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Analyse of the health care systems of the accession countries and the possible consequences for the accession negotiations

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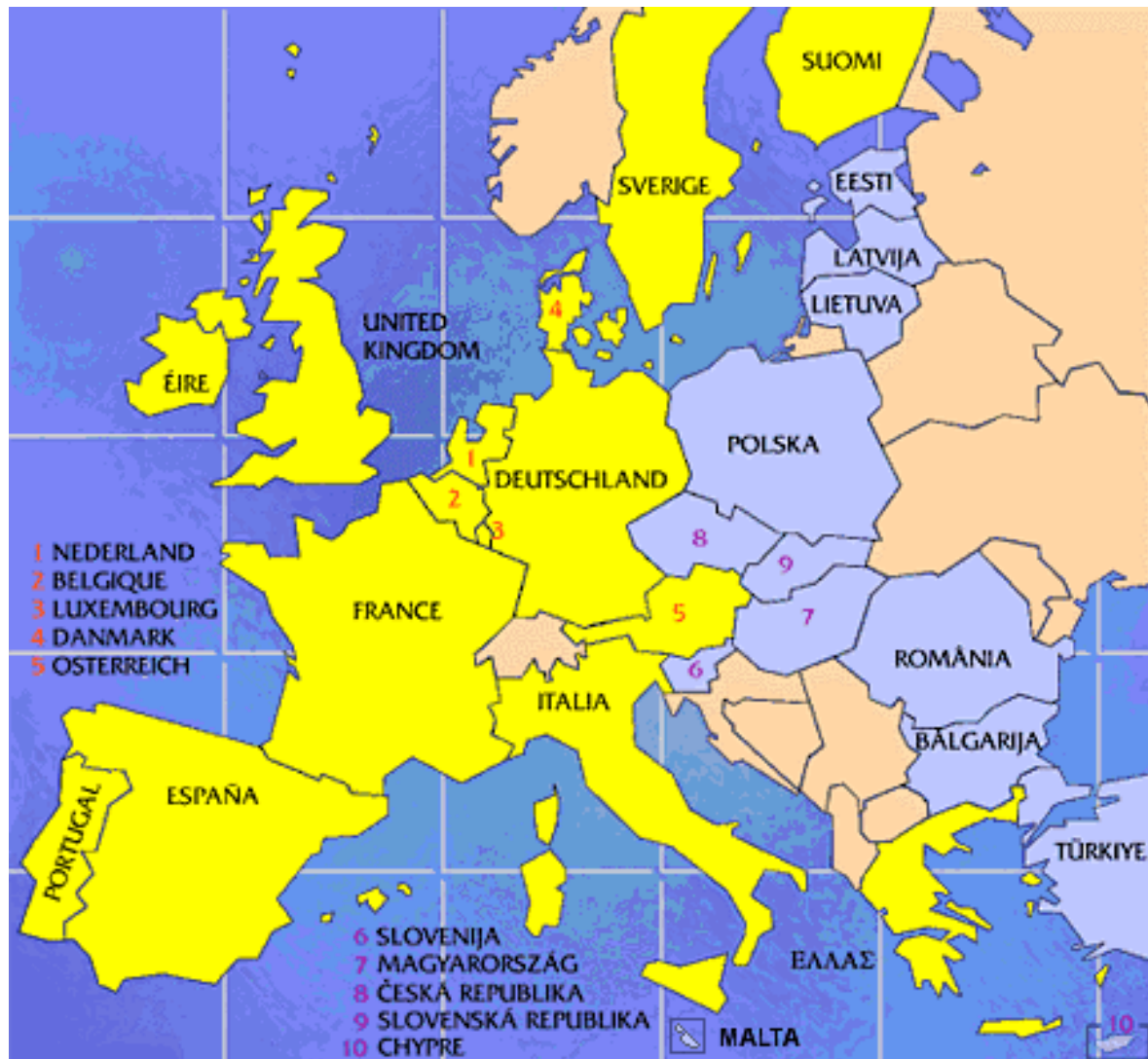
EU-enlargement

EU Enlargement

regarding the health care systems
(excluding dental care)
of the applicant countries

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I. Introduction

1) Applicant countries:

The European Union consists of 15 member states since 1-1-1995. Another 13 member states have addressed their accession applications to the European Union between 1987 and 1996.

The official accession negotiations were opened on 31-3-1998 with six applicant countries, namely with Estonia, Poland, Hungary, Slovenia, the Czech Republic and Cyprus. The accession negotiations were extended to another six applicant countries on February 15th, 2000, namely Bulgaria, Latvia, Lithuania, Malta, Romania and the Slovak Republic. Only with Turkey, which submitted its accession application on 14-4-1987, no negotiations were held until now.

2) Working document of the Commission on health and EU enlargement:

The European Commission, Directorate General for health and consumer protection - Directorate G - for public health, has presented a working document on health policy and EU enlargement on 18-5-1999 (SEC (1999), 713). In this working document, the Commission notes that the state of health of the population in the candidate countries is considerably worse than in the EU, with the

exception of Cyprus, Malta and Slovenia. In the majority of the candidate countries, the most important health indicators like life expectancy and infant mortality are drastically below comparable EU values, a fact which is supposed to be due to the high prevalence of risk factors such as smoking, unbalanced nutrition, lifestyle habits and pollution. In addition, it is worth pointing out that, candidate countries show considerably higher accident and suicide rates, as compared with the present EU member states, as well as an increasing incidence of certain communicable diseases, such as tuberculosis. In its working paper, the Commission also expresses concern about the scarcity of the resources available for the health care sector.

At present, accession countries spend on average only 4,5% of their GDP for the health care sector, compared with an average of nearly 8,5% in the EU countries of today. In the document, the Commission points out that, due to the EC Treaty, the organisation of the national health care systems lies entirely in the competence of the individual Member States and is therefore a purely national duty, and that the Member States, following a recommendation of 1992, made efforts towards harmonisation in complying with common basic elements, irregardless of the financing structure of their national health care system. The following features are considered desirable in all health care systems: solidarity, provision of health care in all areas of the countries, and equal access of all citizens to effective and affordable health services. In this respect, the Commission presumes several deficits in the accession countries. In this context, points of criticism are: modest remuneration of physicians implying motivation problems and the lack of knowledge in the field of health care management. In

addition, it is pointed out that the professional organisations of the EC Member States have played an important role in the development of the health care sector, whereas these institutions in the accession countries still have to develop their potential to the full. Another striking problem concerns the fact that the formerly exemplary systematic vaccination rate and the systems of epidemiological surveillance have deteriorated drastically due to financing problems. For these reasons, the Commission of the EC sees a need for action mainly in the following areas: enhancement of prevention and health promotion, as well as the development of clear public health concepts, the strengthening of public awareness in health matters, considerations on how to meet the growing demand for modern medical equipment and how to establish functioning institutions providing emergency care all over the country, improvement of financial incentives and of the social status of health care professions, because otherwise, increased migration would imply shortage in manpower in the field of trained and qualified health care professions.

In summarising, the Commission proposes different approaches for tackling health care relevant problems in connection with the accession of new countries. One approach is that each accession country elaborates action programmes by which the most important health related problems shall be resolved by priorities. Furthermore, it is of vital importance to establish the infrastructure which is necessary for the implementation of the *acquis communautaire*. Another mission is the promotion of research activities in the field of public health and the enhancement of exchange of experience on the use of

information systems and technologies in the health sector. Trans-border cooperation between the accession countries and the Member States needs to be simplified, primarily in the field of environmental medicine and of the surveillance of communicable diseases. Emergency measures need to be taken in order to reduce the production of tobacco products and the number of smokers. Finally, it is considered important to support the establishment of non-governmental, non-profit oriented organisations in the field of health promotion.

3) CP study:

The present enlargement process has a special dimension compared with prior enlargement. On the one hand, the number of the present Member states will almost double with the accession of the candidate countries, on the other hand, the economic situation of the predominant number of accession countries differs from EU average to a fundamentally higher extent than this was the case at previous accession rounds. For this reason, the accession will have far-reaching consequences not only for medical doctors from the candidate states, but also for medical doctors in the present Member States. Being the umbrella organization of European doctors, the CP has decided therefore to devote itself to the issue of EU enlargement in the context of a special study. This study shall cover:

- a) an analysis of the health systems of the accession countries, as well as
- b) conclusions which must be considered by the European institutions, but also by the CP in connection with the enlargement process.

The study was developed by a working group set up by the CP. This working group was under the chairmanship of Dr. Brettenthaler and had the following members: Dr. Holm, Dr. Leth and Dr. Lemye from the CP, Dr. Harvey from the UEMS, Dr. Farkas as a representative of the PWG and Dr. Fabian as a representative of the UEMO. Furthermore, representatives were invited from every candidate state to the meetings of the working

group. The working group held meetings on 12.7.2000, 9.11.2000, 20.3.2001 as well as on 18.10.2001. The analysis of the health systems of the candidate states has been carried out on the basis of the answers returned. The questionnaires were answered by the representative medical organizations of the following candidate states: Cyprus, the Czech Republic, Estonia, Hungary, the Slovak Republic, Romania, Poland, the Slovenia and Malta. No replies were available from Bulgaria, Latvia, Lithuania and Turkey.

II. Health service and EU enlargement

From the point of view of the Standing Committee, the following consequences are worth considering in the context of EU enlargement:

a) at community level:

1) In most of the candidate countries, the share of health care expenditure in the gross domestic product is dramatically lower than the average share in the present EU Member States. Whereas at community level, roughly 8,5 % of the GDP are allocated to health care, this share lies between 4,5 and 7 % in most of the candidate countries, only the Czech Republic (7,4 %) and the Slovenia (7,73 %) nearly reach EU average. The economic and political unification of Europe will only be successful if the population is provided health care at comparable standards as to quantity and quality. Therefore, the CP emphasizes the importance of increasing the share of health care expenditure in the gross domestic product in the candidate states in order to provide the populations concerned with health care systems which comply with present EU standards.

2) As stated also by the European Commission, the social situation of the health care professionals, particularly of medical doctors, is considerably worse as compared with other academic professions in most of the candidate countries. This concerns in particular the

income level of hospital doctors. This unfavourable economic situation of medical doctors, together with their low social status in most of the candidate countries may lead to migration into the EU Member States of today, even more, as some of the present EU Member States witness increasing shortage in medical manpower. If such a migration should surpass the currently ongoing migration between the EU Member States, there is a risk of brain-drain and deterioration of health care provision in the accession countries. Therefore, it is the duty of the CP to point out the urgent need to improve the social situation of the health care professions, in particular of medical doctors, in the applicant countries.

- 3) If attempts were successful to align the social situation of medical doctors in the accession countries to the one of other academic professions with comparable responsibility and qualification, the CP does not expect migration flows of doctors between the accession countries and the present EU Member States to exceed the present extent. None of the candidate countries presents a considerable oversupply in fully trained doctors,- the Slovenia expects in the forthcoming years even a shortage in medical manpower. For this reason, we part from the assumption that migrational flows will be mainly due to private motivations (such as family reasons) and will therefore have no bearing on the present migration rates of medical manpower within the EU, provided that the economic situation of medical doctors in the candidate countries is to be consolidated.

4) In most of the accession countries, a restructuring of the health care systems is under way. Primary health care is increasingly provided by self-employed established general practitioners (GPs) and paediatricians, which was formerly the task of polyclinics in the Eastern European candidate countries. The survey revealed that GPs in most of the candidate countries are under-represented compared with the situation in the present EU Member States. The CP explicitly welcomes the development of primary medical care in the candidate countries and points out the underlying need to enhance specific training in general medical practice.

5) If the candidate countries follow the path they have already taken in providing primary medical care by self-employed established GPs and paediatricians, they will need economic and structural conditions which allow them to provide higher quality medical care. This means in particular, that

- a) the fees paid by health insurance funds to primary care physicians allow them to establish properly equipped practices,
- b) self-employed physicians are given the possibility of a planning horizon through long-term contracts with health insurance funds, which allow them to invest in their practices - short-term or terminable contracts would be an obstacle to investment activities on the one hand, and determine negatively their choice to engage in primary medical care, on the other hand,

- c) the interests of self-employed primary care doctors are safeguarded by a strong collective representation with regard to mainly monopolistic health insurance funds, in order to allow the construction of an efficient primary care structure,
 - d) it has to be guaranteed that the rising use of primary care services will be covered by social insurance and that the providers of services will not have to bear the risk of increased use of services by lump-sum payments.
- 6) The supply with medical doctors seems to be sufficient in the candidate countries, with the exception of the Slovenia, where shortage of medical manpower - at least in certain specialities - is expected within the next years. However, a number of candidate countries are concerned about uneven distribution of medical doctors and the fact that in remote areas, medical supply is below average. From the view of the CP, it would therefore be desirable to create structures which allow an even distribution of medical doctors over the whole countries concerned, for instance through incentive systems for medical doctors.
- 7) According to the data collected by the CP, it may be parted from the assumption that medical training in the candidate countries, in principle, is in compliance with present EU standards. At present, all Member States are interested in a short-term alignment of possible deviations. The system of specialist degrees which is presently still applied, but under review some of the candidate

countries, however, is not in accordance with the general system of the Medical Directive 93/16/EEC. In Eastern European countries, with the exception of Hungary, specialists were conferred a first degree diploma after three years of training. The second degree diploma, which foresaw additional training, was only necessary for obtaining higher positions. This levelled specialist training is not in compliance with the requirements of the Directive. However, this system has, in the mean time, been abolished in practically all countries. Therefore, the CP parts from the assumption that specialist training in all candidate countries will be harmonised in time with the Medical Directive 93/16/EEC. Therefore, some Member States (not all) will have to urge transitional periods in the accession negotiations for those specialists, who have been trained according to the former training system.

- 8) The data collected show that the standard of the medical professional law, conduct rules and professional ethics, in the candidate countries are compatible with the standards in the present EU Member States. The CP also noticed with satisfaction that the supervision of the rules of conduct lies predominantly under the discretion of the medical professional organisations in the candidate countries.
- 9) The difficult social situation of the medical doctors in the candidate countries with the exception of Slovenia has led to the fact that patients pay their doctors for medical services which are provided

under the health insurance funds. From the point of view of the CP, it is worth considering the introduction of patient co-payment, which is to be paid directly to the doctor, in order to avoid professional ethical problems.

- 10) Even an increase in the share of health care expenditure in the GDP will change nothing to the fact that absolute health care expenditure in most of the candidate countries, due to the clearly lower GNP, will not reach EU standard in the short or mid-term. The CP holds up the principles for medical care, as set out in 2000/87. One of the main principle is, that the European health care systems are based on the idea of solidarity. This implies that each patient, irregardless of his financial means, has access to necessary medical care. On the other hand, the principle of solidarity provides that everyone contributes to the funding of the health care system according to his financial means and that persons with a higher income have to pay higher contributions. This principle has to be applied in the public system without exceptions. The CP is aware that the funding of the health care systems in the Eastern European candidate countries is supported by the existence of a private sector besides a solidarity-based public system. The CP reiterates its view that in any health care systems, there should be free choice for patients and doctors and the co-existence of both private and public sectors in health care provisions.

- 11) The enlargement of the EU will make a number of deficits

inherent in the present Medical Directive 93/16/EEC even more striking and topical:

- a) The Medical Directive guarantees automatic recognition of medical diplomas and qualifications and, in this way, unhindered access to medical practice within EU Member States only for those medical doctors who are fully licensed. However, in a number of Member States, but also in the majority of the candidate countries, a postgraduate practical training period is foreseen between the graduation from medical studies and the actual award of the license, which is usually undergone in hospitals. With regard to the fulfilment of the free movement of persons, it is a deficiency of the Medical Directive that doctors in training who are not fully licensed, are not, or only barely in the position to undergo postgraduate practical training in training institutions of other EU Member States.

- b) The Medical Directive 93/16/EEC foresees only automatic recognition of specialist diplomas, and does not foresee automatic recognition of specialisation qualifications acquired within specific specialist training. Such specialisation qualifications exist in a number of EU Member States, but also in the training systems of the candidate countries. Medical doctors with such subspecialisation qualifications are not covered by the Medical Directive, which causes practical difficulties, because there is a number of specialities which, in

some Member States, are considered subspecialties. Although the quality of training would justify mutual recognition, migration is in these cases not possible between States, where the speciality is considered a subspeciality.

- c) The CP has pointed out repeatedly that the Medical Directive, resp. the jurisdiction of the European Court of Justice in this field, gives rise to problems in connection with third country diplomas which were recognised by one of the Member States. Despite the amendment of the Medical Directive, third country diplomas, that are diplomas which were obtained outside the EU area, still do not lead to automatic recognition, even if they were examined and recognised by an EU Member State. The problems in connection with citizens of a Member State with part of their training undergone outside the Community will become even more dramatic with regard to the candidate countries. In the accession countries, there is a number of doctors, who underwent at least part of their training in the area of the former Soviet Union, and therefore, under the provisions of the present Directive, have no right to automatic recognition in case of migration to another EU Member State.

b) at CP level:

The statutes of the CP provide that the representative medical organization of each EU Member State is conferred the status of a full

member. For this reason, the enlargement of the EU will, besides others, lead to the fact that the number of CP members will almost double. In the past already, the mode of operation of the CP has been subject to considerations, in order to achieve efficient opinion and decision making. The situation in the committees of the CP is characterised by the fact that the discussions led not only in the General Assembly, but also in the subcommittees, which function as working groups, a high number of representatives are involved, which makes meetings time, cost and administration consuming. The considerable extension of the number of CP members, which is expected in the forthcoming years, will dramatically aggravate this problem.

Therefore, the CP will have to consider an amendment of the statutes in time, in order to guarantee that the working groups represent all members, and to make sure at the same time that the number of actual participants will be limited to an extent, which allows efficient decision making.

Finally, it has to be pointed out that the question of simultaneous interpretation in the committees, too, will be given a completely new dimension by the accession of new medical organisations from the candidate countries, and, therefore due to cost reasons, will need to be settled in time.

III. Comparative representation of the health care systems of the accession countries

A) Medical Doctors:

The different size of the candidate countries implies considerable differences with regard to their health care systems. The same goes for the number of doctors, ranging between 800 doctors (Malta) and 133800 (Poland).

The ratio between male and female doctors in the candidate countries is the following: Hungary is the only country with an equal number of male and of female doctors. In the other candidate countries, there is dominance of one group:

- with a share of 2/3 of male doctors, Cyprus and Malta have a 1/3 share of female doctors,
- in the other candidate countries, there is predominance of female doctors: in particular in Estonia (3/4 share of female doctors).

It is worth mentioning that all candidate countries have practically no unemployed doctors.

The relationship between general practitioners and specialists is the following:

Whereas general practitioners in Cyprus and Hungary represent only 18% resp. 19% doctors in the medical profession, the Czech Republic and Estonia have a GP percentage of 23%. In all other candidate countries, the number of general practitioners is much higher: 30% (Poland), 31% (Slovenia) and 31,4% (the Slovak Republic).

Accordingly, the share of the specialists is varying: Cyprus and Hungary have the highest number of specialists with regard to the total number of doctors (82 and 81%), followed by the Czech Republic (77%), Poland (70%), Slovenia (69%) and the Slovak Republic (68,6%). No data were available from Romania. Malta will have a specialist register under their new law which is tabled in parliament. It will be effective within the next one and a half years.

It is remarkable that only 9,2% of the doctors are self-employed and established in Slovenia. The situation is completely different in Cyprus, where 73,7% of all doctors practise in a self-employed capacity.

In the remaining candidate countries, the percentage of self-employed established doctors ranges between 37,4% (Poland) and 54 % (the Czech Republic). Estonia has a share of 46, 5%, the Slovak Republic 32,15 %.

90,8% of the doctors in Slovenia are employed, 62,6% in Poland, 67,85% in the Slovak Republic, 53,5% in Estonia, 46% in the Czech Republic and only 26,3% Cyprus.

14 -21 % of the doctors work in the field of primary medical care.

In the Czech Republic 26,9% of the doctors (8 220) are in training. 5 037 of them undergo training in general medical practice, and of which one third (3 183) undergo into specialist training.

In Slovenia, the share of doctors in training is 23,3% (996 doctors), with 214 doctors undergoing specialist training in general medical practice resp. in family medicine. 547 doctors are undergoing specialist training, 235 are undergoing basic training.

In Poland, about 35 280 doctors are in training, that is a share of 26% of the entire medical profession. About 33 460 are undergoing training in general medical practice, paediatrics, and undergo other specialist training; about 1 820 doctors undergo specialisation in family medicine.

In Estonia, the share of doctors in training is only 12% (469 doctors), in the Slovak Republic only 11,2% (2270).

Cyprus has 36 doctors in training, that are only just 2% of the medical profession. The training program is undertaken in cooperation with the Athens University (Greece) and there is also an unknown number of Cypriot doctors in training abroad, mostly in EU countries.

The provision and supply with medical care in the candidate countries is judged sufficient (Cyprus, Estonia, Poland, Hungary and Malta). Bottlenecks are indicated by Slovenia and Romania. In this context, Romania states insufficient supply in remote and rural areas and a surplus of doctors in large towns. The Slovak Republic reports too

high numbers of doctors. This surplus concerns in particular: general (internal) medicine, gynaecology, ophthalmology, urology, ear-nose and throat specialists, paediatricians, general surgeons in hospitals, whereas the number of doctors in the following specialities is reported to be too low: psychiatry, radiology and microbiology.

In Poland, there is a need for family doctors. At the same time, there is a surplus of paediatricians. Slovenia states a shortage in the number of family doctors, specialists in ophthalmology, specialists in ear-nose and throat and anaesthetics.

In Hungary, there are too many surgeons and specialists in gynaecology and obstetrics on the one hand, and too little anaesthetists and pathologists on the other hand.

Romania reports shortage in the number of radiologists, specialists in laboratory medicine and in intensive care, while there is a surplus of general practitioners.

The standard of living of doctors in the candidate countries was determined by means of a comparison with the standard of living of other occupational groups. Comparison of the data shows that general practitioners in particular reach a middle standard of living in the candidate countries. Gynaecologists are considered to have the highest standard of living. In Cyprus, gynaecologists enjoy the highest status and come even before top managers and bank directors. Paediatricians, too, have an extremely high standard of living in Cyprus.

In the other candidate countries, the standard of living of gynaecologists and paediatricians corresponds to the one of the

average population, in Malta, Poland, Romania and in the Czech Republic they belong to the upper middle class.

In all candidate countries, self-employed specialists in general internal medicine, together with GPs, have an average standard of living.

Hospital doctors, too, have to be situated in the middle classe, what the standard of living is concerned, with heads of hospital departments coming before subordinate hospital doctors, followed by doctors in training.

Only in Poland, even fully trained hospital doctors have a very low standard of living, comparable to the one of secretaries and teachers. Doctors in training in Cyprus, Estonia and Poland, too, are facing a low standard of living. In the Czech Republic, the standard of living of doctors of training is the lowest.

On the other hand, hospital doctors heading a department in Slovenia, have a very high standard of living and nearly reach the ranking of bank managers and ministers.

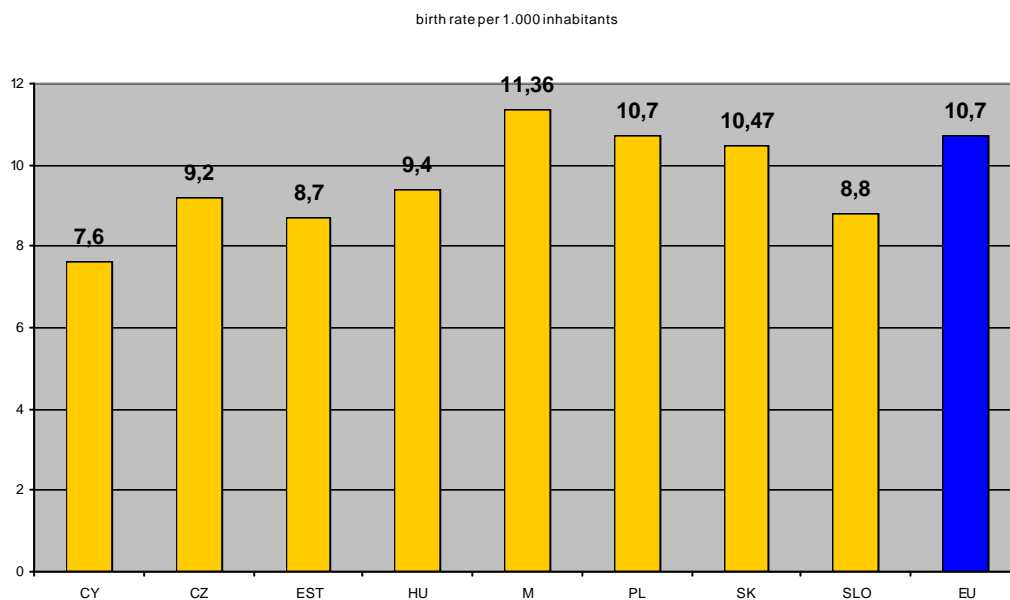
The retirement age of hospital doctors ranges in all candidate countries between 60 and 65 years. Self-employed established doctors normally retire between 65 and 70 years, with the exception of Polish and Slovenian self-employed doctors, who retire like their employed colleagues between 60 and 65 years (Poland), resp. between regulatory 62 and 64 years (Slovenia; some doctors retire a few years later), and in Poland there is no retiring age for self-employed doctors.

The number of doctors who exercise the medical profession in part-time employment is negligible.

Asked about the number of doctors who engage in medical activities in addition to their hospital employment in an own practice, resp. who are in an employment relationship besides their self-employed activity, the candidate countries have no data to report about. Only the Slovak Republic indicates a share of 5% or less of doctors with two or several professional sources of income. Slovenia estimates this share at 15%.

B) Population:

Poland and Romania (38,7 and 22,5 million inhabitants) have, by far, the highest population number of the candidate countries. Compared with Malta, the candidate country with the smallest population number (only 379 000 inhabitants), the population number of Poland is one hundred times larger.

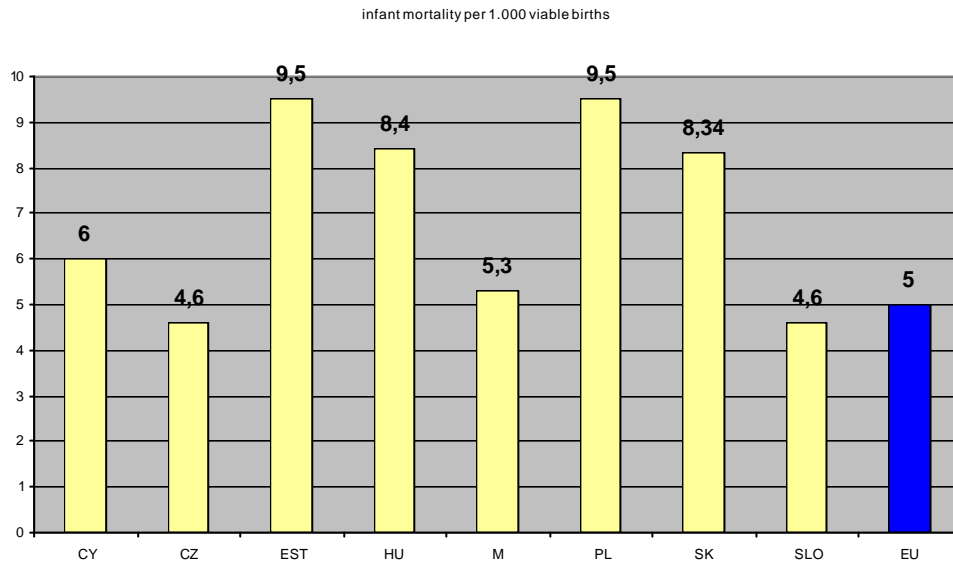


Compared with EU average, Slovenia and Estonia - with birth rates of 8,8 and 8,7 births per 1000 inhabitants - are bottom of the league, all other candidate countries range within EU figures.

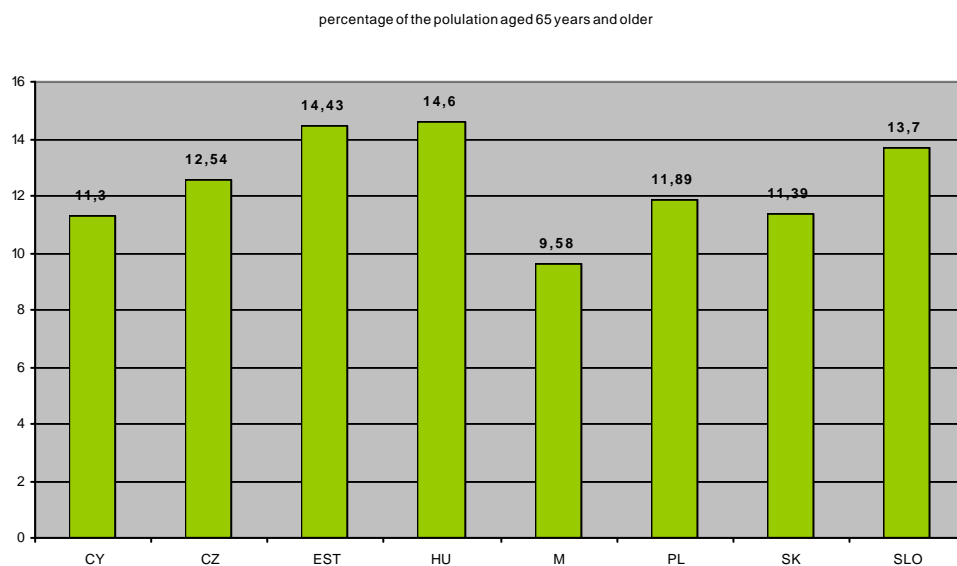
What the rates of infant mortality is concerned, there is a need for several candidate countries to catch up.

Only Slovenia, Malta, the Czech Republic and Cyprus have infant mortality rates comparable with EU average: 4,6 cases per 1000 viable births in Slovenia and in the Czech Republic and 5,3 in Malta as well as 6 cases in Cyprus.

The other candidate countries have a considerably higher infant mortality rate. The rate in Romania (18,6 deaths per 1 000 viable births) is alarming. In the Slovak Republic, Hungary, Estonia and Poland this rate ranges from 8,3 to 9,5 cases, which is clearly above EU average of 5.



The share of persons over 65 years ranges between 11,4 and 14,4%, which represents an average share of 13% in the total population of the candidate countries.



Life expectancy at birth in the candidate countries ranges between 77,1 years (Cyprus) and 69,2 years (Romania), and, therefore, lies below EU average which is at present 77,8 years. The comparison made between the candidate countries has shown that Cyprus and Malta have a relatively high life expectancy (over 77 years), whereas this rate is 4 -7 years lower in Romania, Estonia, the Czech Republic and Poland.

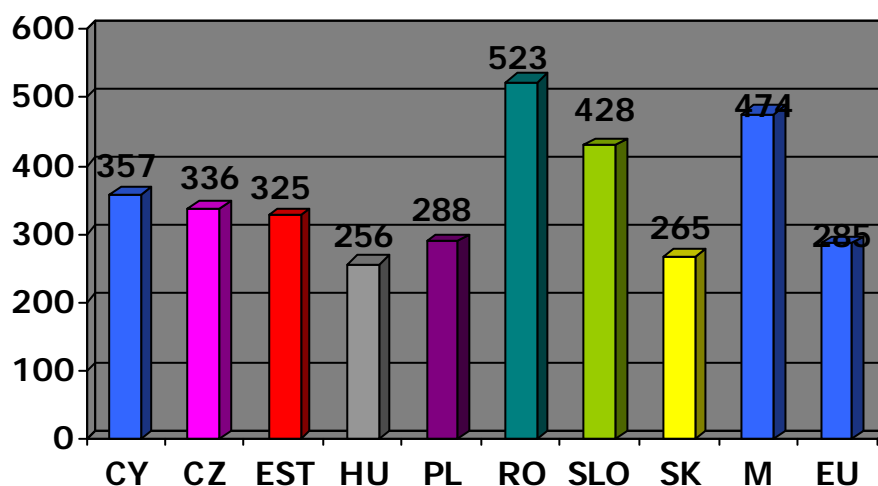
Country	Life expectancy at birth		
	female	average	male
CY	80,00	77,1	75,00
CZ	78,35	75,0	71,65
EST	76,09	70,72	65,35
HU	75,20	70,65	66,10
M	79,16	77,02	75,00
PL	77,00	72,64	68,50
RO	73,32	69,24	65,46
SK (1999)	77,00	72,85	68,70
SLO	79,5	75,65	71,8

The death rate in the candidate countries, too, is strongly varying. Whereas Cyprus has a rate of 7,6 deaths per 1 000 inhabitants, in Hungary 14,2 people die per 1 000 inhabitants, which is almost twice as much.

It is interesting that among the candidate countries, Cyprus has the lowest death rate and at the same time the largest share of old people in the total population.

Considering the total population number and the number of doctors providing health care in the candidate countries, it turns out that this ratio ranges between one doctor for 256 inhabitants (Hungary) and one doctor per 357 inhabitants (Cyprus). The other candidate countries range in between with 265 (Slovak Republic), 288 (Poland), 325 (Estonia) and 336 (Czech Republic).

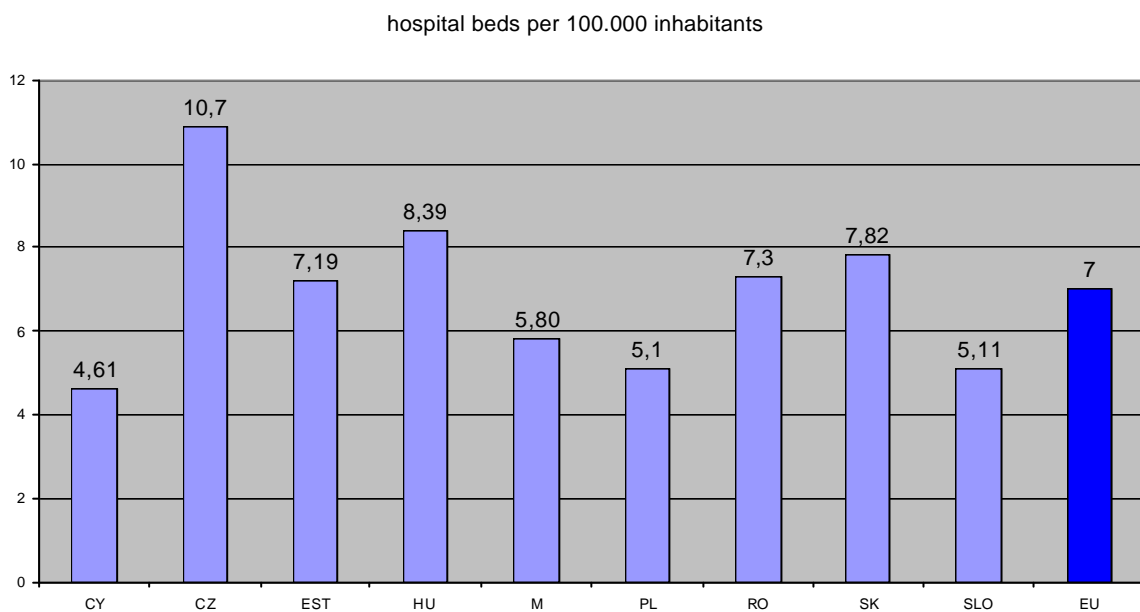
The density of medical doctors is considerably lower in Slovenia, Malta and Romania where for 428 inhabitants (Slovenia), 474 (Malta) and 523 (Romania) only one doctor is available. In the EU, one doctor attends, on average, 285 persons.



The density of hospital beds, too, is strongly varying in the candidate countries and ranges between 4,6 hospital beds per 1 000

inhabitants (Cyprus) and 10,7 beds per 1 000 inhabitants (Czech Republic), which is a factor of 2,3 but includes also special hospitals and sanatoriums.

In the remaining candidate countries, the number of hospital beds available for in-patient care per 1000 inhabitants ranges between 5,1 and 8,4. This range corresponds to EU average (7 beds per 1000 inhabitants).



What the admittances to hospital in-patient care is concerned, Estonia, Malta, Romania and the Slovak Republic have an average rate of 200 with regard to 1000 inhabitants. This number is clearly lower in Poland and in Slovenia (120 -130 per 1000 inhabitants per year); Hungarian hospitals show a higher rate with a number of 254 hospital admissions per 1000 inhabitants per year.

The duration of hospitalisation is relatively short in Malta lasting in average for 4,5 days. In Cyprus, this rate is 1,5 days longer, whereas in the Czech Republic, Estonia, Hungary, Poland, Romania and the

Slovak Republic patients' average hospitalisation duration usually extends over 9 to 10 days. In Slovenia it lasts in average 8,6 days (including psychiatric beds) and 7,5 days (excluding psychiatric beds).

C) Economy indicators:

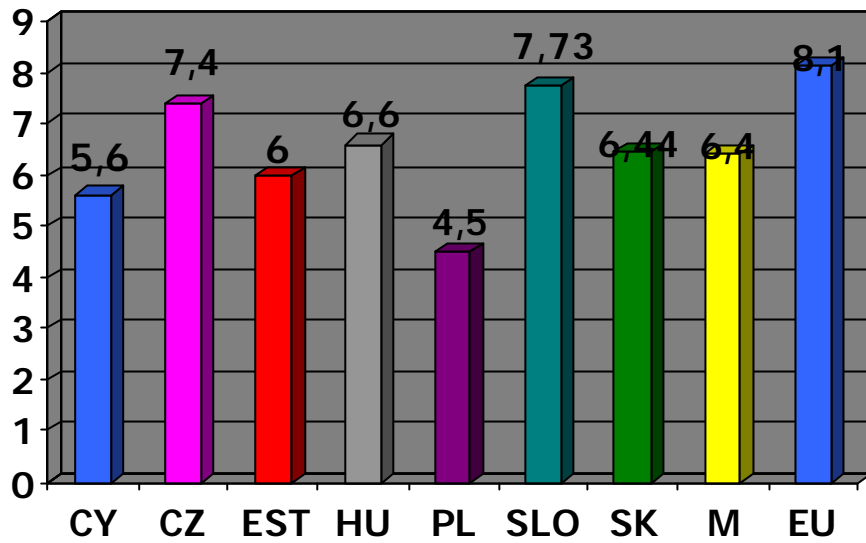
Considering the different gross domestic product (GDPs) per inhabitant, it is evident that any comparisons made between the candidate countries, resp. with the EU countries, have to be in a differentiated manner, if one considers that the GDP of Romania in 2000 was 1 621 USD and the GDP of Slovenia 9 364 USD per capita, which corresponds to a factor of 5.8. That means that Slovenia does not even approach the present EU average of estimated 20 808 USD. Even the GDPs of the “poorest” EU Member States, that are Portugal (10 439 USD) and Greece (10 648), are far more significant.

At present, the candidate countries have an average GDP of 4 340 USD. As explained before, Romania and Slovenia, ranging below average, constitute an exception.

The share of the health care expenditure in the respective gross domestic product, too, corresponds to the average income situation in the individual candidate countries. In Romania, this share is the lowest with 3,8% of the gross domestic product, in Slovenia and in the Czech Republic, this share is the highest with 7,73% and 7,4%.

In the remaining candidate countries, this share ranges between 4,5 and 6,6%, being once again, significantly below comparative figures of the EU, where an average of about 8,5% of the GDPs is spent for health care.

percentage of health care expenses in the gross domestic product



The ratios between public and private health care expenditure show clearly that the public sector is predominant.

Only in Malta private health care expenditure is relatively high with 40%, whereas in most of the other candidate countries it amounts to only 10%.

In Cyprus, private health care expenditure even exceed the public, implying a ratio of 34,8 : 65,2% in the total health care expenditure.

D) Medical studies:

Corresponding to the size of the countries, Poland and Romania have the largest number of medical faculties: in Poland, there are 13 medical faculties including the Centre for Postgraduate Training, in Romania, there are more than 10 state universities and 3 recently inaugurated private medical universities.

In Cyprus, there are no medical education facilities although there is a university. (Ongoing) Cypriot physicians study medicine abroad, but they have the possibility to undergo postgraduate training in their country.

Estonia, Slovenia and Malta have only one medical faculty, in the Slovak Republic, there are three, in Hungary four and in the Czech Republic seven.

Per year about 7700 medical students graduate from university in the candidate countries. Unfortunately, no data were available from Romania in this respect. We assume, however, that the total number of graduates from medical faculties in the candidate countries is about 9 000 per year.

All candidate countries, with the exception of Romania, have access restrictions for medical studies. In Malta students must attain the minimum grades as required by the University of Malta medical School.

Only a small number of students in Hungary and foreign medical students in the Slovak Republic and Poland have to pay tuition fees. The same is the case for medical studies at private universities in Romania, but not for studies at Romanian state universities.

The minimum duration of medical studies is six years in all candidate countries.

E) Licensing and registration of doctors:

At present, there are two licensing systems of doctors, which means the granting of the right to the independent free practice of the medical profession in the EU:

In the majority of the Member States, a non-specific license for the independent, free exercise of the medical profession is awarded, either immediately after graduation from medical studies, or after completion of subsequent postgraduate training. In these countries, in general, fully licensed doctors undergo postgraduate training in general medical practice or specialist training. In these countries therefore, the general license for free exercise of the medical profession differs from the specific license in general medical practice or the specialist license. In the other group of countries, which, at present, constitute a minority, the license for free medical practice is in actual fact the GP or specialist license. Therefore, those countries have no general medical license, but only the license as a specialist or as a general practitioner.

The educational systems in the accession countries, too, provide two options described above. In most of the training systems a basic qualification is foreseen which is obtained either immediately upon graduation from medical studies (Hungary, Romania), or after completion of postgraduate training of 1 to 2 years (Poland, Cyprus, Malta). Only the Czech Republic and Slovenia have no basic qualification, there the license to free exercise of the medical profession is obtained only after completion of specific training in

general medical practice or specialist training. The situation is still unclear in Estonia because the bill regulating the registration system has to be adopted in the parliament.

In most of the Mediterranean countries (comparable to Great Britain and the Scandinavian countries), licensing is carried out by state authorities (Medical Council in Cyprus, Malta). In the majority of the Eastern European candidate countries, the Medical Chambers, that are Medical Associations with compulsory membership, are the licensing authority (Czech Republic, Poland, Slovenia, Hungary). The Slovak Republic takes in this respect a special position, as licensing falls under the competence of the Slovak Postgradual Academy of Medicine. Romania, too, is an exception, as the College of Physicians is the licensing authority there.

The prerequisites for the registration as general practitioner or as a specialist will be dealt with later.

An unusual feature in the field of registration is observed in some candidate countries, where doctors need a specific license for self-employed establishment. Such a license is foreseen in the Czech and in the Slovak Republic, as well as in Hungary, Poland and in Slovenia. This license is, in general, awarded by the Medical Chamber (Czech Republic, Slovak Republic (partly) Slovenia and Poland). In the Slovak Republic it is partly carried out by the state authority. In the Czech Republic, the prerequisite for the granting of such a license is besides completion of training an additional period of medical practice of 3 years. In Poland, in Slovenia and in the

Slovak Republic, the proof of a properly established practice is required (in the Slovak Republic, where at present and in contrast to the other Eastern European candidate countries no obligatory membership is foreseen with the Medical Chamber, the conferral of this license preconditions the affiliation to this professional organisation).

F) Postgraduate medical training:

With the exception of Slovenia, doctors in all candidate countries must complete postgraduate practical training of 12 -30 months before they are authorized to engage freely in medical activities.

Such training is foreseen for general practitioners and specialists in all countries (at present, a bill is being dealt with in the parliament in Malta which should regulate this matter).

Postgraduate training in the candidate countries already corresponds to a large extent to the requirements of the EU Medical Directive 93/16/EEC. In Poland the minimum duration of postgraduate training is 4 years.

Medical doctors have the possibility to specialise in at least 33 (Estonia) and in up to 68 specialities and subspecialities (Slovakia). Slovenia has 37 specialities, the Czech Republic more than 40, Cyprus 45, Romania and Poland 61. In Hungary, there seem to be 30 specialities, too. Unfortunately, exact data were not available.

It is explicitly provided by law that doctors specialise only in one field (in several countries this can also be the speciality of general medical practice). This is the case in Cyprus, the Czech Republic, Estonia, Slovenia, the Slovak Republic and Romania. In Poland, Hungary and Malta such a specialization is not obligatory.

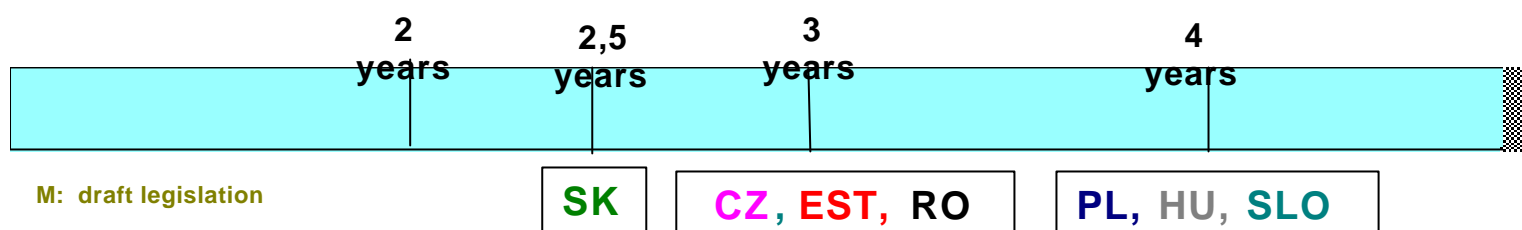
In all countries, postgraduate practical training of general practitioners can be undergone in hospitals as well as at university clinics, in the Czech Republic and in Slovenia, such training may, in addition, take place in the practice of a GP and in the Slovak Republic, the out-patient-department of the Hygienic Institute is also accredited for and takes part in such postgraduate training. In Poland, postgraduate medical training for general practitioners can be undergone in hospitals and teaching practices.

At present, Malta is developing a new training programme for general practitioners and for specialists. Postgraduate training of general practitioners in Cyprus is done abroad, mainly in the EU member states. It is according to the Directive 93/13/EEC.

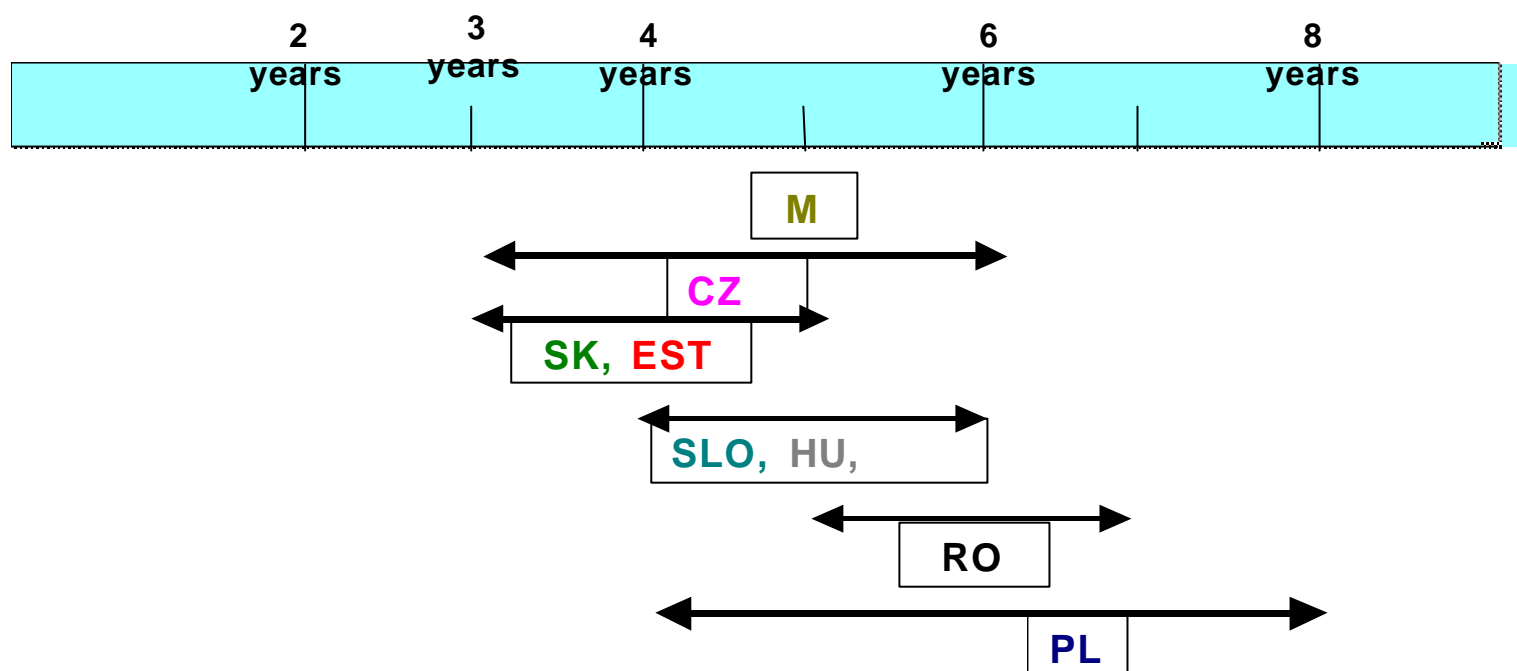
The duration of practical training in general medical practice ranges between 2,5 and 4 years.

Duration of practical postgraduate training...

General Medical Practice



Specialist Training



The duration of postgraduate practical training for specialists is considerably longer. Specialist training duration ranges from a minimum of 3 years (Slovak Republic and Estonia) to a maximum of 8 years (Czech Republic).

Practical training naturally strongly depends on the specific requirements of the speciality in question.

In Slovenia and in Malta, specialist training is provided exclusively in hospitals, in Estonia also in practices and in Hungary also at

universities. In the Slovak Republic, hospitals, universities as well as the Slovak postgraduate Academy of medicine are accredited teaching institutions for practical specialist training. In Poland and in the Czech Republic, specialists in training have the possibility to train in hospitals, teaching practices, universities and in health care institutions - in Poland clearly defined institutions having the right to perform medical services and employ medical personnel.

Cyprus provides specialisation programs only in a small number of fields what is done in association with the Athen university (Greece).

In principle, doctors in the candidate countries, have the possibility to undergo further specialisation.

In all candidate countries graduation from practical training in general medical practice, as well as in a speciality, preconditions examinations, which foresee a practical and a theoretical part. Multiple-choice-tests as well as also written final tests and oral examination tests are foreseen for this purpose.

After the candidates successfully passed their examinations they are awarded diplomas (with the exception of Malta). They are conferred by specific training institutions in the Czech Republic and Poland, namely the Institute for postgraduate medicine (Czech Republic) and the Medical Center for postgraduate training (Poland), the Slovak Postgradual Academy of Medicine (Slovakia), in Estonia by the Tartu University and by the Medical Association in Slovenia.

With the exception of Estonia and Malta, where a need of training posts in general medical practice and specialist posts is reported, the number of training posts in the candidate countries is judged sufficient. In Hungary, the state even guarantees the existence of training posts.

In Estonia and Malta, bottlenecks in the accession to training in general medical practice produce waiting periods. In Estonia, the waiting periods for GP and specialist training are one to two years. In Malta, waiting periods for specialist training of two to three years are usual.

Although the number of training posts is sufficient in the Slovak Republic, this is obligatory the waiting periods in hospital training of 6 months.

G) Organization and supervision of postgraduate medical training:

At present, the legal provisions regulating the organization and supervision of postgraduate training in Malta is subject to amendment. Until now, they fell under the competence of the state, the medical societies and the universities. The content of training was determined by national institutions and by the University of Malta, department of health.

In Cyprus, postgraduate training falls exclusively in the area of responsibility of the medical professional organization, the Pancyprian Medical Association and the Ministry of Health. The content of medical training is determined jointly by the Pancyprian Medical Association and by the medical specialist societies.

Postgraduate medical training lies in the joint competence of the Medical Association, the Institut of postgraduate medicine and the medical specialist societies and other institutions (which were not named) in the Czech Republic. The establishment of the contents of training, too, is incumbent on these bodies.

In Estonia, the Ministry for Education, the Ministry for social affairs, as well as the Tartu university are responsible for the organisation and supervision of practical training. The contents of postgraduate medical training is determined by the first and the least named body.

In Poland, there is a Center of postgraduate training which is competent, together with the Polish Chamber of doctors and dentists, for postgraduate training of medical doctors. It is also incumbent on these two bodies to specify the contents of training.

In Slovenia, the responsibility for postgraduate medical training is shared by the Slovenian Medical Chamber, the universities, the associated medical faculties, as well as the medical specialist societies.

The contents of medical training are determined jointly by the institutions mentioned above and by the Medical Society of Slovenia.

The SPAM (Slovak Postgraduate Academy of Medicine) which falls under the competence of and is funded by the Ministry of Health, is responsible for postgraduate training of doctors in the Slovak Republic. Courses are carried out by the medical professional organisation. The contents are fixed jointly with the medical specialist societies.

In Poland, postgraduate training lies within the competence of the Chamber and the Medical Centre of Postgraduate Training. The contents of medical training are established jointly by the Polish Medical Chamber, the Medical Center of Postgraduate Training .

In Hungary, only the universities are responsible for postgraduate training of doctors. The contents are determined by the "Council for

basic and continuing education of health workers" which is subordinate to the Ministry of health.

All candidate countries, with the exception of Romania and Slovenia, are facing amendments to postgraduate training. In Slovenia, changes of content and duration of specialist training were made last year and compulsory specialization in family medicine was introduced.

In Cyprus and in the Slovak Republic, the training regulations are being amended in terms of the Medical Directive of the EU.

Changes are also planned for this year in the Czech Republic.

In Estonia, changes are expected in the field of the legal regulation of training and of the right to medical practice. In addition, the financing of postgraduate training will be transferred from the Ministry of Education to the Ministry of Social Affairs.

In Poland, the former two-staged training system in which doctors were first licensed for independent, free medical practice and only subsequently were able to acquire additional qualifications, was changed into a uniform one.

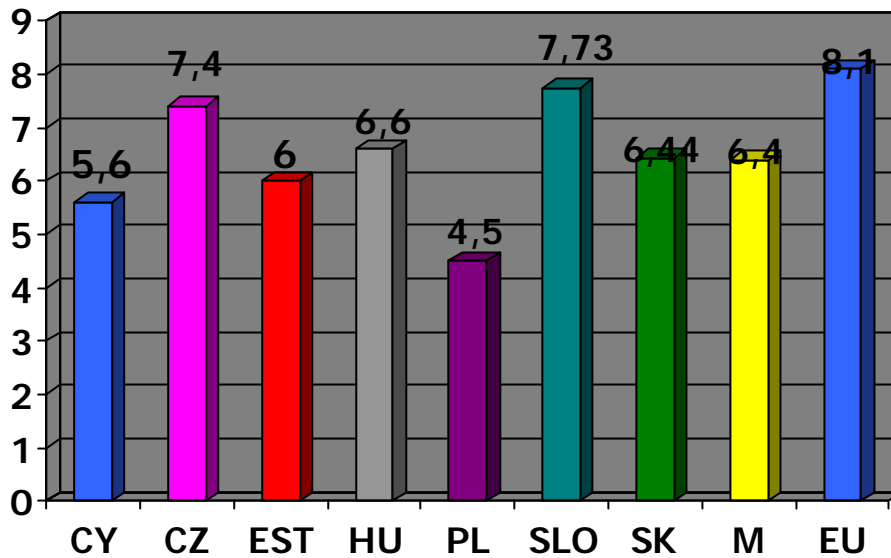
In Hungary, a so-called "resident system" (two years after completion of university studies) is being introduced. In Malta, the present training structure is being formally determined.

H) Financing of the health care system:

With regard to financing sources of the health care system, two different groups must be distinguished within the candidate countries. The Mediterranean accession states Cyprus and Malta have national health care systems (Beveridge models) in which no health insurance funds exist, and where health care expenses are covered either by tax proceeds or by private co-payments. It is striking that, compared with national health care systems of other European States, private co-payments are remarkably high. In Cyprus, about 40% of health expenditure are funded by tax proceeds and 60% by private payments. In Malta, 60% of health expenditure is financed by tax proceeds, whereas 40% are funded by private sources.

After the political turnabout, all Eastern and Central European candidate countries have introduced health care systems on the basis of health insurance funds, this is why the predominant part of health care expenses in these countries are financed by social insurance contributions. In these countries, 80-94% of health care expenditure are funded by social insurance contributions, some Eastern and Central European countries foresee (relatively small) financial contributions in form of tax proceeds (Slovenia 3%, Estonia 5,6%, Czech Republic 10% Romania 10%). With the exception of Slovenia (20%), Estonia (12%) as well as the Slovak Republic (6%), private payment into the health sector is insignificant in the candidate countries.

percentage of health care expenses in the gross domestic product



Only the health insurance funds in Romania determine themselves the amount of health insurance contributions. In the other countries with health insurance funds the health insurance contributions are predefined by law. Health insurance contribution rates range between 7,5% of the income in Poland and 14% of the income in Romania, these contributions being normally shared between employers and employees. (In Poland health care contribution is paid by employees only.)

In the Eastern and Central European candidate countries, the active population is generally subject to compulsory insurance. No exceptions to this rule exist for groups with a higher income, as it is the case in Germany or in the Netherlands. Eastern European health care systems are in so far different, as there are some countries with only one single health insurance fund, which covers the total active population in a monopoly-like manner with no free choice (Estonia,

Slovenia, Hungary). On the other hand, in a number of countries, the affiliated population has a free choice between different health insurance funds (Czech Republic, Slovak Republic, Poland, Romania). All countries have in common, that their insurance system provides coverage not only for the active population, but also to jointly insured family members and the retired and unemployed population. The percentage of the insured persons who are gainfully employed or self-employed ranges from 37% (Slovenia) and 47,7% (Slovak Republic).

In a number of candidate countries, no co-payment is foreseen for patients at present. This is the case in the Czech Republic, in Estonia, in Poland and Malta. However, relative extensive patient co-payments are foreseen in the Slovenia (children and pregnant women are exempted, whereas in-patient and out-patient medical services and pharmaceuticals are subject to co-payment of 5 to 50%). In Poland medications are subject to co-payment. There are patient co-payment provisions in Hungary and in the Slovak Republic as well as in Romania for some medical services.

At present, private (additional) health insurances are not the rule in the candidate countries. Only in Slovenia, 67,8% of the population have such an additional private insurance, mainly in order to cover co-payment provided by statutory health insurance. Not included in the rate mentioned are children and some socially endangered groups which do not need to pay co-payments and are fully covered without additional insurance for the basic basket of benefits.

In Hungary, there exist two private health insurances, which cover better hospital accomodation, in Romania, there is one private health insurance which covers services which are not provided as basic package under the statutory health insurance. In Malta, about 15% of the population are covered by one of the five private health insurances which cover services which avoid waiting lists and enables better 'hotel services and also access to certain procedures not available on the national health service such as removal of tattoos for example.

l) Primary medical care:

In all candidate countries, out-patient medical care is provided by self-employed doctors (general practitioners and specialists), health centers and out-patient departments of hospitals.

In Cyprus and in Malta (both have national health systems), primary medical care is provided by health centers under the national health system, resp. by out-patient hospital departments as well as by self-employed private, where the patient has to pay the fees directly.

In the Central and Eastern European candidate countries with their health systems based on insurance funds, out-patient medical care is provided by doctors who conclude contracts with the health insurance funds. Besides self-employed doctors there exist also health centers which are under contract with the health insurance funds and employ doctors. In the states with health insurance fund based systems, doctors are required to apply for a license at the Medical Chamber before they establish themselves. Apart from other criteria, they have to furnish the proof of suitable premises. The selection of the doctors who are taken under contract lies exclusively in the decision of the health insurance funds (Czech Republic, Poland, Slovak Republic), resp. the municipalities (Hungary, Slovenia).

In most of the Eastern European candidate countries, primary out-patient medical care is limited to certain specialities (general practitioners, specialists in general internal medicine, gynaecologists,

ophthalmologists, paediatricians). Only in the Czech Republic and in Hungary, specialists in other fields provide primary medical care under health insurance funds.

In the national health systems (Malta, Cyprus) doctors providing out-patient care under the health service are salaried. In the Central and Eastern European health insurance fund systems, self-employed doctors are remunerated by the health insurance funds. Lump-sum payment is, in general, foreseen for GPs, specialists are remunerated according to a fee-for-service system. In Estonia, the remuneration level of physicians providing primary care is determined by the health insurance fund, subject to approval by the government. The Czech Republic has a tariff system which is provided by the state, under which the health insurance funds and the medical organisations negotiate the prices per unit. If there is no agreement between doctors and funds, the government takes a final decision. In Hungary, medical fees are determined by the state, financial supplements by the municipalities are foreseen. In Romania, the fees are negotiated between the medical organisation, the unions and the health insurance funds. In Slovenia, a new remuneration system was adopted in 1999, which has not been introduced until now. This remuneration system shall take account of the effective working time of doctors and is determined by a collective agreement between the medical organisation, the fund and the state. In Poland, the fees underlying the individual contracts are determined jointly by doctors and health insurance funds (no collective tariff system).

In the Central and Eastern European health insurance fund systems, patients have to register in the list of a family doctor, switching is possible only after expiration of a predetermined period (between three and twelve months). With the exception of the Czech Republic, primary care physicians (general practitioners and paediatricians) function as gate-keepers. Specialist care can therefore only be provided after referral by a general practitioner (with the exception of psychiatry and certain specialisations in Slovakia).

In most of the Central and Eastern European states, there is one general practitioner for 1500 to 2300 inhabitants. Only in Poland, the number of GPs is lower (one specialised family doctor per 6 300 inhabitants). On the other hand, Poland and Slovenia report an extremely high density of specialists in internal general medicine (Poland 1:2887, Slovenia 1:2316).

J) Hospital structure:

In nearly all candidate states, hospitals are operated by the state. In the Czech Republic and in Poland, there are some hospitals which are run by charitable organisations. In Poland, majority of hospitals are operated by local governments, and only few are run by the state (these are mostly university clinics. Several private hospitals exist in Cyprus, in the Czech Republic, in Estonia, Poland and in the Slovak Republic.

Whereas hospitals in the Mediterranean candidate states with a national health system are financed by tax proceeds, a mixed financing exists in the Central and Eastern European health systems based on health insurance funds. It is common in all states, that the health insurance funds finance the hospital sector, state subsidies, however, being the rule. In all countries, the legal entities concerned foresee predetermined salaries for hospital doctors. This does not apply to Poland, where salaries of hospital doctors depend on the hospital's managers. Only in Cyprus, there are private hospitals, where doctors are directly remunerated by private patients.

The colleagues from Cyprus, Romania and Hungary indicated no significant problems in connection with waiting periods for in-patient care. In the Czech Republic, there are waiting periods for several interventions of up to one year, in Slovenia waiting periods of up to two years are common (for hip operations 18 months, for cataract operations 24 months), the Slovak Republic reports waiting periods

for hip operations of up to six months and Poland indicates waiting periods of up to two years for this intervention.

The Slovakian and Romanian colleagues considered the number of hospital doctors too large (in Romania, this statement concerns only large towns). There is a shortage of hospital doctors in Slovenia. Romania reported also shortage of doctors in remote areas and Hungary stated shortage of medical manpower in certain specialities (pathology, anaesthesia). In general, hospital doctors are not engaged in self-employed activities (establishment in a practice) besides their hospital employment. Only in Hungary and Poland, there is a relatively large number of hospital doctors which are engaged in self-employed activities.

K) Professional law and rules of conduct:

All candidate states have detailed medical professional laws and rules of conduct. In most of the states, this professional law is laid down in legal provisions as well as in regulations by medical organisations. In Poland, the Chamber is responsible for the rules of conduct. Professional medical law is specified by the state after consultation with the Chamber.

The professional duties such as the obligation to conscientious patient care, adequate patient documentation, medical secrecy as well as the obligation of continuing medical education and professional development are laid down in the professional rules of conduct in the candidate states, and satisfy present EU standards.

As opposed to most of the present EU Member States, some candidate states even foresee obligatory continuing medical education (CME) for doctors. Accordingly, doctors in Slovenia are obligatorily subject to relicensing every seven years. In Hungary, a license is withdrawn if the doctor does not fulfill the requirements of obligatory continuing education. In Poland, where a doctor can be obliged to further education, he/she may be punished if this requirement is not met. In Malta CME is an ethical duty for all doctors, with some academic societies requiring mandatory participation to maintain membership.

In general, the medical organisations are in charge with the supervision of professional law and the rules of conduct. In Estonia,

this competence is incumbent on the Ministry. Malta has a Medical Council (similar to the UK) which is legally responsible for the supervision of the profession, both within the parameters set out by the law regulating the profession and the ethical standards expected of the profession. All doctors must be registered with the Malta Medical Council prior to being eligible to practice in Malta.

In most of the candidate states, doctors are obliged to exercise only on the grounds of academic, conventional medicine. Only by Hungary it was reported that certain non-conventional medicinal procedures are allowed, subject to a special authorisation.

All candidate countries (with the exception of Slovenia) indicate an increasing number of actions for damages. As obviously opposed to the present EU Member States, these actions for damages are less based on the question of patient information, but rather on medical malpractice.

L) Medical professional organisations:

In the majority of the Central and Eastern European candidate states, there are Medical Chambers, that is to say medical professional organisations provided by law with compulsory membership (Czech Republic, Poland, Slovenia, Hungary, Romania). In Cyprus, too, there is a medical professional organisation with obligatory membership. In the Slovak Republic, membership is compulsory only for self-employed doctors, in Estonia, the affiliation to the medical association is on a voluntary basis (not provided by law). The same is the case for the Romanian Medical Association, whereas affiliation to the Romanian College of Physicians is compulsory.

In general, there are scientific societies with voluntary membership (Czech Republic, Slovak Republic, Slovenia, Hungary, Poland) besides the medical chambers, as well as unions (Czech Republic, Poland, Slovenia, Hungary, Slovak Republic), also with voluntary membership.

All medical associations are charged with the supervision of professional law and rules of professional conduct. Several Medical Chambers are, in addition, competent for license and diploma issuing (Cyprus, Czech Republic, Slovenia, Hungary, to a certain extent also in the Slovak Republic). In Poland, Chambers are competent for licence, and medical faculties for diploma issuing. Furthermore, most of the Medical Chambers represent the economic interests of their members. In the area of self-employed doctors, in particular, it is

incumbent on the Medical Chambers to take quality assurance measures.

***IV. Detailed evaluation
of the questionnaires
on the health care systems
in the candidate states***

A. Doctors (persons graduated from medical schools)

1. Number of doctors:

Country	Number of doctors in total (1999/2000)
CY	1.863
CZ	32.559
EST	4.426
HU	46.560
M	800
PL	133.800
RO	42.975
SK	20.354
SLO	4.641

	Male doctors	Female doctors
CY	1285	578
CZ	44%	56%
EST	1119	3307
PL	64 100	69 700
SLO	44 %	56 %
HU	18.102	18.284
M	70%	30%
SK	8906	11448

	Active doctors	Unemployed doctors
CY	1863	
CZ	32.559	

EST		
PL	133 800	1200
SLO	4.641 (4.272 in medical service, with different employments)	30
HU	36386	~ 186
M	~700	0
SK	20354	108

	General Practitioners	Specialists
CY	328	1478
CZ	Cca. 5000	Cca. 27.500
EST	1009 (GP+family doctors)	3327
PL	40.100 (these are primary care physicians, such as: family physicians, general medicine physicians - old specialisation, internal medicine physicians, paediatricians and doctors in training)	93 700
SLO	982	2.140
HU	6.322	26.215
M	No data	No data
SK	6570	12632

Suppl. 1: Number of doctors directly engaged in patient care respectively medical practice (excluding all physicians with exclusively administrative or scientific tasks)

CY	1771
CZ	32000
SLO	3952
HU	36,386 (out of 44,200)
SK	(20354, stomatologists 2496, without stomatologists 17858), 17531 (327 doctors out of medical practice). The data are not precise (no data from the pharmaceutical companies, no precise data from the Ministry of Education and Slovak Academy of Sciences)
PL	data unknown
M	~ 700

Suppl. 2: The number of doctors aged over 65:

CY	149
CZ	2135
SLO	60 (includes only active doctors)
HU	2165
SK	481
PL	circa 17.000
M	~ 320

	established self-employed doctors:	Employed Doctors:	Both (established and employed):	Doctors in training:
CY	1373	490	1863	36
CZ	15700	14859	30559	
EST	no exact number available	2060		469
PL	Established self-employed and employed doctors: it is difficult to cut a clear boundary between those two categories, and show the relationship between them in percent. We are only able to give the number of doctors working in individual medical practice, which is about 50 000 (many of them are employed in other health care institutions as well)		133 800	(no data)
SLO	392	3.880 (med. serv.) 369 (diff. empl.)	4.272 (med. serv.) 369 (diff. empl.)	895
SK	8299	12055	20354	2270

Suppl. 3: Number of doctors in training:

CY

- general practitioners and specialists in general medical practice/family doctors: 66
- specialists . 52

CZ

- general practitioners: 400
- specialists 2600

SLO

- general practitioners: see secondment
- specialists in general medical practice/family doctors: 214
- specialists 547
- secondment: 235

HU

- general practitioners: 6800
- specialists in general medical practice/family doctors 5000
- specialists 30000

SK

data available in the end of August

- general practitioners: _____

- specialists in general medical practice/family doctors: _____
- specialists _____

PL

- general practitioners: -
- specialists in general medical practice/family doctors: 1 821
- specialists: 33 457 (21)

M ~ 65 in total

2. Medical manpower:

Excessive number of doctors:	SK, RO: in the big cities
Shortage of doctors:	SLO, RO: in remote areas - rural zone
Sufficient number of doctors :	CY, EST, PL, HU, M
No answer:	CZ

Excess in doctors is found mainly in the following specialities:

Paediatricians (PL)
 Internal medicine, gynaecology, paediatrics in hospitals, general surgery in hospitals (ophthalmology, urology , otorhinolaryngology) (SK)
 Surgery, Obstetric, Gynaecology (HU)
 RO: general practitioners

Lack of doctors is mainly observed in the following specialities:

family physicians (PL)
 psychiatry, radiology, pathology, microbiology (SK)
 family medicine, ophthalmology, anaesthesiology, otolaryngology (SLO)
 Anaesthesiology, Pathology (HU)
 Radiology, laboratory, intensive care (RO)
 radiology, pathology (CZ)

CYP	CZ	EST	HU	M	PL	RO	SK	SLO
1 GYN/s-e	top manager	bank director	bank director	lawyer	bank director	bank director	top manager	top manager
2 PAED/s-e	bank director	Lawyer	minister	t/m cons	top manager	top manager	bank director	lawyer
3 dentist	lawyer	top manager	lawyer	top manager	lawyer	minister	lawyer	bank director
4 3 OPHT/s-e	architect	Minister	top manager	bank director	t/m cons	dentist	t/m cons	minister
5 lawyer	minister	Architect	univ prof	minister	minister	t/m cons	architect	HD/HD
6 t/m cons	t/m cons	t/m cons	dentist	GYN/s-e	architect	GYN/s-e	minister	OPHT/s-e
7 bank director	dentist	Dentist	comm empl	OPHT/s-e	public servant	OPHT/s-e	comm empl	dentist
8 top manager	GYN/s-e	univ prof	HD/HD	HD/HD	GYN/s-e	INT/s-e	public servant	INT/s-e
9 minister	OPHT/s-e	public servant	architect	PAED/s-e	OPHT/s-e	PAED/s-e	univ prof	10 HD/QUAL
10 INT/s-e	GP	GYN/s-e	engineer	GP	dentist	GP	dentist	10 GYN/s-e
11 10 HD/HD	INT/s-e	OPHT/s-e	GYN/s-e	dentist	HD/HD	univ prof	HD/HD	10 t/m cons
12 10 architect	PAED/s-e	HD/HD	OPHT/s-e	HD/QUAL	univ prof	HD/HD	GYN/s-e	11 PAED/s-e
13 10 GP	univ prof	INT/s-e	GP	univ prof	GP	HD/QUAL	GP	architect
14 10 univ prof	comm empl	PAED/s-e	t/m cons	architect	INT/s-e	HD/TRAIN	HD/QUAL	14 univ prof
15 10 teacher	HD/HD	HD/QUAL	teacher	INT/s-e	PAED/s-e	lawyer	INT/s-e	GP
16 12 engineer	HD/QUAL	GP	INT/s-e	HD/TRAIN	ind empl	architect	OPHT/s-e	ind empl
17 12 HD/QUAL	engineer	Engineer	HD/QUAL	teacher	comm empl	public servant	PAED/s-e	HD/TRAIN
18 tech mech	teacher	Secretary	HD/TRAIN	engineer	engineer	engineer	teacher	engineer
19 public servant	tech mech	ind empl	PAED/s-e	comm empl	worker	comm empl	HD/TRAIN	comm empl
20 nurse	public servant	tech mech	nurse	nurse	tech mech	nurse	engineer	nurse
21 comm empl	ind empl	Teacher	tech mech	public servant	teacher	tech mech	tech mech	secretary
22 ind empl	secretary	comm empl	worker	secretary	HD/QUAL	ind empl	nurse	public servant
23 HD/TRAIN	nurse	HD/TRAIN	secretary	tech mech	secretary	teacher	ind empl	tech mech
24 secretary	worker	Nurse	ind empl	ind empl	HD/TRAIN	worker	secretary	teacher
25 worker	HD/TRAIN	Worker	public servant	worker	nurse	secretary	worker	worker

GP = general practitioner

GYN/s-e = self-employed gynaecologist

PAED/s-e = self-employed paediatrician

OPHT/s-e = self-employed ophthalmologist

INT/s-e = self-employed doctor specialized in internal diseases

HD/HD = hospital doctor - head of department

HD/QUAL = hospital doctor - fully qualified

HD/TRAIN = hospital doctor in training

t/m cons = tax and or management consultant

comm empl = commercial employee

univ prof = university professor

tech mech = technician, mechanics

ind empl = industrial employee

Suppl. 4: Doctors engaged in primary/secondary care:

CY

- ◆ primary care? 765
- ◆ secondary care? 1006

CZ

- ◆ primary care? 7500
- ◆ secondary care? 24500

SLO

- ◆ primary care? 948
- ◆ secondary care? 3004 (includes gynaecologists and paediatricians accessible without prior visit at a general practitioner)

HU

- ◆ primary care? 5178 GP and 1563 family paediatricians)
- ◆ secondary care? 29645

SK

- ◆ primary care? GP 2121.5
paediatricians 1201.5
gynaecologists 471.94
- ◆ secondary care? all 3794.94
4429.55

PL

- ◆ ??primary care? 21000 doctors (6 000 Family Medicine doctors and 14 000 others: specialists in internal diseases, paediatricians and doctors without specialisation). Additionally, patients can go to such doctors as a first contact (without referral) as gynaecologists - obstetricians, dermatologists, oncologists, psychiatrists, neurologists and ophthalmologists. (22)
- secondary care? The group of ambulatory specialists is not separated, many of the work both in hospitals and ambulatories

M

- ◆ primary care? ~ 300
- ◆ secondary care? ~ 500

4. Age of retirement:

CY	established self-employed doctors	70 yrs.
	Employed doctors	60 yrs.
CZ	established self-employed doctors	unlimited
	Employed doctors	62 yrs.
	University teachers	65 yrs

EST	established self-employed doctors Employed doctors	65-70 yrs. 65 yrs.
HU	established self-employed doctors Employed doctors	70 yrs. 62 - 65 yrs.
PL	established self-employed doctors Employed doctors No retiring age for established self-employed doctors!	60-65 years 60-65 years
M	established self-employed doctors: no compulsory retirement Employed doctors	60/61 years
SK	established self-employed doctors: Employed doctors Right to pension: male 60 yrs., female 57 yrs. minus 1 year per child, but he or she must require the retirement	65-70 years 60-65 years
SLO	established self-employed doctors employed doctors	63 years for men 61 years for women (full age of retirement) 60 years for men 58 years for women (minimal age of retirement) 63 years for men 61 years for women (full age of retirement) 60 years for men 58 years for women (minimal age of retirement) Data above are given according to law (minimum age for „full“ retirement), but there is another condition for full retirement (minimum 35 years of work for women and 40 years of work for men). Pension system reform from 1999 introduced prolonged age of retirement for few years in the future (step by step). Because of long studies for medical profession doctors usually retire when they are around 62 (women) and 66 (men).

Suppl. 5:

Different retiring age for doctors in public service and private doctors?

no: SLO, HU, PL

yes, the retiring age is...

- a. **for doctors in public service:** M: 61 (men), 60 (women)
CY: 60
SLO: 62-64 estimated
HU: the official age for retirement is 62 years, doctors usually retire at 65-70 years
SK: male 60 - female 57 minus 1 year/child (e.g. 55 with 2 children) - in 2002 probably a new law
- b. **for private doctors:** CY: 65-70
M: usually no practicing after 70 years
SLO 62-64
SK, PL: no retiring age

Suppl. 6: Doctors only engaged in part-time medical practice:

- a. **hospital doctors:** CZ: n.a.
CY: --
SLO: 0%
HU less than 5 %
SK 1-2%?
PL: no data
- b. **self-employed doctors :** CZ: --
CY: --
SLO: 0%
HU: --
SK: probably 0%
PL: no data

Suppl. 7: Doctors engaged in additional professional activities (for instance employment in a hospital and self-employed activity in a practice)?

- a.% **full-time hospital doctors:** CZ: n.a.
CY: --
SLO: --
HU: 5%
SK: 5%
PL no data, but many
- b.% **full-time self-employed doctors:** CZ: --
CY: 0,9%
SLO --
HU: 20%
SK: only duties and similar activities
PL: no data

SLO 15% full-time hospital doctors and self-employed doctors (estimated)

B. Population

1. Number of inhabitants:

Country	Inhabitants 1999/2000 in 1.000
Bulgaria	8.135
CY	666,8
CZ	10.280
EST	1.439
HU	10.043
Latvia	2.465
Lithuania	3.705
M	379
PL	38.654
RO	22.500
SK	5.399
SLO	1.986
Turkey	65.801

1. Birth-rates:

Country	Birth rate, crude 1999/2000 per 1.000 people
Bulgaria	8,70
CY	7,6
CZ	8,8

EST	8,70
HU	9,4
Latvia	8,00
Lithuania	10,30
M	11,36
PL	10,70
RO	10,40
SK	10,47
SLO	8,8
Turkey	22,20

2. Rate of infant mortality:

Country	Infant mortality per 1.000 viable births (1999/2000)
Bulgaria	14,4
CY	6,0
CZ	4,2
EST	9,5
HU	8,4
Latvia	15,0
Lithuania	9,3
M	5,3
PL	9,5
RO	18,6

SK	8,34
SLO	4,6
Turkey	37,9

2. People aged 65 and older:

Country	Population aged over 65	Men	Women
CY	75.400 (1999)	33.000	42.400
CZ	1,418.088	544.859	873.119
EST	207 696 (1999)	67 814	139 882
HU	1,467.815 (2000)	544489	923326
M	36.318 (1999)		
PL	4,594.536 (1998)	1,749.589	2,844.947
RO	2,972,7 (1999)		
SK	615.187 (1999)	235.042	380.145
SLO	272.147 (1999)	99.228	172.919

4. Life-expectation at birth:

Country	Life expectancy at birth		
	female	total	male
Bulgaria	74,40	70,71	67,20
CY	80,00	77,1	75,00
CZ	78,35	75	71,65
EST (1999)	76,09		65,35
HU	75,20	70,65	66,30
Latvia	74,90	69,21	63,80
Lithuania	76,80	71,21	65,90
M	79,16	77,02	75,00
PL	77,00	72,64	68,50
RO	73,32	69,24	65,46
SK (1999)	77,00	72,85	68,70
SLO	78,7	75,3	71,1
Turkey	71,70	69,03	66,50

4. Rate of deaths per 1.000 inhabitants:

	cases of death per 1.000 inhabitants (1999)
CY	6,0
CZ	10,6
EST	12,79
PL	9,9
SLO	9,6
HU	14,2
M	8,16
SK	9,71
RO	11,8

2. Hospital-beds per 100.000 inhabitants:

Country	Number of beds per 1.000 inhabitants
CY	4,61
CZ	10,72
EST (1999)	7,19
HU	8,4
M	5,8
PL (1999)	5,1
RO	7,3
SK (2000)	7,82
SLO (2000)	5,11

2. Average number of admittances to hospital in-patient-care per year (1999):

Country	Number of admittances	Inhabitants in total	= ... admittances per 1.000 inhabitants per year
CY	58441 (public sector)	666.800	88
CZ	2,006.383	10,280.000	195,1
EST	282 302	1,439.000	196
HU	2.557.000	10,050.000	254
M		379.000	202
PL	4,597.000	38,654.000	119
RO	4,653.400	22,500.000	207.
SK	1,059.533	5,399.000	196,26
SLO	263.700	1.985.557	132,81

2. Duration of the average hospital stay:

Country	Days of hospital care in average	Number of cases of hospital care per year (1999)
CY	6	303.361
CZ	9,35	246,3 (?)

EST	9,9	282 648
HU	9,2	
M	4,56	
PL	9,3	5,685.288
RO	9,5	4,653.000
SK	9,06	1,059.533
SLO	9	342.023

C. Economic data

1. Gross domestic products:

	GDP real (changes in %)			GDP per inhabitant 1999 (US\$) at	
	1998	1999	2000	Exchange rate	Purchasing power parity
Bulgaria	+ 3,5	+ 2,5	+ 4,0	1.464	5.218
CY	+ 5,0	+ 4,5	+ 4,8	1.605	18.500 €
CZ	- 2,3	- 0,6	+ 1,5	5.206	13.374
EST	+ 4,7	- 1,1			
HU	+ 4,9	+ 4,0	+ 4,5	4.865	11.346
M				4.380	
PL	+ 4,8	+ 4,1	+ 4,5	3.999	8.910
RO	- 5,4	- 3,9	+ 0,0	1.449	5.872
SK	+ 4,1	+ 1,9	+ 2,2	46,28 SK	(?) 10.418
SLO	+ 3,8	+4,9	+4,7	10.078	15.700

1. Percentage of health care expenses in the gross domestic product:

	Percentage of gross domestic product
CY	5,6%
CZ	7,4 %
EST	~6 %
Hungary	6,6 %
M	6,4 %
PL	4,5 %
RO	3,8% (2,06 in 1999)
SK (2000)	6,44 %*
SLO	7,73 %
Public health expenses	
CY	34,8%
CZ	91,5 %
EST	87,8 %
.....	
* The real insurance payment is and will be lower	

M	60 %
PL	93 %
RO	209968964,2 millions Lei (1999)
SK (2000)	89,99 %
SLO	87,9 %

Private health expenses		
	CY	65,2%
	CZ	8,5
	EST	12,2
	HU	no data
	M	40 %
	PL	7 %
	RO	
	SK	30,817.000 * (40-50%)
	SLO	12,1
<div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>* very rough calculation - private!!!</p> <p>a. hospitals - minimum - non hospitlas</p> <p>b. gps 85,5%</p> <p>c. spec. 34,2%</p> <p>d. dentals care majority</p> <p>e. medicine - about 60%</p> <p>a. = 0</p> <p>b. = from 15,968.000 → 13 653</p> <p>c. = from 14,222.000 → 4 864</p> <p>d. → 2 300</p> <p>e. 10 000</p> <p>-----</p> <p>30817</p> </div>		
CY, EST, SLO, M data not available	PL: ... for hospitals	49,4 %
	... for non hospital care	20,5 %
	... for dental care	5 %
	... for medicine and medical devices	15 %
CZ	... for hospitals	43,4 %
	... for non hospital care	24,1 %
	... for dental care	5,2 %
	... for medicine and medical devices	20,0 %
SK	... for hospitals	47,7 %
	... for non hospital care	15,7 %
	... for dental care	4,7 %
	... for medicine and medical devices	28,5 %
RO	... for hospitals	~ 60 %
	... for non hospital care	~ 25 %
	... for dental care	~ 3 %
	... for medicine and medical devices	~12 %

1. Number of self-employed, unemployed, retired and other persons:
No data from: M

	Number CY (1999)	Number CZ (IV Q. 99)	Number EST (1999)	Number PL (2.q.2000)	Number SLO (1999)	Number SK (1999)
Employed (self- and salaried) persons		4.765,4 tis. (IV Q. 99)	614 000	14,518.000	758.474	2132100
Unemployed persons	10.400	470,4 tis.	86 200	2, 825.000	114.348	416800
Retired persons		1.797,5 tis. (30.6.98)	181 700	9,429.000	479.204	1043500
Others		3.249,3 tis. (approx.)		11,882.000	633.974	1718500

D. Medical studies

Suppl. 8: Number of medical schools:

CY:	--
CZ:	7
SLO:	1
HU:	4
SK:	3
PL:	12 and the Medical Centre for Postgraduate Training
M:	1

1. Number of medical faculties (associated to universities):

	Number of faculties
CY	0 (no medical school in CY)
CZ	7
EST	1
PL	12
SLO	1
HU	4
M	1
SK	3
RO	10 state owned universities, 30 new medical faculties (of non profit foundations)

1. Number of students, who study medicine resp. graduate per year:

	Medical students in total	Number of graduated medical students
CY	---	---
CZ	1.300/yr.	1.300
EST (2000)	737 (dentists not included)	66
PL (1999) actual data kept from: Medical Faculties	29 000	4 547
SLO (2000) actual data kept from: Medical Faculty	165 (new students in the first year of studies 2000/2001)	141 in 1999
HU (2000, estimation)	1.150/yr.	1.000/yr.
M (2000, actual data kept from: Medical School)	241	Average ~ 45
SK (1999)	Appr. 3500 - 250 in CZ	Appr. 600/yr.

1. Access restrictions for medical studies:

Yes: CZ, EST, PL, SLO, HU, SK (entrance examination)

No: RO, M (for students acquiring the required grades)

No answer: CY

2. Fees for medical studies:

Yes: SLO, HU, RO (for non profit universities)

No: SK, RO (for state owned universities (in the limit of places approved by the government), PL, M, CZ, EST

No answer: CY

Suppl. 9: Tuition fees:

CZ: no

SLO: no

HU: generally: no; a small number: yes (f.e. foreign language faculties)

SK: no, only foreign students - about 7000 USD/year

PL: no (only for foreign students)

M: no

3. Minimum resp. average duration of medical studies for students (undergraduate training):

	CY	CZ (1999)	EST (2000)	HU	PL (1999)	SLO (2000)	M (2000)
Minimum study duration	--	6 yrs.	6 yrs.	6 yrs.	6 yrs.	6 (medicine), 5 (dentistry)	5 yrs. + 2 yrs. pre-registration
Average study duration	---	6 yrs.		6 yrs.	6 yrs.	7,9 years (source: Medical faculty of Ljubljana)	as above

	SK (2000)	RO			
Minimum study duration	6 yrs.	6 yrs.			
Average study duration	6 yrs.	1 yr - practical training (stagiature?), 5-7-yrs - residency (according to the speciality)			

E. Licences und Registrations

Suppl. 10: If you have a licensing system for doctors in your country, is there a difference between the basic qualification (license) which entitles doctors to free practice (without supervision) and the qualification of GPs and of specialists?

- **yes:** HU, SK, PL, M, CZ
- **no:** SLO, CY

Requirements for doctors to obtain the qualifications mentioned above:

- a. **basic qualification (license)** CZ: 1st specification level;
CY: Medical Diploma and pre-registration training
SLO: --
HU: medical diploma
PL: after finishing one year training practice starting after graduation
M: 5 years + 2 years registration
- b. **GP qualification** CZ: 1st specification level
SLO: finished secondment (2 years by 2007, after 2007 finished specialisation of family medicine)
HU: special examination (core training)
PL: 4 years plus state examination
M: legislation in process , agreed at 3 years
- c. **specialist qualification** CZ: 1st specification level
SLO: finished specialisation
HU: speciality examination
PL: 5-6-years plus state examination
M: legislation in process which will formalize the situation

SK: The licencing in SK is not qualification, it is "only" certificate for the private doctors, what allows them to work as private doctors. Both private and non-private doctors in hospitals and in out-patient dpts need the same graduation. 1st graduation to free practice without supervision is obligatory (GPs, pediatricians, gynaecologists, all specialists.

2nd graduation to free practice is obligatory for some specialists (e.g. for nephrologists: 1st graduation - internal medicine, 2nd graduation - nephrology)

Suppl. 11: Licensing authorities (issuing licenses to free practice):

CY: Medical Council and Ministry of Health

CZ: Medical Chamber

SLO: Medical Chamber of Slovenia

- HU:** National Institute of Public Health and Medical Offices - NIPHMO (ANTSZ)
SK: State doctors on the level of state administrative districts and Ministry of Health (e.g. the licence for dialysis centres)
PL: Regional Medical Chambers
M: General Medical Council

Suppl. 12: Does the establishment as a GP or a specialist precondition a specific license?

- GP **yes:** CZ; HU, SK; PL **no:** SLO, CY, M
 - specialists **yes:** CZ, HU, SK; PL **no:** SLO, CY, M

If yes, which requirements do doctors have to fulfill in order to obtain a license?

GPs:

- CZ:** 1st spec. level + 6 yrs. practice (total minimum)
HU: membership of the HMA, exam in the speciality (GP is one of them) licence from the Public Health Authority, responsibility - insurance, Contract with the National Health Insurance Company
SK: Criteria by law 277/1994: graduation, practice, moral and ethic eligibility, equipment alignment, membership in the Slovak Medical Chamber, others
PL: the title and diploma of the specialist

Specialists:

- CZ:** 1st spec. level + 6 yrs. practice
HU: membership of the HMA, exam in the speciality (GP is one of them) licence from the Public Health Authority, responsibility - insurance, Contract with the National Health Insurance Company
SK: Criteria by law 277/1994: graduation, practice, moral and ethic eligibility, equipment alignment, membership in the Slovak Medical Chamber, others
PL: the title and diploma of the specialist

1. Is there a license and/or a registration for practising medicine without supervision to be conferred in your country?

License:

Yes CY, CZ,
 PL, SLO, HU
 M,
 SK (private dr.s),
 RO

No EST

Specific registration for

- **general practitioners**
yes CY, CZ, PL, SLO, SK(private dr.s) ; RO
no EST, M, SK (employed dr.s)
 - **specialists**

SK (employed dr.s)

Yes CY, CZ, PL, SLO, (private dr.s); RO
no EST, M, SK (employed dr.s)

	If yes, which is the issuing/registrating authority?
CY	Medical Council
CZ	Medical Chamber
PL	Regional Chambers of Physicians and Dentists
SLO	Medical Chamber of SLO
HU	Hungarian Medical Association
M	General Medical Council of M
SK	1. Slovak Medical Chamber 2. State Administration (Ministry of Health or District Office)
RO	MOH (see below), the college of physicians

	At which moment of training is this license issued / registration done?
CY	After completion of medical studies abroad and after one year of internship
CZ	After specialization examination
PL	After finishing one year training practice starting after graduation
SLO	At finished specialisation (and by the 2007 – for general practice-after secondment (2 years), after 2007 after specialisation of family medicine (for GPs) only.
HU	after receiving the diploma
M	On completion of internship
SK	The specialization diploma is required, then application of doctor; the licencing conditions are dedicated by law 277/1994: Criteria by law 277/1994: <ul style="list-style-type: none"> • Graduation • Practice • Moral and ethic eligibility • Material (equipment) alignment • Membership in Slovak Medical Chamber • Others

RO	after graduation
----	------------------

EST: foreseen registration system in the new legislation (currently in parliament proceeding), license issued / registration after specialization

Suppl. 13: Qualifications needed by GPs and specialist for exercising the medical profession (including basic qualification):

a. in an employment relationship:

GPs:

- CZ: 1st spec. level + 10 yrs practice + CME
- CY: licence - graduation diploma and pre-registration training period
- SLO: diploma at the faculty of medicine, finished secondment by 2007, specialisation of family doctors
- HU: diploma from the Medical University, 2 yrs. residency, exam in the speciality in GP
- SK: 1st graduation for GPs obligatory, 2nd graduation for GPs facultative
- PL: the title and diploma of the specialist
- M: undergraduate degree and registration (obtained after 2 yrs. as ... officer in government employment)

Specialists.

- CZ: 1st spec. level + 10 yrs practice + CME
- CY: licence - graduation diploma and pre-registration training period
- SLO: diploma at the faculty of medicine, finished specialisation
- HU: diploma from the Medical University, 2 yrs. residency, exam in the speciality in the different speciality
- SK: 1st graduation obligatory, 2nd graduation facultative or obligatory for some specialisations (see under 10.)
- PL: the title and diploma of the specialist
- M: prerequisite postgraduate degrees and experience

b. for self-employed activity:

GPs:

- CZ: 1st spec. level + 10 yrs practice + CME
- CY: licence - graduation diploma and pre-registration training period
- SLO: diploma at the faculty of medicine, finished secondment by 2007, after 2007 finished specialisation of family doctors
- HU: there are no self-employed GPs in Hungary
- SK: 1st graduation for GPs obligatory, 2nd graduation for GPs facultative
- PL: the title and diploma of the specialist
- M: undergraduate degree and registration (obtained after 2 yrs. as ... officer in government employment)

Specialists.

- CZ: 1st spec. level + 10 yrs practice + CME
- CY: licence - graduation diploma and pre-registration training period
- SLO: diploma at the faculty of medicine, finished specialisation

HU: --
 SK: 1st graduation obligatory, 2nd graduation facultative or obligatory for some specialisations (see under Suppl. 10.)
 PL: the title and diploma of the specialist
 M: prerequisite postgraduate degrees and training after basic MD and two years ... officer in government employment

1. Is the establishment of a doctor conditional upon an additional license or registration?

Additional license:

Yes CZ, PL, HU

No CY, EST, SLO, SK

Additional registration for

- **general practitioners**
 ...**yes** CZ, PL, SLO, HU

...**no** CY, M

- **specialists**

...**yes** CY, CZ, PL, SLO, HU

...**no** M

M: No additional licence is required from a doctor for establishment. However, access to admitting facilities would require acceptance as a specialist by the registered hospitals.

	If yes, which is the issuing/registrating authority?
CY	Medical Council
CZ	Medical Chamber
PL	Regional Chambers of Physicians and Dentists
SLO	The Medical Chamber of SLO is registering established medical doctors and dentists
HU	Public Health Authorities
M	No answer
SK	The question is not clear for Slovakia: Our licence is factually the additional licence and EU licence is the graduation diploma

	Which are the criteria for granting this additional license respectively registration ?

CY	Law regulating the specialities
CZ	Specialisation examination
PL	Possessing by a doctor an office fulfilling safety conditions
SLO	Additional registration – conditions: to have a license issued by the Medical Chamber of SLO (like all practising doctors) a doctor should (must) not be employed by other employer should not be restricted from practising medicine by the decision of a regular court a doctor must have appropriate ward and equipment. In the case of practising medicine under health care insurance scheme, a doctor should get a concession (for primary care issued by local authorities, for specialist care by ministry of health).
HU	MD diploma, special examination, membership of the Hungarian Medical Association, licence from the public health authorities, responsibility insurance
M	This is due to be introduced when the relevant legislation passes through Parliament later this year. The criteria are as laid down in EEC93/16 and subsequent amendments
SK	(see above)

F. Postgraduate medical training

1. Are medical studies undertaken at the university followed by a postgraduate practical training period ?

a. ... to obtain a licence as a doctor (to work without supervision):

Yes: CZ: 3 years, PL: 13 mths., M: 2 yrs. internship, SK (minimum 30 mths.) - but only private doctors need to obtain a licence, the end of postgradual training for all doctors is graduation (= diploma), RO: 1 yr., HU: 2 yrs.

No: SLO

a. ... for general practitioners:

Yes: CZ. 3 yrs. , EST 3 yrs. , PL 4 yrs. , SLO 2 yrs. , SK (see above), RO: 3 yrs., HU: 2 yrs.

No M (draft legislation due to pass through Parliament: training/vocational (?) to be established)

a. ... for specialists:

Yes: CZ 3-6 yrs. EST 3-5 yrs. PL 5-6 yrs. SLO 4-6 yrs. , M: apprenticeship that may last many years minimum 5 yrs but in reality the training period is much longer due to poor career progression, i.e. due to limited availability of posts, SK (see above), RO: 5-7yrs. depending of the speciality, HU: 2 yrs.

No

1. Doctors have to specialize in general medical practice or in a speciality:

Yes: CY, CZ, EST, SLO , SK, RO

No: PL, HU, M

1. Number of recognized medical specialities:

CY 45,
CZ cca. 87
EST 33
HU 34 specialities and 42 subspecialities
PL 61,
SLO 37
SK: (19) 20 Basic specialisation
(71) 68 all (basic and subspecialisation)
RO: 48

Duration of postgraduate trainings:

- CY** 3-7 yrs.,
Cz 3-8 yrs.,
EST 3-5 yrs.,
HU 4-6 yrs.
PL 4-8 yrs.,
SLO 4-6 yrs. (All doctors, who finish 2 years lasting secondment after 1.1.2000 (until 2007) must specialise (it goes also for family medicine (4 years) which was introduced instead of general medicine from june 2000 on) by the year 2007 – 2014. Enclosure 1 added.),
M no official list. This is included in the legislation that will pass later this year. Duration: (as 1.c.)apprenticeship that may last many years minimum 5 yrs but in reality the training period is much longer due to poor career progression, i.e. due to limited availability of posts
SK: 1st graduation 30 months, 2nd graduation 36-60 months, there is not limited the maximum duration of 2nd graduation, the graduation is required
RO: 5 - 7 yrs.

4. Minimum/factual length of the specialized training courses mentioned below:

- SK:** 1st graduation 30 - 36 months; 2nd graduation or sub-specialisation: 36 months except
- Surgery 2, neurosurgery, orthopaed. 2, , platic, surgery 2, vascular, paed. Surg., maxilo surg. , stomatsurg. = 60 months
 - Internal 2, urology 2, gyn 2, cardio, anaest.2 , ophthalm 2 otorhin. 2 = 48 months

Speciality	Minimum length							Factual length				Minimum length In the EU
	RO	CY	CZ: I.d egr ee	ES T	PL	S LO	HU	RO	CZ: II. de gre e			
General surgery	5	5	3	5	6 (bs)	6	6	5	8			5 years

Neuro-surgery	7	5		5	6 (bs)	6		7	7			
Internal medicine	5	5	3	5	5 (bs)	6	5	5	7			
Urology	5	5	3	5	6 (bs)	6	6	5	7			
Orthopaedics	5	5	3	5	6 (bs)	6	6	5	7			
Plastic surgery	5	5		5	2 (ss)	6	-	5	8			
Thoracic surgery	5	5			2 (ss)	6	-	5	6			
Vascular surgery	5	5		5	2 (ss)	6	-	5				
Neuro-psychiatric surgery		5			6 (bs)	/	6		8			
Paediatric surgery	5	5		5	6 (bs)	/	6					
Gastroenterological surgery		5			2 (ss)	/	-		7			
Maxillo-facial surgery (basic medical training)	5	3			6 (bs)	/	-	5	7			4 years
Gynaecology and obstetrics		4	3	4	6 (bs)	5	5		7			
Paediatrics		4	3	4	5 (bs)	5	5		7			
Pneumo-phthisiology		4		4	2 (ss)	6	-		7			
Pathological anatomy		4	3	4	5 (bs)	5	5		7			
Neurology		4	3	4	5 (bs)	6	5		7			

Psychiatry		4	3	4	5 (bs)	5	5		7			
Cardiology		4		4	2 (ss)	/	-		7			
Gastroenterology		4		4	2 (ss)	6	-		7			
Rheumatology				4	2 (ss)	/	5		7			
Clinical biology					-	/	-					
Radiology		4	3	4	5 (bs)	5	5		7			
Diagnostic radiology		4	3		5 (bs)	/4	-		7			
Radiotherapy		4			5 (bs)	/	5		7			
Tropical medicine					5 (bs)	/	-					
Pharmacology			3		2 (ss)	/	-		7			
Child psychiatry					2 (ss)	5	-		6			
Microbiology-bacteriology			3		5 (bs)	5	5		7			
Occupational medicine				3	5 (bs)	4	4		7			
Biological chemistry			3		-	/	-		6			
Immunology					2 (ss)	/	-		6			
Dermatology		3	3		5 (bs)	/	5		7			
Venereology		4	3		5 (bs)	/	-		7			
Geriatrics		4			2 (ss)	/	5		6			

Renal diseases				4	2 (ss)	/	-		6			
Contagious diseases				4	5 (bs)	6	5		6			
Community medicine					5 (bs)	4	-		6			
Biological haematology			3		2 (ss)	/	-		6			
Nuclear medicine		4			2 (ss)	5	5		6			
Dental, oral and maxillo facial surgery (basic medical and dental training)		2		5	6 (bs)	4	-		6			
Anaesthesiology and reanimation		3	3	3	5 (bs)	6	5		4			3 years
Ophthalmology		3	3	3	5 (bs)	4, 5	5		7			
Otorhinolaryngology		3	3	3	5 (bs)	6	6		7			
General haematology		3		4	2 (ss)	/	-		6			
Endocrinology		3		4	2 (ss)	/	-		6			
Physiotherapy				3	5 (bs)	/	-		6			
Stomatology		2	2		4 (bs)	/	2		5			
Dermato-venereology		3	3	3	5 (bs)	4	5		7			
Allergology					2 (ss)	/	-		6			


M: apprenticeship that may last many years minimum 5 yrs. but in reality the training period is much longer due to poor career progression, i.e. due to limited availability of posts;

minimum duration will be established after enactment of the appropriate legislation later this year.

PL: bs - basic specialities, ss -specific specialities
 First doctors have to finish basic speciality (4-6 years), and only than he/she can specialize in specific speciality (2 years) (34)!!!

5. Practical postgraduate training in general medical practice (Family Practitioners):

Contents of postgraduate training	Duration of postgraduate training	Postgraduate training facilities (hospitals, practices of other doctors, universities etc.)
CY: no answer		
CZ: hospitals Practice at general practitioners	2 yrs. 1 yr.	
EST: no answer SLO: clinical work / training ambulatory work / training	24 month 24 months	hospitals general practices
HU: 2 years residency, 2 years practices of other doctors	4 yers	accredited hospitals, university clinics
PL <u>Introduction to family medicine as well as hospital and specialist training.</u> Hospital and specialist training includes: internal diseases, paediatrics, gynaecology and obstetrics, general surgery, psychiatry, geriatrics.	<u>At least 4 years:</u> for physicians without any specialisation; <u>2 and a half years:</u> for physicians with I grade specialisation in general surgery, gynaecology and obstetrics and paediatrics <u>2 years:</u> for physicians with I grade specialisation in general and internal medicine; 1 and half years: for physicians with II grade specialisation in paediatrics and internal medicine; <u>half a year:</u> for physicians with II grade specialisation in general medicine	Lecture room, room for practical learning, library, computer, projector for written text, overhead projector, phantoms: for learning otoscopy, ophthalmoscopy, resuscitation, minor surgery, intravenous insertions, gynaecological examination, andrological examination, breast examination

SK		
Internal med	12	 Hospital
Surgery	3	
Gyn	1	
Neurology	1	
Otorhinolar	1	
Dermato-vener.	1	
Orthopaedics	1	
Ophthalmology	1	
Contag. Diseases	1	
Anaesthesiology	1	
Hygienics	1	
Out patient and school	6	

M : A formal general family practice scheme is being developed and will be operational in the near future.

1. Practical postgraduate training for specialists:

CY	The CY medical ass. has proposed guidelines to the specialists society
CZ	5-7 yrs.
EST	No answer
PL	<p>It depends on the kind of specialisation - it is practical training based on the program.</p> <p>Duration of practical postgraduate training for specialists:</p> <p>4-6 years</p>
SLO	<p>clinical work / training</p> <p>Duration of practical postgraduate training for specialists:</p> <p>4 – 6 years</p>
HU	25 different specialisations (see 4.a), duration: see 4.b.
M	Under discussion, duration: see above
SK:	<p>Courses of special subjects</p> <p>Innovation courses</p> <p>Specialization courses</p>

	Basis courses Pre-graduation training Training in hospital All: 36 - 60 months Courses 1 day - 3 months
RO	6 - 24 months

These practical postgraduate training periods can be undergone in ...

Hospitals: CY, CZ; EST; PL, SLO; HU
(accredited), M. SK
practices of other doctors CZ, EST, PL
at universities CZ, PL, HU (accredited), SK
in other institutions CZ, PL (Health Care Institutions),
SK (Slovak Postgradual Academy of Medicine)

1. Do doctors have the possibility to subspecialize?

Yes: CZ, EST, SLO, HU, M, SK, RO, PL
no: CY

If yes, how many subspecialities are there? How long do trainings last? Which "common trunk" is required for subspecializations? Please add a detailed description as Enclosure 2 to this questionnaire containing all subspecialities and the corresponding duration of postgraduate trainings.

Number of subspecialities CZ: approx. 40, EST: not determined, SLO 22, SK: 68 (71), PL (not determined); HU: 42

"common trunk": CZ: internal medicine, surgery; EST: 33; SLO: 2 years, M: internal medicine, general surgery, SK: practice in subspecialization and required 1st graduation; PL: no common trunk

Duration of postgraduate trainings:

CZ: 3- 8 yrs,
EST and PL: ?; SLO: 6 yrs. ,
HU: 26 months at least;
M: 6 yrs up to none defined years (not legally defined currently the subject of draft legislation)
SK: 36 - 60 months

2. Is there a final examination at the end of training?

General practioners	Specialists
Yes: CZ, EST, PL, SLO, HU, SK	yes: CZ, EST, PL, SLO, HU, SK

RO No M	RO no M
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If yes, which institution(s) does (do) hold the examinations and what are their methods (f.e. multiple choice, OSCE etc)?

Institution(s):

CZ: Institute for Postgraduate Medicine: practice, MCQ tests, oral examination

EST: Tartu University; Methods: multiple choice questionnaire, assessment of practical skills

PL: Medical Centre for Postgraduate Training; Methods: multiple choice tests, practical exams, OSCE

SLO: Examiners are nominated by the Medical Chamber of SLO; methods: oral and practical examination.

HU: Council for basic and continuing education of health workers supervised by the ministry of health

M: no answer

SK: SPAM - Slovak postgradual academy of medicine (under supervision of the ministry of health)
methods: all of next - test + practical examination (patients, methods) + verbal examination (by board) + written graduation work (about 30 pages)

RO: Minister of Health - College of Physicians

1. Is successful graduation from medical training certified by diplomas?

Yes: CZ; EST, PL, SLO, HU, SK

No: M

If yes, which authority confers the diplomas on the doctors?

Kind of diplomas	conferred by
CZ: Specialisation diploma	Institute for postgraduate medicine
EST certificate	Tartu University
PL Diploma confirming that the physician received the title of a specialist in the	Medical Centre for Postgraduate Training

given field of medicine.	
SLO <i>Certificate on specialist exam</i>	Medical Chamber of SLO
HU	?
SK: Attestation (= graduation) diploma certificates	SPAM Only after courses

1. Do candidates for medical training have to accept waiting periods for a training post; how long is the average waiting period? How do waiting doctors usually bridge the time?

Waiting periods for general practitioners	Waiting periods for specialists
Yes EST (1-2 yrs.), SK (6 - 12 months in hospitals)	Yes EST (1-2 yrs.), M: 2-3 yrs., SK (6 - 12 months in hospitals)
No: CZ, PL, SLO, HU M: not applicable	No: CZ; PL, SLO, HU

Waiting doctors usually bridge the time by ...

M: working in other areas

SK:

1. obligatory before 1st graduation - so called commencing practice in specialization what is probable (this time of practice is counted into 36 months)
2. not necessary before 2nd and subpecializaion graduation (the waiting period and decision by the mangement of hospital)

1. Is there a sufficient number of training posts?

...for general practitioners	...for specialists
Yes: CZ, PL, SLO, HU, SK, RO	Yes: CZ, PL, SLO, HU, SK, RO
No: EST, M: not applicable	No: EST, M

HU: state guarantee

SK : in some regions a small lack of these posts for out patient department doctors

G. Organisation and supervision of postgraduate medical training

M: Currently the subject of draft legislation

1. Postgraduate medical training falls under the competence of ...

...the medical professional organization

CY, CZ, PL, SLO, SK (only courses)

...national institutions

CZ, EST, PL, M, SK, RO

If yes, which ones?

CZ: Czech Medical Chamber, Institute for postgraduate medicine
EST: Ministry of Education, Ministry of Social Affairs
PL: Medical Centre for Postgraduate Training, Polish Chamber
SLO: Medical Chamber of SLO and Medical faculty
SK: SPAM (under supervision and financed by ministry of health)
RO: MOH and Min. of Education

...scientific societies M: to be included in the legislation to be shortly enacted

CZ; SLO, RO

...universities

CZ, EST, SLO, HU, M, RO

...other institutions

CZ, SLO

EST: Tartu University

SLO: Medical Society of SLO in collaboration with Medical faculty is responsible for preparing the contents of specialisations.

2. Which authority is charged with determining the contents of postgraduate medical training?

...the medical professional organization

CY, PL; SLO, SK (just cooperation), RO

...national institutions

EST, PL, M (specialist societies), SK, RO, CZ

CY: Pancyprian medical association
CZ: Scientific Societies und Czech Medical Chamber
EST: Ministry of Education

PL: Medical Centre for Postgraduate Training and the Polish Chamber for Physicians and Dentists
SLO: Medical Chamber of SLO
RO: College of physicians, MOH

...scientific societies

CY, CZ; SLO, SK, RO

...universities

CZ, EST, SLO, M, RO

...other institutions

CZ, HU, M

EST: Tartu University

SLO: Medical Society of SLO, Medical faculty

HU: Council for basic and continuing education of health workers supervised by the ministry of health

M: university of Malta, Department of Health

3. Changes regarding the (postgraduate) trainings of doctors:

CY: Changes according to the Directive of EU 393 L 0016 for the recognition of diplomas

CZ: Yes, in the Year 2002

EST: 1) Legislation concerning the training and right to practice
2) Financing of postgraduate training is transferred from Ministry of Education to Ministry of Social Affairs

PL: There is a new list of specializations. We had two-degree specialization (II degree and I), but now there is one specialisation without any degrees (non-degree specialization)

SLO: In the year 2000 we introduced new contents and duration for specialist's training and a mandatory specialization for a GP.

HU: the introduction of the resident system 2 years after finishing the university studies

M: formalization of current training structure

SK: run-in of new regulation of ministry of health (the postgradual training regulation) compatible with EU-criteria

RO: no - for the moment

4. What are the provisional regulations for doctors who were respectively have been trained according to a former and now obsolete training scheme/regulations (as there was f.e. an one-year postgraduate training for specialists in the Soviet system)?

CY: according to European Directives and Cyprian Law

CZ: the obsolete scheme is in its key problems compatible with EU

EST: This question will be covered by legislation (a new bill is being prepared).
Additional certification of the specialists is foreseen.

HU: There are not such cases in Hungary

PL: They preserve their titles.

In PL we have never had one-year postgraduate training for specialists like it was in the Soviet system.

SLO: There is no regulation for them, but they were all trained for at least 4 years.

M: We do not have such a system. It takes many years for a doctor to be recognized as a specialist.

SK: no restrictions - see Slovak present system

H. Financing of the health care system

1. Way of financing the health care system:

	Taxation	Social insurance contributions	Both % taxation / % Social insurance contributions	Private Payments
CY	40%			60%
CZ	10%	80%		10%
EST	5,6%	80%		12%
PL			9/91 %	
SLO	3	77		20
HU			10/90	
M	60%			x
SK		94%		6% (mainly medication)
RO			10/90	

1. The rates of social insurance contributions amount to

CZ: 13,5% health insurance (different to social insurance)

EST: 13 % of the salary fund paid by the employer

PL: 7,5% personal income

SLO: 13,25 % of gross personal income (employees and employers)

-retired (from gross pension basis)

-farmers (from income from land ownership)

+ average subscriptions (some categories of insured persons)

HU: 31% employer, 8% employee

M: no answer

SK: 0 (run-in of new law)

RO: 7% + 7% =14% (employer, employee)

2. Tax proceeds are determined by....

CY: state

CZ: state

EST: state only

PL: Parliament determines tax proceeds.

SLO: Level of the state.

HU: state

M: state

SK: the state level - law 273/1994

RO: state level

3. The financing of the health care system falls under the competence of ...

the state CZ; EST; PL, SLO, SK, RO

provinces CY, M,

communities SLO

Statutory health insurances: CZ, EST, PL, SLO, HU, RO

Private health insurance. SLO, M

Other institutions, namely ... SK: public health insurances under gestions of ministry of finance (the price assessment)

Personal payments by the patient PL; SLO, HU, M, SK, RO

4. The height of rates of the social insurance contributions are determined by

law CZ; EST, PL; SLO, HU, SK (277/1994; 273/1994; 98/1995)

social insurance agency: RO

government: M

CY ?

5. In case that your health care system is funded by the health insurance, is there a legal obligation to be affiliated to this insurance system?

Yes CZ, EST, PL, SLO, SK, RO

no HU, M

6. In case that your health care system is funded by the health insurance, do you have different types of health insurance funds which for example have been established with regard to different professions or different social groups in your country?

a. several health insurance funds

yes SK ("open system"), PL: several health insurance funds (In Poland there are 17 health insurance funds, so called sick funds), RO

no CZ, EST, PL, SLO, HU, M

b. If yes, here is a short overview about the different health insurance funds, their tasks and competences:

SK:

01 general public, guaranted by state

04 common employees of state (defence, railway etc)

06 Apollo Chemical industry

14 Assessment public (originally for banks)

15 Sideria metal-working industry

RO: Health Insurance House of Transportation, Ministry of Defense, Public Order, National Security and Magistrate Authority

7. In case that the health care system in your country is organised by the statutory health insurance, are patients free to chose their health insurance?

Yes: CZ, PL, SK, RO

no, because there is only one statutory health insurance EST, SLO, HU

no, because the affiliation to statutory health insurances is regulated by law:
EST, SK (prisoners, soldiers etc)

no, because... M: N / A

8. Number of persons insured by a statutory health insurance:

CZ	In relation to the total population
Number of persons being insured by a statutory health insurance	95 %
	In relation to persons being insured by a statutory health insurance
Working people	100 %
Relatives	100 %
Unemployed persons	90 %
Pensioners	100 %
Socially needy persons	80 %
Other persons	80 %

EST	In relation to the total population
Number of persons being insured by a statutory health insurance 1 271 302	88,3 %
	In relation to persons being insured by a statutory health insurance
Working people45,5 %
Relatives28 %
Unemployed persons2 %

Pensioners23 %
Socially needy persons0,5 %
Other persons1 %

as per 2000 (year)

The data above are actual data kept from Estonian Health Insurance Fund

SLO	In relation to the total population
Number of persons being insured by a statutory health insurance	97,7 %
	In relation to persons being insured by a statutory health insurance
Working people	37 %
Relatives	28,8 %
Unemployed persons	1,6 %
Pensioners	23,9 %
Socially needy persons	0 %
Other persons	8,7 %

HU	In relation to the total population
Number of persons being insured by a statutory health insurance	100 %
	In relation to persons being insured by a statutory health insurance
Working people	40 %
Relatives	208 %
Unemployed persons	10 %
Pensioners	20 %
Socially needy persons	10 %

Other persons	--
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as per 2000

The data above are estimations

SK	In relation to the total population
Number of persons being insured by a statutory health insurance	100 %
	In relation to persons being insured by a statutory health insurance
Working people	71,6%
Relatives (non working people) *	26,9%
Unemployed persons	1,1%
Pensioners - IN *	
Socially needy persons - IN	
Other persons	0,4%

Jan-Sept.2000/ministry of health

Suppl. 14: As the formulation of the question about persons provided health insurance coverage and affiliated to statutory health insurance was obviously not sufficiently clear, please indicate:

a. Percentage of persons in the total population (100%) who are affiliated to statutory health insurance:

CY: 35% (estimation)

CZ: 100%

SLO: 97,7%

HU: 100%

SK: 99,6%

PL: almost 100% including unemployed and homeless, a really small number is not insured

M: ~ 25%

b. The population groups within this percentage:

CY:

- active, working population 66%
- unemployed persons 3-4% of the economically active population

CZ:

- active, working population 38,4%
- unemployed persons 4,4%
- retired persons 27,1%
- socially needy person 25,6%
- other persons% 4,5%

SLO:

- active, working population 37%
- jointly insured family members 28,8%
- unemployed persons 1,6%
- retired persons 23,9%
- socially needy person 0%
- other persons% 8,7%

HU:

- active, working population 40%
- jointly insured family members 20%
- unemployed persons 10%
- retired persons 20%
- socially needy person 10%
- other persons% 0%

SK:

- active, working population 47.70 %
- jointly insured family members (children) 13.40 %
- unemployed persons 18.70 %
- retired persons 19.33 %
- socially needy person 0.65 %
- other persons% 0.22 %

PL: no data

1. Are patients usually charged with co-payments when medical services are provided?

Yes: CZ, SLO (Medical services, Hospital stays, Medical services provided in hospital out-patient departments, Medicines, Medical devices-technical remedies, HU (medicines), SK (6%) (only partly medicines, medical devices); RO: special medical services, V.I.P. hospitalisation, medical services provided in hospital out-patient departments after I check up, for non covered medicines, for those medical devices that the prices is over the approved price (by the Health Ins. House)

no: EST, PL, M, RO: in emergency cases when they are sent by a GP (family doctor)

Suppl. 15: If patients are charged with co-payment for medical services in your country, what is the amount?

CZ: (10% from all finances devoted to the health care, it is the co.payment)
 SLO: There is no co-payment for medical services for children and pregnant women, other services are to be co-paid from 5-50% of the price of the medical service
 HU: very different
 SK: 9 % - mainly medication
 PL: no charge...
 M: no charge...

2. Are private health insurance funds of importance in your health care system?

Yes RO, CZ
No CY, EST, PL, SLO, HU, M (but increasing importance)
 ? SK: the private health insurance funds are "public"

3. How many private health insurance funds have been established in your country, what services do they offer?

EST: ---, PL: ---

CZ Number of private health insurance funds
8

SLO Number of private health insurance funds	Services
2	Insurance for additional payment for full price of health care services and medicines Insurance of health care assistance abroad (Triglav) Insurance for additional rights (insurance for absence from work, insurance of compensation in case of home care of a family member)

as per 2000 (year)

HU	Number of private health insurance funds	Services
	2 only complementary	Hosp-Hotel higher comfort

as per 2000 (year)

M	Number of private health insurance funds	Services
	~ 5	All levels of care are available

SK (2000)	Number of private health insurance funds	Services
	06 Apollo 14 Assessment 15 Sideria	All are founded by the same law than general (01) and common (04) - by professional organizations

RO	Number of private health insurance funds	Services
	1	medical services over the basic package offered by the H.I.H.

1. Do private health insurance funds need an official approval? If yes, by which authority? Which are the requirements?

HU: no

M: no

SLO	authority	requirement
	Agency for Insurance Control	Permit for performance of insurance services (for determined insurance categories)
SK	authority	requirement
	Ministry of Health	Law 273/1994 300 000 insured persons, 40 mil. Slovak crowns as the beginning capital

RO	authority	requirement
	Ministry of Justice, Ministry of Health, Ministry of Finance	

1. Number of persons who are insured by private health insurance funds:

HU: no data

SLO: 67,8 % of the population as per 2000 (year)

The data above are actual data kept from Private health insurances („Vzajemna“ and „Adriatic“)

M: more than (estimated) 15 % of the population as per year 2000

SK: see above, 06+ 14+15: 20,87 % of the population as per 1.9.2000 (Ministry of health)

CZ: 3 millions (30% of the population)

I. Providers of out-patient care

2. Who does provide medical services in the out-patient care sector in your country?

established self-employed doctors: CZ, EST, PL, SLO, HU, M, SK, RO

- **only by general medical practitioners**

- **by general practitioners and specialists:** CY, CZ; EST, PL, SLO, HU, M, SK, RO

Doctors employed in health care centers: CY, EST, PL, SLO, HU, M, SK, RO

Out-patient-departments of hospitals: CY, CZ, PL, SLO, HU, M, SK, RO

3. In which form do general practitioners and specialists provide out-patient care outside hospitals?

CY: General Practitioners: Government doctors in rural health centers and out-patient department of hospitals , private in private surgeries and polyclinics,
Specialists: in out-patient departments of hospitals , in private surgeries and clinics

CZ: GP: self-employed physicians in own or rented facilities contracted to different health Insurance Companies (sick funds)
Specialists. See GP

EST: General Practitioners: self-employed doctors
doctors employed in health care centers
Specialists: self-employed doctors
doctors employed in health care centers

PL: General Practitioners: individual and group practice in health care centers and hospitals
Specialists: individual and group practice in health care centers and hospitals

Out-patient care outside hospitals provided by GP-s: General Practitioners provide out-patient care outside hospitals in form of individual and group practice and in health care centres.

SLO: General Practitioners:
As civil servants employed by health centers or as private (self established) practitioners working individually or in group practices
Specialists:
As civil servants employed by health centers and hospitals or as private (self established) practitioners working individually or in group practices

HU: GP: single general practice, very few group practices
specialists: polyclinics, out-patient clinics of hospitals

M: General Practitioners: private clinics, NHS (government), Health centers (walk in Centres)
Specialists: NHS out-patient, private Clinics

SK: General Practitioners: self-employed - 85,5%, employed in health care centers

Specialists: self-employed - 34,2%, employed in health care centers and out patient department of hospitals - 65,8% (no statistical data about distribution of this %)

4. Conditions under which doctors are entitled to freely practising the medical profession in their own practice?

	Conditions for general practitioners	Conditions for specialists
CY	Private GPs are free to provide services Government doctors only in the government premises. It is not allowed private practice for government doctors	See GP
CZ	<ul style="list-style-type: none"> • 6 yrs. postgraduate training in GP • qualification examination • licence bases on qualification and practice • practice registration with authorities 	<ul style="list-style-type: none"> • postgraduate training • qualification examination • 1st degree qualification • license • registration with authorities
EST		a licence must be obtained from the Ministry of Social Affairs
PL	They have to register in Regional Chamber of Physicians and Dentists	They have to register in Regional Chamber of Physicians and Dentists
SLO	<ol style="list-style-type: none"> 1. Citizenship or working permission (issued by local authorities) 2. Substitute in case of absence 3. Proper premises (ward) and equipment 4. A certificate on seminary on private practice 5. Valid license 6. Registration 	<ol style="list-style-type: none"> 1. Citizenship or working permission (issued by local authorities) 2. Proper premises (ward) and equipment 3. A certificate on seminary on private practice 4. Valid license 5. Registration

HU	<ul style="list-style-type: none"> ▪ Speciality exam of general practice ▪ CME ▪ membership of the Hungarian Medical Chamber ▪ Licence from the public health authorities ▪ responsibility- insurance 	the same - exam of the speciality CME
M	<ul style="list-style-type: none"> • basic degree and • registration 	<ul style="list-style-type: none"> • basic degree and • registration
SK	Licence under conditions by law 277/94 - see above)	Licence under conditions by law 277/94 - see above

1. Limitations of the number of doctors providing out-patient care to patients:

Yes CZ; EST (for family doctors), SLO, HU, SK (so called "network")
No CY, PL, EST, M, RO

If yes, who does limit the number of doctors?

State EST, SLO, HU, SK
province HU
municipality SLO

Statutory health insurance/the national health service CZ

Medical professional organisations

Others SK (ministry of health and realised by "state doctors" in provinces

2. Doctors who usually provide out-patient care:

General Practitioners CY,CZ; EST; PL, SLO, HU, M, SK, RO
Specialists in internal diseases CY, CZ; EST; PL, SLO HU, M, SK, RO
Gynaecologists CY, CZ; EST; PL, SLO, HU, M, SK, RO
Ophthalmologists CY, CZ; EST; PL, SLO, HU, M, RO
Paediatricians CY, CZ; EST; PL, SLO, HU, M, SK, RO
Surgeons CY, CZ
Spec. in diabetology CZ
Psychiatrists CZ
Neurologists CZ
Ent specialists CZ, M
Orthopaedics CZ
Cardiologists CZ
Otolaringologists CZ
Many Others: PL
Others: M, e.g. ENT (see there), SK (dentists and less number of all specialists, see above)

Almost all Specialities HU
All Specialities EST

SLO: Out-patient care is carried out on primary level (general doctors, paediatricians, gynaecologists) and secondary level either specialists, paediatricians and gynaecologists.

Health care on secondary level is provided on doctor's note only or after an appointment at a doctor's on primary level (compulsory referral system) (except when paid by the consumer of health care services).

3. Forms of out-patient care:

Single practice CY, CZ, EST, PL, SLO, HU, M, SK, RO

Association of practices CY, CZ, PL, HU, SLO, M, RO

Association of practices using the same equipment, CZ, PL, SLO, HU, M, SK (minimum), RO

Other group practices CY, CZ, PL, SLO, HU, M, SK (singular hospitals), RO

Other legal forms : CZ, EST, PL, SLO, SK, RO

4. Remuneration of doctors providing out-patient care:

lump sum per patient / certain period (month, quarter...) EST (family doctors)

Remuneration of single services: CY, CZ (specialists), EST (all other doctors), PL, SLO, SK (specialists), RO

Mixed system (fee for services provided and lump sum) SLO, HU

Capitation fee for registered patients CZ (GP), EST (family doctors), PL, SK (gps), RO

Other ways of remuneration HU (private practice): **M: NHS: salaried doctors, private care:** direct remuneration by patient or insurance

SK: the patients in out-patient department in hospitals from the prospective hospital budgets

SLO: On the primary level there is a per capita system combined with services (50 percent : 50 per cent). The services are assessed with relative unified quotients, per capita system assesses insured persons (different age groups). Only a certain percent of services above the plan is financed.

On the secondary level the financing is carried out on the basis of provided services. The programs are limited with certain standards for individual out-patient departments.

5. By whom are doctors providing out-patient care remunerated?

%	CY	CZ	EST	PL	SLO	HU	RO	M	SK
State	40	10						x	
Province Municipality									
Statutory health insurance	10	90	x	majority	x	95	x (for the insured persons)		100
Patient	50		x	and employers - It is difficult to determine the number of patients who pay for themselves or those who are paid by their employers in order to increase the quality of care.	x	5		x	A part of dental care
Others					<i>Voluntar y – addition al (private) health insuranc e</i>			Private insuranc e	

1. Remuneration of doctors is determined by....

State, provinces, communal authorities CY, CZ, EST, SLO, HU, M,

SK, RO: for the doctors working in state owned health settings

Statutory health insurance CZ, EST, PL, SLO, M, SK, RO:

for the doctors in contract relation with the Health insurance house

professional medical organisations SLO, HU, M, SK

doctors CY, PL, M

Other SLO (Every year, partners -Ministry of Health or state, providers and Health Insurance Institute of SLO- agree on an extent of necessary means. The most important result of the agreement is determination of distribution and part of activities in available means.)

SK: ministry of finance - "the cost order" (on the base of "law about therapeutic regulation")
Health insurance - in the limits of the "cost order", the agreement with providers
Medical organisation - negotiation (minimum)

**2. In which way is the remuneration for doctors fixed? Does a national authority determine the medical fees? Are they agreed upon by negotiations, for example, between the professional medical organisations and health service insurances? Are the fees determined subject to an opinion given by an expert committee? Is there a tariff system (by whom has it been made)...?
Please describe the situation in your country.**

CY: by law it is not permitted to specify doctors fees; the professional medical organisations can only recommend the minimum fee; with certain health scheme plans negotiation with the medical association determines the fee

CZ: doctors are remunerated by a tariff system , which is made by state in state hospitals. General practitioners are remunerated by capitation payments and specialists negotiate the price of 1 unit with the professional medical organisation and health service insurances. The government determines the price, if there is no agreement.

EST: Fees are determined by the Health Insurance Fund and approved by the State

PL: There is no tariff system in PL. The medical fees are agreed upon by negotiations of physicians and statutory health insurance institutions as well as by offers competition.

SLO: Remuneration for doctors is fixed by collective agreement.

A law on medical (doctors) service introduced in dec.1999 a new method of medical fees (not implemented yet). Namely, the value of doctors work within the particular medical treatment (procedure) is to be fixed as a medical tariff for the particular medical service. Medical tariff is to be determined from the value of doctors work (according to number of effective hours per year – determined by collective agreement – for treating the patients within the benefits they have), standardized length for certain procedure and other costs. The tariffs are being prepared right now in The Medical Chamber of SLO.

There is no independent professional institute in our country for determining tariffs.

For the time being we have a combined system and a service system (see question no. 7). The final „price“ is a result of negotiations among partners (government, representatives of health care providers, Health Insurance Institute of SLO).

HU: National authority determines the basic medical fees, which can be complemented by special bonus/premium from the local authorities,

in out-patient care system, financed by the state, remuneration is determined by state officers, the doctors and medical Organisations have no right to intervene, in private practice the remuneration is variable

M: Remuneration for doctors: Doctors' fees are not specified by law. The Medical Council

sets the minimum fees (although they have not been revised for more than twenty-five years). Voluntary healthcare insurances negotiate fee maxima that are reimbursable. The practitioner is free to set his/her fee.

SK: 1. Self-employed doctors - see question 9
3. employed doctors - law 98/95 about the tariff salaries, national medical authority does not determine the fees, expert committee doesn't exist, tendency of health insurances to adapt the payment to available sources, minimum of negotiation between doctors and insurances (formal), non transparent financial system

RO: Ministry of Health determines the medical fees for the hospital and preventive care doctors. National Health Insurance agrees upon negotiations with the professionals (medical organisations), trade unions and employers, the level of the fees for the GPs in primary health care and for the doctors from the ambulatory

11. Are patients in your country registered in a panel and so bound to one doctor within a certain period?

Yes : CZ (to GPs, patient can change every three months), EST (1 yr.), , HU, SK (only GPs, gyn, paediatricians), RO: at least 3 months to a family doctor
No : CY; PL; SLO, M

If yes, how long are patients bound to the registrations?

Registration period: SK (minimum 6 months (law 273/94)

PL (by correction): Patients are bound to one doctor (General Practitioner) for a period of 1 year. (There is a special procedure of changing the patient's GP more often.)

HU: unlimited, however can be changed by the patients every year

RO: 3 months

4. Do general practitioners have a gate-keeper function within the health care system?

Yes: EST, PL, SLO; HU, SK, RO, M
No: CY, CZ (it is not based on legislation), (HU in very few cases, changes are foreseen in the future)

5. Do doctors who provide out-patient care receive any financial support with regard to the operational costs of their practice?

Yes: EST (family doctors), SK (advance payment), HU, RO
No : CY, CZ, PL; SLO, M

If yes, what kind of support?

EST: a lump sum determined by the Health Insurance Fund
 HU: capitation fee in general practice and fee for service in secondary care
 RO: according with the Health Insurance Law

6. How many inhabitants are allotted to one established self-employed doctor mentioned below?

	per inhabitants						
	RO	CZ	EST	PL	SLO	HU	SK
1 general practitioner	1.500 - 2.000	1.600	up to 2.300	6.300 (spec.fam. doct.)	1.739	1500 - 1700	1864
1 gynaecologist		4.000		6 483	7.003	11.500	4612
1 paediatrician		900		3.977	1.436	1.500	1183
1 ophthalmologist		not allotted		13 790	31.992	21.500	576
1 specialist in internal medicine		not allotted		2 887	2.316	8.500	404
1 radiologist		not allotted		14 401	20.020	14.300	No data

Suppl. 16: Medical emergency care:

Are there first aid facilities in the whole country? yes: CY, CZ, SLO, HU, SK, PL, M

Who provides emergency care?

CZ: rescue service, GPs, hospitals
 CY: government hospitals, private hospitals,
 SLO: GPs
 HU: national ambulance service
 M: There are first aid facilities in the whole country, with emergency care being provided by the national health service
 SK: hospitals, out-patient dpts, special Services

PL: healthcare providers on contracts with sick funds; nowadays in the Polish Parliament there is the law regulation being discussed according to which the state will be responsible for emergency care in Poland.

If supply in emergency care is insufficient, in which respect:

- **Qualification of the providers** no: CZ, SK, CY, M
- **Insufficiencies with regard to certain regions** no: CZ, SK, M yes: CY
- **Other insufficiencies** yes: CZ, HU, CY no: SK, M

J. Hospital structure

1. Hospitals are run by....

State	CY, EST, PL, SLO, HU, SK (ministry of health), M
... province	PL, RO
... county	PL
... municipality	EST, HU, CZ
National organizations or charitable organisations	CZ; PL
Private owners	CY, CZ, EST; PL, SK (singularly), M

1. Financing of hospitals:

a. Financing of public hospitals:

CY: taxation

CZ: health insurance, state budget

EST: 1. contract with the Health Insurance Fund
2. state budget (investments for state hospitals)

PL: Public hospitals are financed mainly by statutory health insurance institutions and the state. The state finances highly-specialised procedures, such as heart transplant. (The list of these procedures is determined by the Minister of Health)

SLO: The basis for financing is a day in hospital care, which includes all care for a patient in 24 hours including food and lodging. The value of a day in hospital care is different for individual specialities (according to nature and requirements of work). There is a separate financing of insured materials (agreed beforehand) and transplantations of some organs.

HU: by national health insurance

M: general taxation in the National Health Service, from other sources in the private sector- either voluntary healthcare insurances or out-of-pocket payments. There are a few clinics that work with no permanent medical staff-they are remunerated in a similar manner

SK: the prospective budget

RO: the owner - Ministry of Health, Ministry of transportation, Ministry of defence etc.

b. Financing of private hospitals:

CY: out of pocket

CZ: health insurance, state budget, municipality budget

EST: 1. contract with the Health Insurance Fund
2. Patient fees

PL: Private hospitals are financed out of pocket money, employers who pay for their employees, statutory health insurance institutions and the state.

SLO: The basis for financing is a day in hospital care, which includes all care for a patient in 24 hours including food and lodging. The value of a day in hospital care is different for individual specialities (according to nature and requirements of work). There is a separate financing of insured materials (agreed beforehand) and transplantations of some organs.

HU: medical fees

SK: the prospective budget as the main part of budget
RO: Health insurance house - according to the contracts signed

c. Financing of private hospitals, with no permanent medical staffing and serving for private patient care (as far as this exists in the health system of your country)

CY: out of pocket
CZ: absent in our region
EST: ---
PL: ---
SLO: ---
HU: ---
SK: no
RO: private funds

M: Public hospitals are funded from general taxation out of a central budget administered by the Department of Health. (This is being reformed at present and is being devolved to an autonomous body). Private hospitals are funded through voluntary health insurance or from out-of-pocket payments.

1. Whom do hospital charge fees for the medical treatments and services?

a. Public hospitals:

CY: government
CZ: to health insurance institutions
EST: Health Insurance Fund
PL: Statutory health insurance institutions and the Ministry of Health
SLO: Health Insurance Institute of SLO
Private health insurance funds
HU: national health insurance company
SK: health insurance companies
RO: Health Ins. House

b. Private hospitals:

CY: patients and insurance companies
CZ: to health insurance institutions
EST: Health Insurance Fund
Patient
PL: Private companies, statutory health insurance institutions and the Ministry of Health
SLO: Patient
HU: --
SK: health insurance companies
RO: private persons

c. Private hospitals with no permanent staffing, private patient care

CY: patients
CZ: to health insurance institutions
EST: ---
PL: ---

SLO: Patient
HU: --
SK: no
RO: private persons

1. Are hospitals involved in the provision of out-patient care?

No provision of out-patient services

Running of out-patient departments which provide specialized services: CY, EST, PL, SLO, HU, SK, RO, M (predominantly)

Hospitals are free to provide out-patient care in the field of general medical practice PL, RO

CZ: out-patient care paid by health insurance institutions

1. In which way are hospital doctors remunerated?

Salary CY, CZ, EST, PL, SLO, HU, SK (the source for salaries is the prospective budget), RO, M

Private insurance

Mandatory health insurance

The patient is charged directly by doctors CY (Private hospitals)

Both

Other ways of remuneration PL (contracts: a physician treated as a company)

1. In case there are privately insured patients in your country, do doctors, providing in-patient care to these patients, have the possibility of charging them medical fees/bills (payed by the private insurance) and receiving thereby additional remuneration beside their salary?

yes CY, M

no CZ; EST, PL, SLO, SK, HU, RO

1. Do hospitals in your country have sufficient resources in order to avoid waiting periods?

yes: CY, RO (usually): depends on the disease and the level of the hospital, M (private hospitals)

No (average waiting period): CZ (1 week - 1yr.),
EST (1 week - 2-3 months),
PL (It depends on the planned treatment),
SLO (*8 months*),
HU (there are no waiting periods, waiting list is limited)
SK (accounts of hospitals are immediately used)
M (public hospitals)

Suppl. 17: What waiting periods for in-patient care is concerned, please indicate the medical services, for which patients have to wait. Please indicate the 3-5 most significant services and the average waiting period:

- **hip - replacement** CZ: 6 months
SLO: 18 months,
HU: 1-5-weeks,
SK: 3-12 months,
PL: 2 yrs.
M: 5 yrs. maximum

- **varicotomy** CZ: 0
SLO: 12-18 months;
HU: none
SK 2 weeks - 6 months;
PL: 0
M: 3 - 6 months

- **cataract operation** CZ: 8 months
SLO: 24 months,
HU: 0-3 weeks
SK: 2 weeks - 6 months,
PL: 3 months
M: 6 to 18 months

(additional note from SK: MR examination: 24 hours- 2 months)

1. How do you consider the number of hospital doctors in your country?

- There are too many hospital doctors** SK, RO: in the big cities
There is a sufficient number of hospital doctors CY, PL, HU, SK (the discrepancy consequential from lack of motivation (by payment) of out-patient doctors and their bad equipment)
There is a shortage of hospital doctors SLO, RO: in the remote areas, isolated zones

Other statements:

CZ: wide difference among regions

HU: in a few cases there is a shortage (pathologists , anaesthesiologists)

M: Regarding the number of doctors in Malta-there is no shortage. We have maldistribution due to poor working conditions which do not retain enough doctors within the NHS to manage the demand catered for by a completely free at point of use healthcare system. The system allows NHS employees to carry out private practice; and in fact most do practice privately, so as to maintain an adequate standard of living.

1. Are hospital doctors allowed to run their own practice beside their hospital job?

- yes** CZ, EST, PL, HU (just in private out-patient offices), RO
No CY, SLO, SK (10% yes?, but avoidance of regulation possible)

1. What is the percentage of hospital doctors running an own practice?

	CY	CZ	EST	PL	SLO	SK	HU
percentage of hospital doctors having an own practice	0	minimal	?	data not available, but many	0	0 (non permissible practice)	27,3

RO: no data available

K. Professional law and Rules of Conduct

1. Which authority is charged with determining professional law and rules of conduct?

The state CY (for government employed doctors), EST, HU (partly), SK (law about medical chambers (run-in law about medical profession), RO: Ministry of Health, PL (professional law)

the medical association CY, CZ, EST, SLO (Medical Chamber of SLO), HU, SK, RO: College of Physicians, PL (rules of conduct), M (Medical Council - as a statutory body established by law charged with these responsibilities All the mentioned areas (general duty to take due care, duties relating to the issuing of medical certificates.....etc) fall within the competence and duty of the Medical Council.)

1. What are the main obligations of doctors covered by the determining professional law and rules of conduct?

- **General duty to take due care**
CY, CZ, EST. PL, SLO, HU, SK, RO
- **Duties relating to the issuing of medical certificates**
CY, CZ, EST. PL, SLO, HU, (SK), RO
- **Disclosure and information duty**
CY, CZ, EST. PL, SLO, HU, SK (limited), RO
- **Keeping of written records**
CY, CZ, EST. PL, SLO, HU, SK, RO
- **Medical secrecy**
CY, CZ, EST. PL, SLO, HU, SK, RO
- **Notification duties**
CY, CZ, EST. PL, SLO, HU, SK (limited), RO
- **Duty to undergo continuing medical education**
CY, CZ, EST. PL, SLO, HU, SK, RO
- **Other obligations**
- **Medical Ethics** CY, CZ, EST. PL, SLO

SLO: Physicians may not refuse to give emergency aid appropriate to their level of professional competence.
Physicians must treat children as a separate group of patients.

PL: Physicians may not refuse to give emergency aid appropriate to their level of professional competence.

Suppl. 18: Please provide us with some information on obligatory CME:

- **Is obligatory CME based on provisions:**
- No:** CY, M, CZ
- yes:** SLO, HU, SK, PL

If yes which are the provisions:

- CZ: Medical Chamber
- SLO: Rules on Licence extension: licence to be re-newed every 7 yrs., 75 CME points necessary for extension (1 point = 1 hour of seminar or congress or workshop)
- HU: the responsibilities are under revision, 50 credit hours (points) per year
- SK: n.a.
- PL: Parliamentary Act of 5 December 1996 on the Profession of a physician and resolution of 15th April 2000 no. 013/97/00/III of the Supreme Medical Council on Continuing Medical Education

• Who adopts provisions on obligatory CME?

- CZ: IPVZ;
- SLO: Medical Chamber of Slovenia;
- HU: Hungarian Medical Chamber
- SK: Slovak Postgradual Academy of Medicine,
- PL: Medical Chamber

• What are the consequences for a doctor who does not participate regularly in CME activities?

- CZ: cannot obtain a licence; SLO: the licence cannot be extended (re-newed),
- HU: the licence can be with-drawn,
- SK: they cannot graduate, they cannot obtain the licence for private practice, they cannot be head of dpts, some lack of salary
- PL: 1. he/she might be sent for obligatory training,
2. or exposed to disciplinary punishment including the suspension of his/her right to practice medicine

M: CME is an ethical duty-it is not obligatory

1. What are the sanctions in case doctors fail in their professional conduct, respectively their professional obligations? Which authority imposes sanctions?

	Authority	Possible Sanctions
CY	Medical association	Ethics Committee
CZ	Medical Chamber law-courts	withdrawal of licence in case of crime
EST	administrative authority	withdrawal of licence for private doctors (Ministry of Social Affairs)

PL	Medical Court law-court	Admonition, suspension or taking away physician's licence to practice medicine Fine, damages, imprisonment
SK	Medical associations law-courts Administrative authorities	Disciplinary proceedings Crimes, delinquency Management of hospital
SLO	Medical associations law-courts - civil suits	Medical Chamber may enforce: 1. collegial recommendation 2. a professional warning by the Medical Chamber 3. public reprimand 4. apologies to the person harmed 5. compensation for the damage in financial form 6. money orders for humanitarian purposes 7. professional education according to instructions of the professional supervision 8. compulsory treatment of addiction 9. conditional, permanent or temporary seizure of license
RO	Medical Association Law-Courts administrative authorities	from verbal attention to cancelation of the practice authorisation financial penalties to prison
HU	Medical Association Law-Courts administrative authorities	Ethical Procedures, even exclusion criminal prosecution suspension of licence

M	Medical Council Law-Courts	Penalty or erasion from the medical register Doctors can be charged under criminal law if criminal negligence is likely to be present. It is possible to face charges concurrently within the Criminal Court and the Medical Council
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1. Which requirements fall under the doctor's obligation to documentation?

- CY: question not clear
 CZ: all data concerning patient's status, including history, examinations and treatment must be recorded
 EST: Legislation is currently being prepared
 PL: Minister's of Health regulation
 SLO: - the reason and mode of treatment /assessment
 - full history and clinical presentation;
 - treatment (detailed documentation of all applied drug and other types of therapy and diagnostic interventions);
 - all signed informed consents regarding diagnostics and treatment.
 HU: documentation has to be prepared by doctors (medical history, status, investigations, operations, follow up, reports, medication)
 SK: history, clinics, laboratory testing, examinations, diagnosis, therapy, recommendation, next visitation, valuation (points), others
 M: documentation is an ethical duty

2. Is there a general obligation for doctors to practice traditional medicine (scientifically based medicine)?

Yes : CZ, EST, PL, SLO, HU, SK
 No. CY, RO

M: Doctors use scientifically based medicine. However, alternative medicine is being accepted (in the UK sense) e.g. general practitioner who also practices acupuncture.

1. Are doctors also permitted to practice non-conventional medicines? Which are the conditions, if there are any?

- CY: no
 CZ: doctors are permitted to practice only scientifically based medicine
 EST: Not regulated
 PL: Doctors are not permitted to practice non-conventional medicines
 SLO: no
 HU: yes, upon special licences
 SK: no

2. Is criminal prosecution a possible consequence of a violation of medical professional obligations?

Yes : CY, CZ, EST, PL, SLO, HU, SK

No

If yes, in what cases of violation

CY: ---

CZ: It depends on the level of prejudice or neglect

EST: in case of death or injury leading to permanent handicap of the patient

PL: If the patient's harm fulfills the conditions of the criminal code

SLO: All criminal acts punished according to official duty, particularly acts not connected to medical profession but which can have a negative impact on reputation of medical profession. They represent a serious violation of professional rules.

SK: criminal procedure - damage of patient (mainly willful and neglectful damage), civil law (compensation for damage) - hospitals and private doctors

HU: any malpractice, negligence

M: Doctors can be charged under criminal law if criminal negligence is likely to be present. It is possible to face charges concurrently within the Criminal Court and the Medical Council

If yes, is there a restriction of a doctor's liability in comparison with everyone's liability for cases of physical injury or death?

Yes SK

No: CY, CZ, EST, PL, SLO, HU

If yes, what are the differences?

SK: doctors: in the case of professional service is the public agent, general duty to take due care
penal sanction in the case of not relieving is higher

1. The number of civil suits in your country

increased: CY, CZ, EST, PL, HU, SK, M

decreased

remained quite the same SLO

during the last three years.

1. The main reasons for civil suits regarding the violation of medical professional obligations are

Treatment malpractice CY, CZ, EST, PL, SLO, HU

Organisational shortcomings CY, CZ, PL, SK

Disclosure malpractice CZ

Other reasons: M - malpractice and organisational shortcomings

SK: the lack of health care financing, non transparent financing system

HU: negligence

1. Are there any exceptions to medical secrecy?

Yes CZ, PL, SLO, HU, SK, RO, M
No EST (not regulated by law)

If yes, what kind of exceptions?

CZ: contagious diseases, criminal cases

PL: - if the patient expresses his/her consent to reveal secret information - if the maintenance of confidentiality constitutes a threat to health or life of the patient or other person

1. if this is a duty in law

SLO: A doctor is relieved of his obligation to medical secrecy if the patient agrees with that or if it is urgent for the patient's well-being, his family or society or if so prescribed by special legal provisions.

HU: on demand of state authorities strictly regulated by law, upon requirement of law courts

SK: public utility (epidemic, prosecution...), agreement of patient

RO: in case of justice procedure (request in written)

M: contagious diseases and criminal cases

1. Are doctors obliged to lay information to police, criminal court or other public authorities in case they come to know of relevant criminal circumstances or facts?

Yes: CZ, EST, PL, SLO, SK, HU, RO; M
No

If yes, under what circumstances have doctors to lay informations to whom?

	Circumstances or facts	Authority to which information has to be laid
CZ	in cases stated by law	police court
EST	---	---
PL	When crime is stated.	Information has to be laid to the police.
SK	Determined by law	Authority acting in criminal prosecution
SLO		A court of law can relieve a doctor of medical secrecy according to a legal act (or the patient himself).

HU	Criminal Cases	Ministry of the home affairs
RO		Justice

1. Doctors are entitled to make publicity for their medical practices in...

CY, CZ, EST, PL, SLO, SK, HU, RO

M: Advertising is prohibited. Notices regarding changes in clinic times etc are permitted up to a maximum of three times.

There exist restrictions to advertising in...

CY, CZ, EST, PL, SLO, SK, HU, RO

- CY: not to(?) the medical profession
- CZ: ?
- EST: Only the time, place and title can be advertised
- PL: Information permitted, not advertisement
- SLO: Every kind of direct or indirect publicity is forbidden if it was not designed for educational purposes.
Announcements can be made in daily newspapers when opening or closing a private practice. An announcement can appear three times in a newspaper in the first three months.
- SK: the ethical regulation (codex) of Slovak Medical Chamber (the advertising is not allowed, just an information about new licence, practice, diagnostic or therapeutic methods)
- HU: different positions (example: academic) cannot be mentioned in advertising
- RO: no booklet regarding their professional activity, advertising only by the name, title, distinctions

2. Doctors are permitted to work together in group-practices in ...

CY, CZ, EST, PL, SLO, HU, SK, RO, M

Do group-practices work under the same legal conditions as doctors in single practices do ?

- Yes** CY, CZ, EST, PL, SLO, HU
- No** SK (difference to single practice: graduation of doctors, equipment, conditions for consultation) , RO

1. Is dispensing of medicines in your country also done by doctors?

Yes CY, SK, HU limited for small settlements

No CZ, EST, PL, SLO, M

If yes,

CY: in remote areas where doctors visit the communities

1. Established self-employed doctors are entitled to employ other doctors in...

CY, CZ, EST, PL (only doctors in training), SLO, HU, SK, RO, M

L. Representation of interests

1. Representations of doctors' interests:

CY:	Pancyprian Medical Association, District medical Associations
CZ:	Czech Medical Chamber and other special organisations
EST:	Estonian Medical Association
PL:	The Polish Chamber of Physicians and Dentists, Regional Chambers and trade unions.
SLO:	Medical Chamber of SLO (membership obligatory), Slovenian Medical Society – scientific role (membership voluntary), Fides – trade union of doctors (membership voluntary)
HU:	Federation of Hungarian Medical Societies-Motesz, Hungarian Medical Chamber and democratic trade union of health workers
SK:	1. Slovak Medical Chamber - professional 2. Slovak Stomatologic Chamber - professional 3. Doctors' trade union - trade union 4. Association of private doctors - empoyers org. 5. Slovak Medical Society - scientific org.
RO:	1. A.M.R. Romanian Medical Association) College of Physicians - str.Visarion 4-6 secti, Bucharest, Romania
M:	Medical Association of Malta

1. Has the representation of doctors' interests been established by law?

yes	CY, CZ, PL, SLO, HU, SK: 1. + 2. By special law, with pharmacutists (run-in the new law about medical profession); 3.+4.+5. - laws relating also non medical organizations, RO: College of physicians
No	EST, RO: A.M.R., M

2. Is doctor's membership in the representation of interests obligatory or voluntary?

obligatory	CY, CZ (Medical Chamber), PL (The Polish Chamber of Physicians and Dentists), SLO, HU (in the medical chamber), SK: Slovak Medical Chamber for private doctors, RO
voluntary	CZ (Czech Medical Association), EST, HU (in federation of medical societies and in democratic trade union of health workers, see above), SK: SMC for employed doctors and other organizations (see 3.+4.+5. in point 1), PL - trade unions, M

1. In case there exists an obligatory representation of interests, are there also voluntary organisations representing the interests of doctors?

yes CY, PL (trade unions), SLO, HU, RO
 No SK (see point 1., 3.) every representation of doctors has the main field of its activity

2. Which is the main representation of interests and what are their main tasks?

Name of the institution:

CY: Pancyprian Medical Association, District medical Associations, Specialist's associations
 CZ: Czech Medical Chamber
 EST: Estonian Medical Association
 PL: The Polish Chamber of Physicians and Dentists (look at Enclosure 2), Regional Chambers and trade unions.
 SLO: Medical Chamber of SLO (membership obligatory),
 HU: Hungarian Medical Chamber and democratic trade union of health workers
 SK: see points 1. and 3.
 RO: Romanian Medical Association, Federative Chamber of Physicians
 M: The Medical association of Malta is the representative body of doctors' interests affecting all areas of professional practice including ethics, representation and economic interests.

Tasks:

Licences	CY, CZ (Medical Chamber), PL, SLO, HU (Hungarian Medical Chamber), SK: partly - Slovak Medical Chamber
Diplomas	CZ (Ministry of Health), SK: certificates only - Slovak Medical Chamber, Slovak Medical Society
Disciplinary actions	CY, CZ, PL, SLO, HU (Hungarian Medical Chamber), SK: Slovak Medical Chamber
Medical ethics	CZ, EST, PL, SLO, HU (Hungarian Medical Chamber), SK: Slovak Medical Chamber
Economic matters	CY, EST, PL, HU (Hungarian Medical Chamber), SK: Ass. of private doctors, Slovak Medical Chamber, doctors' trade union
Secondment	SLO
Specializations	SLO
Professional supervision and counselling	SLO
Official register of doctors	SLO, HU

SLO: From the statute:

1. Having and issuing a Code of Medical Ethics and Deontology, monitoring the behaviour of doctors and administering any measures necessary for violations of the Code;
2. Maintaining a register of members and issuing membership cards;
3. Issuing, extending and revoking the doctors' licenses for independent work;
4. Participating in the development of the undergraduate education program for doctors;

5. Managing (planning, monitoring and supervising) the secondments of the two year compulsory postgraduate training in hospitals; secondments for specialisation's; other postgraduate professional training and examinations;
6. Organising professional seminars, meetings and other types of professional medical development;
7. The professional auditing and appraisal of each doctor practising in SLO;
8. Participating in the preparation of regulations, planning and staffing plans health care issues;
9. Determining doctor's fees and participating in agreeing the prices of the health care services;
10. Representing the interESTs of doctors in determining contracts with the Institute of Health Insurance of SLO;
11. Participating in the negotiation of collective contracts, and agreeing them on behalf of private doctors as employees, thereby managing the value of medical professionals' salaries;
12. Providing legal assistance and advice to members on insurance against medical compensations claims;
13. Maintaining a Welfare Fund to help its members and their families;
14. Monitoring the demand for doctors and helping unemployed doctors find job;
15. Assisting members to find suitable locums during their absence;
16. Publishing activities, editing activities; issuing a free journal to members, publishing books and other publications;
17. Encouraging co-operations between members and arbitrating in disputes;
18. Encouraging the cultural and social activities of members; organizing the culture, sporting and other social events and activities;
19. Monitoring alternative methods of treatment;
20. Deterring prohibited and unacceptable medical practices;
21. Providing a free permanent consulting service to member;
22. Undertaking other tasks pursuant to legal regulations and the statute.

HU: Tasks of democratic trade union of health workers: national representation of health workers in the field of life and work conditions, conclusion of collective labour contracts, conclusion with government on wages, opinion in legislation, right to strike.

Suppl. 19: The quality of medical services is assured by...

- | | |
|-----------------------------------|---|
| a. Extramural area | CZ: Medical Chamber, Ministry of Health
SLO: private physicians: They are under professional supervision of the Medical Chamber of Slovenia,
HU: n.a.;
PL: regional chambers |
| b. In hospitals: | CZ: hospital management,
SLO: internal professional supervision by the hospital itself, they are under professional supervision of the Medical Chamber;
HU: ISO,
PL: the "president" of the district, so called voivode
M: self-regulation |
| c. In health care centres: | CZ: Medical Chamber
SLO: internal professional supervision by the health care center itself, they are under professional supervision of the Medical Chamber of Slovenia;
HU: ISO;
PL: the "president" of the district, so called voivode
M: self-regulation |

SK: Answer is about quality of medical care, but not about official System of Quality.

- Extramural area yes
- In hospitals yes
- In health care centres yes

M: The quality of medical services is assured by professional self-regulation.

Suppl. 20: Are there generally valid provisions for quality assurance, if yes, which? By whom are they adopted?

CZ: Medical Chamber, IPVZ, scientific societies

CY: no provisions

SLO: Rules on professional supervision with counselling adapted by the Medical Chamber of Slovenia together with the Ministry of health

HU: the law is under revision; there is continuous inspection over any health provider by the National Institute of Public Health and Medical Officers . NIPHMO (ANTSZ)

SK: Ministry of Health, Slovak Postgradual Academy of Medicine, Slovak Medical Society, Slovak Medical Chamber

PL: no provisions

M: so far, self- regulation is standard

M. General considerations

1. Do you see any problems resulting of your country's integration into the European Union for the doctors in your country and how may/might the CP help?

- CY: recognition of diplomas from third countries
post-graduate training programs
C.M.E.
- CZ: low incomes of physicians
- EST: 1) Approval of the training system of doctors
2) Recognition of diplomas
- PL: We do not see any major problems with our integration in EU. Law has been just passed.
- SLO: We do not see any major problems with our integration in EU
- SK: the financing system
The lack of standard market relations
The approximation of some laws
More self government
The decentralization
Cardinal professional problems - none
- HU: We cannot see any problem of Hungary's integration . It is important to participate in enlargement working group, and we would appreciate if the meetings were held on Saturdays (less travelling expenses)
- RO: We have to carry out mutual recognition of diplomas
- M: Problems associated with EU accession:
- No significant problems.
 - CP can help with support for CPD which at present is entirely funded by doctors locally, with no possibility for tax deduction

1. Do you see any possibilities for the migration of doctors (especially in the field of general practitioners or in the field of which specialities)?

possibilities for the migration of doctors:

- CY: for doctors from other countries it can not be foreseen, adequate salary and standards of living in CY will not lead local doctors to immigrate
- CZ: we don't expect a large migration
- EST: possible, but not in large numbers
- PL: In case of PL the main problem would be the knowledge of a foreign language.
- SLO: We see possibilities to accept GPs to work in SLO because we are in shortage and expect to be in shortage for the next 6 years. We do not expect migration of our doctors abroad.
- SK: not clear question - do you mean the migration in EU (we don't expect it during some next years because of big language barrier) or migration between specialists (now very difficult, also psychological barrier)
- RO: outside the country - like any Romanian citizen - limited by the mutual diplomas recognition;
inside the country - limited by the promotion of the specific exams in order to have the possibility to practice in the cities
- M: No significant numbers, in both general practice and specialist areas.

especially in the field of...

general practitioners	yes	SLO, RO
	no	CY, SK, HU
specialists	yes	EST, SK (internal medicine, surgery - subspecialisations), HU (anaesthesiologists, pathologists, laboratory medicine), RO
	no	CY, SLO

2. What are actually the main reformation intentions of your country concerning your health care system

- CY: introduction of a universal coverage national insurance system; it is pending at the national assembly for enacting
- CZ: recodification of all acts in health care system
- EST: 1) Health insurance (reform is implemented)
2) Primary care (reform is implemented)
3) In-patient care reform (prepared)
- PL: Our main reformation intention is the improvement of a newly introduced social insurance system.
- SLO: Balancing the financial resources with the basic basket of benefits from the mandatory health insurance
Focusing to out-patient care
Focusing to home care
Implementing QCD
Transparent financing
- SK: privatisation, decentralisation of hospitals
Changes in health insurance
Stabilisation of regional system
Changes in cash flow
- HU: development of public health and primary care
- RO: setting up the payment "fee for service" in hospital, establishing a coherent method to set up the budget for the hospitals
- M: devolution of healthcare to autonomous organisation and ensuring the sustainability of healthcare

3. What are the main problems concerning the health care system you have to cope with by the moment?

- CY: anachronistic, bureaucratic, inefficient, unfair to all concerned - it dates back to the British Colonial Rule
- CZ: many with regard to the transforming system with the trend to the European standards
- EST: 1) Shortage of finances
2) Restructuring of the hospital network
- PL: The main problem concerning the health care system we have to cope with is its financing.
- SLO: Constant raise in expenditure for drugs
Long waiting times for procedures especially in surgical specialities

- MRSA in hospitals
- SK: see above
- Non transparent health care financing
- HU: underfinancing state of all providing systems
- RO. low level of financial resources, establishing the budget for hospitals on historical premises
- M: Falls under the (bureaucratic) civil service, which also means that salaries are pegged in with the low levels therein. This brake has now been removed and in future, doctors will fall under an autonomous organisation

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