The Physician Salary Paradox: When Does an Expensive Physician Actually Cost Less?

Policy discussion for Polish healthcare policy decision-makers

Poland is confronting a legitimate policy problem. Recent reports of exceptionally high physician contracts in publicly financed hospitals have raised concerns about equity, transparency, excessive working hours, and the sustainability of hospital finances. In July 2026, the government announced proposals intended to limit physician remuneration, increase transparency of publicly funded contracts, improve reporting of actual work schedules, and address irregularities in hospital employment arrangements. [1]

These concerns deserve a serious response. Extraordinary compensation resulting from artificial staffing shortages, overlapping contracts, poorly structured incentives, or inadequate oversight should not be defended simply because physicians are highly trained professionals.

But the policy question should not be "How much does the physician cost?" It should be: "How much does the healthcare system spend to achieve a successful patient outcome?"

This distinction creates the physician salary paradox: an expensive physician may actually cost the healthcare system less than a less expensive physician if greater expertise, productivity, and clinical judgment reduce the total resources required to care for patients.

Consider two surgeons. Physician A costs a hospital PLN 600,000 annually and Physician B costs PLN 900,000. Viewed only as payroll expense, Physician B is 50% more expensive. But suppose Physician B performs more operations, has fewer complications, reduces length of stay, avoids unnecessary testing, and produces fewer readmissions. The additional PLN 300,000 in compensation may be more than offset by savings elsewhere in the patient's episode of care.

The same principle applies to intensivists, emergency physicians, anesthesiologists, and primary-care physicians. An experienced intensivist who prevents prolonged mechanical ventilation or recognizes deterioration earlier can avoid days of ICU care. A skilled emergency physician can decrease unnecessary admission and testing while identifying high-risk disease earlier. A primary-care physician who effectively manages hypertension, diabetes, or heart failure may prevent hospitalizations costing many times that physician's incremental compensation.

Physician remuneration in economic context

International comparison provides an important perspective. Nominal salary alone is a poor measure because national wages and economic conditions vary dramatically. A more informative indicator is physician income as a multiple of the average worker's income.

Country	Average physician salary	Average worker salary	Data year / physician category	Physician income as multiple of average worker income
United States	$277,260 [≈€237,465]	$69,770 [≈€59,756]	2025; physicians, BLS	**3.97×**
Poland	≈PLN 174,000 [≈€40,441]	PLN 72,433 [≈€16,835]	2022; salaried GPs, OECD-derived	**≈2.4×**
Germany	€156,900	€62,235	2024; salaried specialist physicians	**2.52×**
United Kingdom	≈£97,100	£46,511	2025; specialist medical practitioners	**≈2.09×**
France	€99,974	≈€42,447	2023; salaried specialist physicians	**2.36×**
Spain	€83,067	€28,050	2023; salaried specialist physicians	**2.96×**
Norway	NOK 1,319,400 [≈€121,364]	NOK 744,840 [≈€68,514]	2025; specialist physicians	**1.77×**
European Union	≈€115,000*	€39,800	2024 EU worker salary; physician analytical estimate	**≈2.9×***

The multiplier produces a more nuanced picture than headline reports about individual contracts. Polish physician remuneration at approximately 2.4 times average national wages is not obviously exceptional internationally. It sits within the broad range observed in Western European health systems and below the approximately 4-to-1 relationship found in the United States.

OECD reports that physician remuneration is substantially above average national wages throughout member countries. Salaried specialists commonly earn several times the earnings of an average worker, while self-employed specialists frequently earn still more. OECD also identifies physician remuneration as one factor affecting specialty choice and international physician migration. [4]

These figures must nevertheless be interpreted cautiously. The physician salaries in this table should be regarded as comparative analytical estimates rather than a single official harmonized salary statistic. Physician remuneration datasets differ between countries in whether they include private-practice income, overtime payments, bonuses, supplementary income, employer contributions, and whether physicians are salaried, self-employed, or combine both forms of employment. Some datasets also include different categories of physicians. OECD specifically identifies these limitations when discussing international remuneration comparisons. [5]

Furthermore, the nominal salary figures and euro conversions shown above do not incorporate purchasing-power-parity adjustments. They therefore should not be interpreted as measures of equivalent purchasing power or standard of living across countries. OECD uses PPP-adjusted comparisons when directly comparing absolute physician purchasing power internationally. The multiplier column is emphasized here because it asks a different and particularly relevant policy question: how highly is physician labor compensated relative to other labor within the same national economy?

The EU figure deserves an additional qualification. Eurostat reports an average annual full-time-adjusted employee salary of €39,800 in the EU in 2024. [6] There is no single harmonized official EU-27 specialist-physician salary. The approximately €115,000 figure shown here therefore represents an analytical estimate based on an approximately 2.9-times worker-income relationship, rather than an official European Commission or OECD physician salary statistic.

Access, unmet need, and avoidable mortality

Compensation policy should also be linked to the outcomes that the health system is trying to improve. Two indicators are particularly relevant for Poland: access to care and avoidable mortality.

On the broad 2024 Eurostat headline measure of self-reported unmet need for a medical examination or treatment, Poland and the EU-27 were both approximately 3.8% of people aged 16 years or older. That apparent parity should not be interpreted as evidence that Poland has no access problem. The measure is self-reported, excludes people living in institutions, and aggregates different reasons for unmet need. Eurostat identifies long waiting lists as a major specific barrier in Poland. [17] A complementary 2025 State of Health in the EU profile, using the narrower denominator of people who specifically expressed a need for care and focusing on cost, waiting time, or travel distance, reported 5.2% unmet need in Poland compared with 3.6% across the EU. [18] These measures use different denominators and should not be treated as contradictory; together they reinforce the importance of looking beyond a single headline access statistic.

The outcome gap is even more consequential. In 2022, Poland's age-standardised preventable mortality rate was 244 deaths per 100,000 population compared with 168 across the EU, while treatable mortality was 140 per 100,000 compared with 90 in the EU. [18] Treatable mortality is specifically intended to capture premature deaths that could mainly be avoided through timely and effective healthcare interventions. The leading treatable causes in Poland included ischaemic heart disease, pneumonia, colorectal cancer, stroke, and breast cancer. Cardiovascular disease therefore remains central to Poland's avoidable mortality burden. Under the joint OECD/Eurostat methodology, ischaemic heart disease, stroke, and diabetes are allocated 50:50 between preventable and treatable mortality when neither prevention nor healthcare clearly predominates. [19]

These indicators suggest that physician compensation policy should not focus exclusively on the numerator of salary. It should also consider whether compensation supports measurable improvements in access, timeliness, continuity, clinical outcomes, and resource use. In specialties where physicians directly influence these outcomes, value-based contracts could incorporate risk-adjusted measures such as waiting time to consultation or procedure, treatment delay, complication and readmission rates, length of stay, guideline-concordant care, and specialty-relevant components of treatable mortality.

Avoidable mortality should not, however, be used as a crude individual physician score. It is a population-level outcome influenced by public health, primary care, workforce supply, hospital capacity, socioeconomic conditions, patient behavior, and the organization of care. Its appropriate role is as a system-level quality signal that helps determine which clinical services require stronger accountability and investment. Individual physician compensation should then be tied to measures that are clinically attributable, risk-adjusted, and within the physician's reasonable control.

From salary control to value accountability

The government’s effort to improve remuneration data may therefore be more important than any predetermined salary ceiling. In June 2026, legislation was adopted allowing the Ministry of Health, NFZ, and AOTMiT to obtain more detailed physician compensation and employment information. The stated purpose includes understanding the relationship between personnel costs and the cost of healthcare services, identifying multiple employment arrangements, and improving healthcare financing decisions. [3]

Those data create an opportunity to move beyond salary regulation toward value accountability.

- How many patients are treated?
- What are risk-adjusted outcomes?
- What are complication and readmission rates?
- What is length of stay?
- How efficiently are diagnostic tests and hospital resources used?
- Does the physician improve access to services that would otherwise be unavailable?
- Does the physician provide teaching, leadership, emergency coverage, or care in underserved regions?
- Does the physician or service reduce clinically important waiting times and unmet need?
- For relevant specialties, are risk-adjusted outcomes improving, including complications, readmissions, and treatable mortality proxies?

A contract paying exceptionally high compensation without corresponding productivity, scarcity, responsibility, or clinical value should be challenged.

But an arbitrary ceiling can create a different problem. If compensation limits make difficult specialties, rural hospitals, emergency coverage, or high-intensity services economically unattractive, physicians may migrate to private medicine, reduce hours, relocate abroad, or leave shortage specialties. The resulting vacancies can increase waiting times, reliance on temporary staffing, delayed treatment, transfers, complications, and hospital length of stay. The apparent payroll saving can therefore increase the total cost of care.

The objective should not be to make physicians cheap. It should be to make healthcare productive, clinically effective, and accountable for public expenditure.

Exceptional compensation without exceptional contribution is difficult to justify in a publicly financed system. But exceptional compensation associated with exceptional clinical and economic value may be one of the health system's best investments.

Sometimes the most expensive physician in the hospital may ultimately be the physician who costs the healthcare system the least.

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