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Young doctors want to have fixed salaries in general practice. We cannot afford to disregard this wish.

A permanent doctor with a fixed salary

When the «Regular GP» (RGP) reform was introduced in 2001, it was against the backdrop of a long-standing wish on the part of the authorities and doctors to strengthen the primary health services. They disagreed, however, about the instruments to be used. The health authorities wanted the public sector to assume responsibility as well as operate the general practitioner services, preferably with permanently employed doctors. The Norwegian Medical Association, on the other hand, wanted to preserve general practice as a liberal profession with reimbursements from the national insurance system. The doctors did not agree among themselves either: in the decades preceding the RGP reform, a growing number of primary care doctors, especially among the younger generation, had called for public employment on a fixed salary (1). The main reason was that the increasing priority given to primary health services from the 1970s onwards had given rise to an increasing need for better premises, more equipment and more auxiliary personnel. The costs of establishing a private practice rose, and a growing number of young doctors were reluctant to accept them. As a result, the number of fixed-salary positions in the municipalities increased. In 1990, a peak was reached when nearly 40 per cent of all GPs had fixed salaries (1). The RGP reform made self-employment the clearly preferred form of organisation: at the time of the introduction of the reform in 2001, altogether 10.3 per cent of the practices were paid a fixed salary; by 2015, this proportion had fallen by more than half, to no more than 4.3 per cent (2).

In recent years, many young doctors have again spoken up publicly in favour of revising a scheme that forces nearly all GPs into private business (3–5). As previously, the arguments are that the high costs and need for high earnings frighten away younger doctors from the profession (4) and that the incentive system leads to overconsumption of services and distorted priorities in clinical practice (3). The response from the representatives of the Norwegian Medical Association remains the same: that «private enterprise is the best way to ensure high quality and continuity in the health services» (6). History repeats itself: again it seems that the young and the established members of the profession are divided in their views on what form of remuneration will be best for the public general practice services.

This piece-rate payment for operating a public service is an oddity in the Norwegian context. Few would be eager to introduce anything similar for other groups of public service providers, such as teachers, police officers or hospital doctors. The fact that the scheme has nevertheless remained in place without any great degree of protest, is because the RGP reform has been a success – with self-employed doctors as an integral element. For the same reason it has been difficult to evaluate the piece-rate payment in isolation from the RGP scheme as such.

Moreover, for those who have attempted this, the results have been mixed. Although there is a comprehensive literature showing that economic incentives may have an effect on the behaviour of doctors (7), this is harder to establish in practice. For example, an obvious problem in the current piece-rate system is that the GPs, who are «gatekeepers» for their patients' access to public goods, also have the same patients as their «customers» in a «market» among other GPs. The extent to which this may result in overconsumption of goods, such as medical certificates, is hard to determine. It has been estimated that a hypothetical transition to fixed salaries for all Norwegian GPs would result in a 3–4 per cent drop in sickness absence (7). These figures are fraught with great uncertainty, nor have any other effects of such a hypothetical change been taken into account.

The other main argument for a wider use of fixed salaries has been that young doctors, and women in particular, abandon general practice because of the high requirements for earnings, few opportunities for updating professional skills without loss of income and because self-employed doctors are not entitled to paid sick leave or other forms of leave (4, 5). The age composition of the GP corps has nevertheless remained largely stable in recent years, with a minor increase in the proportion of GPs younger than 40 years (2). However, if we look at the gender distribution, a different picture emerges. The proportion of women among all doctors under 70 years increased by 42 per cent from 2002 to 2014. In the same period, the proportion of women among GPs increased by only 33 per cent (8) – i.e. a relative decline in the proportion of women GPs.

In the same period there has been a clear change of opinion among GPs with regard to the desired form of contract. The proportion that prefers self-employment has fallen from 52 per cent in 2009 to 36 per cent in 2012 (9). Moreover, young GPs in small municipalities had the strongest preference for fixed-salary arrangements. The tendency is even clearer among the very youngest: less than 20 per cent of interns and students want a payment scheme similar to the current piece-rate (10). Unsurprisingly, in this study as well as others, women were least in favour of the current system for general practice.

This latter point is essential, since women are the doctors of the future: in February 2017, altogether 66.3 per cent of all members of the Norwegian Medical Students' Association are women (11). In a situation where the recruitment to general practice is at risk and GPs are fleeing from rural areas (12), we need more and better knowledge on the effects of different payment schemes for GPs, not least during their vulnerable establishment and specialisation stages. The RGP scheme will remain the most important health service to the population also in the future. We need to listen to the wishes of the next generation of men and women who will staff this scheme. If we do, there are strong indications that the GPs of the future will draw fixed salaries.

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