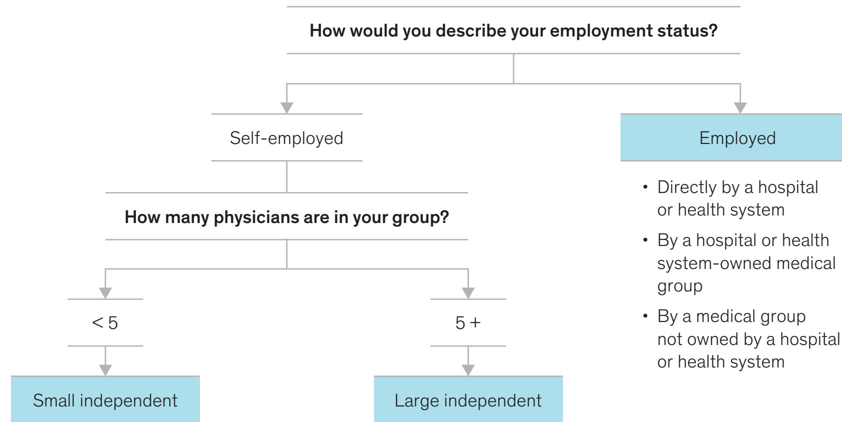
8 QPA14: What made you shift from independent to employed? Please select all that apply (n = 66 population [physicians employed by a hospital or health system within last 5 years]; May 2019).

9 QFIN_ATTR1.

10 QCASH_NOW: How many days of cash on hand does your practice currently have? (n = 284 population [small- and large-group independent physicians familiar with the financial position of their practice], May 2020).

Exhibit 1

Each survey tracked responses across three physician groups—small independent, large independent, and employed.



for partners ranked financial support as their number-one reason.[11] A third of small independent physicians reported that they believe working for a larger practice may provide greater benefits.[12] Many independent physicians said that, due to COVID-19, they were considering partnering with a larger entity, selling their practice, or becoming employed (Exhibit 2).[13]

When asked in 2019, 75 percent of respondent physicians preferred to join an independent physician group while 41 percent preferred to join a hospital or health system.[14] Six weeks into COVID-19, 89 percent of respondents preferred to join an independent group while 28 percent preferred to join a health system.[15]

Despite increasing interest in joining a practice or health system, 26 percent of physicians who joined a practice or health system reported "buyer's remorse," stating that they were interested in returning to self-employment.[16] Respondent physicians in large independent groups reported being less satisfied than smaller independents.[17] Fifty-eight percent of respondents in large groups compared with 71 percent of respondents in small groups reported that they would like to remain independent.[18] In light of these survey findings, health systems and other stakeholders may consider strategies to optimize the mutual benefits of physician practice acquisition.

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[11] QPARTNER_WHYRANK: What are the primary areas of support you'd seek from a future partner? First choice when ranking up to 5 (n = 106 population [large- and small-group independent physicians with ownership in their practice likely to sell practice or seek partnership or alignment with a larger organization]; May 2020).

[12] FIN_ATTR7: The COVID-19 challenge has shown me that the benefits of working for a large practice outweigh the benefits of working in a smaller practice. How strongly do you agree or disagree (n = 508 population [physicians familiar with the financial position of their practice]; May 2020).

[13] FIN_ATTR7; QPARTNER: How has the COVID-19 challenge influenced your decision to pursue a partnership or alignment with a larger organization? (n = 230 population [large- and small-group independent physicians with ownership in their practice]); QSELL_POST: How has the COVID-19 challenge changed your interest in selling your practice? (n = 230 population [large- and small-group independent physicians with ownership in their practice]); QEMP_CHANGE: How has the COVID-19 challenge influenced your decision to pursue employment? (n = 58 population [large- and small-group independent physicians without ownership in their practice]); May 2020.

[14] Rank = 1st or 2nd QPA15: If you were to formally partner with a separate organization to build a new approach to deliver better care, which would be your most trusted collaborator? Please rank up to 3 (n = 425 population [large- and small-group independent physicians]; May 2019).

[15] QWHORANK: Please imagine your practice was potentially acquired. How appealing would the following organizations be for you to join? Please rank from 1 to 5 (n = 166 population [small- and large-group independent physicians with ownership in their practice and more than "no" interest in being acquired]; May 2020).

[16] QPA16: Thinking out 5 years from now, which company would you be most excited to be employed by? Please rank up to 3 (n = 1,008; May 2019).

[17] QPA16.

[18] QPA16.

Our survey results indicate that while physician referrals historically may be less influenced by formal alignment mechanisms than by patient cost, access, and perceived clinical quality, some physicians are reconsidering referral choices in the context of COVID-19

Physician referral patterns—which hospitals, specialists, or testing centers they recommend to their patients—have often been difficult to change. Almost all physicians refer patients to just two hospitals, and 91 percent have not changed their referral destination in the past five years, even though nearly a third of respondents changed their employment status in that period.[19] A minority of physicians said they consider their employment when making a referral.[20] Physician respondents said they were most concerned with quality of care and patients' ability to access care once referred, including concern for patients' affordability and insurance network, suggesting potential areas for health system focus (Exhibit 3).[21]

However, when judging quality, physicians reported relying on their own impressions over publicly reported quality metrics.[22] In addition, small independent physicians cite cost and insurance coverage more frequently than others, while small and large independent physicians said they are more swayed by their own convenience than employed physicians reported.[23]

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[19] QREF3: How many hospitals account for 80% of your admissions/procedures? (n = 835 population [physicians with admitting or procedure privileges]); QREF4: Thinking about the hospital you most often refer patients to, is it the same hospital that you most often referred patients to 3–5 years ago? (n = 992 population [physicians who refer patients]); QPA9: If not currently employed, in the past 5 years were you employed by a hospital or health system? (n = 617 population [currently independent physicians]); QPA13: If currently employed, how long have you been employed by a hospital/health system? (n = 391 population [currently employed physicians]); May 2019.

[20] QREF7_1: What factors do you consider when recommending a hospital to a patient? Please rank up to 5 most important factors (n = 705 population [hospital is 1st or 2nd most frequent facility type for referrals]; May 2019).

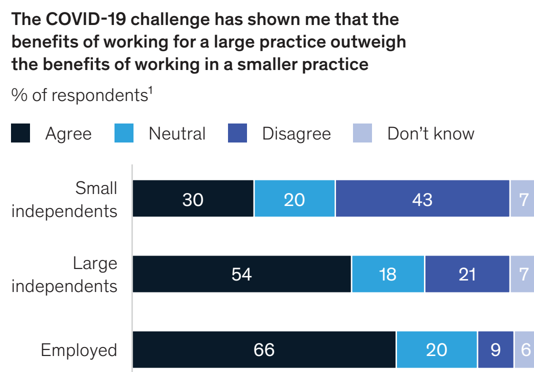
[21] QREF7_1.

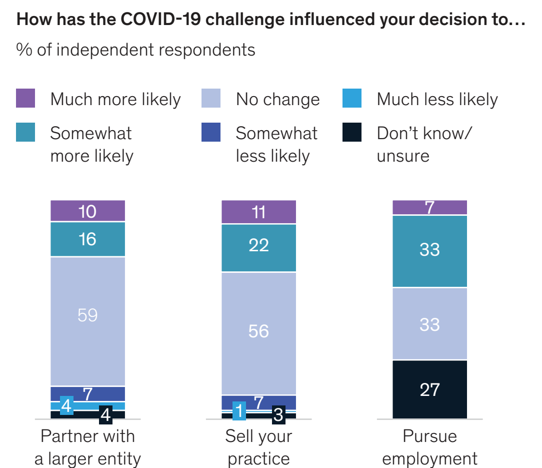
[22] QREF7_1.

[23] QREF7_1.

Exhibit 2

COVID-19 has convinced some small independent physicians that there are benefits in working for a larger practice, and a significant proportion of all independents are now considering selling their practice or partnering with a larger entity.





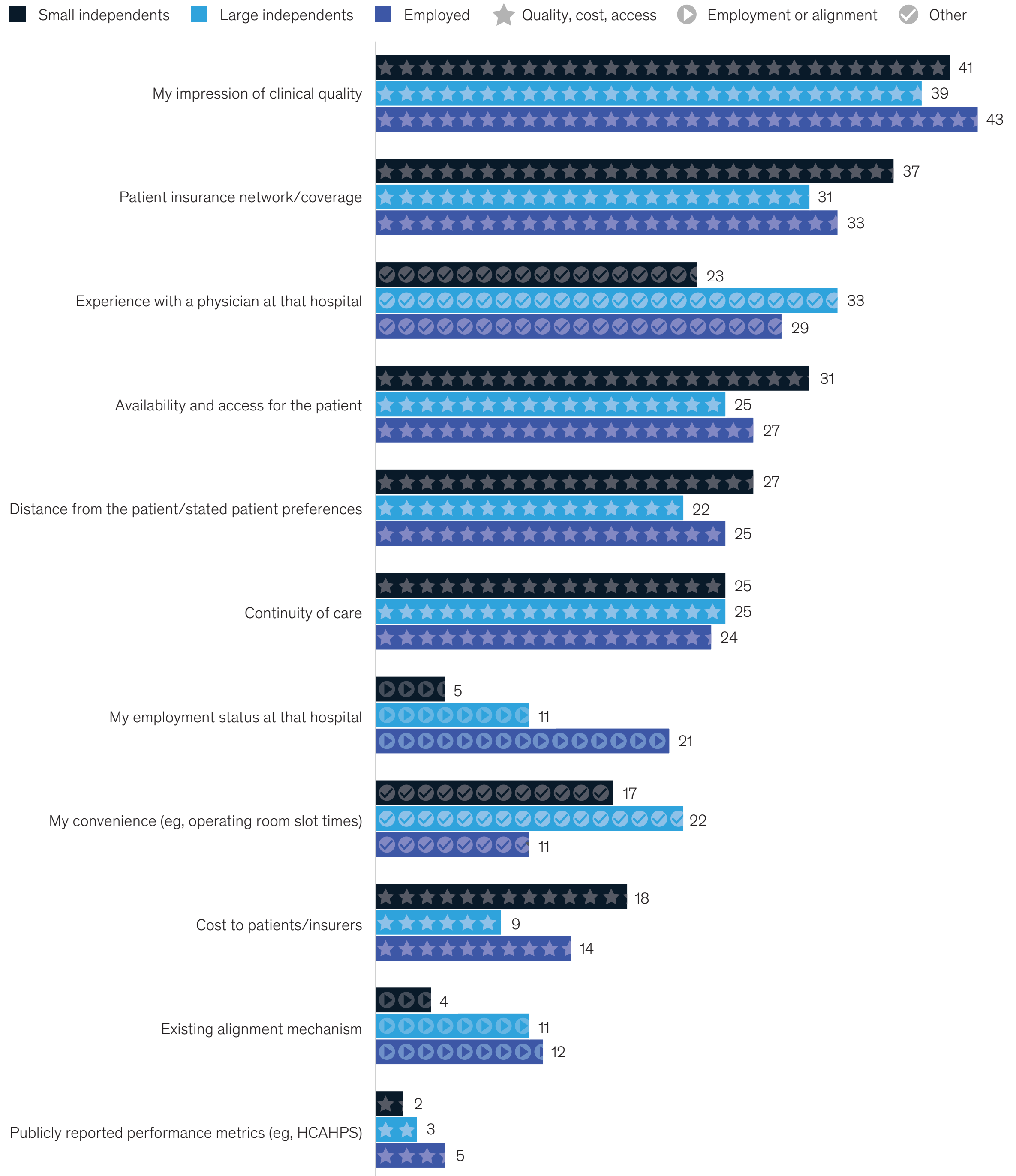
[1] Figures may not sum to 100%, because of rounding.
Source: McKinsey COVID-19 Physician Survey, May 2020

Exhibit 3

Physicians report that patient access and experience, cost, and quality are the key drivers for their referrals, and that employment and alignment have little influence on their referral patterns.

Top 3 factors considered when recommending a hospital to a patient[1]

% of respondents



HCAHPS, Hospital Consumer Assessment of Healthcare Providers and Systems.

[1] REF7 asked to rank up to 5.

Source: McKinsey Physician Survey, May 2019

Sixty-five percent of respondents said they were concerned about infecting family members with COVID-19....

Six weeks into the onset of the COVID-19 pandemic, 8 percent of physicians report having changed their hospital referral destination.[24] Physicians' reported reasons for referral remain largely unchanged from prior to COVID-19.[25] The 2020 survey offered two additional COVID-19-related options, with 14 percent of physician respondents selecting access to COVID-19 testing (rank 10) and 12 percent selecting access to personal protective equipment (rank 12) as drivers.[26]

More than 40 percent of physicians reported that post-COVID-19, they will be more likely to refer patients to non-hospital facilities for procedures, office visits, and diagnostic testing than they were pre-COVID-19 (Exhibit 4), with a more pronounced effect on independent physicians than those who are employed.[27] A possible rationale is that physicians may be wary of the safety of hospital-based care in the return from COVID-19, although the survey did not include questions to that effect. Sixty-five percent of respondents said they were concerned about infecting family members with COVID-19, while 72 percent said they were concerned about ensuring their patients' safety from

[24] QREF: Is the site you currently refer patients to most often the same site of care you referred to most often before the COVID-19 crisis? (n = 538; May 2020).

[25] QREF7_1 versus QREF_DRIVERRANK: What would make you change referrals to a different site of care? Please rank up to 5 most important factors (n = 456 population [physicians who have not switched referral sites]; May 2020).

[26] QREF_DRIVERRANK.

[27] TREF_ATT2: I am now more likely to refer procedures or surgeries; physician visits; diagnostic testing (e.g., lab, radiology) to non-hospital locations than hospitals. Please rate how strongly you agree or disagree now compared to how you felt before the COVID-19 challenge (n = 538; increased likelihood for procedures/surgeries 35 percent of employed versus 45 percent of independents; for physician visits 42 percent of employed versus 52 percent of independents; for diagnostic testing 45 percent of employed versus 54 percent of independents; May 2020).

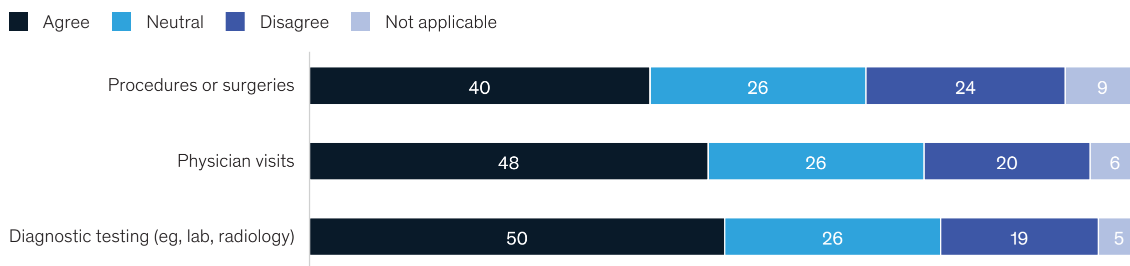
Exhibit 4

Experience with COVID-19 has made physicians more likely to refer procedures and surgeries, physician visits, and diagnostic testing to non-hospital locations.

I am now more likely to refer…to non-hospital locations than to hospitals

% of respondents[1]

Agree · Neutral · Disagree · Not applicable

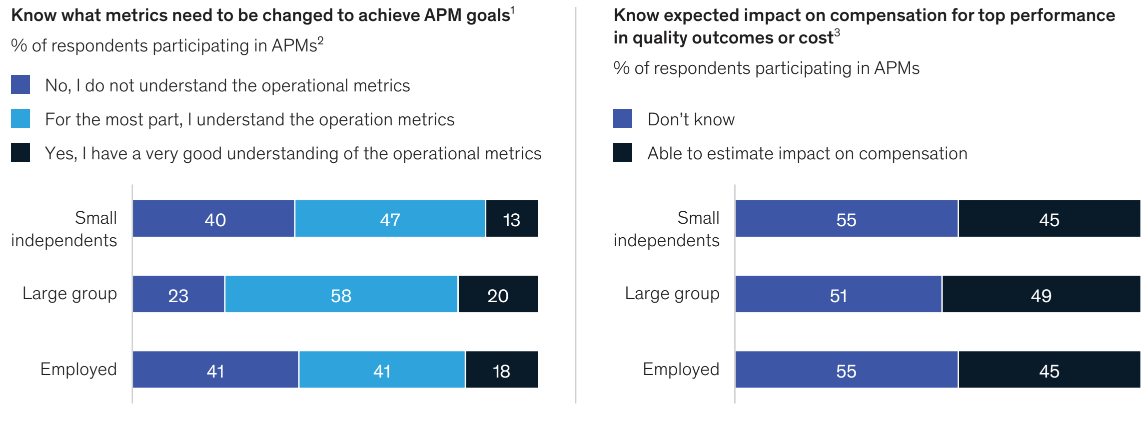


[1] Figures may not sum to 100%, because of rounding.

Source: McKinsey COVID-19 Physician Survey, May 2020

Exhibit 5

Physicians who are employed have no better understanding of operational targets or compensation at risk in value-based payments.



APM, alternative payment model.
[1] QVB9_2.
[2] Figures may not sum to 100%, because of rounding.
[3] QVB9_1.
Source: McKinsey Physician Survey, May 2019

COVID-19.[28] This finding could suggest that proactive communication and engagement may be critical for health systems still addressing COVID-19 while building physician relationships.

Our findings indicate that respondent employed physicians do not have a better understanding of, or participation in, value-based care models than independents, and 25 percent of independent respondents are now more skeptical of such models in a post-COVID future

Respondent employed physicians were equally likely to be participating in an alternative payment model (APM) in 2019 as large-group independent physicians.[29] In addition, both employed and independent physicians reported a lack of understanding regarding the impact of their performance on their compensation.[30] Employed and small independent physician respondents, however, are twice as unlikely as large independent physicians to report understanding the types of operational metrics that are used as incentives by APMs (Exhibit 5).[31] These survey findings suggest that while small independents may lack the scale to operationalize success, physicians' employers may enroll physicians in these models without providing sufficient communication or education.

Additionally, while physicians reported that they would like to use their patients' medical and social risks, costs, and communication preferences to tailor value-based decision making at the point of care, they do not always have the required tools and information

[28] TREF_ATT: I am very concerned about giving COVID-19 to a member of my household when going back to 'normal' care. I am very concerned about ensuring my patients' safety when going back to 'normal' care. Please rate how strongly you agree or disagree (n = 538; May 2020).
[29] QVB6: Do you currently participate in any alternative payment models with health insurance companies (e.g., episodes, capitation, gain-share arrangements)? (n = 1,008; May 2019).
[30] VB9_1: If you were to perform very well or very poorly on quality outcomes or cost, approximately how much would your total compensation change? (n = 196 population [participating in APMs]; VB9_2: Do you know what types of operational metrics need to be changed to achieve goals? (n = 196 population [participating in APMs]); May 2019.
[31] VB9_1.

to do so (Exhibit 6).[32] This finding is generally consistent regardless of employment status, although respondent small independents report better access to data to understand patients' communication preferences.[33] All independents report better data availability for patients' medication list and social risks than employed physicians report.[34]

Given physicians' reported perceived lack of capabilities to perform in APMs, it is unsurprising that they reported caution about adopting more value-based payment models within the environment of COVID-19. Twenty-one percent of physicians said they will be less likely to participate in APMs in the future.[35]

Employed physicians do not necessarily report better patient access tools, despite potentially greater access to capital, but they do report better operational tools than respondent independent physicians

Despite the importance that physicians report placing on patient access when making referrals (Exhibit 3), it appears as

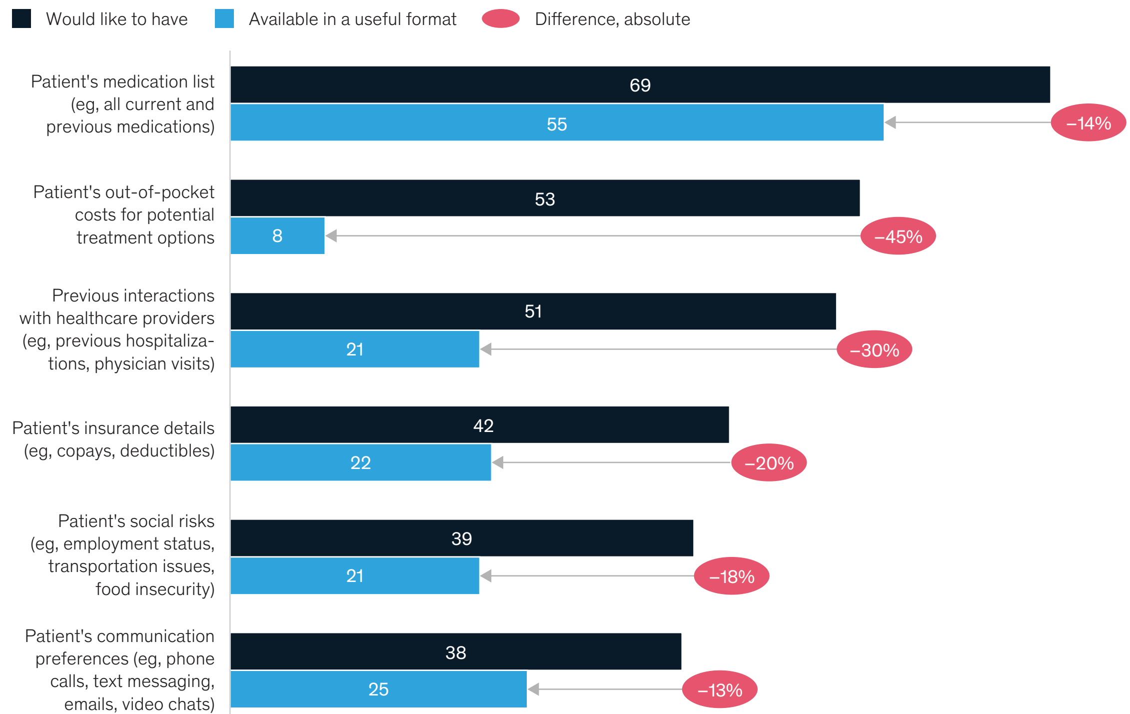
[32] QPA22: What type of information would you like to have to support decisions you make or recommend to your patients? Select all that apply (n = 1,008); QPA23: How often do you have the following information in a useful format when you're making decisions or recommending treatments to your patients? Select one frequency for each (n=332–696 population [physicians desiring each type of information]); May 2019.
[33] QPA22 subtracted from QPA23: communication preferences (small independents -1.9 percent versus employed -18.2 percent).
[34] QPA22 subtracted from QPA23: medication list (small independents -3.0 percent versus large independents -7.6 percent versus employed -20.3 percent); social risks (small independents -15.5 percent versus large independents -8.6 percent versus employed -23.8 percent).
[35] VB3: Thinking about as your practice returns to normal post-COVID, do you think you'll be more or less likely to participate in risk-based payments? (n = 192; May 2020).

Exhibit 6

All physician respondents said they are not always equipped with the information or practice tools needed to make high-value decisions at the point of care.

Desirability vs availability of patient information

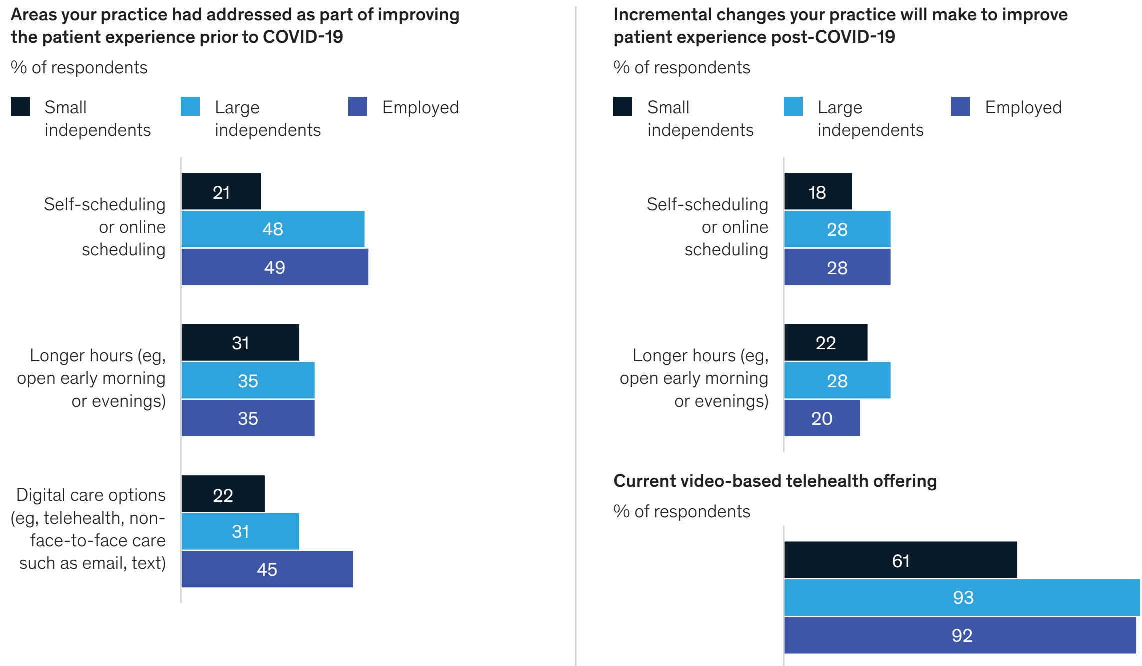
% of respondents stating information is available most of the time



Source: McKinsey Physician Survey, May 2019

Exhibit 7

Prior to COVID-19, employed physicians had an advantage over independents in digital care offerings, but now employed and large groups have quickly scaled up, widening the gap to small independents.



Source: McKinsey Physician Survey, May 2019; COVID-19 Physician Survey, May 2020

though respondent employed physicians have not been as advantaged over large independents in digital access investments as might have been expected. Our survey results suggest that large and employed practices are both more likely to offer access through expanded hours than small practices, even though this offering requires minimal capital (Exhibit 7).[36] Prior to COVID-19, employed physicians also reported that they were more likely to offer digital care access such as telehealth, but equally as likely as large independent physicians to report self-scheduling and longer hours.[37]

It appears as though respondent employed and large-group practices are equally likely to have rapidly scaled up digital care offerings in response to COVID-19 to meet their patients' needs.[38] Forty-six percent of physicians report using telehealth during COVID-19 compared with 11 percent in 2019.[39] This finding may be explained by larger entities' greater access to capital required to invest in technology. In addition, employed practices are more likely to report planned updates to facility infrastructure or flow and to have added disinfection procedures.[40] Based on survey results,

[36] PA20: Which of the following areas has your practice addressed as part of improving the patient experience? Select all that apply (n = 1,008; May 2019).
[37] PA20 (May 2019).
[38] PA20 (May 2019); TEL_ABLE: Does your practice currently offer video-based telehealth to patients? (n = 538).
[39] Bestsennyy O, Gilbert G, Harris A, and Rost J, "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?," May 2020, McKinsey.com.
[40] PA20: Which of the following areas do you expect your practice will change to improve patient experience once the COVID-19 challenge has passed? Select all that apply (n = 538; May 2020).

they also are more likely to offer COVID-19 testing (46 percent employed compared with 37 percent independent) than both small and large independent physicians.[41]

Survey results further suggest that physician satisfaction with operational tools, such as documentation or referral decision support, is generally low regardless of employment status.[42] Less than half of respondent physicians believe that technology improves their productivity.[43] However, employed physicians are consistently more likely than independent physicians to give high ratings to the helpfulness of their electronic medical record (EMR) systems (34 percent compared with 22 percent), EMR IT support (31 percent compared with 18 percent), scheduling software support (26 percent compared with 17 percent), revenue cycle support (23 percent compared with 15 percent), and care management and social work support (26 percent compared with 18 percent), with a slight advantage reported by large-group independent physicians compared with small groups.[44] These findings suggest that the scale to invest in new infrastructure, technology, and people may be an advantage of health system partnership.

Our findings indicate that understanding what physicians want and what they are able to provide could inform a more successful health system strategy for sustaining physician engagement in the medium and longer term

The negative financial impact due to COVID-19 indicated by more than half of independent practices[45] may lead to a new wave of partnerships and consolidation. However, physician respondents stated that they are looking to gain financial security and operational support without losing too much of their autonomy. Health systems may be looking to increase patient access through an adequate network. Both are committed to providing high-quality, high-value care. As consolidation and partnerships occur, patients could gain greater access to digital care, newer facilities, COVID-19 testing, and social worker support through their physicians' employment. Yet patients also may be concerned that consolidation would impact the personalization of care.

As health systems explore the next chapter of physician acquisition, our research in the healthcare sectors suggests all parties should deepen their understanding of physicians' needs. Clear communication between health systems and physicians on the expectations and benefits of alignment, including the implications for physicians, their teams, and their patients, will be important considerations in building longer-term successful relationships.

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[41] PA20 (May 2020).
[42] PA19: Do you think that technologies would have an impact on care delivery by improving or harming physician productivity (e.g., documentation, diagnosis support, referral decision support, telehealth, non-face-to-face care such as email, text, etc.)? Sum of top 2 box (out of 5) somewhat or significantly improve (n = 1,008; May 2019).
[43] PA19.
[44] SUP3: How helpful are the types of practice support you receive from a hospital or health system? Sum of top 3 box (out of 10) (n = 1,008; May 2019).
[45] QFIN_ATTR1.

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