National Reports – Rapports Nationaux 2002

AUSTRIA / AUTRICHE

We, the Austrian delegation to the UEMS permit ourselves to submit the following report for the preceding calendar year to the Management Council:

1. Medical Training

At present, the Austrian Medical Chamber, in close cooperation with the Federal Specialist Section representing the group of medical specialists, works on a complete amendment of the legal provisions which regulate specialist training. This undertaking launched in 2002 is expected to be finalised this year.

In this context, the Austrian Medical Chamber plays a central role in coordinating the efforts made by the Ministry of Health, the Scientific Societies and the Federal Specialist Groups. The training programs and definitions of all specialties are being revised and the works are about to be terminated. During our work, we have resorted to a large extent to the programs of the Specialist Sections of the UEMS. This year’s project is the institution of “grid certificates” for all specialties, where knowledge and skills are specified for each specialty, with a view to establish log books for all specialties according to international models.

In this context, the Austrian Medical Chamber plays a central coordinating role, which includes mediation in conflicts between specialties.

It is under discussion to introduce compulsory rotations for all future specialists in 2007. The long transitional period will allow to develop rotation programs at Austrian level.

2. Visitations

After longstanding efforts by the medical representative body, visitations are now provided by law at national level, this year they were started on a large scale. In this context, we achieved that visitations are performed by a team which is delegated by the competent province Medical Chamber. For this purpose, a visitation guideline was adopted by the Austrian Medical Chamber, based on the principles of the “Charta of Visitation“ by the UEMS.
We see it as a big success that the competence of accrediting and dismissing of training centers was transferred on August 1st, 2002 from the Federal Ministry of Social Security and Generations to the Austrian Medical Chamber, as part of the administrative reform in our country. In this way, not only the quality of training is under the control of the medical profession, but also we, as an authority, have a margin of action.

3. CME

In the field of CME, we fully started our work as National Authority for CME in Austria and we already deal routinely with applications. At large, both, the system and our activity, was well accepted by doctors. As per 1.1.2003, we have full competence in accrediting CME events; presently, the first applications are under consideration.

4. Health policy

In November 2002, elections were held in Austria and the new government was constituted recently. In this context, too, the health care sector plays an important role, as the financial resources available allow only short term funding of health care with present high standard. The medical profession itself requests an increase in health insurance contributions, in order to guarantee funding of medical services.

On the whole, we cannot predict future developments - see Germany - as we are always confronted with plans to economise at the level of service providers. We, however, have by all means clearly signalized that we will not accept excessive economies without a word of protest, if done at the expenses of patients and physicians.

Präs. Prim. MR. Dr. Walter Dorner
Head of delegation
In 2002 Belgium promulgated a law on euthanasia making it the second country (after the Netherlands) to legalize euthanasia. Another new and important law concerns patients’ rights. The government promised to concomitantly issue a law on medical liability but did not keep its promise. Syndicalist elections took place and showed a centrifugal trend between GPs and Specialists.

The government imposed regulations rendering doctors or departments personally responsible and threatening them with sanctions and a refunding of fees should they transgress the averages.

In the 2003 budget GPs are advantaged. Specialists are still awaiting a reasonable settlement of their financial controversy with the hospital managers.

The left-wing ministries and parties launched a campaign to promote General Practice for which the enthusiasm of medical students is greatly reduced.

Some smaller universities and the government of the French-speaking part of the country challenge the numerus clausus in medical training.

Financial and administrative support is requested by the profession in order to further maintain and develop C.M.E. and Peer Review.

Quality control is implemented through the establishment of colleges in the different disciplines, a central governmental data bank and the imposition by the authorities rather than the proposition by the profession of guidelines and care programs.

Prof. J. Gruwez
The professional-scientific societies (sections) of the Croatian Medical Association (CrMA) have continued to hold CME courses, symposia and meetings with even more intensity than a year before. There remains the problem of financing the meetings. A small number of participants are paid by their institutions, most of participants pay the fees of the courses themselves. The problem has yet to be solved.

The last plan and curricula of postgraduate training in Croatia were made in 1994. These plans and curricula are similar to (yet) various programs in the EU countries, but with some differences. The CrMA started the initiative for its specialist societies to promote the harmonization of training programs (duration, content) to those in the EU countries. That would be done together with the University officials (chairs of medical faculties).

In the Republic of Croatia the parliament will soon pass a new law or will renew some laws concerning the medical profession: the law on health care (renewal); law on drugs use (renewal); law on medical profession (new); law on the rights of patients. The CrMA has been desultorily consulted upon the drafts of the above mentioned laws and the procedure is going on without our cooperation.

The Croatian Medical Trade Union, assisted by CrMA and by the Croatian Medical Chamber, has organized a strike of hospital specialists claiming for the rise in salaries and a better appreciation of medical profession. The strike bare upon only to the medical care of non-urgent patients. After 30 days the strike ended since the government, being the owner of hospitals, introduced the working obligation to all doctors.

Prof. A. Drazancic
The activities developing in Czech Republic in 2002 and concerning the goals of UEMS were realized in two fields:

A/ There is permanent negotiation of the Board of Czech Medical Association with Government in preparation the Law on Medical Education, especially on the content and duration of specializations concerning the postdoctoral development. The proposed system of education is compatible with those in the western European countries and we find it as important for the process of harmonization in EU. The physicians preparing in separate specializations have schedule (including log-book) which has to be filled before admitting to the final examination. The system is now finalized by determining the content of education in separate specializations. There is i.e. discussion to join metabolic and endocrine disorders into one postgraduate specialization closely to the system in other countries. (Up to now there were two separate specializations, one in endocrinology, the other in diabetology).

B/ We continued in 2002 with the system CME/CPD in medical activities in Czech Republic. This recommendation formed as Regulation Nr.16 of the Czech Medical Chamber is based on credit system and is fully compatible with that present in countries of UEMS members. There exists close collaboration between Czech Medical Association and Czech Medical Chamber in confirmations of educational activities for medical specialists. Credit points are evaluated every 3 years.

We propose that further cooperation with UEMS activities will continue in future years.

Professor Jan Škrha, MD, DSc.
contact person for UEMS
Czech Medical Association
DENMARK / DANEMARK

Economic Issues
The Danish government continues the work from last year in providing more economic means to the sector. An additional extension of free choice for the patients was implemented in 2002, whereby patients can be treated in private hospitals/clinics, if he or she has been waiting for more than 2 months for treatment in the public hospitals. Such private hospital treatment is free for the patients, provided a contract exists between the hospital/clinic and the regional authorities.

An extra non-recurrent appropriation of 1.5 billion Danish kroner (200,000 Euro) has been allocated to reduce the waiting lists for hospital treatment. The hospital owners (i.e. the counties and the Copenhagen Hospital Cooperation) can obtain a share of the 1.5 billion Danish kroner (200,000 Euro), by demonstrating an increased activity in proportion to the target figures included in the former government’s agreement with the counties. There is a shortage of medical specialists, nurses and other health care personnel, so the additional appropriation increases pressure on the personnel to take on overtime and extra work.

The Danish Association of Medical Specialists has not entered into an agreement with the employers about conditions for the medical specialists who take on extra activities. It is the association’s standpoint, that the members themselves should locally negotiate the salary for taking on extra work.

Collective bargaining
As of 1 April 2003 chief physicians will be paid according to a new system with their existing salaries as basic payment, as well as the possibility of entering individual agreements locally for increments based on functions, qualifications and results and quantity.

A new collective agreement for specialist practitioners entered into force on 1 April 2002. The agreement supplied a substantial increase in the economy, quality and flexibility of the sector. This was much needed to keep specialist practitioners from early retirement, in a time where Denmark suffers from a shortage of medical specialists.

Among other things, the agreement introduced the possibility to alter or add to the collective agreement without central approval, for instance with regards to treatments and surgery as well as economy and benefits. The specialist practitioners and counties have to be in agreement to make these alterations. There has been a vast increase in the amount of the above agreements, which improves conditions for specialist practitioners and encourages production.

Doctors’ Directive 93/16/EEC
During the Danish presidency, the Danish Medical Association and the Secretary-General of the CPME Lisette Tiddens-Engwirda had a meeting with the Danish Ministry of Health. The DMA and the CPME explained their concern to maintain the number of specialties in the Doctors’ Directive. The Danish Ministry of Health stated that it might be able to support the listing of specialties acknowledged in 80-90 % of the European countries. The Ministry has since communicated that decision on this issue was unlikely to be taken during Danish presidency, which has indeed turned out to be the case. The Danish Ministry of Health supported the claim that the medical profession is to be represented in the committee to replace the ACMT.

Dr. Lars Bjørn Rasmussen
Head of the Danish Delegation
National Health Project
In order to solve many current problems in health care the Finnish government launched in 2001 a large project to safeguard the future of health care in Finland. The recommendations of the project were approved by the government in April 2002. These included access to primary health care and to specialist health care and treatment within certain time. The minimum requirement for continuous medical education for all health care professionals will be put into legislation. Collaboration between primary health care and specialised health care will be strengthened. More emphasis will be put on management training for health care professionals. Above all more public money will be put into health care since Finland is below the average of EU in health care spending in relation to GNP.

Shortage of doctors
There is a shortage of almost 1000 doctors in public health care which employs about 11000 of all Finnish doctors. As a result of the national health project the number of new medical students was raised to 600 yearly. As a part of specialist training all doctors have to spend at least 9 months (instead of 6 months earlier) in primary health care. At least half of the specialist training time in most specialities will be demanded to be done outside of the university hospitals. These measures are taken to spread newly qualified doctors into public health care. The number of doctors in Finland has exceeded 19000. The Finnish Medical Association has stressed that the solution to the problem is not to increase the number of students and force doctors to stay in public health care but rather to look at the reasons behind this phenomenon.

The Minister of Education has proposed that in order to ease this situation medical faculties should start to train nurses into doctors through a shortened training period. The Ministry is still pursuing this plan in spite of wide resistance. The Finnish Medical Association, Nurses Association, Ministry of Social Affairs and Health and most other institutions do not support this plan. The Internal Market DG of the European Commission has recently given its response to the plan. According to FMA it is not an approval to start the training although the Ministry of Education has marketed it has such.

Evaluation council for CPD
The FMA, The Finnish Medical Society Duodecim and The Swedish-speaking Medical Society started in February 2002 an evaluation council for physicians continuous professional development. Specialist societies and universities also take part in the council. As its first task the council has set up criteria for quality CME/CPD. In the future it will eventually evaluate courses and providers. This council will also collaborate with EACCME. The system of CME in Finland is based on voluntariness.

Dr. Hannu Halila
Head of Education
Finnish Medical Association
In 2002 the Hungarian health care received a new government and a Health Minister, however the Health Care policy has not been changed fundamentally.
The main strategic objective is the modernization of health care in the spirit of equal opportunities.
In Hungary the health care provision is free for all the population and is based on the solidarity.
General Practitioners usually provide out-patient care in single practices, in properties belonging to local governments. The remuneration of General Practitioners is held by insurance companies. The out-patient care has been running by both, the Local Governments and by insurance companies as well.
Hospitals are run by health insurance companies with the exceptions to: Army, Railway Company, Internal Affairs, VIP patients. The financing is according to DRH and the value is determined annually.
Important news that the new government raised the compensation of the health care workers by 50%, however this is still not up to the wages of the employees of other grades of society.

Basic Training
Annually c.a. 800 new physicians graduate from Hungarian faculties of general medicine and dentistry. The attraction of being physician has been severely diminished.
The number of the medical students is controlled at the entrance examinations done by the respective faculties by the agreement of the health policy and the professionals on the grounds of manpower planning projections.

Postgraduate training
A newly registered doctors are expected to apply for specialist trainee (resident) position in any specialities recognized by national legislation upon requirements of specialization in medicine, in dentistry, in pharmacy and in clinical psychology. Universities are responsible for postgraduate training and education.

Continuing Medical Education
Structure of the National CME
Practicing medical doctors and all the upper-mentioned professionals are subject of continuing medical training in order to update their knowledge and skills about the current novelties in the concerned field. This practice provides that the expertise of medical doctors (and others) who graduated earlier remains updated and relevant.
Medical faculties are responsible and in charge for organizing and coordinate medical CME in their respective region. University departments, (teaching) county hospitals, scientific societies etc. may organize courses or programs for continuing education. Special attention has been paying to the specialists in private practice. The academic institutions are obliged to organize CME programs appropriate as far as the topics and quality is concerned for each speciality, and the attendees are honored in points upon credit hours.

So, a credit-hour system is used for CME in Hungary. 250 credit points are recommended over a 5-year-period, meaning that the requirement is 50 credit points per year. The CME requirement consists of two important parts: practical and theoretical activity. The practical part is working in the given speciality, and it is recognized by an annual 20 credit points. The theoretical part consists of two types of educational activities: external (structured or planned) learning programmes and internal (voluntarily or self-initiated) activities. Half of the remaining 30 credit points per year (15 points) has to be gained through external programs, while the second half by the internal part. The credit points are registered in the
physician' CME log-book as well as at medical faculties' postgraduate offices and finally all the data are forwarded to the Hungarian Medical Chamber's county offices.

So, the successful completion of requirements in CME is the basis for re-qualification in the medical practice register controlled by the Hungarian Medical Chamber. This Body and the Chief Medical Officer's Office are authorized to make proposals to revalidate the medical license, partly by the completion scores of the prescribed educational program.

Dr Z. Magyari
IRELAND / IRLANDE

The last year has seen some interesting developments. The implementation of the Competence Assurance scheme by the Medical Council has been announced for 2003. In preparation for this IMO held its annual meeting of UEMS Specialist Boards and Sections Irish Representatives. Professor Paul Finucane, Head of Competence Assurance at the Medical Council, delivered a detailed and instructive seminar on the new system and its expected impact. His paper was well received and provoked some cogent questions from the audience. As yet the full structure is not in place so evaluation of it must await further experience.

The National Taskforce on Medical Staffing was established, in February 2002 to follow up the work of the National Forum on Medical Manpower, published in January 2001. It is believed that the Taskforce will study the implications of a promised increase the number of consultant posts.

The Clinical Indemnity Scheme which introduces ‘enterprise liability’ has just been issued in draft form. The government hopes to reduce the cost of liability cover through transferring liability for negligence and malpractice cases to the doctor’s employer hospital of health board. The scheme does not apply to General Practitioners.

The National Treatment Purchase Fund has been established. This fund will purchase treatment for patients on waiting lists either within Ireland or from foreign providers. As yet the scheme has not begun operation. It is unclear how the scheme will effect the relationship between Consultants and their patients on the one side and foreign providers on the other.
The main activity of the AMMD during the year 2002 were multiple negotiations with all political parties and the major trade unions about a reform of the relationship between the doctors and the social security. Doctors in clinical practice in Luxembourg are all paid on a fee for act system, either individually or on a group basis via a pool system. The tariffs are negotiated between the doctor's union and the "Union des Caisse de Maladie" a public non profit social security insurance system whose management is dominated by worker's trade unionist. Nearly all citizens have to be affiliated to this system. Each doctor has to comply to the tariffs negotiated and has no right to opt out, neither partially nor totally. The mechanism according to which the tariffs for doctors are negotiated have lead to a constant erosion of the income and working conditions of doctors compared to other professionals over the last 20 years, not to mention the problems of rising liability insurance fees, increasing involvement in organisational tasks in hospitals and so on.

The AMMD has asked for a revalorization of our tariffs to catch up with the development of income of the general population, tax advantages for night and weekend work, support for the problem of rocketing liability fees and the possibility to opt out of the mandatory tariff system. The last point was met with unanimous blockage from all political parties and definitely by the whole of the worker's trade unions and high reluctance to do anything about a just development of doctor's fees, particularly from trade union side. The present system is probably considered to be the cheapest to insure global and equal health care coverage ignoring the already existing and the looming problems of recruitment of doctors in certain areas.

The AMMD has then stopped negotiations with the managers of the Social Security because we realised that they were sham negotiations and has turned to talking directly to the government who seems to have more understanding and long term views. A revalorization of the tariffs for clinical inpatient and outpatient work has been promised but has to undergo the whole process of a change of a law through parliament. In case these promises will be kept a partial compensation for the last ten years of doctor's erosion of their status will be given but the fundamental problems of the mechanisms of that erosion and the working conditions will not be resolved.

Other main points were
- the introduction of a government supported infrastructure for urgent home visits by general practitioners after the previous system had collapsed.
- the collaboration on a reform to reorganise the inner structure and functioning of hospital departments
- an agreement about a nation-wide framework for contracts for hospital practitioners

Dr Alexandre Bis dorff, national delegate
Working conditions for hospital physicians in Norway in the new system of hospital enterprises.

The Norwegian Parliament approved a new Act concerning public health enterprises in June 2001. 5 regional public health enterprises (RHE) were established. The enterprises are 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. A more comprehensive description of the Hospital reform is available 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 in French on http://odin.dep.no/shd/sykehusreformen/aktuelt/rapport/030071-990118/index-dok000-b-n-a.html

HE is responsible for hospitals` managing medically and within budgets. The state has the superior economical responsibility for the hospitals and other specialist health care services in the region. As an owner the state will attend the management through an enterprise meeting once a year and also has the right to appoint board members. By legal regulation it is also decided that important matters should be presented to the Ministry of Health. Based on activity plans from the HE`s the Government will work out a national plan for the specialist health care services.

The physicians are employed by the HE. An association called NAVO manages negotiations about wage and working conditions. The negotiation process has three phases, which have to be completed to make an agreement. Two phases are on a central level. The first concerns wage and working conditions for all employees in the HE, and is negotiated by the Union of Professional Organisations, Akademikerne. The second phase is an agreement for physicians negotiated by the Norwegian Medical Association (NMA). The third phase is negotiations between the HE and the local representatives of NMA.

By entering a new system, the physicians kept their legal rights according to their employment contracts and former agreements.

An increase in basic wage level for all physicians was very important for the NMA. Low basic wage level and a progressive increase in pay per hour for agreed extension of weekly working hours in the previous system, made most physicians work quite a lot extended time to get better paid. One of the results was an improvement in basic wage level.

Another result is that on duty services by presence in hospitals mainly are paid as full time work and not by a fraction of 1/3 as in the previous contract. On call duty at home is still counted by a fraction of ¼.

Most physicians in Norway have mandatory participation in on call duty systems. In the new system the physicians are better paid for the inconvenience of on duty service, given as a certain percentage of the basic wage.

Extended working hours are extra paid also in this new agreement, but at a lower level than it was in the former system.
Year 2002 was the 1st year at which first doctors trained according to new regulations began to pass specialty exams. These exams are State exams administered by specially created office called “Center of Medical Examinations” fully supported by the Ministry of Health. They have similar format in each specialty and are composed of test (written), practical and theoretical (oral) exams. Test exam is composed of 120 multiple choice questions. Format of practical exam varies depending on specialty (for instance in hematology it is composed of review of a clinical case and evaluation of 3 bone marrow smears). Theoretical exam is composed of between 3 and 5 questions related to specialty program. Vast majority of candidates passed these exams but majority of them have actually been overtrained working already in given specialty for up to 20 years without simply earlier applying for the exam.

Year 2002 was also marked by almost complete replacement of the so called National Consultants. National Consultant is in the Polish system, a senior professor of given specialty appointed by the Minister of Health to supervise all aspects of practice of given specialty. This also includes decisions concerning number of trainees in this specialty, preparation and performance of exams, accreditation of facilities, decisions concerning import of life-saving drugs that are not yet registered in Poland, solving conflicts, and dealing with the most difficult clinical cases. National Consultant is also an adviser for the Ministry of Health and Sick Fund on all matters related to the specialty.

Usually, National Consultant collaborates very closely with the President of medical society representing the same specialty and with the Polish Chamber of Physicians. Usually commissions that handle specialty matters such as state exams are chaired by the National Consultant and include representatives of both appropriate medical society and Polish Chamber of Physicians.

Additionally, two specialties have been created. Of them clinical immunology is a specialty equivalent to specialties existing in many European countries, while transplantation medicine is most probably pioneered by Poland. Transplantation medicine deals with tissue matching, cell, tissue and organ banking and procurement, transplantation of organs such as kidney, liver, heart, lung etc as well as with cellular transplantation particularly with stem cell transplantation. The next major issue is immunosupression and care of immunocompromised patient.

Prepared by W. Wiktor Jedrzejczak
PORTUGAL

Following general elections, about one year ago, we now have a new centre-right Government in Portugal.

The main problem for this government continues to be the balance of the budget. New legislation concerning the prescription and sale of drugs has been in force since the beginning of the year with the objective of increasing the use of generic drugs. A new medical prescription form was created which includes the possibility of the doctor authorising the pharmacist to substitute the medication. The Ordem dos Médicos (Portuguese Medical Association) is of the opinion that prescribed medication should not be substituted.

Since 13th March 2003 a reference price was established for the reimbursement of drugs that have a generic on the market.

The Government approved a new law that makes important changes to the functioning of health centres. This law has been strongly opposed by the two medical unions, the general practice associations and the Ordem dos Médicos, and resulted in a three-day strike with a very significant participation in February 2003.

The law regarding the private management of hospitals was approved. Thus, 34 hospitals of medium size are now under private management, although remaining public and maintaining an identical relationship with the patients. The only alteration to date was the nomination of 70% of the managers without any experience in the health sector and with huge salaries.

These measures are probably an artificial form of correcting the deficit in public finance. University hospitals and central hospitals will have their own laws.

The new law for hospital management is mainly characterised by the attribution of greater power to the heads of service (managerial and disciplinary power over all the staff, irrespective of their professional sector) and allowing doctors’ civil service contracts to be changed to individual contracts of employment. It also establishes the possibility of productivity incentives and the subcontracting of services or departments by groups of doctors or private bodies.

The public hospitals continue to have a recovery programme for surgery waiting lists and it is also beginning in private clinics and the social sector under the same economic conditions. This new programme encompasses practically all of the surgical procedures. The Manchester Protocol is being introduced for the prioritisation of access to the emergency services of the main hospitals.

The lack of doctors is becoming acute, mainly in some specialties. This situation is particularly critical in the emergency services since, by law, doctors can request exemption from nocturnal emergency duty after the age of 50 and full exemption after the age of 55.

Another critical issue in emergency services is the price of overtime; there are differences of more than 50% in payment per hour for exactly the same work depending on whether the doctor is working in exclusivity.

The Government has restricted the pensions and rises in salary of the civil servants. This alteration strongly penalises those who retire before the age of 60, even with the required years of service and there was no update in salary for the civil servants who earn more than €1000 a month. It should be pointed out that 95% of doctors are civil servants.

The Ordem dos Médicos created a new medical competence in management and approved the scientific curriculum for the postgraduate course in management for doctors. A prestigious university was selected to provide the course at the beginning of March.

The Ordem dos Médicos is implementing a support programme for doctors with health problems, with the collaboration of doctors from Barcelona – PAIM.

The Ordem dos Médicos held its national congress on medicine in Lisbon in February. The general theme was “Doctors and power”.

On the first day of the congress all the newly graduated doctors took the Hippocratic oath.
Several issues of interest to the medical profession were debated, such as “The prescription of drugs and the conditioning factors”; “The power of the doctor-patient relationship and its management”; “Medical procedures - who may condition them”; “The doctor should be the administrator of the health unit”; “The new models of hospital management and medical careers”; “Academic - industry relations”; “Private medicine” and “Is recertification necessary?”

The congress ended with a tribute to the doctors who have achieved distinction in their careers.

**ROMANIA / ROUMANIE**

Romanian College of Physicians is pleased to report the main activities organised in 2002:

1. **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 organiser(s) and for the sponsor;
   - Guidelines for the journals indexed by the Romanian College.

2. **Medical guidelines.** Second volume on Medical Guidelines for Diagnosis and Treatment was published in March 2002. This included 14 guidelines from different specialities. A program dedicated to the elaboration of the 3rd volume was started (deadline for the publication of the 3rd volume being October 2003).

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

4. **Economics.** Costs of the main medical services were reviewed and updated with the help of the Specialist Sections of the college.

5. **Meetings.** Apart from participating to the UEMS meetings, President and Vice-presidents of the college participated to joint meetings with similar organisations from France, Germany, Central European countries. EU experts visited Romania, and details regarding medical laws and regulations were discussed extensively.

Yours Sincerely,

Dr Liviu Cocora
Dr Dragos Vinereanu

Members of the UEMS Management Council
SLOVAKIA / SLOVAQUIE

Slovak Medical Association (SkMA) is a non-governmental voluntary organization consisting of XXX regional and XXX specialist societies. Moreover several alike societies build Correspondent societies. SkMA initiates, submits, asserts and publishes proposals and opinions related to specializations, educational and scientific standard of different medical branches. SkMA initiates and mediates transfer of the newest scientific, medical, diagnostic and therapeutic information into practice by means on non-institutional education. SkMA cooperates with Slovak Medical Chamber and Postgraduate Medical School and it is continuously invited by the Ministry of Health for consultations. It participates also in the Health care reform in Slovakia. Moreover, it secures the international contacts by memberships in WMA, UEMS, CIOMS, WHO to bring impetus from the world to Slovak medicine.

The mission of SkMA is to transfer the newest scientific information by means of congresses, conferences symposia and other professional meetings with both domestic and international participation and supports the congress participation of our experts in foreign countries and to issue medical journals. In this respect the cooperation with Czech Medical Association is outstanding.

The large effort has been spent to establish the accreditation according to international criteria during the last years, i.e. the constitution of National Accreditation Council and the preparation of conditions for its accreditation by the European Accreditation Committee.

Professor R. Dzurik, MD
Slovak Medical Association
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 2002 the MCS prepared necessary data and calculations for four national Public Tenders of the training posts for SPGMT. It means that the number of specializations for the year 2002 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 will be 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 2002 we awarded credit points to 248 organisers of domestic professional meetings and 500 individual applicants. More detailed analysis of our 10 years experience with mandatory recertification in Slovenia could be presented at the next EACCME meeting if there will be the opportunity to give such a presentation.

Dr Zlatko Fras, MSc., MD
Mojca Vrečar, MBA
SWEDEN / SUEDE

General Health Policy

Sweden held General Elections in September 2002. The outcome was no great surprise, and the governing Social Democrats were returned to power for another four years. Once again, it is a minority government that can only rule with the support of the Left Party and the Swedish Green Party.

The indications are that government health policy will continue without any major changes. Primary health care, psychiatry and care of the elderly together with a review of highly specialised care (see below) remain the core focus of government health care policy. The ever-increasing cost of medicines is also a matter of concern for the government, and the year 2002 saw the launch of the new Pharmaceutical Benefits Board (“Läkemedelsförmånsnämnden”). The Pharmaceutical Benefits Board will be responsible for the cost of medicines in general, and in particular for determining whether a drug covered by the pharmaceutical benefits scheme is to be subsidised.

Review of Highly Specialised Care

A project group within the Ministry of Health and Social Affairs has embarked on a review of highly specialised care. Highly specialised care is defined as “health care that is concentrated in one or more units with a catchment area of one or more health care regions”. The aim is to solve certain problems within the discipline and create a climate conducive to development and efficient use of resources. The work will involve identifying the scope of existing highly specialised care, and its place in health care. The group will also examine the effects of increased EU-cooperation in the field, particularly within certain target groups of patients/diseases. Furthermore the conditions for clinical research and dissemination of results within the health care system will also be investigated. Lastly, the project group will analyse the role of university hospitals in the health care system and analyse divisions of responsibility with regard to treatment, research, development and education.

High Proportion of Population on Long-Term Sick Leave

Today 15 % of the working age population is on long-term sick leave or has taken early retirement. This figure is among the highest in Europe, and the problem remains high on the Swedish political agenda. Suggestions have been put forward indicating that patients’ general attitude to sick leave must be changed in order to increase awareness of the value of staying at work and the need for rehabilitation. On the other hand, doctors issuing sick notes and all other responsible parties such as employers and the Social Insurance Office must take greater responsibility as well. It has been proposed that the general rule for doctors should be to issue sick notes for sick leave on part time.

Doctors are, however, affected by the high sick leave rate themselves. The vast majority of Swedish doctors are employees, and their working conditions are currently difficult, as they do not have sufficient opportunity to influence and take part in decisions affecting their work. This contrasts with the great responsibility that doctors have in running the clinic. Taken together, this leads to stress and a general lack of fulfilment among working doctors. The number of doctors on long-term sick leave is increasing and is currently around 4-5 %.
Review of Medical Specialties

Recently the National Board of Health and Welfare ("Socialstyrelsen") presented its review of the Doctors’ Specialist Training and the Structure for Medical Specialties. The review is presented from the patient’s perspective. Age structure, disease panorama, structural changes within the healthcare system and the future supply of medical doctors have all been taken into account. Developments within the different medical fields have also had an impact on the review.

The Board proposes a number of measures to improve the quality of training, for example the introduction of a compulsory specialist training assessment. In addition, a new specialist training structure is to be introduced, with key components such as “base specialties”, “branch specialties” and “supplementary” specialties. In brief, the number of specialties will be reduced from 62 to 53. “Base specialties” will be, first and foremost, surgery, internal medicine, paediatric medicine, psychiatry, and there is an option to add branch specialties. The goals and objectives for each base specialty will require at least five years training and with the addition of branch specialties the total training period will be 6.5 – 7.5 years. The supplementary specialties “pain management” and “emergency medicine” are more flexible, and can be added to different base specialties.

The Institute for Doctors’ Professional Development in Sweden

The Institute for Doctors’ Professional Development in Sweden is the result of cooperation between the Swedish Medical Association, the Swedish Society of Medicine and the Federation of County Councils. Since the launch of the Institute in 2001, the Institute has built up its organisation, and its first secretary-general is now established in his post. Gradually more and more CPD-related matters (for a description of the Institute’s remits, see document D 0201 Annex) will be taken over by the Institute. In September last year the Institute took over responsibility for specialist training courses from the Swedish National Board of Health and Welfare. In connection with this, state funding of SEK 15 million was transferred to the Institute. An important task for the near future is for the Institute to establish itself as a key player with politicians, specialist doctors, medical faculties, etc. According to the plans, the Institute will take over the national responsibility for EACCME accreditations by the second quarter of 2003.

Quality Assessment of Internships

For some ten years now, the Swedish Society of Medicine and the Swedish Medical Association has – through its Specialist Training Council – conducted on-site visits in clinics, where it has assessed training conditions. This work is now being extended to encompass visits where internships are assessed. Two pilot projects have taken place thus far, with excellent results. Permanent quality assessment of internships is expected to be launched during 2003
The year 2002 was of great significance for Switzerland as a whole and for the Swiss Medical Association (FMH) in particular. Thanks to the bilateral agreements with the EU which came into effect on 1 June 2002, the supervision of further training for doctors – which has been privately built up and organised by the FMH over the last 70 years – was handed over to the state i.e. to the Swiss confederation. On the same date, the confederation charged the FMH with the organisation of medical further training (44 federal titles as medical specialist). The mutual recognition of medical specialist titles causes problems not only in the EU owing to varying objectives and content, but also in Switzerland because of the varying length of training. The new legislation makes it compulsory for holders of a medical specialist title to undergo continuous professional development.

Mid-2002, the confederation issued a freeze on licenses for doctors in general practice. This resulted in an increase in title applications of over 100%.

The reduction in the worktime of junior hospital doctors has put increasing pressure on the organisation of further training. Ways will have to be found for the organisation of examinations and surgical procedures within the term provided for (five to six years) and as required by the training programmes.

Quality assurance techniques of further training are based on the survey of the junior doctors carried out on that topic, the training concepts at the relevant training institutes and the inspections. The survey took place for the sixth time and 75% of the participants responded. New further training concepts were requested for the end of the year. The first inspections took place in the second half of the year.

Dr med. Max Giger
Medical Education Section
The Swiss Medical Association
L’année 2002 s’est révélée très importante pour la Suisse, et particulièrement pour la Fédération des médecins suisses (FMH). Lors de l’entrée en vigueur des accords bilatéraux avec l’Union européenne le 1er juin 2002, la haute surveillance de la formation postgraduée médicale, mise sur pied et appliquée pendant 70 ans par la FMH en tant qu’organisme privé, est passée aux mains de l’Etat, soit de la Confédération suisse. À la même date, la FMH a été mandatée par cette dernière pour la mise en œuvre de la formation postgraduée des médecins (au total 44 titres postgrades fédéraux). La reconnaissance mutuelle des diplômes de spécialiste ne pose pas seulement des problèmes au sein de l’Union européenne en raison des objectifs et des contenus différents, mais également en Suisse, notamment parce que la durée de la formation y est différente. En outre, il convient de relever que la nouvelle législation astreint dorénavant chaque médecin à la formation continue.

Vers le milieu de l’année dernière, la Confédération a bloqué l’accès des médecins à la pratique privée. Cette limitation a entraîné une augmentation des demandes de titre de plus de 100%.

De par la réduction du temps de travail des assistants dans les hôpitaux, la pression sur la formation postgraduée est de plus en plus forte. Il s’agit de trouver des moyens d’effectuer, au cours de la durée de formation prévue (5 à 6 ans), les examens et les interventions prescrits par les programmes de formation postgraduée.

La garantie de la qualité de la formation postgraduée se fonde sur une appréciation de celle-ci par les assistants, sur les concepts de formation postgraduée des établissements de formation et sur les visites d’évaluation de ces établissements. L’enquête sur l’appréciation de la qualité a eu lieu pour la sixième fois consécutive avec la participation des trois quarts des assistants. Les concepts de formation postgraduée ont été exigés pour la fin de l’année. Les premières visites d’établissements ont été effectuées dans le courant du deuxième semestre 2002.

Dr Max Giger
Domaine «Formation médicale» de la FMH
The Turkish Medical Association within the year of 2002 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 standardisation of specialty training in Turkey: This annual meeting has been organized yearly since 6 years. All specialty societies are involved in this activity. This year's meeting was organized in Ankara and over 350 attended the meeting. Various aspects of specialty training and accreditation was discussed.

2) The Turkish Medical Association was involved in a process of preparation of new legislation for specialty training in Turkey prepared by the Ministry of Health.

3) The Coordination Committee of Specialty Societies continued its activities under the auspices of the Turkish Medical Association. 66 specialty societies and 9 associate societies are represented in the structure of this committee.

4) 24 specialty societies prepared their bylaws for creating their "Specialty Boards" as non-govermental organizations.

5) 4 of these "Specialty Boards" Board of Neurosurgery, Board of General Surgery, Board of Chest Diseases and Boards of Internal Medicine prepared their Board examinations. Board of Neurology, Board of Ophthalmology are in preparation to give their own Board examinations.

6) European Board of Physical Therapy and Rehabilitation Board examination was given at Hacettepe University School of Medicine for Turkish Candidates.

7) The Turkish Medical Association CME Accreditation Committee continued to monitor the CME activities in Turkey. A close relation has started with the European CME Accreditation Committee thru UEMS for CME accreditation for international meetings to be held in Turkey.

Dr I. Sayek
The consultant contract negotiations

Following extensive negotiations with the UK health departments, the British Medical Association reached an agreement on a new contract framework in June 2002. The negotiators then embarked on a campaign to explain the agreement to the consultant body. It soon became clear that the response of the majority of consultants to the proposal was negative. The general view was that it gave trust managers too much opportunity to direct the working patterns of consultants. In particular, there was concern about management control over working hours and pay progression. There was also concern about the different treatment of new consultants under the proposals. A referendum of consultants and specialist registrars was held in October. The overall result was a rejection of the framework. In England and Wales 66 per cent of consultants, and 86 per cent of specialist registrars (doctors in training), voted 'no'. However, in Scotland (59%) and Northern Ireland (54%) the framework was narrowly accepted by consultants (but rejected by 72% and 76% of specialist registrars respectively). There was an overall majority in Scotland and the Scottish consultants' committee agreed to work towards implementing a new contract based on the framework. In England, the Secretary of State for Health, Alan Milburn, initially responded by stating that there would be no re-negotiation. Instead the government proposed three alternatives: local implementation of contracts based on the framework; new incentive payments; or increased numbers of clinical excellence awards. The BMA remains determined to continue discussions at a national level. It will resist strongly local implementation of a new contract.

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 British Medical Association 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. The BMA believes that priority should be given to helping under-performing hospitals to improve and that more freedom to innovate would help them to do so. At present such freedoms are reserved for three-star and foundation hospitals only. The BMA fears that government policies may be mutually contradictory. Foundation Trusts 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 currently 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 trusts with worsening recruitment difficulties, as well as producing problems in local bargaining procedures. These effects work against the concept of a truly national health service.

Revalidation

UK consultants and specialists have accepted in principle a system of revalidation procedures developed by the General Medical Council. A form of appraisal will function as the basis of these procedures, which each doctor will be required to undertake every five years. The British Medical Association's Central Consultants and Specialists Committee has agreed this plan as an acceptable compromise.