Rethinking salary bonuses for public-sector doctors

Without incentives linked to outcomes, salary top-ups for physicians in state healthcare systems may backfire.



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Public healthcare systems form the bedrock of welfare states across Europe, and keeping government hospitals and clinics well-staffed will become an increasing challenge as

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populations age and a generation of doctors prepares to retire.

Policies that balance public and private practice will be essential for governments as well as doctors. Private practice coexists alongside public systems in most countries, and doctors choose whether to practice in one or the other, or in both. In the U.K., for example, an estimated 90% of private-sector doctors are also consultants in the National Health Service (NHS).

Dual practice — where doctors work simultaneously in the public and private sectors — can offer the best of both worlds, allowing providers to complement public-sector salaries with income from private patients. In several specialties, large and technologically advanced public hospitals are also the settings where physicians build their clinical expertise and professional reputation.

Proponents argue that dual practice helps retain talent in public hospitals, where remuneration is often lower, and keeps highly skilled doctors anchored within the public system. Critics, however, point to the risks of conflicts of interest, reduced availability of physicians for public patients and distorted incentives. In particular, the prospect of higher private-sector fees may encourage dual-practice doctors to shift time and effort toward private patients, potentially undermining access and quality of care in the public system.

Research by IESE's Nuria Mas, Jonathan Gruber of MIT, NYU's Jaume Vives and Judit Vall of Universitat de Barcelona examines a policy option to encourage doctors to dedicate themselves fully to the public system: exclusivity bonuses. In theory, these salary top-ups paid to doctors who work only in the state system will lead to an increase in the availability of care within the public system.

More doctors, fewer hours

Although the number of doctors working only in public hospitals and clinics rose by about 2 percentage points, the bonus provoked a decline in actual working hours. Governments were spending more money for less work.

-7.1 %

Fall in the number of working hours

Following the introduction of exclusivity bonuses

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When going exclusive backfires

Like many European countries, Spain has a comprehensive public health system that provides coverage for more than 99% of the population. Despite this universality, there's also a thriving private market, and about 30% of Spaniards pay for voluntary private health insurance. Including public and private outlays, Spain spends just under 10% of its gross domestic product (GDP) on healthcare.

Salaries for Spanish doctors, as is the case for most workers, are low and hiring processes rigid. Of all doctors, 50% practice exclusively in the public sector and 42% are exclusively in the private sector; the remaining 8% split their time in both. Though dual-practice doctors represent a relatively small percentage of providers, concerns about public-private conflicts of interest led different autonomous regions to introduce exclusivity bonuses of various amounts.

The research finds that these financial rewards did, in effect, encourage some doctors to drop their private practice. But it ultimately backfired because it ended up reducing the total amount of care provided.

Despite the greater number of doctors, the average hours worked declined by 1.8 hours/week per worker, or by 7.1%, in the public sector after the bonuses were introduced, and by 1.2 hours in the healthcare system as a whole (aggregating both public and private care).

Why? It's difficult to pinpoint a single reason, but the majority of doctors in the public sector were already exclusive, and they also received the bonus. With the extra cash, they no longer needed to put their hand up for extra night shifts or volunteer to work over holidays. Instead, they could just work less — and that's what they did.

Policy implications for bonuses

"These findings provide important lessons for nations struggling with the proper rate of private care in their public systems," the researchers write. Bonus programs involve substantial government spending: the study estimates that the exclusivity bonus program cost the public health system nearly a billion euros per year, or 1.5% of total public health spending.

The findings of Mas and colleagues serve as a cautionary tale. More spending doesn't automatically translate into better health services. Additional compensation that isn't linked

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to outcomes or performance in any way may create the wrong incentives.

All of this will be of increasing importance in the coming decades as the population ages, putting new strains on healthcare. At the same time, Europe is set to experience a wave of retirement by doctors. According to OECD statistics, more than one-third of doctors in the EU are 55 years or older, meaning they will begin leaving the workforce in a decade.

“Urgent action is needed to address health workforce shortages in Europe,” the OECD warns. That is undoubtedly true, but actions must be effective as well as urgent.

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Nuria Mas

Professor of Economics at IESE Business School and holder of the Jaime Grego Chair of Global Healthcare Management.

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