OECD Health Statistics 2023
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 10 February 2023. 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 10 February 2023. https://www1.health.gov.au/internet/main/publishing.nsf/Content/Medicare%20Statistics-1 (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). The fees fixed by the health insurance cover all practice expenses, ranging from the equipment of the practice up to possible supporting personnel, rent, energy costs, etc. Also supplements charged by doctors for non-reimbursable acts or as supplements on the fees, are to cover all practice expenses. The fees paid to doctors cover all practice expenses, but the amount doctors pay to hospitals can vary from doctor-to-doctor and hospital-to-hospital. For those physicians who are linked to one (or several) hospitals, they usually have an agreement with the hospital that the latter will retain a part of the fees as compensation for the use of the hospitals' facilities by the doctor.
- All specialties, excluding pharmacists, pharmacist-biologists, dentists, parodontists or orthodontists.
- Figures are means calculated per head-count.

Canada

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 2020/2021*	**Total professionally active physicians excluding residents on 31 December, 2020****	**Physicians in private practice who received fee-for-service payments in excess of CAD 100 000 as a % of total physicians**
Specialists	28796	39,686	72.6%

* CIHI, National Physician Database - Payment Data, 2020/2021 - Data release of November 17, 2022 (latest release available). See https://www.cihi.ca/en/physicians-in-canada.
** CIHI, Scott's Medical Database (SMDB), Supply, Distribution and Migration of Canadian Physicians, 2021: Data Tables. See https://www.cihi.ca/en/physicians-in-canada.

- 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

Data not available.

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.

Czech Republic

Salaried specialists:
Source: Institute of Health Information and Statistics of the Czech Republic, National Health Information System (Statistical surveys on employees and structure of wages in healthcare establishments).
Coverage:
- Since 2016, data come from a new survey on independent establishments of outpatient care. Some new types of healthcare providers were included, e.g. medical transport & emergency services.
- Until 2015, salaried dentists are included (the share of dentists in total dentists and physicians was about 1.5 %).
- General Practitioners (GPs) working as employees (about 15% of all GPs) are included from 2000 to 2013.
- Physicians in training are included.
- Data include all additional payments including overtime payments. Data do not include benefits in kind.
- There are salaried specialists who also work in private practice but the data do not include the income from private practice.
Methodology:
- Until 2015, imputation of data for the types of health establishments surveyed on sample basis was applied.
- The Ministry of Health increased the remuneration of specialists in 2011, following the physicians' campaign titled "Thank You, We Are Leaving" (Děkujeme, odcházíme), launched by the doctors' union.
Break in time series in 2016: Data come from a new survey on independent establishments of out-patient care. The data collection covers both full-time and part time workers but reflects the workload of physicians, i.e. the total income is divided by the estimated number of full-time equivalent physicians. Also, data include some providers of healthcare services not previously covered, e.g. medical transport and emergency service. Dentists are not included from 2016 onwards.
Break in time series in 2014: Data exclude selected independent establishments of out-patient care (GPs for adults, GPs for children and adolescents, practical independent dentists, practical independent gynaecologists and independent specialists).

Self-employed specialists:
Source: Institute of Health Information and Statistics of the Czech Republic, National Health Information System.
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 healthcare personnel in March.
Coverage:
- All healthcare providers.
- Only specialists with working contracts.
- Average remuneration for salaried healthcare 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 healthcare 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).

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.
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 unique factor (24 %) for all types of doctors, despite the disparities in the real rates of social charges. 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
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) 2021 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.
Further information: http://www.destatis.de.

Self-employed specialists:
Source: Federal Statistical Office, Cost Structure Statistics 2021, special evaluation by the Federal Statistical Office.
Methodology:
- Specialists are defined as all practices of physicians excluding the practices of general practitioners. Dentists and psychologists have also been excluded.
- Data include all self-employed specialists in panel practices and private practices. Included are physicians with the following specialties: General practice, Surgery, Neurosurgery, Orthopaedics, 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.
- Students who have not yet graduated are excluded.
- The figures are calculated for each practice owner and not per FTE.
- 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.
Further information: http://www.destatis.de.

Greece

Salaried specialists:
Source: 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.
- During 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 healthcare 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).
- Data relate to specialists working in publicly-funded hospitals and exclude income from private practice.
- Approximately 75% 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 2,430 to EUR 22,303 per annum. An estimation of average allowances however cannot be given, due to the vast range of combinations of payments claimed by specialists. These allowances are also subject to reductions under the Financial Emergency Measures in the Public Interest (**FEMPI**) Act 2013 (potentially up to 10%).
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 and 2015: As of April 2019, wage indices were released based on the new reference period (December 2015). 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 and from 2010 to 2014 are based on the previous reference periods (December 2005 and December 2010).
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 contract for the period 2019-2021 has not been renewed yet.
- 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”.

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.
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.
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 and 2018, 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 healthcare 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 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.
- Data include physicians who are majority shareholders and directors (with a wage) in their own business.
- 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.
- 2014: Decreases due to lowering of several overtime payments in the collective agreements in the healthcare sector.
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.
- Data refer to the average per FTE. From 2006 onwards, a new source is used for the calculation of FTE.
- Figures are derived by combining the BIG register and the Social Statistical Database from Statistics Netherlands (including the municipal registers and social security databases).

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.
- Data on corporate tax are excluded.

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 and receive 'usual wages' and when desired dividend from beneficial ownership. This category is not covered in these statistics, also not in the group of employees, given their special status.
- The average wage is 121 500 Euro, plus average income out-of-profit of 6 700 Euros; 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 2022 is the 29th 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 (2/3/23) the data have been provided by 15 out of the 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 5014 specialists in 2022 (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 DHB employment for most, if not all, of their careers.
Note: The terms and conditions of employment for medical specialists are set out in the Multi-Employer Collective Agreement (MECA), which will last for a period of 3 years. The full salary report for the previous year is available at 'Salary survey analysis 2021' at https://www.asms.org.nz/publications/. The 2022 report will be uploaded here once available.
Further information: Survey publications from 2004 to 2021 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:
- 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 and also to newly-qualified doctors (assistant doctors) and GPs (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 is made 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 for the group 22 excluding the sub-groups 222, 223, 225, 2211 and 221236 according to the Polish Classification of Occupations and Specialties (based on ISCO-08).
- 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.

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).
Break in time series in 2006.
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.
- 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.
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).

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 healthcare 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.

Self-employed specialists: Data are not available.

Slovenia

Salaried specialists:
Source: Statistical Office of the Republic of Slovenia (SURS).
Methodology:
- 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 2020 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 healthcare 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 healthcare and social protection gained the right to higher earnings.

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).

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.

Self-employed specialists: Data not available.

Spain

Salaried specialists:
Source: Ministerio de Sanidad (Ministry of Health).
Methodology:
- 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 Heath (ASPE) for the private health sector.
- Before 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 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 Heath).
Coverage:
- The remuneration average has been calculated using the average remuneration of each autonomous community, without using any proration factor for taking into account the contribution of each community.
- Remuneration data in the private sector is missing for some autonomous communities.
- The contribution of both the private (26.4%) and public sector (74.6%) has been taken into account.
- 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.
- 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.
- 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.
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:
2016 onwards: **Ministry of Health, General Directorate of Public Hospitals.**
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: From 2012, income figures are gross income (include social security contributions and income taxes.)
Note: 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

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.