EUROPEAN FORUM OF MEDICAL ASSOCIATIONS AND WHO

Report on a WHO meeting

Basel, Switzerland
6–7 March 1998
ABSTRACT

Despite the relocation of the meeting from Israel to Switzerland two weeks before the event, 68 representatives from 44 medical associations, and 6 observer organizations attended. They devoted much of their time to considering two major public health issues: “Future Health Policies: 2000 onwards”, based on presentations by WHO, the European Commission, and the Council of Europe; and “Trends in sexually transmitted diseases”. Other issues discussed were tobacco control, autonomy of medical practitioners and engagement of medical practitioners in Quality of Care Development (QCD).

The Forum had earlier commented on the WHO Health for All (HFA) consultative document, noting the common features of the health policies being developed by the Regional Office for Europe and the European Union. In subsequent debate reflecting major concern over inadequate budgets for health in many countries in Europe, the Forum adopted a Statement on HFA Strategy and Health Care Resources. Major concern was also expressed over the adequacy of resources for curative care, on which the Medical Associations present in Basel themselves adopted a statement. Statements calling on the European institutions to resist amendment to the proposed tobacco advertising directive, and on the threats to the health of civilians in Kosovo were also adopted.

The Forum noted that pilot project surveys of smoking among medical practitioners were nearly complete. Medical Associations will be receiving the material to carry out their own surveys in the near future. The Quality of Care booklet has been distributed to most National Medical Associations (NMAs), 17 of whom reported not only the establishment of QCD action groups or committees, but also many other actions. In response to wishes expressed in writing by NMAs, the Forum agreed to convene a meeting in autumn 1998 to determine the best way to set up joint collaborative efforts at regional or subregional level and promote engagement in QCD by their members. Financing of the Forum was the subject of a presentation and subsequent debate, and will be further explored. The establishment of a network of experts in identifying evidence of torture was reported.

Owing to technical problems, the new enlarged Handbook of National Medical Associations in Europe, which contains all the Forum Statements, is being reprinted and will be distributed later in the year.

Keywords

SOCIETIES, MEDICAL – congresses
HEALTH POLICY – trends
HEALTH CARE REFORM
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EUROPE, EASTERN
COMMONWEALTH OF INDEPENDENT STATES
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Opening

The meeting was opened by Dr H.H. Brunner, President of the Swiss Medical Association speaking in English, French and German. Referring to the surprise circumstances that had led to the meeting being held in Basel, he said that the association when asked to respond to the request to organize the meeting acting for the Israel Medical Association because of the imminent crisis in the Gulf Region regarded this as a pleasure as well as a challenge. That this was a success was the result of very hard work by the task force consisting of Dr Rene Salzberg and members of the Secretariat of the Swiss Medical Association in Basel. On behalf of the Forum and its participants he expressed thanks to Rene Salzberg and his collaborators. Their work was a fine example of the Swiss tradition to be active where there is a need.

Another Swiss tradition was that of collaboration between the state authorities and the Swiss Medical Association, and he expressed his pleasure that Dr Hartmann, Vice Director of the Federal Office of Public Health, would address the meeting later. This Office had immediately granted significant financial support which allowed the Medical Association to organize this meeting. He then expressed the thanks of the Forum to the Swiss Bank Federation which had, with its traditional generosity, also made an important financial contribution.

Continuing in French he repeated the above welcoming remarks and referred to the major discussion point on the future health policy in Europe. This subject was absolutely crucial for those in Switzerland. Whilst at the moment Switzerland was outside the European Union, it was directly affected by developments in Europe. The Swiss shared European concerns arising from limited financial resources and the downgrading of social policy and high quality health services which are sometimes sacrificed to economic policies intended only to enrich a minority of people. This development is to be feared all the more, because we are in a situation where our health systems face a number of problems which have not been resolved, e.g. STDs, AIDS, the consequences of alcohol and tobacco abuse. These will be topics dealt with at this Forum as well as the challenges of molecular biology and the ethical and economic consequences of genetic engineering, which are practically unpredictable at present, but which will definitely have far-reaching consequences in the future.

Welcoming the German-speaking participants, he referred to the long historic tradition of Basel which had been the place for many meetings and conferences called to deal with important issues. The most important was the famous Council of Basel in the 15th century and which had important influences leading to the Reformation. Turning specifically to health problems he considered that there were many developments today which we would like to shelve and put in cold storage. However, there are some problems like rationing of medical benefits in the health systems which have become a central issue in all countries. Welcoming especially health colleagues from eastern Europe he reminded the conference that Basel was the place where the independence of Switzerland was proclaimed in 1499. He expressed the hope that in the open city of Basel participants would get some stimulating ideas.

Dr Y Blachar, Co-Chairman, President of the Israel Medical Association, expressed his pleasure that the meeting was taking place and commended the Swiss Medical Association, Dr Brunner, Dr Salzberg and the organizing committee for setting up this meeting at such short notice. The meeting had been planned to take place in Jerusalem, was moved to Tel Aviv, but, due to the tension in the Persian Gulf this was cancelled and the Swiss Medical Association kindly agreed
to undertake the organization of the meeting. He expressed pleasure at the outcome of the dispute in his region, although the IMA regretted not hosting the Forum this year when especially important subjects vital to the medical profession as it approached the 21st century, in particular the HFA policy which WHO wishes to adopt, would be discussed. The medical profession has undergone profound changes in the last century, as well as great advances and achievements which raise difficult ethical and moral questions. The physician’s role is undergoing tremendous changes and physicians with their patients are sometimes stretched to new limits. In his view these changes present a great opportunity to affect physicians’ work whilst evolving and preserving the fundamental principles which have guided them for many years. One of the great challenges is to develop a health policy relevant to all the members of national medical associations and at the same time recognize the different problems faced by various countries. Common issues such as quality assurance, patients’ rights, limited resources, prioritization, etc. must be clearly identified and new ways found to meet the challenges.

Attention also had to be paid to regional problems, acknowledging the fact that eventually a regional problem becomes everyone’s problem.

Dr Hartmann, Vice President of the Federal Office of Public Health also welcomed participants to the meeting organized by the Swiss Medical Association and WHO. Whilst very happy to host the meeting, they were very sorry that the meeting planned to take place in Israel was not able to take place. There were of course security reasons which prompted them to take this decision. He expressed the hope that stability and peace would soon return to all the people of the Near East. He turned to the interesting issues for discussion in the next two days, health policy in the year 2000, the autonomy of physicians, tobacco control, sexually transmitted diseases, and the legal consequences of torture. As in many other European countries, the health status and conditions in Switzerland were relatively good. However, there is a paradox because demand for health benefits is increasing daily. There might be several reason for this: aging of the population, progress in medical technology, new treatments and increased expectations and demands from the population. There is also an increase in some diseases, such as asthma and certain allergies. In addition, there is an increase in cost levels which now take up somewhat more than 10% of GNP in Switzerland, one of the highest in Europe.

The other paradox is a clear cut discrepancy between the objective health parameters, for instance very low infant mortality, and increased life expectancy and the subjective feelings of the population. Only 20% of the population say that their health levels are not satisfactory or only moderate. He would submit that this is related to the social status and reflects developments which are, in many parts of the population, related to anxiety and fear of unemployment. In a survey conducted recently amongst the Swiss population, a number of very important health problems were policy; illicit drug consumption; abuse of alcohol and tobacco; AIDS and new or renewed communicable diseases; cancer; chronic diseases; accidents; suicides and violence.

Comparing national health problems with those of other European states, we see that we are short of an international comparison and therefore this is a good reason for closer cooperation in Europe. An exchange of facts and expertise so as to avoid duplication will assist in creating some synergy. Dr Hartmann concluded by addressing two topics which might be of interest to the participants whilst in Switzerland. The first was heroin prescription for heavily dependent drug addicts. The results of this therapy, conducted over the last three years, had shown some surprising results. The number of crimes decreased by about 60% and the results of illegal gains declined considerably. There had also been an increase of 15–30% in wellbeing. This programme of heroin prescription was approved last year by 71% within the framework of a referendum concerning the conclusion of the end of this heroin prescription programme. Switzerland was well aware that this programme was not assessed in the same positive fashion
by all countries. there had been total rejection in some and approval in others. Heroin is still a prohibited substance in his country and its use should be based on restrictive medical applications and use in research. This programme therefore will be applied again until the year 2000.

Then there is the 12th World AIDS Conference which would be held in Switzerland at the end of June. The Federal Office had been very active in organizing this Conference and they would be very happy to be able to come in touch with the worries and needs of AIDS for a couple of days. The Office particularly wished to focus on prevention, because of its concern about the overriding optimism which has been the result of new therapy. Of course, the most recent therapeutic results were welcome, but he urged caution because there were no results yet about long term therapy. In the meantime, prevention is the most effective weapon to control AIDS. Dr Hartmann concluded “Ladies and gentlemen, in our efforts for the wellbeing of our population we know that we can enlist your support and have competent cooperation, and I would like to express my heartfelt thanks for this assistance. I do hope you will enjoy these two stimulating days in Basel”.

Professor Rohr, speaking for Ms Veronica Schaller, Basel Minister for Public Health, welcoming participants to Basel, expressed some critical ideas concerning the development of the health system in Basel. 200 years ago, Gill Christian Listenberg, the Gottingen philosopher, said that “in German countries diseases are so cheap and treatments also expensive”. 200 years later the situation has remained unchanged. World wide, in highly industrialized countries we see the need for rationing or restriction of medical care. Ricardo Bonfranci said “He who can pay will also in future be able to remain healthy. He, however, who cannot afford to pay for care will have to die early”. Are we then to have a two level medical system? What can we do to resolve these problems? Ethical criteria and standards will first of all have to be defined. We are all involved in setting ethical standards. Turning now to physicians, he posed the question “How far can the physicians think on a cost-efficiency basis?” He did not want to talk about rationing but the focus on cost-efficiency requires the assessment of diagnostic systems, and quality control. Cost efficiency has now become an important criterion. In some countries low level investment can yield very results; however, in other countries a similar investment with very highly developed medicine does not yield such results.

Today we have standardized methods to assess qualitatively the quality of medicine. We need to enhance the quality of medical care and maybe this is the way to achieve this goal, to get better efficiency and better quality. This is an ongoing process. At the end of the day this can only happen if we have a proper patient-doctor relationship and if we have enhanced cooperation between the doctors and the entire health personnel. In spite of this pessimistic assessment, we have excellent medical care in Europe, but it is one of the most expensive. We do not want to have a two class medicine. The basic idea of solidarity is of course deeply anchored. We can still afford access to all medical treatment, even to sophisticated treatment, and nobody should be refused an expensive operation if he belongs to the marginal social groups. We need to deal with this problem actively; we need to face these ethical and solidarity issues.

Report of the WHO Regional Director for Europe – Dr J. Asvall

This is the fifteenth time that I have attended this meeting and every time it gives me more pleasure. I feel that we have come to a way of working together which is quite unique and now increasingly effective. I would like on behalf of the Regional Office staff in Copenhagen to
extend our warm thanks to our Israeli colleagues for all the fantastic preparatory work they did. In the end, for reasons totally beyond our control, we had to make a last minute effort to relocate the meeting. That being the case, however, we could not have found a better place than to be here in Switzerland. This is the most international of countries. This is the country which was first in the world in really turning altruistic thinking into very practical work through the creation of the Red Cross and all that followed from that. It is also a country which in today’s fractured Europe can be an example. It is now 700 years since the cantons of Switzerland came together for the first time in 1291 to form the Swiss Federation, in a Europe which was at that time not a place where this type of peaceful working together was the rule. With groups as different as you find inside this country, the Swiss have managed to make a society that is both purposeful, has clear humanitarian values and has proved itself to be an extremely efficient working democracy.

What has happened in the 51 countries and 870 million people of our Region? First, good news, the armed conflicts that we saw in Europe in the 90s are subsiding. We are still seeing some activities in Tajikistan, where there is still tension, but where armed hostilities have been substantially reduced and we may, with some luck, see an end to that civil war in the fairly near future. We have been active there, providing assistance, and more recently also dealing with malaria and typhoid problems.

The war in Chechnya also came to an end, although the situation inside Chechnya is still rather chaotic. We have therefore also reduced our humanitarian assistance in that area, basically concentrating on war victims.

In Croatia, Bosnia and the Federal Republic of Yugoslavia, the situation in the last 12 months has seen a lot of positive developments, and some negative. In Croatia we had a humanitarian assistance programme as part of UN efforts until last month when Croatia finally took over the total control of Eastern Slovenia and we are ending our humanitarian assistance programme there. In Bosnia we are still continuing and we have the chairmanship of the multisectoral Task Force that brings all the major organizations and the government together in health development. In the Federal Republic of Yugoslavia, together with UNICEF, we have tried to help the situation in Kosovo through immunization and other programmes, but unfortunately, as we all know, that area is again becoming a major problem.

If you look at the economic developments in general in our region, I can give you a few figures which show in dramatic terms what has really happened in Europe in the 90s. Consider poverty. The poverty level in developing countries is US $1 a day; in the Caribbean, US $2 a day; in the CCEE and NIS countries (415 million people) it is US $4 a day. If you look at developing countries, 32% of the population lived in poverty in 1994, the last year for which we have world wide figures. If we look at the 415 million in the 26 countries that used to be under communist rule, 32% of the population live in poverty. This of course hides huge differences. You cannot compare Chechnya and Tajikistan, just to give two examples. But the figures I have provided give you an understanding of what has happened during the 1990s. In reality we are probably going in opposite directions, because if you look at the development of GNP per capita from 1994, it rose by 4.5% in developing countries and it fell by 9.1% in the countries I just mentioned. So we have seen tremendous change in our region, and actually we have now 8 to 10 countries which are in the least-developed countries category, with a tremendous impact on health.

What has happened in some of the more easily understandable health indicators? You will see that in the big diphtheria epidemic and campaign in 1994, we had a real impact. We have now prevented close to half a million cases of diphtheria and probably 10–15 000 deaths from this
campaign. Polio is another important area. We have a huge programme which is coordinated with our Eastern Mediterranean Region in which we are vaccinating close to 70 million children every year. In 1996 we had around 186 cases in 8 countries in our region. Last year we had seven cases in two countries, one in Tajikistan and six in Turkey. We are coming very close to eradicating poliomyelitis now in the European Region, with the global goal to do so by the year 2000.

But there are other problems coming up. Big changes in cultural norms, in travel, in rising crime, increasing prostitution – in particular in the former Soviet Union countries – are giving huge problems, for example in STDs. We are in a phase of a huge epidemic of STDs in the former Soviet Union countries and the danger of that spreading westward, because of the flow particularly of infected prostitutes, is a very real one. This has also led to an increased danger of HIV transmission. We have already seen a sudden increase in HIV infections in many countries of the former Soviet Union. Until now this is mainly due to drug abuse, but with the STD epidemic that we are seeing there is an explosive danger of HIV transmission. If you already have a STD the danger of transmissibility is increasing manyfold. For this reason we created recently a new initiative, a task force that brings together all the major organizations involved in this field, UNICEF, Red Cross, UNFPA, WHO, etc. and we have created a consortium to try to pool all our efforts, to have a concerted campaign against STDs, as we did against diphtheria. But we all know that it is not going to be as easy as with diphtheria.

Another initiative last year was in the area of health promotion. There we did an interesting review in Hungary, requested by the Parliament, to look at the overall effectiveness of the national health promotion programme. A kind of audit on health promotion. We did it in Slovenia the year before, and this was presented and discussed in Parliament in December. This represents an interesting new role for us in which we are asked to come in as a kind of “external auditors” to look at what a country is doing in health.

Very important last year with regard to lifestyle and health was the Regional Committee’s approval of a new five-year action plan against tobacco, for a smoke-free Europe. You will hear more about that later, in particular the actions that were done by our Forum. The important creation in London of the Centre to support the Forum, was funded by the European Commission. It will be run by the BMA as a service to all of you. A related issue was the very successful organization in September of an action to try to get smoke-free airlines in Europe. Here 23 of you participated in the same week with national airlines in fighting for that, with an impact in several countries. In the environmental and health area, we have been following up very intensely the outcome of the big conference in Helsinki in 1994. A key part of the strategy adopted at that conference was a decision that every country should create a national environmental health action programme jointly with the Minister of Health, Minister of the Environment, and other ministries and partners that could have an impact on environmental health. To our great surprise I must say, we have had a large number of countries following this up. Usually these things go slowly, but already now, a bit more than two years from the start, we have had a big impact. The first plan came from the United Kingdom, but we now have some 40 countries where work is in progress. In London in 1999 we will hold the next big conference of Ministers of Health and Ministers of the Environment and we are going to be able to hold that conference with almost the whole of Europe having had a substantial new development in the environmental health field. This is a very interesting example of all the countries involved in substantial planning for improving their sector. We should try to do something similar with regard to lifestyle and health issues, where we could get stronger and purposeful development.
In the area of health care we published the final analysis that came out of the Ljubljana conference of Health Care Reform. It is now being widely used in Europe, very much as a teaching material in many schools of public health, and it is considered the basic book on health care reforms – what works; what does not work; what have been the different experiences in different countries. In order to follow up that analysis which we did for Ljubljana, we have created in the last few months a new structure, or a new project, which is called the observatory on health care system and reform. It is an initiative which will make permanent and continuous the analysis which we did for Ljubljana. So we will follow in detail the health care reforms in all our Member States and beyond and thereby provide analysis continuously, building up a database and providing analyses and products. The partners in this project are WHO, as Secretariat, the European Investment Bank, Norway, the London School of Economics and Political Science, and the London School of Hygiene and Tropical Medicine. We hope that it will take a lot of the myth out of current policy making in some countries. With regard to other areas of reform, we had a big conference in Lisbon March/April 1997 on the diabetes programme following up on the St Vincent movement. We now have national programmes in about 40 countries endorsed by governments. This is now a truly European-wide programme to show how this care should move in practical terms. In order to help support those developments, we developed last year a new communication tool called Qualicare data collection. We will have in EURO a series of databases fed by national and subnational ones. that can provide information on quality of care that can be useful to compare data amongst countries.

Finally we had in Stockholm, in cooperation with the Swedish Medical Association, a very important meeting on what we now call Depcare, which means quality of care in depression. For example, we have developed with European experts over the last few years, a very simple screening tool, to try to help with depression and suicide. As you all know, a large number of patients that commit suicide have contacted the health care system during their last few weeks – up to 50% in some American studies. We also know that the ability of physicians to identify depression requiring treatment is not very good, perhaps only 35–40% in primary care. The tool we have developed consists of five simple questions. You ask those five questions and from the score you identify immediately whether this person is at risk of depression. If that is the case you go on and use the second tool for definitive diagnosis. The introduction of the simple screening tool can improve the ability to correctly diagnose a severe depression from about 40 to 80–85%. If national medical associations could encourage all your physicians to do that, you could have a major public health impact on treatment of depression and prevention of suicide tomorrow without any additional expenditure.

With regard to formulating national policies on health we had a leadership seminar for public health officials in Baden, Austria in July 1997, and we have worked on the updating of the Health for All Policy to which I will come back later.

With regard to our collaborative networks we have a very important strategy to help European countries to move in the right direction. These networks are permanent long-term collaborations between the Regional Office and a set of partners in all or most of the Member States. We have several types of networks. The first you know well, represented by this Forum, and also the EuroPharm network. Importantly, in the last twelve months we have also got a similar network for the national nursing associations which had a first meeting in Greece. This is a very enthusiastic group, it has already taken a lot of initiatives of tobacco, quality of care, primary health nursing, and is very interested in establishing contact with the European Medical Forum. We have a second set of networks which are problem orientated, e.g. the CINDI network which deals with noncommunicable diseases, the communicable diseases networks, the diabetes networks, stroke, etc. The third one deals with the settings of levels in countries, regions, cities,
schools, hospitals, prisons. We have the geographical networks where we try to bring these various initiatives together in countries or regions. Let me just go through these and see where we are. I do not need to talk about EFMA or the EuroPharm Forum geographically. The new network of nursing associations is basically at the moment a western affair, although they have a strategy for involving the countries further east. The health promoting hospital network recently had an important conference in Athens, which really brought that network forward. We now have more than 4500 schools in Europe that are part of the network of Health Promoting Schools, and I think that there are around 36 countries that are now members.

We also have four geographical networks as I mentioned, one called CARNET for Central Asian republics and Azerbaijan, one called EASTNET for Russia, Ukraine, Belarus, etc. We have the MIDNET from the Baltic down to Romania, and last year we created SOUTHNET. These networks we bring together at least once a year and discuss major changes in health and health care reform issues.

Our main programmatic emphasis has been on the countries in central and eastern Europe and NIS, in the so called EUROHEALTH programme. Here we had a lot of activities last year. We are changing our Liaison Officers in the WHO Offices in the 26 countries where we have these established, and made them full time WHO employees, in order to be more strongly involved with the UN reforms. The first experimental country for a united UN country presence and programme development is Romania. In a major initiative last year to try to upgrade our public relations, we have taken a number of actions, including a special with World Television Networks, which is providing regular material to 1000 television stations around the world. Second, we have established a special collaborative agreement with BBC London with whom we are doing specific issues including two country products last year in Romania and Uzbekistan. The project involved experts from BBC working with national people, to consider how to better present health problems and get the media interested in health developments. Lastly, we are creating a network of counterparts in all our Member States to work directly with us on specific campaigns. We issued a new newsletter which is now our basic information to Ministers of Health, to all our collaborative partners, called the Health Catalyst.

Finally, there were important developments also at global level during the last few months. In January we had a very important Executive Board meeting in Geneva. Most importantly we are getting a new Director General. Dr Gro Harlem Brundtland from Norway will be elected at the World Health Assembly in May. She will have an immediate impact on four areas which have been major problems for the organization during the last nine years. She will immediately change the global image as she is well known as a strong and honest politician. She is a physician; she has a Master of Public Health degree; and she has been a public health physician in her own country. She is also known from her work as a Chairperson of the Global Commission on Environment and Health that brought us the concept of sustainable development. So she is a very well known international politician. Second, she comes with strong donor support. The USA and all European donor countries were all behind her and pushing hard, and we hope that they will remember that when WHO’s budgets are up for vote. Third, she will be a very pro-active person with regard to WHO’s role in the whole UN reform process, which will of course be an important element in the years to come. Fourth, she will definitely change the management style of the Director General, and it will be a very much more businesslike leadership of the Organization when she takes over at the end of July this year. The second important decision taken by the Executive Board was to endorse the new Global HFA policy which will go forward to the World Health Assembly in May. Finally, the Executive Board did something it has never dared to do. It took a sharp look at how WHO finances its operations. Until now there has been no system of logic in the way that WHO has distributed the
approximately 870 million US dollars which is its biennial budget. This meant that a country like Singapore with 600,000 inhabitants and its present level of development gets about 1.3 million US dollars support from WHO, whilst a country like Russia with 145 million inhabitants and an average lifespan for males of 58 years, gets 200,000 US dollars. Similarly, Tajikistan gets 135,000 US dollars while Indonesia gets 7.5 million US dollars. The EB, after long discussion, took a decision to advise the WHA to change all this and to introduce an objective mathematical formula that will distribute the money to country programmes on the basis of objectively measurable criteria for each country. And what we will be using looks likely to be the UN human development index, which basically takes into account health status, average life expectancy at birth, educational level (literacy rate) and socioeconomic development (GNP per capita). This mathematical formula is applied to the number of population and out of that you get an index which tells where the country is in relation to other countries, which will then be used for distributing the money. Every two years it will change when countries move up or down. If this is approved at the WHA, it will almost cut in half the total money that now goes to the Region of the Western Pacific and South East Asia. It will increase by 50% what goes to Africa, and substantially what goes to Europe. Actually, in the least interesting scenario, we will get another 1.5 million US dollars and move from about 50 to 66 million US dollars in a biennium. All the extra will go to our country operations in the more eastern part of the Region. If a second scenario is adopted, which would be more fair in our view, and in the view of the European Member States at the EB, our budget would move twice as much, about 30 million US dollars more. It will be extremely important that every European Member State is aware of what is going to happen and fights for that. We will be having a meeting with all the European Member States just before the WHA starts to discuss strategies on how to assure the changes through the WHA. But it would mean a tremendous improvement in the resources that WHO has to help the countries in Central and Eastern Europe and NIS if it goes through.

Dr Pedersen thanked Dr Asvall for an interesting and impressive report and invited comments from the floor.

The Croatian Medical Association found the most interesting part of the presentation the new allocation of money in WHO. Would the programmes from the countries play a role in getting the money?

Dr Asvall said that the redistribution of funds is primarily the funds going to WHO’s country operations. We have for instance now some 26 medium term programmes with CCEE/NIS countries. This is where the money would go. It would not go to the Regional Office in Copenhagen, it would not go to HQ. And those country programmes are an agreement between the Ministries of Health and the Regional Director, they are the two signatories, that the money goes to those cooperative programmes.

Dr Macara (BMA) congratulated Dr Asvall and his colleagues on succeeding in carrying out so many imaginative and extensive programmes despite the severe cuts which they have had to sustain in the level of their resources and therefore in the level of professional staffing in the last few years. He welcomed the prospect of more adequate funding which would recognize the need to develop more country programmes, especially in CCEE and NIS. His question was, what additional programmes, what additional topics or what extension of existing programmes would he like to introduce if and when he gets the additional resources?

Dr Asvall commented that it was dangerous to start dreaming. “Basically the money would go proportionately more to the most needy countries. The priority would be influenced by the condition in each individual country. In Tajikistan, the emphasis would be different than it would
be in Belarus. But we always try to have in our programmes a clear link in the intercountry programme to the European HFA policy and targets which is what all countries have together. I feel the most needed things would be health care reforms, entrenching and strengthening the PHC level, and getting a real quality of care programme going. The second thing is that I hope that on the lifestyle and health issues we can get a simultaneous move in as many countries as possible. I believe we have moved a lot with regard to the general concept, methods and motivation for improving lifestyles and health, but we have not got all or almost all countries to change. This is a European culture and what happens in one country influences what happens in another. There are many other individual things one could talk about, e.g. communication technology, how that can be improved. One could talk about new genetic services and many others things, but I would mention these two main ones.”

**Dr Piatkiewicz (Polish Medical Chamber)** asked whether with the increased financial possibilities of the European Region would it not be possible to increase the financial support for the European Forum?

**Dr Asvall** indicated that America had pleaded that the additional moneys should be devoted to national programmes and this income could therefore not be applied in this way.

**Report of Liaison Committee**

**Dr Pedersen**: Now we have to proceed to the report of the Liaison Committee, and Alan Rowe will present it.

**Dr Alan Rowe**: After that remarkable tour d’horizon of what is going on in the European Region, I have no doubt you will find the work of your Liaison Committee rather more plebeian, but nevertheless they have worked very hard this year, they have met four times in Tel Aviv, in Copenhagen, in Hamburg and then the very intensive meeting yesterday. The Committee would like to express its gratitude to the National Medical Associations who host these meetings of the Liaison Committee.

As usual, much of the time of the Committee has been devoted to the preparation of this 1998-Forum and in this instance the Committee most particularly wishes to express its deep gratitude and thanks to the Israeli Medical Association for their very great understanding and collaboration in dealing with the problems of siting during this year. As members of the Forum are aware, earlier this year, as a consequence of the tensions in Jerusalem itself, when the Israeli Medical Association was approached it very graciously agreed to change the venue within Israel, when we decided to hold the meeting in Tel Aviv. However, as you all know, the situation changed and we had to take the decision to which the RD and others have already referred.

The Swiss Medical Association with their, if I may say so, characteristic generosity, had some time ago indicated to the Liaison Committee that were we ever to be in some difficulty with the Forum, they would always be prepared to assist us. Their President and Dr Salzberg have worked remarkably in the last fortnight or so to get this meeting going and I think it is almost unbelievable that you are all here. We regret that we had to modify the dates slightly and that has naturally had some impact on the attendance.

We were very gratified when they heard that the attendance was such as it is. In taking this decision, we did have regard to the absolutely vital issues that we are going to consider this
morning. We are looking at health policies for the next ten or twenty years. These policies are being formulated at the moment and the earlier this Forum has an opportunity to discuss them the more influence it will have.

You in this Forum are aware of a very substantial wave of infectious disease that is going on in various parts of Europe at the present time. This has affected our speaker from the European Commission, Dr Hunter, who is not able to be with us today. His place is going to be taken very kindly at short notice by Mr Merkel, who will give his presentation.

Turning to the outcome of the Forum in Copenhagen the statement on anti-personnel landmines was sent both to the Council of Europe and to the International Committee of the Red Cross and other relevant organizations. The Forum will be well aware that in the last 12 months a worldwide ban on anti-personnel landmines has been the result of enormous pressure. I am sure the Forum itself felt that its expressions of views on this matter did play a part in assisting that process. The statement on tobacco was very well received. In relation to the draft general practice charter which you considered some two years ago, we are able to report that I attended a meeting to consider the redrafting of the document following the consultation to which you in the Forum and the Liaison Committee had contributed. Many of you will remember there were certain fairly strongly expressed reservations on the manner this document was presented and in particular its implications for the interface between the secondary care specialists and the primary care physicians. I am pleased to tell you that a substantial modification of this document is taking place.

The Committee was very pleased to hear that the final English version of the quality of care report had been translated and distributed and I understand that you medical associations have taken some very positive action on that which Dr Vigen will be reporting to you later in the meeting. The Liaison Committee looks forward very much to your increasing engagement in encouraging members to engage in quality initiatives.

Turning to membership, the Committee has considered correspondence relating to an application by the Federation of Polish Physicians Abroad to the Forum for membership and having examined their statutes they do not recommend to you that that association be invited to become a member of the Forum. We have also received an application from the Uzbekistan Medical Association, and I must tell the Forum that we did have a major reservation which we explored with our Uzbek colleagues, namely that it is a mixed association of physicians and pharmacists. The Committee taken the view that reflecting the guiding principles upon which this Forum is based, national medical associations would in fact be medical associations of physicians led by physicians, taking decisions only on matters affecting physicians. The Uzbek medical association, when we made these representations, made it very clear that they also shared our reserves. We recognized that much of this derived from the previous legal regime in the former USSR. The Uzbeks gave us an undertaking that they were in fact actively changing their statues to move towards being a single profession organization. In these conditions, having received this response from our Uzbeki colleagues, we would strongly recommend that the Forum admits the Uzbek medical association to full memberships of the Forum. The Liaison Committee agreed that as the World Medical Association is an observer in this Forum, it was appropriate we should seek the equivalent, i.e. collaborative status, with the World Medical Association. I am happy to inform the Forum that the Council recommended this to the General Assembly in Hamburg and that this recommendation was adopted.

Now turning to today’s consideration of the WHO HFA-strategy document, we have kept you fully informed of the developments in relation to this. The Committee is most grateful to those
national medical associations who responded by sending in their views and these were taken into account in drawing up the letter of response to WHO, which was circulated to you all. The Committee would stress that in addition to the covering letter, which you have all seen, a detailed analysis of all the comments submitted was sent to WHO together with the original comment that you sent to us. So your original comments went to WHO, an analysis went and an overview from your Liaison Committee, which you have read, also went. In the light of the RC decision taken in the autumn which also was circulated to you, the Committee felt that national medical associations should be asked to express their views of priorities which should be given to any of the targets included in the document. And you remember there were about 28 in the original document and it also requested that when the new document, which the RD also has referred to, was finally prepared, the Liaison Committee and national medical associations should have an opportunity of seeing this in order that they may express their views to their own governments before the RC in September which would take the final decision on the document.

I am delighted to tell you that having seen the analysis of the comments made to this HFA-process it is very clear that your comments have been given very careful consideration and that a number of the comments you have made have also been made by other organizations. So I think the Forum should feel very strongly that it has played its role thus far in contributing to this discussion and I have no doubt that the RD will make this point. But I think it is a point the Committee particularly wish you to be aware of. The Committee has devoted some time to considering its future meetings in Kazakhstan and in Warsaw in this coming year. During the year the Committee also received information about other newly formed and emerging medical associations in some Member States and further enquiries with these organizations are continuing. The Forum, as you know, is represented at the RC and this year, or last year rather when it met in Istanbul, our current Chairman for this session, Dr Torben Petersen attended the meeting and presented a formal statement which was available to all delegations. A great deal of time this year has been devoted to the funding of the Forum. We will be making a formal recommendation concerning the participation contributions when we come to the funding debate. But I would, in ending this report, like to stress the importance of reading in detail the funding document which was sent to you all.

Finally, Chairman, I would like to express my particular gratitude to the member of the Liaison Committee, who have had an extremely difficult year this year and who have been very supportive of me.

**Future health policies in Europe – 2000 onwards**

**Chair Dr A.W. Macara:** The Chairman introducing this section emphasized the vital importance of this topic for all physicians. The Forum was privileged to have three distinguished representatives of the major European bodies, the Council of Europe, the European Commission and, of course, the Regional Director of WHO. The presentations would be opened by Mr H.C. Kruger who was the Deputy Secretary General of the Council of Europe who he invited to take the floor

**Mr H.C. Kruger:** It is a great honour and a pleasure that I am able to address you today at this Forum which is timely and of significance for the future of health in Europe.

The WHO, the European Union (EU) and the Council of Europe (CE) are the three European organizations which have health on their agenda. The WHO as its sole objective, the EU as an
element in political and social integration and the CE as a dimension of human rights and social justice. The membership of all three has increased or is in the process of increasing following the political changes in central and eastern Europe since 1989. WHO’s membership has gone up to 50 and the CE’s to 40. Five European states are now in the process of negotiating membership in the EU, bringing Union membership up to 20 in the coming years. The Parliamentary Assembly of the CE is examining the requests for membership by Armenia, Azerbaijan, Bosnia and Herzegovina and Georgia.

European Union competence in health matters has been steadily expanding as it becomes increasingly obvious that no political integration can be satisfactorily achieved without an appropriate health policy. These are significant changes which will inevitably affect the international organizations concerned and influence the social and health orientations of our European countries. They are changes that can have a beneficial effect if channelled through dialogue and coordination in the right direction. They can be seriously damaging if they are left to run uncontrolled without a common guided orientation. In particular, conflicting messages on important health issues must be avoided. Moreover, measures need to be taken to maintain European cohesion and avoid creating two sets of European countries, the rich developed countries on the one hand and the poorer countries on the other. I feel that this Forum provides the opportunity to start a dialogue between the three organizations which I hope will be pursued and strengthened in the future.

I am particularly glad about the opportunity I have today to explain how the CE is approaching the issue of relationships between the social and health field. The role of social factors in the health status of our European population is of course not a recent discovery. The WHO has been a pioneer in addressing this issue; the CE’s European Social Charter dating back to 1961 includes health protection, health education and preventive measures amongst the social rights of European citizens; and more recently the Maastricht Treaty and subsequently the Amsterdam Treaty, made health protection requirements a constituent part of the European Union’s other policies. Health is part and parcel of the social fabric of our societies.

The last few decades have been marked by dramatic events in Europe: increasing unemployment, new technologies and in Central and Eastern Europe political and social changes. Most countries in Central and Eastern Europe have seen their life expectancy decline during the 80s and 90s. For example in Russia, there has been a 5.2 year decline between 1989 and 1993.

Western countries have a higher life expectancy; however morbidity is however increasing for poorer and lower status people as are mortality and morbidity differences between socioeconomic groups within each country. In the UK for example the gaps between professional and manual classes has increased. A 1997 community report in public health in Europe indicates that people with higher income and educational levels have longer life expectancy and lower mortality rates. In Germany the blue collar workers have a life expectancy some 2 years lower than that of white collar workers. According to a 1996 Commission report the homeless, numerous in France, Germany and the United Kingdom, suffer from more stress and chronic illness than the rest of the population. In general, economically inactive men have three times the risk of premature death observed for employed men.

Similarly, in 1997 a CE report on the health aspects of single parent families has shown that a single mother with a dependent child is often associated with a greater morbidity and demonstrates more frequent use of medical services, as compared with mothers living as part of a couple.
A major enquiry which we have carried out within the framework of the CE’s project on human dignity and social exclusion has revealed that poorer people – and poorer countries – also have poorer health. Yet the major causes of death, (heart diseases, respiratory diseases, infectious diseases, accidents, homicides, suicides) in the Community countries are similar to those in these causes in the Western European countries in Central and Eastern Europe. Behavioural factors, such as smoking, alcohol, diet and exercise are obviously determinants in health but do not explain the inequalities. On the other hand health promotional activities and preventive campaigns do not manage to reach the poorer category. In a health education project, which the CE ran together with the WHO and the EU in the 80s, parents of school children in middle class areas were far more easily contacted and involved in the project than parents in underprivileged areas.

Poverty and lifestyles are closely related: unemployment can lead to homelessness, which can bring about tuberculosis, alcoholism, drug dependence, and low self-esteem. In Central and Eastern European countries, it is likely that psychosocial stress leading to ill health is linked to the stress of transition to a market economy. Thus, although behavioural factors affect all categories of a population, it is more likely that the poorer people develop unhealthy lifestyles and neglect medical care.

Unemployed or homeless people fail to get preventive and diagnostic treatment and end up in emergency services. Particularly, in systems where patients pay and are later reimbursed, poor parents tend to call a doctor for their children but not for themselves.

Moreover, budgetary restrictions in most countries are leading to limited health services. In Central and Eastern Europe where reforms are under way, they can be problems of universal coverage as well as of proper funding. The poorer groups suffer accordingly.

The basic principles at issue are equity and the defence of the more vulnerable groups of society – not so much in law as in fact. The CE has several major instruments establishing these principles.

We have already referred to the European Social Charter, and reference can equally be made to the Convention on Human Rights and Biomedicine, which in its article 3 requires contracting parties to provide “equitable access to health care of appropriate quality”. At the national level, in general, the right to health care is either enshrined in a constitution or established by legal resolutions. However, the enquiry carried out on social exclusion has shown that a legal framework is not sufficient to ensure access to health care. It is quite indicative that three countries, which had shown health deterioration, namely Latvia, Lithuania and Estonia, all had access to health care laid down in their constitution and laws granting equal rights to health care.

In fact, although legal instruments at both national and international level are useful and even necessary, they risk being emptied of their purpose unless policies are developed for their practical implementation. This was the main concern of the 5th Conference of European health ministers in Warsaw in November 1996. The final text of that conference had this to say:- “To face up these challenges it is necessary to focus on the most appropriate method for ensuring good conditions for health and for proper health care for everyone, how to counter unreasonable differences in socioeconomic position is a result of one’s health status on the one hand and how to counter discriminatory access to health care on the basis of socioeconomic positions on the other”.
“A new social deal on health and society is needed, with a commitment not only by the health sector but of all other sectors involved, with the empowerment of individuals to look after their health and the participation of all the protagonists in order to achieve equitable distributions of scarce resources, thereby eliminating exclusion”. 

The ministers called for action at the individual, institutional and governmental level – to promote democratic participation; to achieve solidarity by balancing the right to health care and financial constraints; and to re-evaluate the importance of the health policy in the present economic environment.

That conference has been followed by a series of activities relating to vulnerable groups, people in detention, single parent families, the elderly in homes and chronically ill people, aimed at making practical proposals for the organization of health services in such a way as to ensure equitable good quality health care. Always in relation to the problem of equity, we are currently studying ways and means of reaching all sectors of the population in health promotion and preventive treatment and establishing criteria for an equitable use of waiting lists. These activities are not intended to lay down principles, long established and long known, but to devise procedures, methodologies and policies for their practical implementation.

And this brings me to a major activity which is at the very heart of the CE’s vocation, the respect for human dignity. The project on Human Dignity and Social Exclusion which I mentioned earlier finds its origin in a Colloquy on Poverty and Marginalization held in 1991, which identified an increasing problem of poverty and social exclusion. The CE, an organization committed to the promotion of democracy and human rights, felt it should take a lead in promoting new policies. This led to a pan-European research project, to diagnose trends in poverty and social exclusion, identify the relationship between social exclusion and social rights, propose concrete principles and standards of action. The project is intended as a tripartite partnership between the state, the social partners and civil society.

Following a Europe-wide enquiry a research report has now been prepared and will be presented at a conference in Helsinki next May, namely on the 18th to 20th. This report covers five areas: health care, labour market, social protection, education and housing, and it clearly shows the intricate and inextricable relationship between all five areas.

If I have lingered on this project it is for two reasons, firstly, because of the importance it attaches to health care in the overall context of social exclusion and the impact which social conditions can have on health and vice versa. Employment, education, housing and social protection are as important for health as the health care system itself. In this respect, it is worth mentioning that the Warsaw Ministerial Conference stressed “health has become an indispensable prerequisite of individual and social wellbeing”, and calls for “greater control over policy development in all the mains/domains ? which may influence health determinants, lifestyle, economics, social education, transport, labour, housing, etc.”

Secondly, because this project is having already and will continue to have in the future, considerable influence in shaping our future work in the social and health field. In this context I wish to refer to the second Summit of Heads of State and Government which recognized that “social cohesion is one of the foremost needs of the wider Europe and should be pursued as an essential compliment to the promotion of human rights and dignity”. The Summit also called for a new strategy for social cohesion “to respond to the challenges in society”, and for the necessary structural changes “including the setting up of a specialised unit for monitoring, comparing and handling issues linked to social cohesion”. These reforms are now under
discussion and will inevitably redirect our activities both in the social and health fields towards social cohesion in its widest sense.

A new body will be established to prepare a strategy for the development of social cohesion activities, coordinate, guide and stimulate cooperation, and follow the implementation of CE conventions, in particular the revised European Social Charter. An interesting feature of this body will be the participation of representatives of other Council of Europe bodies, dealing with migration, health, population, children, rehabilitation, drugs, the Parliamentary Assembly, the Congress of Local and Regional Authorities, representatives of the Social Partners and NGO. This participation will underline the fact that social cohesion runs through all fields of human activity. It will also stress that social cohesion is everybody’s business and must involve a wide spectrum of individuals, institutions and authorities.

We have already seen how a number of activities in the area of health moving in this direction. This trend will continue with a study in 1999 on the adaptation of health care services towards meeting the demand for health care of marginalized groups and with a Conference of European Health Ministers in 1999 on health problems of our aging populations in Europe. Elderly people are amongst the more vulnerable, physically and economically, and are often discriminated against as an unproductive category of society.

 Needless to say, we would like our traditional partners – the EC and the WHO – to participate as fully as possible in this new work. The WHO is preparing a health policy for the 21st century, which is based on an integrated approach where social cohesion plays an important role.

The European Union, under the Amsterdam treaty, now has an obligation to ensure a high level of human health protection in implementing all community policies and activities. The Treaty requires the community to direct its activities towards “improving public health, preventing human illness and diseases and obviating sources of danger to human health”. It is an interesting and strategic: all three organizations are at the start of a new venture:

   WHO with the Health Policy for the 21st Century
   The European Union with new duties under the Amsterdam Treaty and
   The Council of Europe with the follow-up to the second European Summit and the Human Dignity and Social Exclusion project

May I suggest that with such a convergence of events and new ventures, it would be appropriate for the three organizations to meet and discuss their strategies for the future. All three organizations have already since 1990 been jointly running the Health Promoting Schools project, which is intended to inculcate in young people a sense of responsibility in their lifestyles and thus combat addictions. It is a project which straddles three areas, health, social and education. It is a practical example of the multi-dimensional aspect of social cohesion. I believe that on the basis of what we have jointly achieved in this area, we could go further in developing together policies and strategies for social cohesion. After all, social cohesion seems to be a common concern, but is will remain a vain term if we fail to develop practical policies to achieve it.

Dr Macara: Now Dr Rowe has prepared for us a paper which sets out the history of the development of health policy in the European Union. I would like to invite him briefly to introduce the paper
**Dr Rowe:** I wrote this document of which you all have a copy, primarily for the benefit of our colleagues from the NIS because, whilst those in the West ought to know something about the evolution of the EC, those in the Central and Eastern European countries and the NIS may not have such a clear view. When you talk about the EU, you are talking about an aggregation of political treaties, starting with the Treaty of Rome, modified and adapted by the Treaty of Maastricht, modified and adapted by the Treaty of Amsterdam, if, this is ratified. Health interests started with the Coal and Steel Treaty in relation to the wellbeing of workers. But it was not in fact until the EURATOM Treaty a couple of years later that a quite specific reference was made to health and to the development of a part of the European Commission dealing with health and safety. Our next speaker, in fact, comes from that Directorate, now of Public Health and Safety at Work. The next point is that within the treaties up to the time of Maastricht, which is relatively recently, mention of health was very limited. Indeed, the only quite specific one related to the mutual recognition of qualifications. The treaty of Rome indicated that it was the aim of the treaty to achieve mutual recognition of qualifications. In the case of the medical and related health professions, there had to be unanimity between all the Member States in agreeing this directive. Apart from that, there was a passing reference to health and safety. All the major actions within the Community were done by special resolutions of the ministers of health and the governments, agreeing that an issue was of such importance that it was in the interests of the development of the Community that action should be taken. These key areas, and in which the ministers took this view, were cancer, AIDS and drugs. These are issues which are constantly on our table in this Forum.

I know that the next speaker will be referring to the new state of affairs which occurred with the development of the Treaty of Maastricht and latterly of Amsterdam, which put health on the agenda as Mr Kruger said just now, in a formal way and now in a very much more evolved way. This development has implications for everybody, not only for the present members of the European Union, but also the accession countries.

The full text of Dr Rowe’s paper “Health and the European Union” can be found as Annex 1 to this report.

**Dr Macara:** we are now looking forward to hearing from Dr Bernard Merkel, who will bring to our discussions the valuable perspective of a political scientist. He works in the public health directorate of the European Commission and is responsible in particular for the work of the analysis and development of policy. Before coming to the Commission, he served for 16 years in the health department of the US and had a particular interest in AIDS and child health. He is also a visiting fellow in the London School of Economics and he has an honorary teaching position in the London School of Hygiene.

**Dr Bernard Merkel:** let me first say how very pleased I am to be here. I have heard from a number of people that you are in a sense all surprised to find yourself in Basel thinking until fairly recently that actually you were going to be meeting in Israel. Let me assure you that no one is more surprised than me to find myself in Basel, because it was only in fact two days ago that I received an urgent telephone message that my Director, Dr Hunter, who had unfortunately been struck down with some mysterious virus, invited me to undertake two engagements for him that he unfortunately could not do himself. The first one was actually to meet a delegation from a European research institute which shall be nameless. The delegation consisted of a number of professors of something called clean surface engineering science of which I knew little, and still know almost nothing at all. The reason why they wanted to meet Dr Hunter was to give a presentation of their work on the development of new prosthesis, artificial hips and the latest technology on false teeth. Now I do not want to denigrate this, I for one think that false teeth are
particularly important, but I have to say that listening to a presentation of 1.5 hours about the latest technology on false teeth was not particularly my idea of an interesting tie. I was much more interested to be invited to come here today to this rather more important Forum to discuss general issues of health policy.

I want to speak today essentially about the work of the EC in public health and also to present a few reflections on the future of health policy and the community. Let me begin with a key point. I think it has already been made, certainly in Dr Rowe’s excellent paper, but the point is this: what the EC is doing, has been doing, and could do, in future in the field of health is not at all an arbitrary matter. We cannot do what we like, and I am sure that a number of the delegations here are very pleased to hear me saying that. In fact, what the Community does in health and in public health is governed by what is set down in the Treaty, the current treaty being the Treaty on European Union of 1993, the Maastricht Treaty. This specified a number of very broad tasks and objectives for the community, including promoting a high level of employment and social protection, raising living standards and the quality of life; and promoting economic and social cohesion and solidarity. These are the key points already referred to by Mr Kruger.

In addition, there is a specific objective on health. Community policy according to the Treaty shall contribute to the achievement of the high level of health protection. It is therefore clear that within the overall framework of the responsibilities in the Treaty, the Community has an important obligation to pursue policies related to health and to ensure that the health of Community citizens is fully protected. This is applicable right across the wide range of the EC’s policies which have or could have an impact on health.

To pursue these policies the Treaty puts forward a range of instruments at the disposal of the Community. These include legislative measures right through to so called incentive measures such as action programmes. Now I am making this point really in order to emphasize one thing: that the basis of the Community’s activities in the field of health are focussed in legislation. Therefore in developing policy we must respect the powers and obligations that are set out in the Treaty and in particular we have to accept the limits of what is in the Treaty.

Now I want briefly to describe the current framework of community responsibilities in public health, and the main areas of work that we are currently involved in. The Treaty of Maastricht included a new article 129 on public health, which set out the scope for community action. This made it plain that community action on public health should focus on activities related to prevention, particularly prevention of the major health scourges. That is to say the major diseases affecting the population and also drug abuse, which was specifically identified in the Treaty. The organization of health care systems and the delivery and financing of health services remain the responsibility of the individual states of the EU. Just after the Treaty came into force, at the end of 1993 the Commission presented a communication on the framework for action in the field of public health. This made proposals for implementing the new public health provisions. In particular it identified a set of eight priority areas in which five year action programmes would be launched. Five of these programmes are now under way. These are programmes on AIDS and communicable diseases, on cancer, on health promotion, on the prevention of drug dependence and most recently on the programme on health monitoring, i.e. information and surveillance. In addition, last year the Commission put forward proposals for the remaining three programmes which are on diseases related to pollution, rare diseases and injury prevention. These proposals are now currently being discussed by the European Parliament and by the Council of Ministers, and we hope that the three proposed new programmes will be agreed in the near future, hopefully within a few months.
As well as these action programmes initiatives have been taken in other areas. I give just two examples. Firstly, the Commission put forward a proposal for a European Community network for the surveillance and control of CD, in which it is highly desirable that there is effective international cooperation in responding to them. The Commission’s proposal is designed to give real benefits to citizens by creating networks to monitor major CDs. It also includes provisions for common response strategies. The second example I shall not say much about, because I know it will be discussed later in this conference, namely we have undertaken a number of activities related to tobacco and smoking, including work on labelling and on the tar and nicotine content of tobacco products, also the recent important agreement on limiting tobacco advertizing.

As I have indicated, all these activities are being undertaken on the legal basis of the 1993 Treaty, which offers, it has to be admitted, a very restricted legal basis. However, the agreement reached at Amsterdam last year on a new Treaty for the EU, included a number of changes to widen the scope of provisions of public health. When this treaty is ratified, perhaps I should say if and when this treaty is ratified, the new provisions should enable the Community to do more in the area of public health. The new public health article, Article 152 of the Treaty, will bring about a number of important changes. First it fosters an integrated view of health related community policy. The treaty is very clear on this point as it says that a high level of human health protection shall be ensured in the definition and in the implementation of all community policies and activities. What does this mean? This is essentially about the need to assess the impact of all community legislation and all community actions which have an impact on health, and the community will have to develop an effective methodology to implement this.

The new article also broadens the Community’s areas of activity in the field of public health. At the moment, as I have mentioned, the Community’s action must focus on prevention of diseases, particularly the prevention of major diseases. But under the new Treaty they can be directed also towards improving public health and obviating sources of danger to public health. This provides the possibility of putting greater stress on actions to promote health and secure health gain, and also on actions with regard to identification and assessment of risks and to the management of risks to health. The new Treaty also mentions a number of new areas for community activities; in particular the Community can take measures “setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives”. Finally, the new Treaty reaffirms the existing commitment to foster cooperation with countries outside the European Union and with the relevant international organizations, notably of course, the WHO and the Council of Europe.

Now these new provisions will enable the European Community to extend its range of public health activities, but they are of course still limited and to underline the limitations the last part of the new article makes the following declaration: “Community action in the field of public health shall fully respect the responsibilities of the member states for the organization and delivery of health services and medical care”. A very important declaration. I think personally it is important that the member states felt that they needed to say it indicated perhaps a worry that if they did not say it the Community might well move ahead into these other areas. I should reassure them that was never our intention. In the light of this new legal basis the Commission is currently considering how to develop public health policy beyond the year 2000. Besides reflecting the Treaty changes the policy needs to respond to the developments in the health status of the Community population. Let me just briefly go through a few points that we want to take up. In many respects of course the overall health status in the European Community is better than ever. Life expectancy is rising and infant mortality is falling. But there are a number of worrying trends. Current levels of premature mortality before the age of 65 are too high. More than 600 000 people in the Community die every year in the age group between 35 and 64, and they die
particularly of lifestyle related diseases and from accidents. In addition there are a number of new risks to health, e.g. from new diseases such as the new variant CJD, Hong Kong or Asian flu, Ebola, and the spread of food-borne infections, as well as from the resurgence of old infectious diseases, perhaps most notable tuberculosis. I would also mention the growing problem of resistance to antibiotics.

There are also very wide variations and inequalities in health status both between the member states and among the different population groups within the member states. These inequalities include not only differences as we have heard in morbidity and mortality, but also in the determinants of health, including a key health inequality relating to socioeconomic position. People in lower socioeconomic classes simply have higher mortality and morbidity rates. Some UK data for example shows that a baby born today to parents in one of the highest social classes can expect to live 5 years longer than a baby in the lower socioeconomic class. Such inequalities are of great concern in the EU which as I mentioned earlier is dedicated to raising living standards and equality of life and also to promoting economic and social cohesion and solidarity.

A different kind of issue is the rise in cost of the provision of health services. Over the last three decades health care spending in the community has roughly doubled and as a proportion of the GDP it ranges now from 5% to 10% in a number of countries. This is clearly a major burden for member states’ budgets. I shall not go into the factors behind this, they have already been mentioned, but I should say that without in any way wanting to infringe on the responsibilities of member states for how they finance and deliver health care, the Community can and must play an important role in supporting them in developing and maximizing the effectiveness of their health systems. A further key area particularly important in this Forum is the potential impact of the enlargements of the EC. States in Central and Eastern Europe which want to join the Community have generally speaking significantly lower health status and of course fewer resources available for health care. Therefore the potential implications of the accession process and of the joining the Community, both for them and indeed for the existing member states, have to be carefully considered and addressed.

Commissioner Flynn recently announced in the European Parliament that he hoped to be able to present a paper in some detail shortly setting out our ideas on future public health policy. Now this paper, called a Communication in the jargon, requires some more internal discussions and it has not yet been finally agreed by the Commission. Therefore I cannot reveal its contents, but I can give you some broad indications of the main lines of our thinking on what our future policy might be. In the first place Community public health policy must meet the main criteria which actually apply right across the board of all Community actions. That is to say, that whatever we do a Community level must focus on areas where we can do better collectively than the individual countries can do separately. In our case of course, this means areas where we can do better to achieve the goal of improving the level of health protection. On the basis of this, our view is that Community action on public health should be grouped into three broad strands of work.

The first of these is health information. The Community should have a system for sharing information between member states and also the capacity for undertaking analysis and assessment. This information should cover health status, health determinants and also health systems. The analysis for example could be directed towards identification of patterns of mortality and morbidity and trends in health determinants, or assessments could be made for example on needs for health services, on evidence of the effectiveness and cost effectiveness of health interventions, as well as international comparisons for example of cost containing measures. I should stress that whatever is done should take fully into account the existing work
that is going on in Europe. It was interesting to note this morning that Mr Kruger referred to a Commission document on the state of health in Europe and that document I should say was prepared largely on the basis of work undertaken by WHO. I think this is a very good example of how it is useful to combine activities in these areas.

A second strand of action that we want to develop is a capacity for reacting rapidly to emerging risks to health. This means in effect monitoring and also investigating phenomena which are causing concern. The subject matter for this would include communicable disease surveillance and control; veterinary matters such as BSE; rare diseases; environmental risks, safety and risks from medicinal products and from chemical substances such as poisoning and allergies.

And a third strand of action would be on diseases prevention and health promotion with a focus on devising strategies, new methods and large scale projects involving all member states. And in this strand we would build on the work that’s already been undertaken in areas such as cancer, drugs and AIDS. It could also equally bring in other areas, other issues where we haven’t done very much work, such as on mental health, on problems of aging, on cardiovascular diseases, on nutrition, etc. Within such a framework the Treaty obligation to look at the impact on health of other Community policies could be met rather better than we meet it now, I think. For example, policies on large scale programmes with a long term impact on health and health systems, such as the research programme, transport policy, environment policy and the food policy, could all be assessed using the new information base that we have to develop. Similarly, legal instruments on specific aspects of food safety, for example, could fall within the new rapid response strand of action. The timetable for developing a new policy framework is actually rather short. We need to have a new strategy in place by about the year 2000. Several of the existing public health programmes will have come to an end by then. However, we can’t present any concerted proposals until the new Treaty has been ratified. So that the communication we will be publishing shortly is therefore not a firm statement of policy, instead it simply presents some ideas which are really intended to stimulate debate about the way forward, about what we should be doing. And I must stress that I would look forward to having the input and the views of the organizations here on the ideas that we have put out in this document.

So in conclusion, let me just say that public health is now higher than ever on the agenda of the European Community. People are becoming more and more concerned about a whole range of health issues and their expectations about health systems are constantly rising. At the same time, governments are being faced with many similar problems in the organization and financing of health systems, and health services are increasingly seeing the benefit in working together to find the best solutions to their problems. Against this background the European Community can make an important and growing contribution to improving the health of all our citizens and that must be the goal of all our efforts.

Dr Macara: Thank you very much Dr Merkel. Already we see many common elements. The most striking to me was to place alongside each other the points made by the first two speakers. Mr Kruger discussed the Warsaw conference of health ministers just over a year ago, and spoke of the new deal on health and society which had to involve all sectors, and then Dr Merkel talked about the Amsterdam Treaty of 1997 which “fosters an integrated view of health, health related policies involving all human activities”. So there is our agenda – we are concerned with the significance of health in all human activities. Later today you’ll wish to discuss ways in which we can actually achieve this, what epidemiological tools are available; what are the political pressure points where we can exert influence on governments.
Now we come to the last speaker in this session, Dr Asvall, European Regional Director at WHO. Dr Asvall has been an architect of many activities in the region, and not just confined to the World Health Organization. Dr Asvall, we look forward to hearing you tell us about the redrafting or the updating of European health policies for the next millennium.

**Dr Asvall**: We are talking about health role policy development and first let me just say I thank you all very warmly for the replies you have given to the draft Health for All policy document. I’ll try to take out some of those things I thought are more important in this policy. We have taken care working closely with our colleagues in Geneva so that the draft of the new global policy update and the regional draft are not identical, but they cover the same strategy and are based on the same values and principles. Naturally, ours is specifically oriented to the conditions here. You remember also that we have in this region, first in 1984, a policy with 38 targets. It was updated in 1991, and we are now updating it again. So in this Region from 1984 onward health role was a thing which was not a one off, but a continued periodic updating taking into account what we all learned. By this continued process of learning we shared the experience obtained in all the countries. The policy is inspirational, that is it is not a blueprint that every country should take and say that’s what we do. It should be recreated within the specifics of each country.

What have we learned during this time from 1984 until now? We know that communicable diseases are improved somewhat in the West, but going up in the East. Accidents are down in the West, up in the East. Social ills are up all over the Region, in terms of social tension, drug abuse and inner-city problems. Politically, of course, the collapse of the Communist system was a huge happening with many, many implications. The expansion of the European Union membership means that now we are getting to a situation where there is more and more commonality of the territory covered between the WHO European Region, European Union and the Council of Europe, which gives a very interesting new opportunity for cooperation. In the past cooperation has been good but not good and planned enough, and I would much agree with Mr Kruger that the time is right now to sit down with the EU and the Council of Europe and see how we could make more concerted actions in the years ahead. Very importantly we have seen in many countries a weakening of the state authority during the first ten to fifteen years. Increased pluralism has meant that whilst the strategy for the future may not be so different from the past, the approaches need to be adapted to that new political reality which we have in Europe. All of the NIS and half of the CCEE countries are still in a terrible situation of poverty and unemployment, social disintegration and there have been ten countries at war during the 1990s. In the other half of the CCEE there was a down turn, but now increased development. Western Europe has also not been doing as well as we wanted. The economies there have been sluggish, whilst unemployment is continuously rising. And urban tension has been an increasing problem. So actually I’m not so sure where we will really be going in western Europe in years ahead. I think I can’t see a major change. I think we will continue to see a continuous, rather sluggish growth. It will be very important, as was said by Mr Merkel that we use resources effectively if we are going to address the social cohesion problems that Mr Kruger underlined. What has happened with regard to our strategies during the last fifteen years. I think that we have seen a major change.

Health promotion has developed as a real force, and a concerted effort of policies and programmes. In terms of improved lifestyles, we have seen a deterioration in the more eastern part of the Region, and the further east you go the worse the situation becomes. There have been important developments in the health care area. If you go back to 1984 there were a lot of dogmas around. The communist one was the most easily recognizable. From 1990 that fell and then we realized that there were also some other dogmas. There were very staunchly defended
different systems in Europe: the centrally funded systems in Scandinavia, the British National Health Service, the pluralistic systems in Central Europe, all fervently defended almost ideologically. Now we have a new situation, which is much more open. People look much more realistically and objectively at what is happening, what is good, what functions, what doesn’t. We already had reduction as a major issue from the second half of the 80s, which intensified in the 90s. We also had an awakening of the importance of quality of care which was not there in the 80s. The Health for All policy has generally been recognized and accepted within European countries and more than thirty have made specific national policies accordingly. I am quite convinced that quality of life is going to be a much more important element than it has been. But I can’t see that change not having an impact on how we’re going to run our societies in this part of the world. The question of social alienation, which is the issue of social exclusion is going to be a very, very important debate.

In stark health terms as we all know we are not doing well as a Region, comprising the 51 countries and 870 million people from Greenland to the Mediterranean to the Pacific shores of Russia. This slide shows the average life expectancy at birth – relatively good in the Nordic countries and the EU – countries, less good in CCEE countries and relatively poor in NIS countries. You may think these are statistical artefacts. However, that is not correct. Certainly the “Gorbetjov” alcohol campaign had a very real positive impact on health status in that country. But it didn’t last for all kinds of reasons, but it is not an artefact, it’s reality. Also you see again what has happened since 1990, a fantastic negative impact as also already mentioned, I think by Mr Kruger. This means that we now have tremendous inequity in Europe. Trying to reduce inequity between countries east and west is a key challenge, but also seeing the whole possibility of policy making on that European wide level. We need to move towards a more common goal and a sharing of experience in a more planned and systematic way.

The second issue has already been mentioned both by Dr Merkel and by Mr Kruger. I just give you a recent figure from one of the most advanced countries in the Region which underlines what was already said. The inequities in health between social groups is staggering. Up to eight years between social class is the difference in average life span, whether you are born in this house in that street or two streets down. This is an incredible injustice when we come to think about it. Eight life years of difference just because of social class. In Europe at the end of the twentieth century, I can’t see us continuing not to realize this and not to put it much higher up on national policy agendas. Why isn’t it there? Because it’s such an uncomfortable question to ask. Because you cannot solve that problem only by improving the health care for the poor, e.g. unemployed ethnic groups, migrants. You also have to address more clearly the fundamental economic and social policies that do create those social inequities in the first place. And that is going to be a bitter fight because it means giving up something and giving more to society rather than the individual. These have not been the policies that have been dominant during the last few years. But I can’t see us continuing in this direction. If we do, it’s going to be a loss to society, including economically. So that is one of the big challenges where health and other sectors really come together and where policies can only be sensible if they’re seen in a wider perspective. Now how can we keep people more healthy throughout their life span has been dealt extensively in the new HFA policy update. We are looking at a number of things in a little bit different light. You’re saying that perhaps in the past one has seen a number of the initiatives to promote healthy lifestyles and to deal with individuals through the healthcare system in a too fragmented way. The more you look at social research the more you understand that there are a variety of relevant practical approaches which we have adopted in the HFA revision.

- Taking a “life course” approach
- Improving socioeconomic determinants
• Making healthy choices easier options
• Promoting a more healthy environment
• Utilizing the “new genetics” and understanding better the biological basis for health
• Employing health impact analysis within multisectoral policy formulation and implementation
• Promoting people focussed primary health care teamwork and management
• Focus on comprehensive disease management programmes both at population and individual levels, including all the elements of health promotion, disease prevention, therapy and rehabilitation
• Focus more sharply on the health benefits of programmes and interventions.

I would like to focus particularly on the major challenge of improving quality of care in daily practice, for example diabetes, depression, stroke etc. We need the help of the health professions, including of course and particularly, the medical profession, to take up this cause in a determined, systematic way.

If HFA is to be achieved we need to create broad societal movements involving many actors, not just at central Governmental level. The creation of partnerships, the building of networks, the focus on settings e.g. cities, schools, prisons etc. are important elements of this approach.

Targets for improvement remain a vital feature of the HFA revision, 21 targets for the 21st century.

Discussion

Dr Minga, Albania: I would like to inform you about the very difficult situation in Kosovo where more than 2 million Albanians live. We cannot speak about good health and a good health service in conditions where the national human rights do not exist. Instead of protecting and strengthening the people’s health, the Serbian government in Kosovo is killing the Albanians. We must try to retain national and human rights but we will be stronger if we feel you near us.

We know that reforms in health system of Albania are our duty and we must do them, especially primary health care. It is very difficult but we have now the main lines of primary health care policy. The realization of this policy is more difficult especially in the rural areas. Also we don’t forget the secondary health care, the hospital/medical service where there are many problems, such as absence of medicaments, laboratories poorly established, inadequate emergency and therapeutic sectors. Our economy is not able to support these properly for the moment. Last year began a heavy crisis, an economical disaster after a long difficult period of transition. During this crisis the medical services continued their work,

In conclusion I can say: firstly, we are living in a very hot region in Europe, which has seen the most terrible events and crimes after the Second World War in Bosnia and Herzegovina and in Kosovo. We have so much need for your help to condemn the genocide and military violence, respect the national and human rights and voluntary of the people of Kosovo.

The first target of Health for All 2000 now is one of main problems because the differences between developed Europe and developing Europe are now bigger than before 1989. We need
the help of Europe, and Europe and WHO is helping us. How to construct a good system of health legislation with duties for all the structures of the Albanian state. How to organize the best reformed health system. How to evaluate and to promote the health and health system. How to have a good honest and functionally efficient primary health care and hospital service. We are optimists for the future because we have so many friends, we have all of you. Thank you very much.

Dr Macara: Thank you very much for a very powerful message. One recalls that in the preamble to the original HFA declaration of Alma-Ata, as it then was, it was recognized that the essential pre-criterion for health was peace, and you have reminded us very strongly about the need for peace if we are to develop health policies and health care. Thank you very much.

Dr Brunner: I would like to give you some presentation or information concerning our political system in Switzerland. I think it is for the European situation a very special system in the sense that you have two political levels of responsibilities, the federation and cantonal levels. So the Medical Association has always to deal with these two levels. This kind of dichotomy, if you want, is also represented in the Swiss Medical Association, within our Organization.

We have a social insurance system, containing many social insurance companies which are in a market situation. These have a common board. This board represents also internal struggles between these social companies. The situation is very difficult for us as a professional organization to deal with.

Then there are two important freelancers within the system, one is responsible for checking and also controlling the prices of the services which are given by the medical doctors and also by the hospitals and the other key players in the system. He makes recommendations which are very strong and which are in most times or very frequently adopted. He is a kind of ombudsman if you want. Then we have the consumer organizations. These are other single persons without legitimation by a political process or a political body; nevertheless they have a very – and increasingly – powerful situation in the system.

Now, what is our situation in front of the state authorities? One instrument is boards on the canton level, and at Swiss federation level. These boards always contain representatives of the Swiss Medical Association. They have consultative functions which are very effective in the political sense. In these boards the medical doctors are heard by the state authorities. We are asked questions, we can present our policies and we can also give some advice. That’s a very important instrument.

Postgraduate education has a special situation in Switzerland, as a strong component of the Swiss Medical Association, managed independently by the Swiss Medical Association. Here changes are coming, because of the bilateral treaties we will have with the European Union. The state authorities will have much more influence in the future than they have now.

What will happen in the near future? I think the balance is going to regulation, because there are strong arguments for this from the political processes as we can see them in Switzerland. There will, I think, be a national social insurance system. Managed care will have some importance but only on the micro level, not as a market system. People very vehemently now feel a loss of social security. Unemployment is a problem, now we have about 5%. This creates much insecurity. We need a re-engineering of the system, otherwise it will be impossible to manage a modern health system. Until now there are no visible signs that this re-engineering of the system will be possible.
There are elements also for deregulation. In addition, the people of Switzerland are not conscious of the choices and the facilities of a market system, because there is a system of solidarity which is very deeply entrenched here in Switzerland.

What are the pillars, if you want, of our professional policy. The first two points concern the media. We have built up a strong contact through the media to stress the importance of the professional autonomy. They are also pushing ahead with the rationing debate, where we have here to get strong positions in the discussion for this upcoming rationing debate. Managed care now in Switzerland is completely in the hands of these social insurance funds. Managed care will exist, we must ensure that, whilst managed by physicians and not the social insurance companies. The Swiss Medical Association is a strong key player, as I showed you, in the medical education. It will be in the future in the quality of care discussion. Here the hospital directors, state authorities, nurses and so on, have already positions which are very strong and we are critically a little bit late. There we have to build up a strong position. I personally think that this is for the future a most important point to have a strong position in information relating to medicine. This must be under the management control of the professional organization. And that’s the reason why we own an electronic network, which is coming up and which has now a very important position.

Dr Fras, Slovenia: The title of my speech today is “The national medical associations and future health policy in Europe: present circumstances and objectives of action for medical doctors in the Central European countries area”. I would like to stress that the contents of my speech today are based on the operating strategy of the Medical Chamber of Slovenia, which was adopted in May 1997. After more than five years of operation in politically changed system, the medical associations in different central European countries are in the position to detect the problems of the physicians they represent more accurately, and also to recognize the possibility of their influencing the performance of the medical profession.

In the Medical Chamber of Slovenia, we are fully convinced that documents like we have adopted in 1997 represent obligatory guidelines for operations of the national medical associations, while for its members it could be the basis for checking and evaluation of the work of the elected representatives. My talk is divided into two parts. In the first part, I will tell you something about the present situation, economic, characteristic and capacity of the health care system in countries of central Europe, then something on primary health care and private practice in these countries, as well as hospital service and outpatient specialist services. In the second part of my talk, I will give some proposals for activities for the national medical associations in the form of objectives and guidelines.

I can present you with the data of the WHO Regional Office for Europe, from 1994, where you can see clearly that the share of the GNP in the countries of central Europe as the share of the total health care expenditure is comparable, and low relative to Western Europe. There are huge differences from the western Europe in the ratio between public expenditure for compulsory health insurance and the share of funds collected with additional methods. In Slovenia public expenditure for services based on compulsory health service amounts to 88%, and for voluntary insurance 12% of the total public health care expenditure. We all know very well that in the EU the ratio is approximately 75%:25%.

I now turn to primary health care and private practice. Unfortunately in many countries of the central European area the new health care legislation’s did not define the status of physicians properly. Medical doctors are still not defined as responsible for health activities, which means
that they are legally still recognized fully as public employees. In most countries of the central Europe the issue of the legal status of doctors was indirectly solved with the legalization of private medical practice. In such systems only doctors in private practice are the true bearers of their own private practice and professional autonomy. However, on average only relatively small number of physicians have taken advantage of private medical practice. The decision to perform independent medical practice in countries of the central Europe area is still associated with too great a risk. The first difficulty and the risk related to it is the provision of proper and suitable premises. The granting of concessions is another problem. In many cases there is always a possibility that the concession will not be granted to a doctor who fulfils all conditions and accepts all the obligations of his previous jobs, and whose transition into private practice would in no way impede the public health care service. In such cases many times doctors receive no explanation.

The general agreement on the performance of medical services covered from compulsory health insurance is still not defined well enough. Another great problem of general practitioners is that the limit for the number of insured persons per doctor is too loosely defined. The limited financial capabilities of doctors in countries of the central European area is another important risk factor. If health care services are financed from public funds in the existing way and with the bank credit conditions currently in force, e.g. in Slovenia where there is a maximum repayment period of 5 years and annual interest rates 10–11%, it is practically impossible for doctors to repay the loans for equipment and premises.

In many countries of the Central European area, it is still the case that too few health care services are performed at the primary level. There is also an insufficient network of outpatient specialist services and there are too few standards for procedures and services that doctors in primary health care would need to perform before they refer their patients to a higher level. Specialization and continued postgraduate education of doctors in primary health care is also an important issue. For example, according to the health care legislation in Slovenia, all the primary health care physicians should be specialist GPs after the year 2000. The providers of health care services do not have sufficient funds available to enable specialization or additional specialization as required under the new terms.

In the field of hospital services and outpatient specialist services, the status of physicians in hospitals has remained mainly unchanged in the years of the transition period. As public employees they are caught in the old system of organizational hospital health care which is extremely rigid and financially non-transparent. There are too few, or in many cases no, realistic guidelines for quality improvement of the hospital systems. The contrast between regional secondary activities, and central teaching and university hospitals, is becoming even greater. Doctors who have left clinical institutions and started private practice have very limited possibilities for further creative cooperation with the former as they are in the majority of cases not allowed to perform the same activities they did before.

The integration of Europe in the future decades will provide the greater opportunities for physician migrations, outflow of doctors from the countries of Central Europe to the present EU countries and vice versa. The loss of the most capable specialist practitioners from our hospitals could have fatal consequences for the quality of services, especially since the budget for the education promotion of potential successors to the top professions has been reduced. I have to mention also that waiting periods are too long in several fields and may already pose a threat to the health of patients, e.g. in some special fields such as heart surgery and so on. The structure of employees in hospitals is inappropriate. In Slovenia only about 10% of employees in hospitals
represent physicians. Another problem is the cooperation of hospitals and family doctors, which is insufficient, poorly organized and doesn’t create the conditions for so-called rational medicine.

Now I will proceed with the second part, with some proposals for the activities of the national medical associations. These proposals are also divided into the different fields of health care. We propose in the field of primary health care that the NMAs should represent the interests of all doctors in primary health care, try to change the legal status of doctors and define them as the main and responsible bearers of health care and thus enable a flexible system of salaries. The NMAs should try to reduce the possibility of over-commitment of physicians, that means they have to negotiate to reduce the maximum number of insured persons they provide medical services for, and stimulate the introduction of mechanisms which will reduce the number of unnecessary visits to doctors in primary health care. Then, the national medical association should work in the field to provide high quality graduate and post-graduate specialist education for general or family medicine and continued monitoring of professional achievements in cooperation with the professional societies and medical faculties. It is very important to arrange the appropriate financing of specialization and additional training in general and family medicine.

It is also very important for NMAs to try to prepare safe conditions for doctors who decide to go into private practice, to ensure the possibility of using the existing premises, to ensure unified concession contracts with provisions which ensure safe transition into private practice, to ensure conditions for more correct cooperation between health centres and private practitioners, and to assure to the doctors the possibilities of obtaining long term financial credits with favourable annual interest rates. It is very important to initiate and participate in the preparation of the standards for procedures and services prior to referring patients to higher levels, and to propose an appropriate redistribution of funds for this purpose, to actively participate in the preparation of the proposal for a balanced development of primary health care and to ensure equal participation of all doctors in programmes of prevention.

In the field of professional medical issues, the objectives are:

- to participate in setting the norms and conditions for quality assurance of medical services to monitor the level of professional qualifications of doctors
- monitoring reports on professional problems, difficulties and possible errors of doctors, and reacting to them appropriately, and informing the public on the viewpoints, procedures and reactions of the national medical associations.

It is important to prepare changes to the regulations on the issuing, extension and revoking of medical licences, and regulations on professional supervision through consulting.

In the field of education, the objectives are:

- to harmonize the contents and duration of specializations to the EU directives and its advisory professional bodies
- to determine the proper rules for recognition of specialists and licensing of specialized knowledge to non-specialists
- to determine the criteria for the quality assurance of educational and training programmes, training institutions and trainers
- to set up regulations for recognition of specializations and other postgraduate knowledge obtained abroad.
In the field of social affairs and in economic fields, the objectives are:

- to enforce the regulations for proper evaluation of the doctors’ work, as a part of the fee for medical services provided
- to form the physicians social security funds at the national medical associations
- within the framework of such foundations, the reservation of funds to give loans to the members of NMAs should be proposed.

I would like to conclude that in the countries of the central European area, countries which are still changing their faces in transition periods, national medical associations will always represent the people and culture that is devoted to strive to find synergy and balance between east and west and also between south and north.

**Dr Macara:** You will wish to discuss the proposal which our Slovenian friends have prepared. Dr Rowe will read it for the benefit of the translators. I suggest that as he does so you will bear in mind that it gives us an opportunity to discuss the whole question of the balance of the respective effort that should be given to curative and preventive activities.

**Dr Rowe:** Aware of the importance of the proposed strategies regarding health promotion and preventive medicine actions proposed in the draft WHO strategy for HFA for the 21st century:

- recognizing that such actions require financial resources for their implementation, conscious of the existing problems in financing curative medicine in all countries;
- knowing that the positive results of health promotion and preventive medicine actions may only reduce the needs for curative medicine after a certain period of time;
- considers, *first* it to be in the best interests of patients that initiatives in health promotion and preventive medicine should not be financed by moving resources from curative to preventive medicine until the reduction in demand for curative services justifies it; and
- *second* it is essential that the funding of immunization programmes should be a priority for all health care provision programmes.

**Dr Macara:** Thank you very much. The debate is open.

**Dr Brunner:** As you see we have a very open discussion here between state authorities and the professional organization. My point is, what is the development of the political situation in these countries, and this will go into the direction of regulation. We as professionals should have the management of the data in our hands, because professional autonomy depends on this management of the data This does not mean that we don’t want to have a partnership with the social insurance companies. But now the situation concerning management is completely in the hands of the social insurance companies and that is a situation which is completely unacceptable for the medical profession.

**Dr Bonnell,** France: The French delegation also wishes to endorse the Slovenian motion wholeheartedly. I would like to revert to the last three interventions which were very relevant in their presentations. I believe they were relevant because they did reflect the situation of Albania, Switzerland and Slovenia in relation to their sociocultural situation.
I would like to revert to Dr Minga’s point, because we have to, as a Forum, support the Albanians in Kosovo. They simply defend their right to live in peace in accordance with their traditions.

My second point concerns Switzerland. Our Swiss friends are quite right in saying that they are entitled to have information relevant to the epidemiological or medical insurance system, to assist ongoing medical research. Another question is how the health systems in Europe are developing. Now I am referring to the British system, which is still considered as a rationed or national system. There have been very positive developments of the British system. Last week, also, I was in the Netherlands, well known for a so-called socialized system, going back to a more market orientated system. The system in France, is perhaps overly liberal as regards overspending, but they do apply solidarity principles.

Both aspects must be taken into account in any good system. Any system has of course also to take into account the social, economic and cultural systems and aspects of the country concerned.

**Mr Bop, Council of Europe:** Within five minutes I will tell you what the Council of Europe is doing in the field of blood transfusion and organ transplantation. I am one of the surprise speakers of today. So, I looked a little bit through an earlier presentation on blood, and if after the five minutes people want to know a little bit about what we are doing in transplantation, I am happy to do so. The Council of Europe was founded in 1949 and comprises today 40 member states.

When we discuss blood and blood products we have to distinguish between two things: the first are the so-called plasma derived products, which are products which are now under EU pharmaceutical legislation, as well whole blood and cellular components. Now historically both components have been dealt with in Council of Europe guidelines.

With regard to the selection of donors the general principles of the Council of Europe are based on voluntary donation. Also, the goal is to achieve self-sufficiency in these products and to protect the donor and the recipient. How do we try to achieve these objectives? We try this by studying the ethical, legal and organizational aspects of blood transfusion, with a view to ensuring quality and increasing availability of blood, while avoiding wastage of human substances by ensuring optimal use and to analyse the possible ethical and organizational impact of new scientific developments. Which are the legal tools of the Council of Europe? The Council has a number of legal tools some of which are binding, some less binding. Now the binding ones are European conventions and agreements. The most known one in the area of blood and blood products is European Agreement no. 26, which took effect from 1951 on the exchange of therapeutic substances of blood origin. Two others have in the meantime been overtaken by similar directives from the EU. A more recent one which touches upon a little bit but more particularly on organ transplantation is the Convention 164 on Human Rights.

Now what are our working efforts. Basically, the ultimate decision body at the Council of Europe is the Committee of Ministers, the 40 Member States. They have to decide on a unanimous basis. Now with regard to blood transplantations the ones who are in charge are the European Public Health Committee. Within the blood sector it is the committee on blood transfusion and immunohaematology, and this again has a subgroup which is the most important one, the committee on quality assurance in blood transfusion services. We also have a task force on restructuring the blood transfusion services. On request of national governments, we do look into the national blood transfusion services and give advice where it is considered necessary. We
also do work a lot on recommendations and appeal to governments to take account of what we are proposing. And with regard to the recommendations I think I do in particular emphasize only basically one – the 9515 recommendation has a technical appendix on the preparation and quality of blood components.

Regarding organ transplantation, we do work on the organizational and ethical aspects. Within the legal department there is also a working group working on the subject of organ transplantation.

**Dr Macara:** Thank you, Mr Bop. Now we can come back to continue discussion of the Slovenian resolution.

**Dr Salzburg:** I wish to make some comments about the special situation in Switzerland concerning the data base which is just now not in the hands of the medical profession. Managed care itself is changing and I feel that the message which we can hear from this presentation is that our profession is really threatened by that. Data management is a very important step. It might be that this point could be a draft motion later on.

**Dr Cepulic, Croatia:** We have discussed about the proposal of the Slovenian Medical Association and find that it is very interesting. We support it and we think that in our countries which are now in transition it is very important to keep the security of medicine. It doesn’t affect the change to more preventive medicine but this should not affect the curative

**Dr Orlic, Croatia:** I am president of the Croatian Medical Association. I can show you that in Croatia we made this health policy HFA by the year 2005. The aim of our Croatian policy is collaboration with other sectors, with the World Health Organization Liaison Officer in the Republic of Croatia, with the Minister of Health and also with the Croatian Medical Association. We aim to provide guaranteed basic health care for all citizens in Croatia, regardless of their age, sex, religion or ethnicity, in accordance with the principles and health policies of the WHO.

Dr Virbalis, Lithuania: If we adopt the statement as it is now, proposed by the Slovenian Medical Chamber, it will mean to a certain extent that we are against rationalization of health care systems. HFA strategy declares prevention and health promotion to be among the priorities. In my view we need additional work on the text. For instance, we try in Lithuania to have a health fund from tobacco taxes and alcohol and so on. But in my view there should be a little bit more clarification on that idea.

**Dr Fras:** We are not against health care promotion or health promotion and preventive measures, but we are against a direct flow or shifting the sources which are available for curative medicine.

**Dr Macara:** It may be that as a result of the debate you would wish Dr Fras to suggest an amendment which would remove any ambiguity.

**Dr Andreev, Russia** (interpretation): In Russia we have acquired some experience when resources were moved from curative to preventive medicine. There was a project from an academician who said that the health services have no money to treat everyone, so let’s abandon the present generation and remove all our resources to the new generation so we will create a healthy generation, a healthy young generation. Despite the distinguished academician, this idea did not go ahead of course. I can say that we have very few resources in our country for health, and therefore we believe that it is still necessary to concentrate first on curative medicine.
Another point is that preventive medicine first and foremost will be of concern to the people themselves. But we don’t think that funds should come from curative medicine. First of all we have to convince the people of the usefulness of preventive medicine. And often people don’t understand scientific or health messages. We need to find new ways of getting messages across if we are to carry out campaigns not taking the funds from curative medicine as has been suggested very bluntly here. We realize that we’re going through a transitional period, but the transitional period is becoming lengthy and in countries such as ours we think that just moving funds or resources from curative to preventive health will not be sufficient, and this will not in fact lead to improvement of health status of the people, necessarily. As a resident of the former Soviet Union, of course, I realize that preventive medicine is very important and the preventive message is very important, but the messages can only come across when the people are well educated and when you have special resources to carry that out.

**Dr Blahos, Czech Republic:** Well, the Czech experience is such that for several years now the curative medicine has been supported and in fact several preventive measures have been suppressed to such a level that there was a movement against the distribution between curative and preventive measures. If somebody reads this document he could have the impression that this concerns only individual patients and not the population as a whole.

**Dr Asvall:** World Health Organization: It has been a very interesting debate. If I understand right, the main concerns that came from our Slovene colleagues was that in the situation as it now appears in the countries of Central and Eastern Europe, and the NIS countries, there are too little resources for curative services. If you take a look at the situation as it is now, it is quite clear that in many European Member States there are too little resources going to the health sector. There are many countries that are quite low down with regard to the percentage of GNP that goes to the health sector. I think this applies to almost all of the CCEE/NIS countries. And that is a big problem, because it means that the total resources that we have to improve the health of the populations are lower than they should be. Clearly, if you look around Europe, you should at least be up to something like 7% or something like that for a reasonable health system today. That is far from the situation as it is in any of the CCEE/NIS countries now. Too little importance has been given by politicians of financing for improved health of the populations. That is, in my view, the problem.

Health promotion/disease prevention has of course many aspects. It’s important for health promotion/disease prevention to have better roads, safe cars, people using seat belts. It is important to control driving under the influence of alcohol. To have safer houses and factories – to have leaner pigs etc. These are clearly not things that should be paid by the health sector budget, but I don’t think that we should give the impression that the health sector is not a place for health promotion and disease prevention. I do believe that there were many health promotion/disease prevention activities which were ours and which were important and which were perhaps even more important than the curative services. As a clinical oncologist, if there was a choice within a given budget, whether we should have one more accelerator in the country or whether we should have a decent programme to screen cervical cancer, or screening for mammography, or a programme to help children from not starting smoking or helping our patients to stop smoking. I would have felt those would have been a good investment for money and a right distribution of money for health. We are not responsible for patients only, we are responsible for the health of people and patients are those unfortunate ones who have happened to get to the point where they shouldn’t have been in the first place because we didn’t do the first part of the job well. And health promotion and disease prevention is something for physicians, it is an important task for us.
I would propose that we look a bit at the operating paragraph of the resolution and try to see if we could find some formulations that perhaps balance a bit better these views, and be sure that they are not misunderstood, and that perhaps also deal with the fundamental problem which you want to solve in the first place, which is the question of the amount of resources which go to the health sector in the countries of central and eastern Europe and NIS.

Dr Macara: I said that there is a great deal of sympathy and support for what our colleagues who have spoken, not only Dr Fras from Slovenia, but others who have spoken. Particularly I sense there’s a lot of you feel that it could with advantage be reworded in order to make it unambiguous about what we want.

What I propose is that, perhaps Dr Fras, Dr Asvall, Dr Rowe and myself, find a wording which will express what we all want to say. Are you happy about that? I will put that to the meeting tomorrow afternoon.

Dr Lemye (interpretation): Mr Chairman I have the impression that we didn’t really have a good debate on HFA for the 21st century. I would like to say first of all that I don’t necessarily appreciate very much this procedure. It seems to me that WHO is committing some errors. We are trying to lay down long term objectives which may be unrealistic without the actual means proposed to reach those objectives. This would appear to be a doctrine rather than any genuine scientific thinking. We feel a kind of proselytizing for a particular system, I am very much in favour of people making their own choices. In Belgium we defend a liberal form of medicine – not completely a liberal system because there is some social forms of financing of it – but this calls for efforts on all sides to reach agreements on an annual basis, and this brings in various parties and seeking consensus.

Dr Macara: I am surprised that you should suggest that we have not had extensive consultation. We had devoted a lot of time to this very issue in the Forum last year, and you were actively involved in the debate.

Dr Asvall: I think that we should just repeat the process of consultation that we have had. We had first a consultation with a group which is the kind of executive board of the Regional Committee. First we had a consultation last year with them plus some researchers. On that basis we drafted a version that you saw, for preliminary discussions in the Regional Committee. Then we sent it to individual governments in writing. It was also sent to around 50 organizations in Europe, and EFMA is of course a very important one of those. All the replies have been analysed, sorted, reflected on and conclusions taken. We meet with the standing committee, our executive board of the region, in April. They will have the total amount of comments that have been made, together with the conclusion we have taken. They will then tell us whether or not they feel we made a reasonable choice of those many opinions and we will then redraft the final version which will then go to the Regional Committee again.

Dr Macara: I am going to attempt in between 5 and 10 minutes to give a summation of what we have heard.

The first obvious point is both implicit and explicit, namely that we have been discussing health and discussing policies for health and not just for health care. We recognize that the health care system can only be relevant and effective if it is placed within the right context overall policy for health. It was a British prime minister, as it happened of Jewish descent, Disraeli, who said over a 100 years ago, that “the health of the people, (people being composed of individuals), the health of the people is the basis upon which all our prosperity and powers of state depend” and
that remains every bit as true today as it was 100 years ago. And we have indeed, as Alan Rowe has observed, seen striking similarities in the presentations this morning by the very distinguished representatives of the three European organizations concerned in their different ways with health. Striking similarities in the perception of the issues which matter and in the direction of policy which is appropriate to address these issues.

I think it would be true to say that whilst we observe, and the discussions today have shown this, that there are many types of system throughout Europe, but that these several principles are the same. It was once said by Cecil B. de Mille, the film producer, “these are my principles, if you don’t like them, I’ve got some others”. But we in fact have clear principles which we have continually and continuously repeated, principles of equity, principles of intersectoral collaboration, principles of priorities for promotion, prevention, for primary care, for working with our patients, consumer participation, international collaboration and so on – but top of our agenda is equity. And that has come out today. It was Mr Kruger this morning who said, and I quote “Health is part and parcel of the social fabric of our societies”, and that I think is a splendid motto to sum up what has been said today.

Now what are some of the concerns that we have expressed. First of all, there is grave concern about what were described as unreasonable differentials within society, both in resources of different people, maybe different ethnic groups – one thinks of Kosovo, for example – and differentials in access to services, which arise in part because of the inadequate resources of the people who need the services most. So there is double inequity built into many of our current health care systems. And there is concern about unreasonable differentials because we will never make people equal. What we can try to do is to compensate for inequalities through equity.

There is a recognition of the imperative of an integrated approach, between all sectors of human activity, statutory organizations, voluntary organizations, commerce, industry, sport, every sector of human activity, that recognizes that we have to have respect to the dignity of all and that we have to eliminate discrimination on any grounds – on the ground of age, sex, race, religion, whatever. We have to identify preventable risks and preventable hazards in society, hazards to health of any kind. We have to put a priority into information and into what we might call health impact assessment, so we can both try to predict the impact on health in every sense of all government policies. Indeed, new policies should not be implemented until we are satisfied that the balance in terms of health as against risk is very clearly in favour of health.

It has been recognized that there is a need for a balance between what is done at the centre and what is done at the periphery, whether the centre be the European Region and the periphery individual countries, or whether the centre be government, the federal government of a country and the periphery at the Lande or the canton or the region or whatever. But there has to be a balance in terms of responsibility of society as mediated by the international organization or by the national government, the responsibility of society as a whole on the one hand and the responsibility of those acting responsible at the local level on the other.

Then we saw the need to recognize that there should be no conflict between the interests of individuals in relation to health and a policy for health in the community as a whole. I was reminded in a splendid programme which I saw on television here only the other evening, of the remarkable work by Mother Teresa, who always said what individual doctors have always said “It is the individual that matters. If we care properly for every unique individual, then we will get things right.” and of course our policy is to recognize that societies are made up of individuals, so the approach between what is best for the individual, what is best for society, is a complementary one not in conflict.
Then we recognized that health policies must encompass both a recognition of the importance of the environment and a recognition of responsibility of individuals in their lifestyles. If I could just expand that a little, by the environment I hope we mean not only the physical environment, but the economic, the social, the financial – and no less important, is the political, environment in terms of political will – and that is a matter for everyone but particularly collectively for groups of people and for governments. I’ll come later to the role of medical associations. Dealing with the environment on the one hand and trying to make sure that we have a health-giving, health-fostering environment, rather than one which is inimical to health. So that is one consideration, environment. But that has to be balanced against the importance of lifestyle. And we know what we mean by lifestyle, both for individuals, for families, for groups. We only have to think about a topic like drug dependence, for example, or smoking, which we discuss tomorrow, to see how totally intertwined are the concerns of the environment in all aspects and that of lifestyles. We cannot consider one factor in isolation from the other.

Then we saw the need to identify specific areas which are priorities for action, for example the major causes of mortality, the major causes of morbidity, but most importantly to prevent the preventable, which is why we are particularly concerned about communicable disease and particularly within communicable disease, about the recrudescence of diseases which we thought we had virtually eliminated, like tuberculosis. But it also means we’re concerned about diseases which particularly affect the young, which affect those who have their whole lives to live unless they’re destroyed by drug dependence and smoking and so on.

Then we recognized the imperatives of making the best use of resources, because we know that we will never have all the resources we would like. We were reminded again by Dr Asvall, about the opportunities opened up by understanding of our genetic inheritance. There is the imperative of quality. There is the imperative of a partnership in the health enterprise between the professionals on the one hand and the public, whether they are patients or not. And there is the need for a balance between curative and preventive services.

Finally, I want to address the role of medical associations, because that is our particular responsibility here. I suggest three specific or particular roles, and functions. The first is to regulate our profession, to ensure that we are fit for the task in which we are engaged. Second, it is our function to represent doctors, and if we are wise we do that best by showing that we understand the needs and the aspirations and the concerns of our patients. Third it is – not so much our responsibility, as our privilege, to be given the opportunity, to contribute to the formulation of policy, and the way in which that policy is delivered, within the health care systems which we serve. There are a number of obvious opportunities for the discharge of that responsibility such as communicating effectively with the media, explaining our understanding, our insights, our contribution, networking with other health organizations, not only medical but nursing, pharmacy, professions allied to medicine, social work, and extending beyond the health family, education, environment, experts in environmental control, environmental engineering, road transport – you know, every aspect of human activity.

And acknowledging that without the right political will we don’t get resources, we don’t get commitment by governments, we have the opportunity for dialogue with government. We have a responsibility to ensure that we use every means we have to influence our politicians. Now I hope that that will be regarded as an accurate and a constructive and helpful summary of the discussions we have had today. Thank you very much.
Physician autonomy

The Chairman, Dr Piatkiewitz (Poland) opening the session said “The problem was discussed by the Liaison Committee in Copenhagen in 1996, where it was decided to propose that the Forum create a group on physician autonomy to consider the matter in detail. The working group met in October 1997 in Berlin and consisted of representatives of medical associations from UK, the Netherlands, Germany, Croatia, Lithuania, Latvia and Poland.

The general problem was really a very broad one. Physicians’ autonomy has to be based on some principles, including the present level of scientific medical knowledge; the availability and accessibility of resources, and the ethical rules. Questions resulting from these principles which need to be answered include: have the physicians a general right to be granted the privileges of autonomy? What are the limits of autonomy? What are the threats to autonomy?”

Dr Piatkiewicz then invited Dr Blachar to give his presentation.

Dr Blachar (Israel) “Physician autonomy in the NIS and central eastern European countries is often severely and directly limited. Even in western countries, physicians’ autonomy is being limited in indirect ways that are even more dangerous to the individual doctor and the profession of medicine as a whole because they are less obvious. I’d like to speak today about the ways in which we in Israel are concerned about limited physician autonomy and what is being done to counter this trend.

In our minds the phrase “physician autonomy” means that every physician has the right to exercise his or her best clinical judgement in order to treat his or her patient without outside limitations. We live in a world where physicians must take into consideration a myriad of factors, some of which are clinical, others are legal or economic. Modern medicine recognises that the physician cannot base treatment on clinical evaluation alone. There are questions of culture, resources and patients’ wishes. Yet the main question remains: does the doctor have the right and duty to evaluate these factors and then come to a decision, or is his decision shaped and dictated by outside forces and sources which lack the degree of commitment which physicians possess with regard to their patients and the Hippocratic oath.

This form of indirect interference in physicians’ decisions and autonomy is extremely hard to detect and very hard to oppose because on the surface these outside forces such as government or sick funds or HMOs appear to want what is best for the patient. They couch the guidelines in talk of better health and lower costs which seems very appealing to the public. Furthermore it is easy to oppose the physicians’ right to autonomy by saying that physicians want it only to preserve their power. This is of course not the case – rather without physician autonomy, the profession loses its uniqueness and the doctor becomes no more than a mechanic trying to repair a machine according to a manual written by someone else.

The medical profession rightfully feels its job is to strengthen the bonds between doctors and patients and serve as the patients’ champion by giving the patient the best treatment possible. Yet this may at times bring the doctor into conflict with government, employers or insurance companies.

There are many forms of indirect intervention in the physician’s medical decisions, the first of which is the formulation of clinical guidelines. Such guidelines can be instructive and beneficial when issued by physicians themselves, although even in these cases there is potential for
unfavourably limiting doctors’ discretion. Each patient and each set of circumstances is different so that ultimately the doctor must use his professional discretion to decide upon an appropriate course of action. Guidelines can be helpful but only where they are issued by other doctors with first hand knowledge and experience in the relevant matters and only where they are not coercive. However, when issued by government or by sick funds they become a method of curbing the autonomy of the profession.

Furthermore, the objectives behind such guidelines when not issued by doctors themselves are not always in the best interests of the patients or the betterment of medicine. Although no-one would accuse these groups of intentionally seeking to undermine patients’ welfare, they do introduce factors such as cost-containment or even politics, which may conflict with the doctor’s duty to do what he or she feels is best for the patient.

Both the Ministry of Health and the Sick Funds also put economic restraints on doctors which limit their ability to serve their patients as they see fit. For example, the different sick funds do not all cover the same tests, procedures and drugs, so a doctor must make a decision not based on what he or she feels is best for the patient, but on what the patient’s sick fund will cover. Although this has not reached the level that exists in the United States, where doctors may be financially rewarded by managed care companies for not referring a patient to a specialist or for expensive tests, it is none the less a troubling state of affairs which hampers the physicians’ ability to serve their patients in the way they best see fit.

The next level of restraint is manifested in various forms of monitoring, such as risk management, quality assurance and utilisation research. As one moves further along the spectrum the focus shifts from an effort to maximise effective care to an effort to minimise costs. Whilst quality assurance seeks to ensure that patients are receiving an appropriate standard of care, the primary goal of utilisation research is to ensure that resources are being used effectively. Where this is undeniably a necessary and important goal, a problem arises when it obscures the main goal of optimum care. As a result of utilisation research for instance, some Sick Funds actually issued restraints on prescribing certain drugs. Certainly the doctor must be aware of economic constraints and their effect on health care. Ultimately rampant healthcare costs serve no-one’s interests. Still a patient’s health must always be a doctor’s primary objective as this is the basis of the patient’s trust in his or her physician.

All the above-mentioned checks on physician autonomy are at least implemented by people in the health care industry. Another source of monitoring is imposed upon us by the legal system. At one end there are laws which specifically direct how physicians must practice. One such law in Israel is the Patient’s Rights Act passed in 1996. Although most of the provisions of the law simply reflect how doctors naturally practice and treat their patients, certain provisions could contradict physician autonomy. As one example, the law requires the doctor to administer “suitable medical treatment”, but does not specify what is “suitable medical treatment” or by whose standards it will be judged. Consequently, at the time the law was being drafted, the Israel Medical Association vigorously opposed the wording of this section and sought to have it read that the doctor must practice according to his professional considerations and discretion.

As a general matter, however, the notion of patients’ rights is not in opposition to physician autonomy. Rather, it is a matter of the physicians seeking to do what the patient wishes in the best way possible. Patient autonomy does not licence a doctor to be irresponsible or arrogant. On the contrary it allows him to better serve the patient and the patient’s needs.
One of the problems that we physicians have is in effective public relations. We sometimes do not detect the clever insidious message sent to the public by those who would have the public believe the physician is not always on their side. Yet if we take, for instance, the Israeli law on patients’ rights, there is no doubt that patients’ rights do not conflict with physician autonomy. The physician is guided by the patient’s wants. The problem is where the physician’s autonomy ends, not with the patient’s wishes and needs, but with the dictates of outside sources such as employers, insurers, who wish to limit expenditure.

Besides explicit laws, there are other legal challenges to physician autonomy in the form of case law. Even if a judge’s decision does not constitute an explicit legal directive to practice medicine in a certain manner, it has repercussions which effectively achieve the same purpose. Every medical malpractice judgement issued contains a message – the doctor should have acted this way, the doctor should have acted that way. The hospital was right or wrong acting as it did. Presumably, the next time a doctor is faced with a similar situation, he will take the conservative approach in view of the judge’s recommendation, (even if it would not be his own) merely to avoid the threat of legal sanctions, – this is what we call “defensive medicine”. Furthermore, occasionally the line between legal and medical decisions becomes murky when a court gives a legal decision which overrides a medical decision, such as saying that the baby over 4 kg of birth-weight should have been delivered by caesarean section as happened in a recent case. The court is appropriating the right to decide the correct medical route and thus limiting the physician’s autonomy and discretion.

On a more heartening note, judges will often defer to a doctor’s discretion if it is reasonable. In one recent case, the court found that a doctor was not negligent in deciding not to interrupt a woman’s pregnancy after her membrane ruptured at 24 weeks of gestation, although the woman later died from sepsis. The court found that the doctor’s decision was one of several reasonable stances he could have chosen, but found the doctor negligent not in his standard of medical care, but because he did not discuss treatment options with the patient and hear her opinion. This case and others like it point to the fact that the legal system recognises the danger in limiting the physician’s clinical autonomy by setting the standards for medical care.

The Israel Medical Association and its member doctors are involved in various efforts to prevent a further encroachment upon physician autonomy in the state of Israel and world-wide. Within our own country we have urged doctors to become involved in drafting clinical guidelines and risk management activities, thus pre-empting the appropriation of these areas by outside sources. As pointed out in the World Medical Association Declaration of Madrid on professional autonomy and self regulation, as a corollary to the right of professional autonomy physicians have a responsibility to be self regulating. I would like state at this point that in order for us to appeal to the public and demand more autonomy, we must show that we are responsible, and that we are taking steps to regulate ourselves.

It is our duty to involve ourselves with public health issues, policy, quality assurance and the like. By failing to do so, we lack the credibility to insist that we indeed have our patients’ best interests at heart. To know that we do is not enough – we must assure the public of this as well. But we strenuously oppose economic restrictions which we feel potentially endanger the health and wellbeing of our citizens. Last Fall we engaged in a extended protest over the intention of the government to implement changes in the health care system which we felt would severely limit a doctor’s autonomy, such as opening the health care market for profit making bodies which increase the economic restraints upon doctors, or allowing the hospital director to be someone other than a physician, which could result in decisions being made which run counter to professional discretion. We must be the champions of patients’ needs. If one hand is tied behind
our back, it will become increasingly difficult for us to uphold the tenets of medicine and the Declaration of Geneva, -the health of my patient will be my first consideration-.”

**Discussion**

**Dr Lemye (Belgium)** “Autonomy and freedom involve taking decisions about what may be appropriate when faced with a given situation, so when doctors are faced with a medical situation they have to take the proper decision. There are so many situations where we are prevented for economic reasons to take the proper decisions. This is what is at stake, and this is the situation with which doctors are very often faced.

**Dr Bonnel (France)** “I believe that medical practice can be assessed or evaluated only by doctors. I think that here there is a specific role to be played by doctors’ associations, which have to be responsible for the evaluation of medical practices. They have to present the results to the other players involved in this discussion. Now, as regards the other players, I would like to stress the ambiguity of the term consumer, which is frequently used. Consumers include the patients, the patients’ representatives, and their elected officers. Very often it seems to us to be ambiguous who are the consumers.”

**Dr Sadikova (Kazakhstan)** “We also have to deal with the matter of ethical independence. There are situations when, in agreement with a certain pharmaceutical firm, a doctor prescribes a certain drug and then gets a certain benefit paid by the pharmaceutical company. In Kazakhstan for instance it sometimes happens that when the patient goes to a given clinic, the clinic is paid by the health insurance. The doctor creates special conditions requiring the patient to go to the clinic several times and the greater the number of his visits, the more the clinic gets paid.”

**Dr Virbalis (Lithuania)** “In our country and I think in some eastern European countries, there is a contradiction between the public servant status of physicians and real professional independence. It is very important to have certain agreement or recognition of this issue at international level as well.”

**Dr Kloiber (Germany, BAK)** “I also suggest that we include a remark in this statement concerning the economic conditions to be taken into account, in particular cost containment and economic restrictions.”

**Dr Rowe (EFMA)** “In many of our discussions, from time to time, reference is made to the situation in the European Union. Within the European Union treaty legislation governs the professions. The legislation in the EU relating to the status of physicians as civil servants is quite clear. It appears in a specific provision of one of the articles of the treaty and it requires that those physicians who have civil service status be limited in number to an absolute minimum”.

**Dr Sadikova (Kazakhstan)** “Mr Chairman, you stated very clearly three important things from the beginning, knowledge resources and ethics. I would suggest that ethics should be a basic overarching issue”.

**Dr Kloiber (Germany, BAK)** “I believe there are three areas we should take into account when dealing with and approving his document. The first is the question whether ethics will come as the first point. I think this can be done, although there are also reasons to put the statement on autonomy at the very beginning. The second is the protection of data. I believe we have protected the patient against interference by government, industry and medical insurance, and also third party interests. The third is the extent to which would apply to all European countries,
and not simply be concentrated on eastern Europe exclusively. Perhaps we can deal with all these matters in a small drafting group to meet during the lunch break.”

A speaker from Hungary “It is important to start dealing with this very important topic with a clear philosophical background. In reality to have real professional freedom requires a decent economic background to practice.”

Dr Macara (United Kingdom) “This has been an impressive debate, and we have made a good deal of progress. But complex issues remain. It would not be responsible to take a decision on the draft today, in the light of the need for continuing discussion. For example we need to consider legislative frameworks, economic conditions, national employment conditions, rationing of care, quality issues, information systems etc. In addition WHO would plainly have some difficulty with some of the statements in the current draft. One of the Forums strengths has been that it has concerned itself with professional and care issues only, and this makes it difficult to consider such statements as “all physicians should have the right to independent practice”.”

Dr Piatkiewitz “I believe that in the light of the debate this matter should be looked at again, and should come back to the next Forum.”

Dr Rowe “The Group had hoped to come forward with a few simple principles, because in many countries relevant legislation is being considered at the moment. In view of the discussion the Working Group will consider the matter again, prior to the next Forum. Meanwhile the general principles underlying professional autonomy have been well rehearsed in the debate, which would be of assistance to NMAs in any national discussions.”

Tobacco

The Chairman introduced Dr Macara (UK) to present the report on the Tobacco Control Resource Centre

Dr Macara The Tobacco Control Resource Centre was established in 1997 in London, as a joint enterprise between the BMA, WHO, the European Commission and the national Medical Associations. In that year 1.2 million premature deaths occurred within the European Region due to smoking.

In the United States there have been important developments with class action law suits by states attempting to recoup the costs of treating smoking-related diseases, estimated at some US $385 million. Smaller class actions are also proceeding through the UK courts. Legislation is also proceeding in some other countries.

In the United Kingdom the new Government had taken stronger steps towards an effective tobacco control policy. Three hundred and thirty people die each day in the UK from tobacco consumption.

NMAs had reacted positively towards to the establishment of the Tobacco Control Resource Centre, and there had been a variety of contacts with Ministers of Health and Prime Ministers. On 4 December 1997 a common position on the tobacco issue had been reached by the Health Council of the European Union. This achievement was a great tribute to the representations and lobbying that had been made. However the struggle was far from over, and the tobacco industry
was bound to raise many amendments etc. It was therefore important that NMAs continued to be active in briefing Ministers, MEPs etc on the threats to health posed by tobacco consumption.

The Tobacco Control Advisory Group had been established to oversee the work of the Tobacco Control Resource Centre. Success would depend upon NMAs continued active support and involvement with the project. Dr Bill O’ Neill had been appointed Director of the Tobacco Control Resource Centre.

Dr Macara then moved on to discuss the work of the Centre over the last 8 months. A regular Newsletter had been established, together with a variety of information and research material and a database of smoking related material for the use of doctors. All this could be accessed in various ways, including the Internet.

A survey of smoking prevalence amongst doctors had been piloted through NMAs in 4 countries. The results had been modest so far. Of 388 doctors contacted in one country 130 had replied— including 8 current smokers, 28 ex-smokers and 70 who had never smoked. The questionnaire used had been simple, on a single sheet of paper. It had been made available in both English and French. The results from the other countries were awaited.

The response to date had therefore only been around 34-37%. This modest level of response demonstrates that there would be a hard task to get the kind of response, say 70 or 80% which would enable us to impress upon governments the significance of our figures, and to impress upon our patients the lesson that doctors are leading and showing the way. The Centre will analyse the data and report on the results. NMAs will be asked for a coded summary of each response received, preferably ideally on computer diskette. In order to have a standardised system, written guidance will be provided. This survey was a key aspect of the work. It will be used to raise awareness of the issues – among NMAs members and to highlight the need for change. The survey would be repeated in two or three years’ time in order to measure progress.

The survey project plans to produce a booklet on doctors and tobacco control, which will promote and support doctors in smoking cessation and provide evidence-based advice to doctors and NMAs on the professions’s role in advocating tobacco control policy at every level. A detailed outline of the booklet was considered and agreed at the meeting of the Tobacco Control Advisory Group last November. It was anticipated that the first draft will be ready by the end of the next month. An author had been commissioned with wide experience on the subject and the TCRC was working closely with him in providing research support and in feeding in practical experience which, national medical associations have provided. Examples of good practice in different countries will be incorporated throughout the booklet, so that similar actions can be recommended to other NMAs trying to achieve the same objective.

The Centre has recently written to all asking for information concerning two successful actions taken by national medical associations in the field of tobacco control. These may be effective collaboration with other tobacco control agencies on a particular issue, establishing a no smoking policy in NMA buildings, or may be the development of a smoking cessation programme to help patients, or initiating a media campaign. Negative results are also important. So far seven replies had been received.

Concerning the languages in which the booklet would be available, this posed some problems. The original application to the European Commission for funds for the Centre proposed that it would be translated into eight languages, including the official languages of the European Union and Russian. However, TCRC received only half of the original funding and it no longer seems
feasible to produce it in all these languages. One possible option was that where NMAs have the resources they will be invited to bear the costs of translation of the booklet into the appropriate language themselves.

Another aspect being addressed was that of training doctors in smoking cessation. TCRC was developing a training package for doctors who can be used by NMAs. The advisory group had suggested that where possible, the package should use existing materials, and WHO are currently updating their training package entitled “Helping People Change” which can be designed for use by NMAs. As already indicated TCRC was gathering together a library of materials on smoking cessation, and measures which have been used throughout the world. We recently wrote to the health education centre, or ministry of health, as appropriate, in each country within the European region. We took the opportunity to introduce the work of the Tobacco Control Resource Centre and we sought information about programme being undertaken. We expressed specific interest in any materials they have produced or used for helping doctors who want to help their patients to stop smoking. The Centre has already received a positive response from a number of countries, many of which are interested in hearing more about our work and they have expressed a willingness to collaborate in future projects. So if any medical associations have developed or used training packages on smoking cessation, do please let TCRC know about them so that the message of good practice can be passed to all NMAs.

The last aspect of the work of the Centre was to undertake missions to specific countries requesting advice and support in any aspect of tobacco control. The intention was that each mission should include three experts in different areas of tobacco control policy. The missions would address the specific needs of the individual country and the individual national medical association, and that will determine who the experts to be chosen should be. It was intended that each mission should include a lobbyist with experience of tobacco control at both national and international level, for example a doctor or other individual who can provide the necessary clinical scientific and epidemiological support. In addition a representative from another national medical association with a similar socio-economic infrastructure and resources, which has successfully established an effective tobacco control policy will be included in the mission. The idea is to help countries seeking help by providing an input from countries which have already found out how to do it. The subjects which will be addressed by the experts are smoking levels amongst doctors, development in smoking cessation techniques; work with other health care and tobacco control agencies; lobbying the politicians, parliament and government; and working with the media.

A major constraint on activities was the limited funds and it would therefore not be possible to undertake missions in every country. Indeed this would not be necessary or desirable, we feared that it might not be possible to visit as many as TCRC would wish. Consideration was being given to dovetailing our activities with WHO’s tobacco control missions. In this way, the WHO team will establish contract with key organizations and individuals which could then be followed up at a later date by representatives from our Tobacco Control Resource Centre. This would have the additional advantage of reinforcing and supporting the initiatives generated by the WHO team.

In conclusion, the Tobacco Control Resource Centre has made progress towards establishing the Centre as a key resource. Its success depends not only upon its staff, but upon members of the Forum. He looked forward to continuing support and help in the interests both of patients and the NMAs.
The Chairman thanked Dr Macara for his very informative report and introduced the next speaker on the same, Dr Peter Anderson from the European Regional Office of WHO in Copenhagen.

Dr Anderson. In public health there are few single things that can be done which have a dramatic impact on improving people’s lives. Action on tobacco was one of them. During the 15 minutes of his presentation tobacco will have resulted in thirty-five deaths in the Region, and cost the Region 3 million dollars. A reduction in tobacco use is the single most important action that countries can take for both health and economic gain. Cigarettes are the most commonly used drug in the region. One third of adults are daily smokers. Dr Anderson continued “the health policy for Europe has a target to reduce smoking to below 20% by the year 2000. We are far from achieving this. We could throw up our hands in despair and say that the situation is hopeless. But many people are doing something to reduce tobacco use. Out of the many examples I could give, let me mention the Evin law in France which in 1991 included a ban on cigarette advertising. Five years later cigarette consumption had fallen by 11%.

There is a lot which we can all do before the year 2000. We can prevent a whole new generation of women and young people becoming addicted to cigarettes. We can help 180 million smokers to quit. Tobacco is the most dangerous drug commonly used in the region. One half of all people who regularly smoke die from their habit. Every hour, 140 people are killed by tobacco. This is the same as 25 plane crashes every day. And it is going to get worse. Unless we help current smokers to quit, in 20 years’ time tobacco will be responsible for 2 million deaths a year in the Region, one in five of all deaths.

We can prevent many of these deaths. At any age, there are benefits to quitting, and if smokers quit before the age of 40 years, they will live nearly as long as non-smokers. Maybe these deaths do not matter, we have all got to die some time. But they do! What about the ill health, the pain and suffering caused by tobacco? What about the loved ones left behind? What about enforced smoking? Up to ten per cent of all tobacco related deaths result from breathing other people’s smoke. What about social development? In the countries of eastern Europe, one in five of all 35-year old men will be killed by tobacco before they retire. This is twice as high as in western Europe, and a huge waste of human and economic resources. Maybe this is the price to pay for the economic benefits from tobacco. But this is false – on balance there are no economic benefits from tobacco, only losses. The World Bank has calculated that adding up all the benefits and costs, the world tobacco market produces an annual global loss of 200 billion dollars. It is a simple message – tobacco use is bad news for the economy. There are also significant losses through failures to collect taxes on smuggled cigarettes. The market for smuggled cigarettes in the EU alone is 60 billion cigarettes each year, at a tax loss of 6 billion dollars. Contrary to what we might believe, high price and high taxes are not the major cause of smuggling. The smuggling market in Europe is largely the illegal movement of international brands from northern ports to the south and east. It is the tobacco companies that are the chief beneficiaries of this illegal trade.

We have failed to obtain effective political support for tobacco control policies. It was in the 1960s that the Royal College of Physicians in London and the first United States Surgeon General’s report on smoking and health were published. Both reports called for tough action against smoking, but public health failed. It is difficult to estimate the cost of this failure that let the tobacco industry off the hook and allowed it to take the initiative for more than 30 years. But the tide is changing. With the proposed settlement in the United States politicians are taking a stand against the tobacco industry. As Michael Moore, Mississippi’s Attorney General, said, “we wanted to do things that would punish this industry for its past misconduct and we have done
that”. But we must remember that the proposed settlement in the United States removes the threat of litigation against the tobacco industry and was followed by a rise in the value of the shares of the industry. The proposed settlement is regarded by the industry as the cost of doing business, and is not in the interests of public health.

President Clinton called for tougher measures to protect young people, including large tax increases. The settlement proposes, as Dr Macara mentioned, a nearly 400 billion dollar settlement to pay the US for the costs of treating people from tobacco-related diseases. The settlement has a number of goals for youth smoking, which if not achieved will lead to more fines against the tobacco industry. The settlement calls for stricter advertising restrictions and strengthens the role of the Food and Drug Administration in terms of regulating tobacco products. At the moment the settlement is being discussed in Congress, and there are three possible outcomes—nothing happens in Congress, with no agreement and the status quo continuing with the individual states settling with the tobacco industry; or a tobacco tax gets passed; or the industry gets what it wants, which means complete approval of the settlement. I think at the moment it is not clear what the outcome will be.

We have failed to inform the public adequately on tobacco issues, and to get popular support for action. The tobacco industry is rather good at advertising its cause. We need to be better and to be bold in our advertisements, like this one “Bob, I’ve got emphysema”. Even smokers give support for tobacco control policies, 2/3 of current smokers would like to stop, to quit smoking and most smokers support smoke-free public places. In fact, there is a huge market for cessation advice.

Smoking advice in primary health care setting is a highly cost-effective intervention. Let me illustrate this with this overhead. If you look at the medium cost per life-year gained of over 300 standard medical treatments, the medium cost is 30 000 dollars per life-year gained, but if we look at brief advice, five minutes advice from a general practitioner to an individual smoker to quit smoking it is only 800 dollars per life-year gained. It is a highly cost-effective intervention that all of us should be involved in.

We have also allowed the public to be deceived by the tobacco industry. One of the consequences of litigation has been the exposure of the industry documents which are now all available on the Internet and many of which are published in this book, “The cigarette papers”. For too long, the industry has lied to the public about its knowledge of the harms done by tobacco and the addictive nature of nicotine. In the 1960s, the industry wrote “we are in the business of selling nicotine, an addictive drug”.

It is also clear that the tobacco industry targets young people. This is the first design for Joe Camels for advertising tobacco products. We say that we should protect our children – yes we should – but why should children take notice of school programmes when the outside world proposes a different reality. The reality is that one third of adults smoke. The reality is that there is widespread marketing of cigarettes. If we really want to protect our young, all forms of advertising and sponsorship should be banned. Perhaps now we have a real possibility that this may happen in the European Union with a impact far reaching beyond the Union. The proposed EU ban, if agreed, would lead to national legislation by the year 2001, such that by the year 2002 there would be no advertisements in print media; by the year 2004 no indirect advertisements or sponsorships; and by the year 2006, no sponsorship of world events. Currently this is being discussed in the European Parliament. In 10 days time, on 17 March, the draft report will be presented to the Parliament, leaving until the end of March for any proposals or amendments to be received. These amendments will be voted on 22 April with a debate and vote through
Parliament in the middle of May. It is crucial that the existing proposal is not amended. Any proposals for amendment may undo the already existing agreement.

Within the Member States of WHO, we now have the Third Action Plan for a Tobacco Free Europe. This Action Plan calls for determined and unprecedented action to protect public health from the activities of the tobacco industry. But we cannot act alone. We need the support of other ministries, sectors and settings. And for this we need the support of prime ministers to assure a concerted action. In particular, we must persuade ministries of finance that regular increases in tobacco tax raise revenue, save lives and invest in human development. In terms of concrete action with medical associations, what can we do? On your desk is a recent statement from the World Medical Association on tobacco products. In particular, this urges no smoking at any meetings of national medical associations. I think that is something that already the medical associations of this Region are committed to. It calls for education of the profession and the public on tobacco issues. For example, the associations of this Region have been very effective in encouraging airlines throughout the Region to become smoke free, and increasingly this year, I think we will see almost all European airlines being smoke free. I think there are opportunities for extending this work to other settings, maybe let’s go for smoke free hotels. The World Medical Association calls on medical associations and physicians to act as role models, and here we have the very important survey that Dr Macara mentioned as an example to illustrate the smoking prevalence amongst doctors. Then, the World Medical Association has called on national associations to act as advocates for effective policy. The action plan for a tobacco free Europe which you have on your desk provides the framework for that advocacy.

I think there are three other concrete actions. Firstly, talk to the politicians. As I indicated, it is a crucial time now in terms of the advertising ban in the European Union. You have an important role to play to lobby European members of parliament and the environment committee of the European Parliament. Secondly, talk to the lawyers. Maybe there will be a move in the European Region to strengthen litigation against the tobacco industry. We should make sure that the interests of health are involved in those discussions and it is not just a discussion that benefits either the industry or the lawyers. Thirdly, talk to the people who smoke. I’ve indicated the effectiveness and cost-effectiveness of brief interventions in primary health care settings. We should all encourage our members, whether in primary health care or in hospitals, to be involved in giving simple, brief advice to smokers to quit smoking.

In conclusion, it is time for us to take a stand and say things that may not be popular. During the next decade more than 12 million men and women will die an agonising death from diseases caused by smoking, leaving in their wake countless family tragedies and great economic loss to our societies. Unless we take strong action, future generations will condemn us for failure to control one of the worst scourges facing our people. We should at least issue a health warning, transnational tobacco companies target women and young people. Will these little girls be next?”

The Chairman thanked Dr Anderson for the clear message, which should be certainly passed to our colleagues in national medical associations and to their patients, and from his own observation, about 20% of the members of this room smoke. Wouldn’t it be possible as an act of good will to stop smoking during the last hours of the Forum?.

Dr Orlic (Croatia) gave some data from Croatia relating to the fight against smoking. The proportion of medical doctors who smoke in Croatia is 31.5%. For comparison, a survey done in 1992-93 amongst teachers showed that 25% of them smoke. The other information concerned the fight against smoking in primary schools. In 1997, a booklet why not to smoke was edited by Professor Simonic. In this booklet young children in primary schools can get 515 evidence based
answers. This booklet is distributed to all primary schools in Croatia. The action is endorsed by
the Ministry of Education and Ministry of Health. The children can get this book and take it
home, and discuss smoking habits with their parents if the parents are smokers.

Dr Woy-Wojciechowski (Poland) referring to Dr Anderson’s statement that NMAs have to talk
with politicians, lawyers and people who smoke, emphasised that we must talk to the doctors
who smoke. Before the last war, in Poland produced 7 1/2 billion cigarettes yearly. Now it was
100 billion cigarettes yearly, 14 times more. The Polish Medical Association appealed to Polish
doctors to quit smoking by the end of this century. He proposed a fourth point to Dr Anderson –
talk with doctors. The PMA repeated its appeal in its journals, in its calendars. It would have a
meeting/conference next October together with journalists, with the main topic of “smoking
cessation among physicians.”

Dr Sadikova (Kazakhstan) referred to some successes the KMA had after last year’s
conference in Kazakhstan. A conference of physicians had adopted a declaration to the
government to ban advertising in the media. This request to the government was taken up in his
yearly address by our President and at present this advertising has been banned. KMA also had a
conference on the question of tobacco and has endorsed the World Medical Association’s
declaration which mentioned the fact that physicians through their personal example must show
the way, particularly when actually working in medical institutions. Physicians must continue to
bring pressure to bear on the advertising media, so we also turned to journalists and asked them
to support our request. There is now a medical journalist association group dealing with the issue
of advertising of tobacco and tobacco products, together with the promotion of healthy lifestyles.
A competition on this issue was being planned.

Dr Bonnel (France) referring to Dr Anderson’s reference to the Evin law in 1991 in France
which considerably reduced the use of tobacco in our country, said it was true that this has been
exemplary because even the French Grand Prix this year was cancelled because of the lack of
advertising. So France was doing a great deal. Referring to Dr Macara’s report he said that France
also had centre which was working well, the National Centre for Control of Tobacco Use. Its
President was Professor Gerard Dubois, Professor of Public Health, whom he considered to be
one of the best experts in public health and tobacco control today. He suggested it would be very
useful to use him in the panel of experts, if possible. He reminded the Forum that it was in Basel
that the Forum previously adopted some six years ago a strong position on tobacco control. But
we always encountered the same problem that the European Commission gives money to the
tobacco industry. He thought that we must react strongly against this. He reminded the Forum
that the higher the price of tobacco products, the less temptation there would be for our young
people to buy cigarettes.

Dr Asvall (WHO) “First of all I want to thank the British Medical Association for having taken
on this task of creating a resource centre which means that we have a real resource to underpin
actions. Without Dr Macara, it wouldn’t have happened. I want to thank also the European
Commission. Without the funding from them, it would not have happened. So I think this is an
excellent example of the cooperation between the Commission and also WHO.

Now, we’ve heard about the very important decision in the European Union on banning
advertising. That issue is not firmly settled yet, and it is in real danger that it may be toppled.
Perhaps if we had a resolution from this group to ministers of health saying, look here, be sure
not to accept any amendments which would weaken the present draft. I really feel this could be
an important resolution. I wrote to all the ministers of health in the European countries on the
same issue before the debate which took place in December. I said in the letters that I think this
is an issue which goes far beyond the European Union, and will have major influence on what can be done in other countries in the Region. It was in fact well received, and I got a number of nice replies from different ministries. If the Forum passed a resolution now on this issue I would write to the health ministries of the European Union accordingly.

There are very many interesting points which make it easier to understand for the public what it is really about – I think the 3 million cost to Europe of tobacco during those 15 minutes of Peter Anderson’s speech, is another very interesting kind of figure to use.”

**Sexually transmitted diseases**

**Dr Lemye (Chairman)** opening this session called on Dr Blachar to introduce Dr Rubenstein

The first speaker.

**Dr Blachar (Israel).** “It is my pleasure to introduce Dr S. Rubenstein, who is the head of the infectious diseases unit at the medical centre in Tel Aviv University Medical School. He is one of the founders of the infectious diseases clinical research in Israel. I must tell you that Professor Rubenstein bears two qualifications, the first is after many years he studied at law school but still prefers to be involved in medicine. The second is that he is a very active member of the ethical committee of the Israel Medical Association.”

**Professor Rubenstein** “I am very happy to be here in Basel. I spent three years in this city for two reasons. Firstly, this is the 100th anniversary of the establishment of the Zionistic movement, which took place here in Basel, actually in a hotel which is still in operation, the Three Kings. Secondly, I spent three wonderful years in Basel in medical schools, and I learned to respect the Swiss friendship and hospitality, for which I thank you again.

My task is to talk to you over the next 20 minutes concerning sexually transmitted diseases in Europe. I have in mind three topics that I would like to tackle. The first is to review shortly the situation world wide, but in particular emphasise sexually transmitted diseases excluding AIDS in Europe. The second is the catastrophic increase in sexually transmitted diseases, in particular in the Russian Federation. The third is to give you a hint of how we can correlate the increase in sexually transmitted diseases with various economic parameters which might help investigators in getting financial funds to do relevant research.

In mid 1995, there were globally 250 million people with curable sexually transmitted diseases in the world. This number has increased now, and we can easily say that now there are a million patients every day in the world infected with sexually transmitted diseases. In mid 1995, in western Europe, there were 10 million people with sexually transmitted diseases. Of course the big source of those diseases was in South East Asia with about half of the STDs in the world. Europe, as I said, was 10 million. In 1994, the rate per 100 000 of population were: gonorrhoea, in the EC 38 persons per 100 000; in Israel it was about 50 times lower, at 0.67; in the US it was four times that of Europe, 131 per 100 000. If we look at syphilis, primary and secondary together, 2.63 per 100 000 in Europe, 1.25 in Israel, and 5.67 – twice as much as in Europe in the United States.

Between 1995 and 1996, the global total rate rose from 250 million to already 333 million people infected with STD. In Western Europe the toll rose from 10 to 60 million people over less than a
year, a 60% increase in less than a year. In North America and in the Middle East the figures remained much the same. In South East Asia the numbers rose from 120 to 150 million infected people. In Latin America numbers rose from 24 to 36 million people. So there is a tremendously rapid increase in STD. However, in spite of these increases, there is some very good news if a country takes it to heart to eliminate STD. Thus for example in Thailand, between 1985 to 1993, the rate of reported STDs, without change in the technique of reporting, decreased from 400 to 96 in 1993 and it is still dropping down and in this year it is around 60 cases per 100 000.

Now let’s divide the STD into the three classical elements. When we talk about syphilis, in 1995, there were 200 000 primary and secondary cases of syphilis in Western Europe. In South East Asia the numbers were 58 million cases. In South America the figure was 13 million, and in sub-Saharan Africa 3 1/2 million. Considering gonorrhoea, Western Europe in 1995 had 12 million cases. Again a large number of cases were reported from South East Asia, about 29 millions. Eastern Europe contributed a very fair share of its cases in gonorrhoea.

The prevalence of gonorrhoea in pregnant women in South East Asia and the Pacific is terribly high, it comes to 12 % in Thailand and about 5% in Fiji. That’s so important because a pregnant woman infects her product, the baby, in about 70% of cases. The reported cases of gonorrhoea have also risen rapidly throughout Eastern Europe. Gonorrhoea is important because by treating 100 women for gonorrhoea, of whom 25% will be pregnant, one can avoid 25 cases of pelvic inflammatory disease with subsequent sterility; one ectopic pregnancy; six cases of infertility; and most importantly, one can avoid seven cases of blindness in young children.

Turning to chlamydial infections, we must first say that we do not have good data for the reason they are very difficult to diagnose. Anyhow, globally there are about 100 million chlamydial cases throughout the world. In Western Europe there are 5 million cases reported. It seems to be that in respect to chlamydia there is only about one tenth of the cases reported, so the numbers of actual cases would be expected to be far higher than those that are on this table.

Now I will turn to the Russian Federation. You can see that there is an explosive increase in cases of syphilis. In 1996 there are close to 400 000 cases reported there, and this is compared to less than a few hundred cases between the 80s and the 90s. The rate of reported cases increased from a low of 2.5 or 2.6 per 100 000 in the late 1980s up to 270 in 1996. The difference between females and males is just about the same. There is therefore a tremendous epidemic occurring in the Russian Federation as well as in other ex Soviet Union countries.

I think this is a tremendously dangerous situation for two reasons. Firstly, because of the problems associated with STD, including smoking but also AIDS, poverty and infertility. The dropout and infectious potential of those people is tremendous. Why? Because about 50% of all the cases are reported in people less than 22 years of age, so the potential for recurrence and repeated infections is tremendous. Secondly, because the assistance those people can get from the official public health clinics is rather limited because of the reporting and because the availability of modern and efficacious drugs is limited. In private clinics in the Russian Federation, treatment of either primary or secondary syphilis, or gonorrhoea, costs between 100 to 200 dollars. This is so far above the means of those people that there is a tremendous increase in this rate. Unless some drastic measures are taken, this will become a terribly dangerous situation.

My next three slides ask whether there is any relationship between some socio-economic parameters and the increase in STD. I ask whether the increase in the rate of STD comes before the increase in unemployment or the decrease in the GNP in the economy of a state. I have done
this for 1985. I can tell you that there was no correlation between either unemployment or GNP, and the rate of syphilis and gonorrhoea. I’d like to share the final result with you. Column a) is the rate of unemployment, column b) is gonorrhoea, column c) is GNP in dollars and column d) is the rate of syphilis. So you can see for some countries, e.g. Estonia, there was a 95% correlation between unemployment and the rate of gonorrhoea. What is important is that the rate of gonorrhoea preceded the rate of unemployment by two years. Also for Slovenia, there was an excellent correlation between the rate of unemployment and gonorrhoea. The same good correlation was also found for the UK between the rate of unemployment and gonorrhoea, and between the rate of unemployment and syphilis. So in those two countries there is a complete parallelism between the two rates. I don’t know how it would be for many other European countries because we didn’t have much time to analyse them all. In Estonia the GNP correlates well with gonorrhoea. The only thing that you cannot see on the graph is that the increase in the sexual transmitted diseases precedes the decrease in the GNP and the increase in the unemployment by about 1 1/2 and 2 years. So the thesis is that there is a direct correlation between the changes in the GNP and the rate of gonorrhoea and syphilis for western and ex Communist countries.”

Dr Gromyko (EURO WHO) “I would like to supplement Professor Rubenstein’s paper with a few data which go even up to 1997. So, I will start with syphilis. Syphilis, as you know, is a disease which it is obligatory to report, so we are using syphilis as a marker disease to estimate trends of STDs. In the Baltic States up to 1997 the rate is also high, around 120 per 100 000. It is still going up with a slight sign of stabilisation in Estonia. In the countries of the Russian Federation – Moldova, Ukraine, Belarus – in 1997 there was some slight decrease and we are now puzzled. Is it because these are officially notified cases, or are these cases now really going down? We actually wanted to hear of changes in these countries of STD treatment and prevention, – or these cases going to the private sector, thereby avoiding notification to the public health services. Anyhow officially notified cases of syphilis have declined in 1997, but still remain on quite a high level. In Russia, in some areas the rate of syphilis per 100 000 has increased to 700. And this also is true of other countries like Kazakhstan or Kyrgyzstan, which have seen exactly the same rise. And also for Belarus, you can see it’s 21000 for a tiny country with less than 1 million population in one year, And Ukraine has 77 000 in 1996 and 74 000 in 1997, which is very high. In Norway, with five million population, they had in 1996 only four cases of syphilis, two of them imported by business people, and two infected by spouses. The same population in Moldova had 9000 syphilis cases. In 1996, there were 470 cases of congenital syphilis in Russia, whilst the disease is almost eliminated in Western Europe. Dr Rubenstein has been talking about social determinants. In comparison consider as determinants of STD epidemics unemployment, poverty, early age of sex relations, prostitution and unsafe sex. Another very important aspect is the medical services. These are not user-friendly. They still preserve the conservative approach of the past, with obsolete legislation. People probably don’t want to go to those services.

Trying to modernise the resources WHO, in cooperation with UNAIDS, has founded a task force on urgent responses to the STD epidemic in eastern Europe. Those parties who are interested in eastern Europe came together to decide how they could coordinate joint efforts to assist eastern Europe in that crucial stage of the painful way to democracy.”

The Chairman considered this information to be of great concern. He was sure that everyone to find solutions to the problem of the STD situation, working towards reduction and eventually elimination of the incidence of these diseases. This must be done with the same determination as we did with smallpox some 20 years ago. He called on Dr Andreev of the Russian Federation to give some further data.
Dr Andreev (Russia) drew attention to the comprehensive report including statistical data which his assistant had prepared and which he would not rehearse. He wished to refer to other matters relating to STD’s, but did not want to bore the audience with figures. The approach in the fifties was to claim that there were no STDs in the socialist societies. These were anti-social diseases and they existed only because of capitalism. Of course, this thesis marginalised all the patients and the approach to these patients was very negative. Patients tried to hide their diseases, they never went to see a doctor. The state control of these diseases was based on strictly regulated systems of therapy and accelerated methods were not recognised in our country. There were also preventive organizations, but very often screening was dangerous as cases were also punished by the penal code. But now his country had returned to more sophisticated systems of treatment. However, because of the expensive drugs this is not accessible to the majority of patients. The government does not allocate adequate resources for the procurement of these foreign drugs.

Also, many in his country still consider that the transmission of STD is done by infection of the food chain. People know very little about the STDs, an example is chlamydia. There have been great increases in STD prevalence, for instance, in a city with 200 000 inhabitants, there has been a seven fold increase in syphilis. In one city with a one million population, there was a twenty five fold increase, and in one with seven million population, there was a 44 fold increase.

Presently the main group affected by AIDS are drug addicts. For instance in a city like St Petersburg, there has been an epidemic outbreak. About 10-15 people are AIDS infected every day in Russia. If we do not adopt any measures then 1% of the urban population will be AIDS infected in the next century. Now for drug addicts, the number of sexual partners goes up to 25. The consumption of drugs goes hand in hand with sexual orgies, so it is not very likely that the authorities will succeed in controlling this epidemic. Because the profit in the drug trade is so extraordinary government interference will be hardly possible. Indeed, towards the end of 1997, a law was adopted and doctors were prohibited from treating drug addicts. The drug addicts are afraid of state services and very often they resort to a private physician.

Now this law interferes with the rights of doctors to treat patients. We wanted to introduce control programmes, but so far we have not succeeded in enlisting the long-term support of authorities. There is also an absence in education, both nurses and doctors are not fully informed, in particular about AIDS. Very often in hospitals people forget to wear gloves, the infected patient doesn’t know about it, he doesn’t know that he may have been infected in hospital because of lack of proper equipment and disinfected equipment.

Treatment of AIDS infection is both a difficult and an unrewarding task. We identified that in one city with 320 AIDS patients it is necessary to spend up to 25% of all the resources allocated to the total health needs of a given city. Therefore the AIDS centres basically only record patients and screen them. We forget also about STD complications, for instance. We don’t realise that we have to act immediately and on a large scale. We have to think globally and act locally. We have prepared a programme for existing drug addicts, and also an educational programme for young people, to teach them about safe sex.”

The Chairman thanked the speakers and in view of the likely increase in the problems anticipated its further discussion at another Forum
International network of doctors with forensic expertise relevant to torture victims

Dr Pedersen (Danish Medical Association) presenting this report said that at the EFMA meeting in Copenhagen in February 1997, it was agreed to make a proposal for the establishment of an international network of doctors with forensic and other expertise relevant to torture. This network would have a contact point established within the EFMA through which information on human rights violations could be channelled to relevant international organs such as UN, Amnesty International, Copenhagen’s International Rehabilitation Council for Torture Victims and other relevant bodies. The organization receiving the information could then evaluate the extent to which a further investigation might be conducted.

The network’s purpose will be to receive and report information concerning evidence of torture or inhumane treatment or neglect. It will also seek to identify means of assisting doctors to resist any pressure to transgress their ethical obligations against being involved directly or indirectly in such acts, as for example specified in the Declarations of Tokyo and Hamburg of the World Medical Association.

Of the 39 active participant organizations in the EFMA, 24 had already come forward with a view to participating in the network, and identifying the names of appropriate individuals to participate in this work. A detailed report had been prepared within the Danish Medical Association as to how this network would function. The proposal was to begin this project on 1 April 1998 for a one year trial period. An evaluation report will then be made to EFMA/WHO at its 1999 meeting, with a view to discussing possible adjustments in the project at that time.

The network was not meant to initiate fact-finding missions, but rather to serve as an informal method of gathering information to protect the profession from attempts to enlist doctors in such reprehensible activities. The national medical associations are urged to take an active role in the network. The Danish Medical Association was prepared to serve as the coordination point, providing an e-mail address, fax and mailing address for the receipt of information. Then, in accordance with the wishes of, or in cooperation with, doctors or other persons providing the information, this would be forwarded to a relevant recipient.

On behalf of and in agreement with the EFMA/WHO working group, which consists of the medical associations of the Czech Republic, Denmark, Germany, Turkey and the United Kingdom, as well as the WHO/EURO, he proposed that the Forum agree to go forward with this work as outlined in the report which has been circulated.

The Chairman invited any comments and Dr Asvall WHO said that he considered that really excellent work had been done by the group. On behalf of WHO he wished to support what had been outlined.

It was agreed that the working group would continue its work and aim to produce a new proposal at the next Forum meeting.
EFMA Handbook, Activities of NMAs

The Chairman, Dr Salzburg (Switzerland) opening the sessions on NMAs activities and on QCD, referred first to the excellent booklet in Quality Assurance produced by Dr Vigen and Dr Rowe and then invited Dr Vigen to report on the responses to the NMA Questionnaires.

Dr Vigen first apologised for the EFMA Handbook. Externally it looked fine, but inside some very mysterious things had happened during the print setting. This would be reprinted and sent out in a new version as soon as possible.

On the other hand, NMAs have done a good job by sending in information and corrections. Changes and corrections have been received from more than forty NMAs this year, a better response than ever before.

Turning to the new activities of NMAs he said that this year the Liaison Committee had decided to have a short update form so as not to bring an extra burden on the NMAs. It was decided to focus on continuing medical education (CME), patients’ rights and STDs. Thirty two medical associations answered this update form. As set out in Table 1 of the booklet, fifteen associations reported on major developments in CME in their countries in 1997, and nineteen NMAs reported having taken some new initiatives during the last year. Over the last year one could see that CME is in a constantly changing process in the European Region, and that NMAs were really actively taking part in that developing process. From six NMAs more detailed information had been received.

Patients’ Rights also seemed to be a developing issue within in the European Region, reflecting the more powerful position of the consumer. This might be a subject for discussion at a later Forum meeting.

The Chairman expressed his thanks to Dr Terje Vigen and the Norwegian Medical Association for all the help they were giving to the Forum, and also to Dr Rowe.

Mr Harvey UEMS, referring to CME, said that the UEMS was very much involved in this issue. He considered that it was universally accepted now that the initial system of what is in the vernacular called “the bums on seats” approach, had been a dismal failure. There are now many other initiatives to actually make the doctor himself the owner of the process – you could not impose CME from the top. It is a fundamental ethical obligation and that this should be stimulated at all levels through medical school, and through specialist education. One mustn’t forget that once a doctor becomes either a specialist, whether in general practice or in specialist practice, he has an obligation to maintain his expertise for the next 30 years of his clinical practice.

Too many people, governments, lay organisations, look at this process as a means of trying to weed out bad doctors. That is not what CME is about. If one needed an analogy, it was about polishing the good apple rather than weeding out a bad apple from the bottom of the barrel. This needed to be said repeatedly. Referring to a conference on CME in London in the next month, organized as part of the UK’s presidency of the EU, he commented that undoubtedly there was an agenda behind that conference, as the government was dissatisfied with the amount of money that has been spent on CME as it was concerned that it could see very little change in the quality of health care. That was a very important point. Therefore it is an immense priority that we, the
profession, get it right and we monitor ourselves. They had an obligation to show to the public that they were responsible.

There must be some form of organization to monitor a doctor’s activity and report back. For example, the Canadian Maintenance of Competence Programme was one that he commended. Then, if one got the commitment of the doctor, one would deliver quality. There were also some very innovative, new initiatives going on. He was associated with one on using satellite technology. The might of IBM with an interactive internet response could actually give governance to the doctor himself.

Dr Minga (Albania) reported that in Albania, one of the main problems was continuing medical education, especially for GPs, because of money problems. For the first time in his country a department of family doctors had been created. This is a very important medical speciality. A group of Albanian physicians from various districts of Albania have specialised in this field in Europe. After returning, they immediately began to work, with the financial support of the World Bank. Intense work for the continuing medical education of the family doctors in many districts was beginning. There would be collaboration with the faculty of medicine on one side, and on the other with the medical institutions.

The Chairman, Dr Salzberg, wished to comment on the field of CME, because it was his great interest and he had devoted the past 15 years of his life to the field. He thanked Mr Harvey for mentioning that there were a lot of players now. Whilst this is true, at the same time it means that doctors, and doctors’ organizations, should not waste a moment, not a minute, to try and catch the initiative in this field.

In his country, Switzerland, there was a draft for a new law about post graduate education, stating that a qualification in post graduate education was bound to CME. So the maintenance of a title as a specialist, internal medicine, surgery, whatever, depended upon re-certification in the American sense of the word. One obtained a postgraduate title for a certain period of time, and within that time will be required to do some form of CME. This will apply to GPs who have a five-year postgraduate training, or to any specialist who has a five to seven to nine year postgraduate training and means that the CME period has to be filled with something reasonable. If the profession doesn’t come up with good ideas, he warned that the state authorities would be very glad to fill in with their ideas.

Dr Kloiber (Germany BAK) wished to say a few words about the model with which his medical association is involved. These were the so-called “networking cooperatives” in Germany. So far all agreements in medical care between the medical associations and the medical insurance bodies are embodied in an overall contract covering the entire nation. They are also extended to cover the Länder.

The intention had been to provide a possibility for smaller groups of doctors and patients to try out other forms of cooperation. They had to ensure that care would be provided to patients throughout the country irrespective of salaries. There would be optimum care, but on the other hand this was also a protective measure for doctors who find it very difficult to work in smaller groups and then agree contracts with the sickness insurance funds. They had an association, which had sprung from the physicians, not an organization that was established by an official body. Initially it was a small core of 30 physicians in northern Germany, but this had been extended to include about 110 or 114 physicians in 1997. There will be a few more members who are interested to develop this model.
What were the main items of concern? First of all, they wished to make an offer to patients in this group, and this offer would consist of the following: namely, the wish to provide better service provision. This offer involves both a quantitative and qualitative component. The quantitative component consists first of all in providing additional hours of consultation. Doctors will be available both on Saturdays, Sundays and during holidays. These are not emergency services. They have a sort of an initial service where patients can come and consult. They also wanted to strengthen the service of visiting physicians, who visit their patients at home, alongside nurses. The qualitative component of this network involves services and groups who will be involved in specific diseases. They will try to strengthen cooperation by using standardised protocols, e.g. doctors’ letters, which will also facilitate an exchange of patients because of course not every doctor is free to provide additional consulting hours. If the patients want to accept the system, then they will have the possibility to have referral practices through the usual standardised protocols. There will be case management; protocols for treatment for specific diseases will be established. Hospital services will be resorted to only when problems cannot be resolved on an outpatient basis. This association of course takes account of the economic factors, and this is why sickness insurance funds are prepared to allocate resources to this model, because they are convinced that such associations which will provide more efficient care. At present there were about a dozen such groups that were involved in similar services and others are being planned. These changes had become feasible because of the legal amendments and changes introduced in our social act.

They also had their own tax system, as well as an advisor and a counsellor, and an advisory council consisting of both experts and physicians. Two persons, a GP and a specialist, are responsible for the administration of this group.

QCD

The Chairman called on Dr Vigen to report on QCD actions

Dr Vigen “I want to recall what we decided upon at the London Forum meeting, that there was an urgent need for a glossary on QCD terminology. Secondly, we agreed that the group should produce a short booklet of the philosophy and simple principles on how to engage in QCD. And we gave this booklet to you last year. Then we decided that it should be translated into German, French and Russian, and should be distributed. I believe all NMAs have got it in English. So you will very soon have a French; German, and I hope also a Russian version. I have the impression from the questionnaire, however, that in the eastern countries, the medical associations have already presented in the journals, some translation of this booklet, in whole or as a summary.

During the discussion on QCD in the last Forum meeting in Copenhagen, you left the impression that the QCD action group should follow up their own suggestions as to how to help NMAs in improving QCD in the NMA. Therefore I sent out a questionnaire, and asked for NMA activities and interest in this area. According to the relative non-response, I believe the action group has closed its work so far. A new strategy is required. This strategy must take into account the differences in the health care systems in the various countries, the resources available and how long the NMAs already have experienced QCD.

To get an overview of the situation in the different NMAs in Europe, we sent out a questionnaire on QCD. This was answered by 32 medical associations, and it is already presented in the report. I will just summarise what was said in the responses to the questionnaire. Fifteen NMAs reported
to have QCD policy in their association; fifteen NMAs reported to run some systematic QCD activities; and fifteen associations wanted to engage more actively in QCD – nine of those are already strongly engaged in systematic QCD activities. That indicates to me that perhaps the activity on QCD should be spread more widely than only an elite group. 17 associations report that they have organized a QCD action group or a QCD committee. Sixteen countries are already engaged in working on preparing indicators for quality of care. In six countries Hungary, Israel, Slovenia, Sweden and United Kingdom there is some benchmark comparison between health care centres and health institutions.

Two special questions were given more serious consideration. Firstly whether there was a wish within the NMAs to take part in a sub-regional group on QCD activities. Secondly, whether the medical associations would like to take part in a QCD meeting to be arranged in autumn 1998. Ten of the twenty two reported that they would like the Forum to arrange sub regional groups of NMAs to cooperate on QCD activities, and eighteen NMAs would like to take part in a QCD meeting in the autumn to discuss how NMAs should be more engaged in QCD activities.

What was the idea behind those questions? We believe that NMAs working in similar health care systems would be able to support each other by coming together and discussing QCD activities, and through this activity they would be able to engage their members in QCD. The other idea was to start addressing the real problem of how to get from theory to practice in QCD, and how to make QCD a part of the daily work of medicine.

The problem about QCD sub regional groups is funding. How should we help groups to come together? Have all the NMAs money to consider this? Is it possible for them to do this? Can we obtain resources to obtain the competence from outside to teach them how to advance? Subject to these issues, we will try to arrange a QCD meeting some time in the autumn 1998.”

The Chairman invited Dr Kirsten Staehr-Johansen to give as an example of QCD in medical practice information about the project that WHO has been planning and initiating.

Dr Staehr-Johansen WHO “I have good news. It is not WHO, but actually the Forum who has been present together with WHO with this project for five years. The start was actually in the Utrecht meeting when the policy of quality of care development was accepted. If you remember, in Utrecht, the Swedish Medical Association presented their approach to management of depression, and everybody was impressed, including WHO. And therefore we approached Dr Anders Milton and asked, would you like to help us to develop a pan-European programme for quality development in the areas of depression care. And it was accepted and immediately a meeting was called for in August 1993.

This was the first consensus meeting on quality assurance indicators in mental health. Indicators were agreed upon in the meeting led by Swedish experts, with participation from all over Europe. Then it was agreed that the indicators had to be tested in different European settings, and indeed they were. The second meeting took place two years after, again hosted by the Swedish Medical Association. There was so much agreement that it was decided now to really go for implementation. The first draft report is available there, although I’m unhappy that Dr Milton cannot present this personally, but as far as I know he is sick. In this meeting there was a complete commitment to doing something in Europe. Because if you look in the HFA database you’ll be surprised to see that Denmark, which has a very high rate of suicide, has actually started going down and joining the countries with the lowest rates of suicide. And the question is of course, why? There has been a major effort among the GPs to do something about it. Our journals have been full that the GPs are using “happy pills” for everybody, but nobody has said
that this year we have one thousand fewer suicides. And nobody has said that each time you have a successful treatment of depression, it costs 300 dollars, but if you don’t diagnose it it costs more than $2500.

The Depression Care programme or project is now becoming a member of a family where we have established goals based on studies and scientific evidence. The degree of remission 6 weeks after the start of treatment should be 70%. The percentage of patients completing continuation treatment should be 50% after six months. The percentage of relapse should not be more than 20%. So the goals are there.

In several such programmes, e.g. diabetes care, obstetrical and gynaecology care, stroke and now depression, we now have goals established. In depression care we do not have national programmes, but Denmark has achieved some goals that you saw. The new generation of anti-depressive drugs is now coming more and more into the picture, although they are not necessarily in the essential drug list of WHO yet. We know that four months’ treatment gives a four-fold increase in effectiveness compared to the one month’s treatment. Also up to 12 weeks is the maximum usually people can support tricyclic antidepressants because of their side effects.

In view of the recent problems with use of blood in blood transfusion, you will see here that we have actually all the years included the use of blood transfusion in our quality programme. There is massive abuse of blood and blood products in Europe. We now have data on that.

We have data from 11 million births, including the total population in some countries. This is from the monitoring in 1988, and you’ll see that in some countries you have 7 kg usage of blood per thousand inhabitants and in other ones it’s about one. It does not signify that you will get better outcomes if you use 7 kg. If you look at the obstetrical data, you’ll see an immense difference, demonstrating a complete uncertainty. At a recent meeting it was clearly stated and demonstrated that you can reduce by at least 60% the use of blood and blood products in relation to birth, and probably 80-90%. The same is true for cardiac surgery. And some people have done it – in Belgium it has been achieved, for example, in l’Hopital de Louvain Catholique. It should be possible to reduce the use of blood by 60-80% in Europe doing no harm, and costing less.

The Chairman thanking the speaker said he was sure NMAs would take up the whole subject of quality care in the next Forums.

**Financing of the Forum**

Chairman, Dr Salzberg, “After these medical subjects, we go into daily life, and daily life means finance. And finance means inevitably a short report by the secretary, Dr Alan Rowe, who has presented a paper giving you the history of the financing of the Forum. How it started off with nothing except the funds of WHO; How we tried about 8 years ago to create an organization with structures and a formal constitution, which that was at that time rejected by most of the member organizations. How we lived with the contributions of participating countries plus the contributions of WHO, which had to be decreased in recent years because of other obligations of WHO. The question remains: how are we going to finance this Forum if it’s not kept in a western European country where the funding is, I assume, considerably easier than in countries of Central and Eastern Europe.”
Dr Alan Rowe EFMA, “I hope that the paper I circulated to all members of this Forum makes the realities of the situation quite clear. We started, as the Chairman has told you, with effectively total funding from WHO. Then we recognised that we had to make contributions from the full members. Recently in the very, very difficult financial climate which the Regional Office has been through in the last three or four years, with continuing cuts in resources, WHO felt bound to reduce the amount by which they could support the Forum with direct financing. However, apart from the support which the WHO gives substantially to enable representation from the more difficult parts of the region, they devote a huge amount of indirect resources to supporting this Forum.

I would draw your attention first to the figures which I think appear in the annex to your paper, relating to the average costs of four meetings up to the time of Copenhagen. If you look at those figures, one item stands out starkly – it is the costs of interpretation. We depend on our interpreters, but it is the most expensive item in your budget, and in the budget of all the other organizations, such as the Standing Committee, the World Medical Association, the European Union and the Commission. Therefore one of the things that your Liaison Committee has looked at in relation to the budget, is the provision of languages. I must tell you that on a number of occasions we have discussed whether we should reduce the number of languages, for example whether we should be a one language meeting. For example, here in Basel, one of the languages available at this meeting is being used by two countries only. This does pose very real problems. However, in the event, we decided that on this occasion we simply had had to have four languages. Nevertheless, you have to recognise that if you have four languages provided at all your meetings, you are going to end up with that sort of substantial figure.

Now I want to turn to the lunches and the coffee breaks during the meeting. They are not inexpensive. What you don’t see on this list is the dinners and the receptions, as these have always been regarded as something which the host member association should take upon its own responsibility. But I must tell you, that it can be extremely expensive, although these costs are substantially less in the central and eastern European countries. However, even there these costs are rising pretty steeply. We can no longer rely on the fact that when we are able to hold meetings in the NIS or the CEE countries, the costs, certainly in relation to refreshment, are going to be low, and to the best of my information, this also applies to accommodation.

These figures do not include the secretarial costs. And the costs of the secretariat are not insubstantial – they amount to something in the order of £16 000. There has been support for me from WHO for the last two and a half years, and there has also been some substantial support for me provided by the BMA. I must tell you that this does not include a number of other expenses which the secretary incurs, which are not insubstantial. So for the purposes of our discussion, you certainly need to consider that your secretariat will need supporting. In total, a realistic budget for each Forum is of the order of US $75 000.

You see here the average receipts for this Forum. The shortfall is what it costs the host organization to support the Forum. Some national medical associations have incurred a very substantial amount of loss. Of course, in part, that reflects the amount of hospitality which they feel able to afford.

So in realistic terms, you have got to face the question of how you are going to fund this Forum in the future. And that brings me to the present situation, and I have to remind you of one or two basic facts. At the Helsinki meeting, every medical association which attended became a member of the Forum. A significant number of those NMAs were being supported in their travel and in their accommodation, for reasons which you all understand. With the evolution of national
economies, gradually this situation is beginning to improve and some of these countries have been able either to make a small contribution or to meet, in one or two cases, the actual participation obligation payments. But so far these are a very small number of countries. I did a little calculation based on the present situation and the number of people who had attended in Basel. First of all you will see that I think there are 37 or 38 national medical associations who are members of the Forum at the present time. This is because they were at Helsinki or subsequently they have applied formally for membership to the Liaison Committee, their statutes have been examined, and the Forum has elected them as full members of this Forum. Of these associations only 31 pay the full participation fee. You will recall that the observers pay a half fee, and in addition if you bring more than two participants you pay an extra half participation payment for that third person.

If all the members and observers attending paid, you see what the revenue will be – US $32 000. And if you add to that the US $10 000 which WHO gives us to assist with this Forum, this brings us to US $42 000 or US $43 000. This is a long way away from US $58 000–56 000, and a very long way away from the real costs of the underlying structure of the secretariat, which are being borne in fact by WHO and the BMA. Currently your maximum participation fee is 900 ECUs. We did a calculation as to what the revenue would be if we put it up to 1500 ECUs. And there you see the result. It would bring the figure up to US $54 000. Add to that the US $10000 which WHO is putting in, and this brings you much nearer to the realistic figure.

The third calculation I made was based upon the people who at that time had indicated that they were coming to Basel. You will see that the revenue that you are paying as a Forum in total, is US $26 800. Again a very long way away from covering the costs of this Forum.

Your Liaison Committee has looked at these figures, and I must remind you that last year you put up the participation fee to 900 ECUs from the 800 it had previously been, and you see the effects of that. They have thought very hard and carefully about this and they feel that they feel they must submit to you a suggestion that the participation fee for the next year be set at 1200 ECUs. Now I understand full well, that is a very substantial increase, of 300 ECUs; one third of what you are paying at the moment, but it will not go all that far to solving our problems. Lastly, I draw your attention to the fact that even at 1200 or 1500 ECUs for many countries is an insignificant payment compared with the payments they have to pay to similar organizations at the European or World level.”

**Frau Bosch, Germany** “I have to go back to the very foundation of the Forum. I think you too know that this Forum has been very important for the medical organizations, and it has been important for WHO. That is to say the medical associations have a commitment to WHO to help implement their programmes. It is therefore also the duty of WHO to think about the financing. WHO has very clearly stated that they would be responsible for the secretariat costs, now we are being told that they are very expensive, I don’t understand it. Of course, daily costs are very high and we could make quite considerable savings if we were to meet in Copenhagen. There we have the premises and we don’t have to pay rental. There we have the scientific interpretation equipment; and probably we could also save there if we were to distribute the costs amongst the participants. Of course, socially speaking this would be backtracking because we’ve all enjoyed the hospitality extended by our hosts in the countries where we’ve met in the past.

Then is it really necessary that we should invite speakers with the costs to be borne by the Forum? Isn’t there a sufficient number of professional organizations who could provide speakers and participation? I think that if we think about it very carefully we could cut down costs by one third if not by 50%.”
**Dr Bonell, France** “You know our position and it has been very firm over a number of years. First the question of interpretation. Today, WHO is an organization which has four official languages and which must respect those four languages, Russian, German, English and French. On this point we would not want to have just a single language which might appear to be a monopoly situation. We support however the German proposal to have the Forum in Copenhagen where all the necessary technical facilities exist. So we are in favour of Copenhagen. A third point relates to the considerable increase suggested from 900 to 1200 ECUs. The French delegation is very much against this increase. We already contribute to the Standing Committee of Physicians of the European Community which was established before this Forum. We also pay contributions to other international bodies. We cannot devote more money to all these organizations.”

**Dr Rowe, EFMA** “Within the budget I showed you I have put the cost of speakers. In fact so far, the invited speakers from outside have been paid for by WHO. WHO pays their travel and accommodation. As far as the WHO personnel are concerned, they are not – and I repeat, not – a charge on the Forum, and they are not shown there.”

**Chairman** “In the cost that Dr Rowe put up on the transparency, we did not see the real manpower costs of the Medical Associations organising the Forum. I just want to mention that the colleague who assisted me in organising the Forum, worked for the past two weeks just for the Forum. I don’t want to count the hours and days that some other persons in the Medical Association worked. These are real costs to the host association.”

**Dr Vilmar Germany** “We are faced with a situation here in which WHO is no longer in a position to allocate relevant resources to the Forum and now require the medical associations to do it. Can we not introduce some savings? Also, is this all really meaningful. Is this input worthwhile? If we were to have a cost effectiveness analysis comparing the contributions for the Forum with those paid by the members for the World Medical Associations or for the permanent Committee of the Doctors of the European Union, we would be a bit sceptical. We wonder whether this can be fully justified in relation to our members.

We’ve had considerable discussions to this effect in Germany precisely because of these numerous international commitments, and it was felt that we should not be in favour of a further increase in expenditure because then cost effectiveness no longer shows a reasonable ratio. About 10 days ago we also discussed this in the Executive Committee in the European Union of the competent committee, and there too it was held that this is not justified to allocate greater resources to the EFMA. So I would urge you that if we are to continue, then we should do our level best to have to make some savings. Of course, interpretation costs are very high, but if we save on interpretation, then of course we will no longer be able to understand each other and I think the whole exercise would be meaningless if we were to leave interpretation by the wayside. So let’s save on other things, such as inviting outside speakers, rentals, etc.”

**Chairman** “If I may speak first of the financial burden of the western European medical associations. Complaining about contributions of 800 or 950 ECUs is I think a bit ridiculous. You can of course convert it into your currency. This is per member very little. Its just a few cents. Secondly, since 1991 this Forum has acquired a certain international reputation because of the interest in the eastern and central European countries. I believe this cooperation is extremely important. Then there are countries such as Switzerland which are not in the Permanent Committee and they are not just members of the World Federation of Physicians. For the time being the Forum is the only international body where we can all meet.”
Dr Macara, UK “I did not mean to speak but I have been frankly horrified by some of the things that have been said here. Dr Vilmar is treasurer of the World Medical Association. I wonder what he really thinks about the cost effectiveness and the cost benefit in the past of the World Medical Association? Now, Dr Vilmar and others of us are working hard within the WMA to make it an effective organization and perhaps it will be in future if we work hard enough. But I have to say, although the WMA has cost those of us who are members a very great deal more every year than the Forum, it’s very difficult to see what the WMA has actually achieved in the past. The WMA costs us something like 10 times as much as EFMA.

I would also remind you that Dr Rowe is not paid, which is in great contrast to the WMA where we pay a full time secretary and pay him properly. Now, the EU Permanent Committee, what has it achieved? Those of us who have been members of it for years have been asking about this. This also costs the BMA ten times as much as EFMA.

Now I come to EFMA, and I can say, frankly, this is the only organization to which the BMA belongs which is fully and truly representative of those whom it claims to represent. Medical associations in the whole of Europe, not just those of us who are fortunate enough to live in the west, north and parts of the south of Europe. We wanted to involve and to be involved with our colleagues in central and eastern Europe. I suggest the organization has achieved this precisely because of our partnership.

Now the funding of this Forum is not at all satisfactory. Certainly savings could be made, no doubt by meeting in Copenhagen, but then individual host countries have indicated that they wish us to have their hospitality and to move around. I don’t see what other savings can be very readily be made other than cheaper meals and cheaper hotels. The fact is that we have never had adequate basic core funding for EFMA and unless we are going to provide it I suggest that we should just give it up.”

Dr Lemye, Belgium “It is not possible, in my view, to compare the Forum as a meeting of partners on the basis of equality, with bodies such as the EU Permanent Committee. We shouldn’t forget the fact that WHO represents our governments, in a sense,- all our countries – and in my country my Health Minister and Minister of Social Affairs. Having said that, the Liaison Committee has examined the accounts and it is clear that there has been under-financing of this body. Without doubt I think we all want to continue these meetings. It is extremely important therefore that we should be able to do so. First of all we must have interpretation in all languages, this is important. This will ensure that we make further contacts with countries which wish to host the meetings. I believe that the dues asked of us are not too high. As to WHO’s commitment, as WHO is the first beneficiary of this Forum, so it should be called upon I think to make further efforts. I personally would be in favour of the increase suggested because it remains within reasonable limits.”

Dr Povarnovs, Latvia “The Latvian Medical Association is very small. Further it is in a transitional period, and thank you, WHO, for we have not hitherto had to pay for our participation. Nine hundred ECUs is for us is quite a large sum. If it is to increase even further, then in the near future if this is not provided for by WHO it may be difficult for us to actually participate in the Forum. But I realise of course that money is important and necessary, and I think we need to talk about the principles. If you look at how medical associations work together with governments, we would think that if governments are interested in the work of those organizations, then the governments should be prepared to cover some of the costs. In Latvia, we see that it is the converse situation that applies. We could ask in fact whether governments think
our Forum is necessary? Does WHO think the Forum is necessary? Should it continue? Should that question be put to a meeting of ministers perhaps – or even to the World Health Assembly?"

Dr Andreev Russia "Let’s restrict ourselves to practicalities. There are no additional resources available in European countries. Members simply cannot accept that costs should increase as suggested. So perhaps we could have our meetings in Copenhagen with a fixed team of interpreters, a team that would not need to travel, and which will be there.”

Chairman “Thank you, but I think I will just clarify a misunderstanding. In Copenhagen, too, you have to pay for interpreters. Maybe the infrastructure is somewhat different, but you still have to pay for it, Dr Andreev .”

Dr Andreev, Russia “The interpreters have just told me that Dr Andreev will have to pay ! I think this was a mistake, I’m afraid. The Russian Medical Association for the last two years has been a fully fledged member of this Forum and has been paying the contributions as specified-900 ECUs. Our association is a non-governmental association and this means in our country that the majority of its income is derived within the country. This means that we have practically no income at all. And the contributions we are paying at present are rather difficult to pay. But it is essential and we shall do so and continue to pay. Of course an increase in contributions will be extremely difficult for us. I would like to support our British colleagues, and also state that to save on receptions is to go against health – think of it, social communication, understanding, is so much more important than listening to invited speakers.”

Dr Petja, Austria “This Forum is extremely important and we are very happy about the contacts and information provided by the WHO. We think it is extremely important for us to build bridges to eastern European countries, but we have similar problems in our national association. In the cost benefit aspect, we are always being questioned and undoubtedly time and again we see that costs are rising. I think the wealthier countries surely would be able to spare a few more dollars. But if I have understood proceedings correctly, I see that even with the increase we will not be able to resolve our future financial problems and this item will come back on our agenda. The WHO will have to state just how important this event is for them. I think it is pointless if we fail to achieve the financing in the future, and I think that we need to ensure that all problems concerning eastern and western Europe be clarified in the framework of WHO.”

Dr Mart, Luxembourg “Thank you Mr Chairman. I must say that hitherto we have been paying the total contribution of 900 ECUs, and it would be the limit of what we could manage. This is particularly if you bear in mind the contributions to other international fora, which are proportional to the number of the members of these organizations. A couple of years ago we had a discussion in our board, to see whether we should continue to participate in the EFMA/WHO meetings, and I must say that when I heard that WHO is withdrawing part of its budget allocated to EFMA I was somewhat surprised. If WHO does have financing problems, it’s not the only organization in this situation. We also have financial problems, and we can’t compensate the reduced subvention from WHO through our own contribution.”

Dr Bonnell France “I would like to confirm on behalf of the French delegation the difficulties we all feel at present. We are not discussing the interest we have in the organization of this Forum and its meetings, and the interests we have in meeting our colleagues from other countries. We don’t always meet them elsewhere, and we also understand that other members are interested too in meetings such as these. At the same time, we think these interests are shared by WHO. In this context we don’t really understand why on the one hand one body is reducing its participation whereas on the other hand we are asking other organizations to increase their participation. And I
must say that in this respect we perfectly understand the analysis and assessments made by Dr Vilmar. If we want to retain the reality of meetings such as this one and make them sustainable and durable in the future, beyond this year and next, it will only be through drastic economies that we will be able to continue.”

**Dr Oro, Estonia** “Funding is always a very delicate question and I don’t have any good ideas how to solve these problems we are talking about here today. But I would like to stress the importance of that kind of meeting like the EFMA Forum is from the point of view of young democracies like Estonia. I was really surprised when I heard that some of the delegates here cannot be supported by their organizations because of the lack of money. This EFMA Forum has been very important, because it’s usually our only chance to make an informational discussion even in the social events. In my organization we are thinking about joining other European organizations which also seem to be very important ones, e.g. WMA, the EU Standing Committee. Of course for a small association it would be all the time the question of priorities.”

**The President, Dr Brunner**, “Of course I appreciate the concern voiced by the German delegation and also by other colleagues. As regards this funding please don’t get carried away and think that here in Switzerland we are flooded with gold. In our medical association we have similar problems and we have other foreign commitments. But I am afraid that we are just beating around the bush. This doesn’t seem to be the heart of the matter, so I am somewhat surprised. Why do countries want to host this major event. There must be a good reason for it. There is another reason for this discussion and the issue is what does the WHO want us to do, what they require us to do, what do they expect us to do. What do the national medical associations expect from WHO. This is the level at which we should be discussing this problem.”

**Ms Wapner, Israel** “I think Dr Brunner has touched a few points that I wanted to raise. The question here is whether we have enough funding for the Forum, or whether we do not? If we come to the conclusion that we want to have the Forum that is the first question that has to be answered. If the answer is that we do then the question is how do we get enough funding. Now I have heard a lot of discussion about cutting down costs. I was under the impression that the Liaison Committee at least, showed exactly from what the costs were compiled of. Frankly, even if we were to accept all the proposals on cutting down costs, I don’t think that the problem would be solved. The fundamental problem is not going to change if there is not enough funding. Now the participation of WHO has arisen. I think there is no doubt that the medical associations feel that WHO has a vested interest in this Forum, because everybody knows you cannot bring about changes in health or anything else if you do not engage doctors. I think that WHO should take a strong approach and an affirmative action and say that they would increase their contribution. But after doing so I don’t think that again will solve the problem. So I understood the proposal of the Liaison Committee was to increase the participants’ fee to a certain amount and leave yet a certain amount that should be funded by the WHO.”

**Dr Asvall, WHO** “Firstly, why did WHO reduce the contributions to the Forum? Simply because we have had a 23% cut in general funding in recent years and we have had the increased charge of reorienting our assistance to central and eastern European countries and NIS countries. We have cut 40 posts in the Regional Office, just to give you that background, two years ago.

Now, is WHO interested in continuing in the Forum and what do we expect to get out of the Forum? Why are we interested in you? That was posed by a number of organizations. It is quite simple. We believe, and we truly believe, as you will see when you read the updated Health for
All policy, that in today’s Europe, and even more in tomorrow’s Europe, there is fundamental need for a real partnership between the different partners in countries that can improve health.

The health professions are extremely important and the medical profession is certainly a major resource in a country to improve health. We believe that it is therefore very important that the ideas that come out through the Health for All policies that the European Regional Oganization, and this is the Member States, decide that we have a close dialogue and cooperation between the medical professions in Europe in that way. We believe that this will ultimately help the health of people in Europe. We think it will help the medical associations in giving better service to the people they serve. Also, we think it helps in WHO to get a better feeling and better information of what the medical profession thinks, and of the development products that you are undertaking.

If there is one wish we have, it would be that the type of things we have been doing, for example the Task Forces on tobacco and quality of care, should become more extensive in the future, and even more pragmatic and clearly programme-oriented.

The Forum, being a rather flexible type of arrangement meeting once a year, is not the only issue. The cooperation that different organizations want should try to develop certain areas that are important – we just discussed, for instance, the intensive work that has been done with regard to mental health and where the Swedish Medical Association has been particularly active – these type of initiatives we believe are important.

So WHO has absolutely no intention of pulling out of this cooperation. I would like to be very clear on that. We would hope that this will continue for many years in the future.

I feel that we should go back in the Liaison Committee and take a look again at some of the expenditure issues and some of the possible income issues and discuss and come back to the Forum next year to see if we can find any consensus on the future. I don’t think that after this debate with so many different types of proposals that came now we can really argue and find a good consensus during this meeting. That would be my proposal that we do it that way – go back into the Liaison Committee.”

**Chairman** “That was actually the suggestion I wanted to make to you. I think we go back to the Liaison Committee and think the whole thing over. We will have a structured discussion next year about contents and finances. I would suggest that we take our suggestion back. Those who come next year will pay the 900 ECUs and we will have a Forum next year. Maybe the local organizer will find additional means next year. Next year we will decide upon the contribution to the Forum.

This leads up to the last chapter of the meeting. We have some statements prepared for you and I would like to give the floor to DrRowe to read them.”

**Adoption of statements**

**Tobacco advertising**

After the text of the Statement had been read out by the Secretary, the statement on tobacco advertising was **adopted** by the Forum (Annex 2).
HFA strategy and health care resources

Dr Rowe “While you are finding this May I remind that this came out of yesterday’s debate. After the usual preamble the statement on HFA strategy and health care resources goes on to a second paragraph:

“concerned that for many countries in Europe, the total budget for the health sector is currently far lower than that considered to be adequate for countries in the European Region today;

conscious that this has a negative effect on the health of the population of these countries,

urges governments in these countries to reconsider their policies in this regard and to increase the resources available for health to ensure a good level of curative health care, effective health promotion and disease prevention for the care of both the population in general and of individual patients”.

Dr Fras “I would like to give our original proposal of the motion from yesterday with one correction…. Dr Alan Rowe “and I will read it” considers, first, it to be in the best interest of patients that initiatives in health promotion and preventive medicine should not be financed by moving resources from curative to preventive medicine until the total resources available for the health services justifies it”.

Dr Lemye, Belgium ”In the original motion essentially there is a reference to the fact that resources could be moved from curative to finance preventive medicine. Certain colleagues saw this as an attack against preventive medicine, but I think the text states clearly that preventive medicine has its reason for being and should be supported but that this should not be at the expense of curative medicine.

But there is another fundamental point I wanted to make. We have to make a choice between the individual and society because curative care will relate to the individual whereas preventive care relates to the society as a whole. Of course we hope that all individuals will in the end have better health status. However I think the first vocation of the physician is to deal with the individual patient. That is the humanist role of the physician. This is why I support very strongly the first motion rather than the second one.”

Dr Cepulic, Croatia “The International Monetary Fund is exerting pressure on some NIS and CCEE states to diminish the percentage of GNP used for health care. We saw some disappointing figures shown yesterday with Dr Asvall on deterioration of health conditions in some European areas. Such decreases in the financial resources in those countries is definitely jeopardising the level of health care reached. We do feel that International Monetary Fund and other bodies do not have enough understanding of the problem. Therefore we feel that one of the ways to escape this pressure and diminution of money determined for health care is to preserve the money for curative medicine, and to find other find tax sources for health promotion and preventive medicine.”

Dr Alderslade –WHO “I think that in listening to this discussion there are two issues involved. I think these two issues are, firstly, the level of funding overall within any health system and the second, the balance within any level of funding between prevention and treatment. I would say that a basic objective of a health system in any society is to improve the health of the population of that society as well as to provide that population with effective and good quality health care.
I would like to come from this perhaps philosophical point to an absolutely straight trade-off and look at the issue of lung cancer. We know that much currently expensive medical and surgical treatment of lung cancer is fundamentally ineffective. We also know that it is expensive. The motion which is now before us would actually prevent us shifting any resources from the medical and surgical treatment of lung cancer to something which we all know scientifically would do far more to prevent the disease, namely preventive programmes against smoking. As the motion stands such a transfer of resources would not be possible within any level of funding which was not judged to be adequate, however that judgement was made.”

Dr Lemye, Belgium “I think that this argument which has just been put forward merits a response, because it is not acceptable for me. I know that most cases of lung cancer are incurable and most patients die, but I don’t think it is the reason to abandon them.”

Dr Salzberg “We obviously have two basic opinions. We are not used to have declarations by voting. We have declarations by consensus. That was the policy in the past 15 years. I do not know how to solve that problem because there are really basic issues at stake.”

Dr Fras “After this short discussion and after a long discussion yesterday I couldn’t see anybody from the medical associations who really represent physicians as individuals who are dealing with patients who are against the first draft. All discussions against it came from the representatives of the WHO. I think that that is the main point and I do not believe that there is not consensus.”

A further speaker “I think there is nobody in this room who would speak against preventive medicine or against curative medicine. We need to look at this from a different angle. All the complexity arises from the various interests that are involved there. For states it may be in their interests to do what is cheapest and for physicians it is important to do what is necessary. If a physician thinks it is better to engage in preventive medicine then he will act in a certain way, but if he thinks that he has a patient he needs to treat, then he will treat that patient. There is a problem because of the low level of health resources and because the physician has to work today in existing conditions. Because of this we apparently can’t come to a consensus opinion.”

Dr Asvall “We are looking at the revision you had this morning from the drafting group that met last night. The second draft urges governments or countries where the total budget for the health sector is currently far lower than that that considered to be adequate for countries in the European Region today to reconsider their policies and to increase finding for the health sector. This is in order to be able to make available the resources necessary for a balanced health development. I think we could probably have been clearer in the fourth paragraph. We should have said that we urge governments in these countries to reconsider their policies in this regard and to increase the resources available for the health sector. I think that is an important distinction because I think there is full agreement in this room here that health promotion or disease prevention activities in sectors other than health should be funded from other sources, so there is absolutely no disagreement on that. Now you can get WHO to sign on that one with you. We have great difficulties in signing on the other one, but not from the fact that we don’t think we should treat patients. Of course we all agree that we should make the best possible treatment for the patients with the resources that are given. But we have great difficulty in creating a schism between what you do in the health sector between disease preventive and curative efforts. We don’t think that is right, because we think you should choose in any instance on the merit of the relative effectiveness of that. We agree that you have WHO behind it saying there is a lot more need for funds for curative services, but we believe a lot for funds are also needed for the
preventive services. We think there is too little money going to the health sector in many European countries. You can have a statement on that but we find the second one too mechanistic and putting a too limited view, also on the health profession. That is our problem. If you have a consensus for the first draft I would suggest a different heading, which says that medical associations at the meeting in Basel agreed to this. As WHO we will be happy to put our name on a resolution asking for more resources to the health sector.”

Dr Alderslade “Thank you, Chairman, just very briefly I would like to reply to Dr Lemye’s remarks. As Dr Asvall has said, WHO rejects schism or a conceptual division between prevention and therapy in relation to specific diseases and I certainly reject it too. I actually came into the preventive medicine and public health because I worked on a lung cancer ward. My comments were made from personal understanding of what the condition involves. I never said that people who have lung cancer should not be treated. Of course they should be treated properly and humanely and decently. That was not the point I was making. I was suggesting that anything that puts prevention and care in a form of hostility to each other and which does not look at the relative effectiveness of investing in those two vital elements of the management and care of a specific condition is unfortunate and negative. So I really do want to make those points of clarification.”

Mr Harvey (UEMS) “Why not take the Slovenian motion from the NMAs present only and not from the Forum?”

The Forum accepted that this should be taken as a separate motion of the NMAs present in Basel.

It was agreed that the statement on HFA strategy and health care resources be approved as a Forum statement (Annex 3).

The Slovenian statement on the “Allocation of resources for curative medicine and for health promotion and preventive medicine” was then adopted as a statement by those national medical associations present at the meeting (Annex 4).

Kosovo

The Forum also adopted a statement previously circulated on the threats to the health and civilians in Kosovo (Annex 5).

Date of the next Forum

Dr Piatkiewicz announced that the date proposed for the new meeting of the Forum in Warsaw would be 15–17 March 2000.

Closure

The President, Dr Brunner, in closing the meeting thanked all those who had given support to enable the meeting to take place, in particular the Swiss Federal Health authorities, the Swiss Bank Corporation, The Pharmaceutical Industry, notably Roche, Novartis and the Association of the British Pharmaceutical Industry. He once again thanked Dr Salzberg and others from the
Swiss Medical Association who had worked so hard to enable the meeting to take place at such short notice. Despite the last minute change of location the meeting had been a highly successful one. He was glad that the Swiss Medical Association had been able to assist in this and was sure that everyone looked forward to being in Israel next year.

Dr Sadikova, Kazakhstan, thanked the Swiss Medical Association for their kindness in hosting the meeting at such short notice and for their hospitality during the meeting. She hoped that the Liaison Committee would be able to meet in Kazakhstan in September and looked forward to welcoming them there.
Annex 1

HEALTH AND THE EUROPEAN COMMUNITY

A background note prepared by Dr A.J. Rowe, Secretary of the EFMA/WHO

This paper attempts to outline briefly the way in which health policy has developed in the European Community and to give a few indications of the areas covered by Community legislation and specific information about some areas of particular interest to NMAs. It is not meant to be exhaustive nor to mention all areas of Community legislation which have a direct or indirect influence on health e.g. the exhaustive legislation on Agriculture, regulation of Pharmaceutical Products licensing. The reader is directed to the European Commission’s publication A Public Health in Europe 1997, which provides a much more detailed analysis and the supportive documentation for future action.

The European Community has had a health interest from its very beginnings. The first basis for a limited health interest derived from the implementation of the provisions of article 3(e) of the Treaty establishing the European Coal and Steel Community (Paris 1951). This article sets out as one of the aims of the Community the promotion of improved working conditions and an improved standard of living for the workers in each of the industries for which it is responsible, so as to make possible their harmonization while the improvement is maintained. In the Coal and Steel industries, clearly an integral part of improving working conditions was to reduce the health and safety hazards inherent in the industrial processes. The major legal basis derives however from articles 20 and 31 of the Euratom Treaty established at the same time as the Treaty of Rome in 1957. A chapter of this Treaty is devoted to Health & Safety and it was under this title that the European Commission established a Department in DG V\(^1\) (Social Affairs) which has been the base upon which most developments in the field of health activity (apart from Research, DG XII, and mutual recognition of diplomas for certain health professions, initially DG XII, then DG III and now DG XV) have taken place.

At a later point (1975) in the context of Mutual recognition of qualifications of doctors and subsequently certain other health professions (article 57 of the Treaty of Rome) two bodies, the Advisory Committee on Medical Training (subsequently similar committees for Dentists, Nurses, Midwives), and a Committee of Senior Officials of Public Health were established. The latter body has gained increasing importance as the European Community has extended its activities in the field of health.

Until 1986 activity in the health field was strictly limited to health and safety areas, as the only other legal provision with possible health connections in the context of Community legislation related to a very broad interpretation of article 117 (an expansion of the last words of article 2 – see above) and article 118. This article calls for cooperation in the social field, particularly in relation to (amongst other things)

- labour law and working conditions
- social security
- prevention of occupational accidents and diseases
- occupational hygiene.

Under the provisions of this article, Health and Safety some legislation in such fields as Radiological safety (deriving from the Euratom Treaty provisions) affecting radiological diagnostic activities, and safety provisions for workers using word processors, hazardous materials, etc., was adopted.

\(^1\) The administrative structure of the European Commission is divided into Directorates General (DGs) reflecting broadly the responsibilities of the Commissioners.
From time to time some very limited actions in the Health field were introduced using the catch all provisions of article 203 which allowed for legislation not specifically provided for in the Treaty to be introduced if it was necessary to attain one of the objectives of the Treaty.

In 1986 with in Single Act a new article 118A called for particular attention by Member States to encouraging improvements, especially in the working environment as regards the health and safety of workers and shall set as their objective the harmonization of conditions in this area.

In 1986, with the international concern about AIDS, a political decision was taken by agreement of the Heads of State (in the absence of any specific legal basis for action in the health field) to initiate active programmes to combat AIDS, Cancer and Drug Abuse. This was the first major clear specific public health action in the context of the European Community.

The first real legal provision for substantial action in the health field appeared with the introduction of article 129 of the Treaty of Maastricht 1991, and this was further extended in the text of the Treaty of Amsterdam 1997 (which is still awaiting final ratification). This Article now reads as follows:

1. A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.

   Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education.

   The Community shall complement the Member States’ action in reducing drugs related health damage, including information and prevention.

2. The Community shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action.

   Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination.

3. The Community and the Member States shall foster cooperation with third countries and the competent international organizations in the sphere of public health.

4. The Council, acting in accordance with the procedure referred to in Article 189b, after consulting the Social and Economic Committee and the Committee of the Regions shall contribute to the achievement of the objectives referred to in this Article through adopting:

   (a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;

   (b) by way of derogation from Article 43, measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;

   (c) incentive measures designed to protect and improve human health, excluding any harmonization of the laws and regulations of the Member States.

   The Council, acting by a qualified majority on a proposal from the Commission, may also adopt recommendations for the purposes set out in this Article.

5. Community action in the field of public health shall fully respect the responsibilities of the Member States for the organization and delivery of health services and medical care. In particular, measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.
The legislation affecting health directly or indirectly is substantial and can be found by consulting the Directory of Community Legislation in Force (published by the European Commission every six months).

As indicated above there is a great deal of legislation concerning safety and protection of workers. In relation to environmental protection there is considerable legislation, including international agreements, on general actions to protect the environment as well as specific legislation in relation to the protection of specific areas and localities. There is a substantial collection of legislation aimed at hazard reduction from chemicals both in relation to pollution and also in relation to handling and protection of handlers. As mentioned above there are directives setting out basic measures for the radiation protection of individuals undergoing medical examinations or treatment, laying down the principles of Good Laboratory Practice; regulation of the prices of pharmaceutical products for human use and their inclusion in national health insurance systems, etc.

The programmes concerning AIDS, cancer and drugs were mostly carried out by Council Decisions or Resolutions which enabled the Commission to set up programmes for action in these fields. Such actions include health education and promotion, for which provision was made to identify training needs and provide training for those teachers responsible in Member States for professional training. Research projects both in relation to training needs, epidemiological studies, primary and secondary preventive activities, palliative care of patients with cancer were supported in the programme. Considerable emphasis was placed on public education including relevant health education of schoolchildren.

Tobacco control has had a very high priority in the Europe Against Cancer programme in all its aspects which include education, lifestyle change, legislation on advertising and environmental protection measures to control the risk of passive smoking, tar yield of cigarettes and health warnings in labelling of tobacco products.

In addition, both in the Europe Against Cancer programme and the important Biomedical and Health Research programmes of DG XII 2 research was supported on both epidemiology and treatment of cancers. Resolutions of the Council relate also to the Action Plan on AIDS including public information. This included HIV infection education in schools and workplaces; epidemiological surveys, exchange of information on treatment services, and training of health professionals.

Council Resolutions also established programmes on nutrition and health (in particular the problems of alcohol abuse) and a programme on food, drink and water safety in relation to human consumption.

Programmes were also promoted in relation to cardiovascular disease and an action programme to combat the use of drugs including misuse of prescribed drugs adopted.

All of these actions were taken through the provisions of the Treaty allowing for actions not specifically included in the Treaty but deemed necessary. As such actions were more frequently taken by the Council, it became increasingly clear that there was a need to incorporate formal provision in the Community Acts to provide a legal basis for health actions in the field of Public Health. This culminated in the changes incorporated in the Single Act and ultimately in the revisions adopted in Amsterdam (see above).

Of particular importance to the NIS/CEEC is the legislation relating to mutual recognition of degrees and diplomas with a view to free movement of professionals. The first of these instruments were the Directives of 1975 on mutual recognition and administrative provisions on mutual recognition of qualifications of doctors (75/362 and 363/EC), later to be followed by directives for pharmacists, nurses, midwives and veterinary surgeons. There were subsequent amendments to the doctors’ directives which were ultimately consolidated in 1993 (Directive 93/16/EEC). It was in connection with these directives that the Advisory Committees referred to above were set up.

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2 The very important BIOMED programmes of DG XII support a great deal of research in the field of health, not only in relation to the biological sciences but also in relation to health services, research into their provision and their administration.
Other legislation of relevance to the health field includes a directive on data protection of personal information which raised major concerns relating to epidemiological research.

Throughout this period of evolution of Community Law increasing emphasis has been placed on subsidiarity, i.e. the importance of decision-making and for legal competence to remain as much as possible with the individual governments of Member States. Community intervention in principle should be limited to those areas where it is necessary to the interests of the Community as a whole and could add a beneficial dimension which could not be achieved at the level of individual Member States.

As members of the Forum will be aware however, in addition to rapid technological advances, there have been substantial changes in disease patterns within Europe, an aging of the population, environmental change, the re-emergence of old infectious diseases, and the emergence of new diseases requiring collaborative efforts between Member States to combat them. In addition, with the period of economic recession and other influences, it has become clear that certain public health measures might better be taken on a collaborative basis between Member States. This would permit the collaboration of individuals, institutions and communities in combating disease and improving the health of citizens of the European Community in accordance with the aims set out in the various Treaties.

Thus, with the advent of the newly worded article in the Treaty giving a legal basis for action in the public health field, there is a need to define the parameters of public health policy in the context of the EEC and the manner in which actions in this field should be instituted.

This is relatively easy in relation to epidemiology and disease control as in the Council Decision (35/96) adopting a common position the Council decided that a health monitoring programme should be adopted with a view to establishing a community health monitoring system. It is less simple in relation to the macro and micro economic aspects of health care systems, hitherto strictly reserved for the subsidiarity powers of individual Member States.

Another consideration is the collaboration with other supranational agencies concerned with health policy and disease control. It is clear from the text of article 129 that the activities of these agencies should be taken into account in defining Community policy, to avoid duplication and also to permit collaborative programmes to be established where appropriate.

It is therefore highly appropriate that the Forum should have the opportunity to consider not only the proposals for HFA in the 21st century but also the manner in which public health policy in the European Union will develop.
Annex 2

STATEMENT ON TOBACCO

The European Forum of Medical Associations and WHO meeting in Basel, 6–7 March 1998

Reaffirming its previous Statements on Tobacco (Basel 1992, Budapest 1994, London 1995, Copenhagen 1997);

Calls upon the Parliament and the Council of Ministers of the European Union to resist any amendment to the current proposed directive on the approximation of the Laws, Regulations and Administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products.
Annex 3

STATEMENT ON HEALTH FOR ALL STRATEGY AND HEALTH CARE RESOURCES

The European Forum of Medical Associations and WHO meeting in Basel, 6–7 March 1998

Concerned that for many countries in Europe the total budget for the health sector is currently far lower than that considered to be adequate for countries in the European Region today;

Conscious that this has a negative effect on the health of the population of these countries;

Urges governments in these countries to reconsider their policies in this regard, and to increase the resources available for the health sector, in order to ensure a good level of curative health care, effective health promotion and disease prevention for the care of both the population in general and of individual patients.
Statement on the Allocation of Resources for Curative Medicine and for Health Promotion and Preventive Medicine

The European Forum of Medical Associations and WHO meeting in Basel, 6–7 March 1998

Aware of the importance of the proposed strategies regarding health promotion and preventive medicine actions proposed in the draft WHO strategy for health for all in the twenty-first century;

Recognizing that such actions require financial resources for their implementation;

Knowing that the positive results which health promotion and preventive medicine actions produce may only reduce the needs for curative medicine after a certain period of time;

Considers

(i) it to be in the best interests of patients that initiatives in health promotion and preventive medicine should not be financed by moving resources from curative to preventive medicine until the total resources available for the health services justified it;

(ii) it is essential that the funding of immunization programmes should be a priority for all health care provision programmes.
Annex 5

STATEMENT CONCERNING THREATS TO THE HEALTH OF CIVILIANS IN KOSOVO

The European Forum of Medical Associations and WHO meeting in Basel, 6–7 March 1998

Recalling its Declaration on Conflicts in Europe and Health (Basel 1992);

Recalling its Statements on assistance to war-devastated populations (Utrecht 1993, Budapest 1994, London 1995);

Recalling the United Nations Declaration on Human Rights;

Considering the recent violent events in Kosovo which are severely threatening not only the provision of health services but also the life and health of the civilian population;

Considering the poor working conditions of their medical care in Kosovo;

Deplores the recent violent actions in Kosovo and their effects on the population;

Encourages doctors in Kosovo to care for all wounded and sick people without discrimination;

Strongly supports the physicians of Kosovo in their willingness to promote peaceful solutions to their present difficulties;

Calls on the international community to stop urgently the process of civil disintegration in Kosovo.
Annex 6

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