

- Economic Crises on National Health Care Systems – Experience and Strategies
- The Impact of the Economic Recession on Nurses and Nursing in Iceland

---

# World Medical Association Officers, Chairpersons and Officials

**Dr. Dana HANSON**

WMA President  
Fredericton Medical Clinic  
1015 Regent Street Suite # 302,  
Fredericton, NB, E3B 6H5  
Canada

**Prof. Ketan D. DESAI**

WMA President-Elect  
Indian Medical Association  
Indraprastha Marg  
New Delhi 110 002  
I.M.A. House  
India

**Dr. Yoram BLACHAR**

WMA Immediate Past-President  
Israel Medical Assn  
2 Twin Towers  
35 Jabotinsky Street  
P.O. Box 3566  
Ramat-Gan 52136  
Israel

**Dr. Edward HILL**

WMA Chairperson of Council  
American Medical Assn  
515 North State Street  
Chicago, ILL 60610  
USA

**Dr. Masami ISHII**

WMA Vice-Chairman of Council  
Japan Medical Assn  
2-28-16 Honkomagome  
Bunkyo-ku  
Tokyo 113-8621  
Japan

**Prof. Dr. Jörg-Dietrich HOPPE**

WMA Treasurer  
Bundesärztekammer  
Herbert-Lewin-Platz 1  
10623 Berlin  
Germany

**Dr. Torunn JANBU**

WMA Chairperson of the Medical  
Ethics Committee  
Norwegian Medical Association  
P.O.Box 1152 sentrum  
0107 Oslo  
Norway

**Dr. José Luiz**

**GOMES DO AMARAL**  
WMA Chairperson of the Socio-  
Medical-Affairs Committee  
Associação Médica Brasileira  
Rua Sao Carlos do Pinhal 324  
Bela Vista, CEP 01333-903  
Sao Paulo, SP  
Brazil

**Dr. Mukesh HAIKERWAL**

WMA Chairperson of the Finance  
and Planning Committee  
58 Victoria Street  
Williamstown, VIC 3016  
Australia

**Dr. Guy DUMONT**

WMA Chairperson of the Associate  
Members  
14 rue des Tiennes  
1380 Lasne  
Belgium

**Prof. Dr. Karsten VILMAR**

WMA Treasurer Emeritus  
Schubertstr. 58  
28209 Bremen  
Germany

**Dr. Otmar KLOIBER**

WMA Secretary General  
13 chemin du Levant  
France 01212 Ferney-Voltaire  
France

[www.wma.net](http://www.wma.net)

---

## Official Journal of the World Medical Association

**Editor in Chief**

Dr. Pēteris Apinis  
Latvian Medical Association  
Skolas iela 3, Riga, Latvia  
Phone +371 67 220 661  
[peteris@arstubiedriba.lv](mailto:peteris@arstubiedriba.lv)  
[editorin-chief@wma.net](mailto:editorin-chief@wma.net)

**Co-Editor**

Dr. Alan J. Rowe  
Haughley Grange, Stowmarket  
Suffolk IP143QT, UK

**Co-Editor**

Prof. Dr. med. Elmar Doppelfeld  
Bachmer Str. 29-33  
D-50931, Köln, Germany

**Assistant Editor**

Velta Pozņaka  
[wmj-editor@wma.net](mailto:wmj-editor@wma.net)

**Journal design and**

**cover design by** Jānis Pavlovskis

**Layout and Artwork**

The Latvian Medical Publisher  
"Medicīnas apgāds", President Dr. Maija Šetlere,  
Katrīnas iela 2, Riga, Latvia

**Cover painting:**

Serbian Orthodox Monastery Chilandar, found-  
ed in 1298 and The Medical Code of Chilandar  
from the 16<sup>th</sup> century.

**Publisher**

The World Medical Association, Inc. BP 63  
01212 Ferney-Voltaire Cedex, France

**Publishing House**

Deutscher-Ärzte Verlag GmbH,  
Dieselstr. 2, P.O.Box 40 02 65  
50832 Köln/Germany  
Phone (0 22 34) 70 11-0  
Fax (0 22 34) 70 11-2 55

**Producer**

Alexander Krauth

**Business Managers**

J. Führer, D. Weber  
50859 Köln, Dieselstr. 2, Germany  
IBAN: DE83370100500019250506  
BIC: PBNKDEFF  
Bank: Deutsche Apotheker- und Ärztebank,  
IBAN: DE28300606010101107410  
BIC: DAAEDED  
50670 Köln, No. 01 011 07410  
At present rate-card No. 6 a is valid

The magazine is published bi-monthly.  
Subscriptions will be accepted by  
Deutscher Ärzte-Verlag or  
the World Medical Association

Subscription fee € 22,80 per annum (incl.  
7% MwSt.). For members of the World Medical  
Association and for Associate members the  
subscription fee is settled by the membership  
or associate payment. Details of Associate  
Membership may be found at the World  
Medical Association website [www.wma.net](http://www.wma.net)

Printed by  
Deutscher Ärzte-Verlag  
Köln, Germany  
ISSN: 0049-8122



Opinions expressed in this journal – especially those in authored contributions – do not necessarily reflect WMA policy or positions

## Coming to Vancouver

An exiting year lies behind us since the General Assembly in New Delhi. Council and General Assembly will consider new policy and potentially adopt new bylaws. The work groups will come back with new proposals and Council will start rolling out a new strategic plan for the coming years.

By far the heaviest paper before Council (and if Council adopts it - the General Assembly) will be a consolidated set of bylaws and Procedures and Operating Policies which should bring logically together what has developed as rules of the organization over the past decades, but was scattered over different documents, sometimes with conflicting, often outdated wording.

Our rules weren't bad at all, but they were from a time when mail took weeks, fax machines could only be found in the offices of the big newspapers and the Internet was unknown. The changes that were made merely adapted the old rules, but were added in secondary documents, sometimes in contradiction to the still valid old wording of the by-laws or, at least, leaving some ambiguities.

The consolidation before Council does not bring new rules to be applied, but it provides clarity and stringency returns to our bylaws. As in the past, the General Assembly will charge the Council with the operational policies and procedures, which then will form a clear set of rules, hopefully leaving no questions open.

Our association has been in a difficult situation with our President-Elect, Dr. Ketan Desai, arrested on April 22nd this year. First, under charges of bribery, and as he was not indicted for that, thereafter under charges of "disproportionate assets". He has been kept in custody. Months have gone by, but no "charge sheet", as indictments are called in India, has been filed against him. At the end of September he was released from custody and we are anxious to hear from him in Vancouver. His friends have always stated that the arrest was politically motivated. It was aimed to take him out of power as the government finally tried to dismantle physician self-governance with a new act on the Medical Council of India (MCI).

Indeed the new parliament hurried up and a few days after passing the law that is designed to turn the largest self-governed physician body of the world into a government watch dog Ketan Desai was released. For nearly ten years he had combated the government's attempts to get rid of the self-governed MCI, including protests and a countrywide strike. The charismatic and powerful leader had become a state-enemy.

There are more questions open now than answers are available. But the real answer may lie in what the famous André Wynen told us when he resigned from office: "A medical leader should be intelligent, but in the first place a leader should be courageous." He knew what he was talking about, as a member of the Belgian Resistance he spent the winter 1944 to 1945 as prisoner at the Concentration Camp in Buchenwald. We will have to be courageous and intelligent.

*Dr. Otmar Kloiber*  
*WMA Secretary General*

## WMA Supports Physicians in Refusing Punishment Request

**Press release, 24 August 2010**

The World Medical Association supports physicians in Saudi Arabia in refusing to carry out a punishment as suggested by a court that would be a severe breach of medical ethics.

This follows the recent request to hospitals by a Saudi Arabian judge to damage a man's spinal cord as a punishment for his attacking and paralyzing another man.

Dr. Dana Hanson, President of the WMA, said: "This is an appalling request and one

which every physician must resist. As the WMA's Declaration of Tokyo clearly states no physician should participate in the practice of torture or any other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty of. The Declaration also includes a prohibition of participation in the planning or advising for such a procedure.

"Physicians must at all times preserve their ethical independence. The Declaration of

Geneva states that, 'The health of my patient will be my first consideration,' and the International Code of Medical Ethics declares that, 'A physician shall act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient.'

"This refers to all patients whatever their status".

For further information please contact:

Dr. Otmar Kloiber  
WMA Secretary General  
+33 4 50 42 6757

Nigel Duncan  
WMA Public Relations Consultant  
+44 (0) 20 8997 3653

## Final Conclusions

### WMA conference on “Financial crisis and its implications for health care”, Riga, September 10-11<sup>th</sup> 2010

The global economic crisis has made a significant negative impact on public health and health care systems all over the world. The impact has been particularly detrimental for the health of low-income population groups, as well as for women and children. Growing unemployment and poverty, as well as crisis-inflated payments for health-care services have frequently prevented people from turning to timely health-care. Though countries have had varied success in handling the impact of the crisis on health-care systems, progress has been better in those countries where the respective governments have managed to maintain their health budgets and have seen the crisis as an opportunity for taking strong decisions on the reforms to be carried out, making long-term contributions to the management of the health-care system, prioritising on investments in human capital, improvement of its productivity and better use.

Economic crisis is a time for deeper contemplation. Governments together with medical associations and health-care professionals have to reconsider correlations between economics and health-care policies with a clear understanding that investments in health are investments in a country's human resources which are at the basis for the economic development of any country.

The time of economic crisis is a time for opportunities. It is the right time for modifying health-care systems, abandoning what has been superfluous and excessive, at the same time sustaining the resources for health-care. The emphasis should be on adequate availability of services, through providing for evidence-based patient needs. Decisions have to be taken by way of channelling new resources towards prevention, health promotion and primary health care. It has to be acknowledged that in most countries allocations for prevention are disproportionately small and they should not

be further reduced during a time of crisis; on the contrary – we should look at additional and more focused investment in order to reduce the long-term impact of the crisis on public health.

Economic crisis is a time for taking responsibility, with the public and private sectors having particularly important roles to play in placing health issues high on the public and political agenda. Health budgets should be safeguarded and used rationally. Health is hardly the sector to be reduced when governments have a problem in coping with balancing the budget.

Lessons learned from this conference include the vital importance of setting a higher priority on health-care and health-care spending during times of economic downturn, while understanding and encouraging counter-cyclical health expenditure strategies. Both the private and public health-care sectors must understand that investment in health-care, especially investment in human capital, continuing education and primary care, as well as research is critical for the wellbeing and sustainability of health-care and the economy for present and future generations.

## Impact of Economic Crises on National Health Care Systems – Experience and Strategies

Presentation at the WMA conference on “Financial crisis and its implications for health care”, Riga, September 10-11<sup>th</sup> 2010

The most widely used indicator of an economic crisis is the decline of the Gross Domestic Product (GDP), which measures the economic activity in a country. When GDP declines for at least two consecutive quarters, an economy is typically declared to be in recession. A GDP decline which is substantial (e.g., - 10%) and sustained (e.g., lasting two or more years) is often called an economic depression.

While recessions are part of the business cycle of economies and are nothing new, the most recent recession was unprecedented in its scope. Reflecting the growing interdependency of economies, it was the first global recession, as shown in Figure 1.

There are reasons to expect that the recent economic crisis may result in a health crisis. Because of the economic crisis, health expenditure may be cut. Absent compen-



*Reinhard Angelmar*

sating efficiency improvements, such a cut may lead to a deterioration in a population's

health status. An increase in the need for health care resulting from the negative effects of economic distress on health could further aggravate this deterioration.

I will concentrate here on the impact of an economic crisis on health expenditure. Two main questions will be addressed: (1) Does a decline in GDP always lead to a decline in health expenditure or, less damaging, to a slow-down in the growth of health expenditure? (2) Do public and private health expenditure respond in the same way to a decline in GDP?

Does a decline in GDP always lead to a decline in health expenditure?

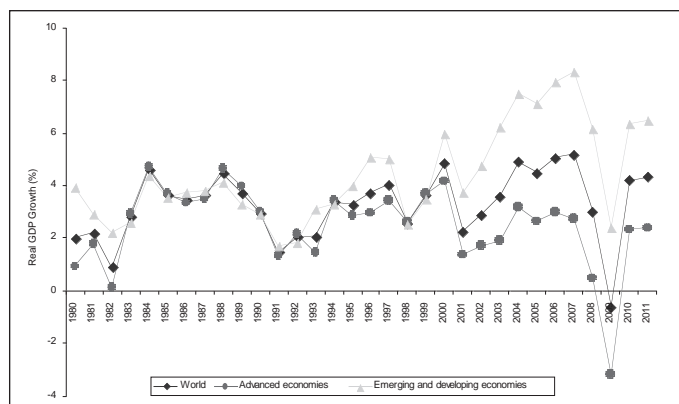
A decline in GDP generally leads to a decline in the financial resources of households, firms, and governments due to rising unemployment, reduced profits, and lower tax revenues. When an economic crisis is accompanied by a financial crisis, the declining value of stocks, houses and other assets further reduces the ability to finance expenditures for health care and other items through the sale of these assets. And when a crisis is global, remittances from abroad and foreign aid are likely to diminish as well. Unless health expenditure is seen as a high priority compared with other types of expenditures, one would expect health expenditure to decline in a recession along with GDP.

The expectation that a GDP decline leads to a decline in health expenditure is consistent with the many studies that have shown a positive relationship between the growth of GDP and of health expenditure [1]. If health expenditure goes up when GDP goes up, it should also go down when GDP goes down. One would therefore expect that the number of years of declining health expenditure over time matches the number of recession years in a country.

Figure 2 plots the percent of years with negative GDP growth against the percent of years with negative health expenditure growth for the 34 countries included in the OECD (Organization for Economic Cooperation and Development) Health Data 2010 database. Both GDP and health expenditure growth are in real terms, that is, removing the effect of inflation, and on a per capita basis. For each country, the analysis uses all available years since 1980.

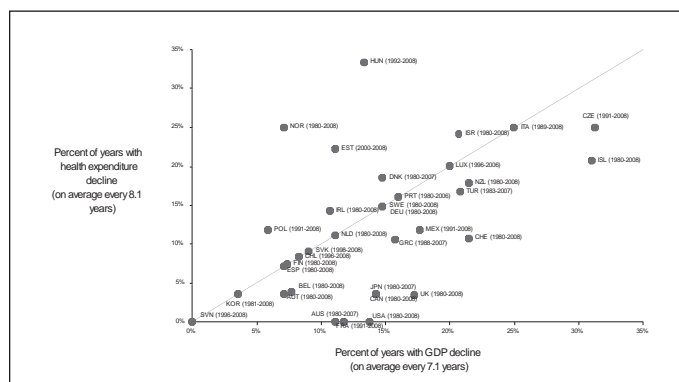
The diagonal line in Figure 2 represents the expectation that the number of years with a decline in health expenditure (negative health expenditure growth) is equal to the number of recession years (years with negative GDP growth). Figure 2 shows that there is indeed a number of countries which fit this expectation (e.g., Italy, Germany, Spain, Chile, Korea) or come close to it (e.g., Israel, Denmark, Ireland). However, there are also three countries which, despite having experienced recessions, have not seen a cut in health expenditure

**Figure 1. Real Annual GDP Growth**



Source : International Monetary Fund, *World Economic Outlook Database*, April 2010

**Figure 2. Frequency of Health Expenditure Decline and of GDP Decline**



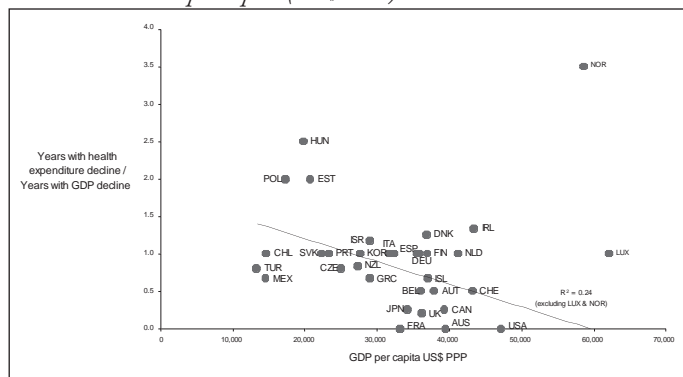
Source: OECD Health Data 2010

(USA, France, Australia). In the opposite direction, one finds countries in which a decline in health expenditure has occurred more frequently than a decline in GDP (e.g., Hungary and Norway).

Economic crises and health expenditure crises therefore are not as tightly connected as one would expect, at least in the OECD countries. A decline in GDP is neither a necessary (e.g., Hungary) nor a sufficient (e.g., USA) condition for health expenditure to decline. Whether an economic crisis leads to a cut in health expenditure varies from one country to the next.

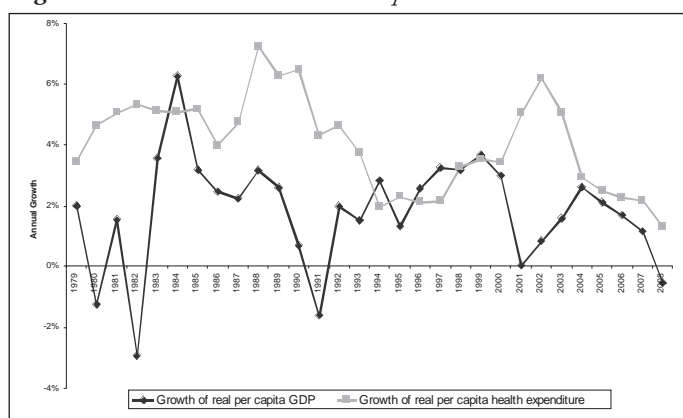
What explains the country differences in the link between economic and health expenditure crises? Figure 3 indicates that a country's income plays a significant role. The greater a country's GDP per capita (at US\$ purchasing power parity), the lower the frequency

**Figure 3.** Years with Health Expenditure Decline / Years with GDP Decline and GDP per capita (US\$ PPP)



Source: OECD Health Data 2010

**Figure 4.** GDP Growth and Health Expenditure Growth in the US



Source: OECD Health Data 2010

of a decline in health expenditure compared with the frequency of a decline in GDP. In high-income countries, health expenditure is more protected in recession times than in lower-income countries.

Does a decline in GDP always lead to a slow-down in the growth of health expenditure?

The preceding discussion has shown that the worst case outcome of an economic crisis, namely a decline in health expenditure, does not always occur. But should one not at least see a slow-down in the growth of health expenditure during a recession?

When one analyzes the evolution of GDP growth and health expenditure growth over time, one sees a diverse pattern of health expenditure response to a recession, both within one country, and

across countries. This diversity is illustrated in the following figures from the U.S., the country with the highest per capita health expenditure (2008), and from Turkey, the country with the lowest per capita health expenditure (2007) in the OECD health data.

Figure 4 shows the evolution of the growth of real per capita GDP and health expenditure in the U.S. between 1979 and 2008. U.S. GDP growth displays significant fluctuations, called business cycles, punctuated by recessions in 1980 and 1982 (a “double-dip” recession), 1991, 2001 and 2008. Three different types of health expenditure response to a recession are apparent:

Acyclical behavior, in which health expenditure growth is unrelated to GDP growth (no correlation between GDP growth and health expenditure growth): in 1982, GDP declined significantly, yet health expenditure growth changed very little; furthermore, while GDP growth fluctuated widely between 1981 and 1985, health expenditure growth showed little variation during the same period.

Pro-cyclical behavior, in which health expenditure growth increases when GDP growth increases, and slows down when GDP growth slows down (positive correlation between GDP growth and health expenditure growth): during the 1991 and 2008 recessions, health expenditure growth slowed down considerably.

Counter-cyclical behavior, in which health expenditure growth increases when GDP growth slows down, and goes down when GDP growth goes up (negative correlation between GDP growth and health expenditure growth): during the 1980 and 2001 recessions, health expenditure growth actually increased; the years 2003 and 2004 also demonstrate counter-cyclical behavior: GDP growth increased whereas health expenditure growth declined.

The diverse response pattern apparent in the U.S. stands in stark contrast to the consistent pro-cyclical behavior one sees in Turkey (see Figure 5). In all recession years for which health expenditure data are available (1985, 1989, 1991, 1994, 2001), health expenditure behaved in a pro-cyclical manner, either declining (1985, 1994, 2001) or experiencing a growth slow-down (1989 and 1991). Pro-cyclical behavior is also present in most non-recession years, with health expenditure growth rising and falling in parallel with GDP growth.

Only a pro-cyclical behavior of health expenditure is consistent with the many studies that have found a positive relationship between GDP growth and health expenditure growth. Acyclical and counter-cyclical responses, such as the ones that one observes in the U.S., are not. The solution to this puzzle may well lie in the methods used in these studies. In a recent study of OECD countries, one econometric method found only positive relationships between

GDP growth and health expenditure growth, indicating procyclical behavior of health expenditure in all countries. However, using another method, the authors found no or negative relationships for some countries, indicating acyclical or counter-cyclical health expenditure behavior in these countries [3]. Again, the link between the evolution of GDP and health expenditure appears to vary greatly across different countries.

Do public and private health expenditure respond in a similar way to a GDP decline?

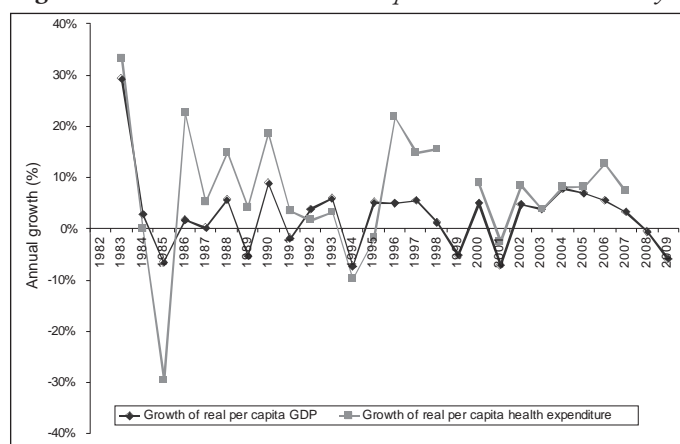
The question of how health expenditure behaves over the business cycle is particularly relevant for public health expenditure. Government policy makers might seek to stabilize health expenditure through a counter-cyclical public health expenditure policy, compensating procyclical private health expenditure. In addition, such a policy could also be an instrument for macroeconomic stabilization. Pro-cyclical public health spending, by contrast, might reflect a passive, hands-off approach to health expenditure and economic fluctuations.

Panel A of Figure 6 shows the evolution of GDP growth and public expenditure growth in the U.S. between 1979 and 2008. In four out of the five recessions during this period, public health expenditure increased, in addition to displaying counter-cyclical behavior in many non-recession years as well. In stark contrast to the counter-cyclical behavior in the U.S., Panel B of Figure 6 shows that public health expenditure in Turkey was highly pro-cyclical. Health expenditure growth slowed down in all five recession years for which health expenditure data are available. Throughout, health expenditure growth generally moved up and down in parallel with GDP growth. The counter-cyclical behavior of public health expenditure in the U.S. and its pro-cyclical behavior in Turkey observed here is consistent with the results obtained by Hercowitz and Straczynski [2] in their analysis of the cyclicity of total government expenditure in these two countries over the 1975-1998 period.

Figure 7 allows to compare the cyclical behavior of public and private health expenditure. Panel A shows that the growth of public and private health expenditure in the U.S. evolved in opposite directions during three out of the five recession years, with growth in non-recession years also often showing opposite behavior. This indicates that public and private health expenditure in the U.S. were to some extent substitutes, with private health expenditure compensating for a slowdown in public health expenditure and vice versa.

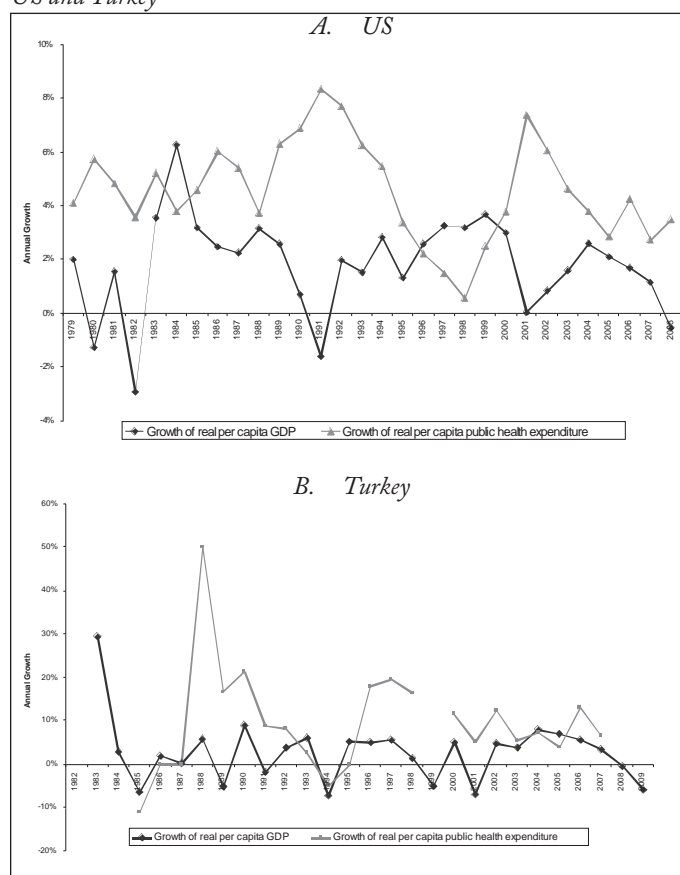
Similar to what one saw in the previous comparisons, the pattern for Turkey in Panel B of Figure 7 is different from that for the U.S. In Turkey, both public and private expenditure growth display pro-cyclical behavior, slowing down together in recession years. However, whereas private health expenditure declined or stopped growing in

**Figure 5. GDP Growth and Health Expenditure Growth in Turkey**



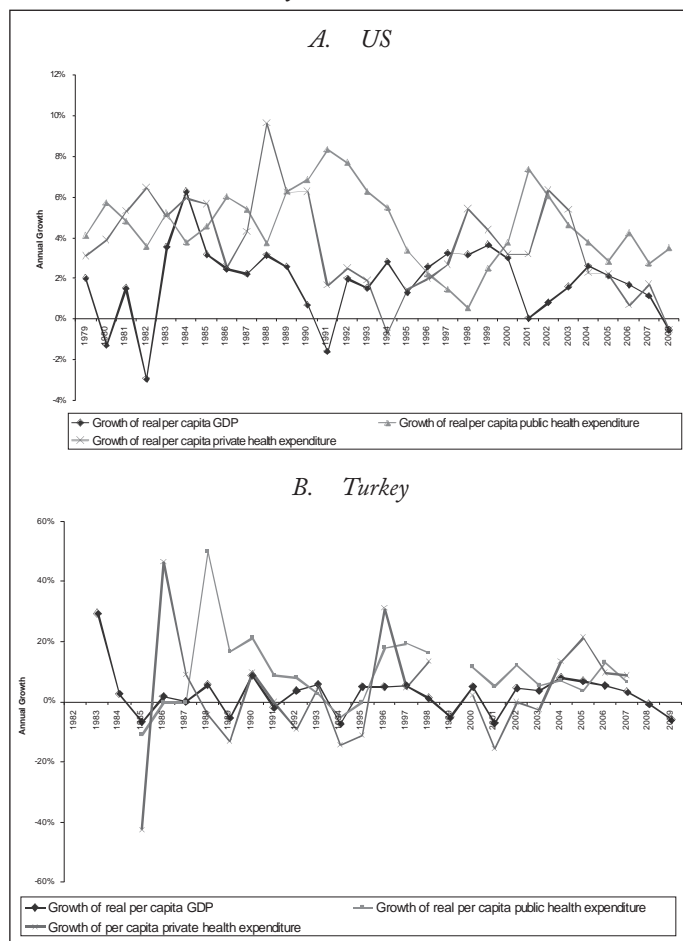
Source: OECD Health Data 2010

**Figure 6. GDP Growth and Public Health Expenditure Growth in the US and Turkey**



Source: OECD Health Data 2010

**Figure 7. GDP Growth, Public and Private Health Expenditure Growth in the US and Turkey**



Source: OECD Health Data 2010

all recession years, public health expenditure kept growing, albeit at a slower rate, in three of these years (1999, 1991, 2001) and declined significantly less than private expenditure during the two other recession years (1985 and 1994). Public health expenditure in Turkey thus was much less negatively impacted in recession years than private health expenditure, thereby softening the negative impact on health expenditure of the latter.

Beyond their differences, there is therefore an important commonality between the U.S. and Turkey. In both countries, private health expenditure responded more negatively to recessions than public health expenditure, and the latter contributed to reducing the fluctuation in health expenditure over the business cycle.

## Conclusion

It is often thought that economic crises induce a reduction in the level or growth of health expenditure. However, the data from OECD countries examined here indicate that the impact of economic crises on health expenditure is more varied than expected.

Some countries have never cut health expenditure in recent decades despite going through several recessions, others have experienced significantly more years with expenditure cuts than years with recessions, and many fall between the two extremes. And whereas in many countries as expected the growth of health expenditure slows down or becomes negative in response to a recession, one also finds countries where health expenditure growth displays a counter-cyclical behavior, going up when GDP declines, and slowing down as GDP growth rises. Public health expenditure in particular may show such counter-cyclical behavior, or at least experience less of a growth slow-down compared with private health expenditure.

Health expenditure enjoys greater immunity against recession-induced cuts in high-income than in lower-income countries. Future research should identify other determinants and discover what explains counter-cyclical or pro-cyclical behavior of overall, public and private health expenditure.

This article has addressed only the question of how economic crises impact health expenditure. Considering their respective impact on health during an economic crisis, a counter-cyclical health expenditure policy seems to be preferable to a pro-cyclical policy. However, the impact of health expenditure on health also depends on how the money is spent. An economic crisis may well be an opportunity for improving the efficiency and equity of health expenditure. One would hope that countries that cut health expenditure during a crisis do so in a way that enhances both of these outcomes.

## References

1. Gerdtham UG, Jönsson B. International comparisons of health expenditure: theory, data and econometric analysis. In: Culyer AJ, Newhouse JP, editors. *Handbook of Health Economics*. Vol. 1. 2000. p. 11-53.
2. Hercowitz Z, Strawczynski M. Cyclical ratcheting in government spending: evidence from the OECD. *The Review of Economics and Statistics*. 2004; 86(1): 353-61.
3. Baltagi BH, Moscone F. Health care expenditure and income in the OECD reconsidered: evidence from panel data. *Economic Modelling*. 2010; 27: 804-11.

Reinhard Angelmar  
Professor of Marketing  
*The Salmon and Rameau Fellow in Healthcare Management*

## Global and local financial crisis – a challenge to the national health system. Example of Latvia

Presentation at the WMA conference on “Financial crisis and its implications for health care”, Riga, September 10-11<sup>th</sup> 2010



*Girts Brigis*

### Background

Latvia is one of the so-called Baltic countries with a population of 2.3 million and a territory of about 64,600 sq. kilometers. It joined the European Union in 2004. Already before that Latvia experienced steep economic growth and continued it within the EU. The maximum increase was reached during the period between 2005 and 2008. Analysts of economy at that time called this process an “overheating of economy” and warned about possible problems in the future. This period was characterized by an annual increase in GDP by 11% (Figure 1), with the annual consumer price inflation up to 17% and high and uncritical crediting by banks leading to a real estate bubble. Despite this growth, the state budget remained with a fiscal deficit. This was different in comparison with the neighboring country Estonia, where the budget reserve was accumulated during the economic growth. It should be mentioned that a very important economic

sector in Latvia was banking which was active in providing international services.

After the breaking down of the Soviet Union Latvia inherited the tax-based health care system. Despite some political willingness to turn to social insurance system, due to pragmatic financial (e.g., relatively low income and essential proportion of “grey” economy) and demographic reasons (e.g., large proportion of the elderly) Latvia found this system feasible and efficient up to the present moment. However, Latvia experienced a period with a marked proportion out of payroll tax for health care in the late nineties. The reason to abandon this approach was the low population income and the necessity to subsidize health system from other taxes by state. Also in the mid nineties Latvia introduced primary health care system with family physicians, did a partial privatization of services, and started successfully to introduce health promotion [1].

However, health care has never been considered as a priority by the Latvian parliament (Saeima) and government. Public expenditure for health has never exceeded 4% of GDP, which is one of the lowest proportions in Europe. Despite that, in general, there was a trend of increase in public spending for health during the years of economic growth (Figure 2).

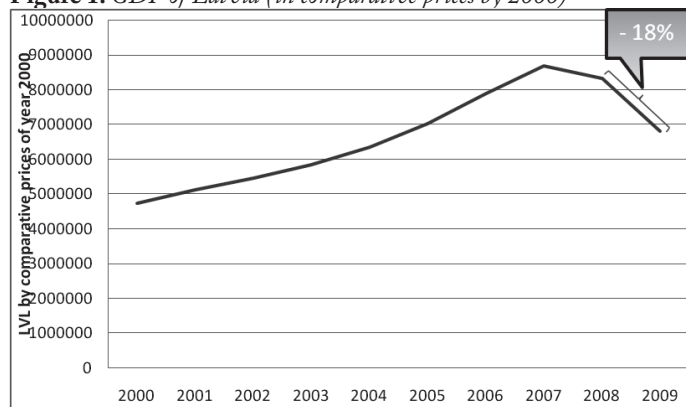
At the beginning of this century, the Latvian government took a World Bank's loan to design and implement health sector reforms. One very important plan concerned the structural reforms of Latvian health care, because, from the Soviet times, the system was oriented to inpatient care with too

many hospitals, hospital beds in comparison with the Western European countries, and correspondingly with an inefficient financial spending. Unfortunately the starting of this plan was delayed and it was not started during the so-called good years of economic growth.

### Effect of the global financial crisis on the financing of Latvia's health system

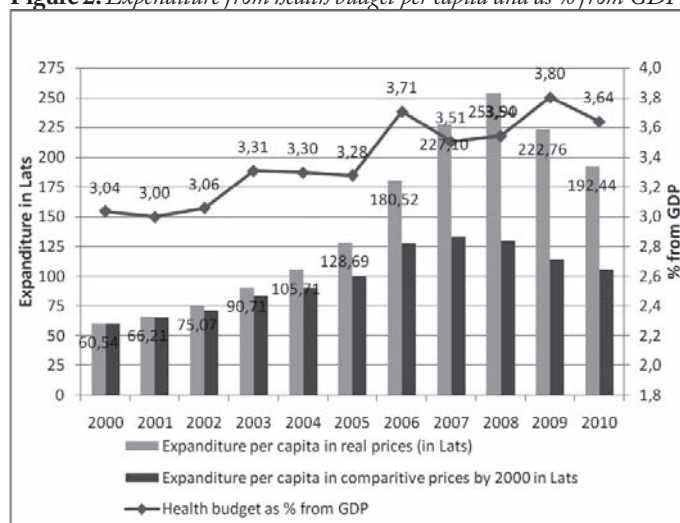
When the global financial crisis started in 2008, many Latvian people did not pay much attention to the events taking place in the American and British banks. Therefore it was quite a shock to the Latvian people to suddenly hear about the bankruptcy of one of the biggest banks in Latvia – Parex Bank. Most of the biggest banks in Latvia are owned by foreign (Scandinavian, German) companies. Parex Bank was exceptionally owned by local investors. After some hesitation the Latvian government decided to save this bank. By the way, today this hesitation is considered as a mistake with quite big losses. About one billion Latvian Lats (about 1.4 billion Euros) were taken from state budget for a deposit in that bank. Taking into account that the GDP in 2008 was about 15 billion Lats (in absolute prices), this decision led to an immediate fiscal crisis with a following economic crisis. The Latvian government of that time decided to apply to the international community, in particular to the International Monetary Fund, World Bank and European Community, for a loan. The loan was given on a very strict condition that the state budget deficit was reduced. The essential budget consolidation immediately influenced all the public sector. The number of employees in the public sector reduced, salaries decreased, institutions closed, and taxis increased. This in turn led to a further slowdown of the economy of Latvia by aggravating the economic crisis with progressing unemployment and other social consequences. During the year after the beginning of crisis GDP decreased by 18% (Figure 1).

**Figure 1.** GDP of Latvia (in comparative prices by 2000)



Source: Database of the Central Statistical Bureau of Latvia.

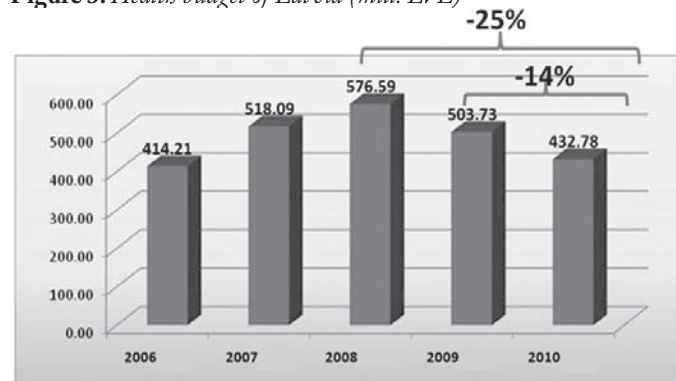
**Figure 2.** Expenditure from health budget per capita and as % from GDP



Source: Ministry of Health of Latvia, 2010

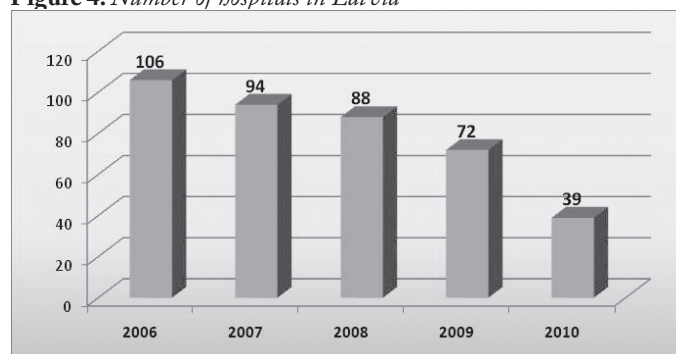
State health budget was cut seriously. Figure 3 shows that during the following 2 years public health spending reduced by 25 % [2]. The same can be seen in Figure 2: per capita expenditure decreased from 253.9 Lats (362.7 EUR) in 2008 to 192.4 Lats (274.9 EUR) in 2010 (budget plan). Already in 2008 out-of-pocket spending was quite high in Latvia – about 39% according to WHO calculations [3]. There is no updated evidence about the current situation, but everyday experience shows that the decrease in public expenditure has led to a dramatic increase in out-of-pocket spending leading to serious problems of access to health care of Latvian population. The Health Minister of Latvia resigned in 2009 just after the categorical request of the President of Ministers to do the next cut of health budget not believing in the possibility to run the system with such a cut budget.

**Figure 3.** Health budget of Latvia (mill. LVL)



Source: Ministry of Health; Report to the Saeima about the current situation in 2010.

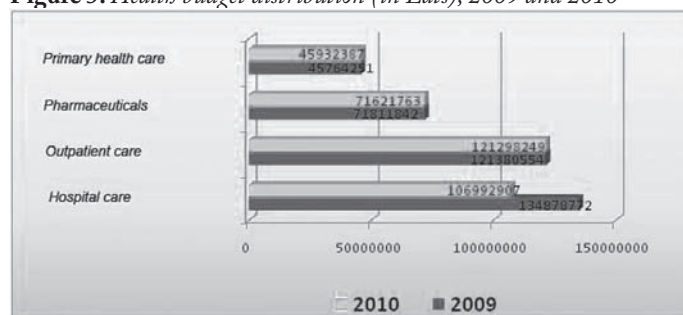
**Figure 4.** Number of hospitals in Latvia



Source: Ministry of Health; Report to the Saeima about the current situation in 2010.

At the beginning of 2010 the Minister of Finance and the President of Ministers recommended the Minister of Health to create an expert working group to make an investigation into the possibilities for a change in the health financing system in Latvia. The idea was to introduce a private health insurance system with an aim to attract additional financial resources for health care and reduce the responsibility of the government sector. The health financing models in the USA, Netherlands, Austria and Estonia were analyzed. Despite disagreements between the experts of health sector and financial sector (Bank of Latvia) the final conclusion was to deny the idea as this involved unavoidable increase in payroll tax and was unacceptable to employers [4]. However, the discussion about health insurance is ongoing up to the present moment, and outcome will depend on the results of the Parliamentary Election (October 2010). There is a threat that the financial and economic crisis in Latvia can lead to mistakes and unjustified reforms with longstanding consequences for the health system.

**Figure 5.** Health budget distribution (in Lats); 2009 and 2010



Source: Ministry of Health; Report to the Saeima about the current situation in 2010.

**Table 1.** Budget cuts in the health care of Latvia (selected)

Function	Cuts in 2009 against 2008 (%)	Cuts in 2010 against 2008(%)
Treatment	-10,2	-40,4
Public health	-24,0	-88,6
Central administration	-28,4	-58,6
Medical and health education at universty	-27,1	-41,7
Administration of health care financing	-19,3	-67,7

Source: Ministry of Health and State's Chancellery of the Cabinet of Ministers.

## Effects of expenditure cuts on the Latvian health care system

At the beginning of this decade the World Bank prepared a master plan for the structural reforms of the health system of Latvia. Reduction of hospital beds was intended. The financial crisis and budget cuts forced the Ministry of Health of Latvia to start immediate reforms. A number of hospitals were closed or transformed into social care institutions in 2009. Figure 4 shows the decrease in the number of hospitals. This resulted in the reduction in the proportion of the health budget spent for hospital care from 61.4% in 2008 to 27.1% in 2010. The relative spending for outpatient care in this situation increased from 21.5% in 2008 to 30.7% in 2010. Unfortunately, there was no increase for outpatient care in absolute numbers (Figure 5) [2]. Also, it means that there was no other aim for reform but cuts. This created additional burden for primary health care and emergency care with no additional resources. Moreover, due to the financial disaster hospitals actually stopped all planned care financed with public money. This raised additional demand for the delayed emergency and acute care. Hospitals did not refuse acute care and found themselves

in serious debts. The Government, as an exclusion, allocated 26 million Lats to partially cover these debts in the current year. It is necessary to conclude that structural and probably other health system reforms carried out during the crisis with the only aim of financial cuts are leading to system failure and social stress.

Probably the public health system (disease prevention, health promotion, technology assessment, health information) suffered and is still suffering most of all during the financial crisis in Latvia. Table 1 provides some selected comparative data on financial cuts. Public health cuts during 2009 and 2010 reached 88.6%. Two leading institutions, the Agency of Public Health and the Agency of Health Statistics and Medical Technology, were closed leaving some minor functions to the Health Economy Center, the Health Inspectorate, and the Center of Infectology. An additional reason for that was pressure from mass media and business to reconsider the functions of government sector including health care and public health institutions. Poor understanding of the functions of public health led to the destruction of the system which was successfully built for the last 15 years. Also, public health represents a long-term vision for health with sustainable achievements. Unfortunately, the financial crisis cancels any long-term initiative.

At present there are some signs of financial stabilization in Latvia. Nevertheless it is difficult to expect improvements in the near future. Because of the too high fiscal deficit, the International Monetary Fund, a provider of the loan, requires further cuts in government spending. The largest proportions of state expenditure pertain to social security, health care and education. Also, the forthcoming election of the parliament (Saeima) is providing a lot of populist promises in the mass media and delays serious budget planning. The nearest future will reveal the ability of the State of Latvia to fulfil the obligation under its Constitution: Article 111 "The State shall protect human health and guarantee a basic level of medical assistance for everyone"[5] .

## References

1. Tragakes, E. et al. Latvia: Health system review. Health Systems in Transition. Vol. 10. 2008: European Observatory on Health Systems and Policies, 251.
2. Informative report "On the situation in health care" submitted to the Cabinet of Ministers on June 14, 2010. 2010, Ministry of Health of Latvia, Riga.
3. European Health for All Database (HFA-DB). 2010, World Health Organization Regional Office for Europe.
4. Report on feasibility to introduce health insurance system in Latvia. 2010, Ministry of Health of Latvia, Riga.
5. Constitution of Latvia. Available from: [http://www.saeima.lv/LapasEnglish/Constitution\\_Saturs.htm](http://www.saeima.lv/LapasEnglish/Constitution_Saturs.htm)

*Girts Brigis, professor of Public Health and Epidemiology at Riga Stradins University*

## What are the Minimal Services to be Provided by the Healthcare System?

Presentation at the WMA conference on "Financial crisis and its implications for health care", Riga, September 10-11<sup>th</sup> 2010



*Konstanty Radziwill*

Most of the European States have got constitutional provisions stating that everyone has the right for health. In most of them public authorities must ensure equal access to health care services financed from public funds to all citizens, regardless of their financial situation and a special health care is provided to children, pregnant women, disabled, chronically ill and elderly persons.

Many European States specify conditions and scope of healthcare benefits in high-level rulings. There is a long list of areas of health care to be covered: disease prevention and early detection of diseases (including vaccinations), primary health care, outpatient specialist services, medical rehabilitation, dental care, hospital care, psychological care, long-term nursing and care (including palliative and hospice care), spa treatment, supply of medicinal products, and devices, transport, medical emergency services, etc.

Of course, the governments or parliaments make decisions on the level of public spend-

ing on healthcare. However, in many European States decisions on public expenditures on healthcare and the basket of healthcare services guaranteed to citizens are made independently. There is very little counting how much the medical services guaranteed cost. Public spendings most often are collected from citizens' contributions based on their income, but they differ very much. Public health spendings reached in Europe an average level of 8.4% of GDP (ranging from less than 3% in Cyprus to over 10% in Sweden). It accounts for between 10 and 15% of total primary government spending in most EU countries, although it is ranging from 6.0% in Cyprus to 18% in Norway. Of course, taking into account differences in the GDP level, in real figures they differ much, much more.

The share of healthcare spendings in all public expenditures in Europe has been growing, suggesting that in majority of the European States health care budgets fared better than other expenditure items during periods of „fiscal consolidation“. Of course, in some countries it has not.

Planning how much should be spent on health care the real dilemma is to be faced: how much responsibility for citizens' health belongs to the state and to which extent individuals should feel it is their own business?

The basic basket of medical services guaranteed to all the citizens of particular country may consist of medical rescue services, prenatal care and newborn care, child care (including assessment of health and development and mandatory vaccinations), care of women during pregnancy, childbirth, the

puerperium and of breast-feeding mothers, long-term nursing and care (including palliative and hospice care), hospital care and outpatient specialist services for chronically ill patients. If there are enough resources, the list can be prolonged with disease prevention and early detection of diseases (including adults' vaccinations), primary health care, medical rehabilitation, dental care, psychological care, spa treatment, supply of medicinal products and devices and medical transport.

It seems that what is proved to be preventive, urgent, necessary but expensive or needed by the weakest and most vulnerable patients should be considered as basic.

Preventive measures, often very simple and relatively cheap, enable to save much in the future. This is why health promotion and information, preventive provisions (anti-tobacco, anti-alcohol, anti-drugs, dietary, sanitary, etc.) and necessary vaccinations (also for adults) should be in the center of public interest.

Urgent measures, such as medical rescue services and emergent outpatient and hospital care must be given to all in need without any difficulties. It should be given also with no limits to refugees, homeless unemployed, etc.

Necessary (from the evidence based medical point of view) but expensive hospital care and one-day inpatient diagnostic/therapeutic procedures should be also in the basket.

Procedures needed by the weakest and most vulnerable patients, such as prenatal care and newborn care, child care, care of women during pregnancy, childbirth, the puerperium and of breast-feeding mothers and long-term nursing and care (particularly palliative and hospice care) should be also guaranteed.

Summarizing, the division of the responsibilities between the state and citizens should

be designed. The state must feel responsible for the health promotion, urgent, necessary and expensive medical services and medical care over the weakest and most vulnerable citizens. The individual citizens should take care of health prevention matters and

all preventable and cheap procedures. In the time of an aging population, rapid development of medical sciences and public money constrictions it is simply to be faced: **“subsidiarity of the state and not replacing all people’s thinking is the must.”**

*Konstanty Radziwill, MD, President,  
Standing Committee of European Doctors*

## How can Health Care Systems be structured and managed to be less sensitive to crisis and play a stabilizing role in economy?

Presentation at the WMA conference on “Financial crisis and its implications for health care”, Riga, September 10-11<sup>th</sup> 2010



*Haino Burmester*

From a theoretical point of view it might seem simple to structure and manage health care systems in a way that makes them less vulnerable to crises and, therefore, able to play a stabilizing role in economy. Since the variables involved in managing such health systems can generally be ascertained or predicted by demographic and epidemiological studies, it should be possible to factor them into a mathematical model to create a program that works. Of course, this is not so! In practice things are far more complicated and unpredictable than expected. So, let us explore the difficulties.

The problem with most health systems is not only lack of proper funding but it is also

the amount of waste it is produced within them. Problems in these systems (mostly in developing countries) are therefore both funding and management. Let’s be provocative. Either we agree with the following assertion of Prof. Rosenthal or we do not: “Health care is the economy and fixing it would free up money for other priorities, such as education and industrial innovation. The health care system is dysfunctional and full of waste — as much as 30% of all spending. Unlike most other markets, consumers rarely know which doctors, drugs or treatments are best for them, don’t price shop and, if they’re insured, don’t know the full cost of care. And that all can lead to unnecessary spending”. (Meredith Rosenthal, a Harvard University professor of health economics and policy).

It is also important to consider health problems beyond local, regional or national contexts only. As a report from the UN states: “the paradigm of self-sufficiency has recently been challenged. As part of the global response to the HIV/AIDS epidemic, the aim of national self-sufficiency was thrown overboard by some activists. Wealthy nations were pressured into contributing their fair share by AIDS activists who adopted human rights arguments to push for expanded access to AIDS treatment, for which the cost at the time greatly exceeded

the present and future financial capacity of some of the most seriously affected countries. This new development aid approach is based on the idea of building sustained transnational redistributive fiscal transfers and creating new within-country protective mechanisms in poor nations. It appears to be gaining ground. In April 2009, the Government of Ethiopia signed a Joint Financial Agreement with the World Bank, the U.K. Department for International Development, Ireland’s Irish Aid, and other donor and U.N. agencies, which stated that Ethiopia needs an additional US\$1.4 billion per year, as a starting redistribution of capital, to achieve the health-related Millennium Development Goals. While this agreement constitutes merely an acknowledgment of a funding gap and a fundamental inequality in resources, the fact that Ethiopia’s present government health budget (including present “on budget” development assistance) stands at about US\$400 million per year indicates that an ambitious target has been agreed to, one that can only be reached through *sustained* transnational redistributive fiscal transfers a form of global social health protection”.

In light of this global concern, there are some policy questions that have to be answered to sufficiently address the issue. These questions are related to the basic difficulties each and every system must confront in order to solve its problems: How are resources mobilized and managed? Who pays for what and how? Who provides goods/services and what resources do they use? How are health care funds distributed across different services / interventions / activities produced by the health system? Who benefits from health care expenditure? In other words:

how the system is planned and how it is managed?

What are the challenges health care systems must address under the stress of an economic crisis? At the fundamental level, it must contribute to restoring confidence among society as a whole by restoring/maintaining the workers' health as well as the health of families and communities. In doing so, it will ultimately be contributing to restoration of the economic health of businesses, which is a vital factor in returning the over-all economy to normal.

Low income countries suffer when there is reduced demand for their exports, which reduces access to capital. Foreign investments decline as do remittances from people living abroad. Unemployment comes and these countries usually have no adequate safety net to compensate for those in need. Public sector services become the more favored source of health care at the very time when government revenues to finance these services are under the greatest pressure.

High income countries also have their share of health care problems. For example, the United States has an incredible amount of resources an unthinkable amount for most countries. Americans spend more on health care than the entire Brazilian GDP, including expenditures for health care provider salaries, hospitals, outpatient centers, Veterans Affairs and other clinics, doctor and dentist practices, physical therapists, nursing homes, home health services and on-site care at places such as schools and work sites. It also includes retail sales of prescription and nonprescription drugs, premiums paid to health insurers and producers of medical devices, surgical equipment and durable medical equipment such as eyeglasses, hearing aids and wheelchairs. It also accounts for out-of-pocket payments by consumers for health insurance premiums, deductibles and co-payments. But, we will see that even with such massive amounts of money spent on health care, Americans also have problems that, as we all know, are not due to any specific

financial crisis. Health insurance premiums have skyrocketed, making it ever-tougher for workers and employers to afford them. From 1999 through 2008, annual health insurance premiums jumped 119%. The average family premium paid by workers rose from \$1,543 to \$3,354 per year, and employer payments per worker jumped from \$4,247 to \$9,325. During that span, worker earnings rose only 34% and overall inflation was just 29%. So worker income has barely kept pace with inflation, more of the paycheck is going to health costs, and there is less income left over for things like vacations, home improvements or a new car — especially for low-wage workers and retirees. This lack of disposable income for such items represents a huge drag on the economic growth, considering that consumer spending powers about 70% of the American economy. For employers, particularly small businesses, rising insurance premiums mean far less money for new equipment, better facilities, research or expansion. That means fewer new jobs, plus smaller raises and higher health premiums for workers, further limiting consumer spending.

High income countries take measures, including complex and politically challenging reform, in anticipation of increases in spending on health and pensions. But there is also evidence that plans to set aside resources and create the fiscal space to address the future health needs of the elderly are shelved as the crisis deepens.

It is critical for countries to protect life and livelihood and to boost productivity by maintaining levels of health and other social expenditures. If countries do not have adequate reserves and revenues decline, the shortfall will have to come from aid. And this aid will need to be skillfully managed for maximum impact. The critical point is that commitments to maintain levels of aid are not an extra element in the recovery agenda, but integral to its success.

Under the circumstances of an economic crisis, what can health systems do to help the

economy as a whole? First and foremost it is important to gather quality, real-time information to guide the response; there is no way to act properly without solid data that allows decision-makers, for example, to be able to identify groups most at risk; to ensure that safety net programs are well targeted so they reach the most needy; to seek efficiencies in spending where possible; to know where and when external aid is required to ensure that it effectively used. It is crucial to sustain spending on prevention (which is often the first casualty of spending cuts). And it is important to recognize that crisis often offer opportunities for reform; some of the best managed health systems in the world verify the potential to improve under critical circumstances.

The former Canadian Minister of Health, Marc Lalonde said in 1974 that the four cornerstones of any health care system are: human biology; the environment; lifestyle; and health care organization. This theory is as true today as it was in 1974. So, health care organization demands a management model that should be as effective in times of crisis as in normal times.

Let us examine how the Brazilian health system is structured and managed to be less vulnerable to crisis and play a stabilizing role in economy, not because it is necessarily a model to be followed but because it has survived the economic crisis without major decreases in supply of health services. In other words the system didn't change its normal level of effectiveness. It should be noted that the system's effectiveness may still have a long way to go in order to achieve excellence. But the system has a long history of trial and errors that brought it to its present stage: far from maturity but with a well-developed management model that is constantly being improved little by little.

The principles of the Unified National Health System (SUS) are the ideological references on which the system is based. They derive from the Constitution that states health care as a right of the people and a duty

of the State to provide. At this moment, the concept is being questioned as far as the responsibility of the individuals themselves for their own health. **Universality** means that every citizen has right to be cared for within the system, but at this point we should also introduce the duty of persons to care for their own health with respect to other citizens. **Integral** is related to the types of services provides. The **equity** aspect is concerned with fairness, equal rights, or equality (same opportunity to all). Another important principle is the **social control** over the system put into practice by participation of the people in the Health Councils. Administrative and political **decentralization** is a cornerstone of the system. The **hierarchy** principle directs access to the services and must be done according to the region where the person resides and the acuteness of his or her condition. Other principles that should be mentioned are: preservation of the **autonomy** of patients facing diagnostic and therapeutic procedures; total **access to information** concerning care delivered; total **knowledge of the types of services** provided by each facility; use of epidemiological data to determine priorities; **integration** of health care delivery with basic sanitation and environmental concerns; **coordinated** use of federal, state and municipal resources to avoid duplication of public services provided at the same location and for the same purpose; and **resolution** of problems at the most appropriated level.

The basic structure of the health care organization in Brazil is based on its division of

responsibilities and attributions among the three layers of power: federal, state and municipal. When these three sources of financing act properly the system has a chance to be successful. The three different levels of financing according to the total budget of each of these sectors of government are, at a minimum: Federal Government 5%; States 12%; and Municipal Governments 15%. Municipalities are responsible for emergencies and primary care; the states are responsible for secondary and tertiary care; and the federal government is responsible for general policy making and strategic decisions plus the federal university hospitals and medical schools.

SUS provides primary, secondary and tertiary care delivered under contract or at its own facilities; control and supervision of procedures, products and substances of interest to health and promoting the production of medicines, equipment, immunobiological products, blood products and other inputs; performing actions of sanitary and epidemiologic surveillance and workers' health; training and development of human resources; policy formulation and implementation of basic sanitation; scientific and technological development; oversight and control of foodstuffs, including control of their nutritional content and water for human consumption; participation in the supervision and control of production, transportation, storage and use of psychoactive substances and products, toxic and radioactive products; collaboration in protect-

ing the environment, including that of labor conditions and workers' health.

In conclusion, we must recognize that health care is one of the pivotal factors that countries can use to overcome an economic crisis. In spite of all the problems we have seen so far, the health care industry is still one of the engines of the economy and it helps countries to face the challenges of economic crisis creating jobs and maintaining consumption of goods and services. Of course, there are always a need for improvement, such as eliminating waste, improving efficiency and increasing preventive care. It is unlikely that health care provider jobs will decline during economic crisis, since demand and supply of health care services are, or should be, basically inelastic.

*Haino Burmester (reghaino.ops@terra.com.br), is Physician and Business Administrator, with a Masters Degree in Community Medicine from the University of London; Professor of Hospital Administration at the São Paulo School of Business Administration (Fundação Getúlio Vargas, Brazil), Chief of Staff of the Superintendence of the University Hospital, São Paulo Medical School; Coordinator of the Program Commitment to Health Quality (CQH) maintained by the São Paulo Regional Council of Medicine and the Paulista Medical Association; Advisor to the World Health Organization; President of the São Paulo Association for Preventive Medicine and Health Administration.*

## Impact of Economic Growth and Financial Crisis on Estonia's Health Care

Presentation at the WMA conference on "Financial crisis and its implications for health care", Riga, September 10-11<sup>th</sup> 2010

This is a case study from Estonia – a country where the health system enjoyed annual budget increase of 20% during 2004 –2008 – and which now has to

maintain and to improve performance in the reality of economic recession. In this short paper some selective examples will be provided on the availability of re-

sources and use of services over the last couple of years as well as lessons learned and challenges ahead.

During the years of economic growth, the Estonian Health Insurance Fund collected financial reserves that can keep the health system public expenditure during 2010–2011 at the level of 2007. However, the reserves will be exhausted in 2012 and if new taxes are not introduced to cover public health care costs, the current health sys-



*Raul Kiivet*

tem shall face drastic cuts that will decrease availability and access to services and care. Moreover, currently there is no political will and leadership to rearrange the financing and governance of health system and services into one based on rational use of resources for the decade of no-growth.

Prosperous years before the economic crisis have allowed to invest heavily into new technologies for both diagnosis and treatment, and to double the salaries of doctors and nurses during 2005–2008 without increase in the volume of services.

Until now (2010) the number of health services provided to the population have decreased by 2–4% in both out-patient and hospital care, as compared to 2008, when the provision of services had reached its ever highest level in Estonia. By 2008, the major achievements can be summarised as following:

- patient satisfaction with availability and quality of care was very high;
- emigration of doctors and nurses had stopped;
- availability of high-tech diagnostic equipment and rate of use had reached European top level;
- use of prescription medicines had doubled in 8 years;

- availability and use of resource-intensive services (hip replacement, invasive cardiology) had doubled in recent years;
- a number of modern and expensive treatments in nephrology, oncology and rheumatology were included to the public insurance basket of services.

During 2009 the economic crisis in Estonia increased unemployment fourfold and it reached 20% at highest. This has put public sector finances under very serious constraints and the governmental spending in 2010 has dropped to the level of 2006. As the need for social support has increased severalfold, the prospects of health care to regain its financial basis are not good at all.

#### Lessons learned:

- During recent years the economic growth in Estonia allowed to introduce new technologies and to increase prices, which has pushed the medical profession to become a service provider for the medical and pharmaceutical industries.
- Economic growth and availability of new financial resources were not managed and governed to increase the availability of human resources and services in the most underdeveloped health sector in Estonia – nursing and rehabilitation – that lag behind the needs of the ageing population.

**Table 1.** Increase in the volume of diagnostic tests and procedures

	2001	2004	2008
Lab tests & analysis (10 <sup>6</sup> )	9.5 (100%)	10.8 (115%)	15.1 (159%)
incl biochemistry (10 <sup>6</sup> )	3.8 (100%)	5.1 (134%)	8.6 (226%)
Ultrasound diagnostics	429 000 (100%)	474 000 (110%)	654 000 (152%)
Endoscopic procedures	83 000 (100%)	79 000 (95%)	91 000 (109%)
CT and MRI investigations	45 000 (100%)	96 000 (213%)	236 000 (536%)

#### Morale for the medical profession

Now, when the politicians are not willing or able to adapt the health system according to the economic reality, it is the opportunity for the medical profession to use its knowledge, skills and prestige and to take the wheel for the benefit of patients and society.

*Raul Kiivet, Professor of Health Care Management, Department of Public Health, University of Tartu, Estonia*

**Table 2.** Change in selected economic indicators in Estonia (% as compared to previous year)

	2007	2008	2009	2010	2011
Change in GDP	14.5%	–3.6%	–14.8%	–2.8%	1.5%
Unemployment rate	4.9%	5.5%	14.4%	16.8%	16.6%
Social tax	25.4%	14.8%	–10.3%	–4.0%	??
Health Insurance Fund spending	27.5%	20.5%	–2.2%	–4.7%	??
Doctors' salaries	22%	39%	–6%	??	??

## The Institutional Factors that help Health Care System to hold up against Financial Crisis

### Lessons based on Taiwan's experience

Presentation at the WMA conference on "Financial crisis and its implications for health care", Riga, September 10-11<sup>th</sup> 2010



*Michael S. Chen*

Taiwan's national health insurance (NHI) program has won its share of international attention for its accomplishments in terms of universal coverage, comprehensive benefit, efficient administration, up-to-par quality of care, and affordability. In line of the theme of the 2010 Conference of the World Medical Association, I shall begin this article by giving an introduction of Taiwan's NHI, followed by the major challenges that the NHI faces, and then, based on Taiwan's experience, summarize the institutional factors that would be inductive to the capacity for the program to neutralize, to certain extent, the impact of economic fluctuations in general, or financial crises in particular.

If any lessons can be learned from Taiwan's NHI, that would be: one must begin with the "right" structure when considering a healthcare system. The "right" structure will

give the program the capacity to hold up against the economic crisis. As summarized by this article, three most prominent factors for the stability of the program are: a social insurance program based on premiums, a single-payer program, and the built-in balancing mechanism under a global budgeting scheme.

#### How did Taiwan's NHI come into what it is now?

Taiwan's NHI was implemented in 1995 by taking in the health components from the then existing social insurance programs and extending the coverage to all others, nationals as well as expatriates who stay in Taiwan with valid residence permits. And out of historical legacy, ideological split did not stand in the way; instead, the political leadership, incumbent and the opposition, was committed to providing universal health coverage and a health program as massive as NHI was able to come into being.

Initially, the medical profession posed a hostile gesture out of fear, uncertainty, and doubt, but soon realized that a health program like this meant a wider clientele and would bring in a stable and ample income stream. The medical profession then became cooperative partners with the NHI, and in the process of working together closely, now has become an integral part of the NHI establishment.

Insurance industry, which bedeviled the US healthcare reform for many times over the

past decades, did not quite constitute a resistance, because they were happy with the lucrative business in life insurance and were not quite interested in extending their business to health insurance for the troublesome administrative loading. Surprises to many, the turf for commercial health insurance has expanded, rather than shrunk after the NHI, possibly because people started to appreciate the value of insurance and desired to seek better protection against hazards of all kinds.

Competent authorities together took many extra miles to put the program on its feet. As time passes, even without anyone's knowing it, the program gradually got what it deserves: the satisfaction rates started to pick up, and have been around 70% for quite some time up to present, ranking among the highest in the world. Delegations from all around the world coming to Taiwan to study the NHI, and more than one third of them are from the US, especially the staffs from the Capitol Hill. Taiwan has offered training courses to high-ranking health administrators from countries as important as the Kingdom of Saudi Arabia, Thailand, Mongolia, the Philippines, Korea, Indonesia, etc. The Public Broadcast System has, in "Frontline – Sick Around the World", chosen along with other four countries as the models that the US can emulate. Taiwan's NHI has won its reputation.

#### What are the main features of Taiwan's NHI?

The NHI is a compulsory program, which requires mandatory and universal enrollment, covering all nationals as well as expatriates with valid residence permits on equal terms. It is a single-payer program run by a governmental agency – Bureau of NHI. Ability-to-pay is the fundamental financing principle, with payroll-based premiums (currently 5.17%) shared by the employee, the employer, and the government. NHI offers comprehensive and uniform benefit package for all. The policy of contracting

with the medical facilities is on the basis of all-willing-providers, and more than 90% of the providers are contracted with the program. The payment system for the program is run on a plural reimbursement schemes (fee for service, case payment, pay for performance, etc) under an overarching global budget.

## What are the major accomplishments in Taiwan's NHI?

The best way to characterize Taiwan's NHI is that the NHI is a program that defies the "conventional wisdom". In the standard textbook of health economics, it is suggested that you can choose some of the virtues for your program; yet, you cannot expect to have all the virtues in one program. These values as indicated in the textbook are: universality, comprehensiveness, freedom of choice, and cost containment. Taiwan's NHI, though has problems of its own, embodies all those virtues in one, and more.

## Universality

Though Taiwan's NHI is a compulsory program, universality is not an action of the law. Instead, it is the human action that brought universality to the program, the human action inspired by the belief that "I am my brother's keeper." Soon after its implementation, the NHI has extended its coverage from 59% to virtually all the population in Taiwan. For those who could not pay the premium, the NHI provides a pretty elaborate safety net to make sure that everyone is protected:

- the premium is 100% subsidized for the households below the poverty line;
- if you are unable to pay the premium for running into one of the vicissitudes in your life, interest-free loans are available or you can apply to pay on installments;
- or, Bureau of NHI can refer you to many of the charitable organizations for help;
- in the case when all these fail to work for you, you can simply take yourself to the hospital should an emergency occur and

leave the financial problem to be taken care of between the hospital and the BNHI;

- with this safety net in place, no single individual on this land can ever be denied health care for lack of means or anything; there must be a way to get the help.

With NHI, bankruptcies out of medical bills have become unheard of since; we don't often use the expression "health care as a human right", yet universality testifies to that our program is an incarnation of the very ideal.

## Comprehensive and Uniform Benefit Package

The benefit package provided by the NHI is comprehensive; all medically necessary services are covered. The package covers inpatient, outpatient, dental services, traditional Chinese medicine, and maintains a very long list of nearly 20,000 items of prescription drugs. Before the implementation of a long-term care insurance, the program also pays for home care, rehabilitative care, day care, and hospice care, provided that certain criteria are met.

Some of the target therapy drugs are covered; many of the expensive drugs for rare diseases are covered too. To provide more options for the insured, some of the high-priced devices such as drug-eluting stents, intraocular lenses with special functions, are covered with extra billings.

The benefit package is rather "generous" when you compare with, say, that of Medicare in the US. US Medicare requires the beneficiary to pay for the first day of hospitalization as deductible that could be as much as \$5,000 or even more, while our program picks up the tab right from the first dollar without any deductibles. For new treatments or drugs, there is a prompt procedure to get those items on the reimbursement list, provided that they are cost effective.

The co-payments are very little, even symbolic in some cases. There is a 10% co-insur-

ance for acute hospitalization, but the maximum amount of that co-payment is capped by 10% of per-capita income. The benefits are provided without any discrimination whatsoever. For instance, anyone who needs and demands a renal dialysis will get one, without discretions on age or anything, even discretionary measures are prevalent in many countries. More importantly from the standpoint of equity, the benefit package is uniform for all: the President of the nation and the people in the street are entitled to exactly the same package of benefits.

## Freedom of Choice and Accessibility

Taiwan's NHI is a single-payer program and therefore it offers no choice of the carrier; it, however, offers unlimited freedom of choice when it comes to the choice of the providers: you can choose your doctors and hospitals from more than 18,000 contracted facilities. Everyone is issued an NHI IC card, with which you can just walk into any of the facilities, oftentimes even without a reservation.

There is no waiting line, or at least not anything like those in some other countries where you might have to wait for months or even years for selective surgeries. You may see people lying in the hallway around the emergency room in some of the medical centers. But that is because the medical center won't turn patients away to the community hospital where there are many vacant beds. And over 99% of those patients will be admitted to the ICU or a regular ward within 48 hours.

Since a referral system virtually does not exist, you can see a doctor or be admitted into a hospital any time if you are not too particular in choosing the facility. Normally, it would take just about a couple of weeks to get a major surgery at the location of your choice. For the people living in the mountainous areas and off-shore islands, the NHI pays extra dollars for the integrated delivery system (IDS) to deliver primary care and some of the specialty care. The co-payments are waived in those areas. Care reaches every corner. Care is even provided in the off-

beaten recreational areas just to assure that you have a care-free weekend.

## Cost Containment and Affordability

Health care in Taiwan is quite affordable: total healthcare expenditure accounts only for about 6.2% of GDP, lower than most of the OECD countries, and slightly more than half of it were spent on the NHI. A family of four pays roughly US\$100 per month as the premium, which is about one tenth that of the US families, accounting for about 2% of the averaged household income.

It is more efficient to run the daily operations of a single-payer program than any others; and a single-payer system with the aid of information technology can even be more efficient. Billions of transactions in claims and reimbursements are handled electronically. As results, the administrative costs for NHI have been controlled below 2% of the medical expenses.

## Quality of Care

Changes in life expectancy (currently 82 years for women, 76 years for men) testified to the quality of care in Taiwan. According to a newly released study, the life expectancy for the ten-year period after the NHI grew twice as fast as that of the ten-year period before the NHI. Health disparities among socio-economic groups and geographic areas had somehow narrowed, though not as significant as one would like to see.

Another piece of information on the quality of care is the performance of organ transplants: although Taiwan has a long way to go in the transplantation of the lung, the records of the kidney, heart, and liver transplantations are as good as that of the US.

## What are the leading challenges faced by the NHI?

### Financial Shortfalls

There are several factors contributing to the financial shortfalls. First is the inherent nature in the structure of the financ-

ing scheme. The premium is based on the payroll, and the increase rates in the payroll always fall short of the increase in the GDP, and the increase rates in GDP always fall short of the increase rates in healthcare expenditures. As a result, there is always a gap between the growth rates of the revenue and the expense. Another factor is the aging population. The aging factor alone explains a significant fraction of the increase rate in the medical expenditure, and the global budget is ratcheted up every year as the aging factor is a "non-negotiable" component to determine the global budget.

What makes the financial situation worse is the political intervention. As stipulated by the NHI Act, the premium rate must be raised whenever the reserve fund is lower than one-month expenditure. In reality, out of political reasons, premium raise is only next to impossible.

Having said all this, the financial shortfall, as much as tens of billions of NT dollars, is not a problem that would cut into the economic competitiveness on the world market, as would the healthcare cost of the US, because Taiwan can still afford to spend a little more on health care. The deficit is basically a "why-me" problem and can be settled with patient consensus-building process. And the following are a couple of strategies to keep the financial house in order:

### Strategies to make both ends meet

Premium based on individual's total income

- An amendment to the NHI Act has been proposed to put the premium on the individual's total income rather than solely on the payroll.
- Incomes other than regular salary, if beyond certain amount, will be levied by a certain percentage for supplementary premium.
- The amendment also calls for lowering premiums paid by the union workers and those who do not have regular incomes.

- If enacted, the amendment can make both ends meet and has a positive implication in social equity.

### Supplementary revenues for NHI

- Before the NHI Act can be amended, the Department of Health and BNHI have gone out in search of all possible sources trying to control the deficit: putting more surtax on each pack of tobacco, raising more revenues from lotteries, going after those who could but failed to pay the premium, etc.
- In addition to making up NHI's deficit, the revenues from tobacco surtax will be used to improve quality of care, provide better care to those living in the remote areas, assist the indigent to pay off the overdue premium or pay the out-of-pocket expenses, etc.

### Ever-Rising Expectations

Health care is a non-satiable good. More can be less, and you can easily fall victim of your own success. You can never catch up in quality improvement; you can never match the demand on the benefit.

This kind of Catch-22 situation is actually faced by all the public projects, and is especially troublesome in health care. To respond to this situation, the BNHI constantly improves on its service by adding new items on the benefit package, by introducing more indicators for quality assurance, by controlling the expenditure so as to defer the need for premium raise, and by providing more information on the website to make the operations of the system more transparent.

### What are the key institutional factors leading to stability over financial crises?

Based on taiwan's experience with the NHI, I would like to summarize some of the factors built in the design of the system that are inductive to the capacity for the program to somehow neutralize the impact of economic fluctuations. And the

lesson is that, when it comes to the stability of the program, it is more important to have the “structure” right, than to have the “operation” or the “administration” right. In other words, it takes a structural reform in order to put thing right. In the following section, I would just like to cite three of those institutional factors: the premium-based social insurance, the effectiveness of the single-payer system, and the built-in balancing mechanism centered around the global budget.

## Stability of Premium-Based Social Insurance

There are a number of options for one to choose as the financing basis for a health-care system, such as government budget from general tax, a surcharge on top of income tax, and premium collected from income or wealth.

As so vividly evidenced by the recent experience in Latvia, the system on government budget can be very vulnerable during economic downturns. A program based on a surcharge on top of income tax can have the similar instability, as those revenues can be hard-hit by the economic recessions. As a user's fee, premium can, to some extent, insulate the impact of a financial crisis, because it is independent from the real income, which can vary according to the economic situation.

I would like to point out that, under certain situations, a user's fee can constitute a burden for some people who just encounter misfortune in the life. And therefore, it is important to have a safety net to come to rescue, as demonstrated in Taiwan's NHI.

## Effectiveness of the Single-Payer System

Taiwan's NHI is a single-payer system that has proved very effective in providing necessary care to all, particularly to those in pov-

erty and other disadvantaged groups. This is a cornerstone for solidarity, and enjoys the maximal capacity to spread out the risks.

A single-payer system serves as a platform not just to pull together all the risks, but also to pull together dollars of various sources. Pooling all the risks in a single pool makes cross-subsidization among the different socio-economic groups very easy and effective; pooling together all the dollars from various sources makes the money flow very efficient. A single-payer system is flexible in that any newly added needs or newly added budgets, resulted from, say, economic recessions, can be incorporated into the program with ease, and the safety net can be continuously strengthened without structural changes.

With a single-payer system, the state acts as a monopsonist on the healthcare market, and the state can wield tremendous leveraging power to co-opt the medical profession to work together for the good of the people.

## Built-in Balancing Mechanism Under Global Budget

The single most important instrument for cost containment is the global budget system, which puts a lid on the overall annual NHI expenditure. The annual growth rates of the global budget are negotiated every year through the Medical Cost Negotiation Committee, whose members comprise of the representatives from the payer groups as well as the provider groups.

With such an overarching global budget, the payment for each service is defined in terms of the number of points, rather than the number of dollars: the value of one point will be lower than one dollar, if the medical profession together provided more services than that expected by the Negotiation Committee. And therefore, when economic crisis hits, the system will respond as a whole by more stringent use of the resources. Of course, the leadership of the medical profession must exercise its coordination power to

make sure that, while saving resources, adequate services will still be provided.

In addition to the function of cost containment, the global budget system is meant to give incentive to the medical associations to rein in their members and ensure appropriate care. The global budget system has worked pretty well, able to control the increase rates between 4% and 5% annually, without compromising the quality of care over these years.

## Lessons and Concluding Remarks

The success of Taiwan's NHI, undoubtedly, should be, to an extent, attributed to the “operation” of the program – the “extra miles” that the BNHI staff has put in. However, it is the “structure” of the program that conveys the resilience, flexibility, and toughness to this program so that the program can weather through the economic crises without losing much capacity to uphold its safety net, which is so crucial for the less fortunate. Therefore, when a nation considers a healthcare system, the first thing coming to the minds of the architects is that the program must be placed on a well thought-out structure which will help the program to hold up against the economic crises.

Based on Taiwan's experience with its NHI, the program better be financed by premiums which, to a greater extent, are independent from the financial crisis. A single-payer system has the virtue of being efficient in administration, effective in cross-subsidization, and therefore makes the safety net resilient and tough to meet the challenges of a financial crisis. And finally, there must be a built-in mechanism that will automatically balance the books in bad economic times.

*Michael S. Chen*  
Former VP & CFO, Bureau of National Health Insurance, Taiwan Associate Professor,  
Department of Social Welfare, National Chung-Cheng University  
e-mail: aping\_chen@yahoo.com.tw

## Singapore Statement on Research Integrity

**Preamble.** The value and benefits of research are vitally dependent on the integrity of research. While there can be and are national and disciplinary differences in the way research is organized and conducted, there are also principles and professional responsibilities that are fundamental to the integrity of research wherever it is undertaken.

### Principles

*Honesty* in all aspects of research  
*Accountability* in the conduct of research  
*Professional courtesy and fairness* in working with others  
*Good stewardship* of research on behalf of others

### Responsibilities

1. **Integrity:** Researchers should take responsibility for the trustworthiness of their research.
2. **Adherence to Regulations:** Researchers should be aware of and adhere to regulations and policies related to research.
3. **Research Methods:** Researchers should employ appropriate research methods, base conclusions on critical analysis of the evidence and report findings and interpretations fully and objectively.
4. **Research Records:** Researchers should keep clear, accurate records of all research in ways that will allow verification and replication of their work by others.
5. **Research Findings:** Researchers should share data and findings openly and promptly, as soon as they have had an opportunity to establish priority and ownership claims.
6. **Authorship:** Researchers should take responsibility for their contributions to all publications, funding applications, reports and other representations of their research. Lists of authors should include all those and only those who meet applicable authorship criteria.
7. **Publication Acknowledgement:** Researchers should acknowledge in publications the names and roles of those who made significant contributions to the research, including writers, funders, sponsors, and others, but do not meet authorship criteria.
8. **Peer Review:** Researchers should provide fair, prompt and rigorous evaluations and respect confidentiality when reviewing others' work.
9. **Conflict of Interest:** Researchers should disclose financial and other conflicts of interest that could compromise the trustworthiness of their work in research proposals, publications and public communications as well as in all review activities.
10. **Public Communication:** Researchers should limit professional comments to their recognized expertise when engaged in public discussions about the application and importance of research findings and clearly distinguish professional comments from opinions based on personal views.
11. **Reporting Irresponsible Research Practices:** Researchers should report to the appropriate authorities any suspected research misconduct, including fabrication, falsification or plagiarism, and other irresponsible research practices that undermine the trustworthiness of research, such as carelessness, improperly listing authors, failing to report conflicting data, or the use of misleading analytical methods.
12. **Responding to Irresponsible Research Practices:** Research institutions, as well as journals, professional organizations and agencies that have commitments to research, should have procedures for responding to allegations of misconduct and other irresponsible research practices and for protecting those who report such behavior in good faith. When misconduct or other irresponsible research practice is confirmed, appropriate actions should be taken promptly, including correcting the research record.
13. **Research Environments:** Research institutions should create and sustain environments that encourage integrity through education, clear policies, and reasonable standards for advancement, while fostering work environments that support research integrity.
14. **Societal Considerations:** Researchers and research institutions should recognize that they have an ethical obligation to weigh societal benefits against risks inherent their work.

The Singapore Statement on Research Integrity was developed as part of the 2<sup>nd</sup> World Conference on Research Integrity, 21–24 July 2010, in Singapore, as a global guide to the responsible conduct of research. It is not a regulatory document and does not represent the official policies of the countries and organizations that funded and/or participated in the Conference. For official policies, guidance, and regulations relating to research integrity, appropriate national bodies and organizations should be consulted.

## The Impact of the Economic Recession on Nurses and Nursing in Iceland



*Elsa B. Friðfinnsdóttir*

### Executive Summary

The worldwide economic crisis has hit Iceland particularly hard and will lead to severe cutbacks in all areas of Icelandic society, including the health care system. The state budget for the year 2009 estimates that 115 billion Icelandic krona (ISK) will be spent on Ministry of Health projects, or almost a quarter of the entire state budget for the year (equivalent to approximately €0.64 billion).<sup>1</sup> It has been proposed that health services must be cut back by ISK 8 billion (approximately €0.04 billion), or approximately 7% this year (2009), and additional ISK 8 billion in 2010. Possible cutbacks for 2011 and 2012 have not yet been announced, however the authorities have announced strict measures in order to curb public spending in an effort to beat the recession. Health care facilities have been merged to decrease administrative costs, with reductions in overtime and shift supplement payments, termi-



*Jón Aðalbjörn Jónsson*

nations or cutbacks of contractual payments to doctors, fewer paid study leaves, etc.

The recession and the proposed cutbacks have already caused changes in Iceland's nursing workforce. A large number of nurses have increased their number of normal hours as the former demand for overtime work has now vanished. Cutbacks, such as reorganised shift routines and change in skill mix, have also brought about a reduction in the number of nurses needed. Increasing nursing hours and in some cases delayed retirements are thus temporarily hiding the shortage of nurses. The shortage is however severe and will increase as almost a quarter of Icelandic nurses are between 55 and 64 years of age and will therefore soon be reaching pensionable age. The recession has also had dramatic effect on the number of enrolled nursing students which has doubled between the years 2008 and 2009.

The Icelandic Nurses Association (INA) has increased its activities to assist its members in adapting to altered working condi-

tions. The general assembly and board of the INA have passed resolutions on various current issues, primarily emphasising the safety and quality of health care services and the importance of nursing. The INA Board published its priorities and proposals concerning health sector cutbacks at the end of June 2009. This is an official policy declaration by the association emphasizing the maintenance of quality and safety of health care, the need to review the health care system and payments for services, the necessity to fix guidelines for prioritisation, and the advantage of merging some health care facilities.

### Introduction

Iceland has been hit particularly hard by the global economic crisis. The rapid development and growth of the country's banking system rendered it vulnerable to the closing of international credit markets. The government takeover of Icelandic banks and the ensuing debt guarantees demand related to collapsed Icelandic banks in the United Kingdom and Holland led to severe cutbacks in all areas of Icelandic society, including health care and education. The collapse of the Icelandic krona (ISK) by around 50% in 2008 has restrained the purchasing power of the general public and led to price escalations as the domestic market is heavily reliant on the importation of commercial goods. In fact, the economic recession in Iceland has had an impact on everything and everybody – on the homes and jobs of Icelanders, social services, price levels and most aspects of daily life.

The purpose of this article is to throw some light on the impact of the economic recession as already felt in Iceland with a special emphasis on nurses and nursing. The article describes human resources in nursing and the role and status of nurses within the health care system. The article also deals with already announced government measures and the foreseeable impact of these measures on nurses, nurs-

<sup>1</sup> All currency conversions in this paper reflect exchange rates as at 17 August 2009, calculated using currency converter at [www.xe.com](http://www.xe.com).

ing and health care services. A brief account is given of nursing education and remuneration matters. Finally, the article outlines the priorities and measures of the Icelandic Nurses Association in the wake of changes within the health care system and the impact of these changes on nurses and nursing.

## Iceland's Nursing Workforce

The current number of INA members is around 3,600 and corresponds roughly to 90% of all registered nurses in Iceland. The INA members' portfolio shows that around 2,800 nurses receive salaries on the basis of collective agreements made on their behalf by the INA and 76% of them are employed by public institutions. According to the portfolio nearly half of all working nurses (or 1,370) are employed by Landspítali, which is the only university hospital in the country and is located in the capital Reykjavík. The same INA data reveals that the average work time ratio of nurses in public employ is currently around 80% of a full time equivalent. The privatisation of health care services is negligible in Iceland and very few nurses work for private institutions. The public sector can thus be claimed to be practically the sole employer of nurses in Iceland, either in public institutions or state-funded private institutions caring for the elderly.

Nursing in Iceland enjoys a strong legal status. Nurses were guaranteed Professional autonomy by law in 1978 and this autonomy was further enhanced by the entry into effect of the new Health Service Act [1] on 1 September 2007. The President of the INA served on a committee preparing the bill to propose a new legislation on health services. The Health Service Act defines the Icelandic health care system as resting on two main pillars, nursing and medicine. All health care facilities shall, in addition to a director general, employ a nursing director and a medical director. Nurses carry full legal responsibility for nursing.

## Health Sector Cutbacks

In Iceland, the health care system is administered by the central government and around 10% of GDP is allocated to it. The system is financed from the state general budget, of which 83% is state financed and 17% are user fees [2].

The state budget for the year 2009 [3] estimates that ISK 115 billion will be spent on Ministry of Health projects, or almost a quarter of the entire state budget for the year. The largest single operational item on the budget is Landspítali University Hospital, which stands to receive ISK 33 billion (€0.18 billion) according to the budget for 2009. At the beginning of 2009, the authorities announced strict measures in order to curb public spending in an effort to beat the recession. It is likely that the health care system will need to be cut back by ISK 8 billion (€0.04 billion) or approx 7% in 2009. This corresponds to the total budgetary resources allocated to the Akureyri Hospital, the second largest hospital in the country located in the north of Iceland, and to primary health care of the Capital Area which serves around two-thirds of the country's population. Additional health service cuts of ISK 8 billion are anticipated for the year 2010. The authorities have not, as yet, announced possible cutbacks for 2011 and 2012, but by 2013 the economy is expected to begin to show signs of recovery.

## Government Plans for Health Service Cutbacks

Following the collapse of the Icelandic banking system in early October 2008 it became clear that dramatic cutbacks in public sector spending were imperative and these would also affect the health services. At a press conference on 7 January 2009 the Health Minister announced fundamental changes to the health care system. Twenty-two health care facilities outside the capital area were to be merged into a total of six facilities, a hospital in a municipality near

the capital was to be changed into a geriatric unit, small operating theatres in hospitals near the capital would be closed, and so on [4]. The aim of these mergers was to cut down administration costs rather than the patient care budget. Furthermore, user fees for health services were increased and moderate admittance charges introduced for hospitals [5] in addition to plans to considerably curtail drug costs.

A new government took over in Iceland on 1 February 2009. The new Health Minister comes from a party to the extreme left in Icelandic politics, while his predecessor represented the political right wing. Changes within the Ministry of Health have had dramatic effects. Two days after taking office, the new Health Minister revoked the regulation on increased health service fees and hospital admission charges [6]. Over the next few days the Minister withdrew most of the changes that had been prepared and announced by his predecessor [7].

On 25 March 2009 the Minister of Health announced the principal features of rationalisation measures to be taken by hospitals in the vicinity of Reykjavík [8]. The focus of the Minister's proposals was for these health care facilities to remain within the budget and, in the long term, look to increase their cooperation with Landspítali University Hospital with the aim to decrease overall costs without decreasing service rendered. The Minister's proposals anticipated reductions in overtime and shift supplement payments, terminations or cutbacks of contractual payments to doctors, fewer administrative positions, fewer paid study leaves and more [9].

Salaries make up around 75-80% of the operating expenses of health care facilities. In 2008, an additional 50% on average was added to basic salaries for overtime and shift supplement payments. Nurses receive just under 25% of the total salaries paid by health care facilities, whereas they fill around 23% of total full-time positions. Av-

erage overtime work for nurses was 32% of their total hours in 2008 [10].

The Health Minister's overall approach concerning health sector cutbacks for the current year and the next years to come was not available when this article was written at the beginning of July 2009. The Minister has, however, announced the merger of health care facilities in West Iceland [11] as of 1 January 2010 as well as the merger of two small facilities in the North [12] that will take effect at the same time. The Minister has also fixed the maximum price for two common prescription drugs [13]. The Health Minister places great emphasis on consulting the local population in the different health care regions but has not looked much to the INA for collaboration. Press interviews with the Minister indicate that detailed proposals for health sector cutbacks for this year and the next are to be expected within a few weeks [14]. The uncertainty surrounding envisaged health sector cutbacks makes all long-term planning difficult for the directors of health care facilities. Lack of integration may mean that rationalisation in one facility results in increased costs at another. The delay in ministerial decisions and proposals also creates uncertainty among nurses as to their working conditions and this environment of uncertainty makes it difficult for the INA to organise its support and work on behalf of its members.

## Impact of Recession on Nursing Shortage

There has always been a nursing shortage in Iceland. When the first educated nurse came back home from her studies abroad at the end of the 18th century people welcomed her but also stated that there really should have been two of them!

In 2006 the INA conducted an extensive survey into human resources in nursing. The results of the survey were published in a report entitled *Nursing Shortage* [15] in

March 2007. In the survey nursing directors of health care facilities nationwide were asked the following questions:

1. How many full-time positions are authorised for nurses at the facility?
2. How many full-time positions for nurses are occupied at the facility?
3. How many full-time positions occupied by nurses have individuals on leave due to childbirth, further education or prolonged sickness?
4. How many nurses are required to fill the full-time positions *authorised* at the facility?
5. How many full-time positions for nurses do you think are required by the facility on the basis of *estimated need* for nurses?

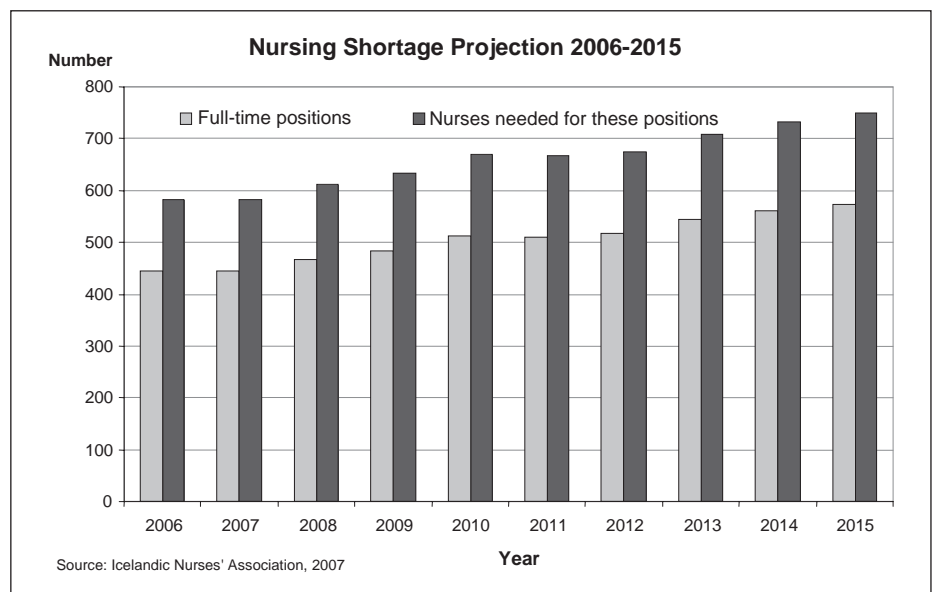
The results of the survey showed that in order to fill the authorised nursing positions, as well as those where individuals were on maternity, study or sick leave, the number of nurses would need to be increased by 15.75%. When taking into account the number of full-time positions considered necessary by nursing directors in order to deliver optimum quality care, however, the overall nursing shortage was estimated at 20.66%. In 2006 the average work-time ra-

tio of nurses was 76.45% and thus a total of 582 nurses were required in order to meet the need. Based on available data, the INA put together a nursing shortage projection for the period 2006-2015 [16].

In March this year the INA conducted an informal survey of nursing shortage [17] in the same health care facilities as participated in the 2006 survey. Replies were received from nursing directors at a total of 50 facilities which together command around 65% of all fulltime positions in the country. The questions in this survey were comparable to those used in the previous survey.

The results of the latest survey indicate that a significant change has taken place. At present, nursing directors' professional assessment is that the nursing shortage, based on estimated needs to fulfil service demands, is 3.84% compared with 21.5% in 2007.

Recent social upheavals have thus contributed dramatically to reducing the shortage of nurses. The change can partly be explained by the INA collective agreement in 2008, in which the aim was to reduce overtime and increase normal hours worked by nurses (see page 190). As a result a large number



of nurses have increased their work-time ratios but, as already pointed out, health care facilities have in the past relied heavily on nurses working overtime. Directors of health care facilities have welcomed this trend as it helps reduce overtime costs. The INA predicts that the average total salaries of nurses will slightly decrease but the reduction is accompanied by better working environment due to higher staffing levels, more regular working hours and less overtime. Nurses have, most likely, opted for part-time work due to family obligations and the stress entailed in working shifts and therefore increased work-time ratios might in the long run have detrimental effects on their family lives. Various cutbacks, such as reorganised shift routines, have also brought about a reduction in funded nursing positions. Finally, nurses previously employed in private sector enterprises are now increasingly seeking positions in public sector facilities.

As of now the INA is lacking data whether some individuals, who have nursing qualifications but were not working as nurses, have come back in to nursing employment. It should, however, be reiterated that this survey was an informal one and therefore the figures cited may not be entirely reliable. It should also be emphasised that this seemingly favourable trend may not necessarily last. While there is still uncertainty concerning the measures intended by the authorities and the Health Minister in order to bring about the extensive rationalisation necessary within the health service sector in coming months, some health care facilities may even resort to layoffs.

So far there have been no mass redundancies, but the directors of many health care facilities have stopped filling vacant positions when nurses either retire or go away on leave. In some facilities there are now fewer nursing positions than before and this inevitably increases the strain on nurses who are still at work. Organisational changes and new shift routines have forced nurses

to move between places of work and even change from regular daytime work to doing shifts.

## Emphasis in INA Collective Agreements

Collective agreements between the INA and its counterparties ceased to apply in the early months of 2008 as planned. In light of the downward trend in work-time ratios and the apparent nursing shortage [18], coupled with the relatively high proportion of overtime in the gross pay of nurses [19], the Association placed heavy emphasis on increasing basic salaries. Following intensive negotiations and an imminent overtime ban for nurses, a collective agreement was signed on 9 July 2008 which fixed the hourly rate for overtime work at 0.95% of an individual nurse's basic monthly salary instead of the earlier amount of 1.0385%. The average increase in basic salaries thus came to around 14%. The collective agreement was valid for nine months only, or from 1 July 2008 to 31 March 2009. Based on information gathered from nursing directors at the largest health care facilities, these salary changes had a considerable impact on nurses raising their work-time ratios and reducing overtime work. As stated above, the recession then had a further impact on staffing and work-time ratios.

The INA's collective agreement has now been open for three months. The INA, as member of the Association of Academics, has participated in the formation of a stability pact between Icelandic employees, the government and the business community. The pact is part of the government's strategy in facing the economic crisis and aims primarily at reaching some sort of stability within the national economy and the employment market, the key element being objectives regarding inflation levels, interest rates, unemployment levels, exchange rates of the Icelandic krona, etc. It is clear that nurses will not receive any pay increases in the coming months, but the INA will focus

on protecting the jobs of nurses as well as the salaries and conditions that have already been achieved.

## Impact of Recession on Nursing Education

All nursing education in Iceland has been at university level since 1986. Nursing is currently taught at two universities: the University of Iceland in Reykjavik and the University of Akureyri. The study programme takes four years and concludes with a BSc degree in nursing. Graduate programmes on offer in Iceland include midwifery, a diploma programme in specialised nursing, MSc in nursing, interdisciplinary programmes in health informatics and public health sciences, and a PhD in nursing.

According to the nursing shortage report of 2007 [20] a total of 145 nurses are expected to graduate each year. During the period of economic expansion and growth there was a decline in the number of students enrolled in the nursing programmes at the universities and in the last three years only around 100 students have graduated. This spring, however, in a climate of recession, the number of applications for nursing studies has more than doubled. In the spring of 2008 a total of 173 students applied to be enrolled in the nursing programmes at both universities. This year has seen a total of 369 applications. Owing to a tight budget and a lack of clinical placements only 170 students will, however, be allowed to continue with their studies on the strength of their examination results at the end of the first semester. The INA believes that 170 new nurses need to enter the profession annually in order to maintain the status quo. This estimate is based on the large number of nurses reaching retirement age over the next few years [21].

Almost a quarter of all nurses working in the country are between 55 and 64 years of age and will therefore soon be reaching pensionable age. In recent years, nurses have

on average started drawing pension at the age of 64, but given the current economic conditions it is to be expected that many will choose to delay their retirement by a year or two. This ageing of the nurse population is taken in to account in the former outlined projection of nursing shortage till the year 2015.

Despite the disappearance of the nursing shortage in recent months it is important to remain vigilant and to ensure that there are sufficient numbers of newly-graduated nurses to meet the needs of society, not least when the nation has managed to weather this economic storm. When such a time comes, Iceland may again be faced with a shortfall of qualified nurses.

Various changes within the health service as well as in the Icelandic society require more nurses to be employed. In the INA's Policy on Nursing and Health Care it is stated that the needs of the public for nursing services are the cornerstone of nurses work. Nurses must, under all conditions, ensure they deliver high-quality nursing services while having the best interests of their clients at heart at all times [22]. More work needs to be done in areas of prevention and health

promotion. Shorter hospitalisation periods mean that health care is transferred to other facilities as well as the homes of the patients and this calls for increased nursing services. At the same time, the age composition of the population is changing. Improved treatment possibilities increase longevity, but as the population grows older the number of serious and chronic health problems also increases. In times of recession the population may require different types of health service and it is important that these needs are assessed so that appropriate measures can be taken.

### INA Emphases and Actions

The 3,600 member association of Icelandic nurses represents nearly 90% of all nurses licensed to practice in the country. Membership is voluntary and annual dues amount to 1.5% of a nurse's basic salary. The INA was established in 1919 and acts on behalf of its members in matters concerning professional issues, economic interests and working conditions. The Association is a professional body as well as a union of nurses. Its purpose is to:

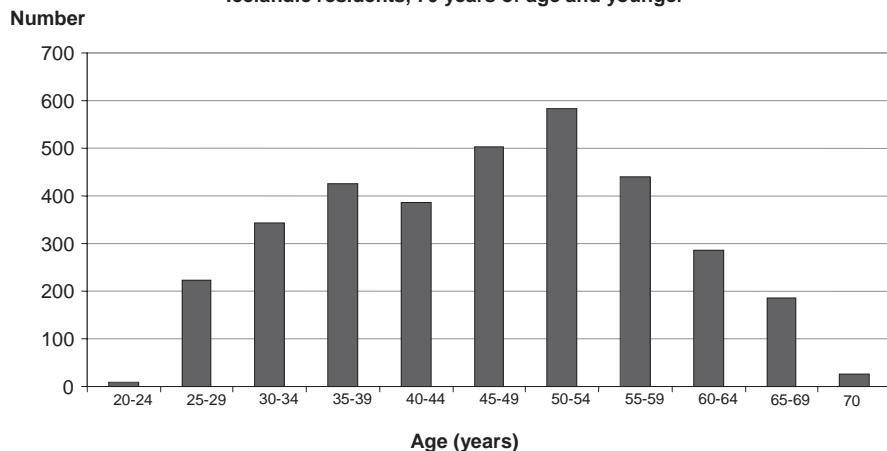
a) Be an advocacy for nursing and nurses and safeguard their interests.

- b) Protect the image and autonomy of the nursing profession, encourage co-operation between nurses and promote professional and social awareness.
- c) Negotiate with employers on pay and conditions on behalf of its members as well as other issues covered by its mandate.
- d) Promote the development of nursing as an academic field of study.
- e) Participate in international collaboration among nurses for the benefit of the profession.
- f) Participate in the formulation of policies concerning health care.

Through new emphases in collective bargaining, the INA has been successful in improving the salaries and working hours of nurses. As the recession forces health care facilities into reorganising their work schedules, i.e. by reducing overtime as much as possible, it can be safely maintained that the move made in the 2008 collective agreement was both correct and timely.

Since the collapse of the financial system in October 2008 the INA has focused its activities on assisting its members in adapting to altered working conditions, for instance through active dissemination of information. Already in January 2009 the budget of the INA was amended so as to allow for improved services to association members. To make room for this change it was decided to cut down on overseas travel in connection with international projects. There has been detailed coverage of health sector changes in *The Icelandic Journal of Nursing* which is published five times a year and distributed by mail to all INA members. Every two weeks the INA publishes an electronic bulletin which is sent out to 2120 members registered on the association's distribution list. The news section on the website [www.hjukrun.is](http://www.hjukrun.is) is also regularly updated. Advisory services to individuals have been increasing, particularly in matters relating to working hours, statutory sick pay and rules on dismissal.

**Age distribution of nurses, 5 years grouped together (June 2009)**  
Icelandic residents, 70 years of age and younger



Source: Directorate of Health, Register of Nurses, 2009

All changes give rise to a range of questions concerning employee rights and the INA considers it to be its duty to assist members in these matters.

The President of the INA and Association employees have actively participated in consultations with authorities, served on committees, and attended meetings and conferences. A good case in point is the recent collaboration with the Directorate of Health on a report concerning human resources in nursing. The General Assembly and Board of the INA have passed resolutions on various current issues, primarily emphasising the safety and quality of health care services and the importance of nursing. All resolutions are forwarded to the authorities, published on the INA website and sent to the media, who have generally been very positive in their coverage of the Association's activities.

The Board of the INA published its emphases and proposals concerning health sector cutbacks at the end of June [23]. This is an official policy declaration by the Association and was sent to the Minister of Health, published on the INA website and forwarded to the national media. The Board's emphases are fourfold:

- *To maintain quality and safety*

The INA emphasises that all decisions concerning health sector cutbacks must take the interests of the population as a whole into account, there must be consistency in the actions taken between institutions and health care regions, and the importance of securing the quality and safety of services for all members of the community should be used as a guiding principle at all times. The INA Board stresses that care should be taken not to make any changes to the health care system that cannot be reversed when the economic climate begins to change for the better. No measures should force specially qualified health service personnel to leave parts of the country or even the coun-

try itself, because the quality of the health services provided rests primarily on the knowledge and skill of the individuals who work in the field.

- *To review the healthcare system and payments for services*

The Board of the INA urges the Health Minister to spearhead a thorough review of the health care system, to determine what should be done and where, and what should be financed from public funds. The kind of services covered (as well as those not covered) by health insurance as defined in the Social Security Act needs to be specified. Decisions must also be taken as to whether health care personnel are permitted to provide services that are not covered by health insurance, since their clients would need to pay the entire cost of such services.

- *To fix guidelines for prioritisation*

The INA Board emphasises the need for defining the extent to which treatment should be provided under specific conditions. Patients, relatives and the general public must be aware that treatment limitations apply equally to all individuals who are in a similar position, i.e. that such decisions are not be taken as a result of limited human resources or finances when and if the situation might arise.

- *To continue the merger of health care facilities*

There are at present 20 hospitals in Iceland and it is natural to question whether this is, in fact, necessary or sensible for such a small population. The INA Board calls for a precise definition of what constitutes basic services that should be provided in each community and then how many hospitals are actually required and where they should be located. The safety of the population must of course be the focal point of any such deliberations.

Based on these emphases, the INS Board has presented the following proposals to the Minister of Health:

- That the Minister of Health establish a five-person task force to work, full time, on developing a health service plan for Iceland up to 2015. The task force will be entrusted with setting out proposals for health sector cutbacks for the next three years by considering, for instance, areas where action needs to be taken, how basic services should be defined and where hospitals should be located in the future. The group should also specify what kind of services are to be covered by health insurance and then to what extent, either temporarily or permanently, as well as patient contributions towards health service costs, privatisation in the health care sector, and the kind of services that should be permitted outside the health insurance system. The proposals should also suggest ways in which to reconstruct the health care system at the end of the recession. The INA Board is prepared to nominate its representative to serve on this task force and to assist the group in any way possible.

- That the Minister of Health immediately appoint a committee on the prioritisation of health services which will be entrusted with making proposals concerning the limitation of treatment and how services should be prioritised. Various other nations have already specified such limitations. It is necessary that this group becomes a permanent advisory committee to the Minister and also handles the introduction of new treatment possibilities within the health service. The INA Board suggests that this committee should be comprised of an expert on ethics, a health economist, a nurse, a doctor and political appointees.

- That work continues on the merger of health care facilities on the basis of the Health Service Act and regulation on health regions. Special attention needs, however, to be paid to the safety of people in rural areas in this respect. Ease of transportation and

the burden of cost for the local population must also be considered when planning the merger of facilities and organising basic services and hospital locations. Decisions on the mergers of health care facilities should form part of the work of the special task force mentioned in the first proposal above.

## Conclusion

There is no doubt that Icelandic nurses, as well as the entire population of the country, are entering into hard times. The health care system is one of the pillars of the community and it is important that good standard that Iceland has already achieved is maintained. The knowledge and skills of nurses and other health care workers is the foundation on which the health service is built. Therefore it is now more important than ever to secure a solid education for Icelandic nurses and that sufficient numbers graduate each year, that new knowledge is put to use within the health care system and that every effort is made to prevent a human capital flight of nurses to neighbouring countries.

All the same, the recession brings opportunities. A higher number of nurses are now working more regular hours than before. With more nurses on each shift it is easier to plan nursing care, aiming to increase the quality of nursing care for each patient. There are endless opportunities to enhance the quality of nursing and to prove the effectiveness of nursing treatments as well as becoming more visible as professionals. Nurses can also take on various different tasks within primary health care, such as patient reception, health protection, etc. Nurses can also enhance and improve general and specialised home nursing. Nurses in sparsely populated areas need to be given the opportunity to work independently. Nurses should take a more active part in the medical surveillance of clients with chronic illnesses, for instance by receiving them at special nursing clinics, and press for licences to issue prescriptions for common drugs.

But the recession also brings serious threats. Although the immediate effects of the recession can be valued as positive by increasing nursing hours and in some cases delaying some retirements and thus hiding temporary the shortage of nurses, the shortage is still underlying and serious and cannot be ignored. The nursing community and the health care authorities still need to focus on replacing and increasing the number of nurses in Iceland, to decrease the long term shortage of nurses and to insure that the health care needs of the population are met. There is also regrettably always the threat that the authorities will resort to measures dealing with the economic crisis that might have a lasting impact on the health service and lead to a reduction in the number of nurses.

The Icelandic Nurses Association will continue to keep up a reliable flow of information to its members. In the upcoming pay negotiations the Association will focus on protecting the jobs of nurses. The Association will also step up its participation in public debates on health care issues and promote the fact that the knowledge and skills of Icelandic nurses are the best tools to secure an efficient and safe nursing service.

## References

1. Health Service Act (2007). no. 40 [www.english.heilbrigdisraduneyti.is/media/Laws%20in%20English/Health\\_service\\_act.pdf](http://www.english.heilbrigdisraduneyti.is/media/Laws%20in%20English/Health_service_act.pdf)
2. OECD (2007). Health at a Glance 2007. Statistics Iceland: [www.statice.is/Pages/444?NewsID=3333](http://www.statice.is/Pages/444?NewsID=3333) accessed 6 August 2007
3. Alþingi (the Icelandic Parliament) (2008). General Budget for 2009.
4. Heilbrigðisráðuneytið (7 January 2009). *Skipulagsbreytingar heilbrigðisþjónustunnar í landinu*. Organisational changes within the health care system. [www.heilbrigdisraduneyti.is/frettir/nr/2957](http://www.heilbrigdisraduneyti.is/frettir/nr/2957) accessed 6 August 2007.
5. Heilbrigðisráðuneytið (29 December 2008). *Reglugerð um blutdeild sjúkratryggðra í kostnaði vegna heilbrigðisþjónustu*. Regulation on patient participation in health service costs. [www.heilbrigdisraduneyti.is/frettir/nr/2955](http://www.heilbrigdisraduneyti.is/frettir/nr/2955) accessed 2 July 2009.
6. Heilbrigðisráðuneytið (2 February 2009). *Innritunargjöld á sjúkrahús og heilbrigðisstofnanir felld niður*. Hospital admission charges revoked. [www.heilbrigdisraduneyti.is/frettir/nr/2988](http://www.heilbrigdisraduneyti.is/frettir/nr/2988) accessed 2 July 2009.
7. Heilbrigðisráðuneytið (19 February 2009). *St. Jósefsspítali sambæfur starfsemi Landspítala*. St. Jósefsspítali Hospital harmonised with Landspítali University Hospital. [www.heilbrigdisraduneyti.is/frettir/nr/2991](http://www.heilbrigdisraduneyti.is/frettir/nr/2991) accessed 2 July 2009.
8. Heilbrigðisráðuneytið (25 March 2009). *Sparnaður og skert kjör í stað stórfelldra uppsagna starfsmanna*. Cutbacks and lower pay instead of mass redundancies. [www.heilbrigdisraduneyti.is/frettir/nr/3015](http://www.heilbrigdisraduneyti.is/frettir/nr/3015) accessed 2 July 2009.
9. Heilbrigðisráðuneytið (25 March 2009). *Sparnaður og skert kjör í stað stórfelldra uppsagna starfsmanna*. Ibid.
10. Heilbrigðisráðuneytið (25 March 2009). *Sparnaður og skert kjör í stað stórfelldra uppsagna starfsmanna*. Ibid.
11. Heilbrigðisráðuneytið (12 May 2009). *Átta heilbrigðisstofnanir sameinast um áramótin*. Eight healthcare facilities to merge at year-end. [www.heilbrigdisraduneyti.is/frettir/nr/3040](http://www.heilbrigdisraduneyti.is/frettir/nr/3040) accessed 2 July 2009.
12. Heilbrigðisráðuneytið (12 June 2009). *Stofnanir í Fjallabyggða sameinast*. Institutions in the Fjallabyggð region to merge. [www.heilbrigdisraduneyti.is/frettir/nr/3060](http://www.heilbrigdisraduneyti.is/frettir/nr/3060) accessed 2 July 2009.
13. Heilbrigðisráðuneytið (3 March 2009). *Ný lyfjaverðskrá tekur gildi*. New price levels for prescription drugs. [www.heilbrigdisraduneyti.is/frettir/nr/2999](http://www.heilbrigdisraduneyti.is/frettir/nr/2999) accessed 2 July 2009.
14. Morgunblaðið Daily Newspaper (25 June 2009). *Ögmundi stillt upp við vegg*. Health Minister faces barrage [www.mbl.is/mm/frettir/innlent/2009/06/25/ogmundi\\_stillt\\_opp\\_vid\\_vegg/](http://www.mbl.is/mm/frettir/innlent/2009/06/25/ogmundi_stillt_opp_vid_vegg/) accessed 2 July 2009.
15. Icelandic Nurses Association (March 2007). *Manneklela í hjúkrun* (Nursing Shortage).
16. Icelandic Nurses Association (March 2007). Ibid.
17. Tálknabrunn (2009). *Miklar breytingar á mönnun í hjúkrun* (Dramatic staffing changes in nursing), Directorate of Health Bulletin on Health Statistics 3(6). [www.landlaeknir.is/lis-alib/getfile.aspx?itemid=4021](http://www.landlaeknir.is/lis-alib/getfile.aspx?itemid=4021) accessed 3 July 2009.
18. Icelandic Nurses Association (March 2007). Op. cit.
19. Heilbrigðisráðuneytið (25 March 2009). *Sparnaður og skert kjör í stað stórfelldra uppsagna starfsmanna*. Op. cit.
20. Icelandic Nurses Association (March 2007). Op. cit.
21. Tálknabrunn (2009). Op. cit.

22. Icelandic Nurses Association (May 1997). Policy on Nursing and Health Care. [www.hjukrun.is/lisalib/getfile.aspx?itemid=34](http://www.hjukrun.is/lisalib/getfile.aspx?itemid=34) accessed 3 July 2009.
23. Icelandic Nurses Association (29 June 2009). *Emphases and proposals of INA's Administrative Board in connection with health sector cutbacks.* [www.hjukrun.is/?PageID=33&NewsID=3749](http://www.hjukrun.is/?PageID=33&NewsID=3749) accessed 3 July 2009.

*Elsa B. Friðfinnsdóttir RN, MSN,  
President of the Icelandic Nurses' Association.  
e-mail [SElsa@hjukrun.is](mailto:SElsa@hjukrun.is)  
Jón Aðalbjörn Jónsson  
International Secretary and Project Manager  
at the Icelandic Nurses' Association  
e-mail [Jon@hjukrun.is](mailto:Jon@hjukrun.is)*

For free access to full this document and other original research on nursing human resources, please visit the ICN's International Centre for Human Resources in Nursing at [www.ichrn.org](http://www.ichrn.org).

## Lifestyle Practices of Medical Students attending an International Student Conference

### Introduction

Medical students and doctors experience high rates of psychological morbidity due to their work and study environment. Medical students are initially similar to general student populations prior to commencing their medical course. As their training commences, however, the reductions in psychological well-being have been demonstrated to increase [1][2]. Stress may be a contributing factor for unhealthy behaviors and co-morbidities. Previous research has estimated that up to half of the medical students reportedly abuse alcohol as well as illicit substances such as marijuana. Other aspects of student health and lifestyle, such as reduced physical activity and poor diet, also suffer with increased workloads [6].

With increases in obesity levels, fast-food consumption, smoking rates, alcohol consumption, and illicit drug use, it is uncertain what the increase of these factors will cause over the next couple of decades. It is inevitable, however, that the diseases which progress from poor lifestyle choices such as regular smoking, poor nutrition and poor exercise will be experienced by the doctors of the future.

### Methodology and Results

The International Federation of Medical Students Association (IFMSA) represents 1.2 million medical students from over

ninety countries worldwide. IFMSA holds biannual general assemblies, hosted by elected member countries. These assemblies gather around 700 medical students, making it an excellent forum for discussion, team building, and cultural acceptance and sensitivity. With such a large number of medical students attending these meetings, primarily to advocate for improved health, the events provide an excellent opportunity to conduct surveys regarding healthy lifestyles. Therefore, a cross-sectional study was conducted at IFMSA's general assembly held in Macedonia in August, 2009. The socio-demographic data was collected on lifestyle choices, tobacco consumption (cigarette, pipe tobacco and tobacco use in any other form), exercise that lasts for 30 minutes or longer, dietary habits (including fruit, vegetable and fast food consumption), alcohol consumption and sexual activity [6].

A quarter of the students exercised regularly with no difference between the genders. The majority of respondents consumed fruit and vegetables on a daily basis. A third of the students also reported regular consumption of fast food. Female students were reportedly healthier in their nutritional choices with higher consumption of fruit and vegetables than their male counterparts. Less than a quarter of the medical students smoked on a regular basis. When comparing genders; males were significantly more likely to be smokers than females. Living in Europe, the

Americas or in the Eastern Mediterranean region also predisposed students to smoking. Sixty percent of the medical students consumed alcoholic beverages on a regular basis. There was no difference in alcohol consumption between the genders.

With regard to sexual health; the mean age of first intercourse was 17.7 years. Regarding sexual orientation; an absolute majority reported being heterosexual with a small fraction (5%) reporting their orientation as homosexual or bisexual. An overwhelming majority stated regular contraceptive use; the most popular methods of contraception being the condom or the contraceptive pill. Over half of the sexually active respondents reported having just one sexual partner over the previous year. Male students reported having twice as many sexual partners as female students. Students from European or American countries reported the highest proportion of sexual activity.

Regardless of predisposing factors, lifestyle choices have a great influence on morbidity and mortality in life. Due to the cumulative effect of adverse factors throughout the life of individuals, it is important to adopt a healthy diet and lifestyle practice. This study assessed the dietary habits and lifestyle choices made by medical students, who are a significant community of future health-care practitioners. Correct lifestyle choices made early on during the medical education period will produce physicians practising as well as promoting a healthy lifestyle. There is a visible need for improvement in some of the lifestyle choices made by medical students. The response rate of the study may have been limited by the sensitive nature of some of the questions and also due to possible language barriers.

Similar studies conducted in Pakistan and the United Arab Emirates have shown similar findings with poor lifestyle choices made by medical students [7][8]. Nisar et al. found a very low smoking prevalence which correlates with our study's regional results described for smoking [9]. A number of American studies also found a relatively low prevalence of smoking amongst medical students [10]. It is a well known fact that health providers (including medical students) smoke and in 2005 the WHO Centre for Disease Prevention and the Canadian Public Health Association developed the Global Health Professionals Survey to survey smoking habits of medical, nursing, dental and pharmacy students in a variety of WHO member states. The results were published in 2005 [11]. Although a large number of medical students smoke regularly there is also evidence to support the fact that the same subset of healthcare students know and understand the health risks of smoking and are ready to promote smoking cessation to their patients. In a recent review of smoking in medical students the rates of smoking were described to increase incrementally with each year of study and it was also suggested that smoking cessation strategies should be put in place by the medical schools themselves [12].

Poor diet has been documented in medical students with nutritional intake being documented to worsen closer to exam periods [13]. British and Greek studies found similar results when reviewing the amount of fruit consumed by medical students with the majority eating fruit regularly but with very few actually consuming the five portions of fruit per day advised by health authorities [14].

Studies on sexual activity in medical students have found similar results as found in our survey with similar mean ages for first intercourse as well as similar preferences of contraceptive methods [15]. The results of the international survey show a high prevalence of sexual activity and an equally high prevalence of contraceptive use with a proportion of the subjects

reportedly using two or more forms of contraception; the male condom and the oral contraceptive pill being the most common forms. Same-sex behaviour described in the literature correlates well with the low levels of homosexual or bisexual activity elicited in the medical student international community [16].

## Conclusion

The self-reported lifestyle choices and habits of international medical students displayed choices of a healthy and unhealthy nature with a predominance of high consumption of tobacco, fast food and alcohol. The healthy choices made by the study group however indicate that some aspects of health promotion may permeate into the lifestyle choices made by medical students, as is shown in the positive prevalence of contraceptive use. The high rates of exercise as well as the clearly demonstrated levels of fruit and vegetable consumption were also some of the positive behaviors elicited.

It is possible that some lifestyle choices made by medical students may be inevitable due to the educational schedule, many of whom live far away from home. It is possible that more directed dietary and tobacco advice may be required as a preventive strategy for this study group. The findings of our study, as well as other studies held in the past, suggest the need for a larger study across more countries so that adequate arrangements can be made for student healthcare [17].

## References

1. Stewart SM, Betson C, Marshall I, Wong CM, Lee PW and Lam TH. Stress and vulnerability in medical students. *Medical education* (2006) 29(2), 119-127
2. Guthrie EA, Black D, Shaw CM, Hamilton J, Creed FH and Tomenson B. Embarking upon a medical career: Psychological morbidity in first year medical students. *Medical Education*. (1995) 29, 337-341
3. Danaei G, Ding EL, Mozaffarian D, Taylor B, Rehm J, et al. (2009) The preventable causes of death in the United States: Comparative risk assessment of dietary, lifestyle, and metabolic risk factors. *PLoS Medicine* 6(4): e1000058. doi:10.1371/journal.pmed.1000058
4. Carter AO, Elzubeir M, Abdulrazzaq YM, Revel AD, Townsend A. Health and lifestyle needs assessment of medical students in the United Arab Emirates. *Med Teach* 2003; 25: 492-6
5. Nisar N, Qadri MH, Fatima K, Perveen S. Dietary habits and life style among the students of a private medical university Karachi. *J Pak Med Assoc* 2009; 59: 98-101
6. Nisar N, Qadri MH, Fatima K, Perveen S. Dietary habits and life style among the students of a private medical university Karachi. *J Pak Med Assoc* 2009; 59: 98-101
7. Conard S, Hughes P, Baldwin DC, Achenbach KE, Sheehan DV. Substance use by fourth-year students at 13 U.S. medical schools. *Journal of Medical Education* (1988) 63:747-758
8. Centers for Disease Control and Prevention (CDC). Tobacco use and cessation counseling – Global health professionals survey pilot study, 10 countries, 2005. *MMWR Morb Mortal Wkly Rep* 2005;54:505-9.
9. Smith DR, Leggat PA. An international review of tobacco smoking among medical students. *J Postgrad Med* (2007) 53:55-62
10. Wolf TM, Kissling GE. Changes in life-style characteristics, health, and mood of freshman medical students. *Journal of Medical Education*. (1984) 59:806-814
11. Bertias G, Linardakis M, Mammias I, Kafatos A. Fruit and vegetables consumption in relation to health and diet of medical students in Crete, Greece. *International Journal for Vitamin & Nutrition Research*. (2005) 75(2):107-17
12. Ortiz-Ortega A, García de la Torre G, Galván F, Cravioto P, Paz F, Diaz-Olavarrieta C, Elertson C, and Cravioto A. Abortion, contraceptive use, and adolescent pregnancy among first-year medical students at a major public university in Mexico City. *Rev Panam Salud Publica/Pan Am J Public Health* (2003) 14(2): 125-130
13. McConaghy N, Armstrong MS, Birrell PC, Buhrich N. The incidence of bisexual feelings and opposite sex behaviour in medical students. *The Journal of Nervous and Mental Disease*. (1979) 167(11):685-8
14. Ashton CH, Kamali F. Personality, lifestyles, alcohol and drug consumption in a sample of British medical students. *Medical Education*. (1995) 29(3):187-192. DOI:10.1111/j.1365-2923.1995.tb02828.x

Dr. Jonathan Mamo MD MSc  
e-mail: Chantal.Fenech@gmail.com  
Dr. Chantal Fenech MD  
e-mail: Jonathan.Mamo@yahoo.com

## The Norwegian Medical Association



*Geir Riise*

### Organisation and membership

The Norwegian Medical Association (NMA) was founded in 1886 as a professional association and trade union for Norwegian physicians. Membership is voluntary and approximately 96% of the Norwegian physicians are members. The main aims of the NMA are to protect and develop the professional, social and financial interests of its members, to promote their interests in matters concerning medical education, professional development and scientific activities, and to advance the quality of the Norwegian health care system.

### Main bodies of the Norwegian Medical Association

The Annual Representative Meeting (ARM) is the chief decision-making body and elects the Central Board of 9 members, including the president and vice-president. The election period for the board is two years. ARM also elects the Medical Ethics Committee.

The NMA consists of 19 local branches (one in each county), 7 occupational branches, 44



*Torunn Janbu*

specialty branches, one for retired doctors and one student organisation.

The seven occupational branches organise members that share occupational interests: junior doctors, consultants, general practitioners, researchers, occupational health doctors, private practicing specialists and public health doctors. The occupational branches have their main interests in salaries and working conditions, while the specialty branches are engaged in scientific and professional activities like education, quality improvement, etc.

### The secretariat

The secretariat has five departments: Dep. of professional affairs, Dep. of information and health policy, Dep. of finance and administration, Dep. of negotiation and legal section and The Norwegian Medical Journal. The number of full-time staff members is 130.

### The role of The Norwegian Medical Association

The Norwegian Medical Association is the only medical association for doctors in Nor-

way. The NMA has two main responsibilities:

- negotiating salaries and working conditions for the members;
- taking care of the members professional and scientific interests.

In addition the NMA is responsible for much of the post-graduate specialist education.

### Prioritised areas

The Norwegian Medical Association will for the next two years (2009–2011) particularly work for:

1. Quality work and measurements, working environment and economy in hospitals. Hospitals have too little focus on quality and working conditions compared to economy.
2. Permanent positions for all doctors in hospitals. Almost all junior doctors today have temporary engagements.
3. Improved interaction between various levels of the health care system.
4. Further development of primary health care, especially the list patient system.
5. Promotion of medical research and professional development.
6. Recruiting, supporting and educating representatives for the NMA (union officials).

### Some data about Norway

Norway has a population of 4,850,000 and is situated in the northern part of Europe, being bordered by Sweden, Finland and Russia.

Healthcare and health services are financed by taxation and are designed to be equally accessible to all residents, independent of social status. With its 220,000 employees, the health sector is one of the largest sectors in Norway.

The healthcare system is under the jurisdiction of the Ministry of Health and Care

# World Medical Journal



services, which is responsible for planning and monitoring national health policy. Responsibility for provision of services is decentralised to the municipal and regional level. The municipalities are in charge of providing primary health services, while the four Health regions provide the specialised medical services, mainly hospital care.

General practice is organised through a list patient system. The list patient system is a national system organised and run through agreements between the NMA and the health authorities where the general practitioners are mainly self-employed.

There are some specialist practices working under agreements with the Health regions.

Norway only has a small number of authorised private hospitals and health services in addition to the public facilities.

The number of doctors, including students and retired doctors, are about 27 000. In relation to inhabitants we have one of the largest numbers of doctors in Europe, in 2007 the ratio was one doctor per 244 inhabitants.

## The Committee on Human Rights

Since the early 1990s, the NMA has run human rights programmes in Turkey, the former Yugoslavia and now in China. These activities are funded mainly by The Norwegian Ministry of Foreign Affairs. In cooperation with WMA, the International Red Cross and Amnesty International the association has published, on the web, free of charge, a course for prison doctors.

**The Journal of the Norwegian Medical Association** is issued every second week.

## Post-graduate medical education

There are 44 recognised medical specialties in Norway of which eight are subspecialties under internal medicine and five are subspecialties under general surgery. The majority of the specialties relate to health services in institutions (hospitals). Specialties in primary health care are family medicine, community medicine and occupational medicine.

## Health politics

The NMA is involved in many of the activities run by the health authorities through meetings, working groups and political work. The NMA also appoints members to participate in different task groups and meetings with the political parties in the Parliament.

## Officers

President Dr. Torunn Janbu, Ph. D., Vice-president Dr. Arne L. Refsum and Secretary General Dr. Geir Riise.

The Medical Ethics Committee: chairperson Dr. Trond Markestad, Ph. D.

## Contact information:

The Norwegian Medical Association  
P.O. Box 1152 Sentrum  
NO-0107 Oslo  
Phone +47 23 10 90 00  
Telefax +47 23 10 90 10  
www.legeforeningen.no

*Dr. Torunn Janbu, President*  
*Dr. Geir Riise, Secretary General*

# Bangladesh Medical Association (BMA)



*Sharfuddin Ahmed*

## Background

The Bangladesh Medical Association (BMA) is the national association of doctors of Bangladesh. It represents 46,000 physicians nationwide and has 67 district branches working all over the country. The BMA looks after the healthcare system of the country, the interests of the doctors, and the overall well-being of the medical community. A 47 member central executive runs the association. The BMA is working hard to ensure good health for every citizen of Bangladesh.

## Overview of the country's healthcare system

A wide range of therapeutic choices are available in Bangladesh, ranging from self-care to traditional and western medicine. The public sector is largely used for inpatient and preventative care while the private sector is used for curative care. Primary Health Care (PHC) has been chosen by the government of Bangladesh as the strategy to achieve their goal of "Health for all", which is now being implemented as Revitalized Primary Health Care.

## Public sector healthcare services

Primary care in the public sector is organized around the Upazila Health Complex (UHC) at a sub-district level, which works

as a health-care hub. These Units have both in-patient and out-patient services and facilities. Most have in-patient care support with a 31 bed capacity, while some UHC's have over 50 beds. Many UHC Units have a package service called "comprehensive emergency obstetric care services" (EOC) available, with an expert gynecologist, an anaesthetist and skilled support nurses on duty around-the-clock as well as in-house basic laboratory facilities. At a lower tier, the Union Health and Family Welfare Centres (UHFWC) are operational, consisting of two or three sub-centers at the lowest administrative level, and a network of field-based functionaries. Above the sub-district are the district hospitals (100-250 beds) and medical colleges (serving a group of districts with approximately 650 beds), providing secondary care, and national tertiary level care facilities.

## Private sector healthcare services

In the private sector, there are traditional healers, homeopathic practitioners, village doctors, community health workers, and, finally, retail drugstores that sell allopathic

medicine on demand. In addition to dispensing medicine, sellers at these mostly unlicensed and unregulated retail outlets also diagnose and treat illnesses despite having no formal professional training.

## Traditional medical practices

Grouped under "traditional medicine" are most of the medical practices that fall outside the realm of 'scientific' medicine. Thus Kabiraj, totka, herbalists, practitioners of 'Folk Medicine' and faith healers of different shades fall under this broad umbrella. Many of these healers (e.g. faith healers) provide a much narrower range of services for a more limited set of conditions.

The BMA supports the country's strategic health profile through different activities, which include involving the healthcare sector in decision making, raising its voice to guide the country's health policy, and arranging meetings, seminars, and symposiums to create awareness of the country's key health issues. The BMA also involves itself directly in professional matters such as:

1. The promotion of public doctors

2. The provision of legal support to doctors, if needed
3. Support for an effective primary, secondary and tertiary referral system
4. Acting as a legal body to oversee physicians' problems
5. The improvement of medical education
6. Solutions for different national issues
7. The training of private doctors as well as healthcare providers
8. Liaising with different international organizations including International Physicians for the Prevention of Nuclear War (IPPNW), the Commonwealth Medical Association (CMA), the World Medical Association (WMA) and other national medical associations.

*Professor Dr. Md. Sharfuddin Ahmed*  
Chairman,  
Department of Ophthalmology,  
Bangabandhu Sheikh Mujib Medical  
University,  
Secretary General,  
Bangladesh Medical Association

## Hungarian Medical Chamber in the Last Twenty Years



*Eger Istvan*

The history and function of the Hungarian Medical Chamber are closely tied to Hungary's political history. After the 2nd World War, Hungary's communist political regime ordered the HMC inactive. A trade union of common health care professionals was created in its place and strictly controlled by the government with no possibility for self-governance by Hungarian doctors during the 40 years of the communist regime. The healthcare system was financed by the state and no provisions were made for a health insurance system. During this time, Doctors salaries were low, paid by the government who (unofficially) encouraged "under the table" payments from patients.

During the early 1990s Eastern Central Europe, including Hungary, underwent major fundamental structural changes. Not only did the political system transform, but a new healthcare system was developed and agreed upon as well. Public healthcare costs were financed through a health insurance company that was paid by the state and whose budget was provided mainly by taxes. Physicians who had previously been government employees gradually became independent practitioners that contracted directly with the health insurance companies, however doctors who worked in hospitals and outpatient care facilities remained government employees. Despite the many changes that occurred within Hungary's healthcare system, healthcare providers salaries remained quite low.



*Building of the Hungarian Medical Chamber*

In 1989, doctors began to anticipate the upcoming changes and possibilities that were facing their nation and a few enthusiastic members of the physician workforce re-established the Hungarian Medical Chamber. In the first period membership was voluntary. The HMC's top priority was creating a new ethical structure, writing an ethical code and organizing committees (e.g. professional, educational, legal, etc.). Moreover they continually sought to connect with stakeholders and decision-makers in an effort to establish their influence and ensure their input regarding important questions of healthcare practice and policy. In 1994, five years after the HMC was re-established, the Hungarian Parliament drafted and voted into law legislation that made the HMC (and the pharmaceutical chamber) part of the public sector.

The most important change as a result of the new law was that membership in the HMC became mandatory. Mandatory membership gave the chamber a powerful regulatory position within the healthcare system since doctors' memberships could be cancelled or suspended for ethical violations, which would prohibit them from continuing to treat patients. In addition, the HMC was charged with tasks regarding ethical issues, including the registration of doctors, organizing and control-

ling continual medical education and creating recommendations regarding medical practice. They were also given the right to voice their opinion regarding proposed healthcare laws. Most importantly, the HMC had a right of concordance (it had a negative voice) regarding the main points of contribution with the health insurance company. The HMC has limited financial resources to broaden their affiliation with international organizations but has been able to represent Hungary in the Standing Committee of European Doctors (CPME) since 2003.

In the second half of the nineties and particularly after 2000, the financial state and functionality of Hungary's healthcare system was in a continual decline. In response, the HMC changed its focus in an effort to provide constructive criticism that would benefit the best interests of the healthcare system. The percentage of GDP dedicated to the healthcare sector decreased year by year (nowadays it is significantly lower than 5%), as did the quality of care offered to patients. The shortage of medical professionals continued to rise due to low salaries and poor working conditions, and became so severe that by 2004 the media was reporting on the difficulty of the situation. Although the previous government searched for answers and solutions to the crisis, their methods were ineffective and unsuccessful.

After Hungary joined the European Union in 2004, Hungary's healthcare crisis worsened considerably as its doctors and nurses sought better working conditions and wages elsewhere in the EU. The Hungarian government seemed uninterested in restoring the failing healthcare system. They refused to hear and understand the HMC's many recommendations for the troubled healthcare system and resented the HMC's strong voice of opinion. In 2007 the government tried to destroy the HMC (and the pharmaceutical and nurses chambers) by reversing the law requiring mandatory membership to the chambers. To further weaken the chambers, the law refused to recognize any member-

ship obtained during the mandatory membership period and as of April 1, 2007 not one official member remained in any chamber. The amount of administrative work in re-establishing membership in the interest of preserving the community of doctors was overwhelming, but in the end the HMC was able to restore 80% of their membership voluntarily. It was a great success for the HMC and the two other chambers (which had also successfully recovered their members) and a big defeat for the government. The political parties in parliament that were in opposition with the majority at that time promised to reinstitute the government's earlier position on mandatory membership if at all possible.

The HMC's greatest success in the last few years has been the successful protection of the existing public health insurance system from a dangerous decision by the previous regime to organize a public health insurance system based on a business model comprised of several competing health insurance companies. In 2008 there was a referendum about these proposed changes and as a result of the voting, parliament had to withdraw the law to create the new health insurance system. During this whole process the Hungarian Medical Chamber had a very important role, and we are very proud of our activity regarding this issue.

In the spring of 2010 a new government was elected in Hungary. The previous opposition became the new majority in the government. The Hungarian Medical Chamber prepared a new proposal to change the law about the chambers within the healthcare system. This will be discussed at the autumn session of parliament and we are hopeful that membership within the HMC will be mandatory again by January 1, 2011. The public body of Hungarian physicians would like to become more influential in the development of Hungary's healthcare system in the future.

*Dr. Eger Istvan, Hungarian Medical Chamber, President*

## MOTESZ – Association of Hungarian Medical Societies



*Béla Szalma*

MOTESZ, the most widespread organization of Hungarian medical doctors based on voluntary membership, had the opportunity to introduce itself in the WMA's periodical publication in 2006. Below is an overview of our organization and what we have been doing the past several years.

MOTESZ was established in 1966 with 36 member societies. Since that time, numerous health care organizations have joined our association. At the moment we have 129 member societies, meaning that some 30,000 medical doctors, dentists, researchers and scientists are connected to MOTESZ.

For almost four and a half decades we have been making efforts to carry out our main tasks: to coordinate the activities and cooperation of the member societies at the association level, and to promote the solution of common problems.

### National activities

MOTESZ has been making significant efforts to facilitate the addressing of interests of member societies in health care-related

legislation and enforcement. As a permanent invited body, MOTESZ observes legislation in the Health Care Committee of the Parliament and gives its opinion concerning significant issues directly affecting the medical profession.

On request, MOTESZ, through its professional committees, regularly provides opinions on health care-related bills forwarded by the Ministry of Health, as well as discussing and formulating, topics affecting all stakeholders in Hungarian health care.

In February 2008 the Ministry of Health requested that we prepare coordinated and reconciled professional proposals. To fulfil this duty, we created the ETSZ-MADOFE Program (Program on Regulating Health Care Activity), a program plan to regulate the handling of operational data, documentation, financing and controlling activity in health care, in order to improve the system of health care services.

As to its principles and essence, the MADOFE program is consistent with the program plan of the Hungarian government, ("Safety and Partnership: tasks in health care until 2010"), which was submitted to widespread social discussion. Our association, based on the request of the Ministry, has organized a sectoral consensus conference to summarize the material that was submitted for discussion.

We continued the National Program on Prevention and Cure of Heart and Circulatory Diseases that was elaborated, accepted and announced by MOTESZ and professionally relevant member societies in 2006. The results of the program were revealed in 2008 to the Health Care Committee of the Parliament, and in 2009, lectures were held on the status of the program and on further

tasks of realization at different scientific professional forums.

Meeting legislative requirements, the minister of health entrusted us to organize and execute the election of the professional boards, the minister's consultative body. MOTESZ successfully carried out this task this year as well.

The association formed an agreement of cooperation with the Ministry of Health, which entailed cooperating with professionals to evaluate bills on the minimum requirements expected from health care providers. In addition, we formulated a professional proposal on the modernization of the present structure of health care services. Professional documents consisted of complex solution programs to develop both basic and emergency health care services and out-patient and in-patient professional care.

The organizing activities of MOTESZ, which are conducted by its Congress and Travel Agency, also play a significant role in the organization. Besides promoting international recognition of the knowledge and results of Hungarian medical doctors at both national congresses with international participants and international conferences, these events are indispensable pillars of continuing education within the profession nationwide. In addition to overseeing the events themselves, the Travel Agency deals with organizing travel, accommodation, and programming for medical doctors, researchers and theoreticians.

Our scientific, political, and informative periodical, MOTESZ Magazin, which has been reaching readers for 18 years, appeared with new design and content in 2009. To further vivify our professional dialogue with our readers, the website of MOTESZ includes an interactive correspondence column and a forum are linked to all columns of the periodical, facilitating the sharing of opinions on all themes appearing in the periodical.

Our homepage provides up-to-date information on professional political events and on the progress of the association's work; we also provide a place for the announcements of our member societies.

## Our international activities

We consider it a priority that our organization's activities fit that of the national and international organizations of the medical profession. Our relations with the following organizations are of major importance: Standing Committee of European Doctors (CPME), World Medical Association (WMA), European Forum of Medical Associations (EFMA), World Health Organisation (WHO), European Union of Medical Specialists (UEMS), European Union of General Practitioners (UEMO), European working group of practitioners and specialists in free practice (EANA).

Though our financial resources make it difficult for us to take part in sessions of international organizations regularly, we can report several positive results from sessions attended. A great point of pride is that at the general meeting of UEMS in Copenhagen held in October 2008, Dr. Zoltán Magyari, member of the international committee of MOTESZ, was the only vice-president, to be reelected, indicating the level of recognition of his work and an appreciation of Hungary's role. Dr. Magyari continues to

play an active role, primarily in accreditation of international congresses.

It is also significant that at the 2009 general assembly of UEMO, held in Budapest, Prof. Dr. Ferenc Hajnal was elected as president, Dr. Renáta Papp as secretary-general, and Dr. Sándor Balogh as treasurer, starting in 2011. They are all members of the international committee of MOTESZ. In the operative work of the UEMO Presidency we work in collaboration with other professional organizations.

As to our bilateral relations, our cooperation with the German Medical Association (Bundesärztekammer) is very active; we participate on a regular basis in the annual German Medical Assembly. We also maintain relations with the American Medical Association, the French Medical Association (Conseil National de L'Ordre des Médecins), the Chinese Medical Association, and the Chinese Medical University in Heilongjiang.

We evaluate the results of relations with the Chinese Medical Association each year. Since 2004, we have alternated sending the MOTESZ delegation to visit their Chinese counterparts one year and hosting a Chinese delegation the following year. In autumn of 2009, in collaboration with Semmelweis University's Faculty of Health Sciences, we hosted two Chinese delegations in Hungary,

from both the Chinese Association of Traditional Chinese Medicine and the Chinese Medical Association. Our association was instrumental in integrating the teaching of traditional Chinese medicine (TCM) into the system of Hungarian medical education, and in securing recognition of Chinese TCM diplomas in Hungary.

Our association returned the visit on 24-25 April 2010, when a delegation was invited to the 24th National Congress of the Chinese Medical Association, held in Beijing. Our delegation held talks with the leaders of the Medical Center of the Beijing University in order to facilitate the establishment of a relationship with the Semmelweis University of Budapest and the University of Pécs, as well as to form an agreement of cooperation with the Chinese.

The major duty of our association is representing the interests of our member societies, and through them, the interests of the medical profession. All our member organizations are informed about our national and international activities on a regular basis through the quarterly meetings of the Association Council, the body consisting of the presidents of the member societies of MOTESZ.

*Dr. Béla Szalma, the Secretary General of the MOTESZ*

## American – Austrian Foundation in Macedonia

### What are we doing?

Continuing medical education is a never-ending story for doctors who want to be up to date and to give their patients the best care possible. What follows is a short introduction to our organization, whose primary goal is to offer theoretical as well as practical

education for doctors from more than 100 countries.

THE AMERICAN AUSTRIAN FOUNDATION (<http://www.aaf-online.org>) is a non-profit, non-governmental organization that seeks to prevent brain drain and foster brain gain in countries of transition through

exchanges in medicine, communications, science and the arts.

### Background:

In 1984, a group of Americans and Austrians interested in fostering closer relations between the United States and Austria established The American Austrian Foundation (AAF). In the years since, the foundation has grown from a bilateral to a multilateral, international institution partnering with

non-governmental organizations (NGOs), governments, and individuals.

## Mission:

The American Austrian Foundation seeks to bridge the knowledge gap by providing qualified individuals with fellowships to pursue postgraduate education in medicine, media and the arts. The AAF's fellowship programs, initially offered to Americans and Austrians, now include participants from more than 100 countries worldwide. The AAF conducts its own programs and joint programs with American, Austrian and international organizations. To facilitate the operation of programs in Austria, the friends of the American Austrian Foundation founded The Salzburg Staffing in 1995, and the Vienna Chapter in 2002. In 2005 the AAF, the Open Society Institute, and the Austrian Ministry of Science and Education established the Open Medical Institute (OMI) to consolidate the Salzburg Medical Seminars International and the Observerships under one name. Later, The Vienna Open Medical Institute (Vienna OMI) (<http://www.aaf-online.org/vienna-omi>) was established as a joint initiative of the Vienna Hospital Association (VHA) ([www.wien.gv.at](http://www.wien.gv.at)), the American Austrian Foundation (AAF), the Viennese Society of Physicians, the Austrian Academy of Sciences and the Vienna School of Clinical Research (VSCR) ([www.vscr.at](http://www.vscr.at)), to provide scientific and clinical postgraduate education in medicine using Vienna's excellent resources. So far, more than 10,000 physicians from countries in transition (fellows) have attended seminars; of these, 1500 have also participated in one-month observerships at Austrian hospitals.

## Medical Programs

The medical educational process is organized through three steps:

### Step One: Knowledge Transfer - Salzburg Medical Seminars

First established in 1993, today there are around thirty seminars per year. These seminars are postgraduate medical educational programs provided by physicians from leading American medical schools and hospitals, including New York-Presbyterian Hospital, The Children's Hospital of Philadelphia, Memorial Sloan-Kettering Cancer Center, The Hospital for Special Surgery, Duke University Medical Center, Cleveland Clinic, and Methodist Hospital, as well as leading European centers. These physicians spend one week in Salzburg working pro bono to teach their English-speaking colleagues from countries in transition. The seminars provide personal contacts and small working groups for fellows, who are admitted through a highly competitive selection process. More than 500 seminars have been organized with 35-40 participants attending each one.

### Step Two: Experience Exchange - Omi Observerships

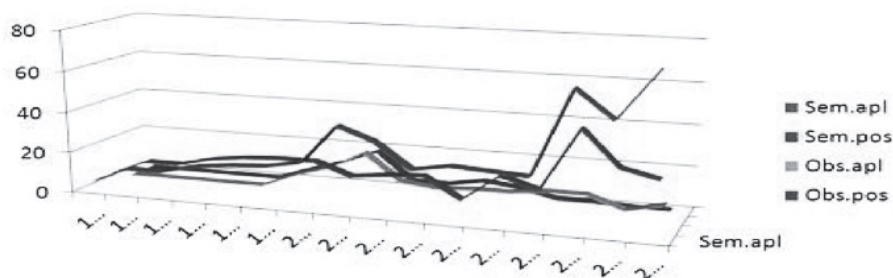
The aim of the OMI-Medical Observership Program is to integrate seminar alumni into the international medical community by inviting them to spend up to 3 months, in one-month periods, at Austrian hospitals to improve their clinical skills. Organizing the Vienna OMI has enabled an increasing number of participants in Observership programs in the last few years. All Vienna hospitals are open to fellows, who conduct



*Marija Vavlukis*  
their Observership programs in many different areas.

### Step Three: Capacity Building – Distance Learning

The Foundation brings distinguished lecturers into different countries by organizing satellite symposia and visiting professorships. Two-day OMI satellite symposia are held in the region with the aim of reaching a larger audience of physicians and health care workers. At the same time, they are an important opportunity to learn about local conditions and foster relationships among senior physicians in the region and American and Austrian faculty members. Satellite symposia typically include six lectures, a hospital visit, and a round-table discussion on a topic agreed by local and international faculty. One-day visiting professorship programs typically include three to four lec-



Graphic 1.

tures, case reports, and an optional hospital visit.

## Omi Alumni Network

The OMI Alumni Network is organized as an open network for all fellows, providing open access to state-of-the-art medical information via Medical Handbook Online and video conferences. This network also helps in the support and improvement of local healthcare systems by providing the possibility of a second opinion in patient care, local knowledge transfer, and a chance to attract new medical talent.

## Activity Report from Macedonia

As a local coordinator, my routine activities include:

- Continuous management of the fellows' data in the AAF/OMI database in order to facilitate their selection, travel arrangements, etc;
- English testing, screening of the applicants and fellows, and recommendations to the Program Director;
- Maintaining relationships with local OMI alumni fellows;
- Maintaining relationships with other local coordinators in order to collaborate in the organisation of local activities;
- Promoting the benefits and opportunities of such collaborations with AAF/OMI in order to facilitate the development of the regional health care systems and scientific research;
- Establishing partnerships with local medical and educational institutions;
- Submitting regular progress reports to the Network Coordinator to ensure progress milestones, or to identify issues and problems that may necessitate assistance from AAF/OMI;
- Working collaboratively with the Network Coordinator and members of the AAF/OMI team;
- Organisation and administration of satellite symposia and visiting professorships.

## Most Significant Accomplishments

The most significant accomplishments of the past two years include:

1. Organisation and administration of OMC-MACEDONIA as a virtual space for promoting the AAF-OMI programs and communication of the Macedonian fellows with one another and with the OMI alumni network. The OMI Alumni Network – OMC Macedonia (<http://www.webdoctor.com.mk>; <http://www.webdoctor.com.mk/index.aspx?IDPage=273>) currently functions as a virtual network where graduates of the OMI-Salzburg Medical Seminars International (SMSI) can come together, share experiences, and acquire new medical information together with the Macedonian doctors. Open Medical Club activities currently include announcing the Salzburg Medical Seminars and publishing reports of the Macedonian fellows that attend Salzburg Medical Seminars. These reports include their activities and impressions from the seminar, topics and faculty.

2. Increasing the number of Macedonian applicants for Salzburg Medical Seminars from 24 in 2006 to 52 in 2007, 75 in 2009, and over 100 in 2010.

In the graphic below, we can see the changes in applications and attendance of the Salzburg Seminars and Observerships since 1994, when the first Macedonian fellow participated at a Salzburg Medical Seminar. Currently, we have 4-6 applications per seminar, which improves the selection process and guarantees the quality of the selected doctors. There are about 600 Macedonian doctors affiliated with the program. Since 1994 there have been 460 applications for Salzburg seminars, 160 of which were made during the past two years (during the author's tenure as coordinator). Of 230 total seminar attendees, more than 40 occurred in the past two years. We have more than 100 Observership applications, 77 of them realized since 1995, and that is the area with the greatest need for improvement. At the

moment, about 25 Macedonian fellows are on the Observership waiting list.

This is the greatest indication of my primary goal – the promotion of the programs of AAF-OMI and the entry of more Macedonian fellows therein.

## Partnerships and Alliances

One of my activities as coordinator is establishing partnerships and alliances with medical institutions and organisations within Macedonia. At present, we have signed Memorandums of Understanding between the Open Medical Institute (a program of the "Association of Friends of the American Austrian Foundation") as well as the Medical Faculty, University St. Cyril and Methodius, Skopje, and the Clinical Center Trifun Talevski, Bitola.

We have also established contacts with local medical and educational institutions, including the Macedonian Medical Chamber, University Clinic for Pediatric Diseases, University Clinic for Gynecology and Obstetrics, and Psychiatric Hospital Skopje.

## Goal Achieved in 2010: Organisation of the Very First Omi Visiting Professorship Program in Cardiology in Macedonia

The first Macedonian visiting professorship program in cardiology was organized under the auspices of the American-Austrian Foundation, the Open Society Institute and the Medical University Graz, Austria, in coordination with the medical faculty of the University St. Cyril and Methodius, Skopje, the University Clinic of Cardiology, and the Macedonian Society for Cardiology. It was organized as preconference activity within the fourth Macedonian Cardiology Congress, which was held from June 2-5, 2010, in Ohrid.

Our first guest was Professor Rainer Riemüller, who is Professor of Radiology and

head of the department of General Diagnostic Radiology in the University Hospital of Graz, as well as a professor at the Medical University of Graz Austria and at the University of Munich, Germany. The symposium consisted of four hour-long lectures given by the professor, followed by a session of six case reports from our daily clinical practice, accompanied by interactive discussions throughout the day. Of course, it was a great pleasure for the regional coordinator

of the AAF for Macedonia finally to see the first such symposium in the country become reality. Preparations are underway to organize the second one during this calendar year in the area of neurology in strategic partnership with Clinical Hospital "Trifun Panovski" from Bitola.

Spreading knowledge among doctors is challenging and dynamic work; though it differs greatly from the everyday work of a

practicing physician, it nonetheless complements and supports the primary goal of improving ourselves in order to improve patient care.

*Assistant Professor Marija Vavlukis,  
MD, PhD, Regional Coordinator  
of AAF-OMI for Macedonia*

## Somali Medical Association MSF- GALKACYO EYE CAMP

### Galkacyo South Hospital Somalia

#### Phase 1: Screening, March 24 - April 28, 2010

The screening phase of this eye camp started on March 24, 2010 at the orphanage center in Galkacyo. Screenings were given by two ophthalmic technicians from Al-Nur Eye Hospital in Mogadishu who were supported by the staff of Galkacyo South Hospital. The eye camp was advertised through the local media and by text messaging using the local telecommunication network so that a maximum number of patients could benefit from it.

Patients were examined and those in need of medicines or glasses were treated. Blind

**Table 1:**  
*Regional distribution of OPD patients:*

Region	No of Patients	%
Mudug	2608	85.87
South Somalia	125	4.1
Ethiopia	118	3.9
Rest of Puntland	93	3.06
Galgudud	55	1.81
Somaliland	23	0.77
Hiran	15	0.49
<b>Total</b>	<b>3037</b>	<b>100</b>

patients in need of surgery were scheduled for treatment during the surgical phase (phase 2) and advised on the date of their surgery.

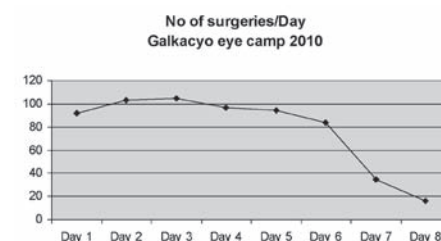
A total of 3037 patients benefitted from phase 1 by receiving free medications and/or glasses and 725 more patients were scheduled for surgery.

#### Phase 2: Surgery April 22-29, 2010

This phase started on April 22, 2010 and was completed on April 29, 2010. The surgi-

**Table 2:**  
*Details of eye surgeries in Galkacyo eye camp 2010:*

Date	Female	Male	Total
22-Apr	56	36	92
23-Apr	48	55	103
24-Apr	53	52	105
25-Apr	51	46	97
26-Apr	46	48	94
27-Apr	41	43	84
28-Apr	18	17	35
29-Apr	8	8	16
<b>Total</b>	<b>321</b>	<b>305</b>	<b>626</b>
%	51.3	48.7	100



*Chart 1: Number of surgeries/Day:*

cal team was comprised of three ophthalmic surgeons and six ophthalmic technicians. Galkacyo South Hospital's operating theatre was used to perform the eye surgeries. We used the two-table technique to speed-up surgical times, maximizing the volume of surgeries able to be performed.

725 patients were booked for surgery during this phase, and 626 surgeries were completed successfully. 48 patients did not keep their appointment, 33 patients' surgeries were cancelled due to underlying eye diseases which might have affected the outcome of surgery, and 18 patients had medical conditions that prevented them from undergoing anesthesia.

**Post-operative Care:** All surgical patients were examined by an ophthalmologist for possible complications on the second day after their surgery, and were given eye drops, antibiotics and sunglasses to protect their eyes. They were also given advice and instructions on mobility, food and work. The Somali ophthalmic technicians remained at the hospital



*This is Ayan Ali. At just ten years old, she was the youngest person we treated. Congenital cataracts in both her eyes meant she had been blind since birth.*



*The surgery is more difficult for children to cope with, so we gave Ayan a general anaesthetic.*



*We only operate on one eye at a time. Here we've made sure Ayan's left eye is covered to protect it from infection.*



*After a short 15-minute surgery, Ayan is carried to the recovery room by one of the many local members of the team here, where her mother was waiting.*



*As you can see, we use only the simplest equipment. A microscope and light – Ayan's surgery is done by hand. It takes a lot of skill and a steady hand. Not many doctors in the UK know how to do this operation manually any more.*



*Just 24 hours later, Ayan returned to the eye camp for a check up. Already, she could see with her left eye. When I held up my fingers, she told me she didn't know how to count very well, so we spent the next few minutes learning to count the numbers from one to ten – using her sight for the very first time.*

for an additional week to treat any post-operative complications and give advice to surgical patients. There was one case of post-operative infection, the source of which was determined to be a personal hygiene issue. The infection was treated aggressively with local and general antibiotics and mydriatics which helped us save the sight of the patient. This represents an infection rate of 0.016% which is well below the WHO accepted level of < 2%.

## Challenges:

During our presence at Galkacyo Eye Hospital, I gave a presentation on the management of ophthalmic emergencies to the entire hospital staff, each of whom also received an eye screening. The Galkacyo Hospital management and staff members were very cooperative and no major challenges were encountered during this eye camp.

## Recommendations:

As this eye camp has demonstrated the high prevalence of blindness in Somalia and the lack of eye services available to the general population, I would like to recommend to MSF the following:

- To hold similar eye camps twice every year, as they have been clearly demonstrated to be a valuable service to the community.
- Improved planning for the logistics, medicines and consumables needed for the eye camp.
- Involvement of an MSF management team in the planning and implementation of the eye camp.

I would like to take this opportunity to thank the management and staff of MSF for their support throughout this eye camp. I am also

grateful to the team of surgeons and technicians that supported me throughout this eye camp for their tireless efforts and their high work ethic. Last, but not least, I would like to acknowledge the support and encouragement I have received from the chairman and operational team of Right to Sight.

Eye camp team: 3 Surgeons, 1 Camp manager, 5 Ophthalmic technicians, 1 Anaesthesia technician, 2 Screening Nurses and MSF Galkayo South hospital team's support

*Dr. Abdirisak Dalmar  
President, Somali Medical Association  
Consultant Ophthalmologist &  
Head of Training and Research  
Right to Sight, London, UK*

## The Irish Medical Organisation



*Seán Tierney*

The Irish Medical Organisation (IMO) was founded in 1984 following the amalgamation of the Irish Medical Union and the Irish Medical Association that brought together the union and professional representative groupings of doctors in Ireland.

Through this process, the IMO became the sole negotiating body on behalf of all doctors in Ireland. The role of the IMO is to represent doctors in Ireland to provide them with all relevant services. It is further committed to the development of caring, efficient and effective Health Services.

### Structure

Council of the IMO is the overall governing body of the Organisation for policy direction and implementation. In addition to Council there is the Management Committee who meet eight times a year and monitors the performance of the secretariat, receives monthly accounts and ensures that policy is being implemented.

The IMO also has four Specialty Groups that address specific issues affecting the relevant groups. Members of the Specialty

Groups are elected annually. Each Specialty Group contains regional and specialty representatives.

The Specialty Groups within the IMO are:

- The Consultant Committee
- The General Practitioner Committee
- The Non-Consultant Hospital Doctor Committee
- The Public Health Doctor Committee.

There are two Standing Committees, International Affairs and Ethics Committees:

The International Affairs Committee has responsibility of representing the IMO at international meetings. The IMO is currently active members of CPME, EANA, PWG, UEMO, UEMS and the WMA.

### Major Issues

Given the economic climate globally – and particularly in Ireland – there are issues that have come to affect the medical profession, regardless of specialty or location.

The IMO is continuously engaging in talks with government over a number of issues, particularly regarding the implementation of policies that have seen a pronounced impact on our membership. The IMO has worked hard to alert the HSE, the Department of Health and Children and the broader Government to the dangers of pursuing cost cuts now that end up costing more money in the long run. It is vital at this time of uncertainty that the IMO remains focused on protecting the essential fabric of our health services for our health professionals seeking to deliver quality services to their patients.

### Research and Policy

As the representative body for the medical profession in Ireland, one of the key activi-

ties of the IMO is advocacy. Through the Research and Policy Unit, the IMO publishes key position papers during the year along with submissions on policy initiatives that represent the views of the membership.

The most recent position paper was published in April on Universal Health Coverage, which looks at the principles that should underpin any Universal Health Care System.

Such papers, along with submissions on various government and non-government consultations, are hoped to influence and inform Government proposals, and to recognise the unique and important role that doctors play within the delivery of health services.

### Role of the Doctor

One of the key roles of the IMO is to protect and promote the Role of the Doctor in Ireland. Through the active representation of Irish doctors both domestically and internationally, we hope to ensure the medical profession is strong and will continue to advocate for the development of a caring, efficient and effective Health Service.

*Chief Executive: Mr George McNeice*

*President: Professor Seán Tierney*

*Vice President & Chair of the GP*

*Committee: Dr Ronan Boland*

*Treasurer: Dr Anthony O'Connor*

*Honorary Secretary: Dr Bridin Cannon*

*Chair of the NCHD Committee:*

*Dr Matthew Sadlier*

*Chair of the Public Health*

*Committee: Dr Paul McKeown*

*Chair of the Consultant Committee:*

*Dr Trevor Duffy*

Website: [www.imo.ie](http://www.imo.ie)

## The Ukrainian Medical Association after Entering to the WMA



*Oleg Musii*

In October, 2008, the Ukrainian Medical Association (UMA) became a constituent member of the WMA during the 59<sup>th</sup> World Medical Assembly in Seoul, South Korea. On November 4, 2008 a press conference was held in Kyiv to announce the membership of the UMA in the WMA. The President of the UMA, Oleg Musii, the Chairman of the Board of the UMA, Stanislav Nechaiv, and UMA board member and Ukraine Parliament member, Volodymyr Karpuk, were present at the press conference to answer questions from Ukrainian and foreign journalists. This marked the beginning of a productive year for the UMA, summarized as followed:

1. In the spirit of co-operation, the UMA's first priority as a new WMA member was to arrange the Ukrainian translation and publication of the WMA's "Medical Ethics Manual"

2. On December 23, 2008, Law (№3539) "About Medical Self-Government" was presented to the Ukrainian parliament. Drafted by the UMA to develop the idea of independence of the medical profession,



*Stanislav Nechaiv*

Law 3539 had long been under consideration by the Advisory Council of the Committee of Health of the Verkhovna Rada (the Parliament) of the Ukraine.

3. From May 19-22, 2009, the Ukrainian Medical Association took part in the 112<sup>th</sup> Congress of the German Medical Association in Germany.

4. On June 5, 2009, the UMA presented its Ukrainian translation of the second edition of the WMA's "Medical Ethics Manual" Carried out jointly by the UMA, the German Medical Association and the Finnish Medical Association, the largest contributions to the quality of the translation are credited to: Yuriy Kundiyev (National Academy of Science of the Ukraine and the Academy of Medical Science of Ukraine), Vitaliy Radchuk (Associate Professor of the Taras Shevchenko National University), Stanislav Nechaiv (Master of Health Management), Dr. Oleg Musii (Master of Health Management), and Dr. Nina Krushinsky (Master of Health Management) with general editorial credit given to Lubomyr Pyrih (AMS of the Ukraine).

5. On September 18, 2009, the UMA became a member of the Forum of Medical Organizations in Central and Eastern Europe (ZEVA) during its 16<sup>th</sup> Symposium held in the Serbian capital of Belgrade.

6. The "Ethical Code of Physicians of the Ukraine" was accepted during the 10<sup>th</sup> Congress of the Ukrainian Medical Association held in Evpatoria From September 24-27, 2009.

7. From October 15-18, 2009, the UMA took part in the 60<sup>th</sup> WMA General Assembly in New Delhi, India.

On December 16, 2009 the President of the Ukraine issued Decree № 1055/2009 "Celebrating 100 years of the Ukrainian Medical Association" and on February 24, 2010 the Cabinet of Ministers of Ukraine issued Order № 364-r "About the preparation for celebrating 100 years of the Ukrainian Medical Association" Celebrations for the occasion were scheduled for September-October of 2010 and invitations were extended to representatives of state and local governments, NGOs, leading medical experts and veterans affairs, students of educational institutions, scientists, and public figures. Events planned for the celebration include scientific, medical and other health care conferences, round tables devoted to the value of the UMA, and the issuance of an engraved commemorative coin, postage stamp and envelope dedicated to the 100-year anniversary of the UMA. The Ukrainian Medical Association has worked many years for the benefit of Ukrainian doctors, and in support of private medical practice.

*Dr. Oleg MUSII, the President of the UMA  
Dr. Stanislav NECHAIV, Chairman  
of Board of the UMA*

## Radical changes proposed in the NHS (England) Government White Paper on the National Health Service – “Equity and Excellence - Liberating the Health Service”.<sup>(i)</sup>

Those working in the UK National Health Service are accustomed to seemingly endless reforms and changes in the NHS. Over the past 15 years there have been many, especially in this century. Barely have the latest changes had time to be put in place. Let alone given time for firm conclusions as to outcome, than further changes seem to appear.

Within weeks of the formation of the new Coalition Government following the June election in the UK, the new government published on the 12th July a White Paper broadly setting out the most radical changes proposed since the foundation of the NHS. The aims of the White Paper are indicated to be “to

- put patients at the heart of everything the NHS does;
- focus on continuously improving those things that really matter to the patient – the outcomes of healthcare;
- empower and liberate clinicians to innovate, with freedom to focus on improving healthcare services.”

The most radical proposals are that General Practices through Consortia of GP's, composed of representatives of each General Practice in an area, should be charged with the Commissioning of most Healthcare services. These Consortia are to replace the Primary Care Trusts (PCTs) currently responsible for the Commissioning of services. PCTs are to be phased out over the next three years.

The GP Consortia are to be supported by guidance from a National autonomous Commissioning Board which will provide

leadership for quality guidelines, aimed at standardising good practice in promoting quality and equity, and promoting patient and carer involvement and choice. This proposal represents a radical change in placing power at the level of the provision of primary care, where, as general practice has always maintained, the direct continuing interface with patients permits a broad knowledge of their needs.

In proposals to increase the freedoms of Foundation Trusts (often referred to as Hospital Trusts), they will be licensed by Monitor (currently responsible for regulating Foundation Trusts) in the same way as other Providers whether from the private or voluntary sector, thus increasing Foundation Trusts' autonomy.

The White Paper includes many other proposals including the introduction of a National Public Health Service, the employment by Local Authorities (who will be responsible for health promotion and improvement) of Directors of Public Health, and also provisions aimed at increasing local coordination of relevant activities between the NHS, Local Authorities and local populations, including empowering patient's input into local services and patients' choice which are part of the democratisation of the NHS at the root of the proposals. A paper on these proposals is promised in the near future.

The White Paper is open to consultation until the 6th of October following which, in November, legislation will be presented to the parliament. No hint of any such radical proposal for change was suggested by any

political party during the run-up to the recent election.

A number of more detailed consultation papers have been published in the weeks following the White paper. They provide more detail of the various proposals and a detailed timetable leading to full implementation in three years. These papers are the subject of consultation with continuing discussions and submissions by designated dates.

Dr Hamish Meldrum, Chairman of Council of the British Medical Association in a letter to all members concerning the White Paper said “Taken together, these proposals represent very significant changes to the organisation of health services in England. The proposals include increased responsibilities for doctors, the phasing out of PCT's and SHA's (Statutory Health Authorities at Regional level) and a greater focus on outcomes, as well as perceived threats to education and terms of service. There are also very significant proposals for the future of Public Health, with closer working with local authorities and ring-fenced budget intended to ensure the provision of a wider public health agenda.” He stressed the key proposal to devolve more involvement and financial control in commissioning to General Practitioners and that to be successful, this would require the fullest engagement with secondary care colleagues and also with the public. High quality management support would be needed and the new GP Consortia would need to engage with experienced NHS managers”

While the aims and proposals offer great opportunities and a challenging agenda, especially given the timescale, overall the proposals are not without risks – as a number of expert commentators have commented.

(i) “Equity and Excellence – Liberating the NHS” Crown copyright  
ISBN 9780101788120

# EFMA (European Federation of Medical Associations) / WHO meeting in St. Petersburg 19–21 September 2010



## Contents

Coming to Vancouver. ....	167	Singapore Statement on Research Integrity. ....	185
WMA Supports Physicians in Refusing Punishment Request. ....	167	The Impact of the Economic Recession on Nurses and Nursing in Iceland . ....	186
Final Conclusions. ....	168	Lifestyle Practices of Medical Students attending an International Student Conference. ....	193
Impact of Economic Crises on National Health Care Systems – Experience and Strategies ..	168	The Norwegian Medical Association . ....	195
Global and local financial crisis – a challenge to the national health system. Example of Latvia .	173	Bangladesh Medical Association (BMA). ....	196
What are the Minimal Services to be Provided by the Healthcare System? . ....	176	Hungarian Medical Chamber in the Last Twenty Years . ....	197
How can Health Care Systems be structured and managed to be less sensitive to crisis and play a stabilizing role in economy? . ....	177	MOTESZ – Association of Hungarian Medical Societies . . .	199
Impact of Economic Growth and Financial Crisis on Estonia's Health Care . ....	179	American – Austrian Foundation in Macedonia . ....	200
The Institutional Factors that help Health Care System to hold up against Financial Crisis . ....	181	The Somali Medical Association . ....	203
		The Irish Medical Organisation . ....	205
		The Ukrainian Medical Association . ....	206
		Radical changes proposed in the NHS (England) Government White Paper on the National Health Service – “Equity and Excellence - Liberating the Health Service”. . . . .	207