

# Green College Lectures: 1984

## Medicine in the European Communities

ROGER BREARLEY

The Common Market Treaty conferred on all citizens of the European Communities the right to migrate and work in any other member state. For doctors this entailed the modification of national laws governing access to practice, which required community legislation in the form of directives. To us in Britain the notion of recognising qualifications obtained in another country or held by nationals of another country is not revolutionary, but in the original member states of the European Economic Community, the practice of medicine was virtually restricted to their own nationals who held qualifications awarded in the home country. The Treaty of Rome lays down that the mutual recognition of medical qualifications shall be dependent on the coordination of the conditions of practice—in other words, the educational standards represented by the various countries' qualifications. At the time that the directives were being worded there was disagreement on just how far this had to go. One powerful lobby took the view that mutual recognition could not be introduced until scientific equivalence of the diplomas had been clearly shown. Such a policy, however, would effectively have prevented any medical migration for an indefinite period. A staged approach was therefore required, and two directives were drawn up and finally signed on 16 June 1975.

### The directives

The first directive requires mutual recognition after a certain date of degrees that conform to certain minimum standards laid down in the second. It also makes transitional provisions for previous qualifications that did not reach those standards (a degree recognised in the home country plus certain minimum further experience in practice). Originally, the minimum basic training standard laid down in the second directive was simply that a course should comprise six years or 5500 hours of theoretical and practical instruction. Britain and the other new member states managed at a late stage to add to this a series of objectives similar in layout and wording to the General Medical Council's recommendations on basic medical training. The original requirements for specialist qualifications were much more precise and comprehensive and included previous completion of basic training; theoretical and practical full time instruction of a minimum duration in a recognised centre, supervised by a competent authority; and personal participation of the trainee.

Based on a lecture given at Green College, Radcliffe Observatory, Oxford.

### Advisory Committee on Medical Training of the European Communities

ROGER BREARLEY, CHM, FRCS, member (also chairman of the medical education committee of the Standing Committee of Doctors of the European Communities)

Correspondence to: 33 Queens Drive, Mossley Hill, Liverpool L18 2DT.

### Medical bodies

Although these standards were sufficient to allow migration to start, they needed continual revision to bring training everywhere up to the best prevailing standards. At the time that the directives were signed, therefore, an advisory committee on medical training was set up "to ensure an equally demanding standard of training throughout the community." The committee comprises two experts each from the practising profession, the teaching bodies, and the national competent authority of each country. It issues reports, opinions, and recommendations. A committee of senior officials in public health was also created to study difficulties in applying the directives. It is composed of government health officials from each country and also covers directives relating to dentists, nurses, and midwives.

These two official bodies make good to some extent the absence of any specific medical department of the community. Nevertheless, there is a lack of coordination of medical matters, which may arise in many community bodies including the commission, the European parliament, the economic and social committee, and outside bodies such as the Council of Europe and World Health Organisation. As a result the medical profession has developed several purely professional European coordinating organisations, which have the mammoth task of watching over the whole field and responding appropriately. Such contacts over a quarter of a century have built up a great sense of mutual understanding and sympathy among the organised medical professions of the community.

### Migration

The community authorities originally hoped and believed that as soon as the obstacles were removed doctors would start moving around freely. In this country many feared that we should be overwhelmed by hordes of foreign doctors. After free migration became possible 867 of the roughly 700 000 doctors in the community were granted full registration by the General Medical Council up to December 1982. We do not know how many were here already with other forms of registration, how many have stayed, or how many are actually in practice. In the same period specialist certificates were issued to 493 United Kingdom graduates for use in the community, but again we do not know how many of these were actually used, or for how long. Table I shows the numbers of doctors who had immigrated into each country in the community by the end of 1982 and what proportion they formed of each medical population. The figures are drawn from the national registering bodies and are not entirely comparable, but they reflect the orders of magnitude.

There are several possible reasons why there has been so little migration of doctors. By the mid-1970s all migration within the community had declined. The numerous vacancies for doctors in the late 1950s had largely been filled by young locally trained doctors. Many new graduates are now facing unemployment, and both salaried posts and openings in social insurance medicine are beginning to be subject to manpower control.

Although the legal rights of the migrant doctor are not impaired, changed circumstances put him at a great disadvantage, and it now seems unlikely that there will ever be a great tide of migration by fully trained doctors.

The tradition of travel during the formative period of professional life, and its wonderfully fertilising effect, could, however, be restored. The standing committee (one of the purely professional bodies mentioned above) is at present struggling to establish a pilot project for transnational training; the advisory committee on medical training has endorsed the principle, reminding national authorities of their powers to recognise such periods of training; and our own developing overseas sponsorship scheme for training could well be adapted to include European trainees. In another context, the community has funds for short study visits and joint research programmes, which are not limited to medicine.

The right to train in another community country can be abused. A doctor intending to practise ultimately as a specialist in his own country has a perfect right to take a complete specialist training in another member country. Not all who do so are motivated by a belief in the virtues of travel. In some countries the numbers accepted for specialist training are controlled, and aspiring trainees who have not been accepted get round the system by taking their training in another country that has no such control, thus thwarting plans to prevent excessive production of specialists. Others choose to train in a country where the duration of the training is shorter than in their own. They obtain a specialist certificate as quickly as possible before returning to practise in the home country, so undermining the home country's standards of quality. Greater uniformity in duration of training would eliminate this abuse but is at present strongly opposed by those countries where training is shortest, and this is not likely to change for the time being.

TABLE I—Immigration of doctors into countries of the European Communities by end of 1982 (expressed as proportions of the total medical populations)

Country	Total no of doctors	No of immigrants (% of total)
Belgium	26 000	190 (0.7)
West Germany	178 000	1565 (0.9)
Denmark	13 000	55 (0.4)
France	143 000	415 (0.2)
Ireland	5 000	31 (0.6)
Italy	200 000	103 (0.05)
Luxemburg	567	66 (11.6)
Netherlands	28 000	540 (1.9)
United Kingdom	90 000	867 (1.0)

## Demography

In about 1960 in Europe, as in the world at large, the numbers of doctors were not excessive and in some places there was a shortage. Germany, France, Italy, and the United Kingdom, with populations of between 55 and 60 million each, had between 45 000 and 80 000 doctors, for whom openings were plentiful. Medicine offered a career with the attractions of interesting work, social esteem, secure employment, and high remuneration. People with adequate school grades had a constitutional right to university education in all six original member states, and this included the right to choose which course to enrol in. There was no limitation on the numbers allowed to enter each faculty (*numerus clausus*). Helped by the wave of economic prosperity, young people flocked to medical schools throughout the 1960s and early 1970s. Table II shows that as a result the number of doctors more than trebled in France and more than doubled in all but Ireland, Luxemburg, and the United Kingdom. Table III shows the ratios of doctors to the total population in 1982. Such rapid expansion results in a high proportion of young doctors. Most doctors who retire in the

next 20 years will be those who were already practising around 1960 and were then aged 25-45. Assuming a homogeneous age distribution in this group, about one fortieth of the doctors in practice in 1960 will retire each year between now and the end of the century. Table IV shows that between three and nine times that number are qualifying each year at present.

TABLE II—Medical manpower 1960-82

	1960	1975	1982	Increase
Belgium	11 380	18 500	26 000	× 2.28
West Germany	79 350	118 726	178 000	× 2.24
Denmark	5 525	9 000*	13 000	× 2.35
France	45 000	81 000	143 000	× 3.18
Ireland	3 000	3 750	5 000	× 1.66
Italy	80 350	126 300	200 000	× 2.50
Luxemburg	319	383	567	× 1.78
Netherlands	12 800	22 000	28 000	× 2.19
United Kingdom	59 600	83 000	90 000	× 1.5

\*In 1974.

TABLE III—Ratios of doctors to total populations in countries in European communities in 1982

Country	No of doctors	Population (millions)	Doctors: population
Belgium	26 000	9.9	1:380
West Germany	178 000	61.5	1:345
Denmark	13 000	5.0	1:385
France	143 000	54.3	1:380
Ireland	5 000	3.4	1:680
Italy	200 000	56.5	1:282
Luxemburg	567	0.4	1:705
Netherlands	28 000	14.3	1:510
United Kingdom	90 000	55.8	1:620

TABLE IV—Yearly numbers of doctors retiring and qualifying between 1980 and 1999

	No of doctors in 1960	Estimated Nos retiring yearly, 1980-99	Nos qualifying yearly at 1982 rate	Excess factor
Belgium	11 380	285	1 000	× 3.5
West Germany	79 000	1975	12 000	× 6
Denmark	5 525	138	700	× 5
France	45 000	1125	5 500	× 5
Ireland	3 000	75	450	× 6
Italy	80 350	2009	18 000	× 9
Luxemburg	319	8	40	× 5
Netherlands	12 800	320	1 900	× 6
United Kingdom	59 600	1500	3 440	× 3

## Limits on qualification

In an attempt to restrain the excessive production of doctors different countries have adopted different approaches, which are determined by their particular laws and traditions. In France the principle of unlimited university entry has been circumvented by introducing a competitive examination at the end of the first year. The number of passes is determined yearly by the Ministry of Health in relation to the estimated future need for doctors. Germany, the Netherlands, and Denmark have limited intake, which operates through quotas based on marks obtained in the school leaving examination. All applicants are admitted from the group with the highest marks, but points are awarded for other considerations in the groups of less distinguished scholars. In Germany and the Netherlands a certain proportion of these groups is then selected on the basis of a lottery. In the Netherlands and Denmark, as in the United Kingdom and France, the required number is decided according to supposed future needs for doctors. In Germany, however, this is constitutionally impossible and the numbers are therefore determined by the facilities available for teaching medical students. This results in an excessive intake and seems at the moment to constitute an intractable problem.

In Belgium, which has no limitation on the admission of students, there is an enormous drop out rate every year

throughout the course. For example, out of 3700 students admitted in 1973, 1400 qualified in 1979, which represented an elimination rate of 62%. Although many of those who are eliminated from medicine change to other related subjects and become medical workers of some other kind, the figures nevertheless show a shocking amount of wasted personal effort and national resources.

The numbers of medical students in Italy have paralleled the economic fortunes of the country, reaching their pinnacle in the mid-1970s and now showing a considerable spontaneous decline. This does not, however, bring them anywhere near the numbers in other countries, and there is growing pressure in Italy for control of student intake. This has been urged by the medical profession since 1972, and successive governments have declared themselves in favour of it. There is, however, little vote catching power in preventing large numbers of the electorate or their sons and daughters from pursuing what they still consider to be a lucrative career. This and the relatively frequent changes of government in Italy have prevented any effective action for a whole decade. For the young Italian graduate the position is made worse by the fact that the hitherto unlimited intake into specialist training is now beginning to be regulated, and as vocational training for general practice approaches many young graduates may find it impossible to obtain the necessary training for any clinical career whatever.

### Unemployed doctors

It is not surprising that unemployment of doctors is now causing universal concern. It is difficult to obtain reliable figures for a number of reasons: national unemployment statistics do not usually recognise doctors as a separate group; many doctors who are unemployed do not register; and the problem is not one of simple unemployment but of under-employment, unsuitable employment, temporary employment, periodic unemployment between posts, etc. It was estimated in 1983 that there were 30 000 unemployed doctors in Italy, 1700 in France, 1500 in Germany, 250 in Denmark, and 1500 in the United Kingdom. There are obvious dangers that doctors will be forced to do work previously undertaken by paramedical workers or to share medical work thinly among themselves, with a consequent lowering of financial reward and dilution of professional experience to the point where their actual clinical competence is also in danger. This is the case in Belgium, where there are now doctors and surgeons who treat only one or two patients a week. It seems paradoxical that an excess of doctors now constitutes a major threat to health care, although in a different way from that which might have been foreseen by Molière, Shaw, or Illich.

### Education

The basic undergraduate courses in all the community countries seem to be much alike. All require around 12 years of previous schooling with success in the national school leaving examinations; all are courses lasting six or seven years comprising instruction in basic sciences, preclinical sciences, clinical subjects, and practical clinical skills; and all are punctuated by various examinations and assessments, and conclude with a final examination of some kind. Yet a few minutes' conversation with young doctors and medical students from different countries shows that what looks so similar on paper contains enormous differences. In reality, "practical clinical experience under supervision" may bear no resemblance to the sort of clinical firms that students pass through in the United Kingdom, and it is in the type and amount of clinical teaching and experience that the courses seem to differ most widely. This is partly related to traditional patterns of education, but it is equally obvious that 28 university medical schools cannot give clinical teaching of the sort known in the United Kingdom to

44 000 clinical students in Italy, or 27 schools to 21 000 clinical students in Germany. Even within a single country there may be variations of standard as no country in the community other than the United Kingdom has an overall controlling body for education such as the General Medical Council or a network of external examiners. The examination systems in general are less elaborate than in the United Kingdom, the final state exam in Germany consisting entirely of multiple choice questions.

### Specialist training

In most countries the practising profession plays some part in providing specialist training and determining its content and standards, and only Italy confines these functions to the universities. In countries with a social insurance system there is a corps of specialists in free consulting room practice who are approached directly by the patient and subsequently reimbursed at specialist rates by the social insurance funds. It is therefore necessary for both parties to be able to identify genuine, fully trained specialists, and this is the purpose of specialist diplomas. It is also the legal effect that member states are required to give to specialist diplomas awarded by other member states. The amount of training required for this type of practice is much less than that required for senior posts in hospital either in the United Kingdom or on the Continent and does not need to correspond with our certificates of higher training. The minimum standards laid down in the second directive provide an excellent set of quality guidelines and also expose important weaknesses previously existing in Europe. For example, the French CES (certificats d'études spéciales) system, with the passive didactic style of part time training, has been abolished; and the Italian specialist schools, in which the training was undertaken part time by doctors earning their living in some form of practice, are being reformed.

### Improvements in training

The advisory committee on medical training, which has met regularly since 1976, has made valuable contributions to the improvement of basic and specialist training. It has produced opinions or recommendations on basic clinical training, the effect of student numbers on the quality of training, and other matters. In the specialist field it has issued two valuable reports, which recommended developing the criteria of the directives and using methods of control and inspection like those used by higher training committees in the United Kingdom. It has also dealt with training in foreign countries, part time training, and vocational training for general practice.

Has all the time and effort required to produce these documents been well spent? I have no hesitation in saying that it has, and that the results of the advisory committee's work have far exceeded anything it would have been reasonable to expect at the outset. Within the committee there is a general if not universal spirit of friendship and cooperation in the pursuit of a common goal, and the number of useful and detailed opinions and recommendations on which it has been possible to secure agreement in a mere seven years is quite impressive. The committee contains many people who are able to exert influence over the direction of events in their own countries. In countries where there is most room for improvement active changes are starting, the direction of which has been strongly influenced by the work of the committee.

### Registration and access to practice

The formalities by which a qualified doctor gains the legal right to practise differ from country to country. Except in Denmark, Luxemburg, and the Netherlands, he must register with a professional body acting under the law. Registration may require a certificate of mental and physical fitness as in Germany,

Belgium, Denmark, and France; or entail swearing an oath (Denmark and Netherlands) or having the option of doing so (Germany and France). In many cases registration is on a local basis, and practice elsewhere may not be allowed. The branch of practice is often registered, and practice outside this is not allowed. This does not mean that there are specialist registers. Indeed, as far as I know, published national registers exist only in the United Kingdom and Ireland. Once authorised to practise medicine, the doctor may find that his conduct is governed by a written code of ethics (referred to as deontology) carrying the force of law, as in France, Germany, and Denmark; or there may be general guidelines, as in Italy and the United Kingdom.

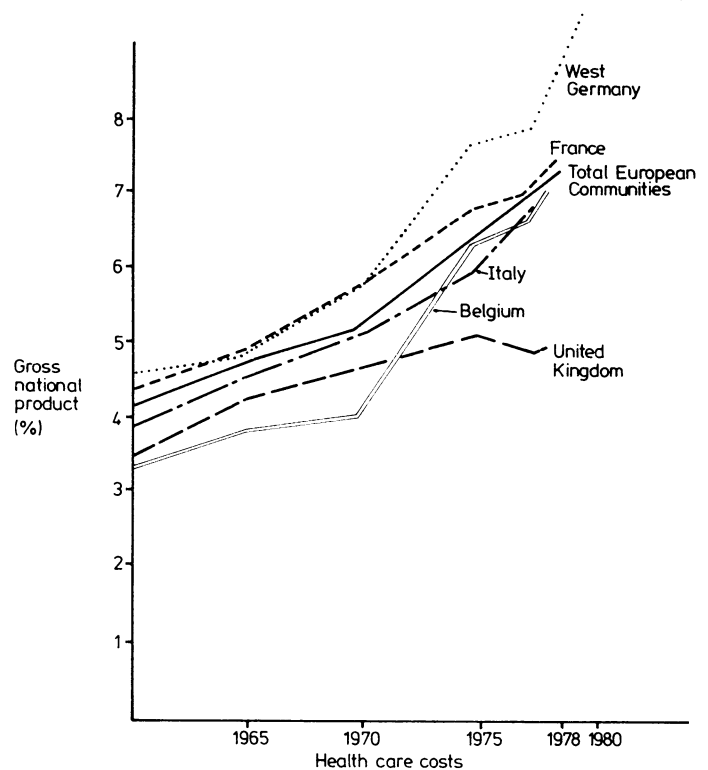
### Finance of health care

In the original six member states health care was and (except in Italy) is still financed through social insurance. This is effected by sickness funds (*caisses*, *Krankenkassen*) that receive contributions and pay out benefits. The obligation to contribute and the right to benefit are decided by governments, with detailed regulations covering the employed, self employed, unemployed, retired, sick, and dependent. Scales of fees for medical and hospital care are periodically negotiated and the actual mechanism of payment (direct or through reimbursement) laid down. Medicines are often classified according to their therapeutic effect, and the cost of those that are life saving is reimbursed while those regarded as mere luxuries (such as oral contraceptives in Belgium) are non-reimbursable.

Under this system doctors in Belgium and France are free to set up in practice and treat all insured persons. In Germany they must be registered with the *Krankenkassen* to treat social insurance patients. In the Netherlands the specialist will be reimbursed only if the patients have been referred by a general practitioner, and the general practitioner recognised only if he has had vocational training. Social insurance may not cover the whole population, and in the Netherlands there are two grades of contributions and benefit according to income. This is also the case in Denmark, although the Danish system is otherwise a national health service. There are also considerable variations in hospitals, with France and Germany having an extensive public hospital system while in the Netherlands hospitals other than university teaching hospitals are nearly all owned and managed by private charitable foundations. Such differences have little practical effect on the economics of sickness for the patient, and serious disease is treated virtually free throughout the community.

In other ways social insurance medicine is very different from NHS medicine. The patient's prized right of free choice of doctor can also mean shopping around, consulting several doctors for the same complaint, and even taking several treatments simultaneously. The allied right of direct access to a specialist means that in addition to hospital specialists, there are large numbers of free practising specialists giving primary care or carrying on service specialties. As a result there are fewer general practitioners on the Continent than in the United Kingdom. Long term association with one general practitioner is less usual, and it is said that in Germany half of the public do not consult a general practitioner at all. Economically the system is demand led, and overinvestigation, overtreatment, and duplication are difficult to avoid. They tend to grow worse where there are excessive numbers of doctors.

The costs of health care rose during the 1970s much more rapidly in countries with a social insurance system than in the United Kingdom, where annual budgets and cash limits ration health care. In 1980 the proportion of the gross national product allocated by each country to health care was as follows: Belgium 6.1%, Denmark 6.7%, West Germany 8.0%, France 8.1%, Ireland 8.4%, Italy 6.4%, Luxemburg 9.5%, the Netherlands 8.7%, and the United Kingdom 5.7%. Table V shows that the cost of health care



Rise in costs of health care in countries with social insurance system compared with the United Kingdom.

TABLE V—Growth of health costs and gross national product (GNP) 1981-2

	% Growth of GNP	% Growth of health care	Difference
Belgium	8.2	11.6	3.4
Denmark	11.0	9.0	-2.0
West Germany	-1.2	+1.2	2.4
France	11.2	17.3	6.1
Ireland	12.3	15.2	2.9
Italy	22.0	22.0	0.
Netherlands	3.8	9.5	5.7
United Kingdom	9.5	8.2	-1.3

related to gross national product was still increasing in 1981-2. Countries with social insurance systems are attempting to control cost by closing hospitals and limiting the building of new hospitals, the development of new services, and the purchase of expensive equipment. (In 1981 Belgium had 29 computed tomography scanners (nine in Brussels alone) for a population of 14 million.) At the same time doctors' fees are being held below inflation rates, and tariffs of medical fees are being reclassified. The mistaken idea is also circulating among politicians that diversion of funds from health care into preventive medicine (which if successful increases the numbers of old people) will somehow save money. One must admire the pragmatic French who have increased the taxes on alcohol and tobacco to help meet health costs. Patients' contributions are also being increased through higher charges for prescriptions and hospital accommodation.

### Conclusions

Firstly, medical migration, the main expected effect of community membership, has proved to be unimportant. Secondly, valuable progress is being made in raising standards of training where this is most needed. Thirdly, excessive production of doctors and medical unemployment are the most serious problems. Finally, the control of health care costs threatens doctors and patients alike throughout the community, whatever the system.