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Title:	Working conditions of the salaried physicians in Europe -FEMS survey		
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Working conditions of the salaried physicians in Europe FEMS survey

During the Spring FEMS GA May 2013 held in Budapest (HU), it appears necessary to elaborate a state-of-play of the working conditions of the salaried physicians in Europe.

We registered the answers of 20 FEMS Member Organisations from **16 European countries**, 15 EU Members States (AT, BE, BG, CZ, ES, FR, HR, IT, HU, NL, PL, PT, RO, SI, SK) and the Turkish part of Cyprus (TCY).

1. Status of the salaried doctors in Europe

In a large majority of countries, the salaried doctors are **public servants** sometimes with a private contracted part-time activity (IT). They are not always satisfied with this situation (IT, HR, SI, PL, BG, RO).
Only in 4 countries (CZ, FR, NL, PT) they have a **special healthcare worker status** in the public sector and, except in CZ, they are satisfied with this legal status that allows them to speak directly with the health regulators.
In most countries the doctors can be salaried in private facilities, under contract. In some countries (ES, FR) the doctors can work partially for the public sector and for the private sector the remaining time.

2. Working conditions

a. Working time: EWTD 2003/88 (reference period, daily rest, opt-out)

Working time is decreasing in Europe. From 40.5 hours on average in 1991, it fell to 37.5 hours in 2010. However, some professions are beyond the average. Salaried physicians are thus part of the 9% of European employees who work more than 48 hours per week and the Commission wants to improve the protection of European workers, especially in the field of health.

The **EWTD is implemented** in all EU Member States (EU MS). But, in some countries all the aspects are not fully respected (CZ, FR, IT, RO, SK, see point 3b). The EWTD is not implemented in TCY (non-EU MS).

b. CME/CPD

An always-higher level of professional requirement increases stress, even though the Continuing Professional Development is down in most European countries.

The CME/CPD training is mostly qualified as "efficient" in half of the countries (AT, BE, NL, ES, HU, PL, RO, SI) and "non efficient" in the other half (BG, CZ, FR, HR, IT, PT, SK, TCY).
This efficiency is not clearly linked to a CPD training program provider: University (BG, HU), Medical Chamber or Association (AT, BG, FR, HR, NL, RO, SI, SK, TCY), Medical Trade Unions (ES), Ministry of Health (BG, CZ, FR, IT, PL), Scientific Societies (BE, CZ) or other (PT).

c. Quality of care, Patient Safety and Risk Management

European medical practitioners see their professional practice increasingly framed by recommendations or standards, officially for improving patient's safety and quality of care but in fact for best performance to improve productivity.

Only in 7 countries (AT, BG, FR, HR, IT, PL, SI) the salaried physicians feel oppressed by **standards not elaborated by peers** and think that these standards are threatening their medical practice and sometimes the patients' safety.
In 2 other countries the physicians feel that these standards can threaten patients' safety (SK, TCY).
In SK many hospitals don’t comply with common international standards, so it is difficult for the management or State to impose too strict working rules …

d. Stress at work, burnout:

2nd EAHP Conference "Healthy Physicians for a Healthy Society": this major international conference took place in Barcelona (ES) from 1 to 3 December 2010.

The main recommendations to avoid burnout are:

- Priority for promotion of health and wellbeing for health professionals
- Early detection to prevent problems before they occur
- Improvement of the caring programmes
- Involvement of policy makers, boards, institutions
- Assessment of effectiveness and efficiency of interventions and their outcomes
- Outcomes should favour human aspects, not only economic aspects
- Support human and social capital
- Hospital managers should care more for physicians’ health, but they are not the only ones
- Interventions to focus on individuals, as well as organizations
- Using the health professional information to help all healthcare staff
- Encourage peer groups support
- Early detection in medical students
- Design of multicentric studies at European level in order to obtain funds from EU

With the exception of TCY and sometimes in AT, situations of medical burnout are observed in all the observed countries.

e. Detection and caring programmes: programs to assist physicians in difficulty (PAIMM-Spain, PAMQ-Canada)

Only Portugal has such type of programme, organized by the Portuguese Medical Chamber. In ES, the Foundation Galatea de Salut organizes the PAIMM programme in Catalunya with the support of the regional Ministry of Health and of the Medical Trade Union (Metges de Catalunya). In FR (Trade unions, Scientific societies) and HR (Medical Chamber), the process is beginning.

In half of the countries, the hospital **Occupational medicine department** covers all the salaried doctors (BE, BG, FR, HR, PL, PT, RO, SI), in CZ and SK the radiologists and physicians with specific risks workplaces only.

f. Age of retirement of the salaried doctors

The legal minimum age of retirement is different from one country to another. In 2013, this age is mainly around 65 years for male (M) and female (F) physicians in BE, ES, IT, PT, RO with 67 years in NL and PL, 63 years in HU, 62 years in FR and SK, 60 years in TCY. We notice

different situations by gender in HR, SI, CZ (65 M – 63 F), AT (65 M – 62 F), BG (63 M – 60 F) and SK (62 M – 57 to 62 F according to the number of children).
Overall, because of the aging population in Europe, the financial effort required to ensure pensions should increase. In most countries it is decided by law to increase the minimum age of retirement and the contribution period in the coming years.

The age of retirement of the physicians is higher by law than in the main population in AT, IT, SI and TCY and the same as in the main population in BE, BG, CZ, ES, FR, HR, HU, NL, PL, PT, RO and SK. But clearly, the physicians with a prolonged duration of study enter later into the workforce, contribute later in pension funds and are thus forced to continue working later than the general population, if they want to receive a full pension.

g. Healthcare workforce demography, feminisation

The Ministerial Conference on the EU healthcare workforce, La Hulpe Brussels (B) 9-10 September 2010 "Investing in the health of tomorrow's Europe" has been one of the most important events of the year 2010. In 2020, there will be a shortage of one million health professionals in Europe, questioning 18% of the activity of health care. It is a social and political challenge across the continent.
The FEMS and other EMOs alerted for years the European political authorities on this threat.

4 large axes of developments were decided, to maintain a correct level of health care professionals in Europe:

- To guarantee our future requirements as personnel for health (number/qualification)
- To prepare the necessary changes (profiles of the jobs/diversity of competences/DPC)
- To create the best environments of work to attract and retain the professionals of health (working conditions / personal and professional-life balance)
- To promote a culture of the training within the professionals of health (safety of the patients/quality of the care).
  Specific financings of the Structural Funds of the EU will be assigned to this policy, under the direction of DG MARKT (Internal market).

In a large majority of the 16 European countries a ***numerus clausus*** is regulating the flow of entrance in the medical schools. This limitation of admissions doesn't exist in BG, CZ, RO, PL and TCY. In AT and BE, there is a quota restrictions on the number of non-nationals permitted to enrol on degree courses for doctors, dentists, physiotherapists and vets that reserves 75% of places in medical schools for natives. Despite a European Court of Justice rule, the European Commission decided to extend its suspension of legal action against Austria and Belgium over this quota system until December 2016.

With the exception of PL and TCY, **feminisation of the medical profession** is reality in all countries. This has consequences on the available medical time and hospital careers. Despite this, only in ES, NL and slowly in AT adaptations of medical staff positions are taken.

Contrary to what is commonly practiced in the northern European countries, the salaried doctors of the 16 countries have no free access to **hospital nurseries** to keep their children during working hours. In TCY, they have no hospital nurseries …

With the exception of AT, a country whose medical demography is the most favorable in Europe after Greece, all the countries are facing **physicians' shortage**, particularly severe in HU. In some countries like BE, PT and TCY, they are some specialities more threatened than other (anaesthesiology, emergency medicine). In RO, there is no problem in university centres but in non-university towns and more rural areas there is a great lack of specialists.

The Hungarian EU Presidency led a survey on the **healthcare professionals migration**. This survey was presented to the EPSCO Council in Gödöllö April 4-5, 2011 and this document is providing the European Observatory on Medical Demography and Migration established during the CEOM meeting, Paris 3 December 2010 with FEMS as founding member.

The Health Care workforce migration flow is **immigration** in FR and NL. In RO some Moldavian doctors, in TCY some Turkish doctors are coming in. But in a majority of the other countries the dominant flow is **emigration** (CZ, IT, HU, RO, PL and SK). Both flows are observed in AT, BE, BG, ES, HR, PT. In SI the native doctors are going abroad and replaced by non-EU physicians.

h. Task shifting

Facing the problems of medical demography (more generally of the healthcare professionals), one of the attitudes of the governments generally observed is the task shifting and the creation of new jobs with new skills. This trend is like opening the "Pandora box" for the future of health care. FEMS and the other EMOs will never accept task shifting threatening quality of care and patient's safety, for reasons of defect of financing and/or bad organization of healthcare.

In HR, HU, SI, PL, SK and TCY the salaried physicians are not facing task-shifting situations. In the other countries (AT, BE, BG, CZ, ES, FR, IT, NL, PT, RO) task-shifting is developing and these situations are threatening the medical practice and the patients' safety in the opinion of the doctors of BE, BG, ES, IT, RO and PT.

3. Remuneration

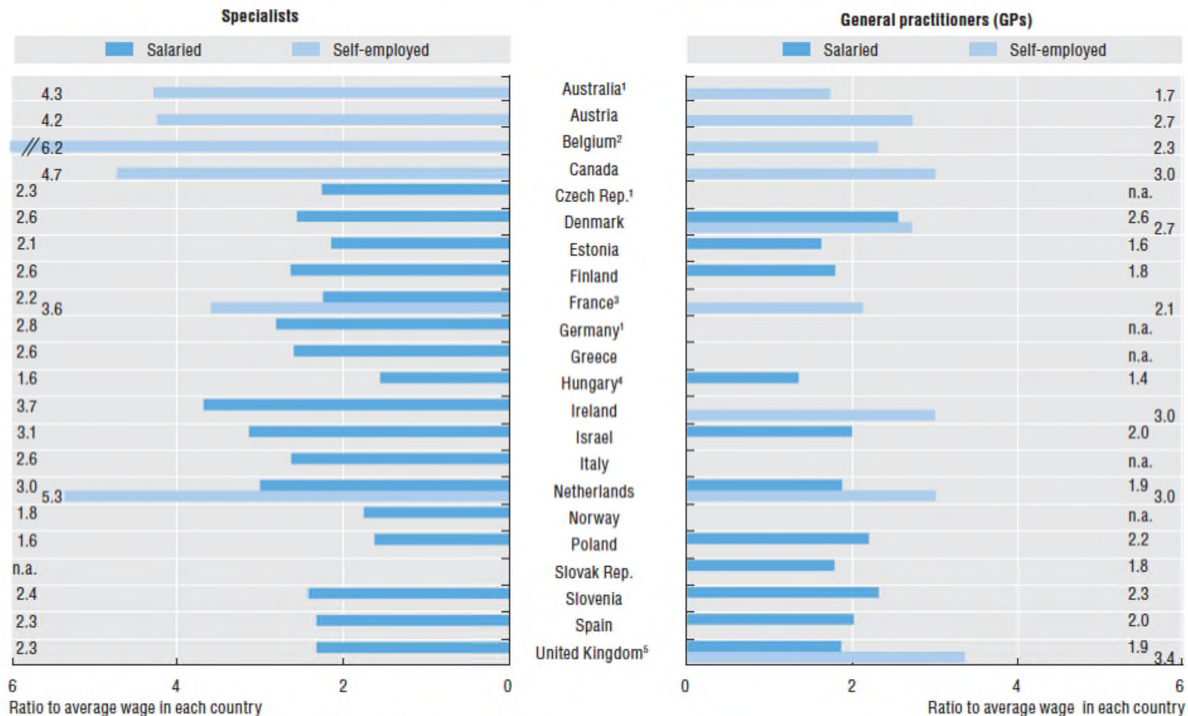
The FEMS GA in Istanbul October 2010 decided unanimously to respond positively to the OZZL/Poland Draft Statement on Minimum Salaries by investigating on average salaries in Europe, to relate with PPP (Purchasing Power Parity), in order to define a formula for minimum salaries for doctors in Europe.
But in reality, the physicians’ remuneration decreased by 10% to 30% in many European countries due to the financial crisis.

a. **Base medical salary** indexed to the national average salary, country's GDP, income *per capita (OECD, EUROSTAT),*

The FEMS' strategic objective to have the medical specialists' salary improved to 2 or 3 times national average salary is realised in AT, ES, FR, HR (2x), IT (2x), NL, PT, SI and SK. It is not yet realised BG (1,2x), CZ, HU, PL, RO and TCY. The situation in BE is specific, because the most specialists are self-employed.

Fems Fédération Européenne des Médecins Salariés European Federation of Salaried Doctors

3.6.1. Remuneration of doctors, ratio to average wage, 2011 (or nearest year)



1. Physicians in training included (resulting in an underestimation).
2. Practice expenses included (resulting in an over-estimation).
3. Remuneration of self-employed physicians is net income, rather than gross income (resulting in an underestimation).
4. Public sector employees only (resulting in an underestimation).
5. Specialists in training included (resulting in an underestimation).

Source: *OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.*

However, the goal for FEMS to have the medical specialists' salary improved to 2 or 3 times national average salary in all European countries remains a priority for the delegates of BE, CZ, ES, FR, HR (3x), HU, IT (3x), PL, RO, SI and SK. This objective is not (or no more) a priority for the delegates of AT, BG, NL, PT and TCY.

With the exception of AT, BE, BG and NL, the delegates notice a **decrease of the salary/income** due to the financial crisis in a large majority of countries: ES (by law), HR, IT, PL, PT, SI, RO. In FR and TCY the wages are frozen for years while the cost of living increases. In CZ, HU and SK the **salaries increased** (but less than expected) in the recent years, due to strong protest actions leaded by the Medical Trade Unions members of FEMS, with the support of the Medical Chambers.

b. **Resident** (in hospital or other health facility) **and non-resident** (at home) **on-call duties** (included in the weekly working time), **legal rests** (daily, weekly)

Everywhere in Europe, the doctors must work much while earning less. They will not accept that a revision of the European Working Time Directive leads them to make unrecognized on-call duty (inactive periods). Otherwise, the medical positions will still lose in attractiveness and the medical shortage will worsen.

The EWTD 2003/88 is fully implemented in all aspects in AT, BE, ES, HR, HU, NL, PL, PT and SI. In TCY (non EU MS) this ED doesn't apply. Surprisingly we discover that in a lot of European countries **some aspects of the EWTD are not respected**, mostly for overtime (opt-out) and on-call duties working time calculation: BG, CZ, RO, and SK. For IT and FR the FEMS delegations are leading official complaints to the European Commission against their governments, with success.

4. Hospital Governance: Physician involvement in health policy and management

The position of salaried doctors is constantly challenged by alternative initiatives to the physicians' statutes, leading to a progressive individualization to isolate the health professionals and make them more dependent on the professional and administrative hierarchy. The loss of autonomy is an important factor in increasing the discomfort of doctors, leading to more burnout.

Except in NL, RO and TCY, in all other 13 observed countries the salaried doctors are facing such situations, reducing their autonomy. In CZ this situation exists only in some hospitals, especially these owned by chains of health care providers.

Except in BE and HU, in the other 11 countries this progressive isolation of the healthcare professionals is considered to be threatening the medical practice and the patients' safety.

The **professional organisations** (Trade Unions, Medical Chamber) are considered threatened by the authorities in AT, BE, BG, CZ, HR, IT, PL, RO and SK. The same professional organisations are considered respected in ES, FR, HU, NL, PT, SI and TCY.

In a large majority of the observed countries, the salaried doctors are not satisfied with the **social dialogue** in the hospitals and other medical facilities. Only in NL and TCY the doctors are satisfied with the social dialogue. In CZ, the social dialogue is considered correct in public hospitals and not correct in the facilities owned by chains of health care providers.

5. Information and Communication Technologies (ICT) in healthcare

Neelie KROES, the European Commissioner for Digital Agenda, called on 25 February 2011 for radical changes to increase the use of ICT in healthcare. The industry of telecommunications had to enter on the market of "e-health" so that the patients can have access to the medical files on line, supervise their health using mobile devices and communicate more easily with their doctor. She declared: *"the chronic diseases are in rise whereas a shortage of specialists and healthcare personnel appears. That will generate an enormous deficit of care, unless it is filled thanks to technology. That means that the collapse of our systems is guaranteed if we do not make radical changes "*. It will be necessary to quickly work out uniform standards for the protected data exchange, to allow an implementation generalized of the ICT in healthcare.

With the exception of HU and SK, an **implementation of the ICT** in the medical practice is noticed in the other 14 European countries.

The very important problem of **medical data protection** is legally guaranteed in all observed European countries (EU MS), with the exception of TCY.

Surprisingly, **free access to telephone and Internet** for the salaried doctors is only guaranteed in 8 countries: BG, CZ, FR, HR, HU, NL, PL and SI. In BE, ES, SK and TCY this free access is not possible. In IT and PT the free access is only for Internet, in AT only for mobile phone and in RO the doctors have to pay for their regular phone access!

To help in administrative duties, the salaried doctors have free access to a **secretariat** in BG, FR, HR, NL, PT, SI and TCY. In AT, CZ, PL and SK it is not always possible, according to the type of hospital but this support by a secretariat is not possible in BE, ES, IT, HU and RO.

6. Financing of the health system

Social budgets are constantly increasing, due to the aging population, growing technology and the demand of the European population to have access to quality care while accessing democracy.

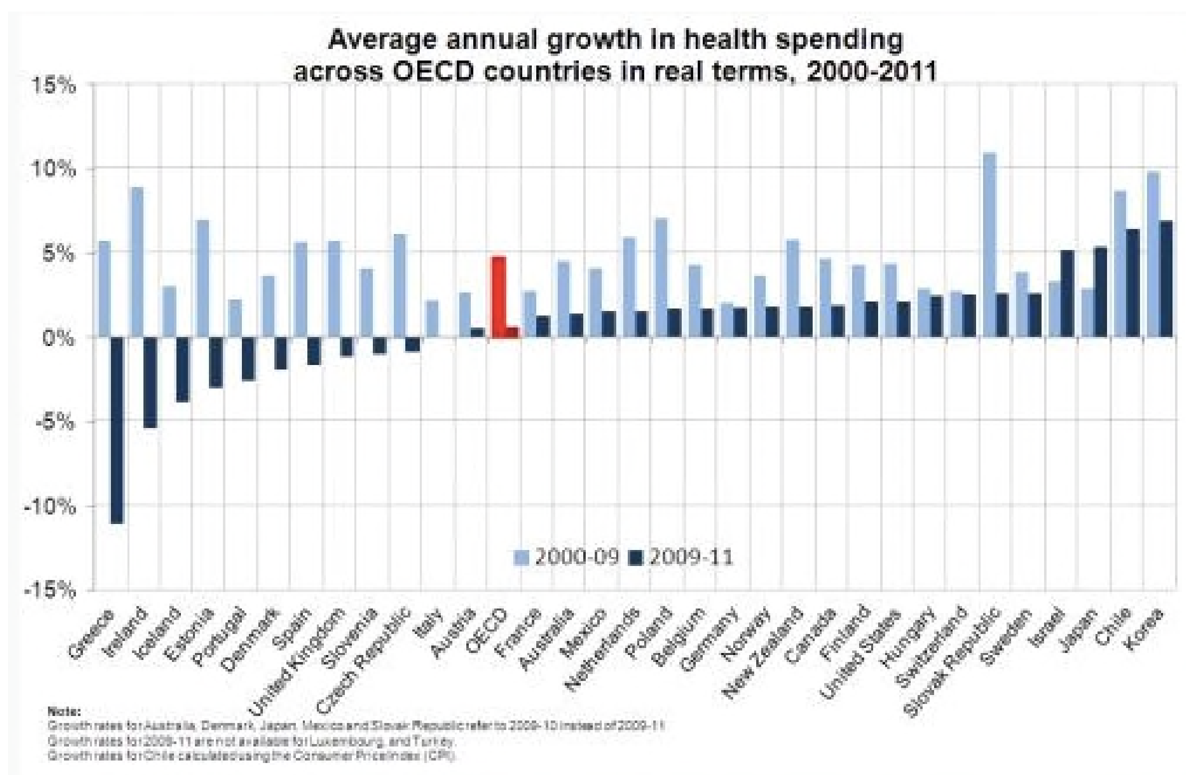
The global financial crisis obviously has a negative impact on the financing of health systems, patient safety, improved working conditions and wages of salaried physicians in Europe. WHO has found it necessary to warn governments, asking them to maintain a high level of service to cope with the deteriorating health caused by the financial crisis.

Reductions in public spending on health in many OECD countries have typically been made across the board. Pharmaceutical spending has been a prime target, with spending falling slightly in 2010 followed by deeper cuts in 2011. Many countries have increased cost sharing for pharmaceuticals, reduced prices and coverage, and promoted the use of generics. In 2011, Portugal, Greece and Spain reduced spending on prescription pharmaceuticals by 20%, 13% and 8% respectively. In Spain, the share of generic drugs (in the total volume of consumption) more than doubled between 2006 and 2011.

In many countries, governments have also decided to cut their spending on prevention and public health, although these typically represent only a small share of their overall health budgets. More than three-quarters of OECD countries reporting expenditure on prevention and public health for 2011 showed a real-term cut in spending.

Many governments have also tried to contain the growth in hospital spending - one of the biggest ticket items in most countries – by cutting wages, reducing hospital staff and beds, and increasing co-payments for patients.

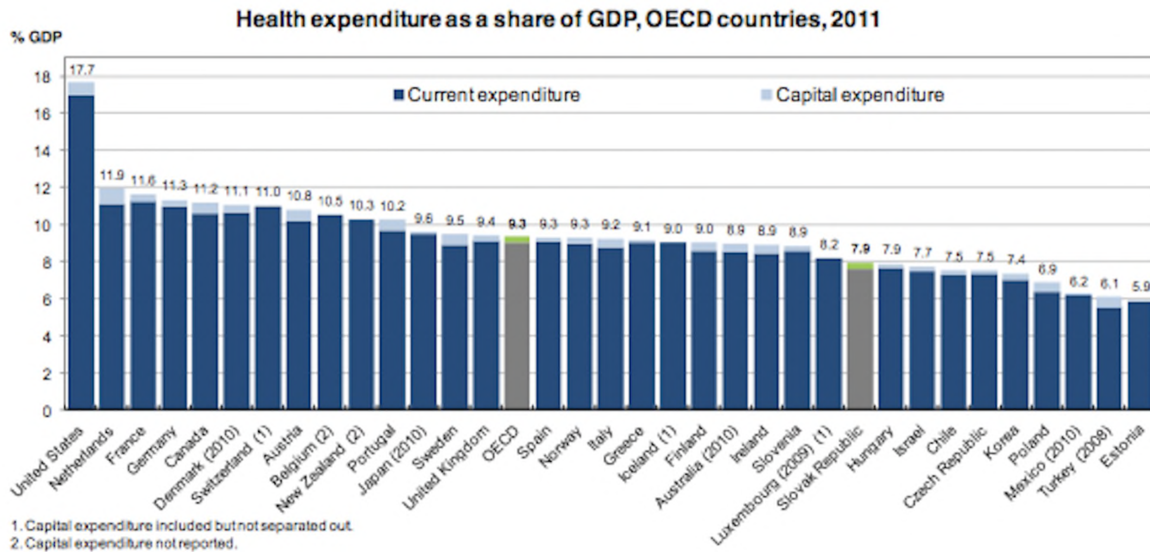
Source: OECD Health Data 2013

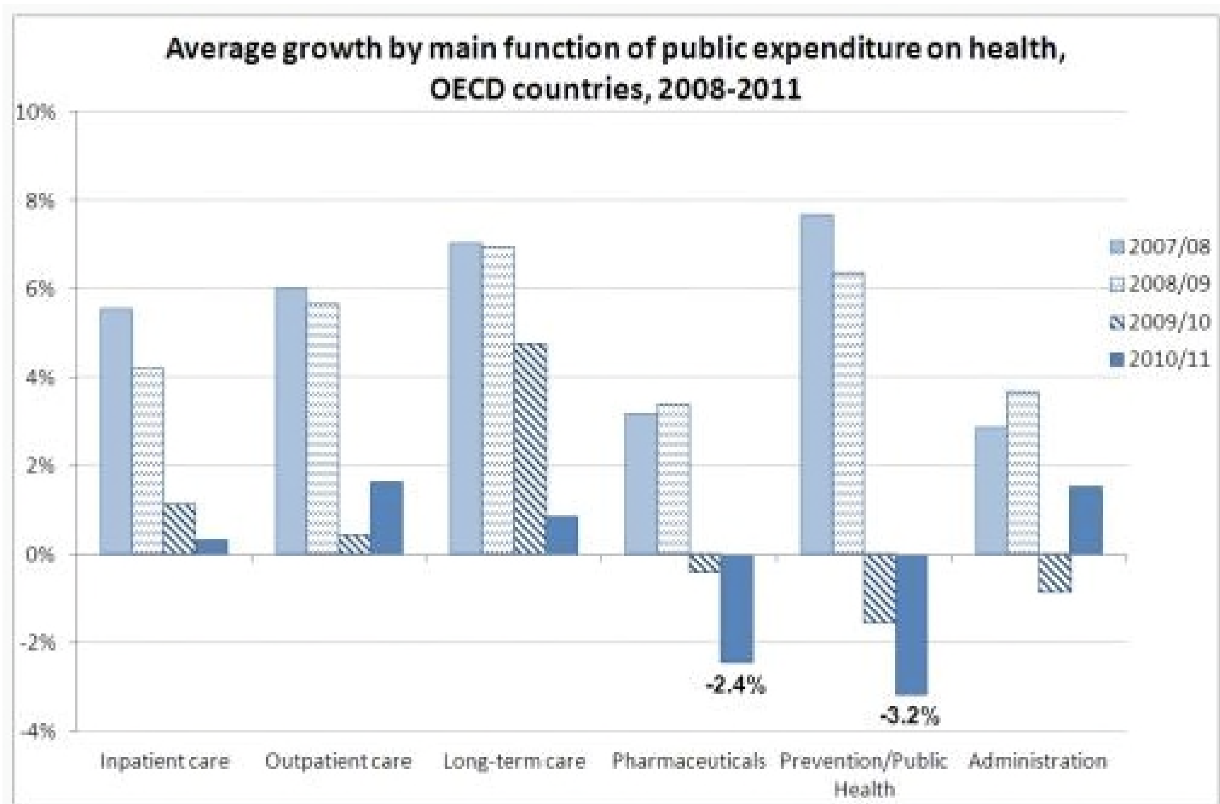


Source: OECD Health Data 2013

As a result of the minimal growth in health spending across OECD countries in 2010 and 2011, the percentage of GDP devoted to health declined slightly in most countries. Health spending accounted for 9.3% of GDP on average across OECD countries in 2011, compared with 9.5% in 2010. Excluding capital spending, current expenditure on health as a share of GDP dropped from 9.1% on average in 2010 to 9.0% in 2011.

Source: OECD Health Data 2013

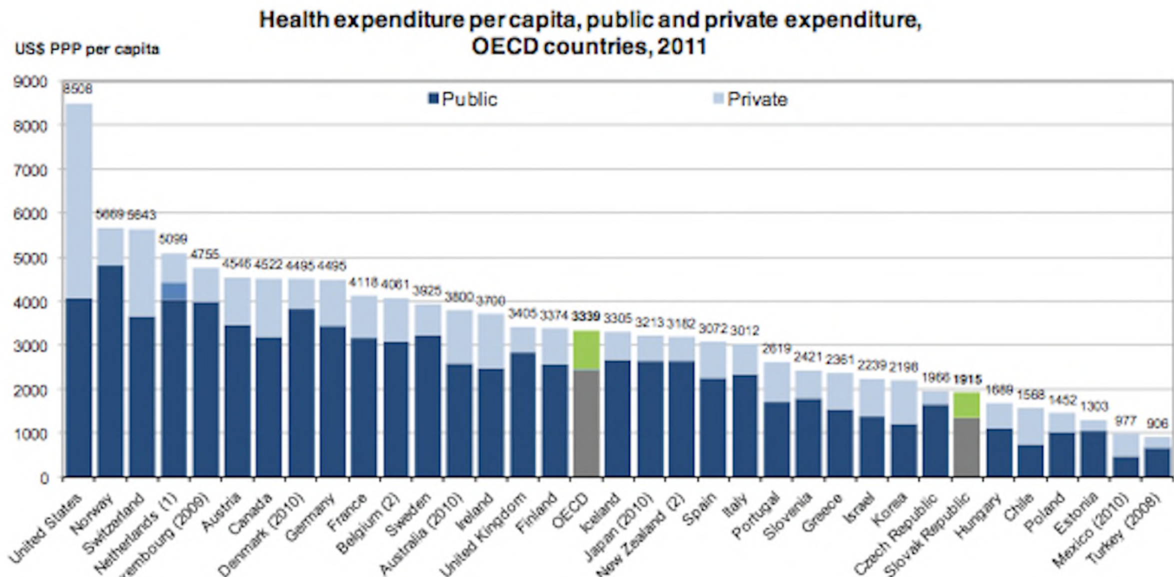




Source: OECD Health Data 2013

a. "Public" funding (National Health Insurances, State, …)

Public funding remains the only guarantee of equal access to health care. Public funding remains, for the moment, the majority in all EU countries.



1. In the Netherlands, it is not possible to distinguish clearly the public and private share for the part of health expenditures related to capital expenditure.
2. Total expenditure excluding capital expenditure. Source: *OECD Health Data 2013*, June 2013.

Data are expressed in US dollars adjusted for purchasing power parities (PPPs), which provide a means of comparing spending between countries on a common base. PPPs are the rates of currency conversion that equalise the cost of a given 'basket' of goods and services in different countries.

The observed countries where **changes in public funding** of HC are noticed are a large majority: BG, BE, CZ, ES, HR, HU, IT, PL, PT. In FR and NL the scope is more to reduce costs or to limit the increase of costs. In AT no changes are noticed in the resource allocation in healthcare, the same in RO, SI and SK but considered insufficient.

b. Privatisation

Most European governments are trying to get rid of social costs, especially those related to health, and to transfer to private insurances, with a significant risk of impossible access to care for a growing share of the population. The privatization of health systems is not a solution for the future. Throughout Europe, but especially in Central and Eastern Europe, the financial situation of public health is deteriorating. Only private hospitals still find a willing ear of financiers, allowing them to take new "market shares".

A trend of the government for privatisation of the HC system is noticed in a large majority of the observed countries: CZ, ES, HR, IT, PL, PT, RO, SK and TCY. There is no privatisation trend in HC noticed in BE, BG, HU, NL and SI. In AT and FR there is more a trend to Public-Private-Partnership (PPP) in some activities.

c. Out-of-pocket payment

An increasing part of patients' out-of-pocket payment in noticed in a large majority of the observed countries: BE, BG, CZ, HU, IT, PL, PT, RO (co-payment), SK and TCY. In FR the out-of-pocket payment is slowly increasing but still remains the lowest in the OECD countries. No changes in the out-of-pocket payment in AT, ES, HR, NL and SI.

7. Hospital funding

Considering the type of public hospital funding system we notice that the historical **block grant funding** is still remaining in BG, ES, PL and SK. The new resource allocation systems based on **DRGs and/or activity-based funding** is now in force in a majority of European countries: BE, CZ, FR, HR, HU, IT, NL, PT, SK (DRGs developing) and RO. In AT, both funding systems are possible.

8. Conclusion

The recent European Commission (DG SANCO) Action Plans highlight the role of public health as a key factor for competitiveness and economic development in an ageing Europe and as cornerstone of the economic success. The EC underlines that a population in good health means more productivity, more time at work, more employed people, more old people at work and less healthcare demand. It also underlines the role of support of the EU' health policy in the economic revival and by helping the Member States to face the current challenges.

Our model of society presupposes the maintenance of growth and there will be no growth without a healthy population. Investing in health professionals with good working conditions, fair wages and a better balance between work and family life is an investment in the economic revival of the EU.

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