OECD Health Statistics 2025
Definitions, Sources and Methods

Remuneration of specialists

Remuneration is defined as the average gross annual income, including social security contributions and income taxes payable by the employee.

Specialists: Fully-qualified physicians who have specialised and work primarily in areas other than general practice. Physicians in training should normally be excluded.

Note: To the extent possible, average annual income should refer to physicians working full-time.

Salaried: Physicians who are employees and who receive most of their income via a salary.

Self-employed: Physicians who are primarily non-salaried. That is, they are either self-employed, or operate independently, usually receiving (mainly) either capitation or fee-for-service reimbursement.

For physicians who are both salaried and operate in a self-employed or independent capacity, they are presented in the category under which they receive the majority of their compensation.

Inclusion:

- the values of any social contributions, (income) taxes, etc. payable by the employee even if they are actually withheld by the employer and paid directly to social insurance schemes, tax authorities, etc. on behalf of the employee
- all gratuities, bonuses, overtime compensation and "thirteenth month payments"
- any supplementary income (income from private practices for salaried physicians or salaried work for self-employed physicians).

Exclusion:

- for salaried physicians, social contributions payable by the employer
- for self-employed physicians, practice expenses.

NOTE:
Average salaries for healthcare professionals are converted to USD PPPs using PPPs for private consumption to bring them in line with average earnings calculations across the OECD.
Average salaries presented from *OECD Health Statistics 2021* onwards cannot be compared with data from previous versions.

Sources and Methods

Australia

Salaried specialists: Data not available.

Self-employed specialists:
Sources:
Headcount data:
2019 onwards: **Australian Government Department of Health.** Health Workforce Summaries. Viewed 14 February 2025. https://hwd.health.gov.au/resources/data/summary-mdcl.html.
2013-2018: **Australian Government Department of Health**. Medical workforce factsheet. http://hwd.health.gov.au/publications.html (and previous versions).
Before 2013:
Australian Government Department of Health. Annual Medicare Statistics. Viewed 24 January 2017. http://www.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-statistics (and previous versions).
Australian Institute of Health and Welfare. Medical workforce. Viewed 24 January 2017. http://www.aihw.gov.au/workforce/medical/ (and previous versions).
Fees charged data:
2013 onwards:
Australian Government Department of Health. Quarterly Medicare Statistics. Viewed 6 February 2024. https://www.health.gov.au/resources/collections/medicare-statistics-collection?language=en (and previous versions).
Before 2013:
Australian Government Department of Health. Annual Medicare Statistics. Viewed 24 January 2017. http://www.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-statistics (and previous versions).
Methodology:
- Data for practitioner type are based on headcount.
- Data are for fees charged by self-employed specialists providing services on a 'fee-for-service' basis for which Medicare benefits were paid. Salary and sessional payments are not included as these are not available from Medicare data. Includes categories: obstetrics, anaesthetics, pathology, diagnostic imaging, operations, optometry, as well as 'specialist' and 'other'. Remuneration for dentists, stomatologists/dental surgeons and psychologists are excluded from this indicator.
- The average annual remuneration presented is gross income net of practice expenses. Practice expenses have been deducted by applying the average across OECD countries (30% of gross remuneration).
Specialists in training are included.
Break in series in 2013: Data for specialist headcount include Australian General Practice Training program trainees. Before 2013, they were included in the GP headcount. The National Health Workforce Dataset is held by the Department of Health and the data have minor differences from the previous AIHW holdings due to the method of imputation for survey non-response and enhanced geocoding methods.
Break in series in 2011: Data for the number of specialists are based on estimates derived from the National Health Workforce Data Set: medical practitioners 2011 (and later years). The NHWDS combines data from the National Registration and Accreditation Scheme (NRAS) with health workforce survey data. Before 2010, the AIHW Medical Labour Force Survey was managed by each state and territory health authority.
Break in series in 2002: Data are calculated per headcount. The numbers of specialists are Medicare billers until 2001, and Australian Institute of Health and Welfare (AIHW) specialist labour force estimates thereafter. Full-time equivalent data are not available from Medicare.
GP labour force estimates for 2010 were incomplete, as two states did not provide full data. As a result remuneration estimates for self-employed GPs or specialists for 2010 were not computed.

Austria

Salaried specialists:
Data not available.

Self-employed specialists:
Source: National Audit Office, Income Reports, "General Income Report under the Federal Constitutional Act on the Limitation of Holders of Public Offices."

Methodology:
- Data refer to self-employed specialists.
- Data are calculated per headcount.
- Data refer to income before taxes but exclude social insurance payments.
Further information: https://www.statistik.at/en/statistics/population-and-society/income-and-living-conditions/general-income-report.

Belgium

Salaried specialists:
Source: Federal Public Service Public Health, Safety of the food chain and environment, Finhosta (financial data on hospitals).
Coverage: Only specialists working in hospitals.
Methodology: The amount is calculated as the ratio of the average personnel cost of employed persons in all Belgian hospitals = total wage cost per category of personnel / number ETP per category of personnel.

Self-employed specialists:
Source: Institut national d'assurance maladie-invalidité (INAMI).
Methodology:
- The remuneration data correspond to the average of reimbursed fees from medical acts (in Belgium, the system is based on reimbursement by act/procedure). Data do not include additional incomes from other payment methods (the patient co-payments and remuneration for non-reimbursable acts).
- For privately-employed doctors, the remuneration corresponds to the amount paid to them following acts/procedures they have carried out. However, for publicly-employed doctors, there is a slight difference. Data include mostly doctors working in university hospitals. In this case, the "remunerations" are billed by the hospital, which has an agreement with doctors, which details are not known. In this case, the average includes the amounts billed by hospitals for those (reimbursed) acts/procedures carried out by those doctors. The average will however not include the real salary paid by the hospital to the doctor.
- As a conclusion, the data provided corresponds to the average of all acts/procedures paid for and divided by the number of doctors (whether they are salaried or not).
Data refer to gross income and include practice expenses (resulting in an over-estimation).
- All specialties, excluding pharmacists, pharmacist-biologists, dentists, periodontists or orthodontists.
- Figures are means calculated per head-count.

Canada

Salaried specialists: Data not available.
Self-employed specialists:
Sources:
Canadian Institute for Health Information, National Physician Database.
Canadian Medical Association, Physician Resource Questionnaire until 2002, National Physician Survey 2010, Physician Workforce Survey 2017.
- 2019 data refer to 74% of all professionally active specialists excluding imaging and laboratory specialists:

	Physicians who received fee-for-service payments in excess of CAD 100 000 in 2022/2023*	**Total professionally active physicians excluding residents on 31 December, 2022****	**Physicians in private practice who received fee-for-service payments in excess of CAD 100 000 as a % of total physicians**
Specialists	30,338	47,728	64%

* CIHI, National Physician Database - Payment Data, 2022/2023 - Data release of October 10, 2024 (latest release available). See CIHI National Physician Database metadata at, https://www.cihi.ca/en/national-physician-database-metadata.
** CIHI, Scott's Medical Database (SMDB), Supply, Distribution and Migration of Canadian Physicians, 2022: Data Tables. See Scott's Medical Database metadata at https://www.cihi.ca/en/scotts-medical-database-metadata.

- Data for average fee-for-service (FFS) per physician who received at least $100,000 in FFS payments by gender breakdown exclude the provinces of Quebec, Nunavut and Northwest Territories.
- Data refer to average fee-for-service payments by provincial medical care plans to specialists (excluding imaging and laboratory specialists) in private practice who billed the plans at least CAD 50000 annually in 1997 and 1999, at least CAD 60000 annually from 2001 to 2011 and at least CAD 100000 annually from 2012 onwards.
- The physicians who received less than CAD 50000 before 2001, less than CAD 60000 from 2001 until 2011 and less than CAD 100000 after 2011 in fee-for-service payments are either self-employed physicians working part-time (or self-employed physicians who were not in practice during the full year) or full-time physicians obtaining a portion, if not most, of their remuneration on alternative payments modes. In Canada, alternative modes of remuneration refer to payments made for clinical services provided by physicians and not reimbursed on a fee-for-service basis. Classifications vary across provincial/territorial jurisdictions.
- Figures are gross income, net of practice expenses. Information on overhead expenses reported by medical and surgical specialists in the 1998, 2000 and 2002 Physician Resource Questionnaire of the Canadian Medical Association (CMA) was used to estimate practice expenses in 1997, 1999 and 2001 (the information collected in the Questionnaire pertained to the last fiscal year preceding the year of the Questionnaire). The average practice expenses of medical specialists and surgical specialists primarily on fee-for-services were roughly estimated as 27% and 33% of gross earnings respectively (29% for all specialists) from 2002 to 2008, based on information on the share of overhead costs collected in the Physician Resource Questionnaire. In the 2010 National Physician Survey, average expenses of practice of medical specialists and surgical specialists primarily on fee-for-services were reported to be 24.3% and 30.0% of gross earnings respectively (26.2% for all specialists). This percentage was used to estimate practice expenses in 2009 to 2011. In the 2017 Physician Workforce Survey, average expenses of practice of medical specialists and surgical specialists primarily on fee-for-services were reported to be 23.22% and 29.66% of gross earnings respectively (25.13% for all specialists). This percentage was used to estimate practice expenses from 2012 onwards. The question on the share of overhead costs was included in the CMA surveys of 1998, 2000, 2002, 2010 and 2017, but not in the survey of any intermediate year.
- Medical specialists tend to receive their professional remuneration either exclusively on a fee-for-service basis or exclusively through alternative modes. Surgical specialists tend to receive the majority of their professional remuneration on a fee-for-service basis.
Break in time series in 2012: Starting in 2012, data refer to average fee-for-service payments by provincial medical care plans to specialists (excluding imaging and laboratory specialists) in private practice who billed the plans at least CAD 100000 annually (was at least CAD 60000 annually in 2011).
Break in time series in 2001: 2001-2011 data refer to average fee-for-service payments by provincial medical care plans to specialists (excluding imaging and laboratory specialists) in private practice who billed the plans at least CAD 60000 annually (was at least CAD 50000 annually before 2001).

Chile

Salaried specialists:
Source: Ministry of Health, Health Human Resources Planning and Control Department from the Division of Management and Human Resources Development. **Management Data Base of the Human Resources Information System (SIRH) of the Public Health Sector**.
Coverage:
- Data include fully qualified specialised physicians, who work for the hospitals of the National System of Health Services (SNSS) and possess a medical specialty certification.

- Data coverage is nationwide but includes only salaried specialists from the public health sector hospitals (majority in the country) and excludes private sector clinics for which information is not available. Data exclude professionals working in Public Primary Care Municipal Health Service (Offices).
- Data include all existing contract categories in the public hospitals: contracts from 11 to 44 hours per week; the Medical statutory law allows working contracts of 11, 22, 33 and 44 hours per week.

Methodology:

- The average gross annual income is converted into Full Time Equivalent (FTE) average gross annual income. In Chile, full time corresponds to 44 hours per week. The figures are expressed in Chilean peso and current value.
- The increase in remuneration from 2016 is explained by the implementation of two important agreements that were ratified in 2015 between the Government and the professional associations and unions of the public health personnel. With respect to specialists, these agreements are described in the Ley 20982 published on the 28th of December 2016, and contain various improvements related to careers, wages and bonuses, and implement incentives to attract and retain a higher number of these professionals in the public sector.
- The increase in remuneration in 2014 is explained mostly by the enactment in 2013 of a new law on remuneration and incentives for Specialists who work in duty shifts in the Public Hospitals Emergency, Critical Patients and Reanimation wards.
- Between 2011 and 2013, the value of various remuneration incentives was increased, with different dates of implementation; some of them applied to all public specialists; one of them (incentives for competency) was created for some specialties that were considered particularly critical and scarce such as pediatric intensive care and anesthesiology, among others. These policies affect the growth rates in public specialists' remuneration between 2011 and 2013.

Self-employed specialists: Data not available. Self-employed specialists work only in the private sector.

Colombia

Source: The source of information is the **Directorate of Human Talent Development in Health (DDTHS)**, from the **OLAP Cube of ReTHUS-PILA**, with a cut-off date of October 6, 2024.

Coverage:

- Contribution values were differentiated according to the type of SGSSS affiliation, classifying contributors as dependents or independents. For dependents, the IBC corresponds to the salary reported by the employer, while for independents, the IBC corresponds to 40% of the monthly fees, not less than the current legal monthly minimum wage.
- The profiles reported correspond to the primary medical specialties (clinical, surgical, and diagnostic). For more detailed information, see the reference table "THSPERFIL".

Methodology:

- Data reported based on information from individuals registered in the **National Unified Registry of Human Talent in Health – ReTHUS** as medical professionals without any registered medical specialty, cross-referenced with the **Base Contribution Income – IBC** reported at the time of contributions to the General System of Social Security in Health – SGSSS through the **Single Payment Form – PILA**.

Estimates regarding the availability of human resources in health are based on individuals authorised to practice professions and occupations in the healthcare sector, registered in ReTHUS, along with data cross-referenced from contributions to the Social Security System (via PILA) and information from the Hospital Information System (SIHO). Based on those data, it is not possible to determine which subset of human resources is directly involved in care provision and receiving remuneration.

Costa Rica

Source: Caja Costarricense de Seguro Social (National Social Insurance Fund).

Coverage: Data include only health workers employed by the National Social Insurance Fund.

Estimation:

- The following parameters were used for the estimation of annual salaries: salary indexes for each year, bonuses inherent to each position, an average of 13 annuities, an average of 30 professional career points, as well as some normative and legal considerations that must be followed for this kind of estimations.

- Estimations do not include any consideration related with overtime payments.
Note: The decrease from 2019 to 2020 can be explained since in 2018 a new law approved by Congress changed some of the rules related to salary bonuses and incentives for public employees; that law took effect in mid-2019; even though the law respected the bonuses and incentives already earned, for new bonuses and annuities earned after 2019 (for both old and new employees) new rules were applied.

Czechia

Salaried specialists:
Sources:
From 2011 onwards: Data from the **ISPV system (Information and Statistics on Average Earnings), Ministry of Finance**.
2000-2010: **Institute of Health Information and Statistics of Czechia**, National Health Information System (Statistical surveys on employees and structure of wages in health care establishments);
Coverage:
- From 2011, only the total number of Specialists – CZ-ISCO: 2222 is reported.
- Data broken down by females and males are not available in ISPV system.
Methodology:
- Data are expressed in Czech currency.
- In terms of reported data for the monitored year, this is always twelve times the average gross monthly earnings. These earnings are determined in ISPV according to the Eurostat methodology for the Structure of Earning Survey (SES). Gross earnings are defined in ISPV as the sum of salaries, salary compensation (e.g. compensation for leave, compensation for work obstacles, etc., but excluding salary compensation for temporary incapacity for work) and standby compensation for the monitored period, related to the number of converted paid months of the employee. i.e. the number of months that the employee worked or for which he received salary compensation (excluding compensation for temporary incapacity for work). The criteria for including an employee in the calculations of the above indicator are (a) the converted number of paid months of the employee is at least one month in the monitored period and (b) the specified weekly working hours for the given job are at least 30 hours, according to Eurostat recommendations.
Deviation from the definition: Results are given for the public sphere (the employer is the state, a territorial self-governing unit and organisations established by them listed in the Labor Code) of the Czech Republic, because in some years, results for the wage (from private income of a healthcare facility) are not available at the level of the five-digit ISCO code (no or minimal number of observations in the time-varying sample of employers of the relevant statistical survey). Healthcare workers could receive a wage in addition to their salary, which is not calculated in the data.
Break in time series in 2011 due to a change in the data source.

Self-employed specialists:
Source: Institute of Health Information and Statistics of Czechia, National Health Information System. Data available only for the years 2007-2008.
Methodology:
- Data are from the survey on independent establishments of out-patient care.
- Figures apply to about one-fifth of all specialists (source: IHIS CR, Registry of Physicians, Dentists and Pharmacists). 14% of self-employed specialists also have a part-time salaried job in a hospital in 2005 (Source: Registry of Physicians, Dentists and Pharmacists). Figures do not include their salary from hospital.
- Data cover both full-time and part time workers but reflect the workload of physicians, i.e. the income is divided by the estimated number of full-time equivalent physicians.
- Data refer to gross income, net of practice expenses. Practice expenses consist of material, wages of employees, social and health insurance of employees, overhead cost (energy, etc.) and other expenditure.
- An adjustment according to financial income and expenditure was applied. An estimation of social insurance premium of the self-employed was made.

Denmark

Salaried specialists:

Source: The joint municipal payroll data office, KRL (previously FLD).
Methodology:
- Data are calculated per full-time equivalent (FTE).
- Reference period: yearly average.
Coverage:
- Only publicly-employed physicians are included.
It is not possible to separate general practitioners and specialists. Data for both groups are reported under specialists.
Further information: From 2007 onwards, numbers for the remuneration of specialists originate from the table "overlæger, Lægelige chefer m.v" in the remuneration overview available at http://www.krl.dk (in Danish).
Self-employed specialists:
Source: Danish Association of Practicing Medical Specialist (FAPS), Cost survey (2008).
Methodology: Survey among representative sample.
Coverage:
- Data do not include privately-employed specialists.
- Physicians in training are not included.
- Figures are calculated per medical specialist.

Estonia

Salaried specialists:
Source: National Institute for Health Development, Department of Health Statistics. Annual report on hourly wages of health care personnel in March.
Coverage:
- All health care providers.
- Only specialists with working contracts.
- Average remuneration for salaried health care workers is calculated on the basis of monthly salary: average monthly gross salary in March multiplied by 12.
- It includes personal income tax, and other taxes paid by the employee. It does not include social tax and other social contributions paid by the employer.
- The average monthly wage includes basic wage, additional remuneration, additional payments for evening work, night work, work on days off or during public holidays and additional payments for overtime. It also includes irregular additional payments (quarterly and annual bonuses and other irregular performance and value payments) which are paid in March. Informal payments are not included.
- All physicians are included, except family doctors, dentists, orthodontists and oral-maxillofacial surgeons. Psychologists are not included.
- Data include both public and private sectors.
Break in time series in 2020: The average monthly gross wages and salaries have been given in full-time equivalent to enable a comparison of different wages and salaries, irrespective of the length of working time. Before 2020, the calculation of average monthly wage involved only full-time employees. From 2020, part-time and full-time employees are included, and average monthly gross wages have been given in full-time equivalent (FTE).
Note: The increase in remuneration is related to collective agreements, which have established minimum wages for health care personnel. New collective agreements have been signed since 2015:
- 1.01.2015: the wage agreement set the minimum hourly wage at 9 Euros for physicians.
- 1.01.2016: the wage agreement set the minimum hourly wage at 10 Euros for physicians.
In 2017, another agreement was signed in April, whose effects are visible in wages reported for the year 2018.
- 1.04.2017: the wage agreement set the minimum hourly wage at 10,53 Euros for physicians and 10,9 Euros for specialists.
- 1.04.2018: the wage agreement set the minimum hourly wage at 11,35 Euros for physicians and 12,0 Euros for specialists. Effects are visible in wages reported for the year 2019 (reference period is March).
- 1.04.2019: the wage agreement set the minimum hourly wage at 13,40 Euros for specialists. Effects will be visible in wages reported for the year 2020 (reference period is March).

- 1.04.2020: the wage agreement set the minimum hourly wage at 14,40 Euros for specialists. Effects will be visible in wages reported for the year 2021 (reference period is March).
- 1.04.2021: the wage agreement set the minimum hourly wage at 15,00 Euros for specialists. Effects will be visible in wages reported for the year 2022 (reference period is March).
- 1.04.2022: the wage agreement set the minimum hourly wage at 16,20 Euros for specialists. Effects will be visible in wages reported for the year 2023 (reference period is March).
- 1.04.2023: the wage agreement set the minimum hourly wage at 17,88 Euros for physicians. Effects will be visible in wages reported for the year 2024 (reference period is March).
Further information: Data are published in the Health Statistics and Health Research Database available at https://statistika.tai.ee/pxweb/en/Andmebaas/Andmebaas__04THressursid__06THTootajatePalk/?tablelist=true.

Self-employed specialists: Data not available.

Finland

Salaried specialists:
Source: Statistics Finland, Structure of Earnings.
Coverage: Data related to the private sector include only salary earners working in a company that employs five or more employees.
Break in time series in 2016: The classification of occupations ISCO-08 was introduced for specialists in 2016. Before 2016, ISCO-88 (COM) was applied. Data have been revised from 2016 onwards.
Notes:
- 2020: Holiday pay reductions were returned to their normal level in the public sector.
- 2017: Yearly earnings decreased in 2017 compared to the previous year due to holiday pay reductions (minus 30%) in the public sector. The reductions were applied in accordance with a nationwide "competitiveness pact". These reductions in holiday pay continued to apply in 2018-2019 but are relinquished from 2020 onwards.
Further information: https://stat.fi/en/statistics/pra.
Self-employed specialists: Data not available.

France

Salaried specialists:
Source: Institut national de la statistique et des études économiques (Insee), Annual declaration of social data (DADS) 2006, 2007, 2008, for the public and private sectors. From 2009, DADS data for the private sector are combined with another source for the public sector, the *Système d'information sur les agents des services publics* (SIASP); 95% of salaried specialists are covered.
Methodology: From 2016 onwards, the annual social data declarations (DADS) sent by companies to the authorities are gradually being replaced by nominal social declarations (DSN). In this context of gradual changes in information sources, Insee has begun to overhaul the statistical processing carried out. Thus, **between 2016 and 2019, the levels of remuneration are not comparable to those of previous years**. More detailed information is available in « En 2016, le salaire net moyen augmente de 0,5 % en euros constants », Insee Première n° 1750, see https://www.insee.fr/fr/statistiques/4129807.
Deviation from the definition: Given that pay grids make their average salaries equivalent, **data for salaried generalists and salaried specialists in hospitals are not available separately**. **Data are reported in the specialist category** as the vast majority of salaried doctors in hospitals are specialists (more than 80%). Some have a double activity, salaried and self-employed. Data are calculated based on gross income including social security contributions but not employers' social contributions. Income is pre-tax.
Note: Data have been revised in 2022 for the years 2013 to 2018, due to an improved identification of salaried physicians in the public sector
Self-employed specialists:
Source: Direction de la recherche, des études, de l'évaluation et des statistiques (Drees), Ministère des Affaires sociales, de la Santé et des Droits des femmes, based on data from the Système national inter-

régimes (Snir) prepared by the Caisse nationale d'assurance maladie des travailleurs salariés (Cnamts) and fiscal declaration (n°2042) from the Direction générale des finances publiques (DGFIP) in the Ministère des Finances et des Comptes publics.
Methodology:
- To approximate gross income, data are corrected by a factor, which represents the mean weight of social charges in the remuneration. The calculations use a factor of 31.5% for self-employed doctors in the agreement sector and 51.5% for self-employed doctors in the non-agreement sector. This gross income must consequently be considered as an order of magnitude.
- Self-employed: self-employed specialists are excluded if they receive the majority of their compensation as salary.
- Data cover all professionals who earned at least one euro during the year.
Note: Data have been revised in 2024 for the years 2005 to 2017, to account for disparities in the rates of social charges of doctors by agreement sector.
Further information:
- *Revenu des médecins libéraux : une hausse de 1,9 % par an en euros constants entre 2014 et 2017*, March 2022, see https://drees.solidarites-sante.gouv.fr/publications-communique-de-presse/etudes-et-resultats/revenu-des-medecins-liberaux-une-hausse-de-19#.
- *Médecins libéraux: une hausse modérée de leurs revenus entre 2011 et 2014*, October 2017, see https://drees.solidarites-sante.gouv.fr/publications/etudes-et-resultats/medecins-liberaux-une-hausse-moderee-de-leurs-revenus-entre-2011#.

Germany

Salaried specialists:
Sources: Kienbaum Management Consulting, Study on Remuneration "Specialists and executive staff in hospitals", several press releases; **Federal Statistical Office**, Hospital Statistics (basic data of hospitals) 2023 and Structure Earnings Survey 2014, 2018 and 2022 and internal calculations by the Federal Statistical Office.
Methodology:
- The calculation of data based on a study among salaried medical specialists of Kienbaum Management Consulting and the hospital statistics of the Federal Statistical Office.
- The reported data comprise all salaried specialists who completed their training (Chefärzte, Oberärzte and Fachärzte).
- Physicians who are still in training to become a specialist are excluded.
Data for salaried physicians are reported in the specialist category: general practitioners are included as 93% of salaried physicians are specialists.
- The reported annual average gross income includes social contributions and income taxes payable by the employee. Also included are any bonus and variable payments to the specialist and income from the so-called "Liquidationsrecht" for leading specialists (Chefärzte). This means, they can treat private patients within the hospitals and charge them directly for the treatment. Excluded are social contributions payable by the employer.
- The breakdown by gender is an estimate and is based on a special calculation by the Federal Statistical Office. The Structure Earnings Survey of the Federal Statistical Office forms the basis for this estimation.
Further information: http://www.destatis.de.

Self-employed specialists:
Source: Federal Statistical Office, Cost Structure Statistics 2022 Statistisches Bundesamt 2024, *Statistischer Bericht: Kostenstrukturstatistik im medizinischen Bereich 2022;* internal evaluations by the Federal Statistical Office. 2023 data estimated by the OECD based on the same methodology using Cost Structure Statistics 2023.
Coverage:
- **The net profit for each practice owner is proven.** It results from the difference of revenues and expenses (including practice expenses) and is not to be equated with the economical profit of the practice. Data are average annual gross earnings of self-employed specialists. Supplementary incomes for salaried work of self-employed specialists are excluded.
- Data cover self-employed specialists in panel practices and private practices.

- Specialists practices are defined as all practices of physicians excluding the practices of general practitioners.
- Included are physicians with the following specialties: Surgery, Neurosurgery, Dental, oral and maxillofacial surgery, Orthopaedics and accident surgery, Internal medicine, Gynaecology and obstetrics, Paediatrics, Paediatric psychiatry and psychotherapy, Ophthalmology, Otorhinolaryngology, Skin and venereal diseases, Urology, Nuclear medicine, Radiology, Radiotherapy, Neurology, Psychiatry and psychotherapy, Psychosomatic medicine and psychotherapy, Anesthesiology, Pathology, Biochemistry, Occupational medicine, Physiology.
- Students who have not yet graduated are excluded.

Methodology:

Interpretation of net profit: In the general public, the net profit, which is calculated as part of cost structure statistics in the medical sector, is often used synonymously with the income of doctors. **The net profit is not to be equated with the profit or income of the doctors**. Although it represents the results of the practice's financial year, it does not take into account, among other things, the expenses for taking over the practice and the private expenses for the old-age, disability, survivors' and health insurance of the practice owners and their family members as well as the contributions to the practice owners' pension funds. In the context of cost structure statistics in the medical sector, net profit is a purely mathematical figure that is obtained when the sum of expenses is deducted from the sum of income.
- The figures are calculated for each practice owner and not per FTE.
- No breakdown by gender is possible.

Further information: http://www.destatis.de.

Greece

Salaried specialists:

Sources:

From 2022 onwards: **General Secretary and Economic Division of the Ministry of Health**.
Up until 2021: **Average of Public General Hospitals** (in Athens).

Methodology:
- Hospitals taken into account are large public hospitals and data are representative of all salaried specialists working full-time in the public hospital sector.
- Data refer to salaried specialists in the middle level of the hierarchy (15 years of previous employment) and exclude dentists and psychologists.
- Informal payments are not included. These payments are common for salaried specialists practising in the public sector.
- No changes were reported between 2013-2014 and 2019-2020 concerning the wages of specialists working in public hospitals.
- From 2021, wages of salaried specialists working in public hospitals were slightly increased.
- From 2010 onwards, a decrease is reported due to the curtailment of salaries. “Additional” payments and Christmas, Easter and Summer vacation bonuses have been reduced.
- From 2005 to 2009, a remarkable increase is reported due to the respective raise of “additional” physicians’ payments such as overtime work, leisure day payments etc.

Self-employed specialists: Data not available.

Hungary

Salaried specialists:

Sources:

2021 onwards: **National Directorate General for Hospitals** (OKFŐ in Hungarian).
2017-2020: **National Healthcare Service Center** (ÁEEK, in Hungarian).
2015-2016: **Office of Health Authorisation and Administrative Procedures** (ENKK, in Hungarian).
2011-2014: **National Institute for Quality and Organisational Development in Healthcare and Medicines** (GYEMSZI, in Hungarian).
2003-2010: **National Institute for Strategic Health Research** (ESKI, in Hungarian).

Methodology:

- Data cover only public sector employees.
- Data on average salaries are based on a sample of 8000 specialists from the OSAP 1626 salary and employment statistics data collection.
- Approximately 60% off all specialists are salaried specialists, while 40% are self-employed.
- Data refer to practitioners employed full-time.
- Data include payments for working evenings, nights, week-ends, bank holidays and overtime.
- Data include only salary paid by the employer, and do not include income derived from private practices.
- The official salary of public sector medical doctors is very low compared with earnings in other sectors of the economy, and informal payments substantially increase the income of some doctors. Most clinical specialists receive informal payments (including gratitude payments) from patients, which provide some financial incentive for the doctors to stay in the profession. These payments, however, are not included.

Notes:
- The Act 2020/100 on medical service contract introduced a new pay scale for doctors in public health which grants a 120% salary increase to doctors in Hungary in three steps (1 January 2021, 2022 and 2023), reaching its maximum in January 2023. The largest increase came in 2021, in 2022 another 28.5% was agreed, while in 2023 an 11.1% increase will happen.
- In 2016, start of salary increase program again for physicians in outpatient and inpatient care.
- In 2014-2015, pause of salary increase program for physicians in outpatient and inpatient care.
- In 2013, continuation of salary increase program for physicians in outpatient and inpatient care.
- In 2012, start of salary increase program for physicians in outpatient and inpatient care.
- In 2009, thirteenth month payments abolished in the public sector.

Further information: http://www.enkk.hu.

Self-employed specialists: Data not available.

Iceland

Salaried specialists:
Source: Ministry of Finance.
Methodology:
- Data refer to annual income of salaried state-employed specialists who work in public general hospitals. Chief physicians are included, and interns are excluded.
- Data relate to full-time equivalent.
- Data include monthly salaries and payments for overtime, evening, night and weekend shifts and others.
- Many specialists working in hospitals also earn incomes from private practices but these incomes are not included.
- 2015: The large increase in the remuneration of salaried specialists can be partly explained by a new wage agreement which came into effect on 1 June 2014 with a new wage rate.

Break in time series in 2019: New wage agreement which came into effect on 1st of March 2019 for doctors and specialists.

Break in time series in 2010: Data as of 2010 reviewed in 2017 with respect to physicians and institutions included resulting in some changes. The data now cover specialists in hospitals defined as health care facilities with 24-hour access to a hospital physician.

Self-employed specialists: Data not available.

Ireland

Salaried specialists:
Source: Department of Health (Consolidated Salary Scales prepared by the Health Service Executive).
- Data relate to specialists (i.e. Consultants) working in publicly funded hospitals and exclude income from private practice.
- Approximately 39% of specialists hold contracts that allow them to engage in some level of private practice, typically capped at 20%.
- Data refer to average gross salary based on a 39-hour clinical week.

- Figures exclude emergency call-out and on-call payments, except for the minimum flat annual payment. It is estimated that allowances (emergency call-out and on-call payments) paid to specialists vary from EUR 4,758 to EUR 41,035 per annum (reference year 2024). These rates are reflective of the minimum and maximum from the Public Only Consultant Contract (the 2023 Consultant Contract) as this is the most prevalent contract in use.
Break in series in 2009: From 2009 onward, a weighted average of consultants in each contract type was calculated. Prior to 2009, data were calculated as the non-weighted average of each contract type.
Further information: http://health.gov.ie/publications-research/publications/.

Self-employed specialists: Data not available.

Israel

Salaried specialists:
Break in time series in 2006 due to a change of source and methodology.
From 2006 onwards:
Source: Physicians License Registry maintained by the Medical Professions Division and the Health Information Division in the **Ministry of Health** and Income tax files - employees and self-employed.
Methodology:
- Data are based on the linkage between Physicians license registry and income tax files performed at the Central Bureau of Statistics.
- Physicians with an income of at least 10,000 Israeli Shekels are included in the remuneration's calculations.
- Physicians are defined as salaried if they have income only from a salary, or in the case they are both salaried and self-employed, if the salary is greater than the self-employed income. In these cases, all incomes (salary and as self-employed) are included in the calculation.
- Specialists refer to physicians who have any specialty.
Deviation from the definition: Data include all salaried physicians, full-time and part-time workers.
Up and until 2005:
Source: Data are derived from the **Ministry of Finance** Department of wages and labour agreements database on state workers' wages and from the major **HMO (Clalit) database** on its wages.
Methodology:
- Data include these two employers' workers, and only income paid by them, including all payments paid by the employer to the employee.
- Data cover both full-time and part-time workers but reflect the workload of physicians, i.e. income is divided by the estimated number of full-time equivalent physicians.
- Data include approximately one half of all employed physicians.
- Data include differences paid for previous years.

Self-employed specialists:
Source: From 2006 onwards, Physicians License Registry maintained by the Medical Professions Division and the Health Information Division in the **Ministry of Health** and Income tax files - employees and self-employed
Methodology:
- Data are based on the linkage between Physicians license registry and income tax files performed at the Central Bureau of Statistics.
- Physicians with an income of at least 10,000 Israeli Shekels are included in the remuneration's calculations.
- Physicians are defined as salaried if they have income only from a salary, or in the case they are both salaried and self-employed, if the salary is greater than the self-employed income. In these cases, all incomes (salary and as self-employed) are included in the calculation.
- Specialists refer to physicians who have any specialty.
Deviation from the definition: Data include all self-employed physicians, full-time and part-time workers.

Note: The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

Italy

Salaried specialists:
Source: Italian National Institute of Statistics: Survey on wages.
Methodology:
- Data relate to the remuneration of salaried specialists working full-time in hospitals.
- Bargained wage and salary: data include basic pay plus all bonuses specified in national agreements that are payable to all workers as well as those paid periodically (e.g. 13th month payments). No account is taken of bonuses related to individual performance or individual working conditions, nor any supplementary payment agreed at the company level. In addition, data include the values of any social contributions, (income) taxes, etc., payable by the employee.
- Data do not include the values of social contributions which are actually withheld by the employer and paid directly to social insurance schemes, tax authorities, etc., on behalf of the employee, all gratuities, bonuses and overtime compensation.
Breaks in time series in 2010, 2015 and 2021: As of April 2024, wage indices were released based on the new reference period (December 2021). This implies a break in the remuneration series as the weights structure (i.e. employment by national agreement, by job position) has changed. Data from 2005 to 2009 are based on the reference period December 2005; data from 2010 to 2014 are based on the reference period December 2010; data from 2015 to 2020 are based on the reference period December 2015.
Further information:
- In Italy, the wages of all public sector workers have been frozen from 2011 to 2015, as provided by Law n.122/2010 and Dpr 122/2013; moreover, from 2011, earnings higher than 90 000 Euro per year were cut by Law n.122/2010. In October 2012, the pay cuts were declared illegal by a ruling of the Constitutional Court, hence from November 2012 full monthly wages were paid (this is why 2012 wages are slightly higher than in 2011). In January 2013, the total amount of cuts was returned, with a lump sum (this is why 2014 wages are less than 2013).
- In 2018, as was the case in 2016 and 2017, the national collective bargaining agreement (January 2016-December 2018) for salaried specialists were not renewed.
- In 2019, the national collective bargaining agreement for salaried specialists were not yet renewed so in April and July 2019 the allowance for the advance payment for the 2019-2021 wage negotiation round was paid.
- In 2020, the National Collective Bargaining Agreement for salaried specialists was renewed. The reference period for the agreement is 2016-2018.
- The increase in salaries in 2020 (+15%) is explained by the presence of arrears paid in January 2020.
- The wage of salaried specialists was lower in 2021 compared to 2020 because there was no lump sum payed in 2020; this decrease was mitigated from January 2021 by the increase of the specific allowance "retribuzione di posizione minima unificata".
- The growth of 2023 respect 2022 depends on the payment of a lump sum provided by the law n. 197 of 29 December 2023 Art. 1 co. 330.
- The remuneration of specialist in 2024 is higher than 2023 for two reasons: the renewal of CCNL 2019-2021 in February 2024; from January 2024, an advance on future increases equal to 6.7 percent of the value of the contractual vacation allowance was paid.

Self-employed specialists: Data not available.

Japan

Data not available.

Korea

Sources: Ministry of Health and Welfare, **National Health Insurance Service, Korea Institute for Health and Social Affairs**, Report on the Korean Health Workforce Statistics.

Coverage: Remuneration of specialists in all medical institutions.
Methodology: Wages are calculated from social insurance contribution data.

Latvia

Salaried specialists:
Source: Data are based on the results of the **Structure of Earnings Survey (SES)** of 2006, 2010, 2014 and 2018 conducted by the **Central Statistical Bureau of Latvia** and represent the series acquired within the framework of the earnings survey conducted every four years in line with the Council Regulation 530/1999 and the Commission Regulation 1916/2000 as amended by Commission Regulation 1738/2005.
Deviation from the definition: In accordance with the International Standard Classification of Occupations 1988 (ISCO-08) (in force until 2010), both occupations of health professionals – general practitioners and specialists – were included in the same occupational group, i.e., 2221 "Medical doctor". Therefore, until 2010 it was not possible to obtain information on the remuneration of these professionals separately.
Deviation from the definition: In 2006, the remuneration of salaried GPs and salaried specialists is reported together under the specialist category as the vast majority of salaried doctors are specialists.
Physicians in training are included for all years.
Break in time series in 2010: Data include the remuneration of salaried specialists only from 2010 onwards, as GPs and specialists are reported separately from 2010 onwards.
Note: The significant increase in average remuneration in 2022 is due to the fact that, during this period, several planning documents have been developed and measures taken to address the shortage of human resources in healthcare. These activities have affected the level of remuneration in the health sector overall. Indirect data sources also indicate a significant increase in wages (see for instance the increase in hourly labour costs by kind of activity).
Further information: https://stat.gov.lv/en/statistics-themes/labour-market/wages-and-salaries/other/5754-average-gross-monthly-earnings?themeCode=DS.

Self-employed specialists: Data not available, as this category of specialists is excluded from the SES.

Lithuania

Salaried specialists:
Source: State Data Agency (Statistics Lithuania).
Coverage: There are several deviations due to the coverage of employees and the Classification of Occupations:
- For 2010, 2014, 2018 and 2022, the SES covered economic activities defined in sections B to S of the national version of the Statistical Classification of Economic Activities, EVRK Rev. 2 (based on NACE Rev.2). Statistical indicators for 2002 and 2006 are classified by economic activity (C to O) according to EVRK Rev. 1.1. (NACE 1.1).
- SES covered employees in full-time units (full-time and part-time).
- Since 2010, occupations refer to the occupations listed in the Lithuanian Classification of Occupations (LCO-08) which is based on the International Standard Classification of Occupations (ISCO-08). According to ISCO-08: Health professionals are classified as follows: Generalist medical practitioners (Code 2211) and Specialist medical practitioners (Code 2212).
- Up to 2006, occupations of employees in the surveys were classified according to the Lithuanian Classification of Occupations LCO-88, which is based on the International Standard Classification of Occupations (ISCO-88 (COM)). According to ISCO-88: Health professionals are classified as follows:
    - Medical doctors (Code 2221): cover all medical doctors (generalist and specialist medical practitioners).
    - Nursing and midwifery professionals (Code 2230): cover nurses and midwifery professionals in all health care institutions.
- Since 2002 data are based on the **Structure of Earnings Survey** (SES). The survey is conducted every four years in accordance with the requirements set in the EU legislation.
- Data for 1995 and 2000 are based on the Survey on Wages and Salaries by Occupation in October. The survey covered economic activities defined in sections A to O of the national version of the Statistical

Classification of Economic Activities (EVRK Rev. 1), which is based on the Statistical Classification of Economic Activities in the European Community, (NACE Rev. 1). These surveys covered all full-time employees who work full October month at the main working place.
Methodology: Since 2015, the national currency is the Euro. Data for 2010 and 2014 in NCU Litas have been converted into Euros at a ratio of 3.4528.
Deviation from the definition: Up until 2006, the remuneration of salaried GPs and salaried specialists is reported together under the specialists category, as it is assumed the vast majority of salaried doctors are specialists. Data for 1995, 2000, 2002 and 2006 include GPs.
Break in time series in 2022: Since 1 January 2019, the calculations of state social insurance (SSI) contributions have changed in Lithuania. The burden of payment of the larger part, i.e. 28.9%, of SSI contributions paid by the employers is transferred to the employees. Respectively, the employers recalculated gross wage of the employee by increasing it by 1.289.
Break in time series in 2010: Data include the remuneration of salaried specialists only from 2010 onwards, as GPs and specialists are reported separately from 2010 onwards.
Notes:
- During the period 2014-2018, pursuant to the Government legal acts, salaries have been raised for medical staff (generalist medical practitioners, specialist medical practitioners, nursing professionals etc.), especially for those on low pay.
- During the period 2002-2006, Lithuania experienced a large economic growth, and the salaries of health specialists doubled. They increased faster than the average salary in the country, as the salaries of health specialists were very low before this period.

Self-employed specialists: Data not available.

Luxembourg

Salaried specialists:
Source: Fichiers de la sécurité sociale (Social Security data files).
Statistical extraction: General Inspectorate of Social Security (IGSS).
Data collection discontinued in 2018.
Methodology:
- Data available for 2003 to 2007 and estimation of the remuneration of specialists for the years 2008-2015 based on fees known from administrative data of the social security.
- Data refer to gross income before tax.
- Data do not include physicians in training.
- Figures exclude foreign physicians who do not pay a social security contribution in Luxembourg and physicians who practice mainly outside of the country.
- Figures do not include physicians whose monthly income is less than the minimum social salary (monthly average) of EUR 1659,60 in 2003, 1694,07 in 2004, 1771,12 in 2005, 1807,87 in 2006, 1884,34 in 2007. Hence, physicians who begin or stop practicing in the year are not included.

Self-employed specialists:
Source: Fichiers de la sécurité sociale (Social Security data files).
Statistical extraction: General Inspectorate of Social Security (IGSS).
Data collection discontinued in 2018.
Methodology:
- Data available for 2003 to 2007 and estimation of the remuneration of specialists for the years 2008-2015 based on fees known from administrative data of the social security.
- Data refer to gross income before tax, net of practice expenses per self-employed specialist.
- Data do not include physicians in training.
- Figures exclude foreign physicians who do not pay a social security contribution in Luxembourg and physicians who practice mainly outside of the country.
- Figures do not include physicians whose monthly income is less than the minimum social salary (monthly average) of EUR 1659.60 in 2003, 1694.07 in 2004, 1771.12 in 2005, 1807.87 in 2006, and 1884.34 in 2007. Hence, physicians who begin or stop practicing in the year are not included.

Mexico

Salaried specialists:
Source: Ministry of Health (MOH), **Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado** (ISSSTE) and **Instituto Mexicano del Seguro Social** (IMSS), "Authorised tabulator of medical personnel".
- The average wage of specialists is based on information from MOH, ISSSTE and IMSS. In MOH and ISSSTE data, the specialists classified as level A, B and C are included. Data from IMSS refer to the gross income of the most represented levels.
- Wages include benefits and advantages according to the law. Data reflect the official IMSS and ISSSTE data.
- Data represent the average gross annual income of specialists in the following public institutions: Ministry of health (SSA), Social Security Mexican Institution (IMSS), and Social Institute of Security and Services of the Workers of the State (ISSSTE).

Self-employed specialists: Data not available. The System of National Accounts in Mexico only reports on the average wage of personnel in the private sector (including doctors, office staff, technicians, nurses, among others). Wages are not reported separately for these professions.

Netherlands

Salaried specialists:
Source: Statistics Netherlands.
Methodology:
- Data refer to all persons in the BIG register with specialties in the following groups: general paediatrics, obstetrics and gynaecology, psychiatry and surgery, who work and live in the Netherlands and are classified as working within the health sector (SIC 3/NACE 1: 85; SIC 4/NACE v2: 86, 87 and 88); have a taxable wage-income and are not self-employed in the same year.
- Figures are derived by combining the BIG register and the Social Statistical Database from Statistics Netherlands (including the municipal registers and social security databases).
- Data refer to the average per FTE. From 2006 onwards, a new source is used for the calculation of FTE.
Coverage:
- Data up to 2020 include physicians who are majority shareholders and directors (with a wage) in their own business (DGAs).
- As medical specialists have the obligation to be currently practicing in order to keep their registration, this economic indicator signals at least being professionally active.
- Physicians both salaried and self-employed are not included in the average wages.
- Part-time factors above 1 are counted as 1. The collective employment agreement is used to define full-time (for salaried medical specialists, the CEA of hospitals is used where 36 hours is full-time).
- 2014: Decreases due to lowering of several overtime payments in the collective agreements in the health care sector.
Break in time series in 2021. From 2021 onwards: The salaries are now excluding director and shareholder businesses (DGAs). The 'usual wages' DGAs pay to themselves are relatively low and usually relate to a portion of the income of the director from their business. Without the salaries of DGAs the average wages from 2021 onwards are higher.
Break in time series in 2006. From 2006 onwards: The yearly wage including bonuses and allowances, such as holiday allowance, profit sharing, performance bonuses etc. Up to and including 2005: The wage as a base for the social security contributions has been used. Wages according to the national accounts are approximately 5% to 7% higher than the social security wage base, in the case of hospitals.

Self-employed specialists:
Source: Statistics Netherlands.
Methodology:
- Data refer to all persons in the BIG register with specialties in the following groups: general paediatrics, obstetrics and gynaecology, psychiatry and surgery, who work and live in the Netherlands and are

classified as working within the health sector (SIC 3/NACE 1: 85; SIC 4/NACE v2: 86, 87 and 88); and who are self-employed and have no wage-income.
- The fiscal profit per person is calculated, however no information on hours worked is available.
- Figures are derived by combining the BIG register, the Social Statistical Database from Statistics Netherlands (including the municipal registers) and fiscal data on self-employed specialists and their fiscal profits. They are calculated as the taxable profit plus the deductibles that may apply: for SMEs (small and medium enterprises), for entrepreneurs (encompassing deductibles for the self-employed, family members as co-workers, startups, R&D) and for investments.

Coverage:
- Data on corporate tax are excluded.
- Physicians both salaried and self-employed are not included in the average profits.

Break in time series in 2021. From 2021 onwards: Data exclude self-employed physicians with director and shareholder businesses (DGAs), who pay out to themselves 'usual wages' and when desired dividend from beneficial ownership. This DGA category was part of the salaried specialist until 2020; as of 2021 the DGA category is not included in the data any longer.

Notes:
- 2015: Remuneration of self-employed specialists has dropped by over 14% in 2015 as the number of medical specialists has dropped. Due to changes in government policy, many self-employed medical specialists have started another type of business, in which they are director and shareholder (DGA) and receive 'usual wages' and when desired dividend from beneficial ownership.
- The average wage was 121 500 Euro, plus average income out-of-profit of 6 700 Euros in 2015; however, part of the profit of their enterprises is used to build-up pensions, which is included in the figures in the case of wages of employees or of profits of self-employed. However, no information is available on the part of the profits of their enterprises used for this goal.
- The remuneration of the remaining self-employed medical specialists has dropped either because the percentage of psychiatrists increased or either because the higher incomes changed to being director/major shareholders. Excluding psychiatrists, the average income was 179 000 Euro in 2015, ten thousand Euros higher than the figure including psychiatrists. The changes in government policy also affected other physicians as well as dentists. However, the impact on those professions seems to be small or negligible.
- The percentage of self-employed medical specialists (excluding psychiatrists) as part of the total count, dropped from 35% in 2014 to 14% in 2015 to 13% in 2018. Among self-employed medical specialists, the percentage of psychiatrists increased from 8% in 2014 to 18% in 2015 to 23 % in 2018. These effects represent a change in population and explain the drop of average remuneration of self-employed specialists from 194 900 Euro in 2014 to 159 100 Euro in 2018.
- 2010: Remuneration of self-employed specialists dropped by over 17% in 2010 after years of high increases (15% in 2008, 10% in 2007 and 2009, etc.). This was due to active policy from the government: as tariffs were regarded to have increased too much, they had been reduced by some 20% in 2010. The 11% drop in 2011 reflected a continuation of the tariff reductions.

New Zealand

Salaried specialists:

Source: Annual Senior Medical and Dental Officer Salary Survey (Association of Salaried Medical Specialists).

Methodology:
- Survey of full-time equivalent salaries for senior medical staff at Te Whatu Ora Health New Zealand hospital districts and their predecessors. The only specialists excluded are those who work solely in the private sector.
- The latest survey on 1st July 2023 is the 30th annual survey.
- Employers were asked for the number of staff on the base salary steps of the scale in the collective agreement covering senior medical officers as of 1st July in each survey year.
- Figures are for the mean specialist base rate on 1st July in each year. At time of writing (8/2/24) the data have been provided by all 20 districts.
- Data cover only those specialists employed by Te Whatu Ora Health New Zealand and whose remuneration falls within the salary scales of the collective employment agreements negotiated by the Association of Salaried Medical Specialists (that is, specialists working in the private sector are excluded,

as are specialists employed by Te Whatu Ora Health New Zealand on individual employment agreements). Some specialists work part-time in both the private and public sectors but incomes from private sector work are not included in the data.
- The remuneration data refer to 5810 specialists in 2023 (the total number of specialists working in the public sector is higher than this because those on Individual Employment Agreements are not included). This figure is also an undercount due to the inability of some districts to provide data by the deadline.
- Data are based on full-time equivalent salaries only. It does not take into account reimbursement of work-related expenses, reimbursement of continuing medical education expenses, hours worked in excess of 40 hours per week (that is, those hours recognised through job sizing; most specialists would work significantly more than 40 hours), the availability allowance for being on an after-hours' roster or any other special enhancements (e.g. recruitment and retention payments).
- Figures include holiday allowances.
- The number of salary steps has changed over the years. In 2006 and 2007 there were 13; in 2008 there were 14; there are currently 15 steps. The average salary increases are affected by the numbers of specialists in each salary step – i.e. they do not necessarily reflect increases in hourly rates. Generally, a specialist will spend a year on each step and then move to the next step unless there is a particular reason for that not to occur. This inevitably leads to a higher proportion of specialists accumulating in the top steps, as many specialists stay in public hospital employment for most, if not all, of their careers.
Note: The terms and conditions of employment for medical specialists are set out in the Single Employer Collective Agreement (SECA), which will last for a period of 1 year (1 September 2023 – 31 August 2024). The full salary report for the previous year is available at 'Salary survey analysis 2022' at https://www.asms.org.nz/publications/. The 2023 report will be uploaded here once available.
Further information: Survey publications from 2004 to 2022 can be downloaded from the ASMS website at http://www.asms.org.nz/Site/Publications/Surveys_and_Submissions.aspx.

Self-employed specialists: Data not available.

Norway

Salaried specialists:
Source: Statistics Norway, Wage statistics for employees in central government-maintained hospitals. https://www.ssb.no/en/arbeid-og-lonn/statistikker/lonnansatt.
Methodology:
- In accordance with Council Regulation (EC) No 530/1999 on statistics on the structure of earnings, as amended by Regulation (EC) No 1893/2006.
- Data cover salaried specialists working in all central government-maintained hospitals.
- Statistics on the income of private practitioners are not available.
Data refer to specialists including newly-qualified doctors (assistant doctors) and GPs with a specialisation in general medicine working in hospitals (probably very few).
- Figures refer to full-time equivalent average annual earnings estimates, based on monthly figures as of November each year.
- Figures include salary according to scale, fixed and variable additional allowances, bonuses and commissions. Variable additional allowances are associated with special duties or working hours and cover allowances for working evenings and nights, call-out allowance, shift allowance, dirty conditions allowance, offshore allowance and other allowances that occur irregularly. Bonuses and variable additional allowances are the mean for the period between 1st January and 30th November. Holiday pay supplement is not included.
Break in time series in 2015: There is a break in the time series from 2014 to 2015 due to a new data source. From 2015, the figures are based on administrative data and not survey data. From 2015, the data are reported in a different way. In order to produce the same variables as before, the production process has changed. The content and definition of the variables are the same, but figures before and after 2015 cannot be compared.
Note: The increase in the remuneration of salaried specialists in 2017 is the result of a labour conflict in 2016. The revenue statistics are produced in the autumn, and usually the pay settlement between employers, the state and the medical association is finished by then. This was not the case in 2016, and that is why there is a negative growth in remuneration for salaried specialists in 2016, and a considerable

increase in 2017. Because of the late pay settlement in 2016, the figures for 2017 include two years of pay settlements.
Further information: https://www.ssb.no/en/arbeid-og-lonn/statistikker/lonnansatt.

Self-employed specialists: Data not available.

Poland

Salaried specialists:
Source: Statistics Poland, Statistical Office in Bydgoszcz.
Methodology:
- Data come from the **Structure of earnings by occupations survey** which is conducted every two years.
- Data are the average monthly earnings in October, multiplied by 12 months.
- Data for the group 2212 - Specialist medical practitioners (excluding the group 221236 - Family medicine physicians) according to the Polish Classification of Occupations and Specialties (based on ISCO-08).

Self-employed specialists: Data not available.

Portugal

Salaried specialists:
Source: Retribution System of Public Administration.
Coverage:
For the period 1995-2005, data include all categories of GPs and specialists working in the National Health Service (Chief of Service, Graduate Assistant and Assistant), including both those with "exclusive" schedules (which do not allow private activity) and those with "non-exclusive" schedules (which allow private activity).
Methodology:
- Data are calculated based on the gross monthly remuneration and refer to full-time equivalent contracts.
- Self-employed, service providers and interns are not included.
- Up until 2021, the amounts indicated correspond to the annual average of the total remuneration of each professional (including holidays and Christmas allowances)
- Additional income (such as payments for working nights, evenings and weekends, overtime payments and bonuses) is not included.
- Data do not include incomes from any private practice.
- 2002, 2003 and 2004 figures are identical, as the Government did not increase salaries during this period.
Break in time series in 2022: The amounts indicated from 2022 onward correspond to the annual average of the total remuneration of each professional (including the thirteen month).
Break in time series in 2006.
Notes:
- From 2011 until 2017, there was a reduction in remuneration, through progressive cuts between 3.5% and 10%, for monthly salaries above € 1,500 (LOE 2011).
- In 2012, the payment of holidays and Christmas subsidies (LOE 2012) was suspended and gradually replaced after 2016.
- In 2013, the Decree-Law no. 266-D / 2012 (December 31), changed the normal working period of the special medical career to 40 hours. The professionals who require changing to 40 hours a week are transferred to a new salary scale with a higher remuneration.
- The slight decrease in 2018 is explained both by the exit, due to retirement, of an increasing number of professionals in 2018 (usually receiving higher remunerations), and a significant increase of new professionals at the starting grade of a career (usually receiving lower remunerations).
- In 2024, the increase in the remuneration of medical staff is the result of the application of measures to enhance the medical career, namely the transition of primary health care units to models that include the payment of incentives based on performance, the adoption of the full dedication regime, supplement for doctors working in emergency services, over and above the annual legal limits for overtime work, modifications concerning performance evaluation scheme as well as other measures across the entire public administration.

Self-employed specialists: Data not available.

Slovak Republic

Salaried specialists:
Source: Ministry of Health. *Quarter Report on Wage Sources and on Employees in Health Service in the Slovak Republic*, M(MZ SR) 2-04.
Methodology:
- Data refer to physicians working in state/public health care establishments and do not include physicians working in private and non-profit organisations.
Data are not available exclusively for salaried specialists. Data for salaried specialists and salaried GPs are compiled together as most salaried doctors are specialists.
- Data refer to the average gross annual income of physicians who receive most of their income through a salaried arrangement.
- Data refer to income before tax and include social contributions, gratuities, bonuses, ex-gratia payments, and thirteen month payments.
- Data do not include severance payments, lodging, transport, cost-of-living, family allowances, social security contributions payable by the employers, maternity leave, and sickness pays.
- **Note:** The increase in remuneration of salaried specialists in 2024 is due to the update of law 578/2024 stating the increase of salaries of the doctors, and also taking into account the number of working years from now on.

Self-employed specialists: Data are not available.

Slovenia

Salaried specialists:
Source: Statistical Office of the Republic of Slovenia (SURS).
Break in time series in 2023 due to a new methodology.
Methodology:
From 2023:
-The purpose of publishing data on **Structure of Earnings Statistics** is to present data on the amount of average monthly earnings of persons in paid employment by selected geographic and socio-demographic characteristics of persons in paid employment (sex, age, education, occupation, territorial unit) and characteristics of employers (activity, sector, territory), and to present the distribution of persons in paid employment by the amount of average monthly gross earnings by activities, statistical regions and sectors (public, private).
-In structure of earnings statistics, the unit described by the published data is average monthly gross and net earnings **for October** of the observed year by sex, age groups, education, occupation, citizenship, activities, sectors (public, private) and territorial units (cohesion and statistical regions, municipalities) of the workplace and residence.
-Observation units in the statistical survey **Structure of Earnings Statistics** are persons employed in business entities (i.e. legal persons of the public and private sectors or their units or registered natural persons) registered for performing activities in the Republic of Slovenia, who in the observed month **(October)** received earnings and/or nonrefundable wage compensation paid by the employer. For each business entity, data on earnings are collected for persons who are employed in this business entity, with a concluded contract (or decision) on fulltime or part-time employment, irrespective of whether they are in employment relationship for a fixed or unspecified period of time.
-The main data source is data from the withholding tax return for incomes from which withholding tax and/or social security contributions are calculated (REK-O form).

From 2023: all gratuities, bonuses, overtime compensation and "thirteenth month payments" are not included if not paid for the reference month (October). Holiday bonus is not included.

Up to and including 2022:

- The annual statistical survey **Structure of Earnings Statistics** provides users with data on average annual gross earnings of persons in paid employment by selection of geographic and socio-demographic characteristics (sex, age, level of school education, occupation). Data on gross wages are obtained exclusively from the existing administrative sources; data on personal income tax are sent by the Tax Administration of the Republic of Slovenia, whereas data on persons in paid employment are obtained from the Statistical Register of Employment. Observation units are persons in paid employment who worked full time for the same employer the whole year. Social contributions and income tax paid by the employees are included. Gratuities, bonuses, overtime compensation and thirteen-month payments are included, but supplementary income (from private practices), payments in kind and holiday bonuses are excluded.
- The annual statistical survey **Structure of Earnings Statistics** is carried out as a supplement to the Structure of Earnings Survey which is carried out only every four years. Data for the latter are gathered from the existing administrative sources combined with data from the questionnaire for every individual employed in the organization selected in the sample.
- Data for the years 2008 to 2023 are final. All other years are provisional data only.
- 2018 salary increase: The Slovenian government reached an agreement with the union of doctors and dentists of Slovenia (FIDES) in October 2017 about the increase of salaries by 5 pay grades. This was achieved by creating a new job and the title of senior specialist doctor that was established in hospitals and health centers. Doctors are promoted to this title 12 years after their professional exam and if they fulfil some other conditions, such as participation in the introduction of new methods, achievement of standards and norms of work, etc. This increase resulted in higher salaries in 2018.
- The increase in earnings in 2020 was significantly influenced by the payment of allowances related to the outbreak of the COVID-19 epidemic. A significant amount of the allowance for work in risky situations was paid. At the same time, new allowances were introduced and paid through the intervention legislation related to the management of the epidemic: allowance for danger and special burdens during an epidemic; allowance due to temporary assignment due to urgent work needs or the so-called temporary assignment allowance; and allowance for direct work with patients or users suffering from COVID-19.
- In addition to the above, the increase in earnings was also influenced by performance-related bonuses for regular work, by performance-related bonuses for increased workload and by payments for raising salary grades based on strike agreements signed in 2018.
- 2021 salary increase: In 2021, an agreement was reached between the Slovenian government and the representative trade unions of health care and social protection on urgent measures in the field of earnings. With the amendment of the Collective Agreement for the Health Care and Social Protection Sector and the Collective Agreement for Persons Employed in Health Care, public employees in health care and social protection gained the right to higher earnings.

Break in time series in 2023 due to a new methodology.

Break in time series in 2008: Average earnings in health and social work increased in 2008 because of the introduction of the new salary system for civil servants. The final settlement from 1st May 2008 was in line with the Salary System in the Public Sector Act (OJ RS No. 95/07) and the Act Amending the Salary System in the Public Sector Act (OJ RS No. 17/08, 58/80 and 80/08).

Note:

Values for 2004 to 2006 were supplied to the OECD in Slovene Tolar but have been converted into Euro using a conversion rate of 1 EUR = 239.640 SIT.

- Gender breakdown available from 2011 onwards.

Self-employed specialists: Data not available.

Spain

Salaried specialists:

Source: Ministerio de Sanidad (Ministry of Health).

There is no official registration system of remuneration of health personnel working in the public or private sector in Spain. There are 18 regional health authorities (Autonomous Regions) with different remunerations, although they have a similar wage structure.

From 2018: Data estimated by the **Dirección General de Ordenación Profesional** (General Directorate for Professional Regulation), based on data provided by Autonomous Communities for the public health sector and the Alliance of Spanish Private Health (ASPE) for the private health sector.

Up until 2017: Data estimated by the **Dirección General de Ordenación Profesional** (General Directorate for Professional Regulation), based on data provided by Autonomous Communities for the public health sector and the National Federation of Private Health Centers (FNCP) and Adecco for the private health sector. Since 2016, FNCP (National Federation of Private Health Centers) is called ASPE (Alliance of Spanish Private Health).
Methodology:
From 2024:
- The remuneration average has been calculated using the average remuneration of each autonomous community, using a prorata factor to take into account the contribution of each community.
- The contribution of both the private and public sector has been taken into account according to the type of professionals. For specialists, the private sector represents 16.63% and the public sector 83.37%.
Up until 2023:
- The remuneration average has been calculated using the average remuneration of each autonomous community, without using any prorata factor for taking into account the contribution of each community.
- The contribution of both the private (26.4%) and public sector (74.6%) has been taken into account.
Coverage:
- 2024: Remuneration data in the public sector is missing for one autonomous community in 2024. Before 2024: remuneration data in the private sector is missing for some autonomous communities.
- In 2021, data reflect the incorporation of younger personnel in the health system. These professionals do not have seniority supplements in their salaries. Also, the COVID-19 salary supplements (2020) stopped being received in 2021.
- In 2012, the rationalisation of remuneration of specialists working in the public health system caused a major reduction of the following fees: elimination of bonuses, reduction overtime compensation, elimination of "thirteenth month payments" and implementation of mandatory retirement at 65 years old.
- Data by gender breakdown not available.
Break in time series in 2024 due to a change in methodology, as a prorata factor has been included to take into account the contribution of each community, as well as a specific prorata factor by type of professionals for both the public and private sectors.
Break in time series in 2018 due to a change in source and methodology, as the Adecco private sector source is missing since 2018.
Self-employed specialists: Data not available.

Sweden

Source: Swedish Association of Local Authorities and Regions (SALAR).
Methodology:
- Data cover salaried specialists employed by the county councils (including businesses controlled by county councils).
- In Sweden, GPs are specialists who work in general practice and are reported separately from other specialists for this indicator.
- Data are calculated per full-time equivalent.
- Remunerations included: supplementary pay for unsocial (inconvenient) working hours, for being on call, for rescheduled hours
Deviation from the definition: Overtime payments are not included. The private sector is excluded.

Self-employed specialists: Data not available.

Switzerland

Source: Federal Statistical Office, Neuchâtel. Structural data of medical practices and ambulatory centres (MAS).
Methodology:
- Remuneration expressed as full-time equivalent.
- Social contributions are included.
- Only data for self-employed specialists are available.
- The following categories have been considered:

- Specialist title in: pediatrics, child and adolescent psychiatry and psychotherapy; psychiatry and psychotherapy;
- Advanced training for these specialist titles: gynecology and obstetrics; Allergology and Clinical Immunology, Angiology, Endocrinology/Diabetes, Gastroenterology, Hematology, Infectiology, Cardiology, Medical Oncology, Nephrology, Neurology, Physical Medicine and Rehabilitation, Pneumology, Rheumatology; Anesthesiology, surgery, hand surgery, cardiac and thoracic vascular surgery, pediatric surgery, oral and maxillo-facial surgery, neurosurgery, ophthalmology, orthopedic surgery and traumatology of the musculoskeletal system, otorhinolaryngology, plastic, reconstructive and aesthetic surgery, urology, vascular surgery, thoracic surgery; occupational medicine, dermatology and venereology, intensive care medicine, clinical pharmacology and toxicology, medical genetics, neuropathology, nuclear medicine, pathology, pharmaceutical medicine, prevention and public health, radiology, radiation oncology/radiotherapy, forensic medicine, tropical medicine and travel medicine;
- Advanced training in relation to a specialist title in primary care medicine; advanced interdisciplinary training.

Further information: *Les revenus des médecins indépendants dans les cabinets médicaux en 2019 - Statistique des cabinets médicaux et des centres ambulatoires (MAS)*, Office fédéral de la statistique (OFS), 2021. Available at https://www.bfs.admin.ch/bfs/fr/home/statistiques/sante/systeme-sante.assetdetail.19704727.html.

Türkiye

Salaried specialists:
Sources:
2012 onwards: **Ministry of Health**, **General Directorate of Public Hospitals, Strategy Development Directorate**.
2005-2011: **Ministry of Health**, Türkiye Public Hospitals Institution; **Ministry of Development**.
Income data (Salary and additional payments) taken from statistical yearbooks published by the **Department of Development, Ministry of Health**. Cost of living index taken from the **Ministry of Development**.
Methodology: Prior to 2012, figures are net income rather than gross income as they do not include social security contributions and income taxes.
Break in time series in 2012: From 2012, income figures are gross income (include social security contributions and income taxes.)
Notes:
- As a result of high inflation rates in Türkiye, the remuneration increased remarkably in 2024.
- The important increase from 2019 to 2020 for the salaries of specialists (+36%) is related to additional payments due to the COVID-19 pandemic.

Self-employed specialists: Data not available.

United Kingdom

Salaried specialists:
Source: NHS Digital - Electronic Staff Record (ESR) data. Coverage, England only. Please note that those data are still defined as experimental.
Methodology:
Data are estimates for the UK based on England figures up to and including 2020.
- Payment made to specialists by private sector organisations is not available and therefore not included.
- All main medical and dental specialties are included in the income figures. Every doctor has a main medical and dental specialty once they complete training and all main specialties are included in the figures.
- Data include all additional income such as “awards”, bonuses, overtime compensation and “thirteenth month payments”.
- Physicians in training are not included.

- Data are provided from 2009 onwards.
- Data only relate to those working full time.
- Figures are calculated per person based on a methodology that does not aggregate all additional payments over and above basic salary by FTE, as additional payments are typically made on an individual level basis only not related to FTE. Mean total earnings are calculated by dividing the total amount of pay earned by staff in the group by the total number of staff.
- Data for 2009 to 2015 are based on calendar years (January to December). Data from 2016 onwards are based on 12 months from October to September.
Further information: https://www.digital.nhs.uk/.

Self-employed specialists: Data not available.

United States

Salaried specialist:
Source: American Medical Association/Patient Care Physician Survey. Various years (data available up until 2001).
Coverage: Nationally representative sample of salaried US general practitioners.
Deviation from definition:
- Data match the OECD definition.
- Data are for both full-time and part-time physicians.
- The data presented are the annual mean physician income, after expenses and before taxes.
- Calculation method matches OECD definition.
Further information: The American Medical Association does not perform surveys of remuneration anymore.

Self-employed specialist:
Source: American Medical Association/Patient Care Physician Survey. Various years (data available up until 2001).
Coverage: Nationally representative sample of US self-employed general practitioners.
Deviation from definition:
- Data match the OECD definition.
- Data are for both full-time and part-time physicians.
- The data presented are the annual mean physician income, after expenses and before taxes.
- Calculation method matches OECD definition.
Further information: The American Medical Association does not perform surveys of remuneration anymore.

NON-OECD ECONOMIES

Argentina

Data not available.

Bulgaria

Salaried specialists:
Source: Structure of Earnings Survey, National Statistical Institute.
Coverage: Enterprises with 1 or more employees in economic activity within sections B to S of NACE.Rev.2 are covered.
Methodology:
- The data refer to employees in economic activity NACE Rev.2 division 86 - “Human health activities” and ISCO-08 code of profession 2212 - “Specialist Medical Practitioners”.
- Gross annual earnings include the value of annual payments in kind (goods and services) made available to employees by employer.

Note: From 2020, due to the COVID crisis, the remunerations of employees in Hospital activities and other frontline workers were considerably increased from the Government.
Further information: Structure of Earnings – national level, 4-year periodicity, see https://www.nsi.bg/en/content/4032/structure-earnings-%E2%80%93-national-level-4-year-periodicity.

Self-employed specialists: Data not available.

Croatia

Source: National central payroll system.
Coverage:
- All employees working in the healthcare system as specialist.
- The data provided fully follow the OECD inclusion/exclusion criteria.
Methodology: Average gross salary paid within the public healthcare sector for specialists.

Peru

Source: INFORHUS-MINSA & AIRHSP-MEF. Registered information from 1 January to 31 December 2024.
Coverage:
Specialists working for establishments managed by the Ministry of Health. Data do not include private practice or specialists working for the social security health system. It is estimated that of the 396,000 human resources (total figures) in the health sector, 70.7% are attached to the Ministry of Health, 19.2% to Social Security, 5% to the private sector and the other 5% to other public subsystems of the sector. It is also noted that establishments attached to the Ministry of Health represent 90% of the health establishments categorised in the public sector, while those attached to social security represent only 4%.
Methodology:
In September 2013, with a regulation with the status of law, the National Registry of Health Personnel was created with the aim of collecting data and generating information on human resources in health. For these purposes, the computer tool called INFORHUS was implemented, which has its own data dictionary. The categories in consultation are obtained from the combination of the variables "position", "is a specialist", "specialty condition" and "category of the establishment". The codes used by INFORHUS are its own and do not correspond to any ISCO codes.
- For specialists working in all different labour schemes: ([Basic Pay + Social Security Contributions]Scheme 276 + [Salary]Scheme 1057 + [Economic Compensations]Scheme 728) / (Total Specialists working at the Ministry of Health).
Note: The remuneration for GPs is very close to the remuneration for specialists. 63% of the personnel evaluated correspond to personnel affected by Legislative Decree No. 1153, and 35%, to Legislative Decree No. 1057. The first does not contemplate a significant differentiation in the income of personnel with and without specialty, the difference is generated by a bonus that is subject to compliance with profiles and criteria; whose maximum value is S/ 1270.00 soles. As for the personnel assigned to the Legislative Decree, it has been identified that the range in which the fees are distributed is wide; lower values affect the mode, mean and median of the evaluated population tend towards the lower percentiles.

Romania

Data not available for average income of specialists. Data available would only represent the medical office's income, instead of the physician's income.

© OECD, *OECD Health Statistics 2025.* September 2025.
https://www.oecd.org/en/data/datasets/oecd-health-statistics.html