

Research Article

Doctoring in Europe: The Perspectives of Primary Care Physicians: A Research Note

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Abstract

This paper explores the views of general practitioners (GPs) in Europe attending the World Family Council of Doctors conference in Dublin, Ireland (2024). Specifically, it engages a cross section of WONCA members by inquiring about their role as gatekeepers in health care, their current thinking about health care costs, their work experience and their stewardship in maintaining health care costs while simultaneously, working to improve the health of their patients. Data was collected from the relevant existing literature and a questionnaire distributed randomly to GPs attending the 2024 WONCA conference in Dublin, Ireland. The questionnaires were developed on the basis of a systematic review of the relevant literature on the changing status of GPs and was distributed to 50 GPs attendees with a return rate of 76%. This paper thus utilized a relatively small sample size focused exclusively on GPs. Based on the data collected, this paper contends that European GPs are generally satisfied with their work (92%) and they overwhelmingly see their role as “gatekeepers” in holding down health care costs, GPs were generally opposed to market reforms in health care. This study has wider implications for: (1) how GPs in Europe are meeting the challenges of their gatekeeping role in the face of financial constraints, and (2) how European GPs are working to reduce health inequalities.

Keywords

GPs, Medicine in Europe GPs, Job Autonomy, Job Satisfaction, Medical Cost Control, Europe Wonca

1. Introduction

Good health and equal access to health and medical care are the fundamental aspects of European health care systems. In recent decades, however, economic incentives have become more and more important in health care, even in welfare states in Europe where health care has been primarily the responsibility of the state. At the same time, a confluence of forces—an aging population, higher rates of cancer deaths, increased health care costs, improved access to health care through innovation in medical technologies, and demands by patients for more choices and better-quality care—have

forced some European countries to rethink their health care delivery systems [12]. Research demonstrates that these trends have altered the nature of health care in publicly financed health care systems [2, 8, 10, 1, 12, 6]. Much of the debate recently has focused on primary care physicians’ burnout, the fragmentation of care, and greater financial responsibility for health care costs. The seminal paper, “Gate-keeping Revisited: Protecting Patients from Overtreatment,” Franks and his associates, the authors asserted that, “The care from primary physicians may be superior to that from spe-

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cialists...as they provide continuity and comprehensiveness of care.” They further argued that, “[b]y virtue of their training and professional socialization, primary care physicians are likely to be more effective than specialists in matching patient’s needs and preferences with the judicious use of medical services” [4]. A much more recent study, Arthur Derse argues that “[p] hysicians must act for the patient’s benefit rather than proceeding under a pure contract model which might permit maximization of the physician’s self-interest” [3].

In an age of cost control, physician shortages, and greater desire by patients for better access to health services, physicians are increasingly required to do more in the face of dwindling resources and increased risks to their own health and safety (as recent attacks on the medical professionals have proven). This is aptly summarized by Song and associates in their paper, “Primary Care and Financial Risk.” “Primary care practices are increasingly taking on accountability for total health care spending for a defined patient population” [11]. Indeed, in a study assessing the role of GPs in the Nordic health care systems, the study argued that GPs in Norway have become less concerned about their gatekeeping role and more focused on retaining their patients, since remuneration is linked to the number of patients they have [12]. A similar trend has emerged in the British National Health Services (BNHS) where GPs are paid an inclusive age -related, geographically weighted, capitation fee based on the number of patients they have.

In addition, in the Swedish experience, the so-called Vardval (Sweden Care Choice encouraged Swedish GPs to enter into “private practice, which by design allowed patients more choice of both private and public primary care centers, allowing the local Swedish counties to contract with increasing numbers of new private for-profit and not-for-profit primary care providers” [10]. Likewise, in the Danish health care system, GPs are the gatekeepers, as patients choose their GP within their geographical area. Recent reforms meant to cap payment to GPs, had the opposite, and unintended consequence of increasing prices, as GP felt they had no financial incentive for keeping the cost down (since patients have unlimited access to health care). From the perspective of the Danish Medical Association, patients trust that their GPs that they will not under- or over-treat them for financial gain [12].

In all these changes, the question remains: has the position of the GPs in the medical division of labor been strengthened, weakened, or changed ambiguously? What better way to gauge this trend than to ask a group of primary care physicians attending the 2024 WONCA Europe Conference in Dublin, Ireland.

2. Objectives & Methodology

This paper’s objectives are as follows:

1. To explore the perspectives of GPs on trends as they report regarding their working conditions

2. To explore their views on recent health care reforms in their respective countries of practice. And to gauge how the increased privatization in health care systems were undermining the professional autonomy of GPs in the overall health care delivery systems.

3. Methods

This research data come from a survey randomly distributed to GPs attending the WONCA 2024 conference. The questionnaires were developed on the basis of a systematic review of the literature on the changing status of GPs. The subjects were asked about their age, years of practice, income from their practice, practice conditions, job satisfaction, views on market competition and privatization in health care, professional autonomy, and the recent health care reform strategies introduced into their respective countries. The survey also asked about their views about future career goals and whether they were more inclined to recommend the profession to their children and or relatives. Finally, we asked questions about the country they practice medicine.

The questionnaires were distributed randomly to GPs attending the Dublin, Ireland 2024 WONCA conference. Break periods of an hour three times a day allowed for easy distribution and completion of the survey. A few emailed their responses. In total, 50 survey questionnaires were distributed. The response rate was 76 percent (38/50).

4. Results

Of the survey respondents, 63% percent were male and 40 percent were female, with 11 percent not identifying their gender. About twenty-six percent of respondents reported that they have been practicing medicine as a GP for 21 years or more. Twenty-eight percent (19%) reported practicing medicine for 11-15 years, with thirteen percent (23%) reporting practicing medicine up to 10 years. About 24 % reported practicing medicine for not more than five years. Regarding the age of our respondents, 32 percent reported a range of 36-45 years, followed by one quarter (29%) of our sample reporting an age range of 25-35 years. Sixteen percent were in the age group of 46-55 years, Sixteen percent were in the age group of 56 to 65 years with 8% over 66 years or more. A majority of our respondents (34%) reported practicing in Ireland, 11 % in the Netherlands, 8 % in Australia, 8% in Portugal, Norway, France, Spain, Canada and Lithuania at 2.6 % each.

Table 1. The socio-demographic profile of respondents is as follows (N= 38).

Gender	N	%
Male	24	63.1

Female	10	26.3	NA	3	7.8
Other	4	10.5	Total	38	100
Total	38	100	Has any Recommendation made regarding profitability of patients?		
Years of Practice			Yes	30	78.9
	N	%	No	6	15.7
1-5 years	9	23.6	No response	2	5.2
6-10 years	9	23.6	Total	38	100
11-15 years	7	18.4	Net income Practice		
16-20 years	3	7.8		N	%
21 years +	10	26.3	Less than 90,000 euros 2	5.2	
Total	38	100	90-100.000	8	21
Age			110-150.000	8	21
	N	%	160-200,000	6	15.7
25-35	11	28.9	210-000+	9	23.6
36-45	12	31.5	250,000	2	5.2
46-55	6	15.7	N/A	3	7.8
56-65	6	15.7	Total	38	100
66+	3	7.8	Work Satisfaction		
Total	38	100	Strongly agree	9	23.6
Country of Practice			Agree	26	68.4
	N	%	Not Much	3	7.8
Ireland	13	34.2	Not at all	0	0
Netherlands	4	10.5	Total	38	100
Australia	3	7.8	Recommend Profession		
France	1	2.6	Strongly agree	8	21
Australia	3	7.8	Agree	16	42.1
U.S.	2	5.2	Not much	11	28.9
Canada	1	2.6	Not at all	3	7.8
Total	38	100	Total	38	100
Practice- Based on Bonus					
Yes	12	31.5			
No	26	68.4			
Total	38	100			
Percentage of Practice Based on Contract with State					
1-10%	0	0			
11-20%	0	0			
21-30%	3	7.8			
31-40	1	2.6			
41-50	8	21			
51+	18	47.3			

5. Views on Profitability of Patients

In response to cost- containment strategies, several Euro-

pean countries have embarked on some form of market in-

centives in health care, with mixed results, what Cortez aptly

describes as “market accommodators.” Given the public fi-

nancing of most health care systems in Europe, we wanted the

views of European GPs by inquiring whether they believe that

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garding how they treat their patients. T As one puts it, “Yes, there are Medicare incentives for a subset of patients as Medicare incentivizes patients with chronic or complex diseases.” As one respondent stated, “Yes, we are encouraged to bill high and to work with private payers and cream skimming, the lazy stuff happens a lot.” While the impact of cost control may negatively impact on patients, anecdotal evidence from the respondents suggest that given the significant role of the government in health care financing, and the fact that majority of physicians are contracted by the government, the impact on their practice is less certain than one would expect in a privately- driven system like the United States where managed care had rendered physicians to act like double agents who must serve both patients and the organizations that pay for their care [9].

6. GPs Respondents’ Views as Gate-keepers

Given the centrality of GPs as gatekeepers, we wanted to explore European GPs views on what they perceive their gate keeping roles were. Overwhelmingly, our respondents reported that they view their role as first line of defense in the health care system. As one puts it, “Yes, we try to manage as many problems as you can without referring patients to specialist even though it is their primary wish to get referred. “From the perspective of a Canadian GP, “Gate keeping is assumed in Canada but dysfunctional. For another, GPs are approachable doctors; all referrals to specialist go through me if not solved by me/patient and to prevent overuse of limited resources and early prevention of chronic disease.” Yes, we have a role in appropriate referral to use/ of tests and specialist input and to prevent people going to secondary care immediately. We keep care equitable and affordable. “Yes, we all have our own patient population, they come with health issues, we decide if we can treat the patient ourselves or if they need to see a specialist.”

7. Health Care Reform

To better understand the perspectives of GPs regarding ways to save money for the health care systems, we asked them to discuss any recent health care reform strategies introduced into their country. We read comments like, “Reform has tended to focus on managing chronic disease management and for centralizing care centers leaving rural areas without specialized centers in close proximity. For another, sadly, a lot of reform are money-driven by insurance companies often at our expense The Slainte Care strategy with more care in the community focused on chronic care patient based on need not ability to pay and a shift from equity to equality- regretfully. For another, the emphasis has been on improved contraception access, improved management of chronic disease and profit sharing with health savings passed on to patients For

another, not right now, the last one was ACA- Obamacare. Further reform has taken the view of emergency care clinics run by GPs, aim to provide extended- hour access to health care and reduce the burden on hospitals and emergency rooms and universal access, GP for everyone and decreasing health inequalities. Overwhelmingly, GPs mentioned the need to reduce useless diagnostic tests, referrals, and medication prescriptions while investing in prevention and primary care. One respondent stated, “cost reducing in health care can be achieved through drug cost caps, allowing private incentive where necessary, and we need to maximize quality of care by increasing health care accessibility for all.” From the perspective of an Australian GP, it is about increasing Medicare rebate introduction of sole trader tax- inability to bulk bill patients with no gap for medical care. The use of telemedicine, continued health insurance with continued health care facilities. For others, it is “chronic disease management in primary care with focus on community- based diabetes clinics by moving patient care into community hubs by freeing up hospital clinics.

8. Changes in Health Care and Professional Autonomy

In his book, *The Social Transformation of American Medicine* [8], Paul Starr had predicted that “The last decade of the twentieth century are likely to be a time of diminishing resources and autonomy for many physicians.” In the United States, the growth of managed care has led several scholars to conclude that Medicine has lost its status as a dominant profession [5]. As McKinlay and Stoeckle [7] asserted, “The growing corporatization and bureaucratization of medicine have resulted in elimination the self-employment and autonomy of physicians.” In our survey we asked our respondents whether they thought the changes in health care are undermining their professional autonomy or not. About 47% indicated yes and 53 % indicated that changes have not undermined their professional status as physicians. From the perspective of one GP., “No doctors have autonomy though there are evidence-based guidelines for the practice of medicine.” For another, “No our level of work is neither increasing nor decreasing. For the majority of respondents GPs have never had much control. For another, Ys, increasing dependence on state for income reduces our ability to practice our craft and yes, more involvement independently of allied health care professional which is good, but leads to increasing fragmented care. Yes we are losing autonomy because people want more information about health but social platforms are providing bad information. Yes, we are subject to moral injury as health systems and insurance companies ask us to do this against our values. Again, yes, because of less investment, some inappropriate allocation of roles to other professions. For example, pharmacists who have strong lobby powers, and these have been shown to cause worse patient outcomes in many cases. As aptly stated, “Yes,

health care insurance companies dictate our rates and work content, therefore, we are losing control over our practices and yes, too much people who need care too less doctors and its getting too expensive. In addition, misunderstanding of patient regarding how doctors are paid in a country where health care is expected to be free. Lack of understanding of specialists and hospital doctors and as a result doctors are losing control over their patients. The hospital owners/businesses drive most part of the accessibility and delivery of care.”

9. GP Satisfaction

We wanted to ASCERTAIN the impact on GPs’ sense of satisfaction in their work from cost containment strategies impinging on professional autonomy. Overwhelmingly, (92 %) expressed satisfaction with their job with only 8% expressing dissatisfaction with their work. We further asked our respondents whether they will recommend their profession highly to their children or relatives. Given the high level of work satisfaction expressed earlier, we expected to see an overwhelming majority of respondents saying yes. Our results, however, showed that thirty-seven (37%) were unwillingly or unenthusiastically recommending the profession. This raises an interesting paradox. We are not sure if respondents were reacting more to the future trends within medicine as it relates to work schedules and income. Perhaps a larger study exploring this issue would yield valuable information for helping to address the “graying” of the medical profession in Europe.

This paper has reported on the perspectives of GPs in Europe. The results from the study suggest that GPs are generally satisfied with their work and they see their role as gate keepers in holding down health care cost. Naturally, given the role of the public financing in health care, and a greater solidarity among Europeans, this was not surprising.

Herein lies the major challenge facing European health care systems: with increased cost in health, the aging population and advances in medical technology, the current strategy would be called into question. As alluded to earlier, we are seeing the “greying” of the profession, as almost half of the respondents reported having been practicing medicine for over a quarter of a century. As eloquently reported by Peter Holden [13], the United Kingdom has fewer doctors per head of population than most other European countries and a decreasing number of general practitioners despite the high rise in demand. This trend is not only true in the UK, but all over the world with implications not only for the medical profession but for patients.

Our study is limited by the small sample size and the sole reliance on GPs. Nevertheless, since GPs continue to play a vital role in health care across the globe, understanding how they feel about issues of cost, medical practice and professional autonomy is critically important.

Abbreviations

WONCA	World Council of Family Doctors
GP	General Practitioners

Author Contributions

Randolph Quaye is the sole author. The author read and approved the final manuscript.

Conflicts of Interest

The author declares no conflicts of interest.

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