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THE EUROPEAN FORUM OF MEDICAL ASSOCIATIONS AND WHO

Report on a Meeting

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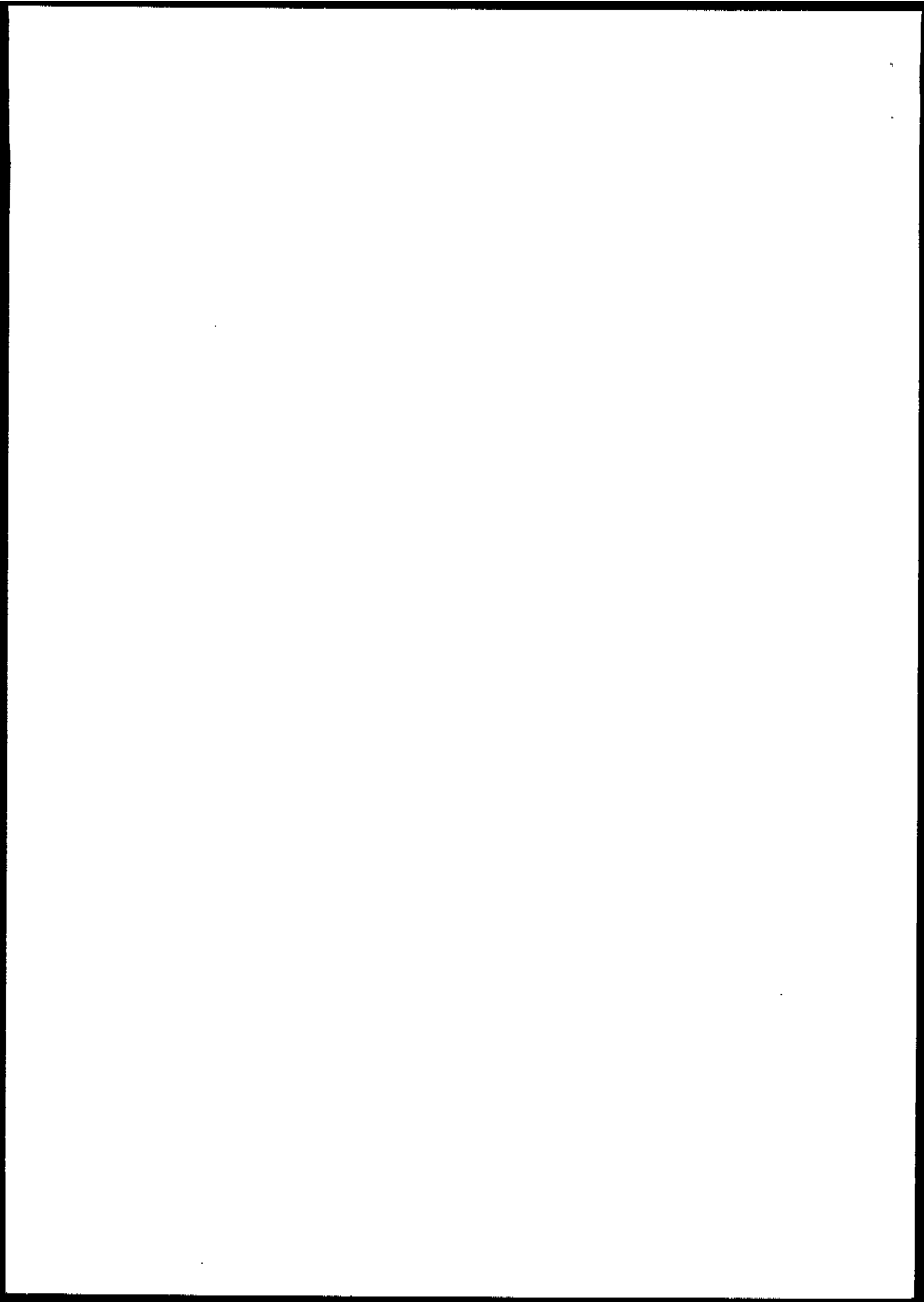
By the year 2000, in all Member States, a wide range of organizations and groups throughout the public, private and voluntary sectors should be actively contributing to the achievement of health for all.

Keywords

SOCIETIES, MEDICAL
HEALTH CARE REFORM
HEALTH POLICY – trends
SMOKING – prevention and control
HEPATITIS B
HEPATITIS C
EXPOSED POPULATION
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CCEE

Contents

	<u>Page</u>
Introduction	3
The state of the European Region	4
Policies for health - the role of Medical Associations	6
WHO activities in the European Region 1994	6
United Kingdom's "Health of the Nation" initiative	7
Role of NMAs in advising on health policies	8
Liaison Committee report	14
Reports from National Medical Associations	17
Alcohol, health and society - an issue for 1995	18
Quality of Care Development Action Group report	18
Tobacco and Health Action Group report	19
Future of the medical profession: role and resources - implications for the 21 st century	20
Next Forum	23
Note of Post-Forum Meeting with Central and Eastern European Countries and Newly Independent States representatives of NMAs and Emerging Organisations	24
ANNEX 1 (Statements)	
- Statement on Health policies	36
- Statement on Tobacco and Health	37
- Statement on Hepatitis B and C	38
- Statement on War-Devastated Populations	39
ANNEX 2 (List of participants)	40



Introduction

This report was the tenth in the series of annual dialogues between national medical associations in Europe and the World Health Organization, which followed the preliminary meeting in Copenhagen in 1984. The discussions were instituted as a forum at a meeting hosted by the Finnish Medical Association in Helsinki in 1991 and associations formally met as a forum hosted by the Swiss Medical Association in Basle in 1992. Following successful meetings in Utrecht, hosted by the Royal Dutch Medical Association in 1993, and Budapest, hosted by the Federation of the Hungarian Medical Societies (MOTESZ) in 1994, this report deals with the fourth Forum meeting hosted by the British Medical Association in London. The two-day meeting covered a wide variety of topics and was followed by a post-meeting (see programme and agenda annex). The meetings were pan-European and once again more countries than ever before were represented by their medical associations, the increase being attributable to greater numbers from newly independent states in Central and Eastern Europe (see final list of participants annex).

Dr Macara, Chairman of Council of the British Medical Association (BMA), in welcoming the participants to London, noted with satisfaction the continued growth in attendance. He particularly welcomed the representatives from Georgia, which he had visited recently and learned of the appalling conditions there following the collapse of the health care infrastructure - a problem shared to a varying extent by other member countries. He noted that apologies for absence had been received from Albania, Bosnia and Herzegovina, Luxembourg, Finland and Iceland, and congratulated Regional WHO Director, Dr J.E. Asvall, on his reappointment for five years.

The Secretary of State for Health in the UK, Mrs Virginia Bottomley, welcomed all those attending in the name of the British Government, making particular reference to those from Central and Eastern Europe. She particularly applauded the European Region of WHO and Dr Asvall. She emphasised the importance of the Forum, saying that it indicated the extent to which the challenges facing health care were being met through shared experience and understanding. All countries benefited from this process, learning better to use their resources to improve not only health services, but the health of their populations. Britain had been reforming its health service, trying to improve efficiency and address long-standing difficulties inherent in a bureaucratic organisation which was

not always sensitive enough to patients' interests, while safeguarding the principle of universal access for all, free at point of need. She noted that many newly-democratic countries were introducing market elements and managed health care. Patients were becoming more assertive everywhere, and this had implications for national medical associations, putting far greater demands on those delivering health care. Britain had set itself strategic health objectives which were constantly monitored and which focused on prevention. For example, monitoring systems had identified growing vulnerability in measles among children, and an epidemic of 200,000 cases with 50 deaths was feared during the winter of 1994-95. To avoid this, eight million children were vaccinated and only six deaths occurred, all in unvaccinated children.

Scientific advance had been responsible for enabling people to live longer, but it had raised many ethical questions. In this respect, the BMA document "Core Values for the Medical Profession in the 21st Century" had identified many of the critical issues facing medicine today and tomorrow. Ministers should think first of the health of the nation, and deploy their resources to improve it.

The state of the European Region

Dr J.E. Asvall, Regional Director, WHO Europe, thanked the British Medical Association for its support of both WHO and the Forum. He said that the meeting came at a fascinating time in the development of Europe. Within the Region, 20 new countries had emerged since the collapse of the communist system, each faced immediately with tremendous changes of which the health service sector had been among the most important.

For the countries of Central and Eastern Europe there had been clear signs of improvement in most since the upheaval, with a growing gross national product (GNP) in several and in some, such as Slovenia, a rapid decline in unemployment. Some of the countries of the former Yugoslavia provided sad exceptions to this, in particular Bosnia/Herzegovina, Serbia/Montenegro and to some extent Croatia. In Croatia and Bosnia and Herzegovina the war had led to 150,000-200,000 killed, tens of thousands severely disabled, hundreds of thousands wounded, perhaps 4 million displaced, and major collapse of the national economy. In the newly independent states (NIS) emerging from the former Soviet Union, except for the three Baltic states, the situation remained bleak. For example, Kyrgyzstan had lost approximately 40% of its GNP in the last four years. Georgia had been ravaged

by three civil wars, had virtually no state economy and no assured basis for funding a health care system.

Life expectancy in the countries of Central and Eastern Europe, which had stagnated or fallen, was now rising again in some countries. However, in the NIS such as Estonia, Kazakhstan, Lithuania and the Russian Federation, life expectancy had fallen back to levels of decades ago. Identifiable contributors to this trend included a high incidence of cardiovascular disease, more cancer, more suicides, a rapid increase in accidents and more violence (much of it related to alcohol or drugs). Previously controlled diseases such as diphtheria were also returning, while health budgets were cut drastically - in Kyrgyzstan, for example, to 12% of the level five years ago.

Parallel with these developments, the recession in west European countries had continued, exacerbating unemployment and the medical problems associated with it. Some 15% of the Western European population was below the poverty level. Social tensions between ethnic groups had also led to increased violence. Unemployment rose from 8% in 1991 to over 11% in 1994. However, the political development of the European Union had exemplified the way in which countries could come closer together, setting mutually supportive development objectives.

These and other factors had led to a much sharper focus on the way that countries had been organising their health services, with debate ranging far outside the health care field into areas which influence health less directly, such as industry, trade, education, information, transport, etc. A strategic view was extremely important, but in many countries the national medical associations were still not involved enough in public debate. They needed to be much more active in making themselves not only accepted but indispensable in efforts to formulate national and regional policy and programmes in health. They also had to prepare themselves better to answer the tough questions which were being asked, relying more on data and less on experience and professional reputation. Every NMA should have readily available information which might be needed to take forward the debate; if the information exists, it must be collected and if not, research should be carried out. The Forum could play a useful role in helping to design models which could be used by the member associations.

The British government had one of the best national health policies in Europe, in the form of the British "Health of the

Nation" document. WHO was now working on similar policies with several other countries.

Policies for Health - The Role of Medical Associations

Discussing health in the European Union (EU), Professor J.-F. Girard said that it was possible to contemplate such a thing as European health, at least in the socio-cultural sense. Some 95% of citizens in the EU believed that their health was good or fair, while the image of health, in matters such as cancer, was homogeneous, although national beliefs might colour the way in which the factors constituting good or poor health were viewed. There were many demands on health care which could be deemed identical throughout the EU, such as seeking the facts about toxic substances in mattresses causing cot deaths, where international cooperation resulted in shared research. In regard to alcoholism, whisky and schnapps were little different. At an international level, there was considerable cooperation in matters like research into cancer and AIDS, while the Maastricht treaty contained the first mention of public health at the EU level.

However, even though there was a clear indication that the term 'health of the EU' could be considered, was it a worthwhile concept, and should integration in this respect be quicker? An answer to this question would not be possible until the future composition of the EU was known: the definition of 'health' must also be made more clear. Health experts must be more closely involved in developing health policies at government level, for otherwise they might be tailored to fiscal requirements rather than the needs of the population. A more mature approach would only become possible as partnership developed between politicians and the medical profession. If policies were adopted without taking the users into account, they would be ineffective. All NMAs must pull together - and the Forum was proof that they were able to do so.

WHO Activities in the European Region in 1994

Dr Asvall said that the situation was changing in Central and Eastern Europe, with GNP returning towards previous levels after a severe decline. Crime was increasing in the NIS and life expectancy was falling, raising profound issues. In 1994, eight countries in Europe were affected by war, but a positive action was the ceasefire between the Bosnian and Serb and Croat forces to improve humanitarian aspects of the conflict and achieve public health protection. Previous vaccination

programmes had broken down in many countries, while basic environmental health services and installations had increasing problems in functioning. This had led to a rise in infectious diseases including poliomyelitis, diphtheria and cholera.

WHO had provided humanitarian assistance to war-torn countries, particularly the countries of the former Yugoslavia; it had instituted health promotive and preventive efforts such as a programme to enhance breast-feeding, cooperation with UNICEF in vaccination programmes and a survey to draw up projects to improve water supply and sanitation in 30 Bosnian towns. There was also a master plan for reconstruction of Croatian health services after the war. In addition, leaders of the warring factions had been drawn together to discuss cooperation in health.

In other countries, efforts had continued to encourage them to formulate their own national health for all policies. Donor-nations had provided vaccines to enable mass poliomyelitis vaccination programmes aimed at more than 63 million children to be carried out.

Family health issues, quality of care, environmental health, lifestyle, smoking, alcohol and drug abuse, nutrition and women's health had also received special attention. WHO was committed to strengthening its public health leadership in the world.

England's "Health of the Nation" initiative

Dr Kenneth Calman, Chief Medical Officer for England, discussed the Health of the Nation, which sets strategic targets for England. Published in 1991, the document selected five key areas for action:

- Coronary heart disease and stroke;
- Cancers;
- mental illness;
- HIV/AIDS and sexual health;
- Accidents.

It set national objectives and 27 targets within the key areas, indicated the action needed to achieve the targets; outlined initiatives to help implement the strategy and set the framework for monitoring, development and review. The strategy had since been overseen by a cabinet committee involving 12 departments (ministries), to take the strategy forward, oversee

government action and coordinate policies. It started from the premise of achieving health for all, but also aimed to ensure that health was achieved by all. Some 24 of the initiatives were going well, but three were still causing significant concern. These were smoking - particularly among young girls - suicide in young men and obesity. The keys to improving the health of the nation were healthy settings, such as the healthy hospital or the healthy prison, and health alliances, for example with sports authorities to improve exercise and reduce obesity, or with the community in terms of supplying a healthier diet. Ethnic minorities had particular health needs which had to be addressed.

Physicians had a leading part to play in health promotion. For example, they should present public health reports on individual populations to identify any special health problems. An information package was made available to hospital doctors to enlist their support in this aim. Primary care - the general practitioner - was the mainstay of the British health service and medical education was the key to change. Backing this must be a research and development strategy, such as the British "Research for Health" document.

The future should see physicians becoming more concerned with health than illness, but Hygeia would provide a better model than Panacea.

Role of NMAs in Advising on Health Policies

The Forum divided into three language-based working groups, to consider the role of NMAs in the formulation of national health policies.

The English/German group agreed that NMAs must and do have a role in advising on the formulation of health policies, and that this was something which bodies such as the EFMA should support and encourage in countries where new policies were evolving. This advice should be given whether or not it was solicited. NMAs should also react to proposals for new legislation, and initiate debate on issues such as tobacco and alcohol, where governments had not yet chosen to act.

The group recognised the dilemmas involved in taking "political" decisions, priority setting, and whether NMAs should only present scientific facts, allowing others to take decisions based on those facts, or whether they should express views which might not be heeded by policy-makers. In giving

advice, NMAs must accept some responsibility for decisions based upon it, but the majority felt there was a duty to speak out.

There might never be unanimity, but majority votes were a feature of democracy. NMAs could play an important role in promoting consensus views, which were hard to ignore. The Norwegian delegation described an interesting exercise in which the NMA had set up a working group to draw up policy and had invited medically qualified politicians from a variety of backgrounds to participate as *doctors*, thus enabling them to put forward views which differed from their "political" opinions.

In the same spirit, NMAs should liaise with other professional groups and patients' organisations, where appropriate, not only formulating policies but promoting them to the public, from whose support they will benefit. This would demonstrate the medical profession's ability and will to act beyond its own sphere of interest, thus strengthening its case on broad health policy issues. The differing democratic mechanisms for devising and implementing policy within NMAs, and the differing types of national health policy would also influence approaches.

NMAs should encourage their members to implement health policies; for example, those relating to smoking and drinking habits. However, individuals should be persuaded rather than coerced into a healthy lifestyle. Political consensus decisions should be accepted in the same way as were clinical consensus decisions.

The Russian Group agreed that NMAs should be prepared to take part in discussion and offer constructive criticism on health policy. In principle they should be prepared to oppose actively governments which proposed health policies which were ill-thought out or not in the public interest. In practical terms the ability of NMAs to carry out this task successfully was often limited by an unstable and constantly changing political scene.

The group felt that NMAs had an active role in formulating health policy. Even in difficult circumstances progress could be made, as had been the case in Estonia, Kazakhstan and the Russian Federation. NMAs must learn to use the political system, to make alliances with the public, patients, fellow professionals and government departments.

NMAs had various mechanisms to ensure that they were aware of their members' feelings in formulating or commenting on health policy. These included conferences, meetings, journals, newspapers and a structure which provided regional and local chambers.

NMAs should take an active role in encouraging their members to implement health policy. In this role there were places for incentives and honours, prizes, a reward system, education and reaccreditation, with a link to continuing medical education.

Health policy formulation depended on persuading governments to provide a fair "slice of the cake", but in some countries of the old Soviet Union there was no "cake" to divide: this underlined a fundamental difference between those countries and the Western democracies. The spectrum of development encompassed political, professional and organisational matters. Common problems in health care included cost, priorities and issues of quality.

The French Group considered that NMAs had a fundamental role in influencing health policy in every country. They considered that the medical profession should be in permanent dialogue with government - in both proactive and reactive fashion. In order to achieve this, the medical profession must be united, resisting the tendency of governments to divide them, with a message of truth and quality that the public could understand, and which the media would accept as authoritative.

NMAs believed that public health priorities varied between countries, according to their cultural, social and economic standards. For example, in Central and Eastern European countries, the priority ought to be to provide citizens with minimum standards of hygiene for life, such as drinkable water, heating and nutrition, rather than pursuing public health themes such as alcoholism or smoking. Nevertheless, doctors should encourage the population to receive vaccinations and to moderate smoking and drinking.

Finally, the spirit of the profession - passion, courage, competence and knowledge - would progressively change the point of view of both physicians and citizens towards a more global view of health. In this respect, exchange of views, criticisms and questions between NMAs both in Eastern and Western Europe should be encouraged, not only to enrich discussion but also to contribute to quality of care.

The freedom of individuals in their way of life was an essential condition for establishing health policies, which demanded collaboration of all sectors, particularly political (government and/or parliament), the insurance authorities (health insurance funds or private insurances) and the medical authorities; the distribution of roles should perhaps be defined contractually following collective agreement on exact objectives.

Discussion

The Czech Republic pointed out that, in contrast to those countries with democratic traditions, in Eastern Europe health care reforms represented substantial change. Policy was still being evolved in the Czech Republic, hampered by frequent changes of health minister, but involving the Ministry of Public Health, the Czech Medical Association and the Medical Chamber. Increasing emphasis was being placed on the responsibility of the individual, a functioning system of quality assurance was being developed, and the privatisation of doctors was being contained.

Health policies in Portugal were established by the Ministry of Health; of the 44 specialised committees in the NMA, only some were involved in policy development, chiefly in the areas of medical education and quality of care, although the NMA had many representatives on Ministry committees. The Association was deeply involved in environmental health, including such matters as smoking and quality of care. The enforced use of generic drugs had been resisted until better standards of quality control could be instituted, as had been a move to allow pharmacists to substitute similar medicines on prescriptions. The unity of the profession had given it strength in negotiations with government.

The healthcare system in Germany was very different from the United Kingdom, where public health insurance was included in healthcare policies, leading to different outcomes. The self-governing organisations of doctors were strongly integrated when negotiation with government was involved and this had proved effective.

In France, public health policy was shared between government and consultative opinion. GPs were in the foreground of public health initiatives, including vaccination, contraception and smoking, with one particular strength being regional decentralisation which allowed better targeting of advice. On a

national level, the NMA was deeply involved in health education, such as smoking, alcoholism, coronary heart disease prevention and reduction of road traffic accidents.

In Norway, while promoting health, the medical profession did not neglect its role in caring for the sick. Health for All could imply a personal responsibility on individuals to the extent that they might be blamed for illness. This political trend, affecting the poor and the elderly, was potentially dangerous. The medical profession must recognise the scientific basis of health care and determine what measures were effective, and there must then be the will to carry them out. Alternative medicine was not an option: one did not seek an alternative electrician or plumber. The NMA had been active in preventive medicine, in areas such as smoking.

In Britain, the Health of the Nation had proved a most important initiative. Health had become a matter for everyone, for now individuals knew that their lifestyle might cause future illness. One potential danger, however, was that focusing on relatively narrow issues might narrow the vision of the health authorities. Another was that in setting targets one neglected individuals. A third potential problem was that the targets did not have a strong emphasis on children, on whom the future of any health service must focus - the future adult population. The British Medical Association had provided a forum for medical attitudes, and a strong influence on governments.

Poland reported an emerging problem - the multiplication of medical societies, each representing narrow interests and thus having less influence. The voice of the medical profession was in danger of becoming less influential because unanimity was more difficult to achieve. Despite this, the Federation of Polish Medical Associations had prepared video cassettes on medical education, for use both in hospitals and schools. The country was involved in preparing a new constitution, but in some proposed models there was no mention of health.

Despite the loss of many doctors in Georgia, the Georgian Medical Association still worked to defend the rights of the profession. The GMA hoped to be able to improve the working environment and was pressing for salaries to be improved from the present very low level.

The Israeli Medical Association worked very closely with government and was actively involved in improving the quality

of care. The IMA had been consulted during the drafting of a law on patients' rights.

In Lithuania the NMA was involved right from the start in forming health policies based on Health for All. The laws relating to the healthcare system had been based on the same principles. At both national and international level the role of NMAs must increase, for doctors within the health care system must influence healthcare policies. The balance of services provided must always relate to limitations on resources, which would differ between Eastern and Western Europe.

The Medical Association of the Ukraine was very concerned with protecting doctors' rights, in the presence of a growing crisis in healthcare, linked to the political and economic crisis. Reform so far had remained more myth than reality, but the intention was to place more emphasis on primary care, while increasing the quality of care. The government was being pressed to enact special laws to enhance the fight against infectious disease and improve the take-up of vaccination, thus improving the poor current situation.

Dr Asvall summarized, agreeing that there were huge problems, particularly in the East. Cultures and traditions might differ, but every country should focus on its basic health problems and their solutions, then working backwards to organise strategies for implementation. There appeared to be little disagreement about strategies for improvement. The organisation of a health service could take many different forms, and argument at that level - for example, whether the service should be private - led to conflict rather than progress. Examples of initiatives showed that NMAs had many ways to involve themselves more extensively at policy level.

This was a moment in history where in some ways health care was deteriorating, being taken over by blind and soulless market forces. NMAs could not allow their role to be decided by market forces alone. These forces could be harnessed, but they must not be allowed to develop unchecked.

It was hard to move the healthcare stone up the mountain, although strength and motivation helped, but decreasing the slope made the task easier. A healthy lifestyle was chosen as the goal, culture and conditions conditioned the means, and a major emphasis should be placed on the conditions that influenced choices in society.

Liaison Committee Report

Dr A.J. Rowe, Secretary of the Liaison Committee, presented the report to the Forum, stating that the Committee had met three times during the previous year, in Paris, Stockholm and London. The Committee expressed its gratitude to the Ordre des Medecins Francaise, the Swedish Medical Association and the British Medical Association for hosting the meetings. The committee had welcomed Professor Wieslaw Jedrzejczak, who replaced Professor Crusciel in representing the Polish Medical Association, and congratulated Dr Asvall on being re-elected Regional Director of WHO.

Following the adoption by the Forum in Budapest of the statement on humanitarian assistance to the war-devastated populations in the countries of the former Yugoslavia, there had been a further meeting between representatives of NMAs in the affected areas. The Nordic group, and the Norwegian Medical Association in particular, played a key part in this process. The French Medical Association, together with other bodies, had launched an initiative in receiving amputees from some of the war zones in the former Yugoslavia and assisting in their rehabilitation. The Committee also supported the encouragement of NMAs to follow the example of the BMA in writing to their governments about this problem and offering assistance where this was possible.

A working party had been set up by WHO to examine rebuilding of the healthcare system when the armed conflict ceased. It also decided that fellowships to provide a break for physicians and permit exchange of experience should be encouraged and that NMAs should be asked to assist in this process where possible.

There was concern that in Bosnia no salaries at all had been paid to doctors since January, and that a very similar situation applied in Georgia. The President of the Forum, Dr Macara, had attended the annual meeting of the Georgian Medical Association and was very concerned about its situation. Dr Macfadyen announced that an appeal to donor organisations was being made to raise funding for immunisation, public health activities, nutritional assessment and essential drugs.

The Committee learned that a formal meeting had taken place between the BMA and the European Regional Office, resulting in agreement for the BMA to establish a coordinating centre for the activities of NMAs in tobacco control. The BMA was to

prepare a business plan and report to the Forum at its next meeting on the best way to proceed. Meanwhile, it was noted that the tobacco action group had met during the World Conference on Tobacco in Paris in October 1994. The further development of the Tobacco Action Plan would depend on funding, which was being sought.

Following the Forum's statements on infectious diseases and immunisation of children, the Committee was pleased to learn that these had been reported both to the Executive Committee and the Regional Committee of WHO, and had been influential in the discussion on this subject. A special initiative was taking place in the Region on this subject. Following a decision of the Committee, the statements of the Forum were sent to the Council of Europe, which expressed a continuing interest in the deliberations of the Forum.

At the Stockholm meeting, the Committee was informed of a further case report concerning the transmission of hepatitis B by an infected surgeon in the UK. After a debate the Committee agreed that, in view of the significant risk (Dr Begg reported to the Budapest Forum that he believed the number of cases to be very much under-reported) consideration should be given to preparing a statement for the Forum at its next meeting. It was agreed that the BMA should produce this. In a supplementary report, Dr Rowe said that the Committee had agreed to submit a resolution for a statement on hepatitis B and C to the Forum. This was later adopted (See Annex).

It was noted that where armed conflict continued in Afghanistan, a two months' "ceasefire" had been negotiated and had continued, in order that the population, all families, women and children, could be immunised against diseases that were threatening the population. The Committee believed that this should be drawn to the attention of the Forum. The Committee expressed its gravest concern that armed conflict in the Region, notably but not uniquely in the former Yugoslavia, continued to inflict substantial pain and suffering on innocent civilian populations. This included an increased risk of widespread infectious diseases due to substantial breakdown of health services and immunisation programmes. It agreed to prepare a further draft statement, which was later adopted. Later, a resolution on this subject was adopted (See Annex).

The Committee received a report on the meeting of the Regional Committee and learned with pleasure that the Forum's statement on the former Yugoslavia was particularly helpful in a

discussion in which a resolution was adopted, reaffirming the role of WHO to serve all populations without discrimination. Cooperation and collaboration with the European Union was increasing, and WHO attended a meeting of the Health Council for the first time. In connection with collaboration with the Council of Europe, the Committee was reminded that its major area of interest was patients' rights, and that it also had interests in the respect for minorities. In relation to the technical discussion in the Regional Committee, it was pointed out that there had been a session on principles of ethics and equity in relation to healthcare.

Dr van Leeuwen presented a report on the Amsterdam consultation on the rights of patients. The document had no official standing yet, but it would be suitable for consideration by the Forum in 1996.

The Committee agreed to recommend to the Forum that, whether or not participating medical associations from any member state paid a contribution to the Forum, any NMA bringing a third participant should pay a half contribution to the Forum (ECU400).

As London was the tenth meeting of the Forum and as many CCEEs' and NISS' new medical associations had emerged over the past few years and might now have reached the point at which they fulfilled the criteria for Forum membership, the Liaison Committee felt that those NMAs would wish to regularise their position. It therefore proposed that the secretary should write to all participant non-members, drawing their attention to the criteria for membership and inviting them to apply for membership formally.

The Committee recommended acceptance as observers of the European Association of Hospital Doctors, but felt that a body concerned with catastrophe medicine, which had made a similar request, represented too narrow an interest. In future, the Host President will continue *ex officio* as a member of the Committee for the following year. The size of the Committee was considered, and would be reviewed again in a year after NMAs had considered their positions as full members of the Forum. Following correspondence with the Royal Dutch Medical Association, the Committee considered the relationship between the Forum and the World Medical Association. It was strongly felt that, at present, each had its own distinctive role, but the situation should be reviewed in three years.

Representatives of the Europharm Forum and the Standing Committee of Nurses were invited to attend the next meeting of the Forum.

The Swedish Medical Association had offered to host the 1996 Forum. Suggestions for subjects included patients' rights, substance abuse, funding developments in healthcare and women's health.

Reports from National Medical Associations

This item was presented by Drs Haffner and Vigen, who had prepared questionnaires, analysed them and produced a document: "Reports from National Medical Associations".

In summary they said that all NMAs in the Region were asked to update information about activities related to continuing medical education (CME), quality of care developments (QCD), tobacco consumption and HIV. In addition, a separate questionnaire was prepared on drug abuse. A total of 33 NMAs representing 25 countries submitted information. New CME initiatives had been taken by 16 NMAs, and 6 reported new developments in their countries. New initiatives relating to QCD had been taken by 18 NMAs, and 16 reported that they were actively engaged in QCD projects. Sixteen NMAs were engaged in activities to reduce tobacco consumption. New initiatives related to HIV were undertaken by 4 NMAs in 1995. Only three reported that there were restrictions on the professional activities of doctors who were HIV positive. (Ireland, Italy and UK).

Drug abuse information was submitted by 31 NMAs, representing 24 countries. Nine NMAs were actively involved in preventing drug abuse in the public, eight in treatment of drug abusers. A register of doctors abusing drugs apparently existed only in Hungary and Luxembourg. Only two NMAs had programmes for helping doctors who abuse drugs (Denmark and the Netherlands).

Information about medical manpower (requested by mistake) was sent by 13 NMAs. The ratio between doctors registered and medical students graduating every year varied widely, as did the ratio between specialists and doctors in training grades. Unemployed doctors were reported in 7 of the 11 countries which responded, but there were vacancies in 4 of these. Some reports indicated that there were more doctors, and more unemployment, in urban than in rural areas. Subsequent discussion elicited

information from several other NMAs, emphasising the widely disparate picture of medical unemployment.

Alcohol, health and society - an issue for 1995

Dr Peter Anderson addressed the forum, asking why alcohol was an issue which challenged the medical profession; what could be done; and what was the physician's role. He said that alcohol was very costly as a public health issue and also affected the individual, the family and society. Conditions vary between countries: in Western Europe there was a stable or falling incidence of high alcohol consumption, while in Eastern Europe the incidence was rising rapidly. Alcohol was responsible for 6% of all deaths, but in Ukraine during 1990-93, there were 800,000 preventable deaths and in Russia perhaps two-thirds of deaths were related to alcohol. Across all ranges, greater consumption led to greater harm; there was no lower threshold. The reduced risk of coronary heart disease (CHD) associated with moderate alcohol consumption in people aged <50 years had to be balanced with other alcohol-related problems. The issue of alcohol and CHD was not significant at a population level.

It had been demonstrated that controls on advertising and higher cost of alcohol saved lives. Taxation not only saved lives but provided revenue to combat alcohol problems.

The role of the physician was similar to that in smoking cessation. Doctors must be trained to help people change their lifestyles in many ways, including the consumption of alcohol. Even brief interventions by a GP had a beneficial effect, although reinforcement improves outcome.

Quality of Care Development Action Group

A report was presented, prepared by Drs Vigen and Rowe. It stated that many parties had an interest in QCD, including physicians and other health professionals, patients, health insurers and authorities. There was an urgent need for a glossary of QCD terminology in at least the four languages used in the Forum. The action group recommended that a short booklet should be produced on the philosophy and simple principles of QCD, also explaining how to engage in it.

The St Vincent diabetic QCD had been commended and widely implemented in the European Region. The QCD Action Group recommended NMAs to make contact with any implementation in their own countries and encourage their members to take part,

thus making them better acquainted with QCD. NMAs must recognise the importance of good record keeping, based on the day-to-day work of physicians, as a basis of good quality medical data. The transparency of medical acts was essential for QCD, but this demands a guarantee of confidentiality of data, both for patient and physician. To this end, data from QCD reported to the health authorities or insurers must only be reported by physicians as aggregated data.

Patient input was important to QCD. NMAs should provide members with information about the appropriate instruments to be used in evaluation of patient satisfaction with medical services. Only when NMAs had established a climate of professional duty to engage in QCD activities should they attempt widespread implementation of the second part of the Budapest statement on QCD. A conference on further development of QCD was recommended before the next Forum.

The discussion showed that individual countries were involved in numerous initiatives, including a perinatal care initiative in the Czech Republic which had led to perinatal mortality incidence falling to rates comparable with Western European countries. For two years, the Portuguese Medical Association had led moves to improve quality in general practice, and was now seeking accreditation for specialists in primary care. The European Union of Medical Specialists had developed charters for training and CME, soon to be followed by one for Quality Assurance, which laid down approaches to good practice. Delegates were reminded of the importance of cooperation with nurses and other health professionals in QCD activities.

Action Group on Tobacco or Health

Following the Budapest Forum and its adoption of a statement on tobacco and health, WHO invited representatives of the BMA to a meeting in Copenhagen to discuss the BMA's role in the tobacco area. The BMA agreed in principle to coordinate tobacco control activities by NMAs throughout Europe, to examine existing written material on tobacco control with a view to updating them, and that the WHO would designate the BMA a coordinating centre for these activities.

The action group met during the Paris meeting of the World Tobacco or Health conference, and representatives of 11 NMAs attended. Among the action points agreed were that the BMA should act as a resource centre collecting information on existing tobacco control policies in NMAs; existing EFMA

policies on tobacco should be translated and made available to members associations of EFMA; the BMA should coordinate missions to visit NMAs requesting help in specific policy areas; that the BMA should identify expertise in NMAs willing to assist in these missions; and the BMA should seek funding for these activities.

The BMA had investigated a number of potential sources for funding, including a current application to the Europe Against Cancer programme. Member associations were asked to audit their own policies and activities on tobacco in relation to EFMA/WHO statements. A further meeting of representatives of NMAs would be called when adequate funding had been secured, and the BMA would meanwhile act as a coordinating centre for activities.

During the discussion NMAs were reminded that they should lead in anti-smoking policies; for example forbidding smoking on their premises, or at most designating a smoke-free zone. Several countries, including Germany, Israel, France and UK reported the progress they were making, while Dr Macfadyen reminded NMAs that their mandate was to persuade rather than direct.

Future of the medical profession: role and resources - implications for the 21st century

Dr F.U. Montgomery said that future development depends on realism in the present situation. Countries must reduce morbidity and mortality and link with environmental protection. Their role must be the protection, promotion and maintenance of health. In Western European states there were policies for cost reduction and control, as in Germany where a deficit had been turned to surplus, but rationing had mainly been in terms of priorities rather than quality of care. There had been a tendency, also, for privatised profits and socialised losses. Enormous pressures had been generated in Germany by reunification, but in health terms it was now difficult to distinguish between east and west. In Western Europe financial pressure had been applied mainly on the hospital service, leading to poor buildings, overwork, high staff sickness rates and eventual burnout. The workplace must be humane: a health service could be destroyed by emphasising the ethical responsibilities of staff without providing the resources to carry them out. Focusing on cost alone, and reducing it everywhere, had detrimental side-effects. Staffing crises were now inevitable in many countries, for there had been over-

correction of past tendencies to produce too many doctors. Reactions must remain flexible because, while strategies must be global, the social and cultural differences within Europe were so large that action can only be at local level.

Professor M. Manciaux said that, in order to make sensible predictions, numerous questions must be answered, including:

- What was the most desirable proportion of doctors to population?
- What should be the proportion of GPs to specialists?
- What should be done to overcome inequalities in morbidity, prevalence of major diseases, access to care and mortality between different population groups, regions and countries?
- In health forecasting, how can one allow for the uncertainties of future scientific advance?
- How should forecasters allow for the changes now taking place in socio-demographic, socioeconomic and sociocultural make-up of the peoples in Eastern Europe, or bordering on Central and Eastern Europe, which had been undergoing radical change in the last five years?
- What will be the impact of current trends in the medical profession on the future of society?
- What will be the impact of current social trends on the future of the medical profession?

The current situation might appear catastrophic, but the key to change lay in training. The future ideal doctor would be expected to assess and improve the quality of care; make optimal use of new technologies; promote healthy lifestyles; reconcile individual and community health requirements; and work efficiently in teams. Suitable training would include a stronger connection between the medical curriculum and national health policy.

Dr D. M. Macfadyen pointed out that no scenario for the year 2000 envisioned medical advance in purely technological terms. All included ennobling objectives aspiring to improve the physical, mental, social and spiritual domains. However, instead of progressing towards meeting goals, in some countries the battle was to prevent the situation reverting to the past, in terms of infectious disease for example. Despite this, health goals can be achieved.

In the 21st century, health progress in Europe would be increasingly measured by quality of care measures,

consolidating the 20th century progress in human existence, but healthcare advance was contingent upon social change, particularly the role and professional opportunities for women. The quality of life would increasingly focus on the disabled and the "old old". Health futures methodology must proceed with a process of visioning, followed by scanning of developing technologies and leading to the development of alternative scenarios, bringing a practical application to the exercise.

Beyond the year 2000, altruism would remain a dominant value of the medical profession, with Hippocratic values as important as technology. In the European Region, all citizens, professionals and politicians would demand that quality of care should be raised to the levels of the best. There would be remote telematic access to a "one-stop shop" source of health intelligence. Ethical considerations would influence many decisions relating to the health of individuals, groups and populations.

Discussion

Germany asked where the additional resources for the increasing numbers of elderly people would come from. Dr Macfadyen agreed that it was a challenge, but denied the ubiquity of the stereotypical elderly person with ill health. Also, individuals had contributed to national prosperity over their working lives and expect some return. A balance must be struck. Germany pointed out that it was not the role of the medical profession to execute political decisions, but rather to safeguard the ethical position. Ukraine reminded the delegates how imminent was the year 2000, leaving little time for decisions to be made and implemented. Israel suggested that doctors and NMAs had an obligation to influence treasury spending on health care. Switzerland added that the health sector generated jobs and produced wealth. France said that health care had been drifting: its ideals might never be met. There was a tendency to put career prospects before standards of care. The vast increase of technical potential might not always lead to improving medical care, said Poland, for it encouraged alienation between physician and patient. The Russian Federation emphasised that environmental medicine must provide the way forward. Such initiatives were infectious and had their foundation in society.

Statements

Following earlier discussions, the Forum formally adopted the following statements (see Annex 1):

- *Statement on Tobacco and Health.*
- *Statement on Health Policies.*
- *Statement on War-Devastated Populations.*
- *Statement on Hepatitis B and C.*

Nominations for Liaison Committee

Drs Lemye (Belgium), Milton (Sweden), Završnik (Slovenia), Piaznik (Poland) and Salzberg (Switzerland), were nominated, together with Drs Macara as retiring President, Macfadyen for WHO and Rowe as Secretary. All were elected.

Next Forum

Dr Milton, on behalf of the Swedish Medical Association, said that his Association would be pleased to host the next meeting, and this offer was accepted with appreciation. The next Forum would be almost certainly in Stockholm, on 1 and 2 February 1996, followed by a post-meeting on 3 February.

Programme for next Forum

Israel suggested defensive medicine and litigation as possible subjects. France felt that training was probably the most important subject for discussion. Dr Rowe said that at the next Forum it might be better to limit to two the number of major discussions.

Future meetings

Invitations were received for the Forum to be held in Belgium in 1997 and Denmark in 1998.

The meeting was then closed.

Note of Post Forum Meeting with Central and Eastern European
Countries and Newly Independent States,
Representatives of National Medical Associations
and Emerging Organizations

London, 25 March 1995

Press, Television, Radio and Parliamentary Lobbying

Mr Adrian Roxan, from the BMA public affairs division, said that his association had recognised that, to pursue the interests and policies of its members, representatives in parliament and the media needed to be regularly informed. If the BMA wished to change government policy, influence social debate or simply reinforce current attitudes, both parliament and the media had a clear role; the media both reporting and persuading parliament. For example, if the BMA wanted to see a change in the law, direct pressure on MPs from individual doctors and through the media had succeeded in persuading the government of the day to introduce new legislation. A high media profile could also attract new members and reinforce existing membership.

The BMA public affairs division had contacts with national newspapers, specialist magazines, academic journals, general interest magazine and regional weekly and daily newspapers. In the broadcast media there were contacts with national and regional television and radio. There were also contacts with specialist correspondents - health/medical, political, economic, consumer, environmental and sports.

The action plan undertaken by the BMA during its campaign against smoking was detailed. This included:

- Establishing a network of doctors throughout the country to address local media;
- Ensuring publicity around each key point in the passage of draft legislation through parliament;
- Using doctors to talk about both the dangers of smoking and the economic impact on the health service;
- Challenging the government to justify its policy;
- Ensuring that publicity was focused on MPs who were unsure how to vote;
- Ensuring that publicity was not "party political";
- Publicising any support from organisations outside the medical/health area;

- Targeting key politicians of all parties - not just health
- with media pressure;
- Publicising support from MPs.

Medical Journalists and National Medical Associations

Ms Sue Marks said that the BMA had been regarded as a campaigning organisation since its inception, and had established media relations in the 1930s. Since then, the association maintained excellent relations with the media. At times the message had become distorted, so that in the 1970s coverage seemed to centre almost entirely on doctors' pay. Since then there had been a conscious effort to raise the profile of the BMA's science and ethics activities and to promote its role as a professional association. Since 1980 the BMA had extended its public relations role to include coordinating approaches to parliament. This had proved highly successful, influencing and informing politicians on a wide range of topics ranging from implications of research, to excessive working hours of junior doctors. The approach was integrated and specifically tailored to an issue. Sometimes media publicity might be damaging, so objectives would be better met by private meetings with influential politicians. An important feature had been a national network of doctors involved with presenting the BMA view at local level with both media and politicians. The national head office maintained weekly contact, alerting and advising local representatives.

A typical success was in retaining national pay agreements, when the government wanted to institute local pay deals despite evidence that it would be impossible to establish performance indicators on which to base salary. A high profile campaign was begun, to gain public support via the media and to gain sympathy and support from politicians by gentle persuasion. A campaign team was set up which met regularly to coordinate activities. Political support was obtained by targeting individuals with influence, both in government and opposition. It was difficult to obtain a political focus for the topic, so it was mentioned every time MPs were contacted. Key politicians, including confidants of the prime minister and those in the Treasury, were closely targeted, but groups were also addressed, and BMA members met local MPs of all parties, for politicians value local opinion. Hundreds of doctors wrote to their political representatives on the issue.

A series of regional press conferences took place to brief the media and each time, local doctors wrote to politicians to

reinforce the message in their local papers. During the party political conferences, advertisements were placed in magazines going to every delegate. Thus, the tremendous strength of feeling among doctors was transmitted to politicians and the public. The objective was achieved, national pay negotiations were retained and no local pay bargaining was imposed.

National Medical Associations and Medical Journalists

Medical journalists want to inform their readers, listeners or viewers, said Walter Burkart, but scientific advance had to be translated into terms understood by the layman. Sources of information included scientific journals, congresses, scientific and press conferences. If an NMA wanted to collaborate with medical journalists and convey its opinions to the public, it should know the characteristics of the group - often quite small and knowing one another: sometimes they had their own professional organisations. However, other groups such as political, economic or environmental journalists might also be important. NMAs should hire an experienced professional journalist who not only knew conditions and circumstances of journalistic work but also had personal contacts with many colleagues. This person should have access at all levels of the NMA and their advice should be sought by members having contact with the press. Individual physicians should also have guidelines from this journalist for contact with the local media.

NMAs should generally neither take sides nor arbitrate in scientific controversy, unless the interests of patients were involved. In particular, it must warn against unrealistic expectations of new techniques, medicines or therapies and against unnecessary fears. Medical journalists can act as assistants to physicians; the NMA had to help them in this task.

Discussion

Romania suggested that NMAs in Central and Eastern Europe lacked both the experience and the capacity to influence their societies, as they had no tradition of expressing themselves. Romania had tried to determine the direction in which its healthcare was going and then used British techniques to influence medical and social change. The media were slowly beginning to pay more attention, while MPs, judges etc., were discussing patients' rights.

The Turkish Medical Association had influence on the media, and engaged in open discussion with journalists. However, publicity was not always achieved.

The French medical profession managed to be heard, but great diplomacy was required because editors were not necessarily interested in medicine or the medical profession.

Establishing Medical Networks: How the BMJ can Help

Mr G. Burn of the British Medical Journal explained how the BMJ could assist NMAs in getting medical information in and out of countries in Central and Eastern Europe.

The aims were being met by selling the main BMJ, licensing extracts to local publishers, licensing translated or reprinted editions, sending free copies to selected recipients and creating a local edition. The barriers to entry included language, cost of subscriptions, absences of traditional non-subscription funding, poor distribution systems, relevance of the product to local practitioner, lack of market information, buying patterns, publishers' costs and the possible lack of local publishing.

The BMJ had now established local editions in 12 countries (plus a student BMJ in South Africa) and negotiations were under way in another 8 countries. These were an edition of the BMJ produced in the countries or region for the doctors there. To enable this, a local editor and board selected material from the weekly BMJ that was appropriate to local needs, augmenting this material by local editorials, news, views, commentaries, etc., to fill 4-12 issues per year. Sometimes, books were run as chapters in the local BMJ and published as low-cost editions. Other joint ventures were established and formed the platform for an expanded local publishing programme. Where possible, relationships were formed with NMAs and governments.

Discussion

Kazakhstan had just launched the Kazakhstan Journal of Surgery, but it had no information from other countries and had lost contact with the other component countries of the former USSR. It wished to add a digest of international medical matters of local importance.

It was suggested that the BMJ could become a journal for the international exchange of information on healthcare reform. Mr Burns agreed that this was a possibility, and pointed out that the editors of local editions met each year for a three-day conference.

Government/Profession/Universities: Tension or Harmony -
Problems of Influence and Structure

Professor G Berentey reminded the meeting that in a democratic society every patient had responsibilities and rights. Thus it was inevitable that decision makers would seek and coordinate opinions before allocating central budgets. There were experts who represented the medical profession and public interest, and if their opinions were not sought, government decisions might not be accepted. NMAs must ensure that their opinion can be heard. Civil organisations could be partners in decision making but, should government not agree, a difficult situation might ensue. If an NMA fought for appreciation by politicians, not only did this take time but diminished its professional power. However, if government listened, the NMA would be in a good position because of its wide experience and its contact with public opinion.

The Hungarian Medical Association was playing an increasing part, and talks had begun to establish laws to protect professional interests, but it had proved difficult to obtain media support.

Each NMA should have its own journal, with both doctors and journalists on the staff. There should be an informed press spokesman. In Hungary such a pattern had proved successful. In the newly democratic countries, public service TV suffered serious financial constraints, so it had to accept advertising - and the NMAs were unable to pay the cost. Also, public health policy was generally unsuited to advertising. Thus it was difficult to obtain TV exposure, but matters such as smoking, drugs, protection of the unborn child and healthy lifestyles might be suitable, particularly if advice were sought from TV professionals in adapting and interpreting the message.

Politicians tended to have good relations with universities, and nearly all the leaders of medical societies in Hungary were academics. There was also cooperation with the health insurance companies, with whom a natural alliance might be developed, as both served public health.

Dr Piatkiewicz asked what should be the best model for relations between NMAs, governments and universities in Central and Eastern Europe. The aims and obligations of NMAs should not be lost in their relations with government. Most were created recently by doctors and all professional organisations should act for their own members. The object of their activity was fulfilment of professional aims in a proper way and under proper conditions. The proper conditions demanded good, up-to-date medical knowledge and appropriate medical technology used in an ethical fashion. That allowed doctors not to be preoccupied with their own problems such as living conditions, pay, working hours, etc. Every government trying to achieve this should be supported.

The NMA must be recognised by the government as a partner, in that it was informed, competent to formulate opinions, and could be responsible for carrying them out. In Hungary, the Czech Republic, Slovakia, Poland, Slovenia and Croatia, this essentially happened. Elsewhere, there were significant difficulties, either because the NMA lacked legal status, because government doubted that the NMA really represented the medical community, or through a lack of financial resources.

Relations with universities should focus on helping all medical professionals to be doctors in an appropriate fashion. There were 3 ways to do this: promoting the medical sciences, education and quality of practice. In Poland, cooperation could be improved. There was a deep division between the NMAs and universities, which tended to represent government interests and which were the source of funding. The NMAs were mistrusted as interceding in what had previously been a monopoly. Despite compulsory membership in the Medical Chamber, NMAs remained under-represented. The common interest demanded better cooperation and this should be a major goal of the NMAs in the immediate future.

Discussion

Romania reported that it had doctors in central authority. In relations between the profession and patients, one must recognise that today's potent medicines could only be prescribed by highly skilled doctors, but government and NMAs must cooperate with each other. Doctors had to react for their patients and possibly fight governments which do not view them as partners, in order to achieve justice for patients.

Ukraine pointed out the problems in Eastern Europe of the connection between science and practice in medical training. At one university, they were in contact with management and most professors were now members of the NMA. They had developed new - but time-consuming - curricula to train GPs, and the NMA was playing its part with government, as part of more general discussions on the retraining of professionals. Government had listened attentively to the NMA's proposals and partly implemented them. Further contacts between NMAs, universities and research must be even closer.

In Slovenia, the 3-year-old NMA had good contacts with government - the Minister was a GP. Unfortunately, salaries were very low. Differences with the 135-year-old physicians' association had led to tension, now being dealt with by coordinators. The takeover of medical training by universities had also led to tension, but doctors' unions had worked with the NMA.

In the Russian Federation, the vast problems matched its vast size. There were no relations between academe and clinical practice. The NMA was trying to achieve unity and had so far achieved agreement over ethics, both academic and scientific. The NMA's relationship with doctors' trade unions was ambiguous because of their resistance to private practice. The many bureaucratic levels of management and government make both hard to work with. In addition, Ministers were changing frequently and medicine appeared to be developing along military lines which made it difficult to find a common language.

Lithuania said that its NMA was very active in healthcare legislation, working together with academe and parliament. It was now negotiating with government over the financing of healthcare and changing the salary system but even if the minister agreed, it was difficult to achieve action because the government as a whole did not see health as a priority. It was

simpler to debate with politicians the role of physicians in a changing healthcare system if a Western European-like political climate existed. There was still no channel to parliament, but the various professional bodies were meeting to prepare a united front which should increase influence.

In the Czech Republic relations with the Medical Chamber were good: medical insurance companies were sometimes reluctant to follow medical advice. Several official bodies had representatives of both NMA and universities, while there were close contacts between NMA, the research institutes and the Academy of Science. There were current efforts to unify ethical codes between government, NMA, hospitals and academe.

Poland had 54 medical societies in its Federation. They had differences with the government but the Federation showed unity. Every year a regional conference was held where Eastern European countries discussed regional matters, and this had proved valuable. Relations with academies of sciences were good, but there was a substantial difficulty with technology associations; there was some collaboration but the personality of the medical associations was in danger of being lost. Partners should be carefully chosen and collaboration should not be too close. Parliamentary lobbying was still embryonic.

Germany had over 1,000 medical associations, of which several were large organisations covering substantial segments of the profession. These acted almost as political parties and had lists of candidates in elections.

Estonia had re-established its medical association, originally founded in 1921, and it had real standing from 1991. It negotiated over salaries, working conditions and ethics. The professional and academic societies were much older: talks were under way to discover means of collaboration with the NMA. Health insurance had been introduced 2 years before and the NMA had been successful in influencing some decisions. It was also assisting in legislation for the ministry of social affairs. There was still no channel to parliament, however, and lobbying was not well organised. Doctors had little influence on the faculty of the sole medical university except through their professional societies.

The Czech Federation of Medical Associations had good and close relations with the Medical Chamber, but its advice was not always followed by the health insurance companies. The NMA and universities had common membership on some bodies; there was

contact with the research institutes and good relationships with the Academy of Science on environment and ecological programmes. The NMA was striving to unify ethical committees, currently fragmented.'

Slovakia reported that there was excellent cooperation between universities, the Medical Chamber and NMAs, but there was still a long way to go in collaborating with government.

Kazakhstan had contact with the Ministry of Health and a mutual understanding with government - but there was less support in the regions. They suggested the preparation of a document emphasising the importance of NMAs in health care and in advising the media on health matters.

Dr Asvall summarized, saying that Central and Eastern European countries shared the problems experienced by Western Europe, but in more acute form. NMAs had both professional and trade union roles in the negotiation of pay and development of healthcare systems. Both NMAs and governments had to know which role was being played. Physicians sometimes confused the two. Trust came from long-term cooperation, while in developing health policy there must be input from both NMAs and universities.

Throughout the world no system existed to ensure that new science was injected into a country's health development process. One country had tested an annual report to government but nowhere had there been any other move to solve the problem.

At the suggestion of the representatives, Dr Rowe agreed to update the document on the roles of Medical Chambers and NMAs.

Problems of Organisation and Funding in Central and Eastern Europe

Of the countries represented, 8 had a Medical Chamber or equivalent, responsible for professional discipline, of which 5 had been granted legal power by the ministry. Only one of these disciplinary bodies included lay members.

In France, new laws had been passed concerning regional professional unions. The Order kept the medical register; all doctors voted, all were paid on a regional basis and there was a budget for post-graduate education. This decentralisation had led to greater participation among doctors. However, for effective action the profession must be unified and independent

of government. There must be a dialogue between doctors and patients to establish a code of ethics. Doctors in Central and Eastern Europe must become more assertive in healthcare matters: a health system could not be established without input from doctors and other health professionals. The technological dream of the West was not true - primary care remained more important than technology - only an established, strong GP network could respond to the needs of the population. However, there was no perfect healthcare system; the best should be distilled from each rather than using any one as a model.

In Hungary, social care established under the socialist system, no longer appeared to fit. The government had created more medical organisations to divide power, such as Medical Chambers for sub-specialties. No unified Medical Chamber existed, so there was no unified organisation representing all doctors which would be better able to deal with government.

Germany had a unified Medical Chamber, an umbrella organisation for all physicians and also voluntary organisations for special interest groups which may hold independent views.

In the Russian Federation, safety at work was most important for doctors. The government defined the cost of medical services and also controlled medical associations and professional activity. There was some interest in certification of specialists.

Some 70% of Bulgarian doctors belonged to the NMA, of which pharmaceutical and medical equipment manufacturers could be associate members. There was a united health policy, allowing the NMA strong influence on the Ministry of Health. In the past, ministers had left at the request of the medical profession. Four laws were being drafted: one for health associations, pharmacists and dentists, one for insurance companies, one for hospitals and one for the health of the Bulgarian people.

The representatives were asked if there were any countries in which the profession was not effectively free to control the right to practise - in other words self-regulating. Germany replied that the Medical Chamber often recommended withdrawing an individual's licence to practise but the government had refused to do so. However, the government could not itself act without prior proceedings by the Medical Chamber.

Poland said that until 1989 only the ministry of health controlled the right to practise, but this was no longer the case. The situation remained complicated by the large numbers of "healers".

In Hungary the Ministry of Public Health proposed that it should had the sole right to grant licences, but the medical profession united in fighting that and a compromise was achieved. Licences were now granted by the Medical Chamber in collaboration with the NMA but local authorities had the power to refuse permission for a private practitioner to operate in their area. Doctors refused to negotiate with government until this compromise was established. NMAs must help themselves - no other country could fight their battles for them.

In the Russian Federation there were many healers, but even they needed permission to practise. Regarding licensing, if a licence was to be removed, the doctor could appeal to an independent commission of medical associations to assess quality of practise. This new law was passed after insurance companies had attacked doctors who made enormous claims.

In France, a report was made by 3 experts on doctors suspected of unfitness to practise, and this was submitted to the Region for a decision. The doctor had the right of appeal to the National Medical Council. In the case of a complaint against the doctor, the disciplinary office of the medical council can either issue a warning, order suspension or strike the doctor off the register. Again, there was an appeal system. The government had no role in the process.

Hungary proposed a future debate on the relationship between the doctor and the pharmaceutical industry. France emphasised that it was essential for doctors to remain independent of the drug industry. Dr Armstrong, for the BMA, suggested that a "European" version of the British document "Core Values for the Medical Profession in the 21st Century" might be produced for the Forum.

Concluding the meeting, Dr Rowe said it had been right to have no structured agenda for the post-Forum meeting. All 17 countries present had learned things that would had been hard to put in writing. They had recognised new dimensions in medical activity, of which the foremost had been quality of service to patients. The discussion of which direction the profession was heading was linked to quality and ethics.

Dr Macfadyen said he was struck by the long list of associations in post-communist countries, and how they were becoming re-established. In Britain, the government, civil service and doctors had shared their interest in health in a fashion that many other countries envied.

STATEMENT ON HEALTH POLICIES

The European Forum of National Medical Associations and WHO, meeting in London on 23-24 March 1995,

AWARE of the responsibility of national medical associations (NMAs) in the health care of citizens of their countries;

REAFFIRMS the duty and obligation of NMAs to give considered advice to those responsible for the formulation of health policies and their implementation;

CALLS UPON those responsible, governments, health authorities and other bodies involved in the determination and implementation of health policy, both administratively and politically, to recognize the role of NMAs as key partners in the provision of advice on health policy.

STATEMENT ON TOBACCO AND HEALTH

The European Forum of National Medical Associations and WHO, meeting in London on 23-24 March 1995,

RECALLING its previous statements on Tobacco and Health in Basle (1992) and Budapest (1994);

URGES governments to enact strict legislation in order to:

- prohibit any advertising of tobacco, both direct or indirect;
- heavily tax tobacco products, a proven effective intervention;
- exclude tobacco from the national price index;
- affix appropriate health warnings on cigarette and other tobacco packaging
- ensure the right to a smoke-free environment in public places including the workplace, transportation and educational establishments;

FURTHER CALLS UPON governments to increase information on the hazards of using tobacco products.

Finally, the Forum URGES each NMA in Europe to make its own premises smoke-free, to offer tobacco withdrawal courses for its members and to actively support national tobacco control programmes.

STATEMENT ON HEPATITIS B AND C

The European Forum of National Medical Associations and WHO, meeting in London on 23-24 March 1995,

CONCERNED at the increasing risks to both patients and professional staff from accidental infection with hepatitis B and C;

NOTING that both appropriate use of vaccine together with appropriate training in the handling and disposal of sharps will substantially reduce the incidence of this type of viral hepatitis;

CONSIDERING that for hepatitis where no treatment is available, the most effective action is to ensure careful training in the handling of sharps and assuring that all safety measures are strictly adhered to;

CONCERNED that for many health staff hepatitis B and C are occupational risks;

AWARE that in at least one Member State of the European Region of WHO, joint initiatives are taking place between the health ministry and the national medical association on the health and safety issues of hepatitis B and C, and that protection of staff by vaccination is being supported;

CALLS UPON all governments and those responsible for health care provision and the employment of health professionals:

- (a) to ensure the necessary testing of blood and other biological products for therapeutic or diagnostic use;
- (b) to ensure that health care staff at risk are offered vaccine protection and are also given training in safety procedures to reduce the risk of infection.

STATEMENT ON WAR-DEVASTATED POPULATIONS

The European Forum of National Medical Associations and WHO, meeting in London on 23-24 March 1995,

RECALLING its previous statements on the effects of armed conflict in terms of human suffering, disablement and displacement in Europe (Basle 1992), on help to the war-devastated populations in the former Yugoslavia (Utrecht 1993) and its statement on humanitarian assistance to the war-devastated populations in the countries of the former Yugoslavia (Budapest 1994);

APPALLED that since the statements, despite continuing efforts by many parties, armed conflict has continued in various parts of the European Region and the innocent civilian population continues to suffer directly through physical and emotional injury and indirectly through the threat of disease arising from disruption of all services including health services;

RECALLING that where there is no peace there can be no health, as war destroys the fabric of society with resulting privation and epidemic disease;

PAYS a special tribute to their colleagues, physicians and nurses who continue to provide medical care in terrible conditions without adequate resources, and at peril of their lives;

CALLS UPON all those in positions of authority and influence to recognize their responsibilities and to seek just solutions to their problems by peaceful means, and at all times to recognize their responsibility where widespread preventable disease threatens the civilian population, to arrange ceasefires to enable all necessary measures to be taken to protect the health of citizens.

European Forum of Medical
Associations and WHO

London, 23-24 March 1995

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