

Work Stress of Primary Care Physicians in the US, UK and German Health Care Systems

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Background

- Work-related stress among physicians has been an issue of growing concern in recent years.
- How and why this may vary between different health care systems remains poorly understood.

Objectives

- How do levels of work stress among primary care physicians (PCPs) differ in three health care systems (the United States, the United Kingdom and Germany)?
- Are specific features of the work environment associated with work stress (i.e. professional autonomy)?
- Can these specific system features account for possible country differences in work stress?

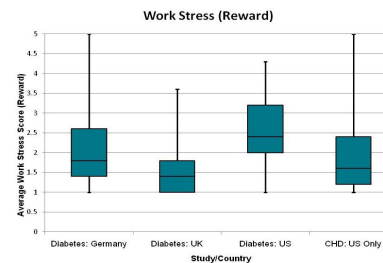
Study design

- 640 randomly sampled physicians were recruited for two international comparative studies of medical decision making.
- Physician work stress was captured using an established theoretical model-based questionnaire (effort-reward imbalance).
- To be eligible for selection for both studies, physicians had to:
 - 1) Have completed a medical residency program in either internal medicine or family practice (US), or general practice (UK, Germany),
 - 2) Provide primary care at least 50 percent of their time, and
 - 3) Work within the designated geographical area.

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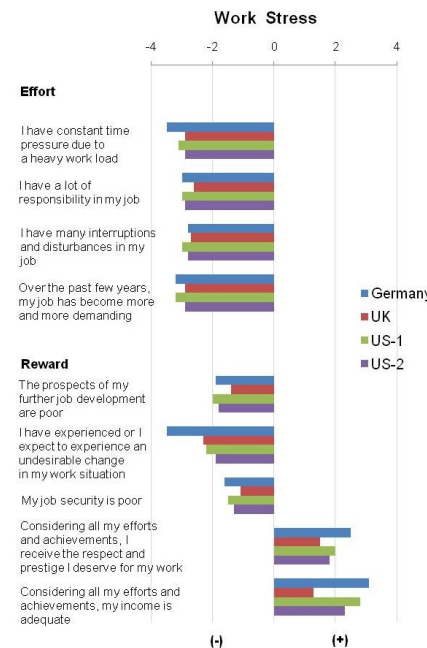
Findings

How do levels of work stress among PCPs differ by country/system?

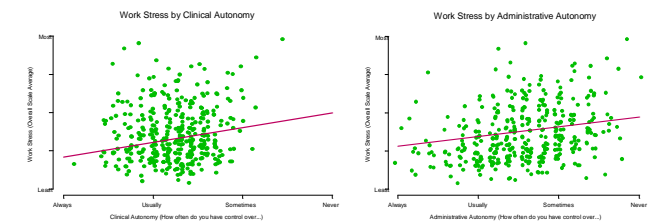


- All pair-wise country comparisons of work stress were significant.
- The highest stress levels are among German physicians.
- The lowest stress levels are among UK physicians.

- Further exploration based on the two subscales of work stress, effort and reward, indicates that significant differences across the reward subscale largely account for the observed study /country differences.
- There are clear, statistically significant variations with regard to *reward* related work stress (money, esteem, promotion prospects and security).



Are specific features of the work environment associated with work stress?



- Significant correlations of lack of administrative autonomy with work stress are observed in the US ($p < 0.01$) and the UK health care system, and a weaker association ($p = 0.07$) is observed in the German system.
- The same pattern exists for lack of clinical autonomy, although correlation coefficients are slightly smaller.
- Interestingly, low reward at work is significantly associated with a greater lack of clinical autonomy in all three health care systems.

Administrative Autonomy	Overall work stress	Effort	Reward
Diabetes – Germany	0.26 (0.07)	0.11 (0.43)	0.27 (0.06)
Diabetes – UK	0.42 (<0.01)	0.38 (<0.01)	0.32 (<0.01)
Diabetes – US	0.42 (<0.01)	0.42 (<0.01)	0.34 (<0.01)
CHD – US Only	0.47 (<0.01)	0.48 (<0.01)	0.37 (<0.01)
Clinical Autonomy	Overall work stress	Effort	Reward
Diabetes – Germany	0.26 (0.06)	0.11 (0.43)	0.27 (0.05)
Diabetes – UK	0.35 (<0.01)	0.27 (<0.01)	0.31 (<0.01)
Diabetes – US	0.25 (<0.01)	0.20 (<0.01)	0.25 (<0.01)
CHD – US Only	0.22 (<0.01)	0.23 (<0.01)	0.18 (<0.01)

Conclusions

- One possible explanation for the high levels of work stress in Germany (particularly in the reward subscale) is the recent implementation of disease management programs.
- These disease management programs are designed to promote quality of care and to foster competition but were perceived as threats by many physicians.
- These programs included substantial changes in the organization and remuneration of physicians' work.