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- Medical Ethics and Personal vs. Public Conscience
- Tobacco-Free World in Twenty Years' Time!
- Czech Medical Chambers' Experience to Make an Agreement

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Cover painting:
This picture is produced by prof. Tae-Sub CHUNG of Dept. of Diagnostic Radiology, Yonsei University, Korea.
Prof. Chung is creating pictures using X-ray art. In this picture titled "It's delicious", X-ray image of tiny granule on tangerine peel meets with bone and skin of a woman's hands bringing fresh and delicious atmosphere.

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World Medical Journal

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Otmar Kloiber

Among the achievements of the World Medical Association are landmark documents like the first **International Code of Medical Ethics** (1948), the **Declaration of Geneva** often referred to as **the modern Hippocratic Oath** (1949), or the most famous of our declarations the **Declaration of Helsinki** – Ethical Principles for Medical Research Involving Human Subjects (1964) – to mention just 3 out of more than 100 policies on medical ethics, human rights and socio-medical affairs. All of them are living documents, up-to date, not trendy, but value- and reality-based. They guide physicians all over the world in difficult ethical situations, from the bedside at hospitals to the battlefields of this world. Our policies have proven value and receive the highest respect.

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More information and the possibility to sign up can be found on our website *www.wma.net*.

For the people of this world health is bridge to peace and a better living.

We are building it. Please join us.

Dr. Otmar Kloiber,
WMA Secretary General

World Medical Journal

Medical Ethics and Personal vs. Public Conscience: a Malaysian Context

David KL Quek

Some time ago, New York Times columnist Professor Stanley Fish (NY Times 12 April 2009) [1] wrote about "Conscience vs. Conscience", where he discussed the conundrum about how people in general and physicians in particular, under different circumstances should or shouldn't abide by their own conscience.

The contending issue was that physicians should not refuse treatment or procedures based on their own personal moral or religious grounds. Professor Fish argued that there is such a thing as a collective "public conscience" which should supersede that of one's personal conscience and value systems, no matter how entrenched these may have been.

During the Bush administration, the culpable clause, called the Provider Refusal Rule, allows health care providers to refuse to participate in procedures they find objectionable for moral or religious reasons. The main bone of contention was of course regarding freedom to choose abortion, pro-choice, or conversely, pro-life.

In Fish's article, he underscored an earlier statement by Mike Leavitt, Bush's Secretary of Health and Human Services, who had said that, **"Doctors and other health providers should not be forced to choose between good professional standing and violating their conscience."** The direction of the Bush doctrine was of course to urge the conservative right against unfettered abortion on demand, which continues to divide the American people.

Professor Fish reviewed the etymology of "conscience" as ascribed to English philosopher Thomas Hobbes. Here one of the earliest definitions of conscience, referred to those occasions *"when two or more men know of one and the same fact ... which is as much to know it together,"* and where, violation of conscience meant that knowing together, men prefer their "secret thoughts" to what has been publicly established.

Fish acknowledged that Hobbes understood that many consider conscience to be the name of the private arbiter of right and wrong. But Hobbes regards this as a corrupted usage invented by those who wished to elevate "their own ... opinions" to the status of reliable knowledge and try to do so by giving *"their opinions ... that reverenced name of Conscience."*

Hobbes's main argument is that if one can prefer one's own internal judgments to the judgments of authorized external bodies (legislatures, courts, professional associations), the result will be the undermining of public order and the substitution of personal whim for general decorum: *"... because the Law is the public Conscience ... in such diversity as there is of private Consciences, which are but private opinions, the Commonwealth must needs be distracted, and no man dare to obey the Sovereign Power farther than it shall seem good in his own eyes."*

Following his article, Fish was roundly criticized for being half-right in his interpretation of conflicting conscience, but intellectual disagreement continues to divide mostly implacable and partisan ethicists. Nancy Berlinger in an ensuing Hastings Center Report [2] has this to say: '*Stanley Fish… recognizes that defining "conscience" more loosely – as "moral intuition," or those "secret thoughts"… does not solve our contemporary problem. When medical professionals believe that they are being forced to do harm or are prevented from doing good, the ethical solution may not always be the conscience-clause remedy of stepping away from troubling situations.'*

Where does this leave the medical professional when it comes to ethical underpinnings of doing what's right or wrong? Would our personal conscience suffice? Or, should we subsume to the greater wisdom of our collective professional voice (e.g. national medical associations, professional bodies, world medical association, medical councils, etc.), which through the long arduous passage of time and historical experiences, would have honed a burnished if straitjacketed version of what's generally accepted as "ethically and publicly correct"?

Be that as it may, does this mean that the medical professional would then have no need to rely on his own personal conscience and moral standing? No, but surely if these are diametrically opposed to the greater wisdom of peers, then one has to justify one's personal convictions all the more!

Again, this cannot be taken out of context of the prevailing society and sociopolitical situation. This becomes extremely relevant in societies such as in Malaysia and other quasi-democratic nations, where governments tend to be paternalistic, even arrogant or worse [3]. The instruments and institutions of power are often abused to forcefully interpret laws or even medical findings in a slanted manner, which severely test the mettle and autonomy of physicians under their charge.

World Medical Journal

In certain authoritative or political circumstances, the medical professional is called upon to exercise extreme judgment calls, which can be sorely tested by either threats from or fears of authority (e.g. police, superior officers, military, even political powers) or worse, direct or indirect "rewards" for passive compliance!

The 1st century AD Hindu code, **Charaka Samhita** [4], exhorts doctors to "endeavor for the relief of patients with all thy heart and soul; thou shall not desert or injure thy patient for the sake of thy life or living", which have been restated in many codes of professional conduct including our own. Yet, these are often pushed to the backburner, when conflicts of duties, arise.

Recent in Malaysia, public spats on medical testimonials and reports have arguably cast long shadows as to the so-called impartiality, ethics or professionalism of some of our medical colleagues [5]. Forensic pathologists are facing some intense scrutiny of late, due to questionable lapses, incoherent practices and perhaps even perceived selective memories, and slipshod standards of duty of care [6].

Other physicians making medical reports are also put under the microscope for their perceived biasness or slant of their reports, one way or the other, until the truthfulness of one vs. the other, appears difficult or impossible to discover [7]!

Such ambiguous if disingenuous medical findings or reports cast a dismal if disappointing view on our profession [8].While some of these appear coerced, some might conceivably be simply venal, just as if medical veracity can be made to sway according to the purchasing power of the most damning and powerful!

Physicians must be reminded that for that patient (deceased or detainee) under his/her charge, there is frequently no other person whose interests can be represented, except from the physician's unbiased assessment… Sadly some of these dubious practices place us at odds with the perceived wisdom and conventions of some greater external collective conscience. These conventions although seemingly unenforceable, have long been articulated by world authorities such as the World Medical Association and even the United Nations Human Rights Commission.

The UN High Commission for Human Rights ***Istanbul Protocol*** [9] is categorical in stating that:

"Dilemmas arising from these dual obligations are particularly acute for health professionals working with the police, military, other security services or in the prison system. The interests of their employer and their non-medical colleagues may be in conflict with the best interests of the detainee patients. Such health professionals with dual obligations, owe a primary duty to the patient to promote that person's best interests and a general duty to society to ensure that justice is done and violations of human rights prevented. Whatever the circumstances of their employment, all health professionals owe a fundamental duty to care for the people they are asked to examine or treat. They cannot be obliged by contractual or other considerations to compromise their professional independence. They must make an unbiased assessment of the patient's health interests and act accordingly."

Unfortunately, this protection by convention appears so remote to the lonely physician standing in the grips of perceived authoritarian powers, whose influence are imaginably all-powerful!

Seen in this context, society must exert its moral imperative of the public good on a universal basis, and demand the application of such universal conventions, to protect the hapless physician at the centre of such political or partisan storms, lest such pressure lead to further erosion of already debilitated institutions.

Similarly, the onus is on members of the medical profession to remain steadfast to the doctrine of public conscience and universal principles rather than personal ones, when carrying out our duties, including when making judgment or pronouncement on some of our possibly errant colleagues. Sectarian perceptions whether religious or political, clearly must take a back seat, and should not be allowed to color our thinking or decision making.

Personal bias or experience or even conviction should yield to the more nuanced, perhaps more balanced decision based on strict interpretations of statutes, codes of professional conduct, and perhaps legal precedents.

The US Supreme Court [10] has ruled that when the personal imperatives of one's religion or morality lead to actions in violation of generally applicable laws – laws not promulgated with the intention of affronting anyone's conscience – the violations will not be allowed and will certainly not be celebrated; because: *"To permit this would be to make the professed doctrines of religious belief superior to the law of the land, and in effect to permit every citizen to become a law unto himself."* Therefore, we must be quite clear to dissect conscionably our dilemma of which is the superior right.

Similarly, in the context of political or authoritarian pressure, especially where democratic institutions are weak, and where risk to the individual may seem likely, it behooves the professional to be reminded about the World Medical Association's ***Declaration of Geneva*** [11], which is a modern restatement of the Hippocratic values, as well as to be cognizant of UN Conventions such as the Istanbul Protocol. Doctors are reminded that the health of their patients is their primary consideration and that we must devote ourselves to the service of humanity with conscience and dignity.

We must learn and adhere to our historical memories, that which are collectively acknowledged as "correct" and first and fore-

World Medical Journal

most for our patients' interests. Certainly, in this context, every professional should not let religious, political or sectarian reasons from influencing our decision-making.

But does this mean that these are fixtures which cannot or should not be modified with the passage of time and perhaps move in tandem with the "fashion" or faddism of current perceptions or even societal movement or direction?

Clearly this will depend on the circumstances and the human aspects of all patient-physician interactions. Although ethics these days are not as immovable or as permanently cast in stone, societal views do evolve. Like sometimes shifting tides, ethical perceptions may very gradually ebb and flow, but often with the anchored moorings and underpinnings of moral public good and greater and greater foundation of universal values.

So changes may occur, but again these must be based on contextual interpretation which should be carefully justified so that the newer interpretation can withstand scrutiny and/or rigorous re-examination, by an increasingly knowledgeable public and also by even more discerning generations of similar professionals.

Thus, personal conscience and public conscience must be employed together to shape our moral compass when we are dealing with ethics and medical professionalism. It helps when we all undertake to reexamine our own values and learn more and more as to how these ethical dilemmas and questions are evolving in this day and age. We must not be cowed into a mindset of convenient way out or of callous expediency [12].

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Dr. David KL Quek, President, Malaysian Medical Association

Clinicians Driving Change: Supporting Patient Care

Speech at the E-health conference 2010, Melbourne, 30th November 2010

The promise of e-health has been on the horizon for many years.

While the full potential of that promise is yet to be delivered, it feels like we are just a little bit closer to making e-health a reality. The very fact that we are here today discussing the practical steps we need to develop the personally controlled electronic health record shows how close we really are. I would like to acknowledge the efforts of Dr. Mukesh Haikerwal in pushing the e-health agenda. In his charming way, he has been tireless and determined in bringing together all of the relevant players over the last few years.

His involvement has had a significant impact on the e-health agenda and its progress.

Steve Hambleton

World Medical Journal

Doctors are excited about the prospect of sharing patient information electronically with each other and with other health care providers to improve patient safety and the quality of care we provide.

Many GPs now hold accurate and comprehensive information about their patients that has been progressively built up over more than a decade.

But at present the only way we can share it is by printing it.Even then, it may or may not be with the patient when he or she arrives at the next doctor – and even then, at best it is subject to transcription errors.

Today I am going to talk about what my medical colleagues think must be done to get the first stages of the electronic health record up and running, and ensure that it is done in a way that will best assist doctors in caring for their patients.

We need to strike a balance between clinical safety and consumer expectations in the design and use of the electronic health record. To succeed, the e-health record must be easy to use, support what doctors already do, and not disturb time-honoured clinical methods.We doctors talk to our patients, take a history, perform a medical examination, assess supporting information, order investigations if needed, then make a diagnosis for the patient and decide on a treatment plan.

That is the hard part about what we do. It takes years to learn and even longer to get good at it. If doctors can rapidly access relevant data via the electronic health record, it will support this process. But irrelevant data will get in the way.

During my consultations with my patients, I find that most of them have a reasonable understanding of their health circumstances – and they are usually very honest with me about what's going on with them. But commonly – despite our best intentions – doctors don't always have all the clinical information that we need to provide the safest, most clinically appropriate care.

This is where information obtained by other health practitioners in relation to my patient during other episodes of health care could ensure that I don't miss the critical issues that could impact on my treatment decisions.

Here is a "live" example from one of my patients last week.John told me that he had a number of times called an ambulance to his home because he had severe abdominal pain – RUQ 10/10.On the first two occasions, his pain had gone by the time the ambulance arrived, and he was not transported. He had a health summary from me with him detailing his cardiac history, his diabetes, his AAA, his past history of cholecystectomy. He also had retained gallstones in the bile duct after the above surgery and needed an ERCP and sphincterotomy to solve the problem.The next three times he was taken to Royal Brisbane Hospital Emergency Department where, once again, they were in possession of his paper history. The pain invariably went away within a few hours of arriving at hospital.His diabetes and vascular disease were proving to be a distraction. The CT Abdomen showed nothing more than his AAA, and the US of the liver was normal.This information trickled in to me some days after his hospital visits.The first discharge letter contained the blood results, which showed a rise in his liver function tests that were consistent with obstruction of the bile duct.The second and third letters from A&E did not include the above but, when I asked for them to be faxed, it was clear that on each occasion that there was acute pain the liver enzymes rose.

For the non-doctors in the room, it was clear evidence of bile duct obstruction.This was enough evidence to convince another gastroenterologist that he needed another ERCP and, sure enough, there were two more gallstones.There were five blood tests on three different pathology computers. A CT scan of the abdomen and an ultrasound of the abdomen were also needed to make the diagnosis.The patient had no way of recalling the sort of detail that I needed to make the diagnosis, or even of being sure what tests had been done.

For example, the negative cardiac enzyme tests were just as important. I was the only one who had all of the information available. The diagnosis would have been made much more quickly if we all had all the detail in "real time". It was time consuming for me and inconvenient for the patient – maybe even life threatening.

This is just one example where the sharing of a patient's information between health care providers could make a real difference to the quality, safety, and cost of the health care that I could deliver.

At the most basic level, doctors should be able to access from electronic health records important information such as:

- pathology results;
- diagnostic imaging results;
- discharge summaries; and
- current medications and adverse events.

This is basic information, yet critical to patient care.

When I talk to doctors, and when I think about my own practice, I am struck again and again by what a difference it would make – even in the case I have mentioned – if we had an electronic health record.

The record could facilitate the sharing of this most basic yet critical patient information between treating doctors and other health providers.

It would deliver a very loud bang for the buck. Clearly, I am talking about a very small but fundamental part of the much grander plan for a personally controlled electronic health record.

World Medical Journal

Let's start with the basics and get it up and running. Let's start with electronically shared patient summary information that cannot be altered by the patient, and which is accessible to all doctors.

I am not suggesting that the personally controlled aspects of the electronic health record are not important. The point I am making is that, if we are to get take-up of the electronic health record by doctors, the doctors need to be able to trust the reliability and accuracy of the information the record contains so that they can act on it.

Most patients would recognise the need for treating doctors to be confident about the information that they have before them. I can't think of any of my patients who would object to me being able to have access to information about where they have recently been hospitalised, or when they needed to see another doctor. In fact, many are surprised when I don't have that kind of information at my fingertips already. How many patients have turned up at their GP before the specialist's letter or before the discharge summary has arrived?In fact, the Menzies-Nous Australian Health Survey published last week found that: *"Most people believed their doctor and all the people treating them should have direct access to their health record."*

The AMA has thought very hard about how doctors will integrate the personally controlled electronic health record into the way they practise medicine. At the AMA, we are talking about the sharing of summary patient information electronically between treating doctors.

We don't talk about sharing all of our patient information – just the key information that other doctors need to provide safe, quality patient care.And that is what we do already – when I refer my patient to a specialist, I don't send their entire file. I just send the key information that I think the specialist needs.

The AMA supports the premise that the sharing of accurate summary patient information between treating doctors is critical to the success of e-health.

This is information that sits beside a personally controlled record. It is essential that this record contains reliable and relevant medical information about individuals. It is important that it aligns with clinical workflows. It must integrate with existing medical practice software. Otherwise we are faced once again with the transcription errors I spoke of earlier. It is also very important that the personally controlled record has appropriate security measures to protect patient privacy.

We believe that if the system is to be truly national and consistent, it must be governed by a single national entity.

We believe governments must fund the system and support its take-up with appropriate incentives, education and training.

Progress in these areas would provide benefits to patients through efficient and accurate communication between GPs, other specialists, hospitals, and other health providers.

Over time, once the initial capability to share the summary patient information across healthcare settings is rolled out, there is significantly more information that could go on the summary.

It could include information such as prostheses, implants, ECGs, referrals, advance care directives, health care plans, and team care arrangements to name but a few.

Clearly, as the information on the record starts to get more complex, patients will inevitably and very reasonably want more rules around who can access all that extra information.

Privacy of and access to those parts of the record will be very important.

This is also the point at which I think the personally controlled aspect of the record is very relevant. A personally controlled record that patients would operate alongside the summary information shared by doctors could prove to be a great motivator for many patients to become more involved in their own health care. In my experience, when my patients take responsibility for their health and work with me, we usually get the best outcomes. Most doctors don't like "Dr Google" and there are good reasons for that. But it is undeniable that the advent of the Internet has produced patients who are more informed and perhaps a bit more prepared when they come to see me.

I actually prefer it when patients with ongoing health concerns take an active interest in informing themselves about their conditions and in actively engaging with me about the steps they can take to manage their condition better.

I think there are generational issues here with some patients older than me who are reluctant to use the web all that much. I find that patients about my age are quite willing to go after information and to inform themselves.

Now there are young people who can't stop pulling down information. The challenge with them is to direct their gaze to useful locations and to stop them getting sidetracked. I think that the personally controlled record will encourage and empower patients to take more responsibility for aspects of their health care. The opportunity to create their own record about how they are managing their health will help patients to keep track of their conditions and medical history. This should dovetail into home monitoring for things like diabetes and blood pressure.

This, in turn, will lead to patients being able to truly engage with their health care provider to provide better management of their health.

World Medical Journal

However, we need to strike the right balance here between the health care provider's need to provide safe patient care and consumer expectations about the role of the information they control in the record when health care is delivered to them.

It is not realistic to expect that doctors will turn to information put in the personally controlled record by the patient as the definitive source of information on which to base clinical decisions. Doctors will always take a history, do an examination, and make an assessment and diagnosis putting different weights on different types of information. We cannot just rely on what is in the personally controlled record. Often, diagnoses or previous conclusions need to be challenged. Just like my patient I mentioned earlier. I have never ever seen a patient with retained gallstones after ERCP and sphincterotomy, but that is what the evidence said. To get it right we need all the evidence though. Even now, doctors have concerns that patients might be reluctant to share some information with them. Patients may think that once information is on the record – somewhere, sometime – that information might be accessed inappropriately. Patients are already concerned about how treatment decisions might affect them in other aspects of their lives.

I recently saw a patient who wasn't sure whether he wanted to be prescribed antidepressant medication for fear that somehow down the line it could "get out" and affect his employment as a teacher. These kinds of concerns will become even more important to patients when diagnoses, treatment decisions, and medications are shared electronically.

So, if we look at a world where there is a personally controlled electronic health record – where information may be in "The Cloud" and therefore truly accessible – it is entirely understandable that those concerns for patients will intensify.

Unfortunately, if patients have the ability to remove or "make private" facts that are part of their summary information, they might do so – for all kinds of reasons. And if they choose to do so, then the record may becomes useless to a doctor because the doctor could never rely on it.

For example, when prescribing medication, if the anti-depressant was hidden, the real possibility of a serious adverse medication interaction could exist. If Tramadol is prescribed, then it could precipitate a serotonin syndrome if the patient was taking an SSRI (*Selective serotonin reuptake inhibitor)*.

Once the personally controlled record is up and running, if there is just one serious adverse medication event like this, then e-health will not have delivered on its promise.

If the summary information was not available to the treating doctor, then the whole venture will have failed.

Failed the patient. Failed the doctor. Failed the health system.

The summary patient information needs to be accessible to all doctors.

It should only be able to be changed by doctors who understand the implication of what is recorded – and this can certainly be done in consultation with the patient.

Conversely, the addition of some information into the electronic record by a patient could also pose a clinical risk – if the doctor were to rely upon it.

For instance, many patients believe they have allergies to drugs, but they are simply side effects. While they are important, they do not have the same clinical impact. For example, Augmentin nausea, muscle aches with statins.

If we think about these examples, it is clearly not true that the personally controlled electronic health record will entirely remove the need for patients to tell their history to every new health professional they see. But it will streamline it.

Doctors and other health providers who are committed to safe, quality patient care will need to have that conversation and practise their craft, no matter what is in the record.

As I said earlier, it is essential that doctors can rely on the summary information including:

- pathology results;
- diagnostic imaging results;
- discharge summaries; and
- current medications and adverse events.

As we develop the personally controlled electronic health record, we need to consider that e-health in primary care will drive most of the health system benefits.

Those benefits will be most apparent in the acute care setting. Most of the costs, however, will be incurred in the primary care setting.

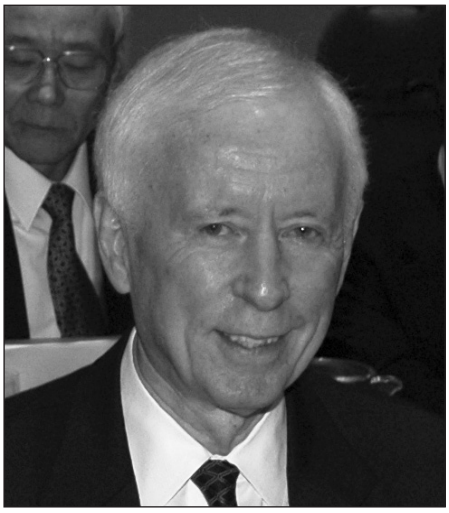
With this in mind, the Government must invest in e-health at the primary care level or the momentum will stall. The right approach, the right information, and the right investment in e-health can deliver real benefits to patient care and to the efficiency of the health care system.

The AMA and the medical profession stand ready to get behind e-health and make it the reality that the Australian health system needs.

Dr. Steve Hambleton, Australian Medical Association, Vice President

World Medical Journal

Humbled by Those Who Crossed *Bridge of No Return*



Cecil B. Wilson

Lately I've been thinking about bridges. One bridge in particular has been in my mind: the so-called Bridge of No Return between North and South Korea.

Here's the story. More than 40 years ago, as a young naval medical officer, I was part of the team that examined crew members of the USS Pueblo after they were released from captivity in North Korea. The Pueblo, a U.S. communications monitoring ship, had been in international waters-legally – when it was surrounded and fired upon by a North Korean warship.

One crewman was killed and 10 others were wounded before Cmdr. Lloyd "Pete" Bucher surrendered the ship. Had he not surrendered, the superior firepower of the North Korean ships would have prevailed and many more of his men would have been killed.

Bucher and his crew – 82 in all – were held in captivity in North Korea for 11 long months, during which time they were beaten, tortured, starved and humiliated on a daily basis. When they were finally released, they walked to freedom across that Bridge of No Return.

Overall, the Pueblo's commander and crew were in pretty bad shape physically. All had lost weight, and there were skin diseases, jaundice, pneumonia, infections, contusions, abrasions and broken bones. Despite their ill health and having been tortured, the Pueblo crew walked across that bridge united, loyal and upbeat. None had been co-opted by the North Koreans. They had not turned on one another.

In their forced confession they had managed to send a message of their own to the American authorities. Their spirit could have been destroyed, but it was not. Today, the behavior of the Pueblo crew during that captivity is held up as model of prisoner-of-war resistance.

I have always felt privileged – and saddened – that I was on hand to meet these men and their commander after they came across that bridge and were brought to the Balboa Naval Hospital in San Diego. It is a time I shall never forget. And a time that remains with me in lessons learned.

As a former naval medical officer, I am keenly aware of how much my civilian medical practice owes to military medicine. Emergency and disaster medicine, in particular, are the offspring of battlefield medical experience. So is public health.

Here are a few examples:

- During the Seminole Wars in the early 1800s, Army physicians discovered that quinine was effective in treating people with malaria
- Following the Spanish-American War in 1898, military physician, Walter Reed, headed a commission that proved the link between yellow fever and mosquitoes
- The North African battlefields of World War II were also a battleground that proved the miracle of antibiotics
- During World War II, the work of Navy Captain, Robert Phillips, broke new ground in the treatment of cholera

Trauma and disaster medicine also have military roots:

- Medical triage first took place on Napoleon's battlefields, offering a way to deal with casualties and save lives in an orderly way
- In the late 1940s, military physicians did pioneering work in the treatment of burn victims
- As a result of casualties in the Middle Eastern conflicts we have seen new treatments for amputees and advances in prosthetic technologies
- Out of Vietnam came an understanding of the importance of the "golden hour" and the need for early, even pre-hospital, treatment. Our civilian EMT and medevac systems are a direct result
- The Vietnam War and more recent military conflicts in the Middle East taught the value of a systems approach to handling mass casualties – a lesson civilian medical teams applied after the 9/11 attacks, the 2004 tsunami, Hurricane Katrina and the earthquake that hit Haiti early this year
- Today the military is a leader in telemedicine, sending patient information from the battlefield and receiving expert advice back from around the world to physicians who are on the front lines. This is technology that ultimately may be as important to a physician and patient in remote rural areas as it is to those on the battlefield.
- All of this is a reminder of the importance of learning from one another, of being united, of facing obstacles together. That is my message for physicians today.

Cecil B. Wilson, MD, President, American Medical Association

World Medical Journal

The Regulatory Framework in the Healthcare Insurance Industry:
In the Interest of Beneficiaries and Public

Monwabisi Gantsho

Michael Mncedisi Willie

Effective regulatory framework is the key to delivery systems that create a well functioning healthcare environment, this article provides an analysis of the regulatory framework of private health insurance as it relates to the protection of beneficiaries and the public within South Africa context. The Council for Medical schemes (CMS) which is the statutory body established in terms of the Medical Schemes Act 131 of 1998 to provide regulatory oversight to the medical schemes industry in a manner that is complementary with national health policy. Medical schemes that are regulated by the CMS are insurance institutions that cover medical expenses and provide health care insurance in the private sector in South Africa. Medical schemes reimburse their members for actual expenditure on health. A regulatory framework must protect the interests of Beneficiaries, thus CMS continues to effectively engage on regulatory and policy developments in the health and insurance industries to ensure that the rights of South African Beneficiaries are protected at all times.

Introduction

An effective regulatory framework is critical to delivering system reform and to creating a well-functioning healthcare market [13]. This paper presents such a framework within the South African context; we give an outline of goals that a regulation should address. It is important to note that the South Africa's health system consists of a large public sector and a smaller private sector. The public sector is under-resourced and over-used, while the private sector caters to middle- and high-income earners who tend to be members of medical schemes (16% of the population in 2009, not significantly different to the 15% cover by medical schemes in 2000). The demographic structure of medical schemes implies a differently structured health system to that of the general population. This is a worrying factor on the resulting efficiency of the health system as a whole, given the substantial resource allocation bias in favour of the medical scheme market. In 1994, the National Department of Health (DoH) allowed medical schemes, which are primary to paying for private health care, to be regulated [16]. The Medical Schemes Act 131 of 1998 gives the Council for Medical Schemes (CMS) power over medical schemes; the CMS regulates not only medical schemes, but also health insurance brokers, medical scheme administrators and managed care organisations [12]. It also imposes much stricter controls upon medical schemes themselves in terms of corporate governance, financial and membership requirements, and provision of benefits. The Act states the functions of the Council in a far more purposeful and consumer-oriented terms, with a defined focus on the protection of the interests of medical scheme members.

To achieve its regulatory goals, the office of the Registrar participates in the consultative process which aims to demarcate medical schemes from health insurance because it is the case that the encroachment of risk-rated health insurance products into the business of medical schemes results in cream-skimming the young and healthy, unfair discrimination against the old and sickly, and a risk to the sustainability of the medical schemes industry [7]. Another critical element of regulating the private health care sector is to, on an ongoing basis, revise benefit and contribution structures to protect community rating, which is the principle that all beneficiaries on the same benefit option pay the same contribution, and that contributions may vary based only on an individual's income, number of dependants, or both [12]. The regulator of medical schemes is in support of the initiation of a proper consultative and research process towards the development of a regulatory framework for collective bargaining between healthcare providers and funders (including the review of the National Health Amendment Bill).

The Bill was published for comments in 2006 with the final comments at the end of February in 2007. The new draft of the Bill was submitted to the Minister of Health in

World Medical Journal

July 2007, and is awaiting discussion and signature of the State President in Parliament. The Bill seeks to address among other key topics the governance issues for medical schemes, including the fit and proper status of trustees. The Bill also seeks to change the manner in which benefits are designed, so as to improve transparency and further reduce incentives for unfair discrimination.

Goals of regulation

The role of market regulation is to facilitate the delivery of overarching policy objectives through economic regulation and consumer protection [13]. The objective of this article is to assess the regulatory framework as it relates to the protection of beneficiaries, thus we focus on the following goals of regulations, the regulatory framework [3].

- Ensuring services (and goods) are safe and of high quality.
- Ensuring fair access to services and (where relevant) also ensure choice of provision.
- Ensuring financial solvency of medical schemes.
- Ensuring transparency and fairness in the contractual relationship between the medical scheme and beneficiary.
- Ensuring that health insurance packages provide adequate financial protection.
- Managing key externalities and by-products of service provision.
- Governance of medical schemes.

Regulation in advanced market economies

The regulatory framework of private health care insurance industries is administered by a government agency or agencies that implement statutory requirements, usually with the authority to establish administrative rules and procedures [9]. This section discuses the some of the regulated activities within the health sector and core functions of such regulating entities.

Licensing of medical schemes, administrators, managed care entities and brokers

A major reason for having regulation is to protect regulated industries from instability and lack of consumer confidence caused by poor administration and trading systems. Setting up minimum registration and accreditation rules and regulations ensures the efficient functioning of market mechanisms. Establishing minimum standards and accreditation rules reduces additional costs of overhead spreads created by artificial market signals that are driven by health insurance administration functions. The Medical Scheme Act gives the CMS regulatory powers over medical schemes, managed care entities, brokers, and administrators. The functions of the CMS are included in Section 7 of the Act. For the purpose of this report, the regulatory functions are expanded using literature on regulatory theory [7]; they are listed are as follows:

Supervising the conduct of registered intermediaries by the Council's line and staff functions, through the implementation of rules-based bureaucratic style of carrying out Council's governance function:

- A managerial approach to the regulator's function of stewardship, controlling conduct by means of quantitative benchmarks and/or qualitative scorecards, monitoring observance to preset specification and performance standards by registered intermediaries
- A collaborative governance approach which allows for a joint learning process in developing health insurance regulatory policy by:
  - configuring formal cooperative interfaces between the regulator's internal operational line functions and staff function (specialist advisors) channels, for the benefit of strengthening the responsiveness of benchmark or peer review policy tools, economic incentives and reducing market uncertainties (market stability and institutional sustainability);
  - Increasing the scope of regulatory transparency and democratizing administrative justice processes by making the Registrar's Office and market information more accessible to medical scheme members

Policing registered institutions in terms of their observance of rules for minimum compliance and mandatory standards intermediaries, such as the observance of:

- Rules of minimum compliance and approval requirements for the registration of medical schemes and other institutions within the regulator's jurisdictional regulatory environment.
- Mandatory compliance standards.
- The regulatory function of: Legal enforcement of provisions emanating from the Act and other forms of precedence, such as behavioural incentives legitimated by enabling rules and guidance notices.
- The regulatory function of: Adjudicating over grievance applications made by medical scheme enrolees.
- The regulatory function of: Educating & Communication of the regulator's fiduciary duty to medical scheme enrolees and, the strengthening of the governance function's role of demonstrating accountability over regulated stakeholder and medical scheme members.
- The regulatory function of: Sanctioning the business of medical schemes and the administration of health insurance business functions.
- The regulatory function of: Observing Fiduciary Obligations arising from Principal-Agent market relationships by, governed schemes and other registered intermediaries and, the Regulatory Body itself.

Solvency Regulation

Solvency regulation includes solvency monitoring, capital requirements, other controls on medical scheme behavior (for example,

World Medical Journal

investment regulations) and, in many cases, establishment of beneficiary protection schemes to pay specified claims against insolvent medical schemes [9]. Beneficiaries pay contributions towards medical schemes for future health care spending and the financial capacity for the scheme to respond to claims/ pay for healthcare spending is dependent on the schemes viability and financial soundness. It is of note that the claims can potentially exceed the sum of the total premiums/ contributions received and this is critical to the viability of the scheme.

With solvency regulation, beneficiaries delegate responsibility for monitoring solvency to regulators, as this is also the case in South Africa. Regulatory monitoring might detect medical scheme financial problems early enough to prevent insolvency. In other cases, monitoring can help regulators intervene before the deficit between an insolvent medical scheme's assets and liabilities becomes large. Some degree of regulatory restrictions on medical scheme risk taking (for example, investment limitations and capital requirements) could be efficient for this reason. Solvency is measured in terms of Regulation 29 of the Act. The net assets, after deducting assets set aside for the specific purpose of and unrealized non distributable reserves, are also referred to as "Accumulated Funds". Regulation 29 prescribes the "Minimum accumulated funds" expressed as a percentage of "Gross annual contributions" is referred to as a solvency level.

The Medical Schemes Act requires schemes to maintain a solvency of at least 25% [12].

In the same breath, a solvency level below 25% does not necessarily mean that the scheme is experiencing financial difficulties. Similarly, extremely high solvency levels are not an indication that a scheme is in "perfect" financial position. Figure 1 shows the number of schemes stratified by the (>25%) and (≥25%) stratum. The phasing in of the statutory solvency reserve requirements was from 2000 to 2004, and upward trend in the number of schemes in the ≥25% stratum is seen until 2004, from 2005 a downward trend is observed and the number of schemes in ≥25% stratum declined significantly by 21% from 111 to 88 medical schemes. The declining trend also correlates to the consolidation in the medical schemes environment. There were no significant declines in <25% stratum from 2004 to 2009. Solvency ratio is one indicator used as a benchmark to measure the "financial health" of the scheme and a noteworthy feature of the ratio is that it triggers interventions on the financials of the medical scheme. Thus the regulator of medical schemes consistently monitors solvency levels of medical schemes together with other ratios, such as investment income, non-health expenditure, and membership profile. In ensuring the consumers' willingness to pay contributions for private health insurance, effective regulation requires that schemes are financially sound such that they are able to reimburse their members for the actual expenditure on health.

Benefit option packages, Scheme Rules, Pricing and Risk Selection

Many governments significantly restrict private health insurance pricing and risk selection (underwriting), including imposing limits on rate differentials among different buyers, guaranteed-issue requirements, and guaranteed-renewability rules. Some governments require medical schemes to obtain prior regulatory approval of certain rate changes [9]. In South Africa, the Council is mandated through the Medical Schemes Act 131 of 1998 [12] to approve all the rules before they are implemented by the schemes (s31). The Council also has to ensure that all proposed new benefit options, restructured options, and new schemes, are assessed fully for viability before they are registered in terms of section 33(2). The most important components of section 33 of the Act include the following. A medical scheme:

- May apply for the registration of more than one benefit option.
- Shall be self-supporting in terms of membership and financial performance.
- Is financially sound.
- Will not jeopardize the financial soundness of any existing benefit option within the medical scheme.

Regulation 4 of the Act states that medical scheme rules may provide members of dependants a right to participate in only one benefit option at a time. The referred regulation that scheme rules may provide that members may change options at the beginning of the month of January each year, and by giving written notice of at least three months before such a change is made. It is also stated that a medical scheme must not in its rules, or in any other manner, structure any benefit option in such a manner that creates a preferred dispensation for one or more specific groups of members or provides for the creation of ring-fenced net assets by means of such benefit option. The CMS also approves the amendments of rules to scheme rules and evaluate these in accordance to the required standards; these include mid-year contribution and benefit changes, new options, and the efficiency discounted options for a number of schemes.

Figure 2 illustrates structural differences that exist between open and restricted schemes in terms of benefit options. The 2009 data showed that 40% of restricted schemes, compared to the 3% of open schemes, consisted only of one benefit option. A similar distribution exists in schemes with two benefit options. However this trend is reversed on schemes with four or more benefit options. There are many options in the open schemes environment and this is worrying as each represents a distinct package of benefits, thus members find it difficult to compare products to see which offers the best value for money. Also, as a general rule, the greater the number of benefit options, the greater the costs of providing these benefits. The CMS continues monitor the registration of benefit options, ensuring that they

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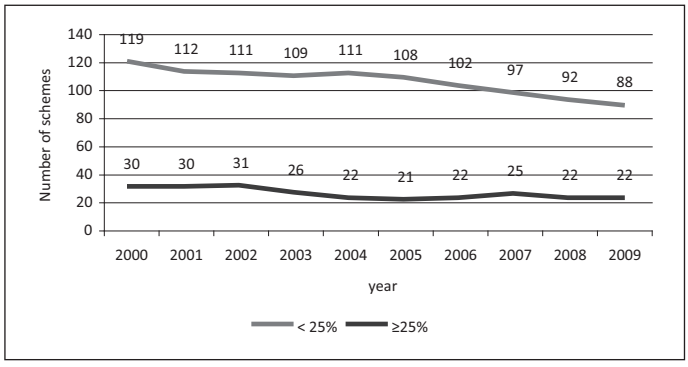

Figure 1. *Industry solvency trends for all schemes (2000–2009)*
Source: [5]

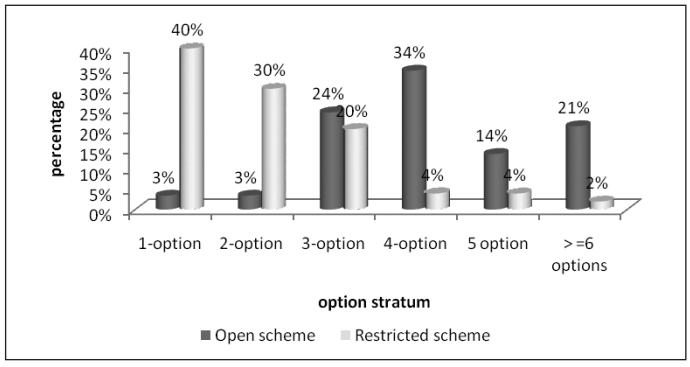

Figure 2. *Distribution of benefit options across medical schemes (2009)*
Source: [21]

are self sustainable, affordable to enrollees, and, indeed, do offer value for money.

Access to minimal level of care

Many governments regulate most language by requiring certain contract provisions and prohibiting others. Some governments mandate minimum coverage provisions [9]. The concept of a minimum level of care is central to the facilitation and achievement of a more equitable and efficient quality health care system in South Africa. The Prescribed Minimum Benefits (PMBs), as provided for by the Medical Schemes Act, have had the greatest importance. PMBs are minimum benefits which, by law, must be provided to all medical scheme members and include the provision of diagnosis, treatment and care costs for:

- any emergency medical condition;
- a range of conditions as specified in Annexure A of the Regulations to the Medical Schemes Act [12], subject to limitations specified in Annexure A; included in this list of conditions are chronic conditions.

PMBs were introduced to avoid incidents where individuals lose their medical scheme cover in the event of serious illness and are put at serious financial risk due to unfunded utilization of medical services. They also aim to encourage improved efficiency in the allocation of private and public health care resources. PMBs are not only legislated, but they are the envisaged platform for the national health insurance package, which defines the entitlement for any person contributing towards such insurance. As a consequence, a package of PMBs with a focus on catastrophic care was developed as Annexure A in the Regulations to the new Act in 2000. In terms of the Regulations, the PMB package was to be reviewed every two years by the DoH. This review must involve the Council for Medical Schemes (CMS), stakeholders, provincial departments of health and consumer representatives.

A review process of PMBs was begun by the Council for Medical Schemes in 2008 [4]. Comments from the stakeholders on the document were taken into account and publication of the third draft of the report in that process was published on the CMS webpage. This process was finalized in 2009/10 and the final draft regulation was submitted to the Minister of Health for consideration for possible publication in the government gazette for public comments. There are, however, challenges with the implementation of the Act and Regulations relating to PMBs. In this regard the CMS continues to engage with the provisions of PMB regulations, including the "payment in full" provisions contained in regulation 8 of the Medical Schemes Act.

Market conduct and unfair trade practices

Insurance regulators often enforce legislation dealing with market conduct and unfair trade practices, such as provisions related to unfair claim settlement practices and potentially deceptive sales practices by medical schemes and administrators [9]. The regulator of the medical schemes in South Africa actively participates in the consultative process which aims to demarcate medical schemes from health insurance. The office of the Registrar is acutely aware that the encroachment of risk-rated health insurance products into the business of medical schemes results in cream-skimming, unfair discrimination, and a risk to the sustainability of the medical schemes industry.

Effective regulation of medical schemes – and the protection of beneficiaries – is critically dependent on all entities and products being subjected to the rigorous oversight and strict protections are contained in the Medical Schemes Act. A serious threat is posed to the sustainability of medical scheme risk pools by the recent proliferation of insurance products which seek to encroach on the preserve of medical schemes. Thus, the CMS continues to participate in the demarcation work group established by National Treasury to draft regulations in support of certain amendments effected to the Long- and Short-Term Insurance Acts

World Medical Journal

of 1998 by the Insurance Laws Amendment Act (Act 27 of 2008). The work group comprises stakeholders from industry, government, and regulatory authorities, and has as its purpose consideration of the underlying principles required to inform the drafting of regulations to ensure that a clear delineation of products is achieved so that the purpose of the Medical Schemes Act is not undermined. The differences between the Medical Schemes and Insurance Products is outlined in table 1.

The Medical Schemes Act also states that it is not a good practice to market, advertise or in any other way promote a medical scheme in a manner likely to create the impression that membership of such medical scheme is conditional upon an applicant purchasing or participating in any product, benefit or service provided by a person other than the medical scheme. Thus, it is an offense to conduct practices that are not in line with the scheme rules, and the CMS secures adequate protection for beneficiaries by approving the manner in which medical schemes carry out business, including the products offered by medical schemes and schemes' compliance with Section 21A.

Table 1. *Differences between Medical Schemes and Insurance Products*
Source [16]

Medical Schemes	Insurance Products
Medical Schemes Act 1998	Long Term Insurance Act 1998 and Short Term Insurance Act 1998
Governed by the Council for Medical Schemes	Governed by the Financial Services Board
May not refuse to admit prospective members	Have the right to refuse to insure an individual on the grounds of carrying too high risk
May not make profit	Insures are listed companies which aim to make a profit for their shareholders
Seek to match premiums and benefits paid over the period of a year	Rely on underwriting and actuarial skills to predict future claims experience for given categories of insured persons over long-term
Medical scheme reimburse members for the actual medical expenses	Insurance companies pay policy holders a pre-agreed fixed rate in the event of a claim
Can be paid directly to the provider of the service, a doctor or hospital	Must be paid to the policy holder, not the provider of the service
Registered medical schemes have to provide certain benefits and may not charge a member contributions based on your	Insurance policies may refuse to sell a policy to an individual or may weight premiums according to perceived extra risk. Insurance companies are allowed to evaluate an individual's life style and general state of health before selling a policy for 'dread diseases cover/for example

Information disclosure and consumer complaints

Many governments make available consumer buying guides and other information about medical schemes contracts. In the United States, many jurisdictions provide contribution rate comparisons, and some publish counts of consumer complaints against medical schemes. Section 48 and 49 of the Medical Schemes Act provide that the Council has authority to resolve complaints between medical schemes and their members. This process requires that complaints to be made in writing to the Registrar, who must then pass on the details of the complainant to the party that is subject to the complaint. The party against whom the complaint is made has 30 days in which to respond to the Registrar. The Registrar is required to resolve the dispute or submit it to Council, which is expected to take necessary steps to resolve the complaint. The following are key problem areas in the medical schemes industry, according to an analysis of complaints data in 2010 [6].

- Intermediary behaviour and the functional dimensions of the registered entities were identified as one of the key problem areas that need to be addressed and monitored closely.
- Lack of product quality and standardization is a policy problem is caused by external factors, related to capitalizing on opportunities to take advantage of un-priced risk positions by market participants.
- Fiduciary duties of intermediaries, duty to disclose and/or unilateral mistake vs. moral hazard and risk-selection are complaints are largely related to non-clinically related entitlements. Undesirable conduct is due to incomplete markets and characteristics of such markets creating barriers to accessing healthcare. These were identified as one of the biggest changes that threaten the systematic sustainability in the industry.
- Conduct inducing market uncertainty is one of the contributing factors that relate to systematic sustainability in the industry. These complaints relate to the restructuring of financial & operating capital and contingencies impacting risk hazards in market environment.
- Clinical treatment, formularies and protocols were also identified as one of the key problem areas dealing with the systematic sustainability in the medical schemes industry. Section 29(1) & Annexure A of the regulation of the Medical Schemes Act 131 of 2008 is to be used as a base or control measure for clinical treatment, formularies and protocols related types of complaints.

The data analyzed by the CMS showed that social regulation, which also relates to

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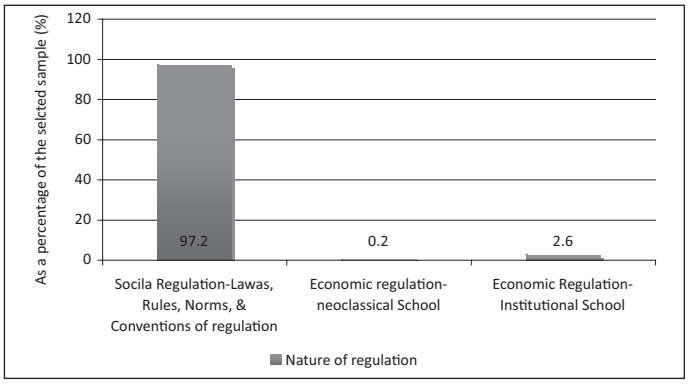

Figure 3. *Nature of regulation classification*
Source: [6]

Laws, Rules, and Norms & Conventions of Regulatory Institutions (456/469, 97.2%), is most dominant in the medical schemes environment. Social Regulation [14] typically focuses on policy levers that enhance consumer welfare interventions within specific policy environments, thus the paternalistic and normative values of regulatory philosophy inform how regulators protect the interests of consumers. There was a significantly a small number of complaints that relate to Economic Regulation – Institutional School (1/469, 0.2%) and Economic regulation – neoclassical school (12/469, 2.6%).

In keeping with the Act's emphasis on complaints, in 2009, the Council embarked on a process of revamping the complaints system that captures complaints. This was to ensure an efficient and accessible, complaints processing system that will be an instrumental tool of health system policy analysis through strengthening the responsiveness of policy levers to consumer needs and the advocacy of consumer interests.

The Governance of Health Insurance

The Medical Schemes Act imposes strict controls upon medical schemes themselves in terms of corporate governance in ensuring the protection of beneficiaries. The framework for medical scheme corporate governance is derived from the common law, King II and the Medical Schemes Act of 1998. A major challenge facing all trustees, including medical aid trustees, is to act "with due care, diligence and the utmost good faith". Section 29 of the Act sets out certain minimum requirements to be contained in the rules of a medical scheme, with a view to protecting the interests of members and also providing a framework for good governance. In terms of section 24(2) of the Medical Schemes Act [12], no medical scheme shall be registered unless the Council is satisfied that members of the board of trustees and the principal officer of the proposed medical scheme are fit and proper persons to hold the office concerned.

The statutory duties of the board of trustees of a medical scheme, however, derive primarily from the provisions of section 57 of the Act. These include: appointment of the principal officer; accountability for operations of the scheme and resolutions passed by the board; ensuring that proper control systems are in place; communication to members on rights, benefits, contributions, and duties in terms of rules of the scheme; ensuring timely payment of contributions to the scheme; procuring professional indemnity insurance and fidelity guarantee insurance; obtaining expert advice on legal, accounting, and business matters as required; ensuring compliance with the Act; and protecting the confidentiality of member information. Ongoing governance failures among medical schemes prompted the Council for Medical Schemes to undertake a project to review their governance practices and to identify the key determinants of governance failures. The findings and recommendations of the Council's "Governance Theme Project" were released in mid 2006, to recommend additional strategies to improve medical scheme governance and to mitigate the risk of governance failure.

Out-of-pocket payments

Out-of-pocket health expenditures represent a significant burden on households globally. Most private health expenditure comprises out-of-pocket payments for health care, and this includes user fees or co-payments for insurance covered services, payments for health service not covered by the insurance and informal payments to providers. Private health expenditure accounted for 40% of total health spending in the EAC countries compared to the 27% in countries that are members of the Organization for Economic Cooperation and Development (OECD). In Latvia, out-of-pocket expenditure for health care represented 4.7% of household expenditure [20].

Health services funded by medical schemes only benefit the 15% of the population who were members of these schemes in 2000; this figured moved slightly to 16% in 2009. Medical schemes cover 16% of the population; this population uses the private sector on an out-of-pocket basis for primary care but is almost entirely dependent on the public sector for hospital care [11]. The total household expenditure in South Africa in 2007 was R148.5 billion. 19% of this was the out-of-pocket payments, which means that the spending over and above the medical schemes contributions was R28 billion [16]. The figures presented in the figure 4 below show South Africa as the second lowest out-of-pocket expenditure with reference to other countries.

The Medical Schemes Act lays down the minimum benefits beneficiaries should receive from their medical scheme; these are benefits that schemes must by law pay for in "full". Earlier in 2009, a task team on the

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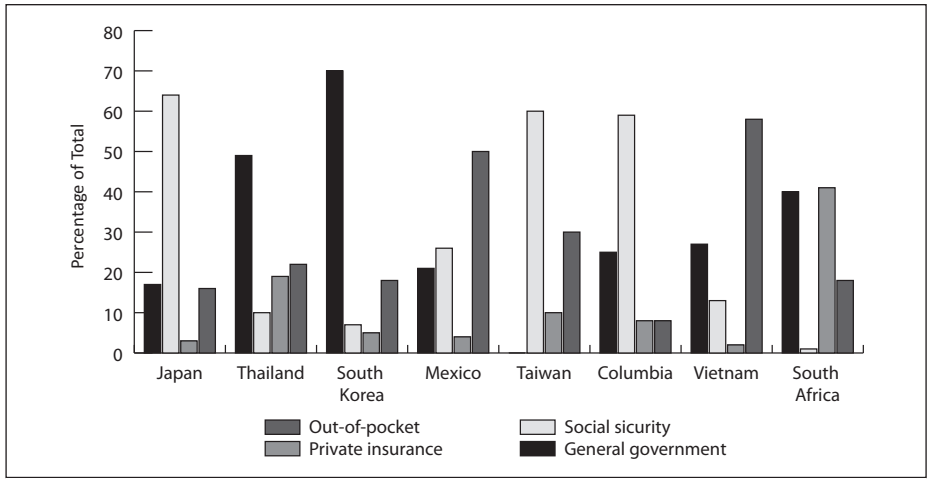

Figure 4. *Out-of-pocket payments (Country comparisons)*
Sources: [22]

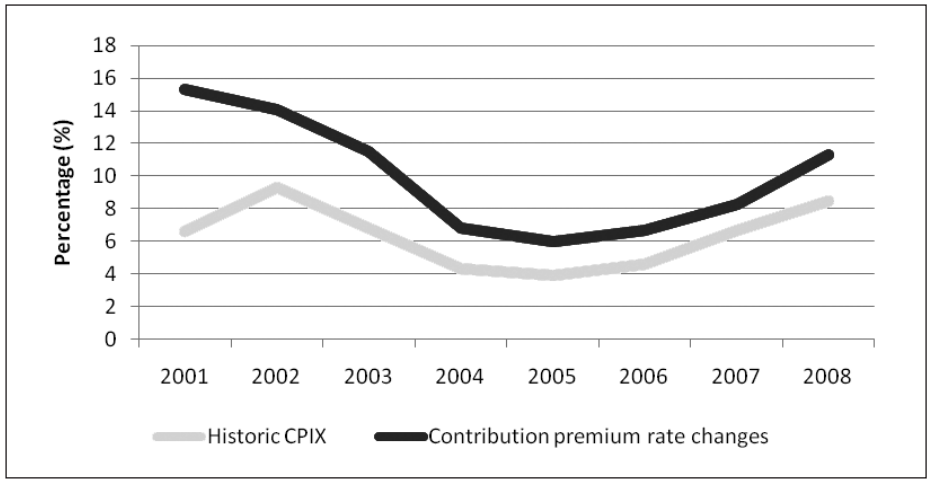

Figure 5. *Contribution rate changes (2001–2008)*
Source: [5]

PMBs was set up by the Registrar composed of the Council for Medical Schemes, medical schemes, healthcare providers and patient rights groups, who are working on clarifying how the PMBs are defined and (at the time of writing this article) this process was still in progress. The outcome of this process could result in schemes becoming liable for more healthcare costs; the successful implementation of PMB could possibly offer members the potential to save on out-of-pocket expenses and contribution costs.

Contribution increases

Increases in excess of the CPI create an affordability challenge for beneficiaries because medical scheme contributions comprise a larger proportion of household expenditure. When the pricing of benefit options increases it is often followed by a downward migration of beneficiaries to cheaper benefits options. Contribution increases are monitored by the CMS on annual basis to ensure the affordability of premiums by beneficiaries. The average increase in contributions per option is compared to a benchmark of CPIX + 3%. Options that reflect increases greater than this benchmark are requested to provide further justification for their increase. This is used as a guideline by the office to ensure that contribution increases are justified and fall within a reasonable range.

The nominal increase in average risk contributions per average beneficiary (as per scheme financials) from 2006/2007 was 9.9% and the comparing figure for period 2009/2010 was 11.6% for the open schemes market, which was slightly higher than the restricted schemes. The average increase for restricted scheme in gross contribution per average beneficiary per month was 3.9% for 2006/7 and the comparing figure for 2009/10 was 11.6%. The contribution increases proposed by the schemes in 2009/10 were 15.7% (a deviation of 4.1% from the actual) for the open schemes and 12.7% for the restricted schemes (a deviation of 1, 1% from the actual). The considerable difference between these estimated contribution increases and the actual increase in the average contribution income of schemes indicates that some beneficiaries bought down from more comprehensive options to cheaper options, with the consequent dampening effect on contributions. This phenomenon is more pronounced in open schemes than the restricted schemes. The CMS vigorously investigates the contribution increases and also monitors the affordability and access to healthcare within the medical schemes industry, which is done through the cost containing strategies.

Non-healthcare costs and contribution increases

Accredited entities, including medical schemes, administrators, brokers and managed care entities do not always act in the best interests of scheme members and the public at large. "Many schemes and administrators attempt to influence brokers to

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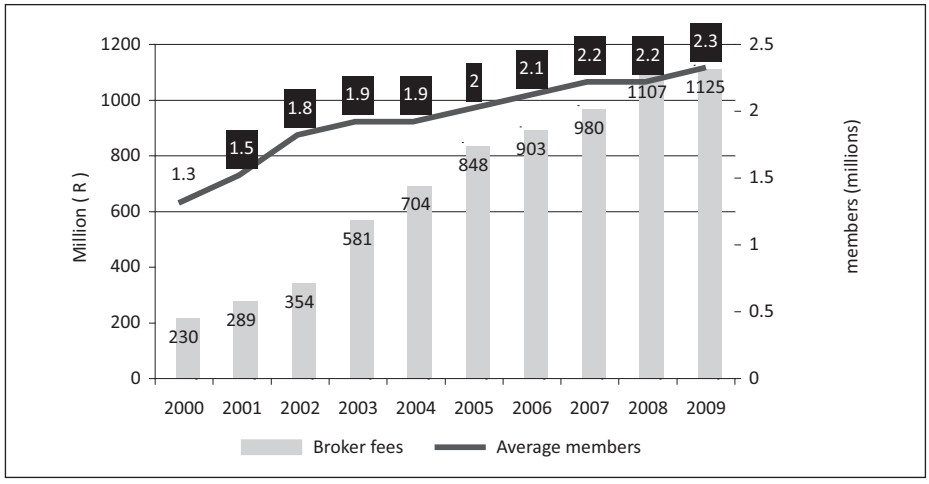

Figure 6. *Broker fees and scheme membership*
Source [5]

advise clients to choose a particular scheme by bidding up broker commissions. This was what largely necessitated the regulated capping of broker fees from 2004. However, the regulatory regime still has loopholes allowing conflicts of interest to exist by permitting schemes to pay the fees in respect of advice to members. The conflicts substantially reduce the quality of advice in the market and permit schemes to avoid being wholly responsive to members and beneficiaries", [4]. Figure 6 illustrates the increase in broker fees relative to membership of schemes that pay brokers. Broker service fees have been rising sharply over the past few years, resulting in rates of increase now far exceeding the increases in number of members. For those schemes that paid brokers, broker service fees PAMPM (per average member per month) increased by 169.6% since 2000 compared with an 81.6% net increase in the average number of members. The substantial increases in broker service fees are not proportional to the increase in new members in the medical schemes environment [5], and this poses questions whether the brokers are indeed adding value to the medical schemes. The CMS has started initiate consultative processes to propose the revision of the regulatory framework for the remuneration of healthcare brokers.

Expanding coverage and health work force

Regulated private insurance coupled with various social health insurance options and government subsidies represent the middle-income country route toward building a universal system. There has been a lot discussion about introducing National Health Insurance (NHI) in South Africa. "The first phase of the project will be rolled out in 2012, and will focus primarily on bringing services to areas with little or no access to quality healthcare and thereafter be extended to other areas of the country. Providing universal coverage for all South Africans, irrespective of whether they are employed or not should aim to ensure equity and solidarity among the population through the pooling of risks and funds. The NHI calls for mandatory membership for all South Africans through mandatory contributions and social solidarity, it is up to the general public to continue with additional voluntary cover with the medical schemes after they have contributed to the NHI Fund" [1]. Private health insurance plays a large and increasing role around the world and it is envisaged that even in South Africa the medical schemes could be an important component of achieving universal coverage. One possibility is envisaged in which medical schemes continue to operate in an NHI setting and function as a supplementary cover; this is, of course, with reference to the international experiences and is also dependent on definition of the NHI package. A word of caution is to learn from the international experiences, so as to mitigate the shortcomings of establishing such a fund and also to be aware of the different characteristics between countries.

As South Africa prepares for the implementation of the NHI, one of the key challenges that needs to be addressed relates to the health work force. "There is a massive global shortage of health workers and these are most intensely in developing countries, the reasons for shortage in health workforce are multitude including underproduction, misdistribution of health workforce, health workforce exit and increase in demand of health care. Many countries in the world with acute shortage of health workforce face a lack of medical schools. For an instance, two thirds of sub-Saharan African countries have only one medical school and some have none" [17]. The number of nurses in South Africa, as estimated by the WHO, is 18000 and these professionals are serving a population of nearly 49 million. This translates to 3.8 per 1000 patients – significantly smaller than the 9.4 and 7.7 per 100 patients in the US and Canada respectively [16]. The national shortage of health care workers is critical to the implementation of the NHI and key areas of attention for the initial roll-out of the NHI are being discussed. These include investing and rebuilding the country's public health infrastructure, developing human resources programs to fill the national shortage of qualified health workers, and establishing a national health fund that would be ensconced in the Ministry of Health but operate autonomously. The CMS' expertise and 10 years of experience can also play a vital role in making NHI Fund work efficiently.

World Medical Journal

Conclusions

The ultimate responsibility for the overall performance of a country's health system lies with government, which, in turn, should involve all sectors of society, promoting the spirit of cooperation and partnerships among private and public health professionals. A government has the responsibility for establishing the best and fairest health system possible with available resources and the oversight and regulation of private sectors, which must form part of the overall government response, must be high on the policy agenda.

Regulation of private health insurance should not only provide oversight to private health insurance companies but it should also focus on encouraging demand for coverage and otherwise facilitating the entry and expansion of access to health care. This will then result in an environment where a greater proportion of the citizens of the country have access to good quality healthcare. In the South African context, the private sector is critical to the implementation of the NHI fund, and policy makers need to confront the role that private health insurance will play. Regulatory approaches and policies can structure private health insurance markets in ways that mobilize resources for health care, promote financial risk protection, protect consumers, and reduce inequities. Regulatory frameworks for private health insurance need to be structured in such a way that they regulate the sector appropriately so that it serves public goals of universal coverage and equity

Effective regulation ensures the protection of beneficiaries and includes a critical responsibility to ensure financial solvency of the schemes. This is achieved by establishing risk-based solvency and minimum capital standards to mitigate risk for the insured population and employers. The rationale for an effective regulation framework should mandate disclosure requirements for policies and costs requiring that their content is understandable to consumers and that the consumers are informed of their rights. Promoting equity involves ensuring access to health care by all income strata of the population, and minimizing risk skimming and adverse selection, which distort health insurance markets, and this is also a key policy goal for effective regulation. Government policy needs to provide a framework that result in coverage for a minimum level of essential services, irrespective of whether it is provided in the public or the private sectors. Given the existence of perverse incentives in unregulated markets for health care, any regulation must pay careful attention to the incentives generated. The use of mixed systems for covering and providing health care, combined with the correct elements of choice, is the best approach to balancing health care objectives with the need for operational efficiency.

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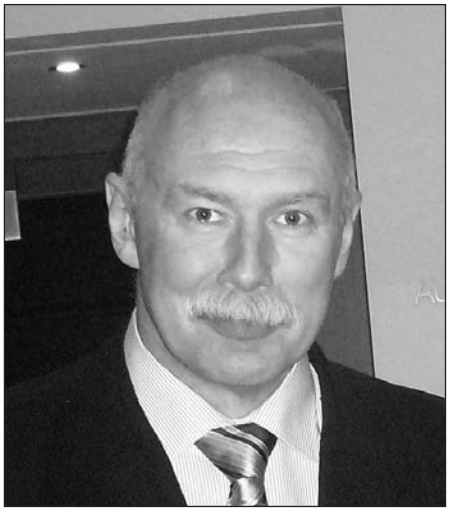
World Medical Journal

Tobacco-Free World in Twenty Years' Time!



Pēteris Apinis

On the threshold of the year 2011 I would like WMA to pay its attention to the damage caused by tobacco smoking and especially to the disastrous consequences of smoking in the presence of infants, young children and pregnant women. Our task is to eliminate this malady forever. This year is favourable for its implementation as our friends in Monte Video have set as the main task for the General Assembly the recognition of the extreme harmfulness of tobacco smoking. The Latvian Medical Association points out that our goal is not restriction of tobacco smoking but total elimination of this disaster. This is not an easily achievable goal as a long and persistent effort is required here; however, it is possible to reach in a twenty-year period.

From today's point of view the most alarming fact is that the Tobacco industry that has been continuously defeated in Europe, Australia and North America, has shifted its business to the Third World countries, increasing the number of smokers among children and young people, especially young girls. The Third World countries do not possess enough resources to fight the Tobacco industry as they lack means to provide their population with food and drinking water and many of these countries suffer from high rate of unemployment. These hard conditions are still worsened by Tobacco stepping in and attracting the scarce resources.

There is a principle that applies to a certain group of countries in the world – the amount of finances spent on smoking equals that spent on healthcare as a whole. The old European countries have imposed high excise duties and VATs on Tobacco, which redirects a significant part of these taxes to the state budget. In the developing countries all money made on tobacco sales flows directly into the greedy arms of producers and merchants. Bread and water get exchanged for Tobacco. Even starving children smoke. So the Tobacco manufacturers kill people not only by means of nicotin, tar and carcinogens but also economically.

Today the World Medical Association has to undertake leadership in the campaign against Tobacco on a global scale. The World Medical Association cannot be bribed and its leaders will not take up any discussion or deal with the Tobacco industry.

The World Medical Association has to use its authority and powers, the knowledge based on evidence and to declare worldwide:

1. Smoking in the presence of a child is violence against a child.

2. Smoking in the presence of a pregnant woman is a crime against humanity.

3. What we can do is protect children and pregnant women worlwide from passive smoking within family, in public, in prmises, cars, hotels, hospitals, at sports events, train stations and anywhere else.

4. Those selling tobacco to young people and children and those involving children into smoking must be considered murderers.

These four messages must become our slogan that we should bring to the WHO and governments of all countries thus obliging them to include these messages into their legislation and to declare smoking in the presence of children and pregnant women a crime to be prosecuted. Only WMA is able to act zealously and forcefully because there is no threat of friendly co-operation between it and the Tobacco industry. WMA should take the initiative of fighting the Tobacco industry in its hands, and especially the tendency that forces children and young women in the developing countries to smoke.

Almost all governments and politicians tend to be close to Tobacco manufacturing and merchandising companies, even receiving direct or indirect support from them. Members of the World Medical Association are able to persuade their governments that flirting with the Tobacco industry is a dangerous game that puts the health and lives of their people at stake.

Passive smoking is a significant cause of illnesses and deaths

Environmental tobacco smoke (ETS) that is also called "second hand smoke" or "passive smoking" is a widespread cause of excessive morbidity and mortality worldwide, which results in significant costs paid by the whole world community. ETS is composed of more than 4.000 chemicals including more than 50 presently known carcinogens and a lot of toxic substances.

The US Department of Health and Human Services has classified ETS as human-generated carcinogen and toxic pollutant.

World Medical Journal

It has been repeatedly proven that passive smoking causes serious damage to human health and life. Continuous passive smoking induces the same diseases that are provoked by active smoking including lung cancer, coronary heart disease and infantile diseases.

A WHO survey states that non-smokers living together with smokers are by 20–30% more exposed to lung cancer. The risk of becoming ill with lung cancer is estimated as 12–19% for those working in a smoking environment. Passive smoking is connected with respiratory diseases and it causes exacerbation of asthma, allergy and chronic lung disease that results in excluding from the social and working environment.

Living together with a smoker increases the risk of cardiovascular diseases by 25–30%, while working in a smoking environment increases it by 15–18%. Besides, the connection between doses and the response is not a linear one. Passive smoking relates to heart diseases and the probability is about half of that resulted from 20 cigarettes a day. Even a small amount of tobacco smoke can have an immediate effect on blood clotting as well as a long-term influence on atherosclerosis, which make the most significant heart disease factors.

According to the European Respiratory Society, Cancer Research UK and *Institut National du Cancer*, more than 79.000 adults in 25 member countries of the EU die annually from passive smoking. Home and work are the two main environments where tobacco smoke acts intensively and chronically.

These estimations include deaths from heart diseases, stroke, lung cancer and different respiratory diseases caused by passive smoking. These numbers do not include adult deaths caused by other conditions connected with ETS (such as pneumonia), early death or both serious acute and chronic diseases caused by passive smoking.

"Second hand smoke" is particularly dangerous for young children and infants. Smoking in the presence of a child is an act of violence that threatens child's health and life. Smoking in the presence of a pregnant woman is an act of violence against her and the unborn child, consequently – a crime against the state

"Second hand smoke" is particularly dangerous for young children and infants, it is related to sudden death, pneumonia, bronchitis, asthma and respiratory symptoms as well as tympanitis. ETS can also result in decreased birth weight, prenatal death or premature birth.

Smoking in the presence of a child can cause addiction that in turn makes the child an early smoker. Parents' smoking becomes a kind of *brand* that is followed in the future life. After seeing a camel or brave horsemen in a prairie in their young years, people consider the image being a positive one in their adulthood.

The WHO Framework Convention on Tobacco Control (FCTC) has recognized that there is scientific evidence of the fact that tobacco smoke causes death, diseases and disability. The convention obliges the member countries to prevent "second hand smoke" risks.

According to FCCT article 8, every member is bound to "adopt and implement effective legislative, executive, administrative and/or other measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places."

Smoking is an economic burden

At the moment when country after country has been stricken by the economic crisis, tobacco consumption imposes one of the heaviest burdens on the economy. However, politicians often pretend not seeing this threat.

At first this burden includes the increased direct costs of health care determined by deseases caused by tobacco smoking. This burden is different in different countries, but in the EU it is considered that at least one quarter (24–32%) of health care costs are related to diseases caused directly by alcohol and tobacco consumption.

Another economic stroke coming from smoking is indirect costs, which occur because smokers fall ill more often than non-smokers, they do not work and do not produce any added value during these periods and thus they decrease the health and social budget. The same is also true for "passive smokers". Their productivity is lower than that of non-smokers – oxygenation in the lungs becomes slower during smoking and smoker's blood oxygen saturation decreases, which results in rapid tiredness and lack of attention. Smokers also tend to take breaks, so no work is being done during these periods.

One more aspect – smoking quite often causes domestic, industrial and forest fires. Smoking while driving has been the reason for thousands of road accidents in the whole world. The policy of the Tobacco industry that supports tobacco manufacturing in the developing countries and a differentiated excise duty policy has facilitated turning of the tobacco goods into a contraband that involves thousands of people trafficking tobacco produced in China, India, the Ukraine or Russia illegally into the EU or the USA.

An essential task is to promote the standpoint that smoking is a calamity and it is "normal" not to smoke. One of the first tasks is to achieve the situation that medical people do not smoke. Smoking by a physician is one of the most negative examples possible.

World Medical Journal

Sixty years of fighting smoking. Sixty years of randomized research

In this article I would like to give some insight into the history of fighting smoking and give evidence of the significant work done by doctors. In 1951 Austin Bradford Hill discovered that smoking causes lung cancer. For the time being it was a sensational discovery as after WW II most of male Europeans were smokers. During the war tobacco acted as a tranquillizer in entrenchments; even if it did not give relief, it kept one busy. It was not an easy task to prove this correlation because both healthy and unhealthy people used to smoke. So statistics was the only tool. The 1950's were the time of paradigm shift in medicine because lung cancer came forward instead of tuberculosis. In England the number of lethal outcomes from lung cancer in 1950 exceeded those from tuberculosis. In 1947 Austin Bradford Hill, Ernest Kennaway from St Bartholomew's Hospital and Percy Stocks, chief government medical statistician, were asked to find out whether smoking could cause the shocking 15-fold increase in lung cancer deaths during the previous 25 years. They were accompanied by Dr Richard Doll. From April 1948 every suspected lung cancer case in 20 London hospitals was reported to Doll. In turn, a lady almoner was sent to interview a patient and two more patients from the control group – one with a stomach or colon cancer and the other one from any other therapy or surgery department. The research proved the correlation concerning smokers and non-smokers, as well as the number of cigarettes smoked a day. A control research was carried out outside London. The results were undoubtable. At the same time similar results were obtained in the USA.

However, this was not enough to persuade the world that smoking is harmful. Bradford Hill was looking for more evidence and he invented a new method of research. The previous method was a retrospective one, but to make it absolutely veritable, similar data had to be obtained in future perspective. So a large number of men and women were questioned, finding out about their habits, including smoking and they were observed for several years. So this prospective or cohort research gave the answer to the question why smokers die. Bradford Hill chose 60.000 physicians from the Medical Registry, who were reliable for his research. There was no better way to promote this discovery than spreading it in the medical environment. The doctors passed the message about the harm of smoking over to their patients. In 1951 Bradford Hill sent a letter to the *British Medical Journal,* asking: "Do you smoke?" In the short period of two years, Bradford Hill got his response. Out of 40.000 respondents, 789 were dead, 36 of them of lung cancer. When the results were put into tables, a correlation between doses showed out. The more cigarettes were smoked, the more death cases occurred.

Thus in 1951 Bradford Hill started the statistical methods that are used by thousands of scientists and physicians in the whole world today. The randomized controlled research came as a substitute for clinical observation.

These findings of 1951 empowered physicians in the whole world to start the battle against tobacco. Smoking doctors disappeared from packages, and some time later – from posters that recommended cigarettes of a certain brand. Today at least in Latvia any advertising of tobacco is banned, and all legally sold packages have visible and serious warnings about the hazards of smoking – cancer, heart disease, impotency or at least bad teeth. In Northern Europe there is no smoking in clubs, bars and public places. In some countries no indoor smoking is allowed, because passive smoke is harmful not only for those standing next to the smoker but for smokers themselves as they are more exposed to cancer (and at the same time financial losses to the state health budget). A lot is achieved, still a lot is to be done.

The Latvian Medical Association is promoting an anti-smoking legislation in Latvia and we are inviting the world to join us

We are supplementing the Children's Rights Defence Law with a thesis that no child must be exposed to tobacco smoke and nobody is allowed to smoke in the presence of a child, to ensure a smoke-free environment for children. The same law states that physical violence against a child is a conscious application of power when approaching a child or a situation when a child is exposed to harmful factors (air pollution, tobacco smoke, etc.). So smoking in the presence of a child, including an unborn one, is considered physical violence against a child and makes it suffer physically.

Latvian lawmakers today are forced to consider whether real imprisonment (5–15 days and work) should be imposed on those selling cigarettes to minors or "kind uncles" buying those for minors. We propose that those who smoke in the presence of children and women should be naturally imprisoned.

Let us join our forces in 2011 to protect children in the whole world against direct and indirect effects of tobacco smoking!

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Climate Change – a Serious Threat to Human Health

Andrew Pesce

While many people and groups have expressed disappointment with the outcomes or lack of outcomes from the Copenhagen climate talks, it remains undeniable that climate change poses serious threats to human health globally.

The world's climate – our life-support system – is being altered in ways that are likely to pose significant direct and indirect challenges to health.

While climate change can be due to natural forces or human activity, there is now substantial evidence to indicate that human activity – and specifically increased greenhouse gas emissions – is a key factor in the pace and extent of global temperature increases.

Potential health impacts of climate change in Australia

In Australia, consequences of climatic extremes and changes to food and water supplies are predicted to have particular impacts on rural, regional, and some remote Indigenous communities, with some coastal communities facing relocation due to storms and flooding.

Significant numbers of Australians are vulnerable to severe storms and to increases in sea level.

There is a consensus that the more vulnerable members of the community – the elderly, the young and those whose health is already compromised – will be most affected by climate-related illnesses.

Children's exposure to climate change-related exposures and social stresses has been highlighted as a particular concern.

By 2056, there will also be a much higher proportion of Australians over the age of 65, as well as a rapid increase in the number of people aged 85 and over.

By 2020, it is expected that Australian doctors and other health professionals will be seeing patients with illnesses and conditions related to both short-term and longer-term effects of climate change.

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Higher temperatures

Heatwaves, especially in cities, can increase the rates of death and illness, primarily from heart and respiratory illnesses.

Australia's ageing population, increasing occurrence of chronic disease and co-morbidities and high levels of urbanisation all serve to increase susceptibility to the impact of heatwaves.

If NSW were to experience a heatwave similar to one that occurred in Europe in 2003, calculations suggest that an extra 647 deaths would occur over a two-week period.

Studies suggest that, over time, levels and patterns of airborne pollens and pollutants, which have significant effects on respiratory health, can be affected by higher temperatures and humidity resulting from climate change.

While the links between ozone and atmospheric warming are complex, elevated levels of ambient ozone have been found to lead to more frequent asthma attacks and hospitalisations and greater morbidity and mortality in patients with pre-existing pulmonary or cardiovascular disease. Investigations of the potential impact of climate change on ambient ozone concentrations suggest that a continuation of current trends over the next 10 years could result in asthma-related deaths rising by almost 20 per cent.

Vector-borne diseases

The potential for the resurgence of old diseases, the redistribution of others, and the emergence of new diseases have all been linked to altered climate and changing ecological balances.

Changes in climate can significantly alter the ecology and epidemiology of viruses and their potential to cause outbreaks of human disease. The transmission of certain arboviruses (transmitted to humans through mosquito bites) is particularly susceptible to environmental conditions that enable breeding and survival – rainfall, tides, sea level, temperature, humidity and wind all play a part.

Climate change is expected to particularly affect the spread of diseases such as malaria and dengue fever.

The arboviruses of greatest concern in Australia are Ross River, Barmah Forest, Murray Valley encephalitis, Kunjin virus, dengue and Japanese encephalitis virus.

The spread of other mosquito-borne diseases such as Chikungunya virus may also be affected, as there is evidence that the virus, previously thought to be limited to particular species of mosquitoes, is capable of being transmitted by species distributed more widely in Queensland and in other areas throughout Australia.

It is believed that global warming will result in tropical conditions in Australia spreading south, as will disease vectors such as mosquitoes.

Food and water-borne diseases

Heavy rain, flooding and increased temperatures are factors that influence water-borne infections.

As the temperature of the environment increases, the quality and the quantity of drinking water could decrease through drought.

In Australia, there are already water restrictions in many States for the first time in 20 years.

It is expected that health disorders related to environmental and water contamination by bacteria, viruses, protozoa and parasites will increase as the quality of water decreases. This contamination also occurs at the other extreme as heavy rainfall and run-off influence the transport of microbial and toxic agents from agricultural fields, human septic systems and toxic dumps.

Warmer temperatures also encourage food-borne infections.

The incidence of bacterial food-borne diseases (and amoebic diseases) increases during the summer months and is worse in the northern regions of Australia, due primarily to the increased bacterial replication where ambient temperatures are higher.

If average temperatures continue to rise, rates of food-borne diseases are also predicted to rise. However, actual health impacts will depend on factors such as food hygiene practices and contributions of different pathogens.

The combination of water shortages and lack of fresh food suggests the potential for significant harm to both the environment and human health in isolated Australian communities.

Changes in the amount and distribution of wildlife, fish and vegetation could also have health consequences for people in remote Indigenous communities who follow a traditional diet.

Mental health

Both extreme events and gradual climate-related changes, such as drought, may give rise to mental health problems, and these may continue for a significant period, and even be delayed.

Populations exposed to climate-related extreme weather events or disasters experience social, physical and material conditions that adversely affect mental health. Post-traumatic stress disorder, depression and anxiety may all result. Because of increasing num-

World Medical Journal

bers of extreme weather events, the impact of natural disasters on mental health is a growing concern.

Studies have found that mental health issues remain for a considerable time after the event and that, while post-disaster morbidity is likely to decline over time, the effects of exposure to the initial disaster and losses are likely to persist.

A number of Australian studies have shown that bushfires increase psychological morbidity among individuals and communities experiencing loss.

These effects can be chronic and delayed and may require ongoing intervention, although relatively few individuals develop serious long-term problems.

Diagnosis of post-traumatic stress disorder requires a clinical evaluation of symptoms.

Other mental health problems occurring in a post-disaster environment include depression, bereavement complications, anxiety disorders, substance abuse and adjustment disorders.

Three years after Hurricane Katrina in the USA, psychiatrists and other clinicians, hospitals, government and non-government agencies, schools and community groups were still working to help adults and children overcome persistent mental health problems.

Studies have found that people recover from extreme events in different ways and that a range of support services across the whole of the community is required. People who had accessed the services of the ACT Bushfire Recovery Centre after the 2003 Canberra bushfires reported that, after the Recovery Centre, doctors were the next most common source of help that they consulted.

In addition to the impact of disaster events, coping with and moving away from longer-term effects of climate change may create mental health problems for some people.

In Australia, drought has had a major impact on farm families and communities reliant on agricultural production.

Levels of depression and suicide in rural Australia have been correlated with prolonged drought, and there are concerns about the likelihood of mental health problems continuing to increase, particularly among rural men.

Many communities, including those familiar with drought, are likely to face the challenges of longer-term climate change.

Action

Climate change is a real and serious problem. The potential health effects are significant, and we need to take steps now to address them. In Australia, we need a national coordinated strategic approach to these health problems. The AMA advocates that a National Strategy for Health and Climate Change should be developed and implemented.

That strategy should incorporate the following:

- localised disaster management plans for specific geographical regions that model potential adverse health outcomes in those areas and incorporate appropriate localised health and medical response measures, including for people who have been evacuated or relocated, temporarily or permanently,
- strong and active communication linkages between hospitals, major medical center and local weather forecasters and emergency response agencies (in at-risk locations) to maximize timely responses and efficient use of health resources in extreme weather events,
- measures targeted to the needs of certain vulnerable population groups (older Australians, children, Indigenous communities, members of remote communities),
- measures to address health and medical workforce needs in rural and remote communities, particularly in mental health services,
- enhanced awareness among doctors and health professionals of the potential consequences on mental health of extreme weather events and disasters,
- development of effective interventions to address mental health issues arising from extreme events, including those involving mass casualties, and from longer-term changes, including drought,
- programs to improve the education and awareness of health professionals about the links between health and climate change, and their understanding of the risks of new vector-borne diseases and their health impacts,
- measures to prevent exotic disease vectors from becoming established in Australia and nationally coordinated surveillance for dangerous arboviruses, with public education programs promoting mosquito avoidance and measures to prevent mosquito/arthropod breeding, and
- preparedness to deal with the temporary and permanent dislocation of people due to climate-related physical events and economic conditions.

Dr. Andrew Pesce, President,
Australian Medical Association

World Medical Journal

World's MDs Discuss Growing Health Threats Posed by Environment

More than 170 doctors from around the world gathered in Vancouver in mid-October for a wide-ranging discussion about the pervasive and profound effects environmental factors such as climate change can have on human health.

The occasion was a scientific session organized by the CMA as part of the World Medical Association's (WMA) annual general assembly. WMA delegates, as well as many BC physicians who attended the meeting, were told how health issues related to environmental change have become a policy focus for both the WMA and the CMA, thanks in part to the leadership of a CMA past president, Dr. Ruth Collins-Nakai.

"Why on earth would we be interested in environment health?" asked Dr. Maura Ricketts, director of the CMA's Office for Public Health, as the scientific session began. "Because our members are interested."

She said members want and expect the CMA to take a strong advocacy stance with respect to issues such as climate change. Because they are "extraordinarily well-trusted resources for information," she added, physicians can play a key role in making people aware of environmental issues and their impact on health.

Dr. Alan Abelsohn, assistant professor of family medicine and community medicine at the University of Toronto, said survey data has shown that Canadians consider physicians – especially family physicians – to be the most credible source of information on the environment and health.

The meeting began with a video greeting from federal Health Minister Leona Aglukkaq, who advised that every aspect of the environment can affect human health, and the discussions that followed supported her contention.

The session's keynote speaker, British Medical Association President Sir Michael Marmot, provided an exhaustive global overview of how social and economic inequities, as well as inequitable exposure to environmental risks, affect health.

"If we put fairness at the heart of all decision-making, health would improve and health inequities would diminish," said ser Marmot.

He presented data which proved that communities and individuals at the lower end of the socioeconomic spectrum also face greater exposure to environment-related health risks.

He was followed by several experts, many of whom work at Canadian centres, who covered issues ranging from indoor air quality in developing nations to mercury toxicity.

For instance, thermometers that contain mercury remain the largest source of that toxic element within health care settings.

"The movement away from mercury thermometers has been global... and is certainly picking up steam," said Dr. Peter Orris, chief of occupational and environmental medicine at the University of Illinois. He noted the number of thermometers broken in hospitals remains "quite extraordinary."

All presentations at the WMA meeting were recorded and will be made available on *www.cma.ca*

Pat Rich, Canadian Medical Association

Physicians Urge Mexican Government to Restore Order in Juarez

The World Medical Association has appealed to the Mexican Government to restore order in the north Mexican city of Ciudad Juarez where physicians are being blackmailed, kidnapped and killed in drug related violence.

Dr. Federico Marin, the President of the Mexican Medical Association, has urged the WMA to intervene to help the physicians in Jurarez. He told the WMA: "Due to the escalating violence and now the kidnapping of physicians, it has become impossible for the physicians in Juarez to provide medical care without threat to themselves. They have had to organise a work stoppage to bring attention to this issue."

Dr. Wonchat Subhachaturas, President of the WMA, strongly condemned the violence facing physicians. This year three medical workers have been killed and 11 kidnapped.

He said: "Physicians have an ethical duty to care for their patients and governments have a duty to ensure that appropriate conditions exist to allow physicians to care for their patients. The situation in Jurarez appears to be out of control, threatening physicians and preventing them from carrying out their clinical work."

World Medical Journal

"The fact that this week thousands of doctors and health workers in Ciudad Juarez went on a 24-hour strike in protest at the high number of threats and attacks they are subjected to shows how desperate the situation has become. The government's inability to curtail drug-cartel violence is unacceptable."

Physicians in the city are calling for more soldiers and the Mexican federal police to bring the violence under control and the WMA and its national medical association members are urging the Mexican Government to listen to what physicians are saying.

Nigel Duncan, WMA Public Relations Consultant

World Organization of Family Doctors (WONCA)

Richard G. Roberts

The World Organization of Family Doctors (WONCA) is the global association of family doctors. Its familiar name "WONCA" is an acronym taken from the first letters of the first five words of the name used at the time of its formation: the ***W****orld* ***O****rganization of* ***N****ational* ***C****olleges,* ***A****cademies, and Academic Associations of General Practitioners/Family Physicians. Beginning with 18 members in 1972, WONCA is now comprised of 122 member organizations in 102 countries that represent about 300 000 family doctors.

Mission

WONCA's mission is to improve the quality of life of the peoples of the world through defining and promoting its values, and by fostering high standards of care in general practice/family medicine by:

- promoting personal, comprehensive and continuing care for the individual in the context of the family and the community;
- encouraging and supporting the development of academic organizations of general practitioners/family physicians;
- providing a forum for exchange of knowledge and information between Member Organizations and between general practitioners/family physicians; and
- representing the policies and the educational, research and service provision activities of general practitioners/family physicians to other world organizations and forums concerned with health and medical care.

Governance afnd structure

WONCA is governed by a World Council that meets once every three years in conjunction with the World Conference. Governance and oversight between meetings of the Council are provided by an Executive Committee, which consists of the President, President-Elect, Immediate Past President, 3 At-Large Members, 7 Regional Presidents, and the CEO, who serves ex officio without vote. Terms of office for the members of the Executive are for 3 years, except for the Immediate Past President (1 year) and the CEO (under contract). The Secretariat is located currently in Singapore; the current CEO is Dr. Alfred Loh.

A regional structure has been created to facilitate the development of family medicine through increased interaction among neighboring member organizations within a region. The regions approximate the World Health Organization (WHO) regions: Africa, Asia-Pacific, Eastern Mediterranean, Europe, Iberoamericana (Latin America), North America, and South Asia. Many, but not all, of the regions convene an annual regional conference. A recent development has been the establishment of WONCA regional organizations for young family doctors, including the Vasco da Gama Movement (Europe), Rajakumar Movement (Asia-Pacific), NaFFDoNA (North America), and Waynakay (Latin America).

Committees, Working Parties, Special Interest Groups

Much of the policy development and activities of WONCA occur through its Committees, Working Parties, and Special Interest Groups, which typically consist of 5–15 family doctors selected from around the world who have a particular interest and expertise. The 7 Committees are Bylaws, Finance, Membership, Nominating & Awards, Organizational Equity, Publications & Communications, and World Conference. The 9 Working Parties include Classification (WICC), Education, Ethics, Informatics, Rural Practice, Mental Health, Quality & Safety, Research, and Women and Family Medicine. There are 5 Special Interest Groups (SIGs): Complexity, Elderly Care, Environment, Primary Care & Cancer Research, and Travel Medicine.

World Medical Journal

Collaboration with WHO and other world bodies

WONCA has been involved in a number of WHO projects, including the Social Determinants on Health, WHO Western Pacific Region Patient at the Center of Care Initiative, Integrating Mental Health Services into Primary Health Care, GOLD – Global Initiative for Obstructive Lung Disease, GARD – Global Alliance Against Chronic Respiratory Diseases, and the development of the third edition of International Classification in Primary Care (ICPC-3). A number of monographs, technical documents, and educational programs have resulted from this collaboration. WONCA participates in the annual World Health Assembly in Geneva.

As the global voice for family doctors, WONCA is also involved with a number of other world organizations, including the World Medical Association and the International Federation of Medical Student Associations (IFMSA). Recently, WONCA and IFMSA have begun to collaborate to promote family medicine exchange experiences for medical students.

The Future: Challenges and Opportunities

In its 2008 World Health Report "Primary Care: Now More Than Ever," WHO concluded that the health systems of the world should be based on primary care. All 194 countries at the 2009 World Health Assembly approved a resolution advocating for countries to train sufficient numbers of primary care workers, including family physicians. Reliant on member organization dues and conference levies, World WONCA operates on a very modest budget. To achieve all that is being asked of family medicine, WONCA must develop a more robust governance structure and garner sufficient resources. WONCA's challenge during the next decade is to grow from an academic club of national colleges to a global professional association.

Richard G. Roberts, MD, JD
President 2010–2013
World Organization of Family Doctors (WONCA)
January 2011

EU Workforce for Health – Putting a Human Face to EU Policy-making

EFN-EPHA Lunch Debate
27 October 2010 – European Parliament

All around Europe the Member States are facing common challenges in terms of ensuring and maintaining an adequate health workforce to meet the changing and growing health needs of the EU citizens. Besides, the rapid changes in demographic, the ageing population, the widening health inequalities and the changing disease patterns place additional challenges to the already stretched European health systems.

Therefore, adequate and sustainable EU Workforce for Health is crucial. Taking this into account, and as a follow-up of the Ministerial Conference, held in La Hulpe on 9–10 September 2010, and the European Parliament Written Declaration, signed by 182 MEPs, the European Federation of Nurses Associations (EFN) and the European Public Health Alliance (EPHA) organised a lunch debate on 27 October 2010, in the European Parliament.

The debate, supported by five key MEPs – Oana Elena Antonescu (Romania, EPP), Jean Lambert (UK, Greens/EFA), Antonyia Parvanova (Bulgaria, ALDE), Marc Tarabella (Belgium, S&D) and Marisa Matias (Portugal, GUE/NGL), analysed the extent of the EU Members states common challenges and showed how the current practice of health professionals recruitment, mainly nurses and doctors, from some European countries and the developing world to fill gaps in the workforce in other areas of Europe is unsustainable. Furthermore, speakers and participants pointed out a common and urgent need for policy makers to take action.

The personal testimonies of a Latvian doctor *(Mr. Peteris Apinis)*, a Polish nurse *(Ms. Paulina Daczkowska)*, a Belgian nurse *(Ms. Heidi Ceuppens)*, and a Bulgarian patient *(Ms. Evgeniya Adarska)*, made this concern clear by stressing that issues like recruitment and migration policies, working and education conditions, attractiveness of health professionals, and improvements in the recognition of qualifications, are essential for the health profession, and that the key EU solutions are undeniably: workforce planning, implementing recruitment and retention strategies, and develop a well-educated and motivated workforce for health.

> *"Recruitment without retaining nurses and doctors is a waste of resources." (Heidi Ceuppens, nurse).*

Myria Vassiliadou (EWL) chaired the following discussions along the debate, highlighting that it is always good to see the human the human face of the problems. During the political roundtable she brought

World Medical Journal

out for further discussions issues such as the mobility and the workforce, legal aspects, working and education conditions and financial crisis were addressed but from a different approach, taking into account and bearing in mind the ones that finally suffer from these challenges, patients and healthcare professionals.

Talking about recruitment and retention, the MEPs present agreed that several countries are putting too much attention on the health professionals coming from third countries and the ones leaving their own countries are not looked enough. Therefore, it is extremely important to understand what makes the professionals stay or leave. So, this is not only about recruitment but also about retention policies. Furthermore, and as part of the strategy, we should not only focus on the new graduated health professionals but also at the existing and experienced workforce in keeping them motivated to stay in the nursing profession, as the difficult working conditions, mainly for women, and all the new demands of care provisions makes it harder to stay in the profession.

As regards migration, the current trends are unsustainable, entailing shortages in several countries.

> *"…due the economic situation in most countries, especially eastern European Member States, and due to the shortage of nurses in all national healthcare systems, member states fulfill these gaps by stealing nurses from each other…" (Paulina Daczkowska, nurse).*
>
> *"…Today, a widespread and unstoppable trend has developed concerning the migration of medical doctors from poorer Eastern European countries to the "elder European world" especially to Great Britain, Germany, Scandinvavian countries and France…" (Peteris Apinis, doctor).*

One of the main causes for nurses to leave is the extremely low salary and unpleasant working conditions they have in their own countries/settings. Excessive workload and lack of personnel in some shifts make nurses feel insecure and in need to find new possibilities for professional development. As well, the lack of recognition and the extreme low salaries make the nursing profession unattractive, losing potential new students to come into the nursing profession. Therefore, surrounded in the new increased demands of healthcare, more emphasis must be put towards recognition of the nurses' value within the society to knock the youth's minds offering them successful opportunities for professional development.

Furthermore, nurses who migrate to another country are not always working with the same tasks and responsibilities they usually perform in their home country. This situation often leads to a downgrading of the nursing profession overall, and mainly to downgrading the individual as a person and a professional. This is where the human rights aspect comes into the equation. Consequently, the migration of health professionals is an enriched process that should be done in a transparent and sound way.

> *"…the process of obtaining the recognition of the diploma and beginning to work and settling down in another country is everything but not easy. It involved me enormous and unacceptable administrative burdens, and long procedures before the final approval was achieved. It gave me many moments of stress, of insecurity and doubts, but I resisted…" (Paulina Daczkowska, nurse).*

As mentioned by **MEP Marc Tarabella**, in order to encounter that shortage of nurses, it is important to recognize the professionals and to improve the mobility started with Bologna. We also need to harmonize the health systems all over Europe in order to improve the quality and safety of care. Only then, it will be possible to have an harmonized highly EU educated workforce guarantying a freedom of movement and a safe, updated and sensible process of professionals' mobility, taking into account the need to update the minimum training requirements as set out in the Directive, the languages competences to provide safe care, and effective administrative process of mutual recognition.

MEP Jean Lamberts took this opportunity to emphasize the need for a more dynamic recognition process and boost the role of employers to deal with the language requirements. It is important to take into account both professionals: the ones being recruited from third countries and the ones leaving the country. In that sense, a need for recruitment policies is essential, as well as the link between the working conditions and the jeopardizing of the quality of care. Urgent actions are needed before the health workforce disappears. Therefore, recruitment and retention strategies are key to deal with the EU workforce challenges.

MEP Oana Elena Antonescu also took this opportunity to mention the difficult situation Romania is living while seeing six thousand doctors and four thousand nurses leaving the country in the last two years to look for better working conditions. It is true that there are difficulties and differences between regions but there is also a common shared problem regarding the shortage of qualified workforce. There is a need for an increase of the attractiveness of health professions. The EU needs human resources strategies to recruit health professionals, and to find strategies to retain them (improving working conditions), as well as data collection of health professionals.

Participating in the meeting, **Ms. Katja Neubauer (DG SANCO)** pointed out that the consultations, with regard to the Green Paper on the EU Health Workforce,

World Medical Journal

made up till now show that people are very concerned by the shortage and that it is necessary to put this topic into the political agenda. The Council Conclusions are being discussed, and should be adopted in December 2010, and the Hungarian and the Polish Presidencies are very interested in this topic. Finally, it is important to look at the workforce planning in a broader way, taking into account what kind of workforce, how many, and with which skills, it will be needed in the future. As it is very difficult to recruit and maintain professionals, it is essential to look at new strategies (as, for example, what is done in Aalst Hospital – Belgium) and to make the link between Health Professional and Quality & Safety of care. DG Sanco hopes that in 2011 some concrete actions can be put forward.

> *"…So together with 3 nurse colleagues, all of us working bed-side, we started a project: introducing nursing and promoting our profession to last year students of the secondary school, being 17 to 18 years old…"(Heidi Ceuppens, nurse).*

From **Mr. Arnaud Senn (DG EMPL)** perspective, facing the needs of patients is one of the main issues to tackle future needs. As topics to go further in we need to highlight: the needs in long-term care, health inequalities and the pressure of health professionals. Regarding the current negotiations of the cross border directive, it is crucial to look at the consequences of patient and healthcare professionals' mobility.

Mr. François Decaillet (WHO Regional Office) stressed that the current challenge with the workforce for health is not only an EU problem but a global one, as shortage is a reality in every country around the world, especially in Africa, and emphasized the need for planning and implementation, next to the need for better coordination between all the countries, and for social innovation (as the project referred by Ms. Heidi Ceuppens – Belgium).

The EFN Secretary General, Paul de Raeve, encouraged the present MEPs to become champions in EU workforce for health, as in other initiatives such as the sharp injuries success story. The EU workforce for health needs to be treated at the highest political level.

> *"…Every health system is unthinkable without nurses. The politicians should understand that …" (Evgeniya Adarska, patient).*

EPHA President, Mr. Archie Turnbull, concluded that with the bologna process, studies will be globally recognised, allowing guaranty and free movement of people. The question is "How to support the sector and the need for thinking in a broader way?"

> *"Today I know quite well that people with health problems seek support; seek someone who offers him hope; someone who will be nearby all the time; someone who could give cosiness and security at the same time" (Evgeniya Adarska, patient).*

Listening to the 4 testimonies, the MEPs present were very clear on concrete actions and see an opportunity for the three EU Institutions: the Council, the Commission and the European Parliament, moving towards a European and innovative approach. Furthermore, synergies should be built between the European Institutions and the Civil Society.

MEP Antonyia Parvanova expressed that there are enough arguments to tackle this subject right now. Seen the future shortage of 500.000 nurses, we need to decide what to do at EU level (European Commission, European Parliament and Council). The current challenge of the workforce is an EU level problem, and it is time to start discussions on these deviations and how it could be done in a more legalised way. Coordination and a legal framework to cope with the challenges of the EU workforce for health are urgently needed, next to a different approach to human resources or employment perspectives towards solving the workforce issues.

Finally, the MEPs considered taking further the following actions:

Putting in place an EU monitoring and planning system to have comparable data available to map to EU health workforce, analysing how many and what kind of health professionals we will need in the future, and what type of policies need to be developed to respond to future needs.

Investing in human capital by covering recruitment and retention strategies, evaluating income and working conditions and stimulate innovation and entrepreneurship. Within this context the social cohesion funds should be used for health.

Establishing an EU Continuous Professional Development Framework to maintain a highly skilled and motivated workforce and to educate health professionals towards the new demands and types of care and train for the use of new technologies.

Taking a gender approach to EU workforce planning and valuing the increased participation of women.

EFN Report – November 2010
The European Federation of Nurses Associations (EFN)
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World Medical Journal

Nurses Impact on the Health System Paradigm Shift

Paul De Raeve

The European Federation of Nurses Associations (EFN) was established in 1971, based on the nursing-education and free-movement Directives being drafted by the European Commission at that time. In 40 years, the EFN has grown to its present political and professional maturity by becoming the one strong independent voice of the nursing profession at pan-European level, representing millions of nurses through the national nurses associations of 34 Member States. As such, EFN is a key partner in the design and re-engineering of the different health systems within the EU, all aimed at delivering high quality, safe and continuity of care to the population.

As part of the origin of EFN, the EU Mutual Recognition of Professional Qualifications (Dir2005/36/EC) is central in EFN lobby strategies towards the European Commission, the Council and the European parliament. When re-designing health systems in the EU Member States (taking into account the re-activation of the "Liberalisation Act") a highly educated health workforce, mainly focusing on nurses, midwives, doctors, pharmacists and dentists, remains the cornerstone for each legislative redesign. Therefore, the implementation of this Directive, alongside the "Acquis Communautaire" compliance process, was analysed in 2010 by different stakeholders.

For EFN, the conclusion represents the same nursing values and principles as advocated for by nurse leaders in the seventies. The Directive, which sets out the minimum education and training requirements for nursing education, substantially impacted the advancement of the nursing profession and the status of nurses across Europe by positioning of nursing education in the Higher Education degree structure, within Universities and Colleges. The minimum education requirements have proven to be a valuable safeguard of quality and safety in healthcare, since they discourage governments from downgrading nursing education as means to reduce costs.

Nevertheless, updating the list of required subjects within nursing curricula is seen as an opportunity to consider topics such as patient safety, quality system thinking and e-Health as advancements in nursing education. One of the deliverables of the European Union Network for Patient Safety (EUNETPAS, 2010) – the guidelines for a curriculum on Patient Safety – in which a basic curricula framework for patient safety to be simultaneously taught to all healthcare professions, engaging patients in the design, could help facilitating the paradigm shift: creating a new generation of nurses, doctors and pharmacists.

The review of the Directive is equally perceived by EFN as a unique opportunity to ascertain that "fitness to practice" remains a professional priority. This challenge is linked to the European Commission Agenda on "New Skills for New Jobs", in which a highly skilled health workforce is prioritized at the same level as modernising labour markets and promoting work through new forms of flexibility and security. Interestingly, the EU health workforce became an essential driver in the EU health policy domain, with nurses – as the largest group of health professionals – playing a central role in pushing the paradigm shift further with the alliances concerned. For EFN, the Council Conclusions on the EU health workforce provide a good political framework for action to move from a "Green" to a "White" Paper on EU Workforce for Health – an initiative that deserves and requires our attention.

Skill mix, skill matching and extending roles and responsibilities for nurses is becoming a key component when re-designing existing health systems, for both the primary and hospital care system ("Nurses in Advanced Roles", OECD, July 2010). Consequently, the establishment of an "EU Skills Panorama' and Sectoral Skills" Councils opens a policy opportunity for the representative pan-European nurses organisation to respond to the societal demands for health systems and their outcomes. The concept of "Innovative Partnerships" is a step in the right direction to scale up "frontline initiatives" into an EU added-value for citizens, patients and health professionals. The concept of the "link nurse" is a positive, innovate example, not only in relation to safety and quality, but in many other aspects of making health systems effective and efficient.

E-health is a tool to decrease the increasing nurses' workload, standardising activities such as documentation, patient records, referrals and discharge, including the surrounding nursing activities such as planning homecare, e-prescribing of medication and wound care. Proper e-Health systems must help nurses to get rid of the excess of administrative work providing them more time for direct patient contact. This is part of the management paradigm shift: bringing the nurse closer to the patient. The condition for success in shifting the paradigm is the

World Medical Journal

end-users' engagement in the deployment of new innovative e-health solutions, which must be used as a tool to improve the information and communications processes, promote the use of standards, indicators, interprofessional communication channels, and encourage continuous professional development. The paradigm shift includes therefore bringing upfront innovative "fieldwork" in patient empowerment, putting gender into the equation, embracing healthy years and quality of life, dignity and ability to self-management next to emphasising an integrated approach of service planning, organisation of care and financing.

From a political perspective, a paradigm shift is only possible if the political institutions themselves, governed by governments, adapt their governance structure to move away from the old fashioned and well-known paradigms that are difficult to reform. Nevertheless, the policy paradigm shift is urgently needed, otherwise Member States will continue to produce Council Conclusions and WHO reports for the book shelves and avoid engaging concerned stakeholders collectively.

Good governance in health systems implies implementing an effective stakeholder approach, which goes far beyond online consultations and bilateral partnerships. The key principles for making the paradigm shift work is to empower transparency, engage a range of concerned stakeholders, build cohesiveness, and make effectiveness measurable to increase responsibility throughout the health system. But these principles require trust and effective implementation.

Therefore, EFN core business is to set the policy agenda pro-actively and design pipeline EU legislation and not to lead EU projects or work packages. As a successful EU legislative outcome, next to the Directive 36/2005/EC, the EU Directive on prevention from sharps injuries in the hospital and healthcare sector was adopted by the European Council of Ministers on 11 May 2010.

Every year huge numbers of nurses and their families face months of uncertainty and emotional anguish following a needlestick injury, not knowing if the accident will lead to a life-threatening infection. For many years EFN advocated for EU legislation ensuring that all healthcare workers (not only nurses) be adequately protected from needlestick and other medical sharps injuries.

The legislative initiative was formally launched on World AIDS Day in 2004, when nurses infected by HIV and Hepatitis C due to a needle stick injury came to the European Parliament to request political attention and action. National requirements were failing to provide adequate protection and an EU added-value legislative initiative was needed. Such serious risks would be considered unthinkable in other occupations, so why should nurses be exposed to life-threatening injuries every day when the majority of these can be avoided with better working practices, continuous professional development, and the use of readily available technologies that incorporates needle protection?

Although it has taken considerable political will and policy efforts, great progress has been made. The EU Directive on prevention from sharps injuries in the hospital and healthcare sector was published in the Official Journal of the European Union (OJEU) on 1 June 2010, the same day the European Biosafety Network, led by nurses, was established. The network has now the challenge making sure each EU Member State brings into force national legislation to implement the Directive by 11 May 2013 at the latest.

To conclude, EU legislation is a top priority for EFN. Therefore, working towards developing a strong policy advocacy strategy for nurses and nursing at the EU level is central to making the paradigm shift possible and consequently, to make progress in society. Therefore, EFN will remain focused on the following key policy priorities: education, workforce, quality, and safety. Rest assured that EFN will maintain its role as a strong advocate promoting a continuous and collaborative dialogue among the EU policy-makers and the stakeholders involved in re-engineering health systems by putting a human face to EU policies.

Paul De Raeve, RGN, MSc, MQA, Mphil/PhD
Secretary General of the European Federation of Nurses Associations

Czech Medical Chamber Request for Support of Hospital Doctors

Distinguished Colleagues, Dear Friends, allow me to inform you briefly about the campaign "Thanks, We Are Leaving", which is a legitimate expression of dissatisfaction of Czech doctors, and at the same time let me ask you for your help and support for my colleagues.

Czech Doctors Trade Union, the largest and practically the only trade union organisation of Czech doctors, announced in March last year a campaign "Thanks, We Are Leaving", which is now reaching its culminating point. It´s essence are massive employment termination notices of hospital doctors in protest against poor working conditions, low wages and complete disruption of education system. The Czech Medical Chamber supports the campaign, because it is a completely legiti-

World Medical Journal

mate demand of the great majority of its members. Another reason for the support is that The Czech Medical Chamber as a supervisor of the high quality of medical care for the past several years is not able to guarantee this care to the citizens, due to the devastation of medical personnel in the Czech Republic. The necessary changes are not coming in spite of years-long debates and appeals to politicians, who are responsible for this situation and have the power to change it.

For twenty years the Czech doctors waited in vain for dignified appreciation of their work. And for twenty years politicians were promising them to implement reforms, the results of which among others would be an improvement of professional and economic conditions of doctors. In reality, however, the situation of most hospital doctors worsened.

Our health care is chronically underfunded as expenditures on health care represent only 7,0 –7,5% of GDP. Fair European level of the Czech health care and good access to health care for the voters (our patients) is secured by the politicians at the expense of doctors and other health care professionals whose income remain low and working conditions poor. As the professional and working conditions are not improving in the Czech Republic, more and more of our colleagues are seeking emigration as solution of their economic problems. Gradually, due to that comes to a personnel decomposition of hospital medical care in the Czech Republic. The gradual devastation of the hospital care due to the shortage of medical personnel is the consequence of such a situation.

The Labour Code and European Working Time Directive (EWTD) are violated in most hospitals, and overworked doctors represent potential danger to patients. Reports on working hours are falsified and the number of doctors in the statistics is increased against the reality..... A qualified doctor must work monthly about fifty percent hours over time to obtain the average income of ca. CZK 45.000, – (about 1800 Euro). Such a salary is indicated in the statistics and it corresponds to less than double of the average income in the Czech Republic.

The doctors demand an increase of their salary for the basic working time to the level of 1,5–3 times higher than is the average salary income in the country, depending on their qualification and length of service. Such a salary level is quite common in countries to which the doctors from the Czech Republic are leaving. This requirement represents an increase in hourly wages of doctors from the current 100–200 CZK (about 4–8 EUR) to 200–400 CZK (about 8–16 EUR). The fulfilment of this demand requires only 3 billion CZK per year, which is approximately only 1% of all the money spent in our health care.

The aim of the action "Thanks, We Are Leaving" is not to drive the doctors into exile, but to improve their working conditions in Czech hospitals and in such a way to remove the reasons for their departure and the consequent personal devastation of Czech health care system. This is the main reason why Czech Medical Chamber fully supports the actions of doctor's trade unions. Enclosed I am sending 13 reasons that lead Czech hospital doctors to proclamation of the campaign "Thanks, We Are Leaving" and that was formulated by Czech Doctors Trade Union. These 13 reasons describe the motives of doctors and the causes of the whole problem.

In spite of the fact that employed doctors announced their intention to leave the hospitals in March 2010, political representation did nothing to avert their decision. Up to the December 31 2010, 3850 doctors handed in their notices of leaving the employment. Unless the government accepts their demands, then after the two month notice period these colleagues will not come

Milan Kubek

to work on March 1, 2011. Doctors from the whole Czech Republic, from various hospitals and departments are involved. The notice of leaving the employment was handed in by the third of the total number of 12.000 doctors working in hospitals. In some hospitals and in some regions the notice was handed in by more than 80% of doctors, but there are departments where the notice was handed in by all doctors.

It is difficult to label the position of Czech government by something else than a hazardous play with the health and lives of citizens when instead of constructive negotiations with doctors and search for a rational solution, government concentrated on threatening doctors by declaring "emergency situation" which would allow to order the doctors to work similarly as is the case during natural catastrophes. Without doctors it is not possible to provide medical care and there is nobody who can replace doctors.

For several weeks the Czech Medical Chamber has very actively negotiated with the representatives of all parliamentary political parties to find an acceptable solution to the current situation. Although the Czech health care is chronically underfunded, only 1% of the funds that flow into the Czech health care are sufficient to

World Medical Journal

meet the justified demands of hospital doctors. The money needed can be obtained by control of expenditures for the overpriced pharmaceuticals, by establishing an order in the completely chaotic investment policy, in the purchases of medical equipment and by reducing corruption. The Government of the Czech Republic has "the fight against corruption" as a main slogan, but in reality is rejecting all economic measures proposed by the Czech Medical Chamber and is trying to intimidate the protesting doctors.

The Czech Medical Chamber would be happy to provide you on your request with additional and more detailed information on the largest protest campaign of doctors in the modern history of our country.

The prestige and dignity of the whole medical profession is involved in the ongoing struggle and therefore we cannot afford to lose this battle. The campaign "Thanks, We Are Leaving" proclaimed by the Czech Doctors Trade Union and supported by the Czech Medical Chamber represents a unique, and regretfully even an unrepeatable opportunity after 20 years of patiently but in vain waiting for a better professional and economic status of all doctors in the Czech Republic. Any defeat, however, would bring disastrous consequences for all doctors.

Not only on behalf of the Czech Medical Chamber, but also on behalf of all doctors from the Czech Republic, I appeal to you for any kind of help, for any kind of statement of support and solidarity.

13 Reasons for the Exodus

1. **Czech health care has been underfunded on a long-term basis.** The share of GDP has oscillated around 7%, while the average in EU is 10%. From the monitored OECD countries, behind us are only Poland, Mexico and Korea.
2. **The low pay contribution of the state for the state insurant** that does not match the volume of funding that these "public patients" consume. **Absence of commercial insurance.** The government´s contribution for citizens without income is much lower than their real spending.
3. **Large reserves in the internal functioning of the health care** – the biggest item is the chaotic drug policy, where hundreds millions of Euros are wasted.
4. **Strange economy in hospitals – overpriced contracts** (construction, purchase of equipment and medicine, etc.). Salaries of health care professionals are the only item for which commission cannot be obtained.
5. **Low salaries for doctors** which do not correspond with the intensity of this profession, the necessary education and prestige.
6. **Completely destructed system of education** is one of the reasons for the departure of young doctors abroad.
7. **Departure of doctors abroad due to better working conditions**. The remaining doctors are burdened with more responsibilities than correspond to their qualification. More overtime work is needed.
8. **The Labour Code is not observed**, more over time is required from doctors and as a consequence of it potential medical errors, followed by legal proceedings may occur.
9. In 2013, the exemption from the **European Directive on Overtime Work** will no longer apply and hospitals will need more doctors.
10. Due to lack of staff, poor organisation and irrational use of funds, **deterioration of patient care** threatens, for which doctors do not want to take responsibility.
11. **Unfulfilled promises of politicians** – since 1989, the doctors have been told that first the system must change and then their salaries will be improved. So far, this has not happened.
12. Health care became the object of an **ideological war** between political parties. The profound changes of the system require an agreement across all political parties, as it happens in other countries.
13. The Ministry of Health experience among all the ministries the **most frequent changes of ministers**, all of them with their own ideas how to change the system. There are constantly some elections taking place, whether they are regular or premature. Under such circumstances, doctors have no guarantee that the necessary changes will take place.

Dr. Milan Kubek
President of the
Czech Medical Chamber

Agreement between the Ministry of Health and the Doctor's Trade Unions

Dear Colleagues, Dear Friends, Allow me to express my gratitude for your support of the Czech doctors and the Czech Medical Chamber. It is my pleasure to announce that today an agreement was signed between doctors and the Czech Republic, represented by the Minister of Health. I believe that the *"Thank You, We Are Leaving"* protest campaign has come after 11 months to a close. Doctors that handed in their notices and were to leave their employment in hospitals on 1 March 2011, based on the above agreement will continue to work in hospitals.

Agreement between the Ministry of Health and the Doctor's Trade Unions

Main agreement parameters:
The base salaries of all employed physicians in all types of health care bed facilities and in the emergency medical service will increase from 1 March 2011 by 5 000,- CZK, 6 500,- CZK and 8 000,- CZK depending on their qualification. This increase represents a raise in base salaries by 21–36 percent.

World Medical Journal

Additional increase by 10 percent, this time of the total salaries of doctors, will occur from 1.1.2012.

The doctors' incomes will be increased from 1.1.2013 so that the employed doctors' average pay would become 1,5–3 times higher than the average national salary (currently ca. 25 000,- CZK) and at the same time with a commitment to cutback the amount of overtime work to a maximum average of 8 hours per week.

The government commits itself to work together with the representatives of doctors, including the Czech Medical Chamber and the Czech Doctor's Trade Union, on the adjustment of the education system of doctors, on anti-corruption measures and on further reform changes in health care.

CMC fully supported the struggle of hospital doctors for the improvement of working conditions, the implementation of the necessary order and enforcement of the long overdue changes in medical care. CMC will continue to provide support to its members and will supervise the fulfilment of the agreement. Personally, I consider the result of this protest campaign as a colossal success of Czech doctors and hope that in the same way as the doctors also the political representation of the Czech Republic will fulfil all obligations stemming from this agreement. Allow me to thank you once again for your kind help and support.

Yours faithfully,
Dr. Milan Kubek
President of the Czech
Medical Chamber

The Georgian Health Care System during the Conflict in August 2008 and World Crisis

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

Tamar Lobzhanidze

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Gia Lobzhanidze

Zaza Khachiperadze

The issue of small countries' development and their integration into the international society attracts more and more attention of the politicians and academic researchers in the modern world with the tendencies of globalization.

Because of its geopolitical location, Georgia, differently from many other small countries, faces specific challenges and threats. The events that developed in August 2008 had a great influence not only on Georgia's positioning on the international level, but also on the processes developing inside the country. With the background of the world financial crisis, they pushed country's economic, social, and political processes to a new phase.

The state governance, besides the Conflict of August 2008, faced the great world financial crisis that limited free finance attraction process, and consequently, the questions of state governance rationality and decrease in officials were highlighted in many countries and in Georgia, too.

In September 2008, the world economy underwent difficulties. The wave of bankruptcy covered all the USA. The first to go bankrupt were the banks, and the investment crisis placed the world in front of big threats. The liquidity-money deficit occurred. The companies that were oriented on everyday credits appeared in a very bad situation. The Index of Dow Jones fell, other indexes underwent big attacks too, and the first time, after a long period, the USA entered the recession process.

World Medical Journal

Soon the recession overtook Europe; the economy of Great Britain was facing serious threats. As for Iceland, it almost totally went bankrupt. During this period and as a result of the situation that developed, the economy of Georgia was also damaged. The income in October 2008 decreased almost 2 times and its GDP reduced 1.9 times.

According to the planned 2009 budget, the economic income was determined as 2%; however, the world economic crisis resulted in determining Georgia's income as 4%. Budgetary incomes decreased by 600 million GEL.

In 2010 the increase in GDP was planned to reach 2%, inflation rate was determined as 6%, more than by 1% in comparison with the indicator in 2008.

This crisis was very harmful to Georgian economy, but the country's economy was not as sensitive to this crisis as many other countries' economies proved to be because Georgia was not as much involved in the world economy. To be more precise, there were no securities on the USA Stock Exchange, which saved Georgian financial assets. In fact, our economy was saved by isolation. The events of August 2008 were soon followed by economic recession. If, according to some sources, Georgia had increased its GDP by 9–10%, there was no indication of improvement in October. In 2009, the signs of large-scale job losses were noticed among employees.

Social politics is an important part of Georgian economy. A large part of it is covered by health care and pension systems. The number of pensioners in Georgia reaches 1 million. According to the data of 2009, the problem of nation's aging prevents the development of effective pension politics. The government accomplishes the issue of satisfying pensioners by a simple model-distribution of the pension. The next necessary step to be done is to work out the strategy to direct pensioners' access to the health care system and to getting the health care goods as it is done in other developed countries. The development of health care system and functions of strategic nature means system infrastructure rehabilitation through maximum objectivity and foreign investment by the medical services of private market health insurance, and voluntary health insurance stimulation. The health care system covers social and age groups with different mechanisms of financing (e. g., refugees, 0–3 years old children, people over 60 years of age). The support to all kinds of medical services increased by 6% from 2007 to 2008. The increase reached 3% in 2009, in comparison with 2008. Mostly the increase was determined by ambulance services and doctors' visits. (Fig. 1.)

In 2008 the hospitalization indicator (100.000 population) was increased by 11.2% in comparison with the indicators of 2007. And in 2009 the increase reached 1.2% in comparison with 2008. As for 2007, the increase reached 8.6%. (Fig. 2.)

The attracted medical insurance premium increased by 72.4% in 2008, in comparison with 2007, and by 25% in 2009, in comparison with 2008. Private money spending decreased lightly. (Fig. 3.)

The tendency of purchasing public and private sector medical services and supply has not decreased, on the contrary, according to some indicators, the tendency of growth is noticed. During the crisis the Georgian health system stability was achieved, first, by the strong support of the state for the medical insurance, through which incurrence of population was managed. Secondly, financing of the system and health care utilization was so small and minimal that the invested budgetary and private sources and the improved business environment maintained the system functioning.

The effectiveness of the functioning of the Georgian health care system in the future will depend on the growth of the state share in health care costs (no more than 2% per year) and the basic improvement of the process administration. It is especially important to work out the 10-year health care system strategic and human resources development plans. That will be the basis for the education and health care system improvement and affordability.

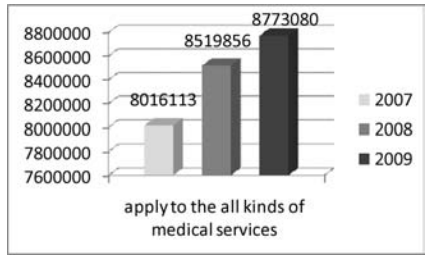

Figure 1

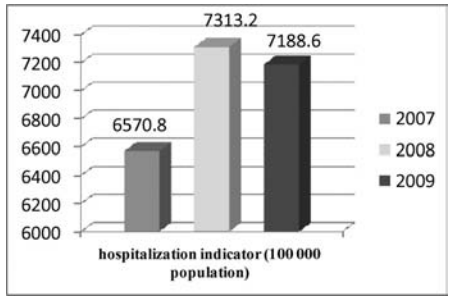

Figure 2

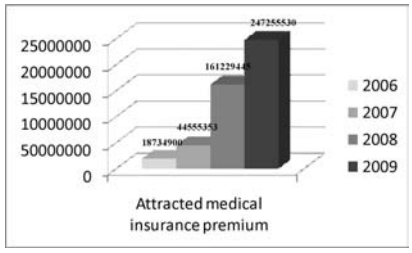

Figure 3

Tamar Lobzhanidze, Assistant Professor of the University of Georgia
Kakhaber Jakeli, Associate Professor of the University of Georgia
Prof. Gia Lobzhanidze, Chairman of the Board of Directors of the Georgian Medical Association,
Dr. Zaza Khachiperadze, Deputy Secretary of the Georgian Medical Association

World Medical Journal

Skopje Declaration on Patient Safety and Quality in Healthcare

The annual ZEVA Symposium provides a platform for exchange between physicians' chambers from Central and Eastern European countries. During the symposium, representatives from EU and non-EU member states discuss common challenges and share experiences in order to find ways to improve the working environment of physicians and the quality of healthcare in the interest of all patients.

The central focus of the 17th ZEVA Symposium, which was held in Skopje, Macedonia, was patient safety and quality in healthcare. After a fruitful discussion, the participating countries agreed on the:

- Safety is the core element of quality in healthcare.
- Physicians have an ethical and professional obligation to always strive for continuous quality improvement in healthcare and must ensure patient safety during all medical decision making.
- Physician self-regulation is based on the trust invested in the medical profession. Physicians' chambers assume this responsibility and guarantee high standards of medical practice and the ethical provision of medical services by physicians. Patient safety and quality in healthcare are core elements that drive the chambers' decisions on policy, ethics, education and training.
- By being competent advocates for patient safety, physicians prove their credibility in the political arena and to the public. Governments should recognize the crucial role of physicians and physicians' chambers in all matters relating to patient safety.
- Patient safety incidents are often reported as errors by individual physicians. However, research has shown that nearly all incidents are actually a result of system failure and rarely errors by individuals.
- Physicians should take a leading role in patient safety and be included in analyzing complex health information processes that lead to errors or create the potential for errors.
- A Critical Incident Reporting System could be a valuable and effective physician-driven instrument. A blame free reporting culture is a precondition for this.
- Most countries face similar challenges in improving patient safety. These primarily concern the provision of appropriate education and training, ensuring a safe working environment, building and maintaining a suitable infrastructure, as well as guaranteeing sufficient financial and human resources.
- Patient safety and quality of care should take particularly high priority when considering task shifting in the delivery of health services. The role of physicians as the health professionals with overall responsibility for diagnosis and treatment is crucial in this respect.
- Physicians' chambers should promote policies on patient safety to all physicians in their country and support the development of appropriate post-graduate medical education.
- Physicians' chambers in the ZEVA region should continue to share experiences in the field of patient safety and foster more intense collaboration.
- The physicians' chambers in the ZEVA region fully endorse the World Medical Association's "Declaration on Guidelines for Continuous Quality Improvement in Healthcare" and the WMA "Declaration on Patient Safety".

The College of Physicians of Senegal

The missions

The College of Physicians is a legal entity of public law with civil personality and financial authority. This is the highest medical professional authority. It ensures the maintenance of the principles of morality, quality and dedication necessary for the practice of medicine. It also ensures compliance by all members with the professional duties and rules enacted by the code of ethics. It also ensures the defense of honor and traditions of the medical profession. It gives its opinion to the public authorities as regards legislation and medical regulations in General on all matters affecting public health and medical course.

Organization

The National Council

The National Council includes:

- The eight (8) elected members of section A (medical officers or public services contract, body teacher from the Faculty of Medicine).
- The eight (8) members elected of section B (private doctors).
- Three (3) members who are:
  - The dean of the faculty of medicine.
  - The director of public health.
  - The director of health of the armed forces.
- A legal advisor (head judge).

The office

The office includes:

- A President.
- A Vice President, Secretary General.
- Two members.

The commissions

There are five (5) commissions:

- The commission of discipline and conflicts.
- The administrative and legal commission.
- The commission of board qualification and specialization.
- The social commission.
- The cultural and scientific commission.

The commission includes a President, a reporter and members.

The section councils

The A section Council members include:

World Medical Journal

- The eight (8) elected members.
- Three (3) representatives of the Ministry of Guardianship.
- A (1) representative of section B in section A.

The section B Council members include:
- The eight (8) elected members.
- Two (2) representatives of the Ministry of Guardianship.
- A (1) representative of section A in section B.

Other agencies

The national order of physicians in Senegal is a member of the national health research Ethics Board. This Committee has four (4) missions:
- Review of research protocols in health in order to ensure the protection of persons that lend themselves to research and scientific quality of collection and data analysis research.
- The issuance of ethical and scientific advice to the Minister for Health with a view to authorization, suspension or prohibition of the pursuit of a search.
- The supervision if there is place for health research.
- The conduct and development of reflection on the ethical and legal aspects arising from the practice of health research.

Conditions to practice medicine in Senegal

- Having the Senegalese nationality.
- Having the Senegalese diploma of doctor of medicine or an equivalent foreign degree recognized.
- Being entered on the roll of the sections of the College of Physicians except for the medical doctors belonging to the active frame of the army medical service Senegalese and foreign military physicians serving as military assistance.

Professeur M.L. SOW,
Président de l'Ordre

National Medical Council of the Democratic Republic of Congo

The National Medical Council has been created by order-law No. 68/070 of March 1, 1968, with the load and mission: defense, honor and the independence of the medical profession. It includes:
- the National Council (CNOM) and its office;
- the provincial Councils (COPROM) and their offices.

The National Council sees:
- To the respect and to the maintenance by all members of the principles of morality, integrity and devotion.
- To the observance by all physicians of their professional duties and rules of the medical deontology.
- To the defense of honor and the independence of the profession.
- To the protection of the population's health.

The physician in the Democratic Republic of Congo is an actor and sanitary operator of a preeminent and important place that imposes on him permanent requirements of knowledge, ethics, morality, dignity, professional independence and sharp sense of responsibility. He dedicates his life to the cause of humanity and the patient remains his first worry. For it, it is necessary that he has the character of a perfect honest man. Honor, dignity, noble traditions must always come with it when he practices his profession.

The Office of the National Council (CNOM) was elected at the 4th convention of the National Medical Council and took its functions on July 28, 2008 for five years. It is constituted by:

The Office is the organ of daily management of the National Council and as such:
Dr. Mbutuku: National President,
Dr. Kaswa: National Vice-President,
Dr. Sese: National Secretary,
Dr. Ebondo: National Associate Secretary,
Dr. Beya: National Treasurer.

National Council and as such:
- It elaborates the plan of action and the budget of the National Council.
- It executes the decisions of the plenary assembly.
- It manages the administrative and technical staff, the plenary assembly of the National Council.
- It coordinates the provincial Council activities.
- It raises the yearly and multi-year reports submitted for the approval of the plenary assembly.
- It initiates the internal and external audits for the improvement of its own management.
- It installs the Office elected from the permanent Commissions of the CNOM and of the COPROM.

The National President represents the National Council and all physicians of the country by the third in the acts of civil life. The National Vice-president helps him and replaces him in case of obstacles. He supervises the general administration, notably the heritage, the bursary, the maintenance and the staff. The National Secretary is put in charge of the secretariat of the Council with a mission and load:
- To look after the good holding and the updating of the Picture of the Council, of the cards of identity of the members and in general of all archives of the Council.
- To conduct the correspondence of the Council that he signs together with the President.

The National Associate Secretary helps the latter and replaces him in case of obstacles.

The Treasurer looks after the good holding and the updating of the financial affairs and the books necessary for accounting.

Dr. Kaswa, National Vice-President

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World Medical Journal

Initiative from Latvian Medical Association

Knowledge and Habits

Latvian Medical Association together with Public Institute to arouse extra motivation in the minds of the population of Latvia to choose healthy foods and make "unhealthy ones" less available to the public.

An extensive study has been performed to determine the main educational and motivational directions that should be introduced in Latvia. A special computer program for the diagnosis of the excess weight was developed. The program is able to determine the knowledge level concerning theoretical excess weight issues for each particular individual, impact of his or her practical actions onto weight fluctuations, as well as mark the psychological attitude of the individual towards the excess weight problem in general.

The user of the program provides answers to 210 questions. In total 31 topics are covered: appetite, breakfast, diet and sports, fats, nutrition, food shopping, sweets, salt, metabolism, and other.

Participants received individual excess weight diagnostics free of charge, based on the answers they provided. Diagnostics included not only the above mentioned results, but also individually tailored practical recommendations about what should be implemented in their daily routine so that they could control their weight successfully.

More than 6000 participants applied for the study within two months. Comparing the number of the participants in the study with the number of inhabitants of Latvia, the proportion was as 800 000 people had been surveyed in the USA.

The general level of knowledge about the weight reduction issues in Latvia is very good – on average 76% of all answers to the theoretical questions were correct. The situation was different with the questions about practical actions; here the percentage of correct answers reached only 40%. In order to make a comparison on what are the most sensitive topics from the point of view of knowledge and implementation of knowledge in everyday life, a term "voice of conscience ratio" was developed. It determines what proportion of the knowledge people possess they actually use in their daily routine. People follow only 1/2 of what they know about excess weight issues. In the topics on shopping, appetite, consuption of healthy food respondents reval that they follow hardly 1/5 of the information they possess.

The study results prove that knowledge alone is not enough to make people live healthier lives. To persuade people to change their lifestyle, additional activities for motivation should be sought.

Find full description of the study in English at page www.dietillustrated.com

Antimicrobial Resistance

EFMA in cooperation with the WHO have set up a joint workgroup on antimicrobial resistance. We would like to bring this important issue to your attention and encourage you to act to promote it to the doctors in your country.

Antimicrobial resistance is continuing to increase throughout the world and has become a serious threat to public health. Approximately 400.000 patients in Europe are annually reported, to suffer from infections which are resistant to antibiotics. It is estimated that within the EU about 25.000 patients each year die from resistant infections. Such data shows that antibiotic resistance remains a public health problem across the European Region.

Prudent use of antibiotics can help stop resistant bacteria from developing and help keep antibiotics effective for the use of future generations. We encourage you to make efforts at national level to reduce unnecessary antibiotic use.

For more information on this topic, we suggest you look at the ECDC website: *http://www.ecdc.europa.eu/en/eaad/pages/home.aspx*

The ECDC has been working on the issue of antibiotic resistance and prepared various information documents in coordination with Antibiotics Awareness day. In preparation for World Health Day, on the 7th April, which will be focused on antimicrobial resistance, we suggest that you start to act in the following areas:

- Increase awareness of the problem of Anti-bacterial resistance
- Promote publications in your medical journals on this issue
- Organise press conferences in your region on World Health Day
- Make contact with experts in the area and encourage the development of committees to work in the areas of surveillance, promotion and protocol.

I would appreciate it if you would please keep us informed of your actions.

Leah Wapner
Secretary General
EFMA-WHO

Contents