

# International models of career structure for medical specialists, other tenured medical posts and general practitioners in public (funded) health systems

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Marie Sutton and Jean Long  
Health Research Board  
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## Table of Contents

|   |    |
|---|----|
| <b>Table of Contents</b> .....  | 3  |
| <b>List of tables</b> .....   | 7  |
| Glossary of terms.....  | 8  |
| <b>Executive summary</b> .....  | 9  |
| Purpose and method .....  | 9  |
| Europe .....  | 9  |
| Specialists in Europe:.....   | 9  |
| General practitioners in Europe .....   | 10 |
| Specialty doctors in Europe .....   | 11 |
| Canada .....  | 11 |
| Specialists in Canada .....   | 12 |
| Hospitalist in Canada .....   | 12 |
| General Practitioners in Canada .....   | 12 |
| Australia.....  | 12 |
| Specialists in Australia .....  | 13 |
| General Practitioners in Australia.....   | 13 |
| Career Medical Officer in Australia .....   | 13 |
| New Zealand.....  | 14 |
| Specialists in New Zealand .....  | 14 |
| Rural Hospital Medicine in New Zealand .....  | 14 |
| General Practitioners in New Zealand.....   | 15 |
| MOSS Grade Doctors in New Zealand .....   | 15 |
| <b>Research question</b> .....  | 16 |
| <b>Introduction</b> .....   | 16 |
| <b>Purpose of the review</b> .....  | 16 |
| <b>Methods</b> .....  | 17 |
| <b>Findings</b> .....   | 18 |
| <b>Specialists doctors in Europe (known as consultants in Ireland and the UK)</b> ..... | 18 |
| <b>Specialist grades</b> .....  | 18 |
| <b>Main responsibilities</b> .....  | 18 |
| <b>Remuneration</b> .....   | 19 |
| <b>Working hours</b> .....  | 20 |
| <b>Additional responsibilities</b> .....  | 20 |

|  |           |
|--|-----------|
| Additional payments.....   | 20        |
| On-call payments .....   | 21        |
| Level of autonomy with respect to medical and management decision-making ..... | 21        |
| Private practice .....   | 21        |
| Proleptic appointments .....   | 21        |
| Special arrangements (for hard-to-fill posts).....                             | 21        |
| Flexible working .....   | 22        |
| <b>General Practitioners in Europe .....</b>                                   | <b>22</b> |
| <b>Overview .....</b>  | <b>22</b> |
| <b>Main responsibilities.....</b>  | <b>22</b> |
| <b>Remuneration of general practitioners.....</b>                              | <b>23</b> |
| <b>Additional payments.....</b>  | <b>23</b> |
| <b>After hours care .....</b>  | <b>23</b> |
| <b>Specialty doctor in Europe.....</b>   | <b>25</b> |
| <b>Main responsibility .....</b>   | <b>25</b> |
| <b>Remuneration .....</b>  | <b>25</b> |
| <b>Working hours.....</b>  | <b>25</b> |
| <b>Additional responsibility.....</b>  | <b>25</b> |
| <b>Additional payments.....</b>  | <b>25</b> |
| <b>On-call payments .....</b>  | <b>25</b> |
| <b>Level of autonomy .....</b>   | <b>25</b> |
| <b>Proleptic appointments .....</b>  | <b>26</b> |
| <b>Special arrangements (for hard-to-fill posts).....</b>                      | <b>26</b> |
| <b>Flexible working .....</b>  | <b>26</b> |
| <b>Specialist doctors in Canada.....</b>                                       | <b>26</b> |
| <b>Overview .....</b>  | <b>26</b> |
| <b>Remuneration .....</b>  | <b>27</b> |
| <b>Special arrangements (for hard-to-fill posts).....</b>                      | <b>27</b> |
| <b>Flexible working .....</b>  | <b>27</b> |
| <b>Canadian hospitalist .....</b>  | <b>27</b> |
| <b>General Practitioners in Canada.....</b>                                    | <b>28</b> |
| <b>Overview .....</b>  | <b>28</b> |
| <b>Remuneration .....</b>  | <b>28</b> |
| <b>Additional payments.....</b>  | <b>28</b> |
| <b>Flexible working .....</b>  | <b>29</b> |

|  |    |
|--|----|
| <b>After hours care</b> .....                              | 29 |
| <b>Specialist doctors in Australia</b> .....               | 29 |
| <b>Overview</b> .....                                      | 29 |
| <b>Specialist grades</b> .....                             | 29 |
| <b>Main responsibilities</b> .....                         | 30 |
| <b>Remuneration</b> .....                                  | 30 |
| <b>Additional payments</b> .....                           | 31 |
| <b>Level of autonomy:</b> .....                            | 31 |
| <b>Special arrangements (for hard-to-fill posts)</b> ..... | 31 |
| <b>Flexible working:</b> .....                             | 32 |
| <b>General Practitioners in Australia</b> .....            | 32 |
| <b>Overview</b> .....                                      | 32 |
| <b>Remuneration</b> .....                                  | 32 |
| <b>Working Hours</b> .....                                 | 33 |
| <b>Additional payments</b> .....                           | 33 |
| <b>After hours care</b> .....                              | 33 |
| <b>Career medical officers in Australia</b> .....          | 34 |
| <b>Overview</b> .....                                      | 34 |
| <b>Main responsibility</b> .....                           | 34 |
| <b>Remuneration</b> .....                                  | 34 |
| <b>Working hours</b> .....                                 | 34 |
| <b>Level of autonomy</b> .....                             | 34 |
| <b>Flexible working</b> .....                              | 34 |
| <b>Specialist doctors in New Zealand</b> .....             | 35 |
| <b>Overview</b> .....                                      | 35 |
| <b>Specialist grades</b> .....                             | 35 |
| <b>Main responsibilities</b> .....                         | 35 |
| <b>Remuneration</b> .....                                  | 35 |
| <b>Working hours</b> .....                                 | 35 |
| <b>Additional payments</b> .....                           | 35 |
| <b>Level of autonomy</b> .....                             | 35 |
| <b>Special arrangements (for hard-to-fill posts)</b> ..... | 36 |
| <b>Flexible working</b> .....                              | 36 |
| <b>Rural hospital medicine in New Zealand</b> .....        | 36 |
| <b>General practitioners in New Zealand</b> .....          | 37 |

|   |    |
|---|----|
| <b>Overview</b> .....   | 37 |
| <b>Remuneration</b> .....   | 37 |
| <b>Working hours</b> .....  | 37 |
| <b>Additional payments</b> .....  | 37 |
| <b>After hours care</b> .....   | 37 |
| <b>Special arrangements (for hard-to-fill posts)</b> .....                              | 37 |
| <b>MOSS grade doctors in New Zealand</b> .....  | 37 |
| <b>Overview</b> .....   | 37 |
| <b>Remuneration</b> .....   | 38 |
| <b>Working hours</b> .....  | 38 |
| <b>Level of autonomy</b> .....  | 38 |
| <b>Flexible working</b> .....   | 38 |
| <b>Special arrangements (for hard-to-fill posts)</b> .....                              | 38 |
| Appendix 1: Data extraction sheets .....  | 39 |
| Appendix 2: Folder of available contracts/agreements and other relevant documents ..... | 42 |

**List of tables**

|  |    |
|--|----|
| Table 1 Search terms used to obtain information from Google and Google scholar.....                | 17 |
| Table 2 Adjusted OECD income figures (in Euro) of medical specialists, 2006-2009.....              | 20 |
| Table 3 Remuneration for hospital-based specialists in Canada.....                                 | 27 |
| Table 4 Potential allowances paid to general practitioners in Ontario and Nova Scotia, Canada..... | 28 |
| Table 5 Remuneration for hospital-based specialists in three jurisdictions in Australia.....       | 31 |

## Glossary of terms

**Medical Specialist:** refers to doctors who have specialist registration by having completed specialist training and are registered with the College of Physicians and Surgeons of the country and who may then practise independently as a specialist. A number of eligibility categories are available for registration within the Specialist Division of the Registers. Medical specialists include any registered specialty of medicine including public health and all surgical specialties. Other terms in use for medical specialist are: Specialist; consultant; staff specialist and specialist physician.

**Specialty doctor:** formerly called SAS grade, this term was introduced as a new grade to include all Staff Grade, Associate Specialist and Clinical Assistants. Doctors at this grade are not on the specialist register and are not in training. However they have minimum 2 years foundation training and 2 years of basic specialist training.

**Career Medical Officer/MOSS grade doctor:** are also known as SMOs (Senior Medical Officers), HMOs (Hospital Medical Officers) and MMOs (Multi-skilled Medical Officers) in various parts of Australia, as well as MOSSs (Medical Officers, Special Scale) in New Zealand. They are salaried non-specialist doctors and are not in training for a speciality.

**General Practitioner:** in this document GP refers to a physician who practices 'general medicine' or provides primary care in the community and who is vocationally trained as a GP.

**Proleptic Appointment:** refers to doctors near completion of HST who can apply for a consultant post and who may be appointed under open competition on condition of attaining the HST qualifications.  
Or a doctor who has attained HST qualifications, applies for a consultant post under open competition and if successful may require further specific training for the specific post and commences the post on completion of this specific training

**A contract** of employment is an agreement having a lawful object entered into voluntarily by two or more parties, which in the case of doctors is between the employer (e.g. minister of health) and the doctors accepting the post. It outlines the terms and conditions of service and is signed by both parties when agreed.

**Agreement** of employment is a standard agreement document outlining terms and conditions of employment that have been negotiated between registered unions that advises and represents doctors and relevant ministries of health. The individual contracts are based on this document

**Tenured Post:** A non-training post of indefinite duration where a doctor may work on a long-term basis.



## Executive summary

### Purpose and method

In July 2013, the Minister for Health established a Working Group chaired by Professor Brian MacCraith, to perform a strategic review of medical training and career structure. The Working Group is examining and will make high-level recommendations relating to training and career pathways for doctors with a view to:

- Improving graduate retention in the public health system;
- Planning for future service needs;
- Realising maximum benefit from investment in medical education and training.

As part of this project the group required current information on career structures for publicly funded tenured **medical** posts in other countries that were relevant to the situation here in Ireland. The countries selected by the group were five European countries (Finland, France, Germany, The Netherlands and the United Kingdom [with particular reference to England]) and three of the commonwealth countries (Australia, Canada and New Zealand).

The information to answer the questions was obtained by identifying and searching the websites of the medical regulatory bodies and medical association websites in the countries under review, by Google searches of the internet using a number of relevant search terms outlined in the methods section and by contacting relevant personnel in the ministries of health in the jurisdictions of interest. All data collected were extracted into a data collection form.

## Europe

### Specialists in Europe:

All European countries have doctors who have completed specialist training and register such doctors as specialists in medicine (including public health) or in surgery. Generally there is one grade of specialist throughout Europe and these specialists are clinically independent practitioners. In Germany there is a hierarchy of specialists with a clearly defined career progression pathway. Progression in Germany is from basic specialist (Facharzt) to mid-level specialist (Oberarzt), and to head of department (Chefartz) or clinical director with increased salary for each level which relate to level of authority and leadership roles.

Specialists in Europe are salaried or self-employed or a combination of both. The method of payment varies: for example, in Finland and the UK all specialists are salaried; in France, Germany and Netherlands specialists are salaried or self-employed in varying degrees. The Organisation for Economic Co-operation and Development (OECD) collects information on the salaries of specialists across Europe but differences in payment mechanisms and reporting make comparisons between countries difficult. The SEO Economic research group published an International Comparison of Remuneration of medical specialists in 2012 and they attempted to correct the 2009 OECD figures for remuneration of specialists, to take account of the differences in measurement. From their adjusted calculations the gross income of salaried medical specialists was highest in England (€175,586) followed by the Netherlands (€147,447), France (€131,716) and Germany (€121,097). Finland was not included in their report. For self-employed specialists the gross income was highest in the Netherlands (€259,131), followed by France (€176,042) and then Germany (€160,253). It is not clear if the gross income for salaried specialists includes professional development grants, indemnity payments, pensions and paid memberships to professional organisations. On the other hand, it is not clear if the salaries earned by the self-employed specialists are before or after other expenses are deducted such as rent, administration services, nursing services, professional development expenses, indemnity payments and pension contributions.

The full time equivalent (FTE) working hours for specialists across Europe are broadly similar with 40 hours per week being the norm. The search did not yield information on the reporting relationships of specialists across European countries with the exception of Germany and the UK. In Germany the senior specialist (Chefartz) is responsible for the entire department both in medical and legal terms. In the UK, specialists report to a clinical or medical director on quality of care issues or organisational issues including job plans and scheduling.

An outline of the responsibilities of the specialist post was only obtained for the Netherlands and the UK and relate to patient clinical care. Duties include: consulting; diagnosing; planning and evaluating treatment; and administration directly related to patient care. In both of these countries additional responsibilities were described which mainly relate to teaching and to medical/clinical governance. In the UK, the NHS has a 'flexible careers scheme for doctors' which is designed to enable doctors to move in and out of full-time and part-time work, reorganise their hours, take career breaks and wind down gradually before retirement. The scheme provides central funding and is designed to find working patterns for consultants wishing to work less than 50% of a fulltime equivalent. Consultants wanting to work as part of a job share or part-time above these hours can apply for any substantive post. In Germany, more than one-fifth of specialists work part-time. For the remaining countries, information on flexible working arrangements was not obtained. Proleptic appointments as described in the glossary are available in the UK but not in the Netherlands. However it must be emphasised that in the UK there is always open competition for all consultant posts. Special arrangements for hard-to-fill posts were described only for the UK, with the Netherlands sources commenting that there are no special arrangements for hard-to-fill posts on a national scale. With regard to the UK, the contract allows hospital trusts under certain circumstances to award a recruitment or retention premium in locations/specialties where the post is difficult to fill.

### **General practitioners in Europe**

All general practitioners are self-employed except in Finland where most general practitioners work in municipal health centres and are salaried but many are paid fee-for-service for overtime work. In France, Germany, the Netherlands and the UK the number of general practitioners working in salaried service (employed by practices or more senior general practitioners) is increasing but self-employed independent contractors are still the majority. In the UK, the Netherlands and Finland, general practitioners act as gatekeepers to specialist services whereas in France and Germany, they do not. Income for general practitioners is derived mainly from salary in Finland but in the remainder of the European countries it is derived from fee-for-service payments, capitation payments or payment for performance or a combination of these methods.

In the UK, individual general practitioners are no longer required to provide after-hours care to their patients (a small minority still do so), but are required to ensure that adequate arrangements are in place. In practice, this means that Community Care Groups (CCGs) contract most of these services to general practitioner cooperatives and private companies.

In France, after-hours care is delivered by a number of entities including: the emergency departments of public hospitals; contracted private hospitals that have signed an agreement with the regional health agency and receive financial compensation for care provided; self-employed physicians who work for emergency services; and, more recently, after-hours public facilities (maisons de garde) financed by social health insurance funds and staffed by health professionals on a voluntary basis. Doctors are paid an hourly rate when working at maisons de garde, regardless of the number of patients seen.

In Germany, after-hours care is organised by the regional physician associations to ensure access to ambulatory care around the clock. Physicians are obliged to provide after-hours care though the regulations differ across regions. After-hours care assistance is also available via a nationwide telephone hotline. Payment of ambulatory

after-hours care is based on the above-mentioned fee schedule, again with differences in the amount of reimbursement for social or private health insurance.

In the Netherlands, after-hours primary care is organised at the municipal level in general practitioners 'posts'—centralised services typically run by a nearby hospital that provide general practitioners care between 5:00 pm and 8:00 am. Specially trained assistants answer the phone and perform triage. General practitioners decide whether or not patients need to be referred to the hospital. The general practitioner post sends the information regarding a patient's visit to his or her general practitioners.

There was no information on out-of-hours care found for Finland.

It was not possible to obtain information on working hours, responsibilities, conditions of employment and arrangements for general practitioners in Europe.

### **Specialty doctors in Europe**

This post refers to a tenured medical post for doctors who are not in specialist training and who are not on the specialist register. This grade of doctor only exists in the UK and not in the other European countries under review. Other terms formerly in use for this grade were staff grade/associate specialist/clinical assistant/SAS grade but now these have been replaced by a specialty doctor grade. For this grade, doctors must have a minimum of two years general (or foundation) training and two years of specialist training. Their roles are more focussed on meeting NHS service requirements. For example, they often have considerably less administrative functions compared to specialists. There are many reasons why doctors might decide to take on a specialty doctor role e.g. they may be overseas doctors that have difficulty getting a training post; or they may prefer the work/life balance in this role as the hours are usually more regular; or they may have a portfolio career i.e. they may have several distinct roles. Additionally their responsibilities may include, for example, being a clinical manager, clinical audit lead or clinical governance lead. Experienced specialty doctors are trained to act as advisers on career development for less experienced specialty doctors within the organisation. Specialty doctors have more defined work patterns and flexibility than consultant posts. The degree of clinical supervision varies with seniority but they work under the supervision of a specialist.

Doctors in the specialty doctor grade earn between £37,176 and £69,325 based on a 40 hour working week. There is a defined salary scale with clear progression criteria and a right of appeal if incremental pay progression is not granted. There are 11 pay points, with annual progression to point 6 and progression is discretionary after point 6. A specialty doctor receives additional payment for additional sessions worked. Specialty doctors usually work an average of 48 hours per week; therefore their total pay will be for at least 12 sessions. Some hospitals offer 13 sessions of pay for 12 sessions of work, depending on the specialty. An additional 2%, 4%, or 6% of basic salary is paid depending upon the frequency of on-call duties. A work session in out-of-hours' time is three hours instead of the standard four hour work session.

### **Canada**

Canada's provinces and territories have primary responsibility for organising and delivering health services. As a result many provinces and territories have established regional health authorities that plan and deliver publicly funded health services on a local basis. The federal government co-finances provincial or territorial health insurance programs. Provincial and territorial ministries of health negotiate physician fee schedules with the relevant medical associations.

### **Specialists in Canada**

There is one grade of specialist in Canada. Specialist doctors are not employed by the state health system but contracted, and their remuneration is currently based on blended models that combine a base rate, a fee-for-service component and incentive or premium payments. Provincial and territorial ministries of health negotiate physician fee schedules with the relevant medical associations. Specialists are clinically independent practitioners and full-time equivalent hours are 40 hours per week. If the job involves shift work, fulltime is 12 (x12 hour) shifts per month. The Canadian Institute of Health Information publish gross clinical earnings per physician in each province and in 2011-2012 the gross clinical payment per physician was CD\$328,000 in 2011–2012, but there is significant variation depending on the specialty and geographical location. This figure does not take account of overheads associated with practices.

Additional payments can be made for additional leadership or academic responsibility and these are usually made through academic funding payments or alternative funding payments. On-call payments are paid with the amount depending on the frequency and intensity of the on-call hours. Contractual hours are agreed on an individual basis and on-call hours are individualised to contract. Flexible working arrangements are possible and arrangements are agreed with the provincial health ministry and individual doctor or groups of doctors. There are a variety of allowances and benefits subject to area and local agreement and many of these are aimed at recruiting and retaining specialists in hard-to-fill (mainly rural) posts.

### **Hospitalist in Canada**

A hospitalist in the Canadian context would be considered a staff position (i.e. they work within a unique hospital or health network), they are fully licensed for independent practice and it is not possible to provide a grade ranking as this approach is not used in Canada. A 'hospitalist' could remain in their post their entire career, however, there are no job guarantees and a position could be eliminated if the funding organisation determined that it was no longer required.

### **General Practitioners in Canada**

Solo general practitioners (or solo family practice physicians), group practices or inter-professional practices are all present in Canada. Family Physicians in Canada work under a variety of remuneration models, from fee-for-service to capitation to capitation with shadow billing to salary. Income for family physicians varies widely depending on hours, location, incentives, and type of practice. Within a group practice, family physicians earn over \$175,000 after overhead and before taxes. Because governments are now realising the importance of continuing comprehensive care, in many parts of the country there is compensation for chronic disease management, with family physicians receiving additional payments for providing such care.

Incentives for practicing in underserved areas range from higher salaries and higher fee-for-service payments to loan forgiveness, lump-sum payments, increased continuing medical education, and holiday support. Most rural physicians have lower overhead costs and the opportunity to earn higher income for performing procedures that would otherwise be carried out by specialists. The incentives are based upon the degree to which the community being served is classified as rural.

Family physicians have the most flexibility in terms of hours of work, when to work, and how to work. Most family physicians work in group practices that have daytime hours as well as evening and weekend hours, and they decide amongst themselves how to divide the responsibilities.

### **Australia**

The Australian government plays a strong role in national policymaking but generally funds, rather than provides health services. The federal government funds and administers the national health insurance scheme, and funds

public hospitals and population health programs (with the states/territories). The eight states and territories administer public hospitals and regulate all hospitals and community-based health services. There are agreements at states and territories level between relevant medical bodies and the local ministries of health.

### **Specialists in Australia**

Generally there is one grade of specialist in Australia. However, New South Wales (NSW) has specialist and senior specialist positions. Most specialists involved in academic medicine will be working in a university hospital and some of their time allocated toward academic activities. For academic consultants it is possible to progress academically to a higher grade such as professor.

Physicians in public hospitals either are salaried (but may also have private practices and additional fee-for-service income, of which they usually contribute a portion from the fees to the hospital), or are private specialist physicians who do some work in public hospitals, where they are paid on a per-session or fee-for-service basis for treating public patients. Any specialist with sufficient experience if they have the necessary skills can apply for clinical director with reimbursement for additional responsibility. Specialists are clinically independent practitioners with fulltime equivalent posts at 40 hours per week in all jurisdictions.

Earnings are partly determined by the different sources of funding for doctors' services. Medical specialists in public hospitals are usually paid a salary or by contract, with this being determined by State bargaining agreements. In addition, some salaried specialists have rights to private practice which means that additional income can be earned from seeing private patients, either in a public hospital or private setting. Hours worked in excess are paid at penalty rates and on-call hours are individualised to contract. Examining three states (New South Wales, Western Australia and Queensland) salary ranges from \$147,486 to \$253,774 (Australian dollars) across these three states with slight variations from state to state. Also available to specialists are management and leadership incentives. The rates of payment for on-call vary from state to state. Working hours are negotiable with part-time permanent posts possible by agreement. The Commonwealth provides a range of financial and non-financial incentives with the aim of attracting and retaining the rural and remote health workforce under the Rural Health Workforce Strategy (RHWS).

### **General Practitioners in Australia**

General practitioners are self-employed with variable levels of remuneration depending on the number of hours worked and medical benefit scheme payments. On-call or unsocial hours is not required unless by agreement. If general practitioners choose to provide after-hours care they receive additional payments. The level of remuneration is variable depending on hours worked and medical benefit scheme payments. Additional payments are available for the treatment of patients with complex and chronic conditions. There is a practice incentives program (PIP) aimed at supporting general practice activities that encourage continuing improvements, quality care, enhance capacity, and improve access and health outcomes for patients. The practice incentives program is administered by Medicare on behalf of the Department of Health with ten individual incentives in the programme. There are also a variety of rural incentives for general practitioners who practice in rural areas.

### **Career Medical Officer in Australia**

Career medical officers have permanent posts in hospitals, which are not training posts and not specialist posts. Some may work in a specialist area such as emergency departments or critical care but many may work in several areas and serve as general medical officers in hospitals. This post is broadly equivalent to specialist doctor grade in UK but training requirements are not specified at a national level. These posts are particularly valuable in remote areas. The main responsibilities of all posts in this category, as far as can be ascertained, are not described. Career medical officers work under supervision but for a senior career medical officer the supervision may be minimal. A fulltime equivalent career medical officer works 40 hours per week and there is

facility for part-time permanent posts. On-call requirements are dependent on the post. There is increased pay for rostered hours outside of normal hours (8am to 6pm) and additional pay for overtime. Salary is based on a nine point scale ranging from \$101,340 to \$156,941 (WA).

## **New Zealand**

The government plays a central role in setting the health policy agenda and service requirements for the health system, and in setting the annual publicly funded health budget. The responsibility for planning, purchasing, and providing health and disability support services lies with 20 geographically defined District Health Boards (DHBs). DHBs comprise seven members elected by the people in their area and up to four members appointed by the Minister of Health.

### **Specialists in New Zealand**

There is one grade of specialist in New Zealand. The responsibilities of specialists in New Zealand are described as responsibility to their patients and to act as a patient advocate. The actual job descriptions for specialists are worked out locally. They are clinically independent practitioners. Generally each employee gets a statement of positions to whom the employee reports and for what purposes, i.e. clinical matters and other matters. It is unlikely there will be more than two such positions. For all clinical matters, the 'manager' is likely to be a senior medical specialist within the organisation and would ordinarily be the clinical leader or head of department.

Specialist salaries are covered by a universal national agreement with a range of NZ \$149,750 – \$206,000. Their working hours are negotiated but fulltime equivalent is 40 hours per week. Initial placement on the salary scale depends on the qualifications and experience of the specialist. The salary increases yearly subject to satisfactory performance. In New Zealand, doctors' salaries are set by the Government through negotiation between the district health boards and union and are consistent on a sliding scale across the whole country. The salaries differ depending on how many rostered hours the particular role requires and on years of work experience. Out of hours availability allowances are paid for doctors' on-call and extra payment for all out-of-hours rostered call duties including telephone consultations and visits. For academic posts, clinical directorship etc. the method of remuneration varies with some specialists paid more, some get time allowance, some get both and some are stand-alone positions.

The employer may pay special allowances or provide benefits in services to specialists where recruitment and retention is a problem. A bonding scheme was introduced in 2009 for medical graduates to encourage working in rural areas.

### **Rural Hospital Medicine in New Zealand**

Rural Hospital Medicine was approved by the Medical Council of New Zealand (MCNZ) as a new vocational scope in March 2008, and the training programme had its first intake of registrars at the end of that year. This grade of doctor is somewhat similar to the 'hospitalist' grade described in Canada. The Rural Hospital Medicine Training Programme is four years long. There is a large emphasis on recognition of prior learning and experience and many registrars apply to have this acknowledged with the result that their programme is shortened. In contrast to rural general practice, rural hospital medicine is orientated to secondary care, is responsive rather than anticipatory and does not continue over time. Training in general practice alongside rural hospital medicine is possible and can be completed concurrently within a four-year period. The specialty of rural hospital generalist requires a broad base of experience in large and small hospitals and in general practice. The single factor that most determines this scope of practice, its depth and its nature, is that it is practiced at a distance from comprehensive specialist medical and surgical services and investigations. A broad body of knowledge, skills and attitudes, not common to any other medical vocational group, is required to deliver optimum secondary care in rural hospitals. Working in a rural area demands high-levels of individual responsibility and clinical judgement.

**General Practitioners in New Zealand**

Most primary care is based in doctor-owned small group practices with general practitioners acting as gatekeepers. Their income is derived from patient charges and government subsidies. Conditions for general practitioners vary widely and are negotiated locally. Many non-specialist (non-vocationally trained) doctors, work in poorer general practices. In 2002 new primary care organisations (known as primary health organisations) were set-up. General practitioners act as gatekeepers to specialist care and are usually independent, self-employed providers, compensated predominantly by a capitated government subsidy paid through primary health organisations in addition to patient co-payments. Patient registration is not mandatory, but general practitioners and primary health organisations must have a formally registered patient list to be eligible for government subsidies.

Over recent years, there has been substantial funding to subsidize primary care and improve access to care. Primary health organisations receive additional per capita funding for promoting health, coordinating care, reducing barriers to care for patients with access difficulties, and providing additional services for people with chronic conditions. Primary health organisations also receive extra funding if general practitioners collectively reach quality and service delivery targets for cancer, diabetes, and cardiovascular disease screening and follow-up, as well as for vaccinations.

**MOSS Grade Doctors in New Zealand**

Medical Officer of Specialist Scale (MOSS) is a staff grade doctor in New Zealand. This is a non-training position for a doctor who has not yet specialised or not yet gained a post graduate qualification. They work under the supervision of the specialist. The salary is based on a 12 point scale ranging from \$111,750 to \$162,250 (NZ dollars). Initial placement on the scale takes into account years of relevant experience and relevant qualifications. Advancement through the salary scales is by annual progression, subject to satisfactory performance. On-call hours for MOSS grade doctors negotiated between the relevant district health board and employee. The employer may agree to provide additional benefits, including special allowances, to employees in those services where recruitment and retention has or may become a serious problem.

## Research question

The research question was to:

Describe the career structure for medical specialists (that is, doctors who have completed specialist training such as physician [including public health specialist], surgeon, or general practitioner, and are registered on a specialist register) and other tenured medical posts (such as, specialty doctor in the United Kingdom (UK) who complete a shorter medical training course and are not on a specialist register)?

The question was to be answered using information from eight jurisdictions, namely: Australia (Western Australia and New South Wales), Canada (Ontario and Nova Scotia), France, Finland, Germany, The Netherlands, New Zealand and UK (England).

## Introduction

This evidence review was undertaken by Marie Sutton with support from Jean Long, Evidence Centre, HRB. The Evidence Review was requested by the Workforce Planning Unit of the Department of Health (DoH) as part of a knowledge brokering service offered through the research utilisation team, DOH, in collaboration with the Evidence Centre. The question was set by the DOH through an iterative process with the research utilisation team and Evidence Centre.

## Purpose of the review

In July 2013, a Working Group chaired by Professor Brian MacCraith, President of DCU, was established to carry out a strategic review of medical training and career structure.

The Working Group are examining and making high-level recommendations relating to training and career pathways for doctors with a view to:

- Improving graduate retention in the public health system;
- Planning for future service needs;
- Realising maximum benefit from investment in medical education and training.

The Group are considering issues including the pathway for training at every level from intern to specialist and the potential for reducing the length of specialist training. It is also considering mentoring and career planning supports for medical graduates, as well as measures to improve the quality of the training experience. In examining the issues, the Group are taking account of international good practice in regard to medical training and developments and medical career structures.

Prof MacCraith submitted an interim report in December 2013<sup>1i</sup> and will submit a final report in June 2014.

As part of this project, the group sought information on medical career structures in eight countries specifically with regard to publicly funded tenured positions. The medical career structures report will supplement the overall work being undertaken by the working group.

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<sup>1</sup> Department of Health (2013) Strategic review of medical training and career structure: interim report. Dublin: Department of Health



## Methods

The countries of interest are Australia (Western Australia and New South Wales), Canada (Ontario and Nova Scotia), France, Finland, Germany, Netherlands, New Zealand and UK (England). The United States of America (USA) was excluded as the health services are mainly funded through private health insurance and specialist doctors are either self-employed or employed by private institutions and so their conditions of employment are not comparable either within or outside the USA.

Two methods were employed to obtain information to answer the aforementioned research question.

Firstly online searching was conducted for relevant material to answer the question. It was clear at the outset that the majority of this information would be available in grey literature and as there was a tight deadline for completion of this work (eight weeks), the search was confined to the Google search engine. The google search terms are presented in Table 1. The search terms in the left hand column were combined with the search terms in the right hand column in various combinations and permutations in an effort to locate the required information to answer the question. Also using Google, websites of medical regulatory bodies and medical associations in individual countries were searched looking for references to state or national agreements on doctor remuneration and conditions of service.

**Table 1 Search terms used to obtain information from Google and Google scholar**

|                                      |                        |
|--------------------------------------|------------------------|
| ➤ (Medical) specialist               |                        |
| ➤ (Medical) (hospital) consultant(s) | ➤ Services             |
| ➤ Physician(s)                       | ➤ Salary               |
| ➤ Hospital doctor(s)                 | ➤ Remuneration         |
| ➤ Doctor(s)                          | ➤ Careers/posts/jobs   |
| ➤ Family physician(s)                | ➤ Contracts/agreements |
| ➤ General practitioner(s)            |                        |
| ➤ Family doctor(s)                   |                        |

Secondly, relevant personnel in the ministries of health in the eight jurisdictions of interest were contacted outlining the information that was required. Contacts in the various health ministries were obtained from the Department of Health and these were contacted through email initially by the Department and subsequently by the HRB; the contact email contained an explanation of the information that was required and a table containing the parameters of interest. For Canada and Australia the initial contacts were at federal level and because health services are organised at province/state /territory level in these jurisdictions, further contacts were established at provincial or state level through the federal level contact. Four ministries responded to the request and their information was used to supplement or validate the information already found through the Google search. Information obtained in this manner is referred to in the report as personal communications.

The information acquired through the combined search methods was read and extracted where it contribution to the topic. The data extraction form used for the review is presented in Appendix 1. The portions of the information that contributed to answering the question were collated and the findings are presented in the next section.

The information obtained was restricted to information available in English which limited the information available for France, Finland and Germany

## Findings

The findings are presented under the headings specialist doctors, specialty doctors and general practitioners in the various jurisdictions. The jurisdictions will be dealt with in the following order: Europe, Canada, Australia and New Zealand.

### Specialists doctors in Europe (known as consultants in Ireland and the UK)

#### Specialist grades

As far as can be ascertained from the available literature, there is one grade of specialist physician or surgeon in the countries being examined across Europe. Specialists in Europe complete the required specialist training programme and are then entitled to register on a specialist register and to apply for a specialist post. In Germany however there is a clearly defined career progression pathway for specialist doctors, as they can progress from a basic specialist (facharzt, resident physician) to mid-level specialist (oberarzt, senior registrar, responsible for a section within the department), and to head of department (chefarzt, head of department, responsible for the entire department), with increased salary for each level which relate to authority and leadership roles. This model is a hierarchy of specialists and not all specialists progress to the top level, Chefarzt, which is equivalent to head of department or clinical area.<sup>2</sup> (Bundesministerium für Gesundheit, personal communication, 2014) Due to language restrictions it was not possible to elucidate further on this hierarchy.

#### Main responsibilities

Details of the main responsibilities of specialists were obtained from the UK (NHS contract)<sup>34</sup> and the Netherlands (Netherlands Advisory Committee on Medical Manpower Planning, personal communication, 2014). In the UK, specialists accept ultimate responsibility for and delivery of expert clinical care, usually within a team. This includes diagnosis and management of complex cases and spending time and effort reflecting on and reviewing patient care activities so that quality and safety improves continuously. UK specialists are also involved in teaching, training, researching, managerial decisions, running departments and developing local services. It would not be expected that all specialists are involved in all of these activities at the same time, but rather that they are undertaken across a team of specialists at specialty or directorate level. The NHS depends on specialists to be involved in the wider management and leadership of the organisations they work in, and in the NHS generally.<sup>5</sup>

In the Netherlands the following items were listed as the main responsibilities of specialists: consulting; diagnosing; planning treatment; evaluating treatment; and assigning diagnosis for billing purposes by the hospital (Netherlands Advisory Committee on Medical Manpower Planning, personal communication, 2014).

<sup>2</sup> Kok L, Lammers M and Tempelman C (2012) Remuneration of medical specialists: an international comparison. Amsterdam: SEO Economic Research <http://www.seo.nl/en/page/article/remuneration-of-medical-specialists/>

<sup>3</sup> Presentation on NHS consultants contract

[http://www.nhsemployers.org/SiteCollectionDocuments/Consultant\\_Contract\\_Presentation\\_aw\\_050309.pdf](http://www.nhsemployers.org/SiteCollectionDocuments/Consultant_Contract_Presentation_aw_050309.pdf)

<http://bma.org.uk/practical-support-at-work/contracts/consultant-contracts/part-time-and-flexible-working>

<sup>4</sup> NHS consultants contract <http://bma.org.uk/practical-support-at-work/contracts/consultant-contracts>

<sup>5</sup> Guide\_to\_consultant\_job\_planning

[http://www.nhsemployers.org/Aboutus/Publications/Documents/Guide\\_to\\_consultant\\_job\\_planning.pdf](http://www.nhsemployers.org/Aboutus/Publications/Documents/Guide_to_consultant_job_planning.pdf).

## Remuneration

The method of payment of specialist physician or surgeon varies. In Finland and the UK all specialists working in publicly funded hospitals are salaried. In France, Germany and the Netherlands specialists in hospitals are salaried or self-employed in varying degrees. The difference between salaried and self-employed specialist physicians or surgeons is not clear-cut. In England, around 50% of the salaried specialists also work in private practice. In France just over half of specialists are self-employed (51%) and their income derives from fee-for-service.<sup>6</sup> Although hospital care is dominated by public hospitals, including teaching institutions with a quasi-monopoly on medical education and research, there are, nevertheless, opportunities for physicians in private practice who wish to have part-time hospital staff privileges in public hospitals.<sup>7</sup> In Germany, regardless of ownership, hospitals are staffed principally by salaried specialists (Commonwealth 2013).<sup>6</sup> In the Netherlands two-thirds of hospital-based specialists are self-employed or work in partnership with other physicians, and are paid on a fee-for-service basis; the remaining third are salaried.<sup>68</sup>

Actual salary is only available for salaried specialists in the UK and a basic salary ranges from £75,249 to £101,451 per year depending on the length of service.<sup>9</sup>

The remuneration of specialists across countries is difficult to compare. The most current information available on specialist remuneration comes from the OECD. A paper published in 2012 by the SEO Economic Research Group on an international comparison of medical specialist remuneration for the Dutch Ministry of Health examined OECD figures on remuneration for 2009 and determined that comparisons are problematic for many reasons some of which include: differing payment mechanisms; inconsistent reporting mechanisms for self-employed specialists; inclusion of post graduate specialist trainee doctors salaries in specialists remuneration in some countries; and some countries reporting gross income and some net income.<sup>10</sup> In this paper the authors adjusted for these differences by gathering additional information from national researchers in the countries under study. Table 2 from the SEO report displays adjusted OECD income figures of medical specialists. It is not clear if the gross income for salaried specialists includes professional development grants, indemnity payments, pensions and paid memberships to professional organisations. On the other hand, it is not clear if the salaries earned by the self-employed specialists are before or after other expenses are deducted such as rent, administration services, nursing services, professional development expenses, indemnity payments and pension contributions.

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<sup>6</sup> Thomson S, Osborn R, Squires D, and Jun M (editors) (2013) International profiles of health care systems, 2013. New York and Washington: The Commonwealth Fund.

[http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717\\_Thomson\\_intl\\_profiles\\_hlt\\_care\\_sys\\_2013\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717_Thomson_intl_profiles_hlt_care_sys_2013_v2.pdf)

<sup>7</sup> Rodwin VG (2003) The health care system under French National Health Insurance: lessons for health reform in the united states. American Journal of Public Health 93(1): 31-7. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447687/>

<sup>8</sup> Thomson S, Osborn R, Squires D, and Jun M (editors) (2012) International profiles of health care systems, 2012. New York and Washington: The Commonwealth Fund. <http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Nov/International-Profiles-of-Health-Care-Systems-2012.aspx>

<sup>9</sup> Pay scales for NHS consultants <http://bma.org.uk/practical-support-at-work/pay-fees-allowances/pay-scales-consultants>

<sup>10</sup> Kok L, Lammers M and Tempelman C (2012) Remuneration of medical specialists: an international comparison. Amsterdam: SEO Economic Research <http://www.seo.nl/en/page/article/remuneration-of-medical-specialists/>

**Table 2 Adjusted OECD income figures (in Euro) of medical specialists, 2006-2009<sup>11</sup>**

|  | England | France  | Germany | Netherlands |
|--|---------|---------|---------|-------------|
| Gross income salaried with corrections | €       | €       | €       | €           |
| 2006                                   | -       | 128,303 | -       | 128,072     |
| 2007                                   | 215,272 | 135,996 | -       | 133,507     |
| 2008                                   | 192,484 | 140,214 | -       | 137,924     |
| 2009                                   | 175,586 | 131,716 | 121,097 | 147,447     |
| Gross income self-employed             |         |         |         |             |
| 2006                                   |         | 165,748 |         | 186,999     |
| 2007                                   |         | 169,925 | 157,000 | 205,059     |
| 2008                                   |         | 174,252 |         | 235,105     |
| 2009                                   |         | 176,042 | 160,253 | 259,131     |

Source: Adapted from remuneration of medical specialists; SEO economic research

### Working hours

Full time equivalent (FTE) working hours are broadly similar across Europe with circa 40 hours being the norm though in Germany doctors can work up to 42 hours in a normal working week (Bundesministerium fur Gesundheit, personal communication, 2014). In the UK, specialists are normally contracted for ten four-hour programmed activities (PAs) per week of which 7.5 are devoted to direct clinical care and 2.5 are for supporting professional activities. Specialists can contract separately for additional programmed activities (PAs) up to the working time directive maximum (max of 12 PAs per week or more if specialists disapply the working time directive limits). The employer is expected to make any extra PAs available to all clinically appropriate specialists.<sup>12</sup>

In Germany specialists can be asked to work up to 18 additional hours in a busy week as part of the collective wage agreement but they can opt out of the wage agreement, earn less and avoid doing additional hours. Additional hours worked can be compensated for in two ways, time in lieu or monetary payment. Time in lieu is the preferred method of compensation (Bundesministerium fur Gesundheit, personal communication, 2014).

### Additional responsibilities

Details of additional responsibilities were obtained only for specialists in the UK and Netherlands. For the UK the NHS lists the following as some of the additional responsibilities: Caldicott guardian (responsible for ensuring safety of patient data), clinical Lead, audit lead, medical director, clinical director etc. Work undertaken for national bodies (for example, General Medical Council), trade unions and Royal Colleges may also be included by agreement. Compensation may be in the form of substitution for clinical duties and/or additional remuneration. Most trusts use locally agreed rates of pay to secure additional work above that agreed in specialists' job plans. These rates can vary between £48 and £200 per hour.

For the Netherlands the additional responsibilities include participating in medical staff of the hospital, participating in board of one's own speciality in hospital and delivering 40 hours of postgraduate training a year. (Netherlands Advisory Committee on Medical Manpower Planning, personal communication, 2014)

### Additional payments

Details of additional payments are available for the UK which are made in the form of clinical excellence awards and distinction awards for specialists. Clinical excellence awards range from 2,957 to 75,796 per year.<sup>13</sup> In

<sup>11</sup> Kok L, Lammers M and Tempelman C (2012) Remuneration of medical specialists: an international comparison. Amsterdam: SEO Economic Research <http://www.seo.nl/en/page/article/remuneration-of-medical-specialists/>

<sup>12</sup> Presentation on NHS consultants contract

[http://www.nhsemployers.org/SiteCollectionDocuments/Consultant\\_Contract\\_Presentation\\_aw\\_050309.pdf](http://www.nhsemployers.org/SiteCollectionDocuments/Consultant_Contract_Presentation_aw_050309.pdf)

<sup>13</sup> Pay scales NHS consultants <http://bma.org.uk/practical-support-at-work/pay-fees-allowances/pay-scales-consultants>

addition, specialists working in London are paid a 'London weighting allowance' and there is provision in the NHS consultant contract to pay recruitment and retention premiums in certain circumstances (Schedule 16). Additional payments are available for unsocial hours which are defined as work outside 7am to 7pm Monday to Friday and any time at weekends or on public holidays. Alternatively this may be compensated for by a reduction in the time value of programmed activities (which are normally four hours duration).<sup>14</sup>

In Germany, earnings comprise the collectively agreed basic salary, payments for on-call and additional payment for call-in, overtime, pension payments and earnings from private practice (Bundesministerium fur Gesundheit, personal communication, 2014).

### **On-call payments**

Details on on-call payments are only available for the UK: An availability supplement is paid to specialists who participate in on-call rotas. The level of supplement will depend on the frequency of the on-call requirement and the nature of the required response (for example, visit to the hospital is more expensive than a telephone consultation). Value of supplement is between 1% and 8% of basic salary.<sup>15</sup>

### **Level of autonomy with respect to medical and management decision-making**

It would seem from available information that all specialists are medically autonomous practitioners but report on medical issues to the hospital board, clinical director or medical director.

### **Private practice**

Salaried specialist doctors in the UK and Finland can undertake private practice outside the hospital outside of their contracted hours or PAs. In Germany senior doctors can treat private patients on a fee-for-service basis. In France and the Netherlands, a large number of medical specialists are self-employed and for those that are salaried it is unclear from the information available in English if they can undertake private practice.

### **Proleptic appointments**

Proleptic appointments as defined in the glossary are available in the UK and from personal communication it would appear that they are not available in Germany or The Netherlands. This information is not available for France or Finland

### **Special arrangements (for hard-to-fill posts)**

Information on hard-to-fill posts was available for the UK and the Netherlands. In the UK, there are various arrangements, either proposed or in use, to attract specialists to and to retain them in hard-to-fill posts.

One example is: the Advance Appointment Scheme for transition of specialist registrar to specialists in Scotland was introduced in 2006 and is an example of proleptic appointment. In summary, the matching scheme identified the career aspirations of specialist registrars (SpRs). These were matched to current and potential future specialist vacancies. The specialist registrars were able to apply for the identified post in advance of gaining the Certificate of Completing [specialist medical] Training (CCT), but had to go through the normal open competition process and had to have gained their CCT before taking up post. In circumstances where there is an overlap between the specialist registrars obtaining their CCT and the specialist vacating the post, then funding will be available, on successful application, to assist the NHS Board in running with two post holders for a period

<sup>14</sup> Presentation on NHS consultants contract

[http://www.nhsemployers.org/SiteCollectionDocuments/Consultant\\_Contract\\_Presentation\\_aw\\_050309.pdf](http://www.nhsemployers.org/SiteCollectionDocuments/Consultant_Contract_Presentation_aw_050309.pdf)

<sup>15</sup> NHS consultants contract structure <http://bma.org.uk/practical-support-at-work/contracts/consultant-contracts/consultants-scotland/structure-of-the-contract>

of between one week and six months.<sup>16</sup> There is a proposal before the Welsh Government that Wales could adopt a system whereby doctors in post graduate training receive a financial incentive to stay in Wales.<sup>17</sup> This is modelled on the New Zealand bond scheme.<sup>18</sup> Sources from the Netherlands indicate that there are no special arrangements for hard-to-fill posts on a national level (Netherlands Advisory Committee on Medical Manpower Planning, personal communication, 2014).

### **Flexible working**

In the UK, the British Medical Association, the Department of Health and the NHS Confederation are keen to encourage flexible ways of working to improve recruitment and retention of specialists in the health service.<sup>19</sup> The NHS has a 'flexible careers scheme for doctors' which is designed to enable doctors to move in and out of full-time and part-time work, reorganise their hours, take career breaks and wind down gradually before retirement.

In Germany, more than one-fifth of specialists work part-time (Bundesministerium für Gesundheit, personal communication, 2014).

In France and the Netherlands there are many self-employed specialists who may be in a position to agree their hours with their contractors. However specific information on flexible working hours was not available.

## **General Practitioners in Europe**

### **Overview**

General practitioners are predominantly self-employed except for Finland where most work in municipal health centres and are salaried. In France, Germany, UK and the Netherlands the number of general practitioners working in salaried service (i.e. employed by practices or general practitioners) is increasing but self-employed general practitioners predominate. In the Netherlands, the contractual conditions for salaried general practitioners are governed by a Collective Labour Agreement, known as the 'CAO-Hidha'. In the UK, the Netherlands and Finland, general practitioners act as gatekeepers to specialist physician and surgical services whereas in France and Germany, they do not.

### **Main responsibilities**

In the UK, the main responsibilities of general practitioners are described: treating the sick and preventing people from becoming sick through the structured management of the long-term conditions which are becoming more prevalent in society. Outside of the consultation room general practitioners do home visits and a large amount of paperwork relating to their patients' care. They also attend Primary Care Organisations meetings and maintain their training and education up to date. A significant minority also undertake shift work for the local out-of-hours organisations.<sup>20</sup>

<sup>16</sup> Advance appointment scheme for transition of specialist registrars to consultants  
[http://www.sehd.scot.nhs.uk/mels/HDL2006\\_37.pdf](http://www.sehd.scot.nhs.uk/mels/HDL2006_37.pdf)

<sup>17</sup> Abi Rimmer (2014) Medical student debts could be paid as incentive to work in Wales, Plaid Cymru says.  
<http://careers.bmj.com/careers/advice/view-article.html?id=20016043>

<sup>18</sup> Health Workforce New Zealand (2014) Voluntary Bonding Scheme terms and conditions for doctors, 2014  
[http://www.healthworkforce.govt.nz/sites/all/files/Doctor%20terms%202013\\_0.pdf](http://www.healthworkforce.govt.nz/sites/all/files/Doctor%20terms%202013_0.pdf)

<sup>19</sup> Part-time-and-flexible-working in NHS consultants contract <http://bma.org.uk/practical-support-at-work/contracts/consultant-contracts/part-time-and-flexible-working>

<sup>20</sup> BMA (2010) General Practitioners – briefing paper. [bma.org.uk/-/media/Files/Word%20files/.../pressbriefing\\_GPs](http://bma.org.uk/-/media/Files/Word%20files/.../pressbriefing_GPs)

In the Netherlands, the self-employed general practitioners, as a contract holder, has a responsibility to provide medical care for all patients subscribed under his name. He must be available for consultation by his patients, and needs to arrange replacements in case of absence and out-of-hours cover (Netherlands Advisory Committee on Medical Manpower Planning, personal communication, 2014).

### **Remuneration of general practitioners**

In general the earnings of general practitioners vary according to the services they provide for their patients and the way they choose to provide these services. There are four contract types available to general practitioners in the UK: General Medical Services contract, Personal Medical Services; Alternative Provider Medical Service; Primary Care Trust Medical Services.<sup>21</sup> Salaried general practitioners in the UK, who are part of a Clinical Commissioning Group (CCG), earn between £54,319 to £81,969 dependent on, among other factors, length of service and experience. They agree with the practice, a job plan for the performance of duties under their contract of employment. In Finland, the payment system for general practitioners in municipal health centres varies between municipalities. The traditional payment method, which applies to between 45% and 50% of health centre physicians, is through a monthly salary with some extra fee-for-service payments for selected time-consuming service items or minor procedures. In those health centres where the personal doctor system has been introduced, general practitioners are paid a combination of a basic salary, capitation payment and fee-for-service payment for visits. In the Netherlands, general practitioners' remuneration is a combination of a capitation fee of €52 per patient per year; and fee-for-service (standard fee for 10 minutes consult is €9). These amounts are determined annually by the Dutch Healthcare Authority (Nza) (Netherlands Advisory Committee on Medical Manpower Planning, personal communication, 2014). Locum general practitioners taking over in- or out-of-office duties from a general practitioner are paid on an agreed hourly rate. For salaried general practitioners in the Netherlands, salaries are governed by the collective agreement (CAO-Hidha) and range from €58,660–€75,936 p.a. (Netherlands Advisory Committee on Medical Manpower Planning, personal communication, 2014).

### **Additional payments**

In the UK, the Minimum Practice Income Guarantee (MPIG) was introduced in 2004 to support some practices in moving to the new General Medical Services contract. Also in the UK there are payments for dispensing, enhanced services, Quality Outcomes Framework, quality reporting service (CQRS) and seniority.

In the Netherlands, in negotiation with health insurers, general practitioners or their practices can get additional contracts for treating patients groups with certain chronic diseases, such as diabetes or chronic obstructive pulmonary disease. Also, general practitioners can receive so-called modernisation and innovation fees (to control prescription of medicines and to control referral to specialists physicians and surgeons as well as promoting the use of e-health services, etc (Netherlands Advisory Committee on Medical Manpower Planning, personal communication, 2014).

### **After hours care**

The 'International Profiles of Health Care Systems, 2013' provided information on out-of-hours cover for general practitioners.<sup>22</sup> In the UK, individual general practitioners are no longer required to provide after-hours care to

<sup>21</sup> NHS England (2013) Managing regulatory and contract variations: standard operating policies and procedures for primary care <http://www.england.nhs.uk/wp-content/uploads/2013/07/mng-reg-con-vari.pdf>

<sup>22</sup> Thomson S, Osborn R, Squires D, and Jun M (editors) (2013) International profiles of health care systems, 2013. New York and Washington: The Commonwealth Fund. [http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717\\_Thomson\\_intl\\_profiles\\_hlt\\_care\\_sys\\_2013\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717_Thomson_intl_profiles_hlt_care_sys_2013_v2.pdf)

their patients (a small minority still do so), but are required to ensure that adequate arrangements are in place. In practice, this means that CCGs contract most of these services to general practitioner cooperatives and private companies. Serious emergencies are handled by hospital emergency departments. In some areas, less serious cases are seen in urgent care centres or minor-injury units. Telephone advice is available on a 24-hour basis through NHS111, a new service introduced in 2013 to replace NHS Direct, for those with an urgent but not life-threatening condition. Details of the care provided by these services are usually sent to the patient's general practitioners.

In France, after-hours care is delivered by a number of entities including: the emergency departments of public hospitals; contracted private hospitals that have signed an agreement with the regional health agency and receive financial compensation for care provided; self-employed physicians who work for emergency services; and, more recently, after-hours public facilities (maisons de garde) financed by social health insurance funds and staffed by health professionals on a voluntary basis. Doctors are paid an hourly rate when working at maisons de garde, regardless of the number of patients seen. Emergency services can be accessed via the national emergency phone number, 15, which is staffed by trained professionals who determine the type of response needed, from a general practitioner's visit to a resuscitation ambulance. Some research studies are currently testing the feasibility of telephone or telemedicine advice. Publicly funded multidisciplinary health centres with self-employed health professionals (physicians and non-physicians) allow better after-hours access to care in addition to more comprehensive care; fee-for-service payment is the rule for these centres.

In Germany, after-hours care is organised by the regional physician associations to ensure access to ambulatory care around the clock. Physicians are obliged to provide after-hours care though the regulations differ across regions. In a few areas (such as Berlin), after-hours care has been delegated to hospitals. The patient is given an overview of the visit afterwards to hand to his or her general practitioner. There is also a tight network of emergency care providers (the responsibility of the municipalities). After-hours care assistance is also available via a nationwide telephone hotline. Payment of ambulatory after-hours care is based on the above-mentioned fee schedule, again with differences in the amount of reimbursement for social or private health insurance.

In the Netherlands, after-hours primary care is organised at the municipal level in general practitioners 'posts'—centralised services typically run by a nearby hospital that provide general practitioners care between 5:00 pm and 8:00 am. Specially trained assistants answer the phone and perform triage. General practitioners decide whether or not patients need to be referred to the hospital. The general practitioner post sends the information regarding a patient's visit to his or her general practitioners general practitioners. Emergency care is provided by general practitioners, emergency departments, and trauma centres, and is covered under social health insurance. Depending on the urgency of the situation, patients or their representatives can contact their general practitioner or a general practitioner post (for after-hours care), call an ambulance, or go directly to the emergency department at the nearest hospital.<sup>23</sup> The great majority of hospitals have emergency departments, and all have a general practitioner post.

There was no information on out-of-hours care found for Finland.

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<sup>23</sup> Thomson S, Osborn R, Squires D, and Jun M (editors) (2013) International profiles of health care systems, 2013. New York and Washington: The Commonwealth Fund.  
[http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717\\_Thomson\\_intl\\_profiles\\_hlt\\_care\\_sys\\_2013\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717_Thomson_intl_profiles_hlt_care_sys_2013_v2.pdf)



## Specialty doctor in Europe

The only European country which appears to have a tenured post for hospital doctors that are not specialist physicians or surgeons is the UK. Prior to 2008 a number of grades of hospital doctors that were not in training or specialists were in existence such as staff grade, associate specialist, and clinical assistant. In 2008 all these grades have been subsumed into the specialty doctor grade.<sup>2425</sup> This grade of doctor is not on the specialist register and not in training and has completed a minimum 2-years general training (foundation training) and 2-years of specialist training.

### Main responsibility

As specialty doctors are not in training, their roles are usually much more focussed on meeting NHS service requirements. For example, they often have considerably less administrative functions compared to specialists. There are many reasons why doctors might decide to take on a specialty doctor role: they may be overseas doctors that have difficulty getting a training post; or they may prefer the work/life balance in this role as the hours are usually more regular; or they may have a portfolio career i.e. they may have several distinct roles.

### Remuneration

Doctors in the specialty doctor grade earn between £37,176 and £69,325. There is a defined salary scale with clear progression criteria and a right of appeal if incremental pay progression is not granted. There are 11 pay points, with annual progression to point six. Progression is discretionary after point six.

### Working hours

Full time equivalent hours are ten programmed activities (PA) per week. One PA is equivalent to four hours. Specialty doctors usually work an average of 48 hours per week; therefore their total pay will be for at least 12 sessions. Some hospitals offer 13 sessions of pay for 12 sessions of work, depending on the specialty.

### Additional responsibility

Additional programmed activity(ies) or additional NHS responsibilities: means special responsibilities within the employing organisation not undertaken by the generality of doctors, which are agreed between the doctor and the employer and which cannot be absorbed in the time set aside for supporting professional activities. These could include: being a clinical manager; clinical audit lead; or clinical governance lead. Experienced specialty doctors are trained to act as advisers on career development for less experienced specialty doctors within the organisation.

### Additional payments

Additional payments are available for additional sessions worked.

### On-call payments

An additional 2%, 4%, or 6% of basic salary will be paid depending upon the frequency of on-call duties. Outside of 7 am to 7 pm on weekdays and for weekend work, a programmed activity is three hours, i.e. out-of-hours' work is paid at time and one-third.

### Level of autonomy

All specialty doctors have appropriate clinical supervision

<sup>24</sup> Terms and conditions of service specialty doctors – England (2008)

[http://www.nhsemployers.org/SiteCollectionDocuments/TandC\\_of\\_service\\_for\\_spec\\_docs\\_FINALpdf\\_300813\\_bt.pdf](http://www.nhsemployers.org/SiteCollectionDocuments/TandC_of_service_for_spec_docs_FINALpdf_300813_bt.pdf)

<sup>25</sup> BMA and NHS A UK guide to job planning for specialty doctors and associate specialists

<http://www.nhsemployers.org/Aboutus/Publications/Pages/job-planning-for-specialists.aspx>

**Proleptic appointments**

No evidence of proleptic appointments for this grade.

**Special arrangements (for hard-to-fill posts)**

There are no special arrangements for hard-to-fill posts

**Flexible working**

Flexible working arrangements are one of the main attractions for this grade though there is also opportunity for defined work patterns. Flexible working is part of an integrated approach to the organisation of work and a healthy work/life balance of staff. Many speciality doctors will work all or part of their job flexibly. Flexible working arrangements benefit both the individual and the service. Speciality doctors work an agreed annual total of programmed activities instead of the same number each week.

**Specialist doctors in Canada****Overview**

Canada's provinces and territories have primary responsibility for organising and delivering health services. Many provinces and territories have established regional health authorities that plan and deliver publicly funded health services on a local basis. The federal government co-finances provincial/territorial health insurance programs. Provincial and territorial ministries of health negotiate physician fee schedules with relevant medical associations.

As the federal government is not directly responsible for delivering healthcare, two jurisdictions were examined in an attempt to gain an outline of career structures for doctors in publicly funded health services in Canada. There is one grade of specialist in Canada. Specialists are clinically independent practitioners. Specialists are not employed but contracted and may be paid through fee-for-service, alternative funding (AF), academic funding plans (AFP) or alternative payment plans (APP). AFPs/APPs are contractual arrangements between the health ministries and a group of physicians, and may include other organisations such as hospitals and universities. Some AFPs/APPs also include funding for teaching and research. The FTE is 40 hours but if the job involves shift work, fulltime is 12 (x12 hour) shifts per month. Contractual hours are agreed on an individual basis and on-call hours are individualised to contract. There are no standard national contracts for hospital specialists but individual provinces have Master Agreements between the medical associations and the relevant ministry of health. Most agreements currently are blended models that combine a base rate, a fee-for-service component and incentive or premium payments. The Ontario Agreement<sup>26</sup> and the Nova Scotia Agreement were obtained for this review.<sup>27</sup>

<sup>26</sup> 2012 physician services agreement between ontario medical association and her majesty the queen in right of ontario, as represented by the minister of health and long-term care

[http://www.health.gov.on.ca/en/pro/programs/phys\\_services/docs/phys\\_services\\_agreemnt\\_en.pdf](http://www.health.gov.on.ca/en/pro/programs/phys_services/docs/phys_services_agreemnt_en.pdf)

<sup>27</sup> physician services agreement between her majesty the queen in right of province of nova scotia, as represented by the Minister of Health <http://physicians.novascotia.ca/docs/Physician-Services-Master-Agreement.pdf>

## Remuneration

**Table 3 Remuneration for hospital-based specialists in Canada**

|                     | Ontario   | Nova Scotia   |
|---------------------|---|---|
| Method of payment   | FEE-FOR-SERVICE or blended payment  | FEE-FOR-SERVICE or alternative to FEE-FOR-SERVICE   |
| Average earnings*   | Can\$323,279 for medical specialties<br>Can\$441,504 for surgical specialties             | \$302,210 medical specialties<br>\$434,488 surgical specialties                           |
| On-call allowance   | On-call payment depending on the specialty, and the frequency etc.<br>Amounts not stated  | On-call payment depending on the specialty, and the frequency etc.<br>Amounts not stated  |
| Additional payments | Academic teaching & clinical director extra payment by AFP/APP<br>On-call rate not stated | Academic teaching & clinical director extra payment by AFP/APP<br>On-call rate not stated |
| Bonus               | Recruitment bonus, amount not stated<br>Retention bonus, amount not stated                | Recruitment bonus, amount not stated<br>Retention bonus, amount not stated                |
| Other               | Generous CME allowances<br>Medical protection paid  | Most or all of medical protection paid. CME allowance paid                                |

\*Earnings taken from the Canadian Institute for Health Information calculated from the average payments to specialists paid out in fee for services<sup>28</sup>

There is one detailed example of recruitment and retention bonus amounts for the Northwest Territories.<sup>29</sup>

### Special arrangements (for hard-to-fill posts)

**Ontario:** Health Force Ontario Northern and Rural Recruitment and Retention (NRRR) Initiative<sup>30</sup> offers taxable financial incentives to each eligible physician who establishes a full-time practice in an eligible community of the province. The grants range between \$80,000 and \$117,600 paid over a four-year period. The grants will be awarded based on eligibility criteria and considerations related to total NRRR Initiative budget allocations.

**Nova Scotia:** The Nova Scotia Master Agreement refers to the Nova Scotia recruitment and retention fund for specialists but precise details of the fund as outlined in Schedule V could not be found. Recently (January 20, 2014) Nova Scotia announced the setting up of a team to advise on doctor recruitment and retention.

### Flexible working

Flexible working arrangements agreed with provincial health ministry and individual doctor or groups of doctors.

### Canadian hospitalist

A hospitalist in the Canadian context would likely be considered a staff position i.e. they work within a unique hospital or health network and are fully licensed for independent practice (Senior Policy Advisor, Health Canada

<sup>28</sup> CIHI National Physician Database, 2011–2012—Data Release Table A.6.1: Average Gross Fee-for-Service Payment per Full-Time-Equivalent Physician by Physician Specialty and Province, 2011–2012  
<https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC2368>

<sup>29</sup> Government of the Northwest Territories <http://www.practicenorth.ca/uploads/Specialist%20Contract%20Summary%20-%202012.pdf>

<sup>30</sup> HealthForceOntario Northern and Rural Recruitment and Retention Initiative Guidelines  
<http://www.health.gov.on.ca/en/pro/programs/northernhealth/nrrr.aspx>

Personal Communication, 2014).<sup>31</sup> The term ‘hospitalist’ was coined in a landmark New England Journal of Medicine article written in 1996 by Bob Wachter.<sup>32</sup> A hospitalist is a physician whose primary professional focus is the general medical care of hospitalised patients. Their activities include patient care, teaching, research, and leadership related to hospital medicine. Many patients are referred to hospitalists by their family physician for treatment in hospital and are then returned to the care of their family physician after discharge. Hospitalists also consult on and treat patients referred by surgeons and medical sub-specialists during their hospitalisations. In addition, hospitalists care for ‘unassigned patients’ who has no primary care physician. In Canada the majority of physicians who identify themselves as hospitalists are specialists in Family Practice. The hospitalists are paid a fee-for-service basis and there is no information on clinical indemnity and pension liabilities.

## General Practitioners in Canada

### Overview

Solo, group or inter-professional practices for general practitioners are all present in Ontario and Nova Scotia. Ontario has seven family practice models: comprehensive care model; family health groups, family health networks; family health organisations; family health teams; rural northern physician group; and community health centres. Working hours are individually decided and agreed. Responsibilities of general practitioners in Canada were not recorded in any of the literature located.

### Remuneration

Remuneration for both provinces is mixed method payment (salary, fee-for-service, capitation and extra payments). Family Physicians in Canada work under a variety of remuneration models, from fee-for-service to capitation, to capitation with shadow billing, to salary. In Ontario the method of remuneration varies between the various models for example, in community health centre general practitioners are salaried, in primary care network general practitioner’s remuneration is capitation-based-blended-payment and in family health groups there is traditional fee-for-service practices (fee-for-service-based, blended-payment model).

### Additional payments

**Table 4 Potential allowances paid to general practitioners in Ontario and Nova Scotia, Canada**

| Ontario   | Nova Scotia   |
|---|---|
| Diabetes Management Incentive   | General practice complex care fee                               |
| Congestive Heart Failure Management Incentive                                     | Compensation for insured well-baby visits                       |
| Premiums for Primary Health Care of Enrolled Patients with Serious Mental Illness | Evening and weekend GENERAL PRACTITIONER office visit incentive |
| Obstetrical Coverage  | Increased payments for doctors participating in hospital care   |
| Palliative Care   | Adopting electronic medical records                             |
| Home Visits (Other than Palliative Care)  | Comprehensive care incentives programme                         |
| Newborn Care  | Chronic disease management                                      |
| Special Payment for Office Procedures   | Collaborative practice incentive programme                      |
| New Patient Fee   | Practice innovation fund  |
| Hospital Services   | Incentives for participating in Continuing Care programme       |

<sup>31</sup> Canadian Hospitalist, Canadian Society of Hospital Medicine <http://canadianhospitalist.ca/content/about-cshh>

<sup>32</sup> Wachter R and Goldman L (1996). The emerging role of ‘hospitalists’ in the American health care system. New England Journal of Medicine 335 (7): 514–7 <http://www.ncbi.nlm.nih.gov/pubmed/8672160>

### **Flexible working**

Family Physicians have the most flexibility in terms of how much to work, when to work, and how to work. Most Family Physicians now work in group practices that have daytime hours as well as evening and weekend hours, and they can decide amongst themselves how to divide the responsibilities. Sole practitioners generally have less flexibility, but they have the advantage of being their own bosses so they can take time off as they want.

### **After hours care**

After-hours care is generally provided by physician-led (and mainly privately owned) walk-in clinics and hospital emergency rooms (Commonwealth Fund International Health Policy Survey, 2013).<sup>33</sup> In most provinces and regions a free telephone service ('telehealth') is available 24 hours per day for health advice from a registered nurse. Traditionally, primary care physicians were not required to provide after-hours care, although many of the government-enabled group practice arrangements have requirements or financial incentives for providing after-hours care to patients registered with the practice. For example, in Ontario, many primary care physicians receive a 20% premium for the provision of specific primary care services to patients after hours. The Commonwealth Fund International Health Policy Survey (2013) of physicians found that only 46% of physician practices in Canada had arrangements for patients to see a doctor or nurse after hours, with the highest rate of afterhours care in Ontario, at 67%. The same survey found that only 30% of physicians received notification when patients had been in a hospital emergency department, and about a quarter received a full report on their patients after they had consulted a specialist.

## **Specialist doctors in Australia**

### **Overview**

Australia's states and territories have primary responsibility for organising and delivering health services. Many states and territories have established regional health authorities that plan and deliver publicly funded health services on a local basis. As the federal government is not directly responsible for delivering healthcare, three jurisdictions were examined in an attempt to gain an outline of career structures for doctors in publicly funded health services in Australia.

Physicians in public hospitals either are salaried (but may also have private practices and additional fee-for-service income, of which they usually contribute a portion from the fees to the hospital), or are private specialist physicians who do some work in public hospitals, where they are paid on a per-session or fee-for-service basis for treating public patients.<sup>34</sup> Australia also has many specialist physicians who work purely in private practice, with admitting rights at several private hospitals.

### **Specialist grades**

Generally there is one grade of specialist (also termed medical officer) in Australia. However, New South Wales (NSW) has specialist and senior specialist positions.<sup>35</sup> In NSW 'specialist' means a person appointed to a position of specialist by the employer with specific training, qualifications and registration. A 'senior specialist' means a

<sup>33</sup> Thomson S, Osborn R, Squires D, and Jun M (editors) (2013) International profiles of health care systems, 2013. New York and Washington: The Commonwealth Fund.

[http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717\\_Thomson\\_intl\\_profiles\\_hlt\\_care\\_sys\\_2013\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717_Thomson_intl_profiles_hlt_care_sys_2013_v2.pdf)

<sup>34</sup> Thomson S, Osborn R, Squires D, and Jun M (editors) (2013) International profiles of health care systems, 2013. New York and Washington: The Commonwealth Fund.

[http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717\\_Thomson\\_intl\\_profiles\\_hlt\\_care\\_sys\\_2013\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717_Thomson_intl_profiles_hlt_care_sys_2013_v2.pdf)

<sup>35</sup> Staff specialists (state) award industrial relations commission of new south wales

<http://www.health.nsw.gov.au/careers/conditions/Awards/Staff-Specialists-Award.pdf>

person who: (a) has been employed by the employer on the maximum salary provided by the state contract or the award for a specialist for a period of at least three years; and/or (b) has gained such experience and attained such ability in his/her specialty which is acceptable to the employer after consideration by the Medical Appointments Advisory Committee who support appointment to the classification for the candidate; and c) is appointed to a position having such duties and responsibilities as are deemed by the employer to require the services of a senior specialist.

### **Main responsibilities**

In Western Australia, specialists are expected to provide professional medical care for their patients; practitioners are professionally responsible and accountable to the statutory authorities including the Medical Board; practitioners are responsible and accountable under the ethical codes and standards of relevant colleges and professional associations; specialists provide best practice services and participate in the development and management of the health system.<sup>36</sup>

In New South Wales specialists duties including clinical care, research, teaching, administration, quality improvement and managerial are functional requirements for specialist physicians or surgeons.<sup>37</sup>

In Queensland, specialists responsibilities include (a) work collaboratively as a team member of the service;(b) report to their manager as required by the service; (c) comply with the applicable legislative requirements; (d) perform the duties of the role as prescribed in Schedule 1 of this Contract and any other duties for which they are registered in the State that are within the medical officer's skills, qualifications and competencies as reasonably required by the service from time to time; (e) comply with the medical officer's performance plan; f) comply with the Code of Conduct for the Queensland Public Service, (g) comply with all applicable professional obligations and standards of conduct including the 'Good Medical Practice: A Code of Conduct for Doctors in Australia'; (h) performing the duties under the Contract as required by the service and assisting in achieving the service's performance targets; (i) undertake any training, education or other activity necessary to maintain the medical officer's expertise and qualifications; (j) where relevant, engage in and/or facilitate the ongoing teaching and training of both medical and non-medical staff; (k) implement and support clinical models of care and patient safety initiatives including supporting alternative revenue sources where granted and maximising funding for the delivery of service; and (l) comply with lawful and reasonable directions of the service.<sup>38</sup>

### **Remuneration**

Table 5 presents a comparison between Western Australia, New South Wales and Queensland with regard to specialist's salary, contract, on-call payment rate, potential for private practice and provision of professional development allowance.

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<sup>36</sup> Department of health medical practitioners (metropolitan health services) AMA industrial agreement 2013 PSAAG 4 of 2013  
[http://www.health.wa.gov.au/awardsandagreements/docs/Medical Practitioners \(Metro Health Service\) AMA Industrial Agreement 2013.pdf](http://www.health.wa.gov.au/awardsandagreements/docs/Medical_Practitioners_(Metro_Health_Service)_AMA_Industrial_Agreement_2013.pdf)

<sup>37</sup> Staff specialists (state) award industrial relations commission of new south wales (Page 2)  
<http://www.health.nsw.gov.au/careers/conditions/Awards/Staff-Specialists-Award.pdf>

<sup>38</sup> senior medical officer contract of employment (page 3) [http://www.health.qld.gov.au/medical/medical-contracts/docs/smo\\_s1\\_contract.pdf](http://www.health.qld.gov.au/medical/medical-contracts/docs/smo_s1_contract.pdf)

**Table 5 Remuneration for hospital-based specialists in three jurisdictions in Australia**

|                                    | Western Australia                       | New South Wales   | Queensland   |
|------------------------------------|---|---|--|
| Contract                           | 5 year renewable                        | Not reported  | Contract will apply until terminated by either party |
| Salary (Aus \$)                    | 171,763 - 253774                        | 147,486 – 199,259   | 158,832 – 221,232                                    |
| On-call rate (Aus \$)              | \$19.21 per hour                        | Year 1 25,662 per year Increasing over 5 years to reach 34,672 per year (known as senior level) | On-call base rate loading of 12%                     |
| Private practice                   | Possible by agreement                   | Possible by agreement   | Possible by agreement                                |
| Professional development allowance | \$26,398 increasing in line with salary | Not reported  | \$20,000   |

**Additional payments**

Additional payments to specialists include managerial allowances, head of department allowances and overtime payments.

**Level of autonomy:**

Specialists are independently clinical practitioners.

**Special arrangements (for hard-to-fill posts)**

The Commonwealth provides a range of financial and non-financial incentives with the aim of attracting and retaining the healthcare workforce in rural and remote geographical areas.<sup>39</sup> These incentives may provide some support but are unlikely to be the sole or even main factor in choosing a career in rural health. Multiple lifestyle and financial factors are likely to influence a health practitioner's decision to practise in rural or remote Australia. In response to the 2008 Audit of the Health Workforce and the subsequent review of rural health programs, the \$134.4 million Rural Health Workforce Strategy (RHWS) was announced as part of the 2009-2010 Federal Budget. The Rural Health Workforce Strategy included several existing workforce programs and introduced a number of new initiatives. Programs under the strategy are listed below:

- The General Practice Rural Incentives Program (GPRIP), which provides incentives to encourage medical practitioners to move to and remain in a regional, rural or remote area.
- The Rural General Practitioner Locum Program, which helps to provide access to locum services for rural general practitioners.
- The HECS Reimbursement Scheme, which introduced scaling to fast track the repayment of medical school fees for doctors practising in outer regional, remote or very remote areas.
- The Scaling Incentive for overseas trained doctors (OTDs), which enables a reduction of the ten year Medicare moratorium for participants practising in a regional, rural or remote location.
- Scaling of Medical Rural Bonded Scholarship and Bonded Medical Places return of service obligations to encourage bonded scholars to complete their obligations in more remote areas.
- The Department also conducted a range of communication activities under the Rural Health Workforce Strategy to address some of the preconceived notions regarding rural practice and promote the benefits of regional, rural and remote opportunities.

<sup>39</sup> Review of Australian Government Health Workforce Programs: 4.2 Rural recruitment and retention strategies <http://www.health.gov.au/internet/publications/publishing.nsf/Content/work-review-australian-government-health-workforce-programs-toc~chapter-4-addressing-health-workforce-shortages-regional-rural-remote-australia~chapter-4-rural-recruitment-retention-strategies>

Financial incentives for rural doctors are a key element of the Government's rural workforce strategy and were a major focus of consultations with stakeholders as part of this review process. A significant ongoing investment has been made in the distribution of retention and relocation payments to rural doctors through GPRIP, which has an allocation of \$116.4 million in 2012-13.

The General Practice Rural Incentive Program (GPRIP) was implemented in 2010 as part of the Rural Health Workforce Strategy. (GPRIP) was established to increase the number of rural medical practitioners, general practitioners and specialists. The purpose of the program was to address the maldistribution of the medical workforce by providing targeted financial incentives to encourage doctors to relocate to and remain in rural and remote areas. The introduction of GPRIP streamlined and consolidated two existing rural incentive programs for general practitioners and registrars that were run separately, the Rural Retention Program and the Registrars Rural Incentives Payments Scheme. This streamlining sought to address inequities in payment amounts between registrars and general practitioners.

Originally GPRIP was intended for general practitioners providing primary care services. However, because of the way in which the eligibility criteria are set with regard to the Medicare Benefits Schedule some specialist medical practitioners (i.e. anaesthetists, cardiologists, and obstetricians and gynaecologists) were subsequently given access to incentive payments.

There has been a significant increase in the number of doctors providing services in regional, rural and remote areas since the RHWS was introduced. Incentive payments for rural doctors may have played a part in contributing to this growth. It is therefore recommended that incentives be a feature in ongoing efforts to support rural workforce sustainability.

**Flexible working:**

Part-time permanent posts are possible by agreement.

## **General Practitioners in Australia**

### **Overview**

Most general practitioners are self-employed and work in multi-provider practices. Some 'corporatization' is under way as eight per cent of general practitioners are employed under contract with private agencies. General practitioners are paid fee-for-service and the majority bulk-bill Medicare. Individuals are not required to register with a primary care physician and are free to consult any general practitioner, to seek a second opinion, or to move to another general practitioners practice at any time. Doctors with busy practices, however, may decide not to accept new patients. General practitioners play an important gatekeeping role as Medicare will reimburse specialists the schedule fee payment only for consultations referred by general practitioners.<sup>40</sup>

### **Remuneration**

Remuneration of general practitioners is variable depending on the number of hours worked and medical benefit scheme payments. General practitioners do not work on-call or unsocial hours unless by agreement. In addition to medicare payments, general practices receive incentive payments for being accredited against the Royal Australian College of General Practitioners practice standards, meeting certain benchmarks for health

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<sup>40</sup> Thomson S, Osborn R, Squires D, and Jun M (editors) (2013) International profiles of health care systems, 2013. New York and Washington: The Commonwealth Fund.  
[http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717\\_Thomson\\_intl\\_profiles\\_hlt\\_care\\_sys\\_2013\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717_Thomson_intl_profiles_hlt_care_sys_2013_v2.pdf)



information technology, providing appropriate care for some chronic diseases, teaching students, and performing some other activities.

### **Working Hours**

Full time equivalent (FTE) working hours are broadly similar across Australia with circa 40 hours being the norm.

### **Additional payments**

There are incentive payments for chronic disease management.<sup>41</sup> The Chronic Disease Management (CDM) Medicare items involve general practitioners managing the health care of people with chronic or terminal medical conditions, including those requiring multidisciplinary, team-based care from a general practitioners and at least two other health or care providers.

The Practice Incentives Program (PIP) is aimed at supporting general practice activities that encourage continuing improvements, quality care, enhance capacity, and improve access and health outcomes for patients. The PIP is administered by Medicare on behalf of the Department of Health. There are 10 individual incentives in the PIP.<sup>40</sup>

A variety of rural incentives (see Australian specialists above)

The Bonded Medical Places (BMP) Scheme<sup>42</sup> is intended to provide more doctors for areas experiencing shortages of doctors and other health care workers. Twenty five percent of all first year Commonwealth Supported (CSP) [medical school] Places are allocated to the scheme. Students accepting a place on the bonding scheme commit to working in a district where there are workforce shortages for a period of time (length of degree) and they can choose between outer metropolitan, rural and remote areas). The length of time may be shortened through scaling credits.<sup>43</sup>

### **After hours care**

General practitioners' clinics vary considerably in the extent to which they provide after-hours care; such care is often provided by a private company through arrangements with local general practitioners clinics. For example, doctors in Canberra set up a non-profit company in 1971 (CALMS Ltd), now also supported by the Australian Capital Territory government, where each member doctor agrees to participate on a roster to provide appropriate after-hours medical care to people in the territory. The Australian government also has offered grants to general practitioners to provide after-hours services. Medicare Locals also are contracted to improve access to after-hours care and this is now leading to improved arrangements in some regions.<sup>44</sup>

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<sup>41</sup> Chronic Disease Management - provider Information: fact sheet

<http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-factsheet-chronicdisease.htm>

<sup>42</sup> Bonded Medical Places (BMP) Scheme <http://www.health.gov.au/bmpscheme>

<sup>43</sup> Bonded Medical Places Scheme Information Booklet for 2014

[http://www.health.gov.au/internet/main/publishing.nsf/Content/85AD9683A6315BB9CA257BF0001AFDDF/\\$File/BMP%20Scheme%202014%20Information%20BookletV2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/85AD9683A6315BB9CA257BF0001AFDDF/$File/BMP%20Scheme%202014%20Information%20BookletV2.pdf)

<sup>44</sup> Thomson S, Osborn R, Squires D, and Jun M (editors) (2013) International profiles of health care systems, 2013. New York and Washington: The Commonwealth Fund.

[http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717\\_Thomson\\_intl\\_profiles\\_hlt\\_care\\_sys\\_2013\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717_Thomson_intl_profiles_hlt_care_sys_2013_v2.pdf)

## Career medical officers in Australia

### Overview

Career medical officers have permanent posts in hospitals that are not training posts or specialist posts. Also known as senior medical officers (SMOs), hospital medical officers (HMOs) and multi-skilled medical officers (MMOs) in various parts of Australia, Some may work in a specialist area such as emergency department or critical care but many may work in several areas and serve as general medical officers. They are particularly valuable in remote areas. They are broadly equivalent to specialty doctor grade in the UK but training requirements for career medical officers are not specified at a national level. In New South Wales there are two grades of career medical officer: a career medical officer and senior career medical officer.<sup>45</sup>

### Main responsibility

The main responsibilities are not documented.

### Remuneration

In Western Australia, the salary for a career medical officer ranges from \$101,340 per year 1 to \$156,941 per year 9 (AUS dollars), on a 9 point scale.<sup>46</sup>

In Queensland, the salary for a career medical officer is between \$137,517 and \$ 141, 814.<sup>47</sup>

In New South Wales, the salary for a career medical officer ranges from \$110, 223 at the most junior level to \$189,789 at the most senior level.<sup>48</sup>

### Working hours

A full time equivalent post is 40 hours per week

### Level of autonomy

The career medical officer works under supervision of a specialist but for a senior career medical officer the supervision required may be minimal.

### Flexible working

There are openings for permanent part-time posts and casual practitioners covering a small number of specific sessions.

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<sup>45</sup> Public hospital career medical officers (state) award industrial relations commission of new south wales  
[http://www.health.nsw.gov.au/careers/conditions/Awards/hsu\\_ph\\_career\\_med\\_officers.pdf](http://www.health.nsw.gov.au/careers/conditions/Awards/hsu_ph_career_med_officers.pdf)

<sup>46</sup> Department of health medical practitioners (metropolitan health services) ama industrial agreement 2013 psaag 4 of 2013

[http://www.health.wa.gov.au/awardsandagreements/docs/Medical\\_Practitioners\\_\(Metro\\_Health\\_Service\)\\_AMA\\_Industrial\\_Agreement\\_2013.pdf](http://www.health.wa.gov.au/awardsandagreements/docs/Medical_Practitioners_(Metro_Health_Service)_AMA_Industrial_Agreement_2013.pdf)

<sup>47</sup> Schedule 2 Senior Medical Officers terms and conditions of employment contracts

<http://www.health.qld.gov.au/medical/medical-contracts/docs/smo-sch2-termsconditions.pdf>

<sup>48</sup> Health professional and medical salaries (state) award industrial relations commission of new south wales  
[http://www.health.nsw.gov.au/careers/conditions/Awards/hsu\\_he\\_profmed\\_salaries.pdf](http://www.health.nsw.gov.au/careers/conditions/Awards/hsu_he_profmed_salaries.pdf)

## Specialist doctors in New Zealand

### Overview

Medical specialist means any medical practitioner who is vocationally registered by the Medical Council under the Health Practitioners Competence Assurance Act 2003 in one of the approved branches of medicine and who is employed in either the branch of medicine or in a similar capacity with minimal oversight.<sup>49</sup>

### Specialist grades

A medical specialist can also be called senior medical officer. There is only one grade of specialist.

### Main responsibilities

Specialists main responsibilities are to their patients and to act as an advocate for their patient(s). Their other specific functions are worked out locally under the headings listed below:

- (a) list of clinical activities required of the particular position;
- (b) an express statement about the standards against which the clinical performance will be assessed and judged;
- (c) a list of non-clinical or 'other professional' activities required of the particular position;
- (d) a summary of key administrative duties;
- (e) a description of clinical or other management duties, if the position has a clinical leadership or management function;
- (f) if appropriate, an agreed statement or list of specific objectives for the particular position

### Remuneration

Medical specialist salaries are covered by a universal national agreement and range from \$149,750 – \$206,00 NZ dollars. Initial placement on the scale depends on qualifications and experience and salary increases yearly subject to satisfactory performance. If working in the public hospital system, all medical specialists are entitled to the same salary dependent on experience and qualification. However, total salaries vary due to the different after-hours expectations and subsequent payments. The law also allows negotiation of additional terms and conditions of employment, provided they are not inconsistent with any current collective agreement.

### Working hours

Working hours can be negotiated but full time equivalent is 40 hours.

### Additional payments

For academic posts, such as clinical directorship, the method of remuneration varies, some receive a higher salary but work longer hours, some get time allowance but no additional salary, some do both and some are stand-alone positions. For out-of-hours' work, medical specialists are paid an availability allowance for the times on-call, plus extra payment for rostered out-of-hours duties where the specialist needs to be in the hospital or providing assistance by telephone. Out-of-hours availability allowance paid for specialists on-call and time and a half for all out-of-hours rostered call duties including telephone consultations. The employer may pay special allowances/provide benefit to someone who makes additional contributions.

### Level of autonomy

Specialists are clinically independent practitioners. Generally each employee gets a statement of positions to whom the employee reports and for what purposes, i.e. clinical matters and other matters. It is unlikely there will be more than two such positions. For all clinical matters, the 'manager' is likely to be a senior medical officer

<sup>49</sup> Association of Dental and Medical Specialists New Zealand District Health Boards senior medical and dental officers collective agreement 20 December 2011 until 28 February 2013

[http://www.wdhbcareers.co.nz/core/lib/other/wysiwyg/uploaded/SMOMECA2011to2013\\_1.pdf](http://www.wdhbcareers.co.nz/core/lib/other/wysiwyg/uploaded/SMOMECA2011to2013_1.pdf)

within the organisation and would ordinarily be the clinical leader or head of department (or applicable designation within each employer). Also staff specialists are responsible and accountable to the statutory authorities such as the medical council and also the ethical codes and standards of relevant colleges and professional associations.

### **Special arrangements (for hard-to-fill posts)**

Employer may pay special allowances or provide benefits in services to medical specialists where recruitment and retention are a problem.<sup>50</sup>

A voluntary bonding scheme was introduced in 2009 for medical graduates. Voluntary bonding is an incentive payment scheme that encourages health graduates to work in hard to staff communities and specialties. It targets medical, nursing and midwifery graduates and facilitates them to repay student loans earlier.<sup>51</sup>

### **Flexible working**

Flexible working options available and can be agreed between unions and the employer. Where shift work is agreed, time and half is paid for unsocial hours (1900 -0800) and all weekend hours. Actual job descriptions are worked out locally and shift work is in place in some services such as, emergency departments and intensive care.

### **Rural hospital medicine in New Zealand**

The speciality Rural Hospital Medicine was approved by the Medical Council of New Zealand in 2008. The full Rural Hospital Training Programme is four years though certain prior learning and experience may shorten the programme duration. In reality, many registrars apply to have their previous learning and experience recognised and as a result complete their training in a shorter time frame. Training in general practice alongside rural hospital medicine and can be completed concurrently within a four-year period

The specialty of rural hospital generalist requires a broad base of experience in large and small hospitals and in general practice. In order to assist a doctor to choose relevant experience that meets both the requirements of the programme and the doctors learning needs, the doctors are allocated an educational facilitator to mentor and guide them and are also allocated a rotational supervisor who works alongside them in clinical practice. The academic content of the programme is delivered by the University of Auckland and the University of Otago. There are a variety of postgraduate papers available that are both compulsory and elective.

‘The vocational scope of rural hospital medicine practice is determined by its social context and the rural environment. The demands of this environment include professional isolation, geographic isolation, limited resources and special cultural and sociological factors. The single factor that most determines this scope of practice, its depth and its nature, is that it is practiced at a distance from comprehensive specialist medical and surgical services and investigations. A broad body of knowledge, skills and attitudes, not common to any other medical vocational group, is required to deliver optimum secondary care patient outcomes in rural hospitals. Working in a rural area demands high levels of individual responsibility and clinical judgement. In contrast to rural general practice, the other rural medical scope of practice, rural hospital medicine is orientated to secondary care, is responsive rather than anticipatory and does not continue over time.’<sup>52</sup>

<sup>50</sup> Employment for Medical and Dental Specialists in New Zealand (2013) The New National DHB Collective Agreement (MECA) [http://www.asms.org.nz/Site/Employment in NZ/The New MECA.aspx](http://www.asms.org.nz/Site/Employment%20in%20NZ/The%20New%20MECA.aspx)

<sup>51</sup> Health Workforce New Zealand (2011) The Voluntary Bonding Scheme Presentation, Beyond the Medical School Gates [http://www.nzma.org.nz/sites/all/files/BTMSG\\_HWNZ.pdf](http://www.nzma.org.nz/sites/all/files/BTMSG_HWNZ.pdf)

<sup>52</sup> HANDBOOK for Division of Rural Hospital Medicine NZ Training Programme DRHMNZ Registrar Training Handbook - Last updated September 2013 <http://www.rnzcgeneralpractitioner.org.nz/assets/documents/About-Us/DRHMNZ/September-DRHMNZ-Registrar-Portfolio-Handbook2.pdf>

## General practitioners in New Zealand

### Overview

Most primary care is provided through doctor-owned small group practices with general practitioners acting as gatekeepers. Income is derived from patient charges and government subsidies.<sup>53</sup> In 2002, new primary care organisations (primary health organisations) were established and these are one vehicle through which the Government's primary health care objectives outlined in 'Better, Sooner, More convenient primary health care' are implemented. The employment conditions for general practitioners are negotiated locally and vary widely. In the less affluent areas many doctors working in general practice are not qualified general practitioners.

### Remuneration

General practitioners' income is derived from patient charges and government subsidies (Thorlby et al for Nuffield).

### Working hours

General practitioners negotiate their hours locally.

### Additional payments

Conditions vary widely and negotiated locally. Over recent years, there has been substantial funding to subsidize primary care and improve access to care. Primary health organisations receive additional per capita funding for promoting health, coordinating care, reducing barriers to care for patients with difficulties in accessing care, and providing additional services for people with chronic conditions. They also receive funding if general practitioners collectively (in their group practice) reach quality and service delivery targets for cancer, diabetes, and cardiovascular disease screening and follow-up, as well as for vaccinations.

### After hours care

General practitioners are expected to provide or arrange for the provision of after-hours care, and they receive government subsidies for doing so. In rural areas and small towns, general practitioners work on-call but, in cities, general practitioners tend to provide after-hours service on a roster at purpose-built, privately owned clinics in which they are shareholders. Patient charges at these clinics are higher than for services during the day (although over 90% of children under-six years can access free general practitioners after-hours services). Consequently, some patients will visit the hospital emergency department instead, or avoid after-hours service altogether. A patient's usual general practitioner routinely receives information on after-hours encounters. The public also has access to the 24-hour, seven-day-a-week phone-based Healthline, staffed by nurses who provide advice covering general health issues. Plunketline provides a similar service for child and parenting problems.

### Special arrangements (for hard-to-fill posts)

Both bonding schemes and recruitment and retention bonuses are available as for general practitioners in New Zealand.

## MOSS grade doctors in New Zealand

### Overview

There are various titles for this grade of doctor in New Zealand and these include medical officer or medical officer of specialist scale (MOSS) or staff grade. It is a non-training position for a doctor who has not yet

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<sup>53</sup> Ruth Thorlby, Judith Smith, Pauline Barnett and Nicholas Mays (2012) Learning from New Zealand's independent practitioner associations: primary care for the 21st century Nuffield Trust  
[http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/new\\_zealand\\_ipas\\_260912-update.pdf](http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/new_zealand_ipas_260912-update.pdf)

specialised or not yet gained a post graduate qualification, or an international medical graduate who is not eligible for a specialist's role. Their actual job descriptions are developed locally.

**Remuneration**

Salary is based on a 12 point scale ranging from \$111,750 to \$162,250 (NZ dollars).<sup>54</sup> Placement on the scale takes account of relevant experience (in years) and relevant qualifications. Advancement through the salary scales are annual but subject to satisfactory performance.

**Working hours**

MOSS doctors negotiate their normal hours and on-call hours with the District Health Board.

**Level of autonomy**

MOSS doctors work under supervision of the specialist.

**Flexible working**

The MOSS doctor can make flexible working arrangements with district health board.

**Special arrangements (for hard-to-fill posts)**

Both bonding schemes and recruitment and retention bonuses are available as for MOSS doctors in New Zealand.

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<sup>54</sup> Association of Dental and Medical Specialists New Zealand District Health Boards senior medical and dental officers collective agreement 20 December 2011 until 28 February 2013

[http://www.wdhbcareers.co.nz/core/lib/other/wysiwyg/uploaded/SMOMECA2011to2013\\_1.pdf](http://www.wdhbcareers.co.nz/core/lib/other/wysiwyg/uploaded/SMOMECA2011to2013_1.pdf)









**Appendix 2: Folder of available contracts/agreements and other relevant documents**

This folder sent as a separate attachment.

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