D 0405 Annex

National Reports – Rapports Nationaux 2003
The year 2003 was characterised by three important developments which are of major interest for Austrian specialists:

Medical Training

After years of preparatory work, we finally have succeeded in obtaining competency from national authorities (Federal Ministry) to set training programs and content of specialist training by ourselves within the Austrian Medical Chamber. Until now, the content of training was determined exclusively by the Ministry, which has led to the fact that some training programs have become inappropriate and obsolete.

In the course of 2004, the Austrian Medical Chamber will define adequate training contents for some specialties, the preparatory work is already at full speed. It is worth stating that in nearly all specialties, the recommendations of the UEMS Sections and Boards are used for orientation and that we have always made it clear to specialist representatives that UEMS recommendations had to be taken into consideration.

Quality assurance

Last autumn a proposal was made from the part of politicians according to which quality assurance of medical practice in future had to be done by a quality assurance agency, under the responsibility of the respective Ministries. This agency does not only define quality criteria for the medical profession, but, in addition, also controls them in detail. We have strongly opposed to this proposal at political level, as we consider quality assurance part of the professional code of conduct which conflicts with the idea of leaving regulations and requirements, as well as control to external bodies.

In Austria, this has led to violent political conflicts, which, nevertheless have led to the adoption of a law last December, according to which quality assurance is a professional obligation for the medical profession, under the control of a society. This society, also setting specifications for quality assurance, is run exclusively by the Austrian Medical Chamber. Other institutions such as insurances, Ministries, hospital owners, etc. are only represented in a committee.

At present, the Austrian Medical Chamber elaborates the establishment of this society and we hope to be able to give you soon further details about its structure. It is a fact that this has been a great success at medical-professional level, as we were repeatedly confronted with the argument that in other European countries quality assurance is not assumed by the medical profession.

Part time medical training

After many years of political efforts, we have finally succeeded in 2003 in making progress in the issue of part time training. From now on, in compliance with the respective EU Directive, it is foreseen that doctors undergo their training on a part time basis. This is in so far important for the medical profession, as the ratio of female doctors in training is increasing and medical practice in Austria is characterised by a pronounced feminisation. With a view to allow these doctors to conciliate family and professional life, the question
of part time training was of great importance for us. From now on, the entire medical training can be undergone on a part time basis, provided that the concerned doctor is able to furnish the proof of pertinent personal reasons.

Miscellaneous

What the issue of specialist examinations is concerned, the transitory periods are about to expire and the number of candidates is on the rise. It seems worth stating that in those specialties where examinations are held in the European context, following EU Board examinations, there will be no problems at all.

Another introduction in 2003 in Austria concerned visitations of training hospitals in the whole country. The overall result was very good, which means that we are able to see first practical success in the implementation of the UEMS Charter, according to which visitations are held.

Präs. Prim. MR Dr. Walter Dorner
Head of Delegation
BELGIUM / BELGIQUE

After the severe electoral defeat of the Greens in March 2003 both in Flanders and in Wallonia, P.M. Guy Verhofstadt reconducted a new coalition with his own right-wing Liberal party and the Socialists. A Walloon bilingual Socialist MP took over the portfolio of the dogmatic Flemish Minister previously in charge of Social Affairs, plus the Public Health Office, earlier managed by a Green Minister.

Among the several problems which have been discussed, negotiated and sometimes initiated, let's quote:
The attempt to reinforce the role of the G.P., whose job is considered as a "first line" one, although the majority of newly promoted M.D.'s is poorly interested in practising Family Medicine and extramural specialists claim their role in the first line.
The plethora of medical students, mostly in the French-speaking Community (Brussels and Wallonia), where the new system of numerus clausus has been abrogated.
The danger for medical professional associations (GBS – VBS) of losing control over the training of specialists to the faculties of medicine.
A more and more stronger "hospital centrism", leaving less and less professional freedom to consultants working in private practice (the so-called "liberal practice").
The professional relationship between the hospital management and the consultant staff.
The impact of so-called "care programmes" devoted to a particular pathology, paving the way for a progressive setting-up of an envelope system with the suppression of the fee for service system.
The reinforcement of the Evaluation and Control Services within the RIZIV – INAMI (National Institute for Health and Invalidity Insurance): quality insurance and quality control.
The attempt to introduce a "no fault system" (reinforcement of medical liability).
The further implementation of the accreditation system (CME – CPD) with a compulsory attendance of 20 hours post-graduate courses, coupled with the GLEM – LOK system (Peer review). About 200,000 meetings were organized during the year 2003.
A strong tendency to promote complementary health insurances.
The fear that young and older handicapped people will become less protected and less efficiently integrated in the society.
A progressive plan to separate the treatment of acute and chronic pathologies, with a new particular conventional system of treatment for the various pathologies.

Luc L.M. Van Calster, MD
Neurologist – Rehabilitation Specialist
Le nouveau gouvernement issu des élections de mars 2003 a été reconduit par le premier ministre G. Verhofstadt, sans les Verts, qui avaient subi une cinglante défaite. Un ministre socialiste wallon bilingue a remplacé à la fois le dogmatique ministre socialiste flamand des Affaires sociales, et le ministre vert, titulaire du poste de la santé publique.

Parmi les points discutés, négociés et parfois mis en œuvre, citons:

Tentative d'introduction de l'échelonnement, avec renforcement du rôle du MG, considéré comme "première ligne", malgré la désaffection des jeunes médecins pour la pratique de médecine générale et l'exigence des spécialistes extramuraux d'avoir leur place dans cette première ligne.

La pléthore d'étudiants, surtout en Communauté française (Bruxelles et Wallonie), où le système de numerus clausus a été supprimé.

Le risque que les associations professionnelles de médecins, en l'occurrence le GBS-VBS, soient écartés du processus de contrôle de la formation des spécialistes au bénéfice exclusif des Universités.

Le renforcement de l'hospitalo centrisme au détriment des spécialistes exerçant en dehors des hôpitaux, "pratique libérale".

Les rapports entre gestionnaires d'institutions de soins et les médecins hospitaliers.

Renforcement des systèmes de "programmes de soins" pour une pathologie spécifique, ce qui prépare progressivement à un système de remboursement par enveloppe avec à moyen terme le risque d'abandon du système de médecine à l'acte.

Renforcement des services d'évaluation et de contrôle par l'INAMI: assurance et contrôle de qualité.

Tentative d'introduction d'un no fault system (augmentation de la responsabilité médicale).

Continuation de l'application du système d'accréditation (PMC – DCP) et des Glems – Loks (groupes locaux d'évaluation par les médecins (Peer Review): près de 200.000 activités en 2003).

Orientation vers un système d'assurance maladie sur base privée.

Risque de dérapage des prises en charge des handicapés, jeunes et vieux.

Préparation progressive d'une séparation dans le concept de la prise en charge de la médecine aiguë par rapport à la médecine chronique, avec mise sur pied de systèmes de conventions spécifiques en fonction des diverses pathologies.

Dr Luc L.M. Van Calster
Neurologue, spécialiste en réadaptation
The Croatian Medical Trade Union, assisted by the Croatian Medical Association (CroMA) and by the Croatian Medical Chamber, initiated the strike of hospital doctors for non-urgent patients at the beginning of 2003. The strike was interrupted after 30 days since the Ministry of Health introduced the working obligation for doctors. Such a situation - the working during the strike - continued up to the change of the government following the elections in December 2003. The working obligation was abrogated by a new Minister of Health and the Croatian Medical Union interrupted the strike too. The new Minister of Health promised the farther negotiations to medical profession. The medical doctors believe to achieve much better working conditions, the higher salaries and - especially - the better appreciation of their profession.

The 133 scientific/professional societies of CroMA continued their efforts to CME. In the Croatian Medical Home in Zagreb, in the headquarters of the Association, 270 meetings have been held with 13,374 attendants. The scientific/professional meetings all over Croatia exceeded that number manifold.

Since many of the specialist or sub specialist societies have been inactive or not fully active, the Executive Board of CroMA prepared the new Rules of Activity of scientific/professional societies that will be proposed to the General Assembly on February 28-th. The adequate Rules of Activity for the regional branches of CroMA will be proposed too. The aim is to hold the active societies, reduce the number of inactive ones, and consolidate the organization itself.

In the course of 2003 the Ministry of Health started the revision of plans and programs of postgraduate training edited in 1993. The Ministry of Health formed the commissions for single specialties, but without corresponding cooperation with the Universities (Faculty chairs) and scientific/professional societies. The CroMA expects the change in such a behaviour for the benefit of the profession and of the patients.
Political, demographic background

Cyprus will be joining the EU on May 1st 2004, together with the other nine eastern European countries and Malta. The Republic of Cyprus has a population of 705,500 inhabitants in the government controlled area. This figure, is however underestimated since the island is, at present, divided, with its northern section under Turkish occupation. Consequently, a large number of settlers from Turkey, that have come since 1974, live in the occupied areas and are not incorporated into these statistical figures. On-going political negotiations, under the auspices of the U.N., are taking place in an attempt to re-unite the island, if possible, before the target date of May 1st, 2004.

Although the population is ageing, the young population remains quite large (22.7%), as compared to the over 65 years old population (11.4%). Cyprus has the highest percentage of young people (0-14 yrs old) as compared to the EU countries and its 65 years old and over population is significantly lower than the EU average.

Health status

The gross mortality rate per 1000 people declined from 7.7% in 1997 to 6.9% in 2001. The life expectancy at birth is approximately equal to the EU average both for males (76 yrs) and females (81 yrs). Infant mortality has gradually declined from 17.2 per 1000 live births in 1980 to 4.9 in 2001, approximately equal to the 4.94 EU average.

The AIDS incidence rate is consistently lower than the EU average. Between 1986 and 2001, 377 HIV cases were reported. In general, AIDS prevalence in Cyprus has remained relatively low and in 2002 it was estimated at 0.1% in the 15-49 age group.

The Mediterranean diet has, unfortunately, been gradually abandoned on this Mediterranean island, in favor of fast-food based dietary habits. This has contributed to the 44.3% male and 29.7% female obesity rate among Cypriots (data of 2001). Furthermore, 24.6% of men and 19% of women are overweight. A recent study (2003) revealed a prevalence of pediatric obesity of 10.3% for boys and 9.1% for girls.

Tobacco consumption is extremely high. Data of 1999 showed consumption average 2780 cigarettes per person, which was 68% higher than the EU average! The sale of tobacco products to individuals under the age of 18 is prohibited. The most recent measure taken to control this epidemic is a Law passed in 2002 by the Parliament prohibiting smoking in private vehicles when there are children under 16 years of age on board.

The most common diseases leading to death are the cardiovascular diseases, cancer and road traffic accidents.

Introduction of the NHIS (National Health Insurance System)
The challenges for the government of Cyprus to reduce the rising costs of health care, reduce the inequalities in access to health care services and improve the quality and financing of the health care system led to the decision for the introduction of the NHIS within the next five years.

The Cyprus Medical Association (CMA)

The Cyprus Medical Association is a professional organization representing the interests of its physicians. It is compulsory that all practicing physicians are members of the CMA. There are today 1863 practicing physicians out of which 578 are women. The specialists in the different fields are the vast majority (1527). The rest are general practitioners and specialists in General Medicine. 75% of all physicians are in private practice.

Its main goals have been the protection of medical ethics, influencing health policy, and developing continuous medical education. Since January 2002 the CMA has introduced a Continuing Medical Education program with the co-operation of all the specialty societies. The system is mandatory and is based on the credit point system as in most of the EU countries. The CMA is the accrediting local authority.

The Cyprus University does not have a Medical School as yet. All Cypriot physicians are graduates of different European Universities.

The Cyprus Medical Association has recently (2004) agreed to participate in the project EPOWEB (European Post Graduate on the Web) within the framework of the Socrates program.

Lakis C. Anastassiades MD, FESC, FACC
The Cyprus Medical Association
CZECH REPUBLIC / TCHEQUIE

Czech Medical Association (CZMA) had 103 Societies with total number of about 34 000 physicians in 2003. This number includes also 5360 general practitioners whereas few societies are not under the umbrella of CZMA. All Societies have their own professional activities and they prepare programmes of postgraduate education. Each society organizes the annual or biannual meetings. Their members take part in the CME/CPD process and postgraduate courses or symposia are therefore evaluated by the appropriate number of credits. Besides annual meetings the activities are provided by local organizing committees also on the district level. Many of these courses are visited by the main representatives of the respective specialty. Part of the activities is covered also by Czech Medical Chamber. Societies are responsible for the quality of educational programmes of CME/CPD which correspond to the European CME goals.

Postgraduate medical training in all specialties is organized by the Institute of postgraduate medical training according to plans confirmed by Ministry of Health. This education is finished by examination which makes possible to physician to work as qualified specialist either at state institutions or in the private practice. Up to now there was a two-stage education system based on two examination – one in the ground (main) specialty and the second involving the subspeciality. However, several years discussions concern to developed only one-stage system with one examination.

Czech Medical Association has had repeated negotiations with Minister of Health as related to the system of postgraduate training. Reform in this area is still awaited because basic and more narrow specialties discuss their overlap and two stage examination system should be substituted by one-step only. This is the source of debate concerning the curriculum in the common trunk and the lengths of education.

In the past year 2003 the core group of CZMA informed societies on the need to join and collaborate with the respective Sections of UEMS. Several societies are already as associate members in these Sections and the process of participation on UEMS activities will continue in 2004 when CZMA will be full member of UEMS.

Prof. Dr. Jan Škrha
Czech Medical Association
DENMARK / DANEMARK

The Commission on Administrative Structure in Denmark
In 2003 a commission set up by the Danish Government has now finished its report and recommendations on the future administrative structure in Denmark. Three administrative levels in Denmark: state, regional or county (14 counties) and municipal (273 municipals). Today, the hospital sector is placed at county level.

The present municipal structure in Denmark is over 30 years old and there is broad consensus that a major examination of the structure would be appropriate to evaluate whether it lives up to the demands of a modern welfare society.

The commission's report was published in January 2004 and the Minister of Health and Internal Affairs had asked a number of organisations in Denmark to present comments before 7 April 2004 to the report, which arranges a number of different general models for the future structure but does not present actual recommendations as to which models should be chosen - that is considered to be a political task.

The DMA is currently preparing comments on the report with regard to the organisation of the Danish health care sector.

The DMA view is that there are a number of important general principles regardless of which administrative structure is chosen for the health care sector. These are:

To ensure a health care sector with equal and free access for all to the services of the health care sector

to ensure an inter-connected health care sector

to ensure a health care sector based on quality, professionalism and organisation.

to ensure a health care sector based on research and education.

In any new structure of the health care sector the following demands are important for the DMA


to maintain one single entrance to the health care sector

to maintain a collective responsibility of the authorities for the hospital and health insurance area

to strengthen the role of the Danish National Board of Health in the central national organisation

to ensure the best use of resources via fewer and larger regions with fewer acute emergency service centers

to ensure that psychiatry is placed on the same regional administrative level as the other medical specialties

to ensure that financing models be employed, which support a professionally based health care sector.
The DMA expects that the question about the future structure of the municipal system in Denmark will cause a serious debate in the "Political Denmark" of near future.

Negotiation situation
There has been no general contract negotiation in 2003, but in 2002 the chief physicians changed to a new salary system - a system in which a part of the total salary is negotiated and agreed locally, contrary to previously, where central negotiations decided the salary of the individual. Both chief physicians and junior doctors are covered by this new system, and this is also the case for other academic groups. In this period there have been many local negotiations, and evaluations of the function of the system varies among the professional groups.

Among the group of chief physicians the evaluation is not so negative as it is for a number of other groups, for example high school teachers, who wish considerable changes in the negotiation system. This is due to the fact that the various professional groups have different negotiation conditions and the chief physicians' negotiation position is strong these years because of - inter alia - a considerable lack of specialists. Also Junior doctors have a more negative view of the system than do the chief physicians.

The forthcoming contract negotiations beginning medio 2004 will show whether the system, called "New Wage", will survive.

General economic conditions
The health care sector generally has a high priority in the political agenda in Denmark these years, which has resulted in supply of economical resources to the sector, though in some connections for example concerning aperture investments, buildings, IT still suffers from the many years of weak supply of resources.

A strong political focus on surgery waiting lists with supply of considerable economic resources has resulted in a considerable reduction of the Danish waiting lists, and the discussion about long waiting lists is no longer a major political discussion topic.
National Health Project
Finnish government gave recommendations in order to safeguard the future of health care in Finland in 2002. More detailed plans at national and local level were made during 2003. More money will be given from the state and also from the local municipalities towards health care. An important legislative proposal deals with the minimum periods to access health care. According to the proposal every citizen should be able to reach a doctor in primary health care within 3 days. A consultation within specialised care should be available within 3 weeks and waiting times for surgery should not exceed 3 to 6 months. These proposals should be made into force from the beginning of 2005.

Shortage of doctors in the public sector
The shortage of doctors in public health care has remained at the same level. About 1000 doctors lack from the total workforce of 11000 doctors in the public health care sector. The total number of Finnish doctors reached 20000 in the end of 2003. From the beginning of 2003 all doctors have to spend at least 9 months (instead of 6 months earlier) as a part of specialist training in primary health care and at least half of the specialist training time in most specialities will be demanded to be done outside of the university hospitals. Finnish Medical Association does not think that these kinds of compulsory methods are the right way to get well motivated doctors in primary health care in the future.

The great challenge for the coming years is the projected shortage of hospitals specialists since they are reaching retirement age in large quantities. Although the number of medical students in basic medical education has been increased by over 70 % within the last six years the number of training posts for specialist education is not sufficient to the future needs.

CME/CPD
The Finnish Medical Association, The Finnish Medical Society Duodecim and The Swedish-speaking Medical Society started in 2002 an Evaluation Council for Physicians’ Continuous Professional Development. Specialist societies and universities are also included in the Council. In 2003 the Council and its founder organisations agreed on the criteria for quality CME/CPD in Finland. A guide for CME providers has also been published. An internal based system of providing on-line information about CME courses has also been launched in 2003. This council collaborates with EACCME. CME in Finland continues to be voluntary and no credit point system exists.

In the end of 2003 Finnish government agreed upon legislation that will make more strict rules for employers to provide possibilities for health care workers for CME. The Finnish Medical Association recommends that all doctors should have a possibility to take part in CME outside of the working place at least ten days yearly financed by the employer. The new legislation is based on the same spirit.

New president of FMA
In December Dr. Pekka Anttila, a specialist in Internal medicine and haematology, was elected the new president of the Finnish Medical Association. He succeeds Dr. Heikki Pälve, an anaesthesiologist, who ended his 3 year term as president.

Head of the Finnish delegation to UEMS Management Council continues to be Dr. Kari Pylkkänen, a psychiatrist. A new member of the delegation is Dr. Olli Meretoja, an anaesthesiologist and a board member of the Finnish Medical Association. They both have background from UEMS sections. In addition to that Dr. Hannu Halila from the Finnish Medical Association is currently president of UEMS.

Dr. Hannu Halila
Director, Education and Research
Finnish Medical Association
IRELAND / IRLANDE

REFORM OF HEALTHCARE.
The position of specialists within the health system in Ireland is in transition. According to the Health Reform Programme, launched in the latter half of 2003, Ireland there will be a significant shift in the balance of its hospital medical workforce. While at the moment Irish hospitals provide a consultant lead service, the Report of the National Task Force on Medical Staffing (Hanly Report), on the introduction of a reformed health service, calls for a substantial increase in the number of consultants in the acute hospital network. In future it is intended that the bulk of hospital services to patients will be delivered by consultants rather than, as is presently the case, by non-consultant hospital doctors (‘junior’ hospital doctors).

Current numbers of consultants will double from 1,731 to about 3,600 in the next decade. By 2013 it is projected that the consultant : junior ratio will change from the current 1 : 2.3 to 1 : 0.6. This represents quite a challenge for manpower planners when the length of time required for training is taken into account. The implications of this policy for the role of trainers, trainees, training institutions, postgraduate training bodies, and consultants who are training non-consultant hospital doctors today have yet to be fully understood.

ENTERPRISE LIABILITY.
On the industrial front the introduction of Enterprise Liability has been deeply troubled. While, at the moment, the Minister for Health and Children has formally introduced the scheme and directed that traditional payments to reimburse consultants for indemnity insurance should stop, a position of stalemate has occurred. Consultants are in fact caught in a dispute between the state and one of the insurers which has provided indemnity cover for over twenty years. The IMO continues to work with the Department of Health and Children to resolve the issue.

EUROPEAN WORKING TIME DIRECTIVE.
The implementation of the European Working Time Directive for junior doctors will occur comes into effect in August 2004 (it already applies to consultants). The IMO is negotiating with the health service employers to accomplish this but the full implications of the SiMAP and Jäger judgements have yet to be clarified. As of now the exact outcome of health reforms for consultants is equally unclear.
The AMMD could successfully negotiate an increase in doctor’s fees for 2003. The government agreed and parliament voted with some abstentions but no vote against to raise the global budget for doctor’s revenues by 6.75%. This money was mainly used to increase tariffs for clinical work and work performed at night or on weekends.

The AMMD has worked out a proposal to implement formal CME together with the Medical Chamber. This has so far not been pursued by the government. The claim of the AMMD is that if a formal accounting of each doctor’s CME is done, then there also to be an official recognition through paid time spent on CME or tax advantages. But this has been refused at the moment, such that CME for the time being remains a moral obligation and voluntary.

Another main field of activity is the reorganisation of the hospital environment. Like in many other countries a movement of concentration of hospitals is going on. An alongside this movement the inner structure of hospitals will change. So far most things were left to auto-regulation of the individual hospitals and the staff working there. At this moment there is an implementation going on where departments will have to be accredited to obtain proper funding. One point of discussing amongst many others was about the introduction of the title head of department and his relationship to the other doctors in the team. The AMMD unanimously is for a collegial system with a head of department having an administrative role. This model was inspired from the Anglo-Saxon and Scandinavian systems as opposed to those of our immediate neighbours France, Germany and Belgium.

Another point is if the so-called liberal practice of medicine will survive the ongoing changes of the internal structure of hospital departments or what changes it has to undergo to adjust.

Dr Alexandre Bisdorff, national delegate.
Restructuring of the Norwegian hospital system

Last year we reported on a reform of the hospital system that organizes the nation’s hospitals in 5 regional public health enterprises (RHE), entirely owned by the Norwegian state. In each region there are public health enterprises (HE) subordinated the RHE. Each of the HE consists of either one or more hospitals.

For those who want more information about the reform may access the web in English on http://odin.dep.no/shd/sykehusreformen/aktuelt/rapport/030071-990126/index-dok000-b-n-a.html, in German on http://odin.dep.no/shd/sykehusreformen/aktuelt/rapport/030071-990119/index-dok000-b-n-a.html, or in French on http://odin.dep.no/shd/sykehusreformen/aktuelt/rapport/030071-990118/index-dok000-b-n-a.html

The reform was intended to introduce a more professionally led system, more like ordinary enterprises with full budgetary responsibility. Health care expenditure in Norway, like in most countries, is soaring, being on the top of the OECD list in Europe. It was a widespread belief that more cost-effective service was possible, i.e. maintain, and even improve quality and access, without adding more money.

The enterprises have been through a tough process and dramatic cost reductions have been introduced. In February this year, for the first time in Norway, the board of one of the regional enterprises (RHE) adopted a budget that implies staff reduction by more than 100 employees, including 14 doctors. Naturally, the decision has led to lot of frustration among doctors and other health care employees. The CEOs of the affected hospitals claim that meeting the targets set by the board is impossible without reducing patient service. The consequence would be increased waiting lists, which have been effectively reduced due to a high DRG stimulus in the new system. It remains to be seen how the Ministry of Health, the hospital owner, will handle this contentious issue.

CPD for doctors

The NMA is still actively pursuing better ways of organizing CME/CPD. It is now generally accepted, also by the National Council for Specialist Training of Doctors, that we do not want a mandatory credit point based system. The NMA is now piloting a planned, structured system of CPD based on annually evaluation and planning meeting between peers, and portfolio documentation of activities.

NMA already has a surveillance system in place for monitoring the quality of specialist training in hospitals (based on forms submitted annually and site visits). We believe that CPD activities should be reported likewise to monitor to which extent the specialists are able to meet set targets, and that the system should be transparent. The basic idea is that also CME/CPD must be system based and adequately funded and not solely left to the individual doctor.

Poland / Pologne

During 2003 new curricula for each medical specialty have been developed under guidance of National Consultants, accepted by the Supreme Council of the Polish...
Chamber of Physicians and finally introduced into practice. They are available (if anyone reads Polish) on the Internet page of CMKP (Center for Postgraduate Medical Education: cmkp.edu.pl). Simply select “Programy specjalizacji”. These are quite elaborate documents, 20 pages on the average containing detailed list of subjects in given specialty, courses, clerkships as well as skills to be acquired during training.

Year 2003 was also the year of basic changes in the system of funding of health service in Poland. For the last 4 years Poland was divided into 17 sick funds (one for each voivodship [voivodship is administrative unit having between 2 and 6 million inhabitants] and additional one for uniformed services, such as army, police, etc.). Each of these funds had monopoly over its territory and was developing different system for reimbursement of health service for its services. This has been changed in a way that all these funds have been combined into one called this time “national health fund” with voivodship branches. The main change was the development and initial introduction of the united catalogue of medical procedures. The idea is that the same procedures would be funded all over Poland and number of procedures would be determined locally by the local voivodship branch. Implementation of the system run into many problems, initially because frequent personnel change and may face also legal problems in 2004. It has also become subject of fierce political fight with both media and opposition accusing government of overcentralizing the system. Also the Supreme Council has taken a stand against the system (as it has been against all previous systems). The main criticism is that system is not able to provide best medical care for everybody for 750 zlotys a year (approximately 150 Euros).

There are worries concerning the situation after Poland would become EU Member because then part of this money may go to pay for Polish patients in other European countries (at local prices) and moreover, that there would be coming to Poland for treatment patients from other countries, but the hospitals would be reimbursed using Polish prices that are currently below the expenses. Otherwise, Polish health service is prepared for the Union and quality of care is quite high.

Prepared by W. Wiktor Jedrzejczak
Romania / Roumanie

The Romanian College of Physicians is pleased to report the main activities organized in 2003:

Continuous Medical Education. New guidelines regarding the quality control were implemented. These included:
- Guidelines for the accreditation of CME providers;
- Guidelines for the organisation of CME activities, separate for the organizers(s) and for the sponsor;
- Guidelines for the journals indexed by the Romanian College.

Medical protocols. More than 70 protocols for diagnosis and treatment were elaborated after discussion in the professional committee. These protocols are now negotiated with the national Insurance House. 12 new guidelines from different specialties were prepared for publication in the third volume of guidelines.

Medical exams. New curricula for the medical exams needed to become a Specialist were developed.

Economics. Because of the high level of inflation, the costs of the main medical services were reviewed and updated with the help of the Specialist Sections of the college.

Meetings. Apart from participating to the UEMS meetings, President and Vice-presidents of the college participated to joint meetings with similar organisations from Germany, Central European countries. EU experts visited Romania, and details regarding medical laws and regulations were discussed extensively.
The 10th symposium of medical chambers of the central and east European countries was organized in Bath Hercules (30-31 May 2003).

Yours Sincerely,

Dr Liviu Cocora
SLOVAKIA / SLOVAQUIE

Slovak Medical Association (SkMA) passed a period of intensive transformation of health care during the previous year:
It was necessary to adopt Slovak health care legislation to the standard of European Union and SMA was continuously consulted on the prepared legislative by the Ministry of Health. The intensive health care transformation with the increased expenses in population is still a subject of political and medical controversies.
SMA participated in the transformation of postgraduate medical education and this area appears to be the most important task for the coming years. The previous form of specialization was abandoned and new one compatible with the EU legislation was implemented. However, the definite form, accreditations etc are still just to be done.
Continuing medical education system was adopted in agreement with the EACCME recommendations. National Accreditation Council was built and a series of information reports at various conferences was presented. The main hindrance appears to be the previous credit system started several years ago with different policy and different values of credits. An agreement has been achieved.
National Medical Societies were stimulated to participate in the activities of European Medical Societies both in postgraduate and continuous education and their activities are respectful.

Prof. Rastislav Dzurik, M.D., DSc
Past President of SkMA
Postgraduate Medical Training (PGMT)

Specialist postgraduate medical training (SPGMT) is being fully under the competence of the Medical Chamber of Slovenia (MCS). This competence includes: (1) adoption of the detailed programmes of SPGMT in all medical fields (43 recognized at the moment), (2) organisation and coordination of training and (3) implementation of provisions on its total quality management. Trainees carry out their supervised medical practice both in the public institutions (hospitals, primary care units for GPs training) and also in private medical practice units, which have to apply and to be given the accreditation through the process run by the MCS and finally approved by the Ministry of Health. At the MCS the database on training posts are available and also the needs on medical manpower is continuously being refreshed. The main responsible body at the MCS is the Council for Education through its working body - Committee for Postgraduate Medical Training.

In the year 2003 the MCS prepared necessary data and calculations for the national Public Tenders of the training posts for SPGMT. It means that the number of specializations for the year 2003 was determined by the MCS in agreement (final approval) with the Ministry of Health. The transparent system on Total Quality Management of SPGMT was also introduced during the past year. The system is based on three hierarchically well defined pillars: (1) Institutional SPGMT Coordinators, (2) National SPGMT Coordinators appointed for each specialist field and (3) five appointed SPGMT Quality Supervisors for logically joined specialist fields. The main role of (1) and (2) is to coordinate work of the tutors and direct supervisors of trainees. SPGMT Quality Supervisors implement and supervise practical operation of the QA, QC and QI systems in various accredited institutions at all the training posts.

In Slovenia 43 different fields of medical and dental SPGMT are defined. Their duration and contents are harmonised with the recommendations stated in various documents (charters) and statements issued by the most important European medico-political organisations. In line with UEMS recommendations (Charter on Visitation of Training Centres) we are continuing the process of visitations and evaluations of training institutions. The main goal is to assure the highest quality during the whole process of SPGMT.

In the year 2003 the new system of financing of SPGMT was finally introduced. The main change is that the trainees will be paid by the institution where they are currently practicing and not as it was the system until now, where they were employed and paid by one institution which chose them for training and then sent to training rotations to different places elsewhere with no real influence and direct insight into their current work.

Continuous Medical Education (CME)

A system of mandatory recertification for physicians and dentists working with patients has been introduced legally in Slovenia since 1992. Licences are awarded / issued to physicians for a period of seven years; recertification is mandated and possible by
gathering at least 75 credit points through participation in accredited forms of postgraduate education (the criteria for 1 credit point is the same as in most of the EU countries and some of them also approved through the system run by the EACCME UEMS). The number of compulsory credit points to be collected during one licence renewal period appears relatively modest comparing with given /established European recommendations (on voluntary basis). Anyhow we feel that, at a time of conflicting views and opinions regarding the relevance of collecting CME points, in given position, this is the best possible compromise between those in favour and those against mandatory recertification.

The authority to award the specific amount of credits points to individual scientific / professional meeting or other forms of CME is held by the MCS in cooperation with the Slovene Medical Society (and its many scientific/professional societies), the authorised representatives of which are reviewers/evaluators of the quality and accountability of registered CME education. In 2003 we awarded credit points to 299 organisers of domestic professional meetings and 595 individual applicants. More detailed analysis of our 10 years experience with mandatory recertification in Slovenia could be presented at the next EACCME meeting.

Dr Zlatko Fras, MSc., MD
Prof. Dušanka Mičetič Turk, PhD, MD
Mojca Vrečar, MBA
2003 was a year which came to be characterized by financial difficulties in the economies of the county councils. In Stockholm employment freeze was announced in spite of a lack of doctors.

The Swedish Medical Association continued to put great emphasis on quality aspects and has among other things continued the development of The Institute for Doctors’ Professional Development in Sweden and Quality Assessment of Internships.

The Institute for Doctors’ Professional Development in Sweden
The Institute for Doctors’ Professional Development in Sweden (www.ipuls.se) is the result of cooperation between the Swedish Medical Association, the Swedish Society of Medicine and the Federation of County Councils. During 2003 the institute took over the national responsibility for EACCME accreditations as planned.

Quality Assessment of Internships
Since about ten years the Swedish Society of Medicine and the Swedish Medical Association conduct on-site visits to assess training conditions for specialist training at the different clinics. Planning for assessments of internships began a couple of years ago. So far seven quality assessment-inspectors have participated in a training day which took place 2003. The first pilot assessments took place 2002 and 2004 there will be on-site visits at three clinics.

Review of Medical Specialties
The review of medical specialties which was presented by the National Board of Health and Welfare last year was commented on by the SMA and other bodies to which the proposal was referred to for consideration. The SMA is awaiting next step to be taken in this matter.
In 2003, the flood of title applications continued, triggered by the freeze on the number of doctors setting up in general practice. This freeze will stay in place until at least 2005 despite the signs of a shortage of doctors in certain fields of activity and peripheral areas.

For the seventh time junior doctors’ opinions with respect to postgraduate training was sought by means of yet another questionnaire. More than one quarter of the junior doctors originate from the European Union. 14.6% of the women and 3.8% of the men undertook their postgraduate training in part-time courses. The postgraduate training was considered well-structured overall, but one-third of those questioned however found it insufficient. The strongest influences on the global evaluation of a postgraduate-training institute were its approach to operation and to guidance and the way it motivated junior doctors. The way it approached learning and agreement on the training goals were also of importance. Systematic differences could be observed between the specialisations. Surgical training institutes came off significantly worse than did those for gynaecology, internal medicine, psychiatry and paediatrics when evaluating their approach to learning. Nearly one junior doctor in three could no longer perform the work to his or her full personal satisfaction during the contractually regulated work time. Only one junior doctor in two could perform the postgraduate training activities to his or her satisfaction during the work time.

Approximately 30 inspections were conducted of postgraduate-training institutes. All but two of the 43 specialised associations had introduced an examination for the approval of medical specialists by the end of 2003.

Max Giger, M.D.
Department of Medical Education
The Swiss Medical Association

Grâce à un nouveau questionnaire, nous avons pour la septième fois consécutive pu procéder à l’évaluation de la formation postgraduée par les médecins-assistants. Plus d’un quart d’entre eux sont des ressortissants de l’UE et 14,6% de femmes et 3,8% d’hommes ont accompli leur formation postgraduée à temps partiel. Dans l’ensemble, la formation postgraduée a été jugée bonne, mais un tiers des assistants l’a toutefois trouvée insuffisamment structurée. L’évaluation globale a principalement été influencée par des critères tels que la culture d’entreprise, le mode de gestion du personnel et la motivation des assistants. La façon de concevoir l’apprentissage et la possibilité de donner son accord aux objectifs de formation ont également joué un rôle. Par ailleurs, des différences systématiques ont pu être observées entre les différentes disciplines. Pour les établissements de formation postgraduée en chirurgie par exemple, le niveau des méthodes d’apprentissage a été jugé significativement plus faible qu’en gynécologie, en médecine interne, en psychiatrie et en pédiatrie. En outre, près d’un assistant sur trois n’a pas pu accomplir sa tâche à son entière satisfaction durant le temps de travail réglementaire et seul un assistant sur deux a pu satisfaire à ses obligations de formation postgraduée pendant le temps travail en étant pleinement satisfait.

Quelque 30 visites d’établissement ont été effectuées. A deux exceptions près, toutes les sociétés de discipline médicale (43) avaient introduit à la fin 2003 le caractère éliminatoire de l’examen de spécialiste.

Dr Max Giger  
Domaine «Formation médicale» de la FMH
The Turkish Medical Association within the year of 2004 was heavily involved with all levels of medical education in Turkey. The following activities were organized under the auspices of Turkish Medical Association in the level of specialty training.

1) Annual meeting on standardization of specialty training in Turkey: This annual meeting has been organized yearly since 9 years. All specialty societies were involved in this activity. This years’ meeting was organized in İzmir and over 400 attended the meeting. Various aspects of specialty training and accreditation were discussed. Moreover two works –shop was placed this year. The first was on the current methods for evaluation of residencies and educational program, and the second was on to prepare a core curriculum. They both were very successful. Statement report of the meeting was published and distributed to all relevant organizations as well as national press.

2) The Turkish Medical Association, members of specialty and associate societies were discussed new legislation (2004) for specialty training in Turkey prepared by the Ministry of Health. As we reported before, the new legislation process was going on for nearly last ten years. For this special purpose, recently a panel discussion has been placed with large contribution of the specialty societies. A detailed report was prepared at the end of discussion and was shared with Ministry of Health. It was strongly advised that the new legislation should not promote ‘over specialization’ and the composition of national health authority on specialist training should consist of non-governmental organizations such as Turkish Medical Association, specialty societies and medical faculties. Unfortunately ministry of health still insist on keeping all control of the specialty training and practice area, and does not want to share the power and responsibility with the non-governmental organizations including TMA and “The Coordination Committee of Specialty Societies”

3) The Coordination Committee of Specialty Societies continued their activities under the auspices of the Turkish Medical Association. 69 specialty societies and 12 associate societies are represented in the structure of this committee. There is an increasing interest to be part of The Coordination Committee of Specialty Societies and to contribute the activities among specialty societies. Two general assemble of The Coordination Committee of Specialty Societies was held on in 2003. The second included regular elections for executive committee. The committee is carrying out its routine activities with new president and members. Dr. M. Umut Akyol from Ankara Turkey was elected to be the special member of the committee responsible for the relations with UEMS and will be in contact in case of any difficulties of the specialist associations and specialist sections of UEMS, and represent our association in relevant meetings. His electronic mail address uakyol@hacettepe.edu.tr as well as our associations address of udkk@ttb.org.tr can be used to send all written communication.

4) 32 specialty societies prepared their bylaws for creating their “Specialty Boards” as non-governmental organizations. Board exams and certification is a hot topic for year 2004 in Turkey.

5) The Turkish Medical Association CME Accreditation Committee continued to monitor the CME activities in Turkey.
UNITED KINGDOM / ROYAUME-UNI

Revalidation

UK consultants and specialists have accepted in principle a system of revalidation procedures developed by the General Medical Council (GMC). Revalidation will be based on a form of appraisal, which each doctor will be required to undertake every five years. Appraisal will provide a regular, structured system for recording progress towards revalidation and identifying development needs (as part of personal development plans) that will support individual consultants in achieving revalidation. It will enable NHS employers to regularly review employees' performance, optimise their skills, and provide an opportunity for consultants to discuss and seek support for their participation in activities for the wider NHS. The BMA has agreed this plan as an acceptable compromise.

Consultant contract

In the summer of 2003, the BMA and government were still disputing plans for the new consultant contract. The UK government was attempting local implementation of the contract, previously rejected in 2002. Frustrated by the Department of Health's (DoH) resistance to engage in discussion on the new contract, the BMA held a conference in May of local consultants' representatives that rejected the government's imposition. Meanwhile the DoH was increasing the pressure on hospitals to encourage consultants to sign up to the new contract locally.

The mood of consultants intensified further in June with the Annual Conference of Senior Hospital Medical Staff debating several motions regarding the lack of progress with government on the new consultant contract. Meanwhile John Reid replaced Alan Milburn as the Secretary of State for Health. The BMA had a meeting with Mr Reid on 4 July 2003, which proved very productive. Unfortunately, the requirement to offer additional work for the NHS before undertaking private practice continued to cause problems. It appeared that for political reasons the DoH could not concede this point. Overall however, the new agreement was a significant improvement on the original contract framework.

Welsh Consultants and Specialists Committee and the Welsh Assembly also drew near to finalising proposals amending the current consultant contract in Wales. Many consultants believed the English agreement to be inferior to the Welsh proposals and the BMA received calls for the Welsh deal to be made available in England. These calls were put to the Department of Health but were rejected. For a while there were serious concerns that the English contract proposals would fail a second time. Scotland and Northern Ireland are introducing contracts for consultants similar to those in England.

The new contract was signed off by the BMA in early September 2003 and circulated to all consultants and specialist registrars in England as quickly as possible. The ballot closed on Monday 20 October 2003. The BMA and the DoH welcomed the result that a majority of consultants (61%), a majority of specialist registrars (55%) and an overall majority (60%) were in favour of the new contract with an overall turn out of approximately
The BMA accepted the new contract proposals on behalf of all consultants in England and started work on implementing it.

A programme of seminars on the contract, involving all industrial relations officers and employment advisers in England, took place during September and October and the BMA worked on resources to support consultants throughout the contract’s implementation. A model letter was drafted in conjunction with the Department of Health for consultants to use to indicate their interest in taking up the contract in time for the deadline of 31 October 2003, after which only three months’ backpay could be granted.

In January 2004, it appeared that around 79% of consultants had indicated their intention to move onto the new contract. However, despite all parties developing a wide range of resources for consultants and hospitals to support it, contract implementation was not progressing as quickly as might have been expected.

Clinical Excellence Awards

The principles for a new scheme of clinical excellence awards (CEAs) to replace discretionary points and distinction awards in 2004-05 were agreed as part of the negotiations on the 2002 framework agreement and during 2003 the DoH worked the principles up into more detailed proposals.

During August 2003 further negotiations shaped the proposals into something more acceptable. The new scheme was to be seamless, comprising local and national elements of a 12-level awards spine. Lower value awards were to be made by local employer committees and the national awards made by regional committees of the new Advisory Committee on Clinical Excellence Awards (ACCEA). Nevertheless, the BMA continued to have some reservations about the proposals. In considering ways in which to improve them, the BMA developed a model that could have been built into the proposed scheme’s structure, based upon the accumulation of merit points throughout a consultant’s career. The DoH rejected this plan. However, the proposals were circulated to the profession for consideration along with the rest of the documentation on the new contract. The newly formed ACCEA published its guidance for the first round of the new awards scheme in October 2003. The BMA will continue to monitor how the scheme beds in and will suggest improvements to the guidance for the 2005 awards round. In Scotland, negotiations will start soon. The Scottish Consultants’ Committee is aiming for substantial changes in the current system to make it equitable and transparent.

European working time directive

Senior hospital doctors have been covered by the provisions of the European Working Time Directive since 1998, when the UK Working Time Regulations were first implemented. That year, a collective agreement was reached between the BMA and the DoH on how the regulations could be retained for senior hospital doctors while ensuring that continuing responsibility to patients was maintained. The agreement confirmed that the 48-hour limit on weekly working hours would apply to seniors, but that the entitlement to the prescribed rest periods of e.g. 11 hours rest in every 24 hour period could be taken in lieu if doctors were required to work during those rest periods (compensatory rest). The
agreement, however, did not closely define the term ‘compensatory rest’ and this led to confusion regarding whether a doctor would be entitled to the full length of the rest break as compensation or only the period of rest lost by the interruption. LNCs around the country were then tasked with coming to an agreement on how compensatory rest provisions could work locally and some did so successfully. Many others did not. Since the introduction of the regulations there has therefore been a confused picture around the country in terms of how the compensatory rest provision has been implemented.

In January 2004 the DoH released advice to hospitals setting out their view of the implications of the ECJ rulings for NHS staff. The advice on how compensatory rest could work in practice following the Jaeger ruling was not prescriptive, but simply stated that local arrangements would need to be determined.

Consultants in the UK are entitled to opt out of some provisions of the WTD, but this is unlikely to continue, in the light of the recent decision by the European Parliament. This is likely to have serious implications for patient care in the UK.

Foundation hospitals

The Government has carried forward its initiative to set up Foundation Hospitals, which would operate as autonomous companies with a contract to provide health services with the NHS. The BMA has warned that Foundation Hospitals risk replicating the disadvantages of the internal market in health care created by the NHS changes of the early 1990s. Priority should be given to helping under-performing hospitals to improve, giving them the freedom to innovate. At present such freedoms are reserved for three-star and foundation hospitals only. Foundation Hospitals will have to demonstrate long term guaranteed income in order to borrow more, but this need for financial stability is at odds with the overarching, but ill defined plan, to give individual patients more choice by ensuring that funding follows the patient. Furthermore, it is not obvious how foundation hospitals will fit in with planning in the wider local health economy. The flexibilities offered to foundation hospitals are likely to leave other hospitals with greater recruitment difficulties, as well as create problems in local bargaining procedures. These effects work against the concept of a truly national health service.