

European Doctors Working Conditions

A FEMS WHITE BOOK

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Fédération Européenne
des Médecins Salariés
European Federation
of Salaried Doctors

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Many thanks to all of you.

João de Deus
FEMS PRESIDENT

PREFACE

The project for a White Book on the working conditions of European doctors was born some time ago as a result of a deficit felt by the Doctors Trade Unions and National Medical Associations when they sought to understand the evolution of medical demography, the reasons that lead to emigration and shortage of doctors, job (dis)satisfaction, burn-out or workload.

But the aim is to go further and try to understand, in a global framework, the reason for the current medical feelings, the different paradigm of the new generations of doctors in the search for well-being in everyday life.

Using data provided by doctor's trade unions and medical associations or resulting from broader questionnaires to the medical population, obtain a portrait, as reliable as possible, of the working conditions of European doctors.

The 7 chapters of this book (working time, psycho-social working conditions, demography / gender imbalance, medical careers, financing, salaries and job satisfaction) intend to reflect on the true causes that led to widespread dissatisfaction among the European medical profession.

We hope that this work, which involved many medical unions, and which had the collaboration of several thousand European doctors in responding to different questionnaires, can contribute in a positive way, to a global understanding of the conditions under which medicine is practiced today.

With this book we intend to challenge all stakeholders in the health sector, at national and European level, to carry out an in-depth reflection that allows, in fruitful dialogue with doctor's trade unions and medical associations, the implementation of measures leading to the improvement of working conditions.

By publishing this work, FEMS goal is not only to leave this written legacy, but turn it into a truly dynamic book, updating it whenever needed in its online version.

João de Deus
FEMS PRESIDENT

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CHAPTER I

THE WORKING TIME DIRECTIVE IN EUROPEAN HEALTHCARE SYSTEMS

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INTRODUCTION

The EWTD establishes minimum health and safety requirements regarding working hours. The original directive 93/104/EC, adopted in 1993, was modified in 2000 by directive 2000/34/EC; both were subsequently consolidated in Directive 2003/88/EC1.

The preamble to the EWTD states that “the improvement of workers’ safety and health at work is an objective that cannot depend on considerations of a purely economic nature”.

It adopts a broad meaning of health, also including respect for the worker’s family life, his psychological well-being and the regulation of rest, breaks, holidays, night shifts. This definition of health is very relevant as it is implicitly admitted that prolonged working periods produce significant effects on the health of the persons concerned and increase the risk of error.

The directive is in force in all the states of the European Union and is directly binding in the body of law of the single state, regardless of the formal act of transposition (it is a self-executing directive). Previous and a fortiori subsequent State laws, which in some way hinder their correct application or deny the enforceability of the minimum protections envisaged, are therefore ineffective.

The directive contemplates:

- A maximum average weekly working time that does not exceed 48 hours, including overtime.
- Paid annual leave of at least 4 weeks.
- A break if the daily working time exceeds 6 hours.
- A minimum rest period of 11 consecutive hours in any 24-hour period.
- A minimum uninterrupted rest period of 24 hours plus the 11 hours of daily rest mentioned above.
- A maximum period of night work not exceeding 8 hours on average per 24-hour period.

The minimum requirements of the EWTD are binding on all EU Member States and are important to prevent employers from gaining a competitive advantage by pressuring workers into agreeing to long and irregular working hours. The current directive is already very flexible: it sets the maximum length of the working week at 48 hours but authorizes the average weekly working time to be calculated over 4-month periods, thus making it possible to compensate for any working weeks which exceed 48 hours with shorter working weeks.

The EWTD also includes two very permissive exemptions, thanks to which it is possible to extend working hours almost indefinitely.

1. Firstly, the reference period of 4 months can be extended to one year, but only in specific cases, based on collective agreements.

2. Secondly, Member States are allowed not to apply the maximum 48-hour limit at all, based on voluntary agreements with individual workers: the so-called “opt-out” (“non-participation” clause). The Commission had the obligation to review this second aspect within 7 years of the implementation of the directive in November 2003. Since then, the European Trade Union Confederation has called for the elimination of the individual opt-out, in line with the obligation, enshrined in the Treaty, to limit the maximum number of working hours for all workers in the EU.

Currently five Member States allow the use of the opt-out in all sectors/activities (Malta, Cyprus, Estonia and Bulgaria).

Eleven Member States authorize the use of the opt-out, but only in healthcare and in professions where on-call time is heavily used (Belgium, Czech Republic, Germany, Spain, France, Hungary, Netherlands, Poland, Slovenia, Slovakia and Latvia).

Another 11 Member States say they do not use the opt-out (Austria, Denmark, Finland, Greece, Ireland, Italy, Lithuania, Luxembourg, Portugal, Romania and Sweden).

During its activity, FEMS has tried to investigate the current conditions of application of the directive and the critical issues encountered by professionals working in public health.

The data collected in the three-year period 2018-2020 is shown below. These do not have the ambition to offer a complete picture of the situation but offer an opportunity to reflect and discuss working times and the current organization of work in healthcare.

An interesting element to underline is that the Directive is not uniformly applied even within the same country, being affected by different interpretations and applications at regional and local level.

In the results below, the views of representatives from FEMS members are represented:

AUSTRIA, BELGIUM, CROATIA, NORTHERN CYPRUS, ITALY, FRANCE, THE NETHERLANDS, SPAIN, PORTUGAL, ROMANIA, POLAND AND TURKEY.

Some countries have offered incomplete answers to the various questions asked over the years.

The EWTD is not implemented in Europe: it is not enforced in 3 countries (Slovenia, Turkey and Romania), while it is partially implemented in the remaining countries. All the aspects that characterize it are otherwise neglected in the various realities but are particularly penalised, compensatory rest, the use of annual holidays compared to daily or weekly working hours.

Indeed, rest is not always guaranteed to the worker in the Netherlands, Romania and Poland; in other realities it is sometimes less than the 11 hours required. The doctors can find themselves working more than 13 consecutive hours in Portugal, Northern Cyprus, Poland, Austria, Croatia and the Netherlands.

Professionals from Slovenia, Spain, Italy, Romania and Turkey report that this can happen in exceptional circumstances, while in France and Belgium, replacement of doctors is always ensured.

The special circumstances that can lead to an extension of working hours are: emergency situations, surgical activity linked to organ transplants, organizational criticalities linked to staff shortages, sudden illnesses or during holiday periods.

The problem becomes more complicated because despite the extension of working hours, adequate rest is not always guaranteed at the end of one's shift.

Stand by duties (at home) are used in almost all European countries. It is almost always organized to follow the on-call activity in the hospital, thus creating the conditions for a deregulation from the directive. In some countries there isn't any limit to the number of stand-by duties a doctor is going to work in a month.

If the standby duties are transformed into active working hours, a compensatory rest period is not foreseen (especially in Northern Cyprus, Italy, Spain, Turkey, Portugal, Netherlands) or it is not of adequate duration to compensate for the duration of the working activity. This problem can cause serious damage if you consider that in some European countries the standby duties can be even 24 hours!

Till now, any FEMS country is adopting a rule or a method to identify when a standby duty (at home) is so often activated than there is a need to commute in on call shift (at hospital). The fact is that standby duty is used both as an integration to a colleague that is working in the hospital and as a replacement for on call activity.

Fortunately, in some realities, some doctors can be exempted from the activity for various reasons: employees with health problems, doctors with management roles or who asks for.

In most European countries, if the standby duty activity is not worked, it is considered rest time. This point raises a reflection:

a period in which a professional does not work but is not free to choose what to do, because at the disposal of the employer, is it really a time of rest?

The **MAZTAK SENTENCE** of the European Court of Justice finds the key to interpretation in the time factor. The worker, who must reach the workplace within 8 minutes, cannot carry out other activities during working hours and therefore this must be considered working hours. So: **WHAT IS THE TEMPORARY RANGE THAT ESTABLISHES THE DIFFERENCE BETWEEN REST TIME AND WORKING TIME?**

This topic is probably one of the cornerstones to reflect on from a trade union point of view.

In many countries the time within which the worker must get to the hospital is not specified, using a generic definition such "as soon as possible" but in Portugal, Turkey, Northern Cyprus, Austria, Netherlands, France, Romania, doctors are forced to stay nearby their workplace, at least during standby duties.

It's not clear if they are forced to have their state of residence near workplace and if there is any compensation for this obligation.

Furthermore, it is impossible to make any comparison among countries regarding the payment of stand by duties. Different factors determine the wage.

The analysis conducted also shows that there is no awareness on the part of doctors and experts of risk management about the issues deriving from the lack of rest. The derogation from the application of the Working Time Directive occurs more frequently during the summer periods and holidays due to the exacerbation of the already ongoing staff shortages.

European trade union associations are aware that the directive is not fully applied and ask for clarifications regarding the specific circumstances in which it cannot be followed (organ transplants, emergencies) in order to protect workers also from an insurance point of view. Chronic understaffing worsens this condition.

The limits of the Directive are amplified by the fact that this not only does not adapt perfectly to some aspects of the medical activity but above all it is not perceived as a good thing for the worker in some EU countries. Indeed, in Austria, Romania and Sweden it is considered a limitation to a better organization of work. Institutions, hospital managers and workers contribute to the non-application. Only the trade unions seem interested in the various European realities in the application of this shield.

Yet there are several aspects that are appreciated by doctors. Here are some comments made by the interviewees:

ROMANIA — *'Doctors work on a separate individual contract for working time and shifts. There is the need for rest compensation and time for gaining money.'*

ROMANIA — *'In Romania doctors are not interested to take a rest after shifts. The work the day after because they want money not time. OK, that was till this year in March, when the salaries increase by 100%. Let 's see in the future, with these very high salaries (compared with the level of life) if the doctors change their style of working.'*

SLOVENIA — *'EWTD is bringing better working conditions: safe work with the patient and safe work for the doctor (less stress at work).'*

SPAIN — *'Better unified criteria for compensatory rest.'*

ITALY — *'Ewtd allows an adequate rest and limits overtime.'*

CROATIA — *'Due to many doctors leaving abroad for better working conditions, doctors in Croatia are practically forced to work enormous extra hours to keep health system working.'*

SWEDEN — *'Increased awareness among both employees and management of the importance of rest. Old traditions force doctors to believe they are in full capacity even after long shifts.'*

SLOVAKIA — *'In past, we regularly worked 32,5 hours without rest, in case of shift and the next working day.'*

ITALY — *'We need to have a common definition about what is inclusive or not in the working hours.'* However, opinions are conflicting, and several colleagues consider as useless a part of EWTD indications.

Below, some comments:

AUSTRIA — ‘You have to work when You are Younger and less when You get older.’

ROMANIA — ‘Doctors are interested in the weekly rest hours and not the daily ones.’

SWEDEN — ‘All parts are important.’

SLOVENIA — ‘Everything mentioned above is important.’

SLOVAKIA — ‘There is no possibility for this kind of work in our country. (referring to stand by duty).’

ROMANIA — ‘...in many shifts, there are not much to do, excepting Emergency Units (where is another organization as in the hospital). Therefore, the shift doctors see all patients till the evening. After that he/she can stay or rest.’

ITALY — ‘When you will have a common definition of Working Time you don ‘t need any other limits.’

SPAIN — ‘Definitions on an European basis (not only national and regional).’

European doctors have ideas about what could be added or changed in the directive. Here are some comments:

	Possible derogation on a voluntary basis	Different rules regarding stand by duties (home based work)	Different rules regarding on call time	Reduction of weekly working time	Reduction of compensatory rest	Better rules for annual leaves	None of the above
Romania					Yes		Yes
Czech Republic			Yes	Yes			
Portugal	Yes			Yes		Yes	
Italy	Yes	Yes	Yes				
Spain	Yes	Yes	Yes	Yes	Yes	Yes	
Slovakia	Yes	Yes	Yes			Yes	
Austria				Yes			
Croatia							Yes
Northern Cyprus		Yes	Yes	Yes			
Sweden			Yes				
Slovenia		Yes	Yes				
Turkey				Yes		Yes	
Netherlands							Yes

However, the willingness remains to derogate from the directive for various reasons, as shown by the following table:

	Yes, for an independent management of working time	Yes, to increase my income	Yes, to offer a better service to my patients	Yes, because I don't see any advantage deriving from the EWTD	No, I wouldn't derogate	Other
Romania		Yes				
Czech Republic		Yes	Yes			
Portugal	Yes					
Italy					Yes	
Spain						Yes
Austria	Yes					
Croatia					Yes	
Northern Cyprus					Yes	
Sweden						Yes
Slovenia					Yes	
Turkey	Yes		Yes			
Slovakia	Yes		Yes			
Netherlands		Yes				

It can be commented that:

- Directive is perceived as a cause of income reduction.
- Directive is meant as a limitation in working time organization, even in countries with a supposed good healthcare system (Sweden)
- Although unionists perceive the role and relevance of EWTD and fully support it, in their own country, they would derogate from the law for different reasons.

INFORMATION ON WORK ORGANIZATION IN SOME EUROPEAN COUNTRIES

QUESTIONS

1. Weekly minimum full working time, according to Collective Labour Agreement
2. Is on call time (at hospital) included in/counted as working time?
3. In your Country, is opt-out allowed?
4. How long is a working day?
5. How many hours can you maximally work in 24 hours?
6. Do you have any exceptions?
7. In your Country, is guaranteed a daily compensatory rest of minimum 11 hours?

	1	2	3	4	5	6	7
Austria	No data	Yes	Yes	8	13	Yes	Yes
France	No regulatory lower limit for service obligations but maximum of 48 hours per week, over a reference period	Yes	Yes, practitioner can voluntarily exceed 48 hours in the form of "additional working time"	2 half-days in approximately 9,6 hours	By way of derogation from labour rights or EWTD, up to 24 hours	no	Yes, even if lately compensatory rest is not respected
Northern Cyprus	No data	No	No	7 hours in summer 8 hours in winter Except mandatory overtime work	24 hours	No	No
Slovenia	40	No	Yes	8 hours	12	On duty you can be on working place for a maximum of 32 hours in a row	Yes
Italy	38	Yes	No	6 hours and 20 minutes (if working on a six days/a week basis) 7 hours and 35 minutes (if working on a five days/ week basis)	13, according to EWTD	Yes, in case of an emergency, it is not allowed to discontinue the service if there isn't any replacement	Yes

	1	2	3	4	5	6	7
Romania	35	No	No	7	7, 16 or 24	Saturday 16, and Sunday 24 hours	No
Czech Republic	40	Yes	Yes	8 hours	12 hours, accordingly to EWTD	No by law Yes, in facts	Yes if not fulfilled, following rest is prolonged
The Netherlands	38	Yes	Yes	08-Oct	13	1x per 7 x 24 hours resting time can be limited to a minimum of 8 hours.	No
Croatia	40	Yes	No	8	24	yes	Yes
Portugal	35-40-42	Yes	No	7-8-9 hours maximum (according to 35-40-42 weekly working time). minimum of 12 weekly hours if ER service (up to 18)	12	No, although some doctors accept to work 24 hours straight	Yes
Spain	35-37.5	Yes	Generally, yes	7 and 7.5	24 hours during on call time 12 hours during ordinary shifts		Yes

8. How many days (minimum and maximum) for annual leave?
9. Do you have other kind of leaves, in addition?
10. If yes, what kind?
11. Do you have sickness leave?
12. Is there any limit to the length of sickness leave?

	8	9	10	11	12
Austria	25	Yes	Care leave	Yes	No, in the first 5 years, workers are entitled to 6 weeks of full pay and 4 weeks of half pay per year of work. From the 6th year of work they receive 8 weeks, from the 16th year of work 10 weeks and from the 26th year of work 12 weeks full pay; thereafter 4 weeks half pay each.

	8	9	10	11	12
France	Hospital doctors work 227 days a year (365 – 104 [weekend days] – 9 [public holidays] – 25 [annual leave])	Yes	Maternity, Paternity, Training (15 days) leaves. Special additional leaves: birth, wedding...	Yes	Long term sick leave is granted within the limit of a maximum period of thirty months during which the practitioner receives all his emolument for twelve months than half for eighteen months
Northern Cyprus	Minimum 15 days Legally maximum 84 days but it is not possible for doctors to leave such long because of the shortage of the staff. Moreover, currently there is a law proposal to decrease max leave time	Yes	Radiation leave Pregnancy and maternity leave Sick leave	Yes	42 days Sick leave depends on a regulation concerning doctor reports
Slovenia	35/50	Yes	For education and training	Yes	No, it depends on the sickness you have ...
Italy	32 or 34 days, accordingly to the length of service	Yes	Anaesthesiologists have 8 days in a year. Radiologists have 15 days in a year. All the employees have parental leave (from 6 months to 11 months, depending on if one or both parents use this leave – salary reduction) 3 days for personal or familiar leave wedding leaves (15 days)	Yes	18 months cumulatively in three years During these months, emoluments are granted but with a progressive reduction
Romania	Minim 20 working days	Yes	Study leave – 3 days a year	Yes	Maximum 90 calendar days (not working) per year, over 90 days a year sick leave is granted only through the commission of expertise
Czech Republic	20 days or 25 working days	Yes	Radiologists have 5 working days as additional leave. maternal leave (only for women) is 6 months and parental leave (both mother and father) is 24 to 36 months	Yes usually 2-3 days depends on employer or CLA	No

	8	9	10	11	12
The Netherlands	Minimum of 4 times the contractual weekly hours. no official maximum. On average people have 5 times the weekly contractual hours for annual leave	Yes	Parental leave, sick leave, maternity leave, extra statutory leave on top of annual leave (the amount depends on the employer)	Yes	Quite complicated, but it is maximised at 2 years with salary. After one year the salary is lowered. After two years in principle, you can still be on sick leave but without salary
Croatia	20 and 35	Yes	For parents/children's death, for education...	No	No
Portugal	22 days minimum, plus 1 extra day for every 10 years of work in NHS	Yes	Compensation for working on Sunday or holidays (paid) parental leave (paid-entirely or partially) working student leave (maximum 10 days – without payment	Yes	Generally, 18 months (36 months in some cases)
Spain	22 days, Saturdays and Sundays not included	Yes	Related to length of service or other provision (minimum 6 days) Parental leave	Same provisions of other workers	18 months

13. Is there a limit to the number of night shift you can work in a month?
14. Is there a limit to the number of on call shift, you can work in a month?
15. When you are on call, how many patients (or beds) do you monitor?
16. How many overtimes can you work in a year?
17. How much is paid one hour of overtime?

	13	14	15	16	17
Austria	Within an average period of 17 weeks (approx. 4 months), a maximum of six extended services may be provided per month, i.e. a maximum of 24 extended services may be provided over a period of 17 weeks.	No	Different		
France	No	No	No regulatory limit, depends on local organization	There is no maximum regulatory threshold specified	An additional time slot (half day) is paid 166,3 euros or 248,22 euros depending on whether it is day or night work respectively; approximately 24 euros (gross income) per hour at night

	13	14	15	16	17
Northern Cyprus	Nights shifts are accepted as overtime work. Legally overtime work cannot exceed monthly working time, which corresponds to 6-8 nights and weekends.	No	No limit	Night/ on call shifts are accepted as overtime. Overtime payment cannot exceed monthly salary	There is inequality in doctors' fees. Approximately 11 euro/hour through the week Approximately 13 euro/hour through weekends and holidays
Slovenia	Yes	Yes	I am an anaesthesiologist, and I cannot talk about patients or beds. When I am on call, I come to the hospital do assist the colleague who is on duty.	5 days per month, 60 days per year app.	30% more, 40% more during the night, 90% more on Sundays and 120% more on holidays (celebration)
Italy	Maximum 10 per month	Maximum 10 in a month	There isn't any limit. It could be defined at local level	200 hours in a year	About 25 euro (gross income)
Romania	Yes	No	In a smaller hospital all the sections of the profile are monitored, for example surgery, urology, traumatology is monitored only by the on-call surgeon. In large – university hospitals, only the profile section is monitored. the number of beds depends on the size of the section	And over 200	Unfortunately, overtime is still paid worse than normal working hours
Czech Republic	No	No but employee must adhere to EWTD	There is a limit to 90 beds or 1 unit of ICU	416 hours if employee agrees. 150 hours without any agreement	Additionally, 25% of average income on Working days, 50% on Saturdays and Sundays and 100% on national holidays. Incl. 20% addition on night hour work (6pm to 6 am)
The Netherlands	maximum of 140-night shifts per year. maximum of 7-night shifts in a row. per 16 weeks a maximum of 36-night shifts	14 days per 4 weeks (consignment shifts)	No data	Not mentioned by law. it should not interfere with the working time law	Only when employer gave. the explicit assignment to work. overtime, there is a possibility of payment. the amount varies between CLA and between professions/salary scale

	13	14	15	16	17
Croatia	No	No	80-100	Officially (by law): 180; Practically unlimited	Depends on level of education. -subspecialist about 15(!) Euros.
Portugal	No Doctors older than 50 years are entitled to be dispensed by nights shifts	No but employee must agree	Undefined	150 hours	Extremely variable From 125% of a normal working hour up to 250%
Spain	No	No, but employee must adhere to EWTD	No defined limits, according to organization needs		According to CLA

18. How much is paid standby time, when it becomes active working time (per hour)?
19. How many stand-by duties in a month?
20. Is EWTD implemented in your country?
21. Is it implemented?
22. If you answered NO or NOT FULLY, why?
23. At the end of a shift work, is there an adequate (11 hours) compensatory rest?

	18	19	20	21	22	23
Austria	No data	No data	Yes	Yes	No data	Yes
France	Same amount as on-site duty, based on the half day periods metric bur whose duration is defined at 5 hours	No regulatory upper limit	Yes	Not fully	Mainly, the calculation of working time is not done on an hourly basis, and this is a limit for an effective application of Directive	Not applied
Northern Cyprus	No standby time payment	Only occasionally, depends on the doctor's initiative. It is not paid	No	No	Since the salaries are low and doctor shortage is high in our country doctors prefer/ has to work overtime. Economic status and human source are not appropriate for the directive yet	No
Slovenia	20% of the working hour is standby time, when it becomes active, you receive 100% of normal hour +30% +night, Sunday, holiday ...	04-May	Yes	No	lack of doctors	Yes

	18	19	20	21	22	23
Italy	About 17 euro	Up to 10 in a month	Yes	Not fully	Italian doctors don't have a full awareness of the relevance of the topic, and they prefer to manage their working time as they prefer. Furthermore, staff shortages affect the possibility to implement the Directive	Not always
Romania	40% of normal daylight hours	3 to 6	Yes	No	the employer reasons that the directive cannot be implemented due to the lack of staff, especially in small hospitals	No
Czech Republic	20% of average salary	up to 4-6, or according to needs	Yes	Fully but it is usually tampered	Especially in healthcare facilities is tampered week overtime and length of shifts	Not always but usually yes
The Netherlands	only active working time, per call a minimum of 30 minutes paid, sometimes payment is in a lower salary scale	3 per 7 days and 32 x per 16 weeks	Yes	yes, but with an opt-out	No data	Yes
Croatia	Depends on level of education – subspecialist about 15 Euro	Unlimited	Yes	No	You should ask Croatian Government	Not always
Portugal	No data	undefined	Yes	Yes		Yes
Spain	According to CLA	Defined at local level	Yes	not always	According to organization needs or to increase salaries	Not uniformly implemented

24. In your opinion, how long should it be an adequate compensatory rest?
25. What happens if you can't enjoy your annual leave?
26. Are you forced to live nearby your workplace?
27. Can you choose full time or part-time job freely? Please give an explanation
28. What's the age of retirement in public healthcare sector?

	24	25	26	27	28
Austria	No data	No data	No data	No data	65
France		By law, payment or deposit time-savings account	Yes. By law in an area where you can reach the hospital in a reasonable time (approx. 20 minutes). Not applied in practice	Transition to part-time is possible after local agreement. there is a non-competition clause which limits the choice of location or exercise	legal retirement age has been 64 since April 17, 2023
Northern Cyprus	24 hours working, 24 hours rest	Wait for the next year	If the doctor has on call duty, he/she must live nearby	There is no part-time option. Because it is against the law. The Supreme Court found part-time option for the doctors against the constitution	60 years but currently there is a law proposal to increase the age
Slovenia	Minimum 2 times working time	It is quite impossible that can occur, but you can receive compensatory money (you can be paid instead of)	No	You can choose but is not so often. You can work in one hospital for less than 100% (50-80%) and in another till 120% of your full time. University hospital and faculty for example ...	40 years of working or at the age of 65 years
Italy	11 Hours	Theoretically, annual leaves should be enjoyed within June 30th. Commonly, leaves are cumulated, and it happens to use it in the months before retirement	No	most positions are full time. in case you look for a part time position, you must ask for, but it can be refused.	from 67 to 68 years old but Law changes very often...
Romania	Minim 12 hours	the law allows you to use your leave not made in the first 3 months of the calendar year. If you cannot get your rest leave during this period, it will be lost, without any compensation	No	no, the choice cannot be made freely. The conditions and working time are set by your employer. Only in exceptional cases can you negotiate half the norm.	62 f, 65 m
Czech Republic	Minimally 8 hours after normal shifts, 12 hours after overtime shift. in case of tampering overtime shift length 24 hours	It's possible to use in the following year, theoretically till 30th of May. There is obligation on employers not employee	No	Yes, it's employees' decision	65 except for Emergency service

	24	25	26	27	28
The Netherlands	At least 11 hours	you can have annual leave days paid in salary, you can take them with you to next year (bound by rules for how long this is possible), or you can loose them after a few years	No	you can choose freely, and most employers agree with working parttime, but the employer can deny an application for parttime work when it intervenes strongly with company policy.	on average 67 years
Croatia	At least 48 hours after 24-hours shift, and 24 hours after 12-hours shift	You can enjoy it until June 30 next year	No	Only if retired	65
Portugal	12 hours	it is possible to use in the next year, until 30th of April	No	No It must be authorized by the hierarchy	same as everybody else Currently, 66 years and 4 months
Spain	12 hours	It's possible to use the year after	No	It's possible to ask in case of work-life balance, assistance for elderly and children	Currently, 60 years and 4 months. in the future, 67 years

ANNEX I

PART-TIME WORK

Lukas Stärker

FEMS DEPUTY SECRETARY GENERAL, AUSTRIA

CONTENT

- A. Current Situation
- B. Making Hospital work more attractive
- C. Part-time and Medical Training
- D. Duty Roster Design and Personnel Requirements
- E. Trend towards higher basic Salaries
- F. Conclusion

A. CURRENT SITUATION

The expectations and wishes of both young and long-serving doctors regarding the framework conditions in hospitals have changed in recent years. Flexible working hours are intended to secure the next generation of physicians and avoid fluctuation or migration of experienced hospital doctors and thus the loss of valuable knowledge. Ideally, all stakeholders in hospitals should be involved; Both employers and employees benefit. The steady increase in the proportion of women and the associated increase in part-time work is sometimes seen as a major problem or even a threat to the system. This requires modern and innovative concepts to ensure the compatibility of career, family and private life as well as to ensure high-quality medical care.

B. MAKING HOSPITAL WORK MORE ATTRACTIVE

The desire for part-time work has many motives. Part-time models should not only ensure the compatibility of work and family. Work intensification, time for research, time for other professional activities, more free time, more relaxation are further reasons for working part-time.

In order to keep doctors in hospital, flexibility in the organisation of working hours is essential and appropriate perspectives are required. The continuing shortage of doctors further exacerbates this.

C.

PART-TIME AND MEDICAL TRAINING

The quality of education is very important to the vast majority of today's medical graduates. In connection with the trend towards a good work-life balance, the compatibility of part-time work and training quality is an essential factor in keeping young graduates in hospitals. In order to ensure a good quality of training, it is essential to keep the experienced, training doctors in the hospital.

D.

DUTY ROSTER DESIGN AND PERSONNEL REQUIREMENTS

For the calculation of personnel requirements, it is clear: the more hospital doctors work part-time, the more heads are needed. More part-time jobs require higher head counts.

Personnel requirements calculations must therefore no longer be carried out on a head-by-head basis, but must be carried out on the basis of full-time equivalents (FTE).

Further problems arise from frequent service handovers, loss of information, etc. Modern information management is required here. Communication channels, mobile workstations, online consultations... Management, administration and logistics must be streamlined to ensure that physicians can focus on medicine and treatment without sacrificing quality.

For example, a department that is supposed to function with a specified 10 full-time equivalents, but consists of 21 heads with different working hours, needs appropriate management and good teamwork to ensure that everything runs smoothly. Satisfied doctors are the key to successful implementation.

E.

TREND TOWARDS HIGHER BASIC SALARIES

The trend towards higher basic salaries in recent years raises the question of motivation for full-time employment. Here it is important to find a good balance between basic salary and remuneration for services completed. Especially against the background of the general shortage of doctors.

F.

CONCLUSION

The issue of part-time work must be addressed in a sustainable manner and taking into account the interests of employees and employers in order to achieve individual solutions in the interests of those affected, which ensure both the running of the company and the implementation of the ideas of the employees.

CHAPTER II

PSYCHO-SOCIAL WORKING CONDITIONS BURNOUT AND VIOLENCE AGAINST DOCTORS (and other health professionals)

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I. DEFINITIONS AND CONCEPTS

VIOLENCE

Violence is a global phenomenon and has a huge incidence all around the world – [Rise in verbal and physical aggressions]

All people (doctors and other health professionals) have the right to work in a safe environment without the threat of violence.

Workplace violence includes both physical and psychological violence.

WHO Definition of “Workplace Violence”:

“Intentional use of power threatened or actual, against another place or against a group, in work related circumstances, that either results in or has a high degree of like hood of resulting in injury, death, psychological harm or depravation.”

Nowadays violence/burnout and psychological risks are a health public problem.

European Medical Organizations (EMOs) recognize the hugely negative impact that violence has on doctors sociopsychological wellbeing, for care received by patients and its contribution to rising levels of burnout experienced by doctors daily in their workplace.



According to world health organizations, throughout their professional lives, 50% to 55% of health workers were victims of some form of violence.

The most susceptible are young people, women, and migrants.

To have more real knowledge of this reality EMOs approved, in 2023, a CEOM proposal for a united European form to collect data on violence against doctors and their staff.

We marked and celebrated the 12th of March as the “European Awareness Day on violence” against doctors and other health professionals and committed ourselves to acknowledge and deal with the exhaustion and burnout factors.

With this involvement and based on the results of FEMS survey, on CEOM observatory on violence and on the work done by European and World organizations in this issue, we can conclude that a high percentage of doctors and other health workers are exposed to physical and psychological risk factors (PSR) in their work places, whose consequences are harmful to themselves, their families, to patients safety, to the organizations and to society in general, and “must be” considered a public health problem.

CEOM, supported by all EMOs, proposed 12 keys points for the future to avoid the harmful consequences of violence and burnout among doctors, medical students, and other health workers:

1. We strongly require a zero-tolerance policy towards violence in the workplaces.
2. We must encourage doctors and healthcare workers to report acts of violence against them.
3. Continue awareness-raising campaigns on assaults on health workers and their consequences.
4. Strengthen preventive measures by increasing security measures in healthcare.
5. Develop, on the part of the administrations, training, and coaching on how to deal with verbal, physical, or psychological violence and possible basis on burnout.
6. Consider professional burnout as a type of psychosocial violence that doctors, and medical students face in their workplace.
7. Clinical Leadership development as a way of improving working conditions, improve physician-patient relationship and decrease the incidence of violence/burnout. Regarding health services management, we must develop a culture of consideration and recognition of the violence against health professionals.

8. Strengthen communication and agreements with health Administrations, the Public Prosecutor's Offices, and the State Security Forces for a comprehensive approach to the aggressions.
9. Call for the enactment of a specific law and consider priority crimes to address violence in the health sector.
10. Ensure that judicial procedures are swift, expeditious and exemplary.
11. Promote resilience.
12. As approved at the EMOs meeting, in Paris, on 24 November 2023, we must disseminate and implement, in the Member States, our unified European form to collect data on violence against doctors and their staff.

BURNOUT SYNDROME

The terminology of burnout syndrome was adopted initially by Freudenberg (1974) and by Maslach and Jackson (1986) defining it as a state of physical, emotional, and mental exhaustion, caused for lasting involvement in situations of high emotional demand in workplace.

EMOs recognize professional burnout as a type of social psychological violence.

The prevalence of burnout is very high:

- 8% among doctors
- 50% of doctors had already got symptoms of burnout syndrome.

A continued confrontation with professional stress factors, often in a silent way, can lead to burnout which involves emotional exhaustion, depersonalization and reduced professional fulfilment.

PSYCHOSOCIAL RISK (PSR)

A psychosocial hazard is an "occupational hazard", related to the way work is designed, organized, and managed, as well as the economic and social context of work.

Health workers are exposed on their workplace to psychosocial risks that can cause physical, psychological, and social harm to themselves and their families.

Psychosocial risks are linked to the organizations of work as well as workforce violence and are recognized internationally as major challenges to occupational safety and health, as well as productivity.

Work context includes impacts on career development and wages, organizational culture, interpersonal relationships, and work life balance.

INTERNATIONAL LABOUR ORGANIZATION (ILO)

ILO define some examples of psychosocial risks (PSR):

- Increase of working hours
- Insecurity at work
- Burnout
- Moral and sexual harassment
- Other types of violence
- Difficult work family balance

The impact of expose to these factors interferes with healthy functioning at one organic/emotional/social and behavioural level and can lead to work accidents, sleep disturbances, additions, substances abuse, cardiovascular and endocrine pathologies.

By all these reasons PSR at work must be considered as a mental disease.

FEMS survey tries to bring contributions for a better knowledge and understanding of these problems, and at the same time help to prepare a concerted and effective response for these sensitive problems.

II. PSYCHOSOCIAL RISKS/BURNOUT AND VIOLENCE AT WORK

1. FEMS SURVEY

QUESTION 1 — What percentage of doctors have experienced burn-out in your country?

Results in accordance with European statistics (8% had already burn-out syndrome and 50% had already at least 1 symptom of burn-out).

QUESTION 2 AND 3 — When considering the gender difference, is there a predominance of any of them?

It is an equal problem for men and women, therefore without statistical meaning.

QUESTION 4 — Older age is it a bigger risk?

Older age increases the risk of BO.

QUESTION 5 — Lack of doctors, does it increase the risk of BO?

Yes.

QUESTION 6 — Over workload is it a risk to get BO?

Yes.

QUESTION 7 — Feeling guilty about not being able to work well, is it a risk to do BO?

Yes.

QUESTION 8 — Which facilities would help to prevent BO?

1 – A sports centre? **Yes.**

2 – Cafeteria? **Yes.**

3 – A rest room? **Yes.**

4 – A library? **No.**

5 – A nursery? **No.**

6 – A comfortable room to sleep? **Yes.**

QUESTION 9 — Is there hot line with psychologists to speak about BO in your country?

Mostly no, but in some countries, it's organized by the medical chambers, hospitals, or trade unions.

QUESTION 10 — Is there psychiatric support to prevent or to treat BO?

Mostly yes.

QUESTION 11 — How many doctors did: a suicide attempt; a suicide; a long work break?

No data available

QUESTION 12 — In your country, is there training available to prevent BO?

Mainly yes, but organized by the medical chambers, hospitals, or trade unions.

QUESTION 13 — Do have newspapers or books speaking about BO?

Mainly yes, but edited by the medical chambers, hospitals, or trade unions.

QUESTION 14 — Does your union have a policy to prevent, diagnose and treat BO?

Mostly no.

2. FEMS SURVEY CONCLUSIONS

1. The statistics about burnout in FEMS members:

- 8 % of doctors already had burnout in their professional life.
- 50% among doctors already had 1 or more burnout symptoms.
- The risk is equal for men and women.
- Age has no influence.

2. Which factors increase the risk of burnout:

- The lack of doctors.
- Over workload.
- Too much work during nights and weekends.
- Not enough solidarity among medical team and healthcare workers team.
- No hot line to call if help is needed.
- No psychiatric consultations organized to help doctors in a short time.
- Burnout not yet considered as a disease by trade unions, health institutions, and medical chambers.
- Not enough information about burnout (books; magazines; press news).
- Stress at work (psychosocial risks).
- Sanitary crisis increases those risks.

3. What can decrease the risk of burnout:

- A pleasant restroom.
- A pleasant place to eat.
- A pleasant room to sleep at night.
- Enough time to rest between working days.
- Less workload.
- A good prevention: staff, e-consultations, psychiatric consultations.
- Meetings among doctors to appreciate psycho-social risks.

3. REASONS THAT CAN INCREASE THE PROBABILITY OF THIS DISEASE

- Over workload (too much work; work is not done in proper way, so high culpability feelings).
- Not enough doctors at work; days are too long; no respect for rest periods).
- Pandemics.
- War.
- Lack of solidarity among doctors and health care team.
- Young doctors in training; the risk is high; the risk of suicide is high.
- Mental or body diseases of doctors.
- Lack of adapted trainings.
- Not enough conditions of work (climatization; problems with computers; no good room to sleep at night).
- Computer inability.
- Conflicts with hospital administration (the financial interest of administration is to organize lack of doctors, even if doctors are available to work).
- Conflicts of loyalty with family life (kids to take care; husband or wife).
- Doctor can be caretaker (aidant) of a kid, a parent, or a partner; it needs time and energy, and it can be a source of depression.
- No respect for European Directives (rest time of 11h after workday)
- Long distance between home and workplace.
- Stress in link with racism, with violence of patients and their family, if repeated it increases PSR.

4. WHAT TO DO TO PREVENT BURNOUT?

- Solutions are, of course, answers to the reasons of burnout.
- Limitation of the number of worked hours every day, week, and month; and to respect it.
- Enough doctors working, if not services or part of services must be closed.
- Hospitals must organize kid's gardens for the babies and young kids of doctors; apartments, very near of hospitals, should be available.
- Psychologists could help to prevent conflicts among medical teams and health care workers.

- Psychologists and psychiatrists must be easily contacted by phone, videocall or in person, to help doctors, as soon as possible, at the first signs of burnout.
- Preventive training for all doctors must be available.
- Violence, racism must be prevented with security guards in hospitals.
- Rooms to sleep and rest at work, must be peaceful and well equipped.
- Secretaries must help doctors in their administrative job.
- For young doctors, prevention of suicide must be organized, with speech groups and individual psychotherapy.
- Medical chambers, medical unions, health institutions must organize congress, symposium, and develop training actions on how to deal and avoid PSR.
- Clinical Leadership programs can improve working conditions and may reduce the risk of violence and BO.

III. SUMMARY OF ACTIONS AND PROPOSALS

- 1.** Monitoring BO situations to implement preventive measures and achieve more effective results.
- 2.** National Medical Associations (NMAs) must lobby in their own country to sign the ILO convention about violence and harassment at work.
- 3.** Ongoing open floor discussions, in EC, regarding PSR European Directive.
- 4.** In each European country, at the state level, we need to improve the doctors work conditions:
 - More doctors in private and public hospitals.
 - Less workload for doctors.
 - Better salaries.
 - Social advantages for doctors: to get an apartment near hospital, to get nurseries, to improve trainings.
 - To improve collective bargaining.
- 5.** On the level of EMOs, NMAs and Doctors Trade Unions:
 - Organize medical congresses about PSR.
 - Get a hot line to listen to doctors suffering of stress, depression, burnout.
 - Offer insurances against the risk of violence at work.
 - Fight to recognize burnout and PSR as an occupational disease.
 - Invite experts in these areas to be present in our EMOs meetings.
- 6.** At the level of every private and public medical institutions:
 - Offer a good room when doctors make night shifts.
 - Organize meals 3 times a day, if necessary, for doctors.
 - Promote urgently consultations with psychologists and psychiatrists, if doctors present any symptoms of mental disorders.

- Promote meetings among doctors to speak about providing a better organization at workplace.
- Let doctors have a better place in hospitals to organize work, financial decisions, to decide about medical materials, more place for doctors, less to administration.
- Organize good professional trainings for medical students; that point is very important.
- Organize a sustainable organization of life in hospitals.
- Promote better collaboration between private and public hospitals, to exchange competence, to share working time.
- Improve trainings: medical trainings, digital trainings, social laws.
- Promote equality in rights and duties among men and women doctors.
- Promote learning languages, to help to care foreigners.

VI. ACRONYMS AND ABBREVIATIONS

CEOM – European Council of Medical Orders

FEMS – European Federations of Salaried Doctors

EMOs – European Medical Organizations

BO – Burnout

PSR – Psychosocial Risks

WHO – World Health Organization

ILO – International Labour Organization

WMA – World Medical Association

NMAs – National Medical Associations

EC – European Commission

EU – European Union

NIOSH – National Institute for Occupational Safety and Health

CHAPTER III

DEMOGRAPHY / GENDER IMBALANCE

Position of female doctors in FEMS countries

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INTRODUCTION

A woman's career as a doctor has its roots in ancient times. At that time, no one forbade women to practice medicine, so they treated diseases and injuries with fruits harvested in nature. In the Middle Ages, medicine became a completely male profession and remained so until 270 years ago.

The first to break that barrier was the German Dorothea Erxleben, who passed the doctoral exam on May 6, 1754. and became the first female doctor.

Although the American Elizabeth Blackwell is considered by many to be the first doctor of the modern era, she became a doctor in 1849, a full 95 years after the German Erxleben (1).

Over the past 20 years, the increasing growth of female doctors has been observed, and medicine is increasingly becoming a female profession in most countries of the world, so we are talking about the *feminization of medicine*.

According to OECD indicators from 2021, published in March 2022, the proportion of female doctors has increased in all OECD countries over the past 2 decades. The proportion of female doctors increased since 2000 and this increase is especially noticed in the Netherland, Spain, Denmark and Norway (2).

According to Eurostat data, in 2018 was a slight majority of physicians in the EU who were female, and this proportion rose in the last three years to reach 52.2 %.

In 2021, a majority (17) of the 26 EU Member States had a higher number of female than male physicians. The largest shares of female doctors were recorded in Estonia (73 %) and Latvia (74 %). In Romania and the Baltic Member States this proportion exceeded 70 %, and in Finland (2018 data), Croatia and Slovenia, more than 60 % of all physicians were women. On the other side is Cyprus, with the greatest share of male physicians (61 %). Malta and Italy were within the range

of 55 % to 57 % male physicians. The smallest gaps between the shares of the two sexes were observed in Austria and Sweden (2020 data) with difference of 2% between genders (3).

Looking at the global level, (data published in 2023), 10 countries with the highest percentage of female medical doctors were Bosnia & Herzegovina (87.7%), Zambia (81.6%), Mongolia (80.7%), Georgia (73.9%), Estonia (72.5%), Belarus (72.5%), Russia (70.5%), Armenia (69.5%), Croatia (67.5%), Romania (66.9%) (4).

However, the numerical dominance of women in medicine is not proportionally followed by the number of leading positions of women in their workplaces.

Unfortunately, the higher the level of decision-making, the fewer women there are in leading positions. The results of various research show that such a situation exists not only in health institutions of all levels, but also in science, academic positions, medical schools, as well as in executive boards of medical associations (5,6).

In several published papers, concern was expressed about the extremely low number of female deans of medical faculties (7, 8, 9).

According to Brogiene (10), women are still underrepresented in leadership positions in European Medical Organizations (EMO's): in 2019 women made up only 12.8% of the members of the executive boards: of 7 EMO's, there was not a single woman in executive board of 3 organizations, 1 woman out of 5 or 6 board members was in 3, and 2 women out of 7 board members were in 1 EMO.

Although there are more women in medicine, many female doctors face gender inequality, psychological and physical violence in the workplace in various forms.

Looking personally from the perspective of a female surgeon, the situation today is significantly better than 25 years ago, but we still witness gender inequality today.

Many female colleagues experienced difficulties in career progression, a difficult opportunity to apply for some certain specializations, psychological pressure, sexism etc.

What is the situation in FEMS member countries? What do our members think about gender inequality and discrimination in medicine? What are their experiences? These are all questions to which we looked for answers and which we deal with in this chapter.

AIM OF THE STUDY

To determine if there is gender inequality in medicine regarding to the number of female doctors, their position, competences, abilities, opportunities for career progression and exposure to violence and/or discrimination in the workplace, in the FEMS members countries.

Based on the results, to promote awareness on the current status of women in medicine in general and propose measures to achieve an equal position for women doctors in the workplace and medical associations, as well.

MATERIAL AND METHODS

The survey was conducted among doctors from 15 European countries, 14 of which are members of FEMS. We also collected a few responses from Germany.

FEMS delegates were asked to send us data on the gender distribution of students, doctors and deans of medical schools in their countries.

The survey was conducted in 2 rounds (April and September 2023), after which the results were analysed and processed.

In some questions, the results were analysed separately regarding to gender, whereby the results were calculated in relation to the total number of participants of the same gender.

The questionnaire contained 16 questions with answers provided:

1. **What is your gender?**
 - a) Female
 - b) Male
 - c) Other
2. **What is your age (years)**
 - a) <=30
 - b) 31-40
 - c) 41-50
 - d) 51-60
 - e) >=61
3. **Are you.**
 - a) Specialist
 - b) GP, family doctor, primary care doctor c) resident d) other
4. **Choose the branch of medicine that best suits your workplace:**
 - a) Surgical branch of medicine
 - b) Non-surgical branch in medicine (conservative treatment)
 - c) The field of interventional medicine
 - d) Preventive medicine
 - e) Work in the laboratory.
 - f) Work in science.
5. **Do you work:**
 - a) Full time
 - b) Part time
6. **Do you have or have you ever held a leadership position at work?**
 - a) Yes, currently.
 - b) Yes, in the past.
 - c) No, never.

7. In your opinion, what gender is in higher and more responsible positions in your institution?
 - a) Men
 - b) Women
8. Have you ever felt discouraged from working in a particular specialty because of your gender?
 - a) Yes
 - b) No
9. Have you ever felt discriminated in your workplace because of your gender?
 - a) Yes
 - b) No
10. Do you think that a female doctor must be much more competent to be as valuable at work as a male colleague?
 - a) Yes
 - b) No
11. Do you think some specialties are unavailable or more difficult to access for female doctors because of gender?
 - a) Yes
 - b) No
12. Have you ever been assumed to be in a more junior role in your workplace because of your gender?
 - a) Yes
 - b) No
13. Do you think sexism acts as a barrier to career progression?
 - a) Yes
 - b) No
14. Have you ever experienced violence of any origin in the workplace (verbal, physical?)
 - a) Yes
 - b) No
15. Do you think that female doctors are more often exposed to violence in the workplace compared to their male colleagues?
 - a) Yes
 - b) No
16. Do you think that younger generations of doctor's care more about gender equality in the workplace and in relation to leadership positions, compared to older colleagues?
 - a) Yes
 - b) No

RESULTS

Data on the gender distribution of students, doctors and deans of medical schools are sent by FEMS delegates for their countries.

Data on the ratio of male and female students at the Medicine Schools were provided for the Netherlands, Spain, Slovenia, Croatia and France (Table 1).

TABLE 1— Students enrolled to medical schools by gender (male/female ratio)

Country	Male (%)	Female (%)
The Netherlands	30	70
Spain	33	67
Slovenia	36	64
Croatia	37	63
France	38	62

Data on the distribution of physicians by gender were provided for Italy, France, Czech Republic, Spain, the Netherlands, Croatia, and Slovenia (Table 2).

TABLE 2— Physicians by gender (male/female ratio)

Country	Male (%)	Female (%)
Italy	55	45
France	55	45
Czech Republic	54	46
Spain	50	50
The Netherlands	42	58
Croatia	37	63
Slovenia	36	64

Data on the gender distribution medical schools' deans were provided for Spain, France, Italy, Slovenia, Croatia and Czech Republic (Table 3).

TABLE 3 — Deans of Medical Schools by gender

Country	Male (%)	Female (%)
Spain	34 (65%)	12 (35%)
France	30 (80%)	6 (20%)
Italy	40 (87.5%)	5 (12.5%)
Slovenia	2 (100%)	0
Croatia	4 (100%)	0
Czech Republic	7 (100%)	0

A total of 4.111 doctors from Croatia (990), Italy (940), France (752), Spain (534), Romania (508), Slovenia (173), Portugal (113), Northern Cyprus (62), Belgium (31), The Netherlands (7), Austria (4), Germany (3), Bulgaria (2), Czech Republic (1) and Latvia (1) participated in the survey.

Out of a total of 4.111 responses, 2.885 (70.18%) were sent by women, 1.214 (29.53%) by men and 12 (0.29%) by others.

QUESTION 2 — AGE

Distribution by age shows that similar number of participants were in the age groups of 31-40, 41-50 and 51-60 years (24.08%, 25.27% and 24.50%), with equal distribution depending on gender.

Those younger than 30 years took part in the survey the least (10.48%).

QUESTION 3 — YOU ARE....

The answers offered:

- a) Specialist
- b) Family doctor, GP, primary care doctor
- c) Resident
- d) Other

Most specialists (3.167 or 77.04%) took part in the survey, while 482 or 11.72% were residents, 329 or 8 % were family medicine, GPs or primary care doctors and 133 or 3.24% others. There was no significant difference depending on gender.

QUESTION 4 — CHOOSE THE BRANCH OF MEDICINE THAT BEST SUITS YOUR WORKPLACE.

Looking at the total, the ratio of non-surgical to surgical branches is approximately 3:1.

The analysis on the field of medicine shows the following results (Table 4):

TABLE 4 — Branch of medicine

Branch of Medicine	(%)			
	All	Male	Female	Other
Surgical	17.61	27.01	13.41	12.50
Non-surgical	59.09	53.45	59.76	62.50
Interventional med.	5.96	7.47	5.4	0.00
Preventive med.	7.66	5.46	9.27	12.50
Lab	8.37	5.08	10.65	12.50
Science	1.31	1.53	1.5	0.00

Analysis regarding to gender showed a significant difference: among female doctors, the ratio between non-surgical and surgical branches is 4.5: 1 (non-surgical branches almost 60% and surgical 13%), while the same ratio for male doctors is 2: 1 (non-surgical branches 53% and surgical 27%).

QUESTION 5 — FULL-TIME OR PART-TIME?

Most participants (3.773 or 91.78%) work full-time, and only 338 or 8.22% work part-time.

The analysis by gender shows that 97% of men and 90.02% women work full time, while 5.56% men and 9.98% women work part time.

QUESTION 6 — LEADERSHIP POSITION AT WORK

Among all the respondents, 27.32% had a leadership position at the time of the survey.

More men than women have had (20.79% vs. 15.94%) or still have (36.97% vs. 26.07%) a leadership position. The results are shown in Figure 1.

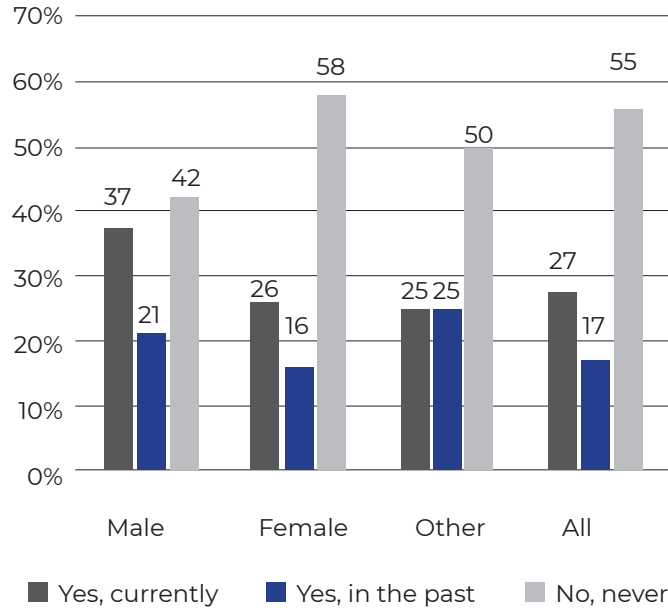


FIGURE 1 — Leadership position at work

QUESTION 7 — WHAT GENDER IS IN HIGHER AND MORE RESPONSIBLE POSITION IN YOUR INSTITUTION?

Results of all participants show that more men (74.81%) than women (25.19%) were in more responsible leadership positions. There is no significant difference in responses depending on gender (Figure 2).

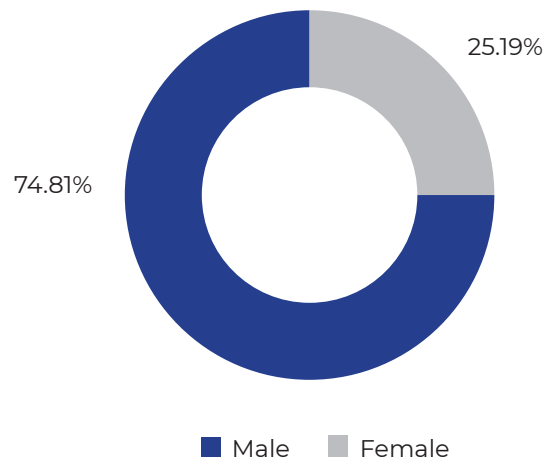


FIGURE 2 — Gender in more responsible leadership position in the institution

QUESTION 8 — HAVE YOU EVER FELT DISCOURAGED FROM WORKING IN A PARTICULAR SPECIALITY BECAUSE OF YOUR GENDER?

Overall results showed that most participants (2.838 or 69.03%) have never felt discouraged from working in a particular speciality because of their gender (Table 5).

TABLE 5 — Discouragement from working in a particular speciality because of gender

ALL	N	%
Yes	1.273	30.97
No	2.838	69.03
	4.111	100

From the male point of view results are different – 92.91% of male participants have never felt discouraged from working in a particular speciality (Figure 3).

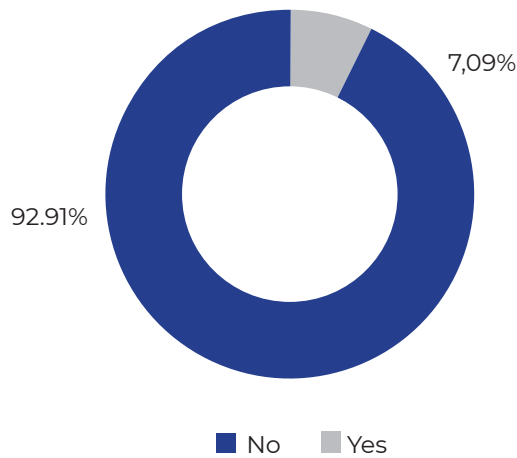


FIGURE 3 — Discouragement of working in a particular speciality — Male

Women’s results are significantly different – much more female (44.02%) than male (7.09%) felt discouraged from working in a particular speciality because of their gender (Figure 4).

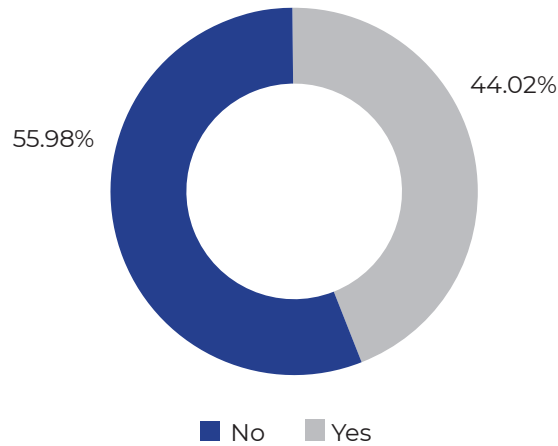


FIGURE 4 — Discouragement of working in a particular speciality — Female

QUESTION 9 — HAVE YOU EVER FELT DISCRIMINATED IN YOUR WORKPLACE BECAUSE OF YOUR GENDER?

The results differ significantly depending on the gender: gender discrimination was experienced by 9% of men and even 47.53% of women. Between those who declared themselves as others, 25% experienced discrimination (Figure 5).

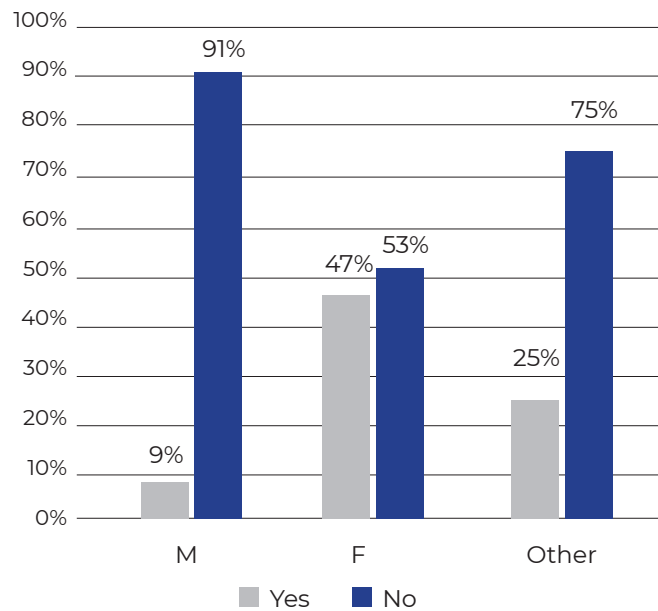


FIGURE 5 — Discrimination because of gender

QUESTION 10 — DO YOU THINK THAT A FEMALE DOCTOR MUST BE MUCH MORE COMPETENT TO BE AS VALUABLE AT WORK AS A MALE COLLEAGUE?

The overall results showed that slightly fewer respondents (48.02%) think that women must be more competent to be as valuable at work as a male colleague, compare to those who think the opposite (51.98%) (Figure 6).

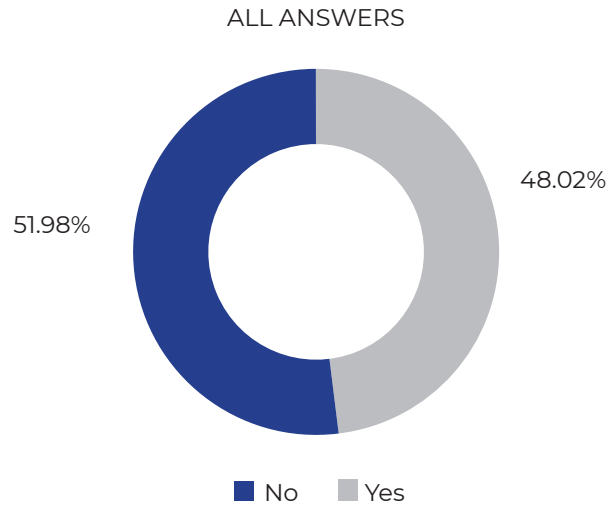


FIGURE 6 — Female doctor must be much more competent to be as valuable at work as a male colleague

Like the previous question, the results differ significantly depending on the gender of the respondents: while 63.63% of female answered that they must be more competent to be as valuable at work as a male colleague, only 15.23% of male think the same (Figure 7).

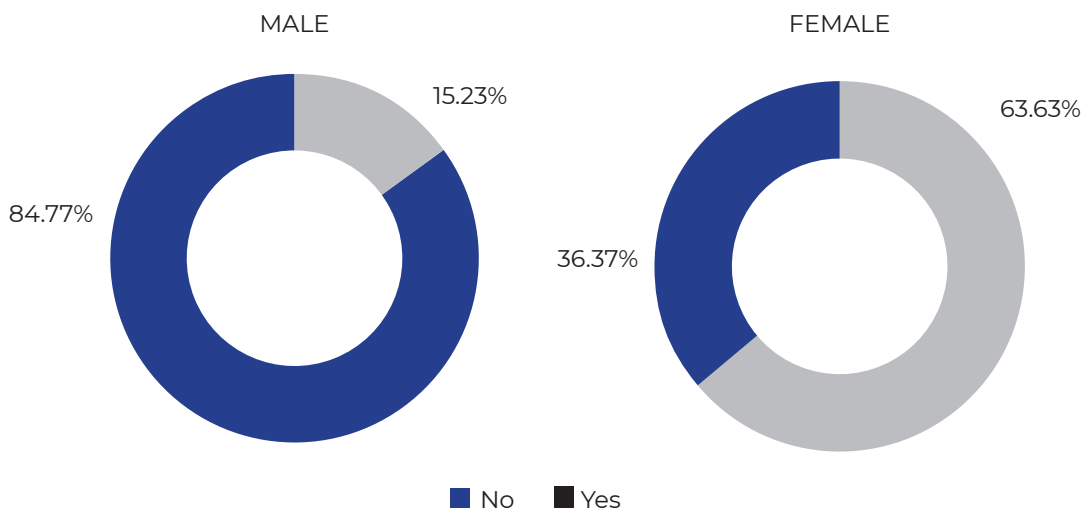


FIGURE 7 — Female doctor must be much more competent to be as valuable at work as a male colleague – male and female point of view

QUESTION 11 — DO YOU THINK SOME SPECIALTIES ARE UNAVAILABLE OR MORE DIFFICULT TO ACCESS FOR FEMALE DOCTORS BECAUSE OF GENDER?

Looking at all responses, 2,551 (62.05%) respondents support this statement, and 1,560 (37.95%) respondents disagree with it. Those who declared themselves as others have a similar point of view. However, significant differences are noticed here as well, depending on the male or female point of view: 53.97% of female and 76.37% of male agree that some specialties are unavailable or more difficult to access for female doctors because of gender (Figure 8).

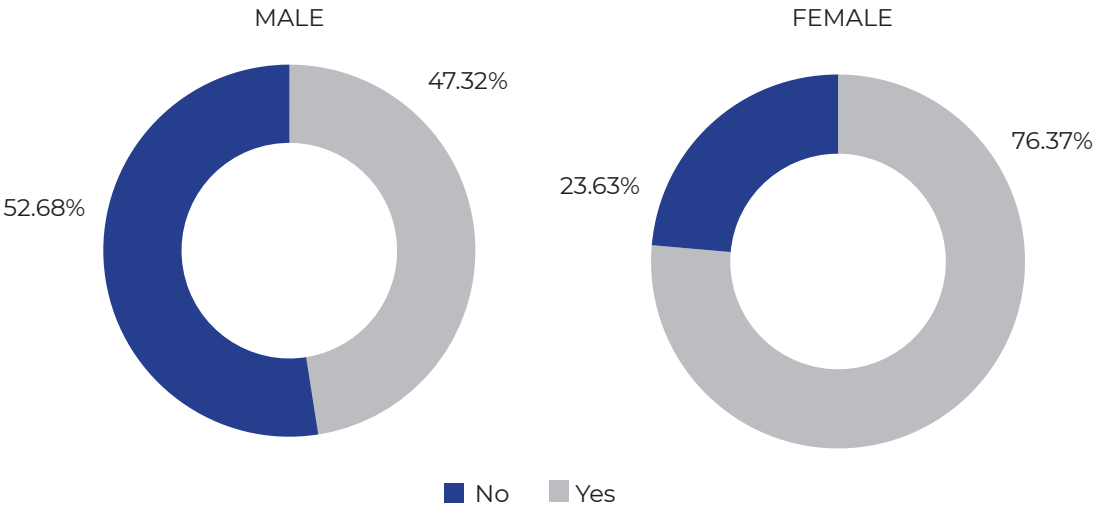


FIGURE 8 — Some specialties are unavailable or more difficult to access for female doctors because of gender – male and female point of view

QUESTION 12 — HAVE YOU EVER BEEN ASSUMED TO BE IN A MORE JUNIOR ROLE IN YOUR WORKPLACE BECAUSE OF YOUR GENDER?

Looking at all responses, 1,449 (35.25%) respondents support this statement, and 2,662 (64.75%) respondents disagree with it. Significant differences depending on gender are noticed here as well: 48.76% female, 62% others and only 8.52% male have experienced to be assumed in a more junior role because of gender (Figure 9).

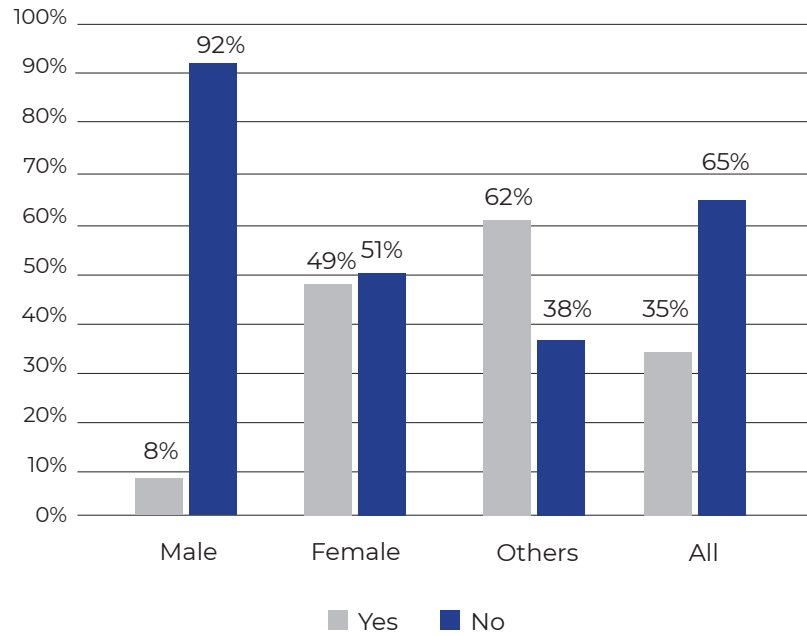


FIGURE 9 — Have you ever been assumed to be in a more junior role in the workplace because of gender?

QUESTION 13 — DO YOU THINK SEXISM ACTS AS A BARRIER TO CAREER PROGRESSION?

2.394 (58.23%) of all participants answered "YES", and 1.717 (41.77%) answered "NO" (Figure 10).

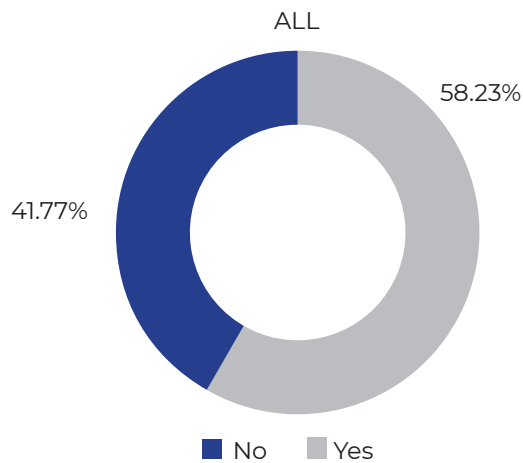


FIGURE 10 — Sexism acts as a barrier to career progression – All answers

Depending on gender, opposite answers are noticed: while almost 70% of female agree that sexism acts as a barrier to career progression, 63% of male do NOT agree with this statement (Figure 11).

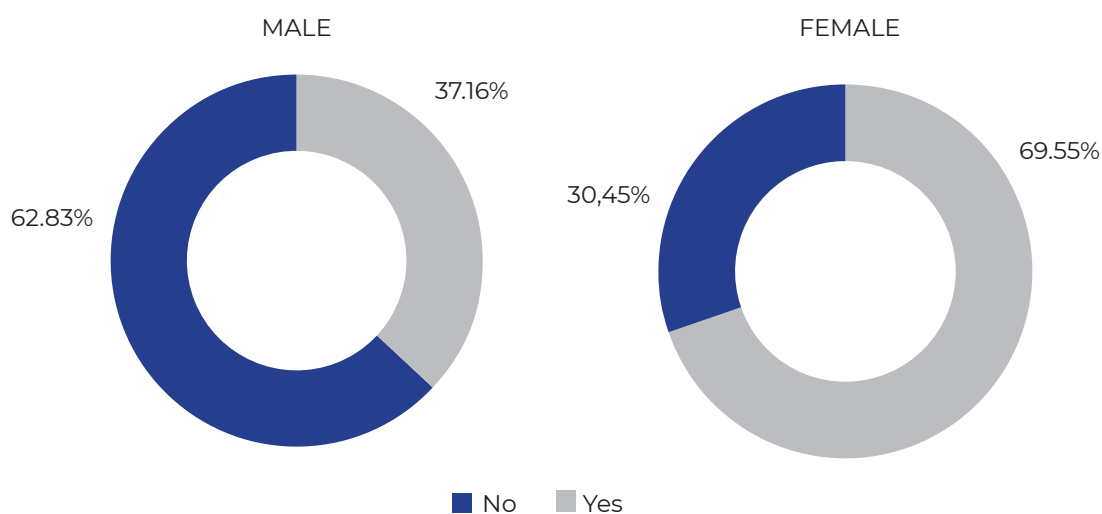


FIGURE 11 — Sexism acts as a barrier to career progression –Male and female point of view

QUESTION 14 — HAVE YOU EVER EXPERIENCED VIOLENCE OF ANY ORIGIN IN THE WORKPLACE (VERBAL, PHYSICAL?)

Overall results have shown that 53.44% of participants experienced violence at their workplace. There were not significant differences between male and female. All of those who declared themselves as others (8 or 100%), experienced violence at their workplace (Figure 12).

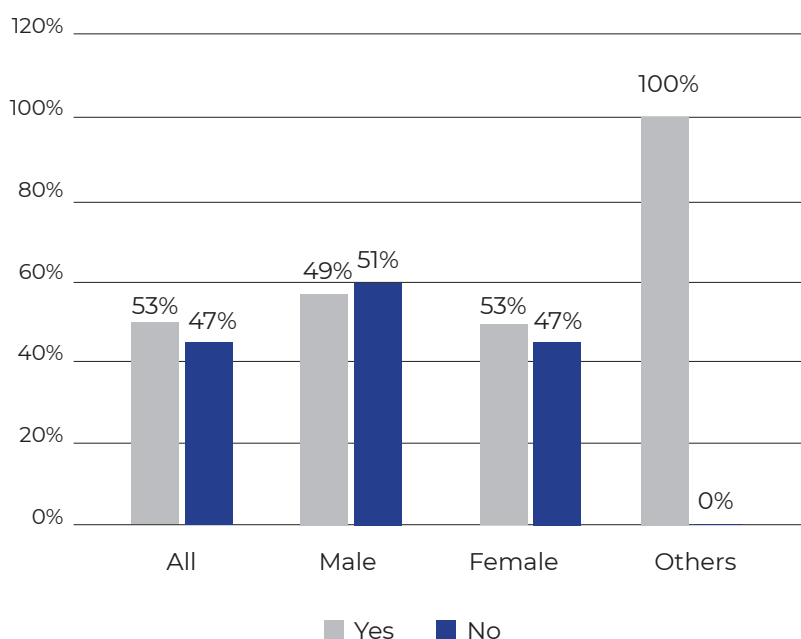


FIGURE 12 — Violence experienced in the workplace

QUESTION 15 — DO YOU THINK THAT FEMALE DOCTORS ARE MORE OFTEN EXPOSED TO VIOLENCE IN THE WORKPLACE COMPARED TO THEIR MALE COLLEAGUES?

The overall results showed that 2.565 (62.39%) agree and 1.546 (37.61%) disagree with this statement. Depending on gender, 69.27% of female and 41.48% male agree, while 30.73% of female and 58.52% of male disagree with this statement (Figure 13).

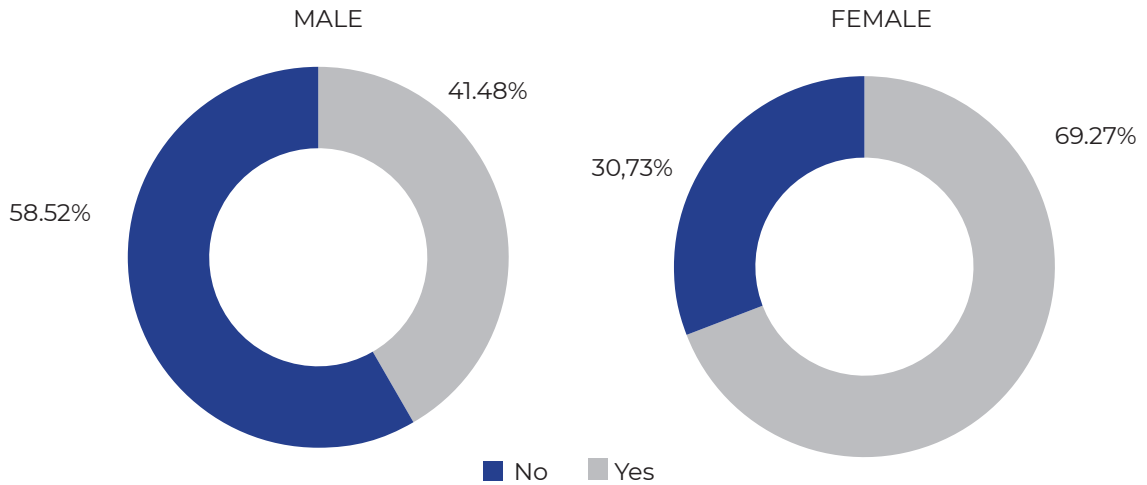


FIGURE 13 — Female doctors are more often exposed to violence in the workplace compared to their male colleagues – male and female point of view

QUESTION 16 — YOUNGER GENERATIONS OF DOCTORS CARE MORE ABOUT GENDER EQUALITY IN THE WORKPLACE AND IN RELATION TO LEADERSHIP POSITIONS, COMPARED TO OLDER COLLEAGUES?

The vaster number of participants (2.903 or 70.62%) answered "YES". There were not significant differences depending on gender (Figure 14).

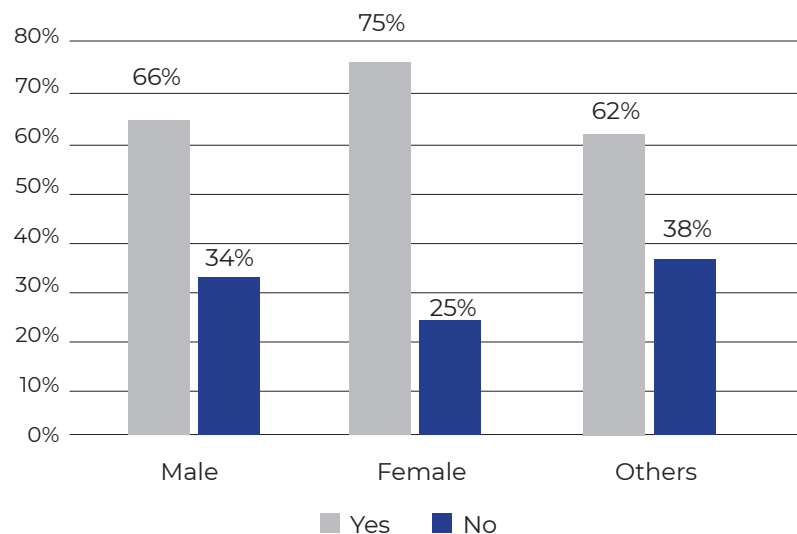


FIGURE 14 — Younger generations care more about gender equality compared to older colleagues?

DISCUSSION

After several centuries of male dominance in medicine, the feminization of medicine is an undeniable fact today.

The numerical superiority of women is visible first in the number of female students at medical schools. An increasingly rapid growth in the number of female doctors is observed in most EU countries, especially in the last 20 years (2,3).

The results of our research also showed that the majority of students at the medical schools in the Netherlands, Spain, Slovenia, Croatia and France are women.

According to data collected from our FEMS delegates, in Italy, France and Czech Republic still dominate male doctors (55%,55% and 54%). Male-female ratio in Spain is 50%-50%, while in the Netherlands, Croatia and Slovenia is more female doctors (58%, 63% and 64%).

However, despite the greater number of female doctors, gender inequality in medicine is undeniable fact. It is noticed at employment, selection of candidates for certain specializations, professional progression, selection for leading positions, current decision-making positions, etc., which is supported by published data (4,5,6,7,10,11).

Our results are consistent with published data: more than twice as many males than female work in surgical branches (27.01% vrs 13.41%), more male than female work in interventional medicine (7.47% vrs 5.40%), while almost twice as many women than men work in preventive medicine (9.27% vrs 5.46%) and laboratories (10.65% vrs 5.08%).

Regarding holding leadership positions, our results showed that much more women than men have never held any leadership position (41% vrs 12%). However, there are more women than men in leadership positions today (18.43% vrs 10.76%). We did not analyse the level of leadership positions, so we cannot claim that men occupy positions with greater responsibility and a higher level of leadership. However, the data on the gender distribution of deans of medical schools we collected, support this claim. Namely, extremely few or no women hold the position of medical faculty dean: 35% in Spain, 20% in France, 12.5% in Italy and no female deans in Slovenia, Croatia and Czech Republic.

Women in medicine are also more exposed to all forms of discrimination at all levels of their careers. An example from Tokyo (12) is particularly worrying: in 2018, Tokyo Medical University admitted to manipulating women applicant's entrance exam scores for years to restrict the number of female doctors, in part because they were performing better than male applicants. The results of research conducted in French-speaking Switzerland indicate that gender discrimination in medicine affects one-third of women, particularly those working in hospital settings and senior positions (13).

Our research has shown that the awareness and judgement on gender inequality differ significantly depending on whether it is viewed from a male or female point of view.

According to this, we received completely opposite answers to questions 8-15, depending on the male or female point of view:

- while 44% female have felt discouraged from working in a particular specialty, only 7% male felt the same.
- women experienced discrimination at their workplace because of their gender 7 times more often than men (47% female and 9% male).

- more than 4 times more women than men declared that they must be much more competent to be as valuable at work as a male colleague (63% female and 15% male)
- 3/4 of women (76%) and almost half of men (47%) agree that some specialties are unavailable or more difficult to access for female doctors because of gender.
- twice as many women (70%) as men (37%) declared that sexism acts as a barrier to career progression.
- more than twice as many women (37%) than men (14%) experienced violence of any origin in the workplace
- almost half of women (49%) and only 12% of men think that female doctors are more often exposed to violence in the workplace compared to their male colleagues.

In the last question we were interested in whether the younger generations care more about gender equality compared to their older colleagues.

Fortunately, the answers to this question give hope for a better tomorrow, because the majority of both male (65%) and female (75%) agree with that statement.

Movement in a positive direction is shown by European Medical Organizations of younger generations (EJD – European Junior Doctors and EMSA – European Medical Students' Association), where women made up half or more of the executive boards (EJD 55% and EMSA 50%) even 5 years ago (13).

CONCLUSION

The research we conducted confirmed once again that feminization of medicine is an undeniable fact, but also that women are underrepresented in leadership and higher decision-making positions. Our results support also the already known claim that gender inequality is still present among doctors.

Undoubtedly, the results of our survey lead to the conclusion that male doctors are not sufficiently familiar with the working conditions of female doctors today, as well as how women perceive all the barriers they struggle with and face in their workplaces.

It seems that even in the 21st century, there are still too many those who perceive medicine as a male profession, even among doctors.

It seems, however, that today's younger generations are no longer ready to accept old rules and way of thinking in the field of gender relations.

Regardless of this, the obtained results indicate the necessity of taking urgent measures and interventions at all levels - from local to global.

Our goal should be to enable women to participate equally in all workplaces, as well as in the leading and most responsible positions in all segments of medicine.

To achieve this goal, all of us must promote awareness of the current position of women in medicine. We must clearly point out the barriers and obstacles women face today, the gender inequality in obtaining certain specializations and election to leadership positions, as well as in all other situations in which gender inequality is evident today.

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CHAPTER IV

MEDICAL CAREER

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INTRODUCTION

The FEMS Portuguese delegations developed a questionnaire to address the organization, structure, progression and regulation of the medical career throughout Europe. It was sent through FEMS secretariat to all delegations via e-mail, with a Google Forms® direct link, in the first semester of 2024. After submitting an open answer enquiry and receiving variable and uneven answers, it was reformulated to contain options (including open answers) and the questionnaire re-sent as shown in the table below (Table 1). We gathered and analysed the results of surveyed delegations until July 2024 from: Austria, Bulgaria, Croatia, France, Italy, Netherlands, Northern Cyprus, Poland, Portugal, Romania, Slovenia, Spain and Switzerland.

TABLE 1— Questions included in the enquiry

1. What is the starting point of the medical career?
2. Does medical career include progression levels? 2.1. If progression levels are included, how many are they?
3. Is there a structured medical career in your country?
4. How is the medical career defined in your country?
5. How does career progression occur? 5.1. <i>If it occurs through application, what is taken into consideration?</i>
6. How is ongoing training possible – considering time and payment?
7. How are leadership roles attained?

RESULTS

There is a structured medical career (MC) in all surveyed countries, mostly exclusively in the public sector (69.2%), except for Bulgaria, Romania and Switzerland, countries in which it occurs in both public and private sectors. The definition of the Medical Career is almost exclusively defined by Law or through the Health Ministry, with the exceptions of Bulgaria and Poland, where there is a participation of medical associations and apart from Switzerland where medical boards define it. Both in Italy and in Portugal, Medical Career is strictly related to the public administration.

Medical residency is integrated on the medical career in 46.2% of surveyed countries, yet it only begins after specialization in approximately a third of the countries (30.8%) (Figure 1). This does not apply to Bulgaria, Croatia or Romania, as the medical career in these countries begins after medical-school graduation, as an independent worker or as a generalist doctor, respectively.

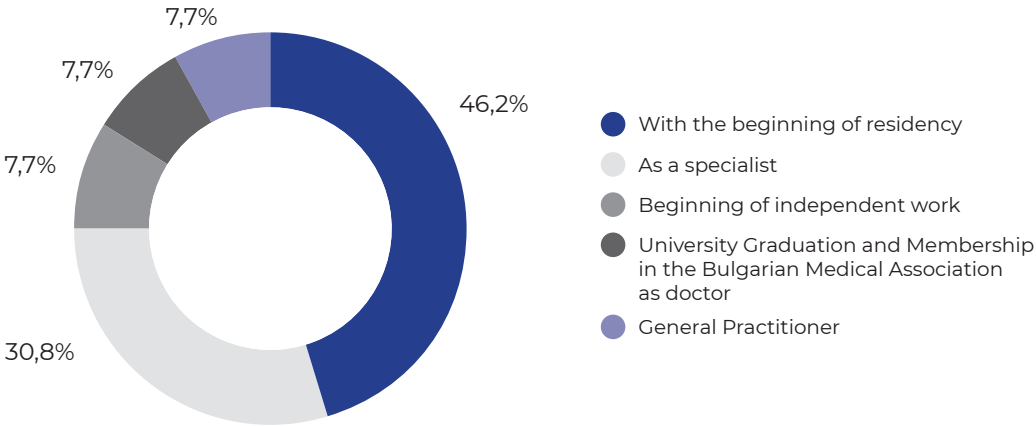


FIGURE 1 — Starting point of the Medical Career

In most countries (84.6%), Medical Career includes progression levels (up to 3 levels in 46.2%, between 4 and 6 in 30.8% and more than 8 levels in 23.1%), although there is no definition of levels in both Bulgaria and Poland. Progress occurs by application in 76.9% of countries, with time of service and skills being the most valuable variables taken in consideration (46.2%) (Figure 2).

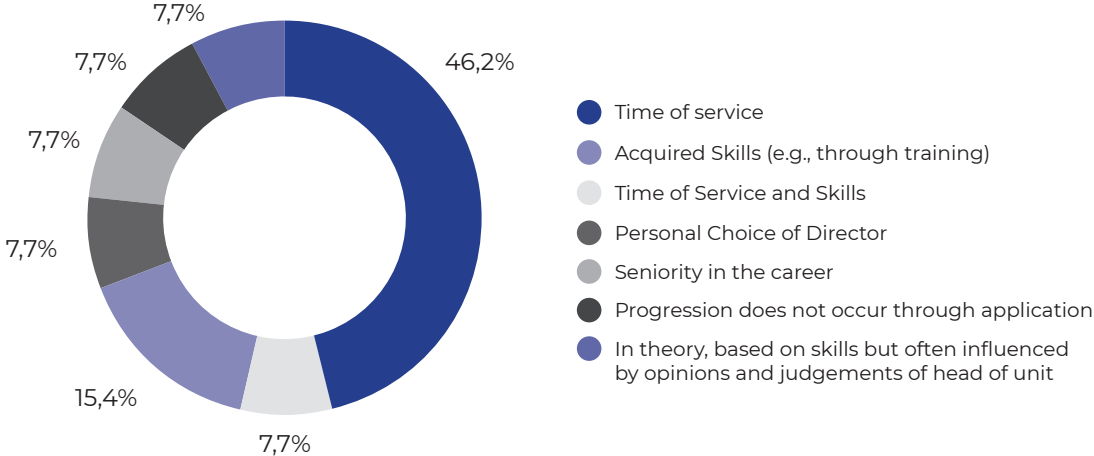


FIGURE 2 — Variables taken into consideration for Medical Career progress.

Ongoing training is either included in working hours or absences are allowed for most countries (53.8%), excluding Bulgaria and Poland, in which neither are comprised. Funding for training is mainly mixed (personal, employer and/or external institutions) in more than half of countries, although in some countries doctors must personally support expenses (such as Italy, Poland and Portugal). In Slovenia, the employer provides funding for training.

Lastly, the majority of Medical Career leadership roles are either attained by nomination (61.5%) or application (38.5%) (Figure 3).

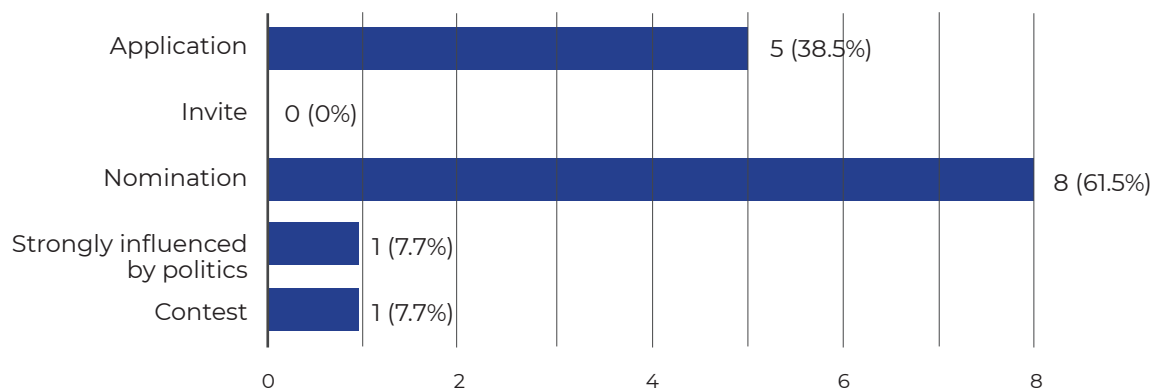


FIGURE 3 — Leadership attainment methods.

CONCLUSIONS

There appears to exist a structured Medical Career throughout Europe, although there are some dissimilarities regarding its organization, definition and progression. There seems to be a predominance of public sector careers with legal definitions and pre-established levels of progression, where time of service and developed skills are most valued for this to occur. Ongoing training is predominantly included in working hours, with leadership roles occurring mostly by nomination. These results display some resemblance in different European countries, yet they also highlight the variances in which focus is needed to standardize medical careers and facilitate medical mobility, improving European doctors training and working conditions.

CHAPTER V

HEALTHCARE – FINANCES

Christiaan Keijzer

FEMS 1ST VICE-PRESIDENT, NETHERLANDS

In this chapter you will find an excerpt from the OECD report health at a glance 2023 and 2022. Here the financial aspects of healthcare in Europe are extracted. In this introduction we will describe the key conclusions on the different aspects reported:

HEALTH EXPENDITURE IN RELATION TO GDP

2019 expenditure on average 8.8% of GDP, 2021 9.7%, 2022 9.2%. USA 16.6%, highest spending country in Europe is Germany with 12.7%.

HEALTH EXPENDITURE PER CAPITA

2022 average per capita health spending in Europe was nearly USD 5000 (adjusted for differences in purchasing power). USA 12555 USD. Highest spending countries in Europe are Switzerland and Germany at around 8000 USD.

HEALTH EXPENDITURE BY FINANCING SCHEME

Compulsory or automatic coverage, through government schemes or health insurance, forms the bulk of healthcare financing in OECD countries. Taken together, three-quarters of all healthcare spending in 2021 was covered through these types of mandatory financing schemes.

HEALTH EXPENDITURE BY TYPE OF SERVICE

From OECD countries the bulk of health spending occurs through inpatient and outpatient services – accounting for 60% health spending in 2021. High allocation of inpatient spending is around 40% of spending. Spending on long care services accounted for 13 of health spending in 2021 but there are big differences between countries.

HEALTH EXPENDITURE BY PROVIDER

In OECD countries 39% of activities are delivered in hospitals. After that the largest provider are ambulatory providers, this covers a wide range of facilities.

EXTENT OF HEALTH CARE COVERAGE

Across EU countries more than three-quarters of all health care costs were covered by government or compulsory health insurance schemes. Inpatient care in hospitals is more comprehensively covered than any other type of care. Across the EU 91% of all inpatient cost were covered.

FINANCIAL HARDSHIP AND OUT-OF-POCKET EXPENDITURE

On average across the EU around 15% of all spending on health care comes directly from patients through out-of-pocket payments (OOP). This spending varies from 7.1 % of household consumption to 1.4% in Europe depending on national regulations.

HEALTH EXPENDITURE IN RELATION TO GDP

The resources that a country allocates to healthcare compared to the size of the overall economy vary over time due to differences in both the growth of health spending and overall economic growth. During the 1990s and 2000s, OECD countries generally saw health spending outpace the rest of the economy, leading to an almost continual rise in the health expenditure to GDP ratio. After the volatility of the 2008 economic and financial crisis, the share remained relatively stable, as growth in health spending broadly matched overall economic performance across the OECD. The arrival of the COVID-19 pandemic in 2020 with a severe slowdown in economic activity and rapidly increasing health spending led to a significant adjustment in the health expenditure to GDP ratio.

In 2019, prior to the pandemic, OECD countries were spending on average, around 8.8% of their GDP on healthcare, a figure relatively unchanged since 2013. By 2021, this proportion had jumped to 9.7%. However, preliminary estimates for 2022 point to a significant fall in the ratio to 9.2%, reflecting both a reduced need for spending to tackle the pandemic as well as the impact of inflation reducing the value of health spending (OECD, 2023[1]). The United States still spent by far the most, equivalent to 16.6% of its GDP – well above Germany, the next highest spending country, at 12.7% (Figure 7.1). After the United States and Germany, a group of

15 high-income countries, including Canada, France and Japan, all spent more than 10% of their GDP on healthcare. In many of the Central and Eastern European OECD countries, as well as in the newer OECD member countries from Latin America, spending on health accounted for between 6-9% of their GDP. Finally, Luxembourg and Turkey spent less than 6% of their GDP on healthcare.

An analysis of the trends in per capita health spending and GDP over the last 15 years shows two shocks: the economic and financial crisis in 2008 and the recent impact of COVID-19 in 2020 (Figure 7.2). While OECD economies sharply contracted in 2008 and 2009, health spending growth was maintained in the short term before hovering just above zero as a range of different policy measures to rein in public spending on health were put in place between 2010 and 2012. This was followed by a return to somewhat stronger growth, both in health spending and GDP up until the pandemic. In 2020, widespread lockdowns and other public health measures severely restricting economic activity and consumer spending sent many OECD economies into freefall. There was a rebound in 2021 with per capita GDP increasing by 5.8% on average. At the

same time, real per capita spending on health accelerated from just over 4% in 2020 to 8% in 2021 as countries allocated additional funding to tackle the pandemic. With countries emerging from the acute stage of the pandemic, health spending per capita is likely to have fallen on average by close to 1.5% in real terms in 2022.

Trends in the health-to-GDP ratio over this period translate into a distinct pattern with significant step increases in 2009 and 2020, and a period of stability in between (Figure 7.3). Italy and the United Kingdom, for example, have closely followed this trend, with the latter showing an even more pronounced jump in 2021. Germany has seen a rather continual increase in the share of GDP over time. Despite the shocks, health spending as a share of GDP in Korea has seen a continual and steady increase throughout the last 15 years, from 4.8% in 2006 and reaching 9.7% in 2022.

DEFINITION AND COMPARABILITY

Expenditure on health gives a measure of the final consumption of health goods and services (i.e. current health expenditure) (OECD/Eurostat/WHO, 2017[2]). This includes spending by all types of financing arrangements on medical services and goods, population health and prevention programmes, as well as administration of the health system. The split of spending combines government and compulsory financing schemes, the latter including private insurance of a mandatory nature. Due to data limitations, private voluntary insurance in the United States is included with employer-based private insurance, which is currently mandated under the Affordable Care Act.

Gross Domestic Product (GDP) is the sum of final consumption, gross capital formation and net exports. Final consumption includes goods and services used by households or the community to satisfy their individual needs. It includes final consumption expenditure of households, general government and non-profit institutions serving households.

In countries such as Ireland and Luxembourg, where a significant proportion of GDP refers to repatriated profits and thus not available for national consumption, Gross National Income (GNI) may be a more meaningful measure than GDP. However, for consistency, GDP is maintained as the denominator for all countries.

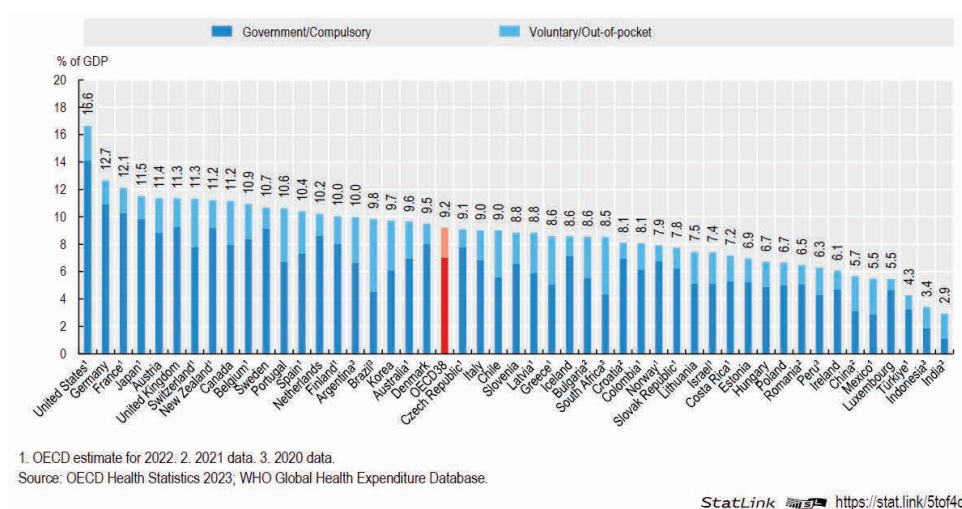


FIGURE 7.1. — Health expenditure as a share of GDP, 2022 (or nearest year)

HEALTH EXPENDITURE PER CAPITA

The level of per capita health spending, which captures both individual and population healthcare needs, and how this level changes over time depends on a wide range of demographic, social and economic factors, as well as the financing and organizational arrangements of a country's health system.

In 2022, average per capita health spending in OECD countries (when adjusted for differences in purchasing power) was estimated to have reached nearly USD 5 000. In the United States, it reached the equivalent of USD 12 555 for every US citizen. Switzerland and Germany were the next highest spenders in the OECD, but at around USD 8 000 this was still less than two-thirds of the level in the United States (Figure 7.4). After Norway and Austria, a further group of western European countries, as well as Australia, Canada and New Zealand all spent between USD 6-7000. Per capita health spending broadly decreased across Southern European countries, Central and Eastern European countries to the Latin American OECD member countries, with spending in Mexico (USD 1 181) at around a quarter of the OECD average.

Figure 7.4 also shows the split of health spending based on the type of healthcare coverage, either organized through government health schemes or compulsory insurance (public or private), or through voluntary arrangements such as private voluntary health insurance or direct payments by households (see also indicator "Health expenditure by financing schemes"). On average across OECD countries, about three-quarters of all health spending is financed through government or compulsory insurance schemes.

The risk of illness and ill-health generally increases with age. A population with an older demographic structure can expect higher mortality rates, greater incidence and prevalence of certain diseases, and thus higher demands for healthcare and, by consequence, higher spending on health. Using a standard age-spending profile, the impact of different population structures on overall health spending across OECD countries can be assessed using indirect standardization (OECD, forthcoming [1]). Figure 7.5 indicates that countries such as Israel and Ireland, and some of the Latin American OECD member countries could expect higher health spending relative to the OECD average if a standard population structure was applied, whereas those countries with older populations (e.g. Japan, Germany and Italy) could expect lower spending.

In the years leading up to the COVID-19 pandemic, annual average per capita spending on healthcare grew by an average of 2.6% across OECD countries (Figure 7.6). In Latvia, Lithuania as well as Korea, annual spending growth between 2015 and 2019 was between 6 and 8%, while in most Nordic countries and France, growth was much more moderate at less than 1% on average. The emergence of COVID-19 in 2020 led to sharp increases in health spending, particularly from governments as they mobilized funds to slowdown and tackle the effects of the pandemic. Between 2019 and 2022, average per capita spending growth in the OECD accelerated to 3.3% per year, with a peak reached in 2021 before contracting in the most recent year (Figure 7.2). However, diverging trends in the pattern of health spending growth across countries during the pandemic could be observed due to the severity of the various waves across different regions, the extent and duration of containment policies, but the variation in how healthcare is financed in countries can also play a role. Of the 38 OECD countries, around two-thirds saw higher growth during the pandemic than in the years immediately preceding the crisis, and only Mexico is

expected to have seen overall negative growth during the most recent three-year period. Some countries – Latvia and Turkey, have seen double-digit growth in health spending between 2019 and 2022, reflecting both the severity and the continuation of the pandemic’s effects into 2022. In the Asia- Pacific region, Korea and New Zealand, have both seen growth of more than 8% on average between 2019 and 2022. Both countries had strong containment policies in place during 2020 and 2021, with a loosening resulting in some upsurge in COVID-19 cases in 2022.

DEFINITION AND COMPARABILITY

See indicator “Health expenditure in relation to GDP” for a definition of current expenditure on health.

To compare spending levels between countries, per capita health expenditures are converted to a common currency (USD) and adjusted to take account of the difference in purchasing power of the national currencies. Actual Individual Consumption (AIC) PPPs are used as the most available and reliable conversion rates. For the calculation of growth rates in real terms, AIC deflators are used for all countries, where available.

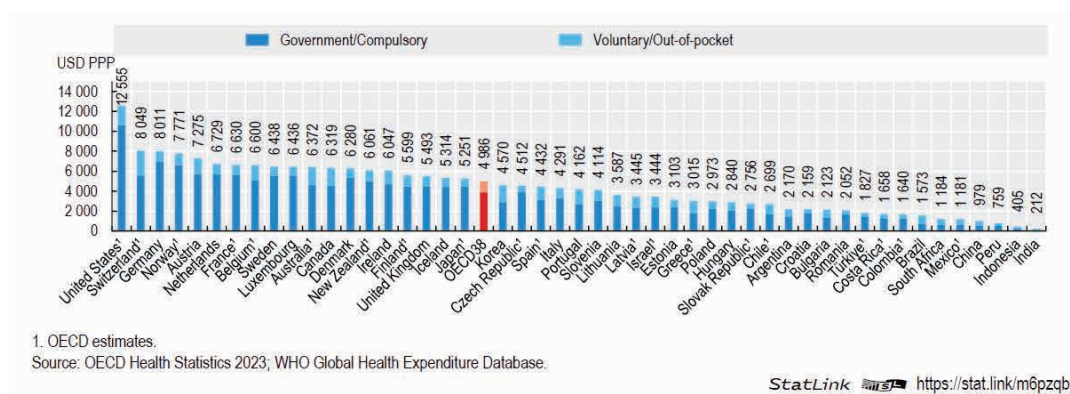


FIGURE 7.4. — Health expenditure per capita, 2022 (or nearest year)

HEALTH EXPENDITURE BY FINANCING SCHEME

There is a variety of financing arrangements through which individuals or groups of the population obtain healthcare. Government financing schemes, on a national or sub-national basis or for specific population groups, entitle individuals to healthcare based on residency and form the principal mechanism to cover healthcare costs in close to half of OECD countries. The other main method of financing is some form of compulsory health insurance (managed through public or private entities). Spending by households (out-of-pocket spending), both on a fully discretionary basis and part of some co-payment arrangement, can constitute a significant part of overall health spending. Finally, voluntary health insurance, in its various forms, can also play an important funding role in some countries.

Compulsory or automatic coverage, through government schemes or health insurance, forms the bulk of healthcare financing in OECD countries. Taken together, three-quarters of all healthcare spending in 2021 was covered through these types of mandatory financing schemes (Figure 7.10). Central, regional, or local government schemes in Denmark, Iceland, Norway, Sweden and the United Kingdom accounted for 80% or more of national health spending. In Germany, Japan, France and Luxembourg, three-quarters or more of spending was covered through a type of compulsory health insurance scheme. In the United States, federal and state programmes covered around a third of all US healthcare spending in 2021. Another 50% of expenditure is classified under compulsory insurance schemes, covering very different arrangements including federal health insurance schemes, such as Medicare, but also private health insurance, which is considered compulsory under the Affordable Care Act (ACA).

Out-of-pocket payments financed just under one-fifth of all health spending in 2021 in OECD countries, with this share broadly decreasing as GDP increases. Households accounted for 30% or more of all spending in Mexico (41%), Greece (33%), Chile and Lithuania (both 30%), while in France, the Netherlands and Luxembourg, out-of-pocket spending was below 10%.

In the years preceding the COVID-19 pandemic (2015-19), per capita spending by compulsory health insurance and voluntary health insurance schemes grew by 3.5% and 5.6% on average per year, respectively, above the growth rate of total health expenditure over the same period (2.6%) (Figure 7.11).

Meanwhile, spending by government schemes averaged 1.3% annual growth. Moreover, with moves towards universal health coverage, health expenditure financed by out-of-pocket payments (1.8%) grew below the rate of overall health expenditure.

The spending trajectory of the various financing schemes changed with the onset of the COVID-19 pandemic in 2020 (Figure 7.11). While spending growth of compulsory health insurance schemes remained largely unchanged during the 2019-21 period, spending by government schemes increased by an annual average of 26% as significant resources were made available to track the virus, increase system capacity, provide subsidies to health providers and eventually roll out COVID-19 vaccination campaigns. The growth in spending by government schemes was particularly high in countries where access to services is generally obtained via health insurance, including Chile, Colombia, Luxembourg, the Netherlands, the Slovak Republic and Slovenia. In those countries, government schemes generally do not play a large purchasing role in the health system, but they have assumed important financing responsibilities during the pandemic. In Colombia, for example, a newly established central government fund to finance COVID-19 response measures allocated approximately 40% of its resources to the health sector for testing, treatment, and vaccination (Vammalle and Córdoba Reyes, 2022[1]).

Meanwhile, spending by voluntary insurance saw a trend reversal in the period between 2019 and 2021 compared to 2015-19, as a result of postponement and reduced demand for elective healthcare services and the partial non-availability of services. In Ireland, for example, private hospitals agreed to provide treatment capacity for public patients during the peak waves of the pandemic, thereby reducing service availability for private payers (including those willing to use voluntary private insurance).

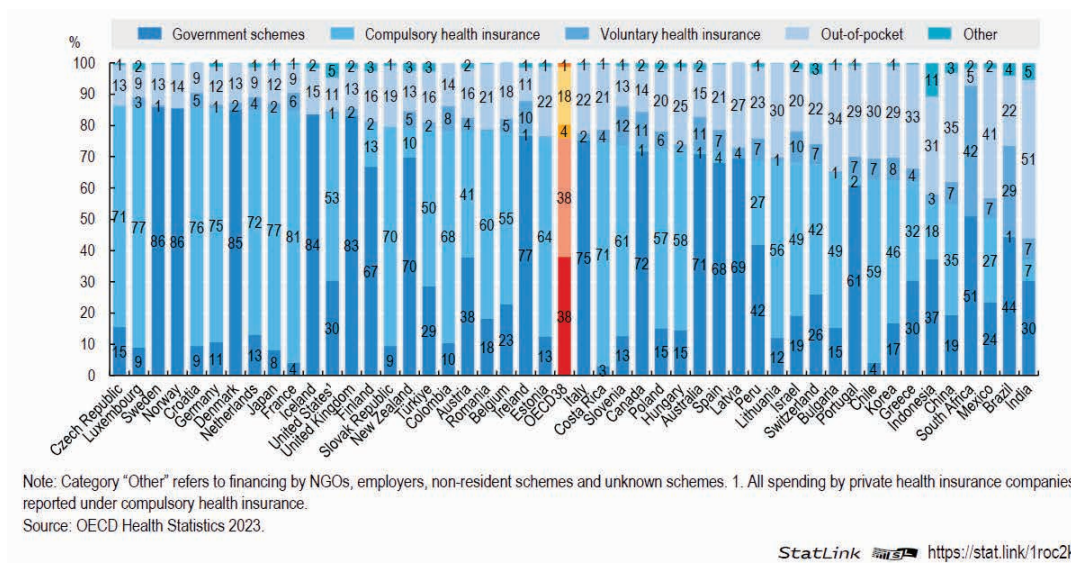


FIGURE 7.10. — Health expenditure by type of financing, 2021 (or nearest year)

HEALTH EXPENDITURE BY TYPE OF SERVICE

A variety of factors, from disease burden and system priorities to organizational aspects and costs determine the allocation of resources across the various types of healthcare services. For all OECD countries, curative and rehabilitative care services make up the bulk of health spending and are primarily delivered through inpatient and outpatient services – accounting for 60% of all health spending in 2021 (Figure 7.15). Medical goods (mostly pharmaceuticals) made up a further 18%, followed by long-term care services, which in 2021 averaged around 13% of health spending. Administration and overall governance of the health system, together with preventive care account for the remaining 9% of health spending.

In 2021, Belgium and Greece reported the highest share of total health spending allocated to inpatient services, at around 40%. At the other end of the scale, many of the Nordic countries as well as Switzerland and the Netherlands had a much lower proportion of spending on inpatient services – at around 20% of overall health spending.

Outpatient care forms a broad category covering generalist and specialist outpatient services, dental care, but also home care and ancillary services. Taking all these categories together, spending on outpatient care services accounted for around 45% of all health spending in Portugal, Latvia and Israel compared to an OECD average of 32%. Given the relative importance of inpatient care delivery, Greece and Belgium allocated a comparably low proportion on outpatient services, with less than a quarter of all health spending.

The third largest health spending category is medical goods. Differences in prices for international goods such as pharmaceuticals tend to show less variation across countries than for locally produced services. As a result, spending on medical goods (including pharmaceuticals) in lower-income countries often accounts for a higher share of health spending relative to services. For example, in 2021, expenditure on medical goods represented

around 30% of all health spending in Mexico, the Slovak Republic and Greece. By contrast, with only accounting for one-tenth of overall health spending, these shares were much lower in Denmark, Norway, the Netherlands and the United Kingdom.

Spending on long-term care services accounted for 13% of health spending on average in 2021, but this figure hides big differences across OECD countries. In countries with formal arrangements such as in Norway, Sweden and the Netherlands, a quarter or more of all health spending is for long-term care services. However, a more informal long-term care sector exists in many Southern, Central and Eastern European countries including Hungary, Latvia, Greece and the Slovak Republic, and in Latin American countries such as Mexico, where spending on long-term care is much lower – typically around 5% or less. The COVID-19 pandemic drastically changed health spending patterns in many countries resulting in notable differences in the average annual spending growth per capita in the years preceding the pandemic (2015-19) compared to during the pandemic (Figure 7.16). Between the years 2015 and 2019, annual per capita spending growth for retail pharmaceuticals (1.2%) and inpatient care (2.2%) was relatively moderate, whereas the average yearly increases for spending on outpatient care, long-term care and administration per capita were more pronounced, standing between 3-3.5%.

The pandemic triggered exceptional spending growth across all healthcare functions (Figure 7.16). Most notably, spending on preventive care increased by nearly 50% per year (up from 2.3% pre-pandemic), with countries dedicating significant resources to testing, tracing, surveillance, and public information campaigns related to the pandemic and the roll-out of the vaccination campaigns in 2020 and 2021. Annual per capita spending growth on inpatient care more than doubled, driven by expenses for additional staff and input costs (e.g. personal protective equipment) and substantial subsidies for hospitals. With around 8% annually, spending on health system administration also recorded strong growth between 2019 and 2021. Some of this increase can be explained by the additional resources required to manage national COVID-19 responses strategies. Preliminary data for 2022 suggests that some of the most recent increases will be short-lived and a normalization of growth rates can be expected with as countries transition out of the acute phase of the pandemic.

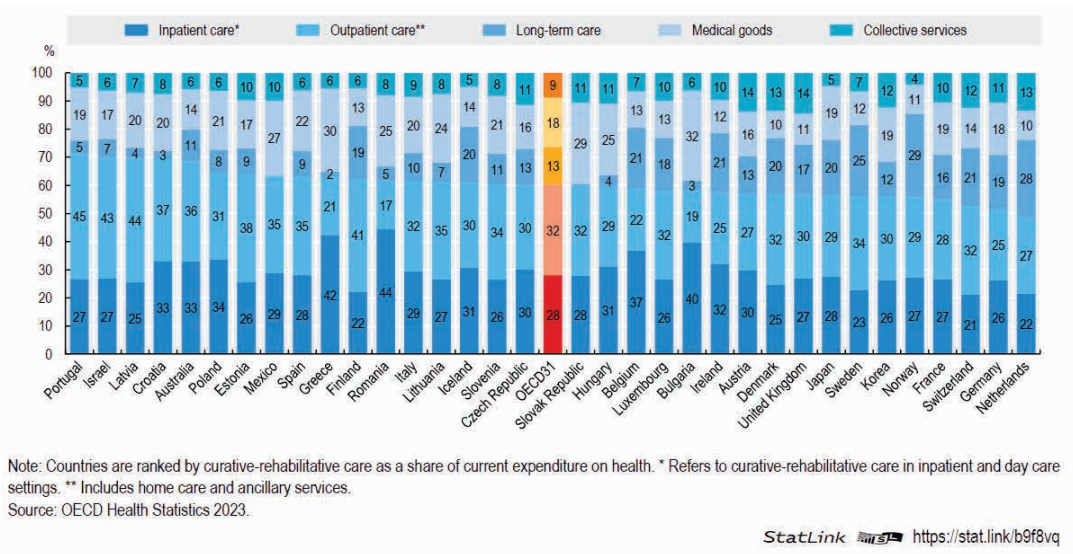


FIGURE 7.15. — Health expenditure by type of service, 2021 (or nearest year)

HEALTH EXPENDITURE BY PROVIDER

Healthcare is delivered by a wide variety of providers ranging from hospitals and medical practices to ambulatory facilities and retailers, which impact expenditure patterns for different goods and services. Analyzing health spending by provider can be particularly useful when considered alongside the functional breakdown of health expenditure, giving a fuller picture of the organization of health systems.

The organizational differences in healthcare delivery across OECD countries can be substantial, resulting in a wide variation in the distribution of health spending across providers. At 39%, activities delivered in hospitals accounted for the largest proportion of health system funding across the OECD. This average was largely exceeded in both Turkey and Costa Rica where hospital activities received more than half of all financial resources (Figure 7.19). On the other hand, Germany and Mexico spent less than 30% of the total health budget on hospitals.

After hospitals, the largest provider category are ambulatory providers. This category covers a wide range of facilities with most spending related to either medical practices including GPs and specialists (e.g. Austria, France and Germany) or ambulatory healthcare centers (e.g. Finland, Ireland and Sweden). Across OECD countries, care delivered by ambulatory providers accounts for around a quarter of all health spending on average – within this, around two-thirds of all spending relates to GP, specialist practices and ambulatory healthcare centers, and roughly one-fifth relate to dental practices. Overall, spending on ambulatory providers exceeded half of total health spending in Israel in 2021 and reached one-third in Latvia but remained at 10% in Turkey and below 20% in Greece, the Netherlands and the Slovak Republic.

Other main provider categories include retailers (mainly pharmacies) which accounted for 16% of all health spending and residential long-term care facilities (mainly providing inpatient care to dependent people), to which 8% of the total health spending can be attributed.

Across OECD countries, there is a wide variation in the range of activities that may be performed by the same category of provider, reflecting differences in the structure and organization of health systems. These cross-country differences are most pronounced in the hospital sector (Figure 7.20). Although inpatient curative and rehabilitative care define the primary activity of hospitals and therefore represent most of their expenditure, hospitals can also be important providers of outpatient care in many countries, for example through accident and emergency departments, specialist outpatient units, or laboratory and imaging services. In Finland, Denmark, Sweden and Portugal, outpatient care accounts for over 40% of hospital expenditure since specialists are typically receiving patients in hospital outpatient departments. On the other hand, in Germany and Greece, hospitals are generally mono-functional with the vast majority (around 90%) of spending on inpatient care services, and very little outpatient and day care spending. Over the last decade, many countries have shifted some inpatient services to day care departments aiming at potential efficiency gains and a reduction in waiting times. As a result, day care services account for more than 15% of all hospital expenditures in Belgium, Ireland and Portugal. Measures taken to address the COVID-19 pandemic have also affected the provider distribution of health spending. In 2020, the proportion of resources allocated to hospitals increased to 40% reflecting higher input costs of inpatient service delivery and important financial support targeted at hospitals. This share dropped again in 2021 with a reduced need for hospital subsidies. Interestingly, while the outbreak of the health emergency has led to major disruptions in the service delivery in hospitals, the spending distribution by type of service remained relatively stable in most countries.

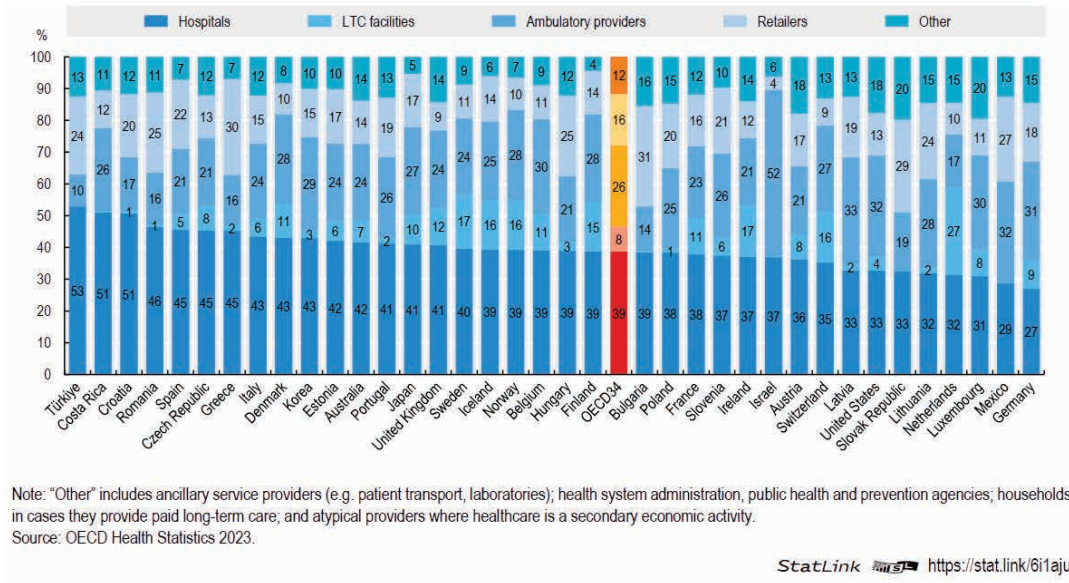


FIGURE 7.19. — Health expenditure by provider, 2021 (or nearest year)

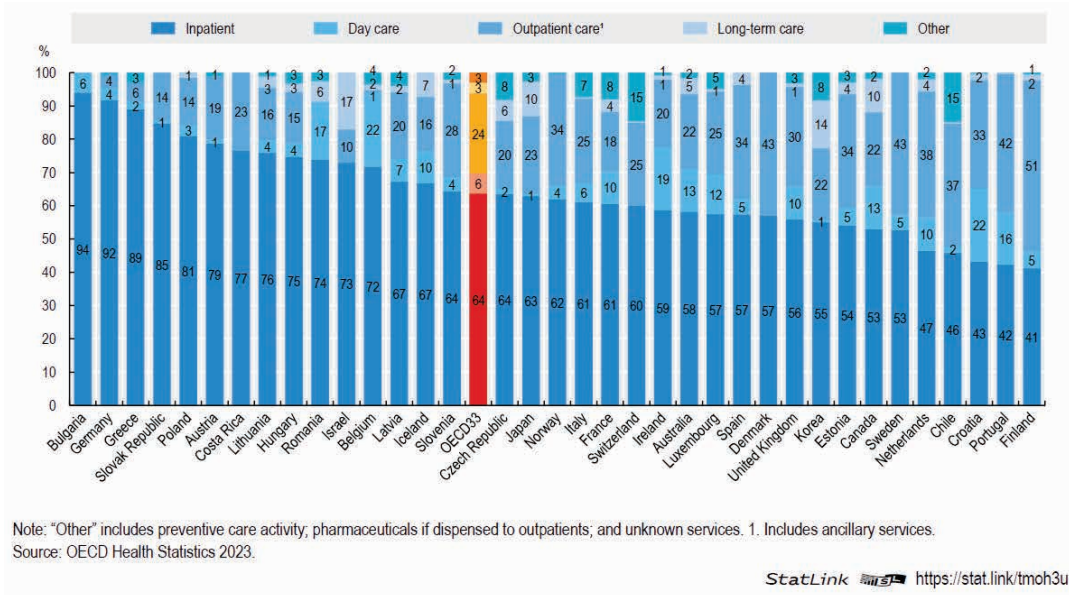


FIGURE 7.20. — Hospital expenditure by type of service, 2021 (or nearest year)

EXTENT OF HEALTH CARE COVERAGE

In addition to the share of the population entitled to core health services, the extent of health care coverage is defined by the range of services included in a publicly defined benefit package and the proportion of costs covered. Figure 7.6 assesses the extent of coverage for key health care goods and services, by computing the share of expenditure covered under government schemes or compulsory health insurance. Differences across countries in the extent of coverage can be the result of specific goods and services being included or excluded in the publicly defined benefit package, different cost-sharing arrangements or some services only being covered for specific population groups in a country.

Across EU countries, more than three-quarters of all health care costs were covered by government or compulsory health insurance schemes in 2020 (see indicator “Financing of health expenditure” in Chapter 5), but financial protection is not uniform across all types of health care services, and the variation across countries is considerable. In nearly all EU countries, inpatient services in hospitals are more comprehensively covered than any other type of care. Across the EU, 91% of all inpatient costs were borne by government or compulsory insurance schemes in 2020. In many countries, access to acute inpatient care is free or subject to very limited cost-sharing. As a result, coverage rates were near 100% in Sweden, Estonia, Romania, the Czech Republic, Germany and France. In Greece on the other hand, financial coverage for the cost of inpatient care was only around two-thirds of total costs.

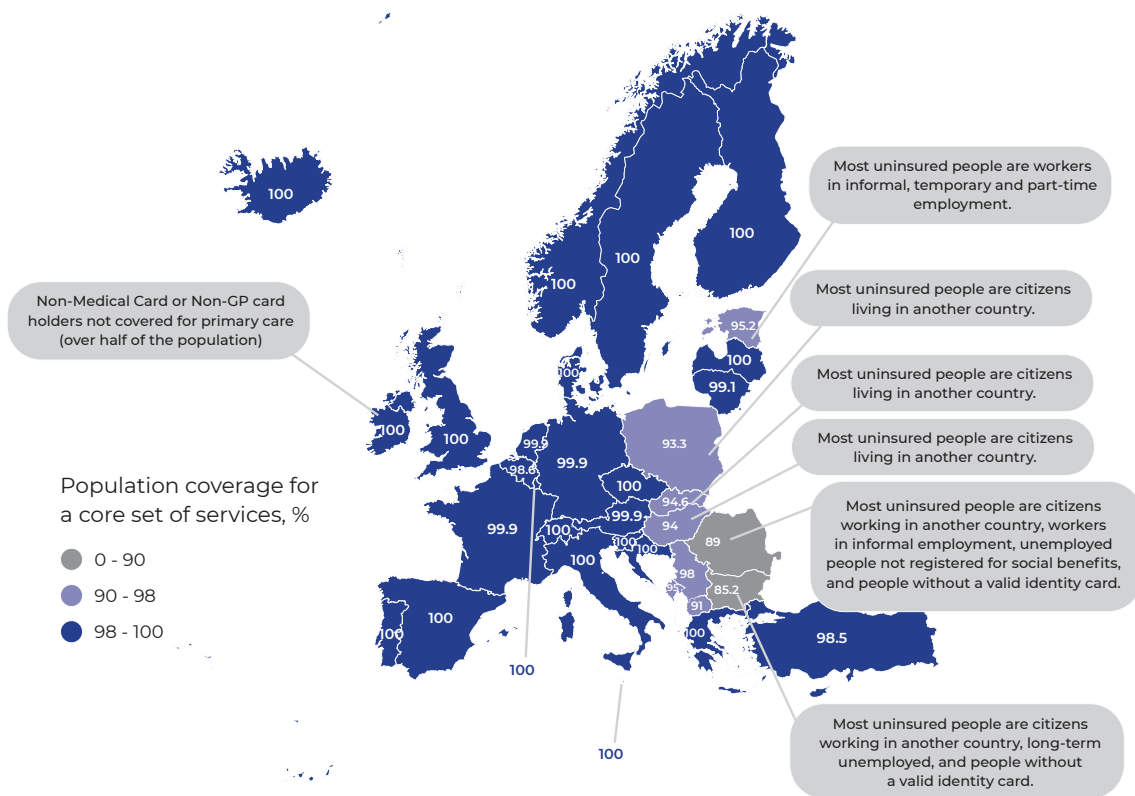
More than three-quarters (78%) of spending on outpatient medical care across the EU was borne by government and compulsory insurance schemes in 2020. Coverage ranged from less than 60% in Malta, Bulgaria and Latvia to over 90% in the Slovak Republic, Denmark, the Czech Republic and Sweden. In some countries, outpatient primary and specialist care are generally free at the point of service, but some out-of-pocket payments may still apply for specific services or if patients consult non-contracted private providers.

Public coverage for dental care costs is far more limited across EU countries due to restricted service packages (frequently limited to children) and high levels of cost-sharing. On average, only one-third of total costs are borne by government schemes or compulsory insurance. More than 60% of dental spending is covered in only two EU countries (Germany and France). In Cyprus, Greece, Romania and Spain, the level of compulsory coverage is very low. Voluntary health insurance may play an important role in providing financial protection when dental care is not comprehensively covered in the benefit package – this is the case for adults in the Netherlands, for example.

Coverage for pharmaceuticals is also typically less comprehensive than for inpatient and outpatient care. Across the EU, around 59% of pharmaceutical costs are financed by government or compulsory insurance schemes. The most generous coverage can be found in Cyprus, Germany, France and Ireland (above 80%). On the other hand, this share is less than 40% in Bulgaria and Poland.

Finally, therapeutic appliances such as glasses and other eye products, hearing aids and other medical devices are typically covered to a lesser extent than other health care goods and services, except for dental care. Government and compulsory insurance schemes cover more than 50% of these expenses in only four EU countries.

Population coverage for a core set of services, 2020 (or nearest year)



Note: Data include public coverage and primary voluntary health insurance coverage.

Source: OECD Health Statistics 2022; European Observatory Health Systems in Transition (HiT)

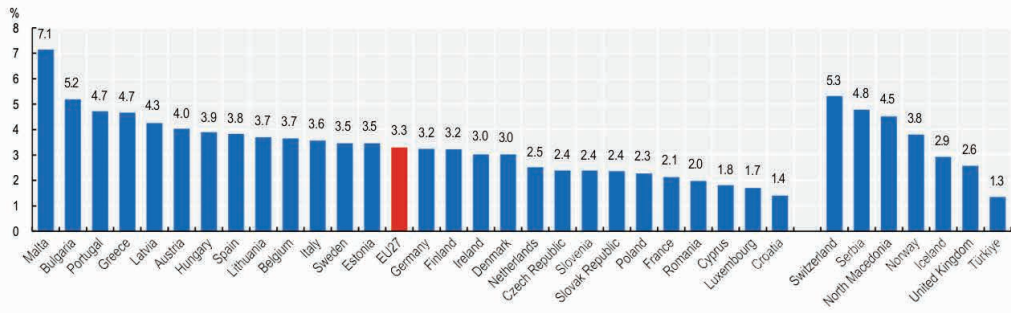
Series for non-OECD countries.

FINANCIAL HARDSHIP AND OUT-OF-POCKET EXPENDITURE

On average across the EU, around 15% of all spending on health care comes directly from patients through out-of-pocket (OOP) payments. People experience financial hardship when the burden of OOP payments is large in relation to their ability to pay. Poorer households and those who must pay for long-term treatment are particularly vulnerable.

The share of household consumption spent on health care provides an aggregate assessment of the financial burden of OOP expenditure. In 2020, around 3% of total household spending was on health care goods and services across the EU, ranging from less than 2% in Croatia, Luxembourg and Cyprus to more than 7% in Malta (Figure 7.7).

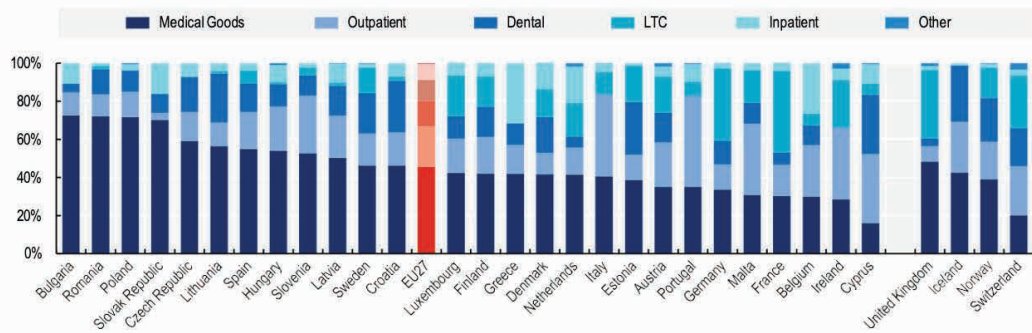
Health systems in EU countries differ in the degree of coverage for different health goods and services. Pharmaceuticals and other medical goods made up the main OOP expense for people in 2020, followed by spending on outpatient care (Figure 7.8). These two components typically account for two-thirds of household spending on health care.



Note: The EU average is unweighted.
Source: OECD Health Statistics 2022, OECD National Accounts database.

Stat Link <https://stat.link/4g9vhd>

FIGURE 7.7. — Out-of-pocket spending on health as share of final household consumption, 2020 (or nearest year)



Note: The EU average is unweighted. "Medical Goods" include retail pharmaceuticals and therapeutic appliances.
Source: OECD Health Statistics 2022.

StatLink <https://stat.link/t3bc7f>

FIGURE 7.8. — Out-of-pocket spending on health as share of final household consumption, 2020 (or nearest year)

ANNEX II

PRIVATIZATION OF HOSPITALS

Lukas Stärker

FEMS DEPUTY SECRETARY GENERAL, AUSTRIA

CONTENT

- I. Privatization Trend
- II. Needs Based Supply
- III. Financial Aspects
- IV. Public-Private Partnership (PPP)
- V. Result

I.

PRIVATIZATION TREND

The increasing economization of the health care system and the increasing interest of private companies, especially in the field of inpatient health care, lead to a broad discussion about the possible effects of this privatization trend.

Rising health expenditure and the problems in the area of the financial viability of public hospitals are closely related to the considerations of optimising social services in a market economy and exploiting savings opportunities or cost-saving measures.

Ideally, there should always be an effective and efficient use of resources with the greatest possible quality in both private and public institutions, regardless of the form of organization.

First of all, in the case of private ownership, a distinction must be made according to whether the owner is also a private person or a private company or whether the public authorities or the State merely use the organisational form of private company law in order to fulfil its tasks and thus remain the owner of this institution. In the first case, privatization really exists, in the second case, the state continues to decide.

II.

NEEDS BASED SUPPLY

The goal of a social health care system must be to ensure needs-based care for patients without undercare, over- or incorrect care through the effective and efficient use of financial resources.

In the discussion about the privatization of health services, various aspects in the relationship between medicine and economics have to be weighed:

- profit orientation vs. solidarity
- dependence on owner interests vs. best possible patient care
- budget scarcity vs. limitation of the scope of services from an economic point of view

Furthermore, the two areas of the private sector and the public sector can also learn from each other and thus benefit from each other: it would be desirable if the motivation and innovative power of the private sector would radiate into the public service, as well as the private sector can benefit from the solidarity idea of a social system financed by the general public.

In both sectors, clear and reliable framework conditions that enable longer-term strategies and further developments are indispensable.

III.

FINANCIAL ASPECTS

Usually, the basic care of the population, very cost-intensive treatments and the treatment of chronic diseases are taken over by public hospitals and thus paid for by the general public, while private providers increasingly focus on standardizable and lucrative treatments. The privatisation of uncomplicated treatment or lighter cases with lower risk and thus also financial advantages must be compensated for by appropriate financing regulations.

Above all, what is needed here is a financing system that conditions in the right direction and counteracts "cherry-picking", whereby it is undisputed that the achievement of a profit is an intrinsic sense of private entrepreneurship.

In this context, the responsibility for complications and the financial responsibility for possible consequences or follow-up treatments must also be clearly regulated.

In any case, savings opportunities must benefit the entire system and not just a part of it.

IV.

PUBLIC-PRIVATE PARTNERSHIP (PPP)

Public-private partnership generally refers to cooperation between the public sector and private companies with the aim of the long-term performance of public tasks through private structures.

Typical for the field of PPP is the outsourcing of secondary services (e.g. cleaning, catering), whereby primary services (e.g. laboratory, image diagnostics) can now increasingly be outsourced within the framework of PPPs. This includes, for example, the takeover of Management by private companies. Ideally, both sides benefit from the transfer of know-how in this way.

Staff is usually the largest budget item in a hospital. Private providers therefore often try to act more economically efficiently by saving personnel costs, for example through better organization. This is sensible and permissible as long as savings are not made at the expense of personnel.

It is in the public interest to maintain the publicly accessible system of social health insurance and to ensure the permeability of medical structures for all patients, provided that the right treatment methods are followed.

V.

RESULT

Privatization expands the offer, but must not only serve to maximize profits for a few in the health care system, but must also be embedded in the system of social health insurance or hospital insurance in such a way that the solidarity community or the general public also benefits.

It is important to find the middle way that treatments are always started and completed in the same hospital.

Possible cherry-picking in the form of patient transfers should be prevented by an equalising financing system for the benefit of patients.

In any case, private hospital operators must also participate in the further development of the medical profession.

Special attention must be paid to employee satisfaction, employee resources and the prevention of excessive workload, not least because of the shortage of manpower.

CHAPTER VI

SALARIES AND OTHER INCOME*

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I. Salaries

INTRODUCTION

The remuneration of doctors plays a crucial role in the appeal of the medical profession, influencing career decisions and migration patterns among physicians. This analysis focuses on comparing the salaries of doctors across various European countries, providing a comprehensive look at the public sector compensation for doctors with different levels of experience: doctors in training, specialists with 0-10 years of experience, specialists with 10-25 years of experience, and for senior doctors with over 25 years of experience.

We utilize data provided by national trade unions and medical associations from 21 countries, representing doctors, specifically examining their pay in the public sector. Our analysis considers three key measures of remuneration: gross salary, net salary, and purchasing power parity (PPP) adjusted salary. These measures offer a detailed understanding of the financial realities faced by doctors in different countries.

Gross salary represents the total earnings before any deductions, providing a straightforward comparison of nominal pay. Net salary, which accounts for taxes and other deductions, offers insight into the actual take-home pay that doctors receive. The PPP-adjusted salary adjusts for the cost of living in each country, allowing us to evaluate the real purchasing power of doctors' incomes.

Taxation and deductions play a significant role in determining the net salary of doctors, varying widely across countries, and impacting the attractiveness of the profession. High taxes can significantly reduce take-home pay, even if gross salaries are substantial. Conversely, lower taxes can enhance net income, making a country more attractive to medical professionals. Cost of living is another critical factor that affects the real value of doctors' salaries. High living costs can erode the purchasing power of nominally high salaries, while lower living costs can make even modest salaries go further. By considering PPP-adjusted salaries, we can provide a more accurate picture of how well doctors are compensated in real terms.

This analysis aims to highlight the disparities in doctor remuneration across Europe, considering the effects of taxation, deductions, and living costs. Understanding these factors is essential for policymakers, medical professionals, and stakeholders who seek to address issues related to physician compensation, career choices. Differences in remuneration levels of doctors across countries can also act as a “push” or “pull” migration trends within the healthcare sector.

DOCTORS IN TRAINING

Germany and Sweden lead in gross salaries

Germany and Sweden stand out as the top-paying systems for doctors in training, offering the highest gross salaries among the surveyed European countries. Germany leads (with a gross salary of €5,507), followed closely by Sweden (with €4,589), indicating robust compensation packages for medical trainees in these countries. Highlight the significance of these high gross salaries in attracting and retaining talent, contributing to the overall competitiveness of the healthcare systems in Germany and Sweden. Countries such as Albania (€1,244), Bulgaria (€1,400), and Poland (€1,400) have the lowest gross salaries, significantly below those of Germany and Sweden, underscoring the wide range of compensation across European healthcare systems.

Germany and Sweden are still the best paying system for doctors in training after taxes

Sweden and Germany show high net salaries relative to their gross figures, indicating favourable taxation or deduction systems for doctors in training. Germany's net salary is €3,194 and Sweden's is €3,212, which are among the highest net salaries. The significant difference between gross and net salaries in the Netherlands and Belgium suggests higher deductions compared to other countries in this category. Countries like Albania (€980), Bulgaria (€1,260), Poland (€1,050), Spain (€1,202), and Greece (€1,250) face challenges with lower net salaries, further impacting disposable income and overall job satisfaction.

Romania, Bulgaria, and Poland join the better paying systems when considering Purchasing Parity Power

Some Eastern European systems catch up on pay when considering PPP, due to a lower cost of living allied with relatively good earnings. Romania (€3,191) shows a high PPP-adjusted salary despite a lower gross and net salary, reflecting a lower cost of living. Germany maintains the highest PPP-adjusted salary (€3,194), indicating strong purchasing power.

The variation in PPP-adjusted salaries highlights the impact of living costs on real income. Some countries with lower gross and net salaries can still maintain competitive PPP-adjusted salaries, making them attractive for doctors in training considering the cost of living, e.g., Bulgaria (€2,346) and Romania. Croatia also performs well, with competitive gross and net salaries and a strong PPP-adjusted salary (€3,089).

Spain faces significant hurdles with one of the lowest gross and net salaries among surveyed European countries. In addition, the situation is compounded by unfavourable PPP adjustments (€1,442), further diminishing the real purchasing power of doctors in training.

Clear regional contrast between Western/Northern Europe and Eastern Europe

When looking at regional tendencies, Western and Northern Europe lead with the highest gross and net salaries. Germany and Sweden, for example, offer high gross and net salaries, maintaining strong purchasing power. In contrast, Eastern Europe shows lower nominal salaries but competitive PPP-adjusted salaries in countries like Romania (€3,191) and Bulgaria (€2,346), indicating a lower cost of living. Romania has the second highest PPP-adjusted salary for training doctors, just below Germany. Southern Europe exhibits moderate gross and net salaries with varied PPP adjustments.

Key takeaways

- Germany offers the highest gross salary for doctors in training, with strong net and PPP-adjusted salaries, indicating favourable living and working conditions.
- Sweden and Finland provide competitive gross and net salaries, with good PPP-adjusted figures.
- Croatia also stands out with competitive gross and net salaries and a strong PPP-adjusted salary.
- Romania and Bulgaria show lower nominal salaries but high PPP-adjusted salaries, indicating a favourable cost of living.
- The cost of living and taxation systems significantly influence the effective salary, making PPP-adjusted salary a crucial metric for understanding the true value of income.

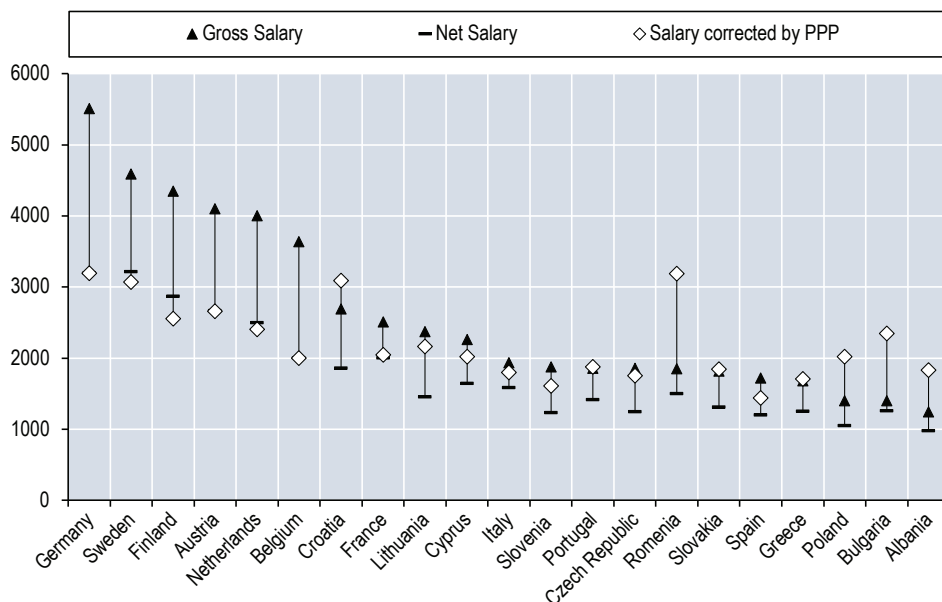


FIGURE 1 — Salary (Gross, Net, PPP-adjusted) of doctors in Training

DOCTORS 0-10 YEARS

The Netherlands is the best paying systems, both in gross and net salary

The highest gross salary is observed in the Netherlands (€10,000), followed by Belgium (€8,450) and Germany (€7,000). The highest net salary is in the Netherlands (€5,750), followed by Austria (€4,305) and France (€4,250). Moreover, it is crucial to acknowledge the disparities with countries at the lower end of the spectrum. For example, Albania (€1,555), Poland (€1,610), and the Czech Republic (€2,055) present significantly lower gross and net salaries, highlighting the wide variation in compensation across European healthcare systems.

France and Austria indicate favourable tax systems compared to other European systems

France and Austria show relatively high net salaries compared to their gross salaries, indicating more favourable tax systems for doctors compared to other Western European nations. France has a gross salary of €5,000 and a net salary of €4,250, while Austria has a gross salary of €6,150 and a net salary of €4,305. The significant difference between gross and net salaries in the Netherlands, where the gross salary is €10,000 and the net salary is €5,750, suggests higher deductions or taxes compared to other countries in this category.

The Netherlands, France, and Austria have the highest PPP-adjusted salaries

The Netherlands (€5,540) has the highest PPP-adjusted salary, followed by France (€4,345) and Austria (€4,292). Bulgaria (€4,277) and Germany (€4,060) also show strong PPP-adjusted salaries. The variation in PPP-adjusted salaries highlights the impact of living costs on the real value of incomes. For example, Bulgaria's PPP-adjusted salary is high despite a lower gross salary. Countries with lower gross and net salaries can still maintain competitive PPP-adjusted salaries, making them attractive when considering the cost of living (e.g., Romania, Lithuania).

Western European systems are the best-paying ones

Western Europe (the Netherlands, Germany, and Austria) leads in terms of both gross and net salaries. France also performs well in terms of PPP-adjusted salary. Northern and Eastern Europe show sharp contrasts. While Sweden and Finland offer competitive salaries, their PPP-adjusted figures are slightly lower compared to their gross figures. Eastern systems are characterized by lower nominal salaries but show high PPP-adjusted salaries, indicating a favourable cost of living (e.g., Bulgaria, Lithuania, Romania).

In Southern Europe, moderate gross and net salaries with varying PPP adjustments reflect differences in the cost of living (e.g., Italy, Spain, Portugal). Italy and Spain fall in the middle of the salary rankings when considering PPP-adjusted salaries.

Key takeaways

- The Netherlands continues to offer the highest gross salary for junior doctors, with competitive net and PPP-adjusted salaries.
- France and Austria show strong PPP-adjusted salaries, making them attractive despite not having the highest gross salaries.
- Eastern European countries like Bulgaria and Romania offer lower nominal salaries but competitive PPP-adjusted salaries due to lower living costs.
- Cost of living and taxation significantly influence the effective salary, making PPP-adjusted salary an essential metric for understanding the true value of income.

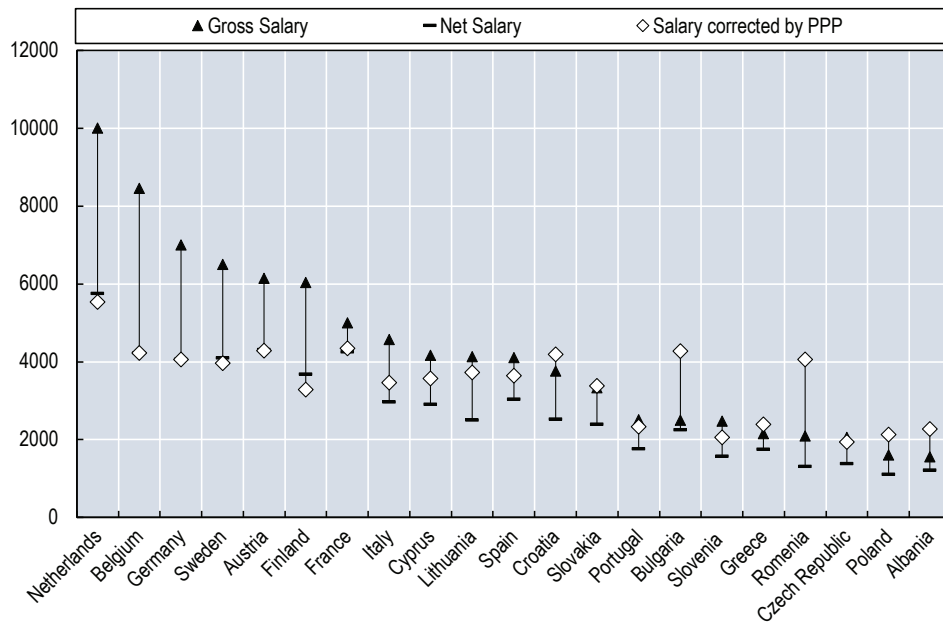


FIGURE 2 — Salary (Gross, Net, PPP-adjusted) of doctors with 0-10 years of experience

DOCTORS 10-25 YEARS

The Netherlands is the best paying system, both in gross and net salary

Similarly to the previous category, the Netherlands maintains its position as the top-paying system for doctors with 10-25 years of experience, boasting the highest gross salary at €12,500 and a corresponding high net salary of €7,000. Austria follows closely, offering competitive gross salaries of €8,200 and net salaries of €5,740, reflecting stable and attractive working conditions for experienced medical professionals. Belgium also stands out with a gross salary of €11,100 and a net salary of €5,550. However, it's essential to recognize the disparities with countries at the lower end of the spectrum. Countries such as Albania (gross: €1,593, net: €1,244), Poland (gross: €1,800, net: €1,240), and Romania (gross: €2,341, net: €1,460) present significantly lower gross and net salaries, highlighting the wide variation in compensation across European healthcare systems.

Belgium and Finland show penalizing tax systems

Belgium and Finland exhibit significant deductions leading to lower net salaries from their gross figures, reflecting penalizing tax systems for doctors with 10-25 years of experience. Belgium has a gross salary of €11,100 with a net salary of €5,550, resulting in a 50% decrease. Finland shows a 40% decrease from a gross salary of €6,520 to a net salary of €3,910. This disparity emphasizes the challenges faced by experienced medical professionals in these countries, where high tax burdens may impact overall income and job satisfaction.

Sweden and Germany also show substantial differences between their gross and net salaries, with decreases of 37% and 38%, respectively, indicating similarly high tax burdens. In contrast, France continues to show a high net salary relative to its gross, with a gross salary of €6,250 and a net salary of €5,312, indicating a favourable tax system for doctors compared to other Western European nations, thereby contributing to greater financial stability and professional well-being.

PPP adjusted salaries are the highest in the Netherlands, Austria, France, and Bulgaria

The highest PPP-adjusted salary is in the Netherlands (€6,692), reflecting strong purchasing power. Austria (€5,722) and France (€5,476) also have high PPP-adjusted salaries. Bulgaria shows a relatively high PPP-adjusted salary (€5,133) despite lower gross and net salaries.

Countries like Bulgaria and Croatia demonstrate resilience in providing competitive salaries for doctors with 10-25 years of experience, despite lower nominal figures. The variation in PPP-adjusted salaries underscores the impact of living costs on the real value of incomes. Bulgaria's and Croatia's high PPP-adjusted salaries reflect a lower cost of living, making them competitive in terms of real income even with lower gross and net salaries.

Regional salary dynamics showcase sharp contrasts across regions in Europe

In examining the regional trends of salaries for medical professionals across Europe, distinct patterns emerge, reflecting the diverse economic landscapes and policy frameworks shaping compensation packages.

In Western Europe, countries such as the Netherlands, Austria, and Germany stand out for offering the highest gross and net salaries, making them attractive for experienced medical professionals. Belgium also offers a high gross salary but has significant deductions leading to

lower net salaries. France distinguishes itself with a high PPP-adjusted salary, indicating strong purchasing power despite not having the highest gross figures. Northern Europe portrays a similar narrative with high salaries, albeit slightly lower in effective salary rankings due to PPP adjustments, exemplified by countries like Sweden and Finland.

Southeast and Eastern European countries generally have lower salaries overall. However, Bulgaria and Croatia demonstrate resilience by offering competitive PPP-adjusted salaries, reflecting a lower cost of living and making them competitive in terms of real income. Southern Europe exhibits moderate gross and net salaries with varying PPP adjustments, indicative of differences in the cost of living across countries such as Italy, and Spain emerge as the better-paying systems after Central and Northern Europe for doctors with 10-25 years of experience, further delineating the regional dynamics of salary structures within the European healthcare landscape.

Key takeaways

- Western European countries, particularly the Netherlands, Austria, and Germany, continue to offer the highest salaries for doctors with 10 to 25 years of experience. Belgium also offers a high gross salary, though significant deductions result in lower net salaries.
- France stands out with a high net and PPP-adjusted salary, indicating a favourable environment for doctors in terms of take-home pay and purchasing power.
- Southeast and Eastern European countries generally show lower nominal salaries, but Bulgaria and Croatia offer relatively high PPP-adjusted salaries, suggesting a lower cost of living that enhances the real value of the income.
- Cost of living and taxation significantly influence the effective salary, making PPP-adjusted salary an essential metric for understanding the true value of income.

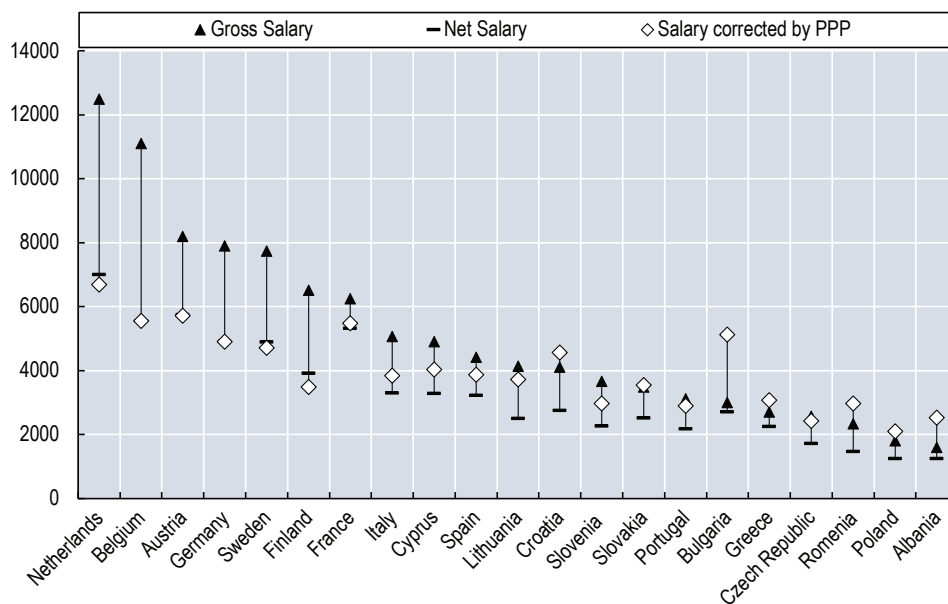


FIGURE 3 — Salary (Gross, Net, PPP-adjusted) of doctors with 10-25 years of experience

DOCTORS +25 YEARS

Western Europe Leads in Gross Salaries for Senior Doctors

Western European countries, particularly the Netherlands, Belgium, Austria, Germany, and France, offer the highest gross salaries for doctors with over 25 years of experience. The Netherlands stands out with the highest gross salary at €12,500, followed by Belgium (€11,100), Austria (€9,225), Germany (€9,167), and France (€8,917). This trend highlights the significant financial investment these countries make in their senior medical professionals.

High Net Salaries Reflect Favourable Tax Conditions in France

Despite having slightly lower gross salaries compared to the Netherlands, France offers the highest net salary (€7,579) for senior doctors, suggesting a more favourable tax environment or fewer deductions. This is followed by the Netherlands (€7,000) and Austria (€6,457). The difference between gross and net salaries in these countries indicates the impact of tax policies on doctors' take-home pay.

Bulgaria and Croatia Show Competitive PPP-Adjusted Salaries

Countries like Bulgaria and Croatia, while offering lower gross and net salaries, present competitive PPP-adjusted salaries (€5,988 for Bulgaria and €4,566 for Croatia). This suggests that the cost of living in these countries significantly boosts the real value of doctors' incomes, making them more attractive financially when adjusted for purchasing power. To a lesser extent Romania also benefits from a favourable cost of living.

Cost of Living Significantly Impacts Salary Adjustments

The data on PPP-adjusted salaries highlights the importance of considering cost of living. For example, although Finland offers a relatively high gross salary (€6,830), the PPP-adjusted salary drops by approximately 46%, indicating a higher cost of living. In contrast, Bulgaria's PPP-adjusted salary is around 71% higher than its gross salary, reflecting significantly lower living costs. This variation is crucial for understanding the real value of salaries across different regions.

Discrepancies between gross and net Salaries Across Europe

There is a noticeable discrepancy between gross and net salaries across different countries. For instance, in Belgium, the gross salary of €11,100 reduces significantly by 50% to a net salary. Similarly, in the Netherlands, the gross salary of €12,500 reduces by 44%, and in Finland, the gross salary of €6,830 reduces by 40%, indicating substantial deductions. In contrast, countries like Bulgaria and France have smaller gaps between gross and net salaries, suggesting lower tax burdens or deductions. Bulgaria's gross salary of €3,500 reduces by only 10%, and France's gross salary of €8,917 reduces by 15%. Understanding these discrepancies is vital for a comprehensive view of doctors' actual earnings.

Key takeaways

- Western European countries like the Netherlands, Austria, Germany, and Belgium offer the highest gross and net salaries for senior doctors.
- France stands out with the highest net and PPP-adjusted salaries, making it highly attractive despite not having the highest gross salary.
- Countries like Bulgaria and Croatia, despite having lower nominal salaries, offer competitive PPP-adjusted salaries due to favourable cost-of-living adjustments.
- Cost of living and tax systems significantly influence the effective salary, making PPP-adjusted salary a crucial metric for understanding the real value of income.



FIGURE 4 — Salary (Gross, Net, PPP-adjusted) of doctors with over 25 years of experience

CAREER TIMELINE SALARY ANALYSIS

Building upon our detailed examination of doctor salaries across various European countries, we now shift our focus to a comparative analysis of pay progression over the course of a medical career. This exercise aims to evaluate which healthcare systems offer the most competitive compensation to doctors as they advance from training through different stages of experience. By utilizing purchasing power parity (PPP)-adjusted salaries, we gain a more accurate understanding of the real value of doctor remuneration in each country, accounting for differences in living costs. By comparing the PPP-adjusted salaries across these categories, we can identify which countries consistently support their medical professionals with competitive pay and which countries fall behind as doctors gain experience.

Examining the compensation of doctors throughout their careers is crucial for several reasons. First, it provides insight into the long-term financial incentives available to medical professionals in different countries, influencing career decisions and satisfaction. Second, it highlights potential “push” or “pull” factors that contribute to the migration of doctors, affecting the distribution of medical expertise across Europe. Lastly, understanding salary progression helps policymakers and healthcare administrators identify areas for improvement in their remuneration structures to retain and attract skilled doctors.

This analysis not only underscores the importance of competitive and fair compensation throughout a doctor’s career but also sheds light on the broader implications for healthcare systems in terms of workforce stability, quality of care, and international competitiveness. By focusing on PPP-adjusted salaries, we ensure that our comparisons reflect the true economic value of doctor remuneration, providing a comprehensive overview of which European countries offer the most supportive environments for medical professionals over the span of their careers.

There are significant changes to doctor’s earning early on in their career

Analysing PPP-adjusted salaries for doctors in training reveals that Germany, Croatia, and Romania provide the most attractive compensation packages for early-career doctors. This suggests a strong initial investment in medical professionals, potentially making these countries more attractive to new graduates. The transition from training to the 0-10 years’ experience category marks the most significant changes in salary rankings, indicating significant shifts as doctors gain initial experience. This phase is crucial as it sets the foundation for a doctor’s career. For instance, countries like the Netherlands and France show significant improvement in their ranking, reflecting their ability to retain newly trained doctors by offering competitive salaries as they gain initial experience.

France and the Netherlands are leaders across all career stages

France and the Netherlands stand out as consistent leaders in PPP-adjusted salaries across most career stages, beginning after the training period. Their robust compensation policies not only attract doctors initially but also maintain financial stability throughout their careers. This consistency underscores their commitment to valuing medical professionals, which likely contributes to higher retention rates and job satisfaction. For instance, France’s progressive salary increases and the Netherlands’ strong economic support for healthcare professionals

ensure that doctors feel valued and motivated throughout their careers. This long-term approach to compensation highlights these countries as exemplary models for sustaining a competitive edge in the global healthcare market.

Mediterranean systems reward more experienced professionals

Italy and Spain demonstrate significant improvements in their rankings as doctors gain more experience, reflecting a structured and strategic approach to compensation. Initially, these countries may not offer the highest salaries to doctors in training, but their commitment to increasing pay with seniority shows a clear path to financial growth. This approach can be particularly appealing to doctors looking for long-term career growth and stability. As doctors in these countries move from early to mid and late career stages, the increasing salaries not only reward experience but also ensure that doctors have a strong incentive to remain in the profession and within the country. This trend highlights the growing competitiveness of Mediterranean healthcare systems in rewarding experienced professionals and suggests a focus on retaining skilled doctors over the long haul.

Finland and Sweden's attractiveness erodes in the long run

Finland and Sweden start with relatively high PPP-adjusted salaries for doctors in training and early-career stages. However, their rankings decline as doctors gain more experience. This erosion in attractiveness suggests that while these countries invest well in attracting new medical professionals, they may struggle to maintain competitive compensation for more experienced doctors. As doctors progress in their careers, the lower relative pay could lead to reduced job satisfaction and increased turnover rates. This trend highlights a potential challenge for Finland and Sweden in retaining experienced medical professionals over the long term, emphasizing the need for more competitive senior-level compensation packages to sustain their healthcare systems' competitiveness.

Economic Conditions and Policy Effectiveness Shape Doctor Compensation

The analysis highlights the significant influence of national economic conditions and healthcare policies on doctor compensation. Bulgaria, despite its lower nominal salaries, ranks high due to favourable PPP adjustments, illustrating the impact of lower living costs on perceived compensation. Conversely, countries like Romania and Finland show declines in rankings as doctors gain experience, pointing to challenges in maintaining competitive pay, potentially due to economic constraints or less effective healthcare policies. These disparities highlight the need for tailored economic and policy measures to support doctor remuneration effectively. Bulgaria's strategic use of economic conditions to enhance doctor compensation contrasts with Romania and Finland's struggles, indicating a need for policy reforms to better support healthcare professionals in these countries.

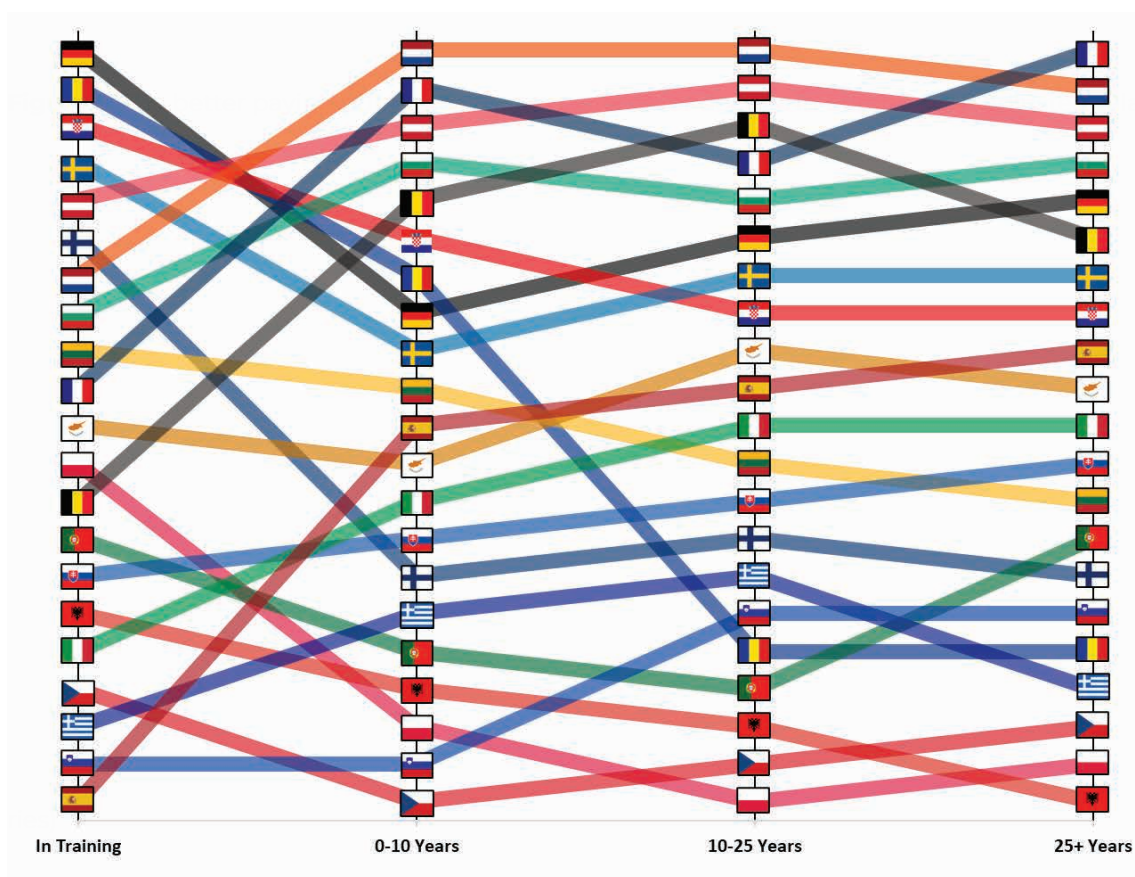


FIGURE 5 — The better paying public healthcare systems for doctors in Europe (PPP adjusted salaries)

These insights provide a nuanced understanding of the dynamic landscape of doctor salaries across different career stages in various European countries. They emphasize the critical importance of competitive and stable compensation policies, the impact of economic conditions, and the strategic approaches needed to attract, retain, and reward medical professionals throughout their careers. This analysis not only highlights best practices but also identifies areas for potential improvement, offering valuable lessons for policymakers aiming to build a robust and motivated medical workforce.

KEY TAKEAWAYS ACROSS ALL EXPERIENCE LEVELS

In examining the salaries of physicians across European countries, it becomes apparent that various regions exhibit distinct trends and patterns. While Western European nations often lead in nominal salary offerings, Eastern European countries and the Balkans present unique advantages and challenges. This section aims to clarify the overarching themes and key messages derived from the data analysis, providing valuable insights into the diverse realities shaping doctor compensation across Europe:

- The largest salary disparities are observed between doctors in training and those in their first years of practice, indicating a critical period of financial adjustment early in a doctor’s career. This is particularly evident in countries like the Netherlands and

France, which show significant improvement in salary rankings as doctors transition from training to early practice stages.

- Western European nations like the Netherlands, Germany, and Austria consistently offer top-tier gross salaries across all experience levels, reflecting their strong economic standing and investment in healthcare infrastructure. Belgium also offers high gross salaries but with significant deductions affecting net pay.
- There is considerable economic variability in Central Europe, with countries such as Slovakia and Slovenia exhibiting variability in their salary structures, with some offering competitive net and PPP-adjusted salaries despite lower gross figures.
- While Western European countries may offer higher gross salaries, some countries from Eastern Europe and the Balkans demonstrate stability and consistency in salary progression throughout different career stages.
- Eastern European and Balkans countries such as Bulgaria and Croatia emerge as attractive destinations for doctors considering real purchasing power, thanks to lower living costs despite comparatively lower nominal salaries. Bulgaria, in particular, stands out with high PPP-adjusted salaries across multiple career stage.
- Northern European countries like Sweden and Finland strike a balance between competitive salaries and living costs, making them appealing choices for medical professionals seeking stable and rewarding careers. However, their attractiveness diminishes slightly at higher experience levels, indicating a need for better compensation strategies for senior doctors.
- France stands out for its favourable combination of high net salaries and competitive PPP-adjusted incomes, particularly beneficial for doctors in training and early career stages, showcasing the efficiency of its tax system.
- Beyond the initial years, the salary landscape stabilizes, indicating a consistent compensation structure for experienced medical professionals across European countries. Countries like Italy and Spain show significant salary growth as doctors gain experience, highlighting a structured approach to rewarding long-term career growth.
- Variation in salary offerings reflects the impact of diverse economic policies, taxation systems, and healthcare funding priorities, highlighting the complex interplay of socio-economic factors in determining doctor compensation.
- When evaluating salary data across countries, adjusting for purchasing power parity (PPP) provides a more accurate reflection of real income levels and cost of living differences, facilitating meaningful cross-country comparisons. This adjustment is crucial for understanding the true value of doctor compensation in different regions.

POLICY IMPLICATIONS

The political implications of the data on doctor salaries in European countries highlight the need for targeted policy interventions to address regional disparities, retain skilled professionals, and promote cross-border cooperation. By prioritizing equitable compensation, investing in healthcare infrastructure, and fostering EU-level collaboration, policymakers can work towards building resilient and inclusive healthcare systems that meet the needs of diverse populations across Europe.

1. Stratification of Salaries Across Experience Levels

The disparity in salaries across experience levels underscores the need for targeted policies to address wage progression within the medical profession. Governments should consider implementing structured career advancement programs, performance-based incentives, and transparent salary scales to ensure equitable compensation and retain experienced medical professionals within the public healthcare system. Highlighting the critical transition period between doctors in training and those in their early career (0-10 years) is essential to ensure smooth financial progression and talent retention.

2. Regional Disparities in Compensation

The variation in salaries between countries reflects underlying differences in healthcare funding priorities and economic conditions. EU policymakers could explore mechanisms for financial solidarity among member states, such as establishing a dedicated fund to support healthcare systems in less affluent regions. Additionally, promoting cross-border mobility and exchange programs could mitigate disparities by providing opportunities for doctors from lower-income countries to work in higher-paying regions. Countries like the Netherlands and France, which consistently rank high across various experience levels, can serve as models for improving compensation structures in other regions.

3. Impact of Purchasing Power Parity (PPP) Adjustments

PPP adjustments reveal the true purchasing power of doctor salaries, highlighting discrepancies that may not be immediately apparent from gross salary figures alone. Policymakers should consider PPP-adjusted data when evaluating the adequacy of doctor salaries and designing cross-border healthcare cooperation initiatives. This approach ensures a more accurate assessment of the economic well-being of healthcare professionals across different countries. Specific examples, such as Bulgaria's and Croatia's high PPP-adjusted salaries, illustrate how PPP adjustments can highlight real income differences and should be used in policy formulation.

4. Retention Challenges in Eastern Europe

Lower salaries in Eastern European countries contribute to challenges in retaining skilled medical professionals, exacerbating healthcare workforce shortages. Governments in Eastern Europe should prioritize investment in healthcare infrastructure and human resources, including competitive salary packages, professional development opportunities, and improved working conditions. Additionally, targeted initiatives to address brain drain, such as loan forgiveness programs or career advancement incentives, can encourage doctors to remain in their home countries.

5. Scope for broader for EU-Level Collaboration:

Addressing disparities in doctor salaries requires coordinated action at the European Union level to ensure fair compensation and equitable distribution of healthcare resources. EU policymakers should facilitate dialogue between member states to harmonize salary standards, promote cross-border mobility, and establish common frameworks for healthcare workforce planning. Successful models in Western Europe can guide these efforts. By fostering collaboration and solidarity, the EU can strengthen healthcare systems across the continent and improve access to quality care for all citizens.

II. Head of Department

Is there a set salary for the head of Department / Service / Unit?

(By head of Department / Service / Unit we mean the Operative Unit dedicated to a specific specialty led by a Chair).

- **Yes** (Albania, Belgium, Bulgaria, Croatia, Czech Rep., Finland, France, Greece, Italy, Lithuania, Poland, Portugal, Romania, Slovenia, Spain) – mostly as an add-on. Germany – individual negotiation
- **No** (Austria – but also depends on individual negotiation, Cyprus, Netherlands)
- **N/A** (Sweden, Slovakia)

In most countries (84%) there is a set salary for heads of Department – mostly as an add-on to the regular salary. In Germany depends on individual negotiation but it represents a significant implement.

III. GP / Family Doctors

Is there a different pay scale for GP / Family Doctors?

- **Yes** – Albania, Austria, Bulgaria, Finland, Netherlands, Poland (per hour)
Self-employed (free practice) – France, Germany, Belgium
Per capita – Romania, Italy, Czech Rep.
Others:
Spain (only one category)
Portugal – Yes, if they work in Family Health Units
- **No** – Cyprus, Croatia, Greece, Slovenia, Lithuania (but depends on number of patients and results)
- **N/A** – Sweden, Slovakia

The GP / Family doctors' salaries are quite different between countries depending how the healthcare system is organized.

IV. Overtime (extra hours)

a) How is overtime (extra hours) paid when the doctor is in the workplace (e.g. Emergency Department).

Albania	49 to 56 euros (Monday to Friday); 53 to 56 (Saturdays); 62 to 75 (Sundays, holidays)
Austria	There is a supplement
Belgium	Overtime is paid. There is no fixed scale. Each hospital or network has its own pay scale
Bulgaria	1,5 to 2 times the normal hourly wage
Cyprus	600 € / 24h (South); 1,1 times the normal hourly wage (north)
Croatia	50% more than regular hour and in addition: Saturday more 25%, Sunday more 50%, on public holiday, Christmas, Easter 150% more, night hours 25% more
Czech Rep.	As an add-on (night shifts)
Finland	1,5 times the normal hourly wage or increased free time
France	320€/period of 2 half-days (10h) of overtime
Germany	Normal hourly wage plus a supplement
Greece	10-12 euros per hour including weekdays, 11-13 euros per hour including holidays
Italy	Hour credit (when weekly schedule is exceeded, 100-120€ holiday and night shifts), 27,64€/h (daily), 31,12€/h (evening and holidays) 35,75€/h (night)
Lithuania	1,5 times the 100% the normal hourly wage
Netherlands	By allowance
Poland	1,5 times the normal hourly wage / hour on daytime; 2 times at night
Portugal	1,5 times (Monday to Friday daytime) 2 times at night, 2,5 times weekends
Romania	Same as the other days (double for Saturdays, Sundays and feast)
Slovakia	N/A
Slovenia	30% add-on
Spain	24,70€/h
Sweden	Simple overtime – 180%. Qualified overtime 240%. Overtime can be compensated in time off instead of money

Overtime in the workplace (e.g. Emergency Department) is usually paid above the normal hourly wage but varies significantly from country to country, whether night shifts, Saturdays, Sundays or public holidays.

**b) How is overtime (extra hours) paid when the doctor is on call
(in the Hospital / Health Unit).**

Albania	6 to 10 euros for medical act
Austria	There is a supplement
Belgium	Overtime is paid. There is no fixed scale. Each hospital or network has its own pay scale
Bulgaria	1,5 to 2 times the normal hourly wage
Cyprus	600 € / 24h (South); N/A (North)
Croatia	50% more than normal hourly wage and in addition: Saturday more 25%, Sunday more 50%, on public holiday, Christmas, Easter 150% more, night hours 25% more
Czech Rep.	As an add-on (night shifts)
Finland	1,75 to 3 times depending on the different hours of the day
France	268€/night or period of 2 half-days (10h) of overtime
Germany	Hourly rate corresponding to salary group
Greece	10-12 euros per hour including weekdays, 11-13 euros per hour including holidays
Italy	Hour credit (when weekly schedule is exceeded, 100-120€ holiday and night shifts) 27,64€/h (daily), 31,12€/h (evening and holidays) 35,75€/h (night)
Lithuania	1,5 times the normal hourly wage
Netherlands	By allowance
Poland	1,5 times the normal price / hour on daytime; 2 times at night
Portugal	1,5 times (Monday to Friday daytime) 2 times at night, 2,5 times weekends
Romania	Same as the other days (double for Saturdays, Sundays and feast)
Slovakia	N/A
Slovenia	30% add-on
Spain	24,70€/h
Sweden	1,25 to 1,5 times the normal hourly wage

Overtime on call (in the Hospital / Health Unit) is usually paid above the normal hourly wage but varies significantly from country to country, whether night shifts, Saturdays, Sundays or public holidays and in most countries is paid in a similar way as if doctors were in the workplace.

c) How is overtime (extra hours) paid when the doctor is on standby call (e.g. at home).

Albania	N/A
Austria	There is a supplement but less paid than the previous ones
Belgium	Overtime is paid. There is no fixed scale. Each hospital or network has its own pay scale
Bulgaria	Additional 0,25€. Official holidays or weekends - 0,50€ / hour
Cyprus	300€/24h (south); 0,15 times the normal hourly wage as an add-on (north)
Croatia	Stand by on working days (Monday to Friday) is paid 4% of basic salary. (about 70-80 € net - depending on length of service and allowances for difficult working conditions) Stand by during the weekend (Saturday, Sunday) and holidays is paid 7% of basic salary. (about 120-130 € - depending on length of service and allowances for difficult working conditions). If a doctor must come to the hospital and work (e.g. if a surgeon at stand by at home must come to the hospital to perform a surgery), hours during working in the hospital are paid as overtime/extra hours, additionally to the previously mentioned standby fee of 4 or 7%.
Czech Rep.	25% of IV.a)
Finland	19 to 35% of normal hourly wage
France	43,00€/period of 2 half-days (10h) is granted
Germany	The doctor receives a daily sum for being available plus a time supplement
Greece	4.0-5.0 euros per hour
Italy	20,66€ and if called paid as overtime or hourly credit
Lithuania	20% of average salary for every week
Netherlands	By allowance
Poland	Quarter hourly wage
Portugal	Half of the price for extra hour
Romania	40% of the value of normal guard
Slovakia	N/A
Slovenia	20% of the normal hourly wage
Spain	5,18€/h Monday to Friday, Saturday, Sunday and non-working days 5,77€/h
Sweden	Compensation is issued with 0,22 of the time during which the doctor does not work

Overtime on standby call (e.g. at home) is usually paid above the normal hourly wage but varies significantly from country to country.

d) Is there any upper limit to the number of extra hours a doctor can do (weekly, monthly or yearly)?

Albania	Max 48 hours / week of total work
Austria	Since July 2021 48 hours / week of total work
Belgium	N/A
Bulgaria	150 hours / year
Cyprus	48h/week (south); Yes, monthly (north)
Croatia	180 hours / year but, in reality, due to the shortage of doctors in Croatia, most of them reach 180 overtime hours already by May, so the rest of the year actually work against the law.
Czech Rep.	150 h/ year. 416 with doctors' agreement
Finland	Max 48 hours / week of total work
France	No
Germany	Max 56 hours / week of total work
Greece	48 hours per week, 60 hours per week maximum with doctor's consent, but not met due to understaffing
Italy	250 hours / year
Lithuania	180 hours / year
Netherlands	Max 52-55 hours / week of total work
Poland	10 hours / week, could be up to 38 hours / week if he signs the opt-out clause
Portugal	150 hours / year (mandatory), more if the doctors agree
Romania	Max hours per week 48 (with or without extra hours)
Slovakia	N/A
Slovenia	230 hours/year.
Spain	Max hours per week 48 (with or without extra hours), in a semester calculation
Sweden	150 hours / year

The limit for working overtime does not follow a defined standard: there are countries that establish this limit annually (mostly 150 hours), others establish a weekly limit (48 hours of total working hours including overtime).

V. Private Practice

Is it possible for doctors working in the public sector to also practice private medicine?

Albania	Yes
Austria	Yes, provided that the applicable service law does not exclude it or foresees authorization requirements
Belgium	Salaried hospital doctors are generally authorized to practice outside the hospital for one or two half-days a week
Bulgaria	Yes
Cyprus	No (south); Yes (north)
Croatia	Yes, with permission from the director of the public institution/hospital
Czech Rep.	Yes
Finland	Yes, but needs permission from the public sector employer
France	Yes
Germany	Yes, but depends on the working contract
Greece	Yes, it was recently legislated, but not yet implemented.
Italy	Yes
Lithuania	Yes
Netherlands	Yes
Poland	Yes
Portugal	Yes
Romania	Yes
Slovakia	N/A
Slovenia	Yes, with the consent of the general manager of the public health care institute.
Spain	Yes, if they request compatibility
Sweden	Yes, but the secondary job must not be competing, damaging to trust or interfere with doctors' tasks in public sector

The possibility of working in the public sector and practicing in the private one is allowed in almost all countries, although in some it is necessary to request authorization from the public institutions where doctors work.

* All data was provided by Doctors' Trade Unions or Medical Associations from 21 countries.

The average salary data for Cyprus took into account the salary differences between the north and south parts of the country and the proportion of doctors in each region.

CHAPTER VII

EUROPEAN DOCTORS AND JOB SATISFACTION

Alessandra Spedicato
ANAAO ASSOMED - ITALY

INTRODUCTION

Doctors' job satisfaction is important to the public health service to ensure commitment, effective training and education, service provision and retention. A good satisfaction at work influences the possibility of suffering from burnout or psychosocial risks. Furthermore, job satisfaction matters to doctors for their personal happiness, fulfilment, patient dedication and duty to employers; if doctors do not achieve a level of satisfaction with their work, that is appropriate for their level of commitment, the health service may risk of losing their valuable expertise to other countries or other careers, particularly in the private sector.

This survey, carried out by FEMS, is the first of its kind on a European level. Its purpose goes way beyond the award of "best workplace", but it is a mean to understand how doctors feel about their work, their social role and professional experience. Those elements must be considered on a policy level to mitigate any shortcomings and, on a union level, to implement organisational solutions.

As an [annex](#), you can find a Dutch survey, carried out in the same period, about similar topics and questions. It offers a picture that complements data collected so far.

The survey was commissioned in spring 2020 and concluded in spring 2021, with data collection taking place in autumn/winter 2021.

The aim: to survey doctors' job satisfaction in Europe. For this, **four topics** were identified:

- **Financial satisfaction.**
- **Professional satisfaction** (*i.e. recognition within the hospital of individual professionalism, how much the individual is allowed to develop and recognition of the social role of the profession*).
- **Satisfaction with well-being in the workplace** (*i.e. work/life balance*).
- **Satisfaction with access to career opportunities** (*i.e. job mobility, and therefore how easy it is to change jobs, to resign and switch from being a salaried doctor to private practice, or to change hospitals*).

As healthcare systems are organised differently, it was necessary to find a common format for the questions in order to make them easier to respond to. For the same reason, the questions were written and designed to be as simple as possible.

We have received responses from:

- Austria (which processed the data on its own account and did not answer question 4)
- Croatia
- France
- Germany
- Italy
- Portugal
- Romania (11 doctors, so not a particularly representative sample, but one nevertheless included in the survey)
- Slovenia
- Slovakia
- Spain
- Sweden
- Northern Cyprus
- Czech Republic (1 doctor, so an unrepresentative sample, and therefore not included in the survey).

TOTAL RESPONSES

In total, 13,461 doctors responded to the survey, of which 7,447 were women and 6,014 were men. Interestingly, most respondents in all countries were women, except Germany (where the majority was 86% male, with 180 men and 30 women), Italy (very slight majority with 1,642 men and 1,640 women) and Romania (small majority with 6 men and 5 women).

AGE GROUPS

Respondents were divided into four age groups:

- 25-35 years old
- 36-49 years old
- 50-60 years old
- Over 60 years old

The main age group to take part in the survey was the 36-49 age group (75% in 9 of the 12 countries). Here too, the main exceptions were Germany and Romania (prevalent age group 50-60 years old) and Slovakia, where most respondents were 25-35 years old.

PARTICIPATION

Participation rate:

1. Italy with 3,282 responses (1,642 men and 1,640 women).
2. Slovakia with 2,066 responses (850 men and 1,216 women).
3. Croatia with 1,940 responses (659 men and 1,281 women).
4. Austria with 1,623 responses (779 men and 844 women).
5. Sweden with 1,335 responses (666 men and 669 women).
6. Spain with 1,059 responses (506 men and 553 women).
7. Portugal with 697 responses (240 men and 457 women).
8. France with 587 responses (257 men and 330 women).
9. Slovenia with 571 responses (190 men and 381 women).
10. Germany with 210 responses (180 men and 30 women).
11. Northern Cyprus with 79 responses (39 men and 40 women).
12. Romania with 11 responses (6 men and 5 women).

TOPICS

A total of 24 questions were asked. Of these, three were multiple choice, and the remainder required a single answer. There were also three questions on the Covid-19 emergency (the survey was launched during the first phase of the pandemic, in spring 2020) and a more general one on possible future public health emergencies.

The first three questions were on the country of origin, gender and age of the participants.

The remaining questions (18) focused on various aspects.

Quality of the profession and facilities: If you had to describe the medical profession today, which adjectives would you use? (multiple choice question with a list of adjectives).

How do you rate the quality of the services provided by healthcare facilities in your country, hospitals in your country, hospitals in your region and outpatient services in your country?

Professional development and career opportunities.

Financial aspects (how you view your pay).

Evaluation of your work as a salaried doctor and degree of satisfaction with certain issues (distribution of workload, job prospects, career prospects, organisation of work, part-time opportunities, training and continuing education, relations with management and patients).

Possibility of balancing work and private life.

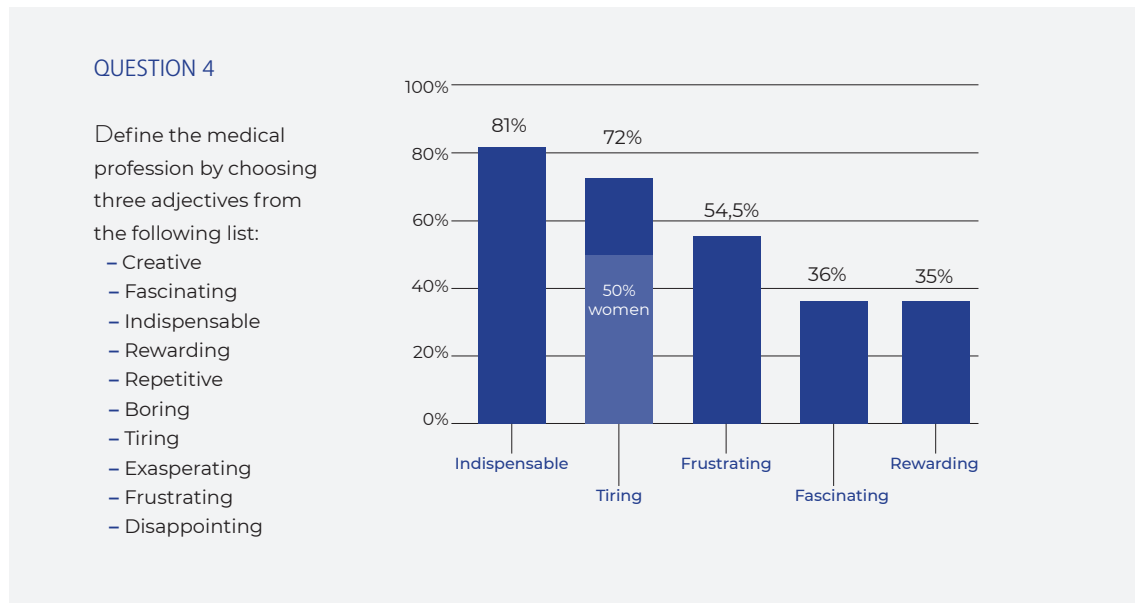
Relations with work colleagues.

DATA ANALYSIS

QUESTION 4 M

If you had to describe the medical profession today using three adjectives, which of the following would you choose: creative, fascinating, indispensable, rewarding, repetitive, boring, tiring, exasperating, frustrating, disappointing?

- **For 81% of doctors, the profession is indispensable**, and it is often the youngest who think of it as such
- **For 72%, it is tiring** (and here there is no gender distinction, with 50% of women choosing this adjective)
- **For 54%, it is frustrating**
- Other adjectives chosen were fascinating (36%) and rewarding (35%)



QUESTION 5.1

In general, how do you rate the quality of services provided by the national healthcare facilities in your country?

- Not very satisfactory 50% (among these, 33% are women)
- Satisfactory 41%
- Unsatisfactory 9% (Austria)

QUESTION 5.2

In general, how do you rate the quality of services provided by hospitals in your country?

- Satisfactory 75%
- Not very satisfactory 25%

QUESTION 5.3

In general, how do you rate the quality of services provided by hospitals in your region?

- Satisfactory 84%
- Not very satisfactory 16% (Austria and Northern Cyprus)

QUESTION 5.4

In general, how do you rate the quality of services provided by outpatient services in your country?

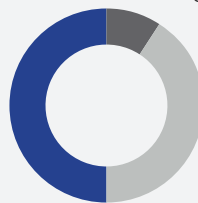
- Satisfactory 59%
- Not very satisfactory 41% (Austria, Northern Cyprus, Italy, Slovakia and Sweden)

QUESTION 5

How do you consider the quality of the services provided?

5.1. By healthcare facilities in your country

50%
Not very satisfactory
(33% Women)



9%
Unsatisfactory (Austria)

41%
Satisfactory

5.2. By hospitals in your country

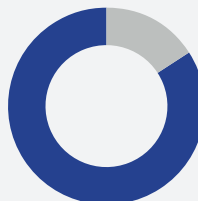
75%
Satisfactory



25%
Not very satisfactory

5.3. By hospitals in your region

84%
Satisfactory



16%
Not very satisfactory
(Austria, Northern Cyprus)

5.4. By outpatient services in your country

59%
Satisfactory

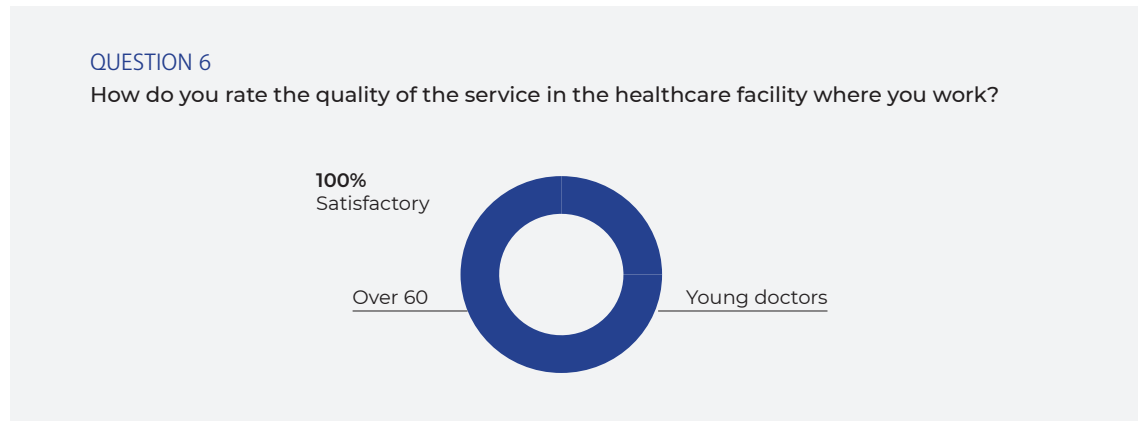


41%
Not very satisfactory
(Austria, Northern Cyprus, Italy, Slovenia, Sweden)

QUESTION 6

How do you rate the quality of the service in the healthcare facility where you work?

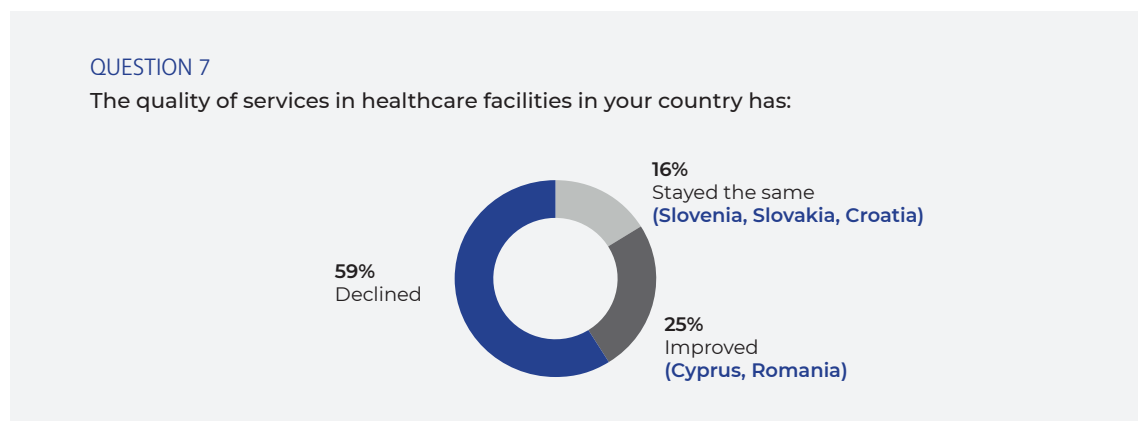
- Here, the response was unanimous: 100% considered it satisfactory
- This is particularly true for the two most extreme age groups, i.e. the youngest and the over 60s



QUESTION 7

In your opinion, in the last 10 years, the quality of services in healthcare facilities in your country has:

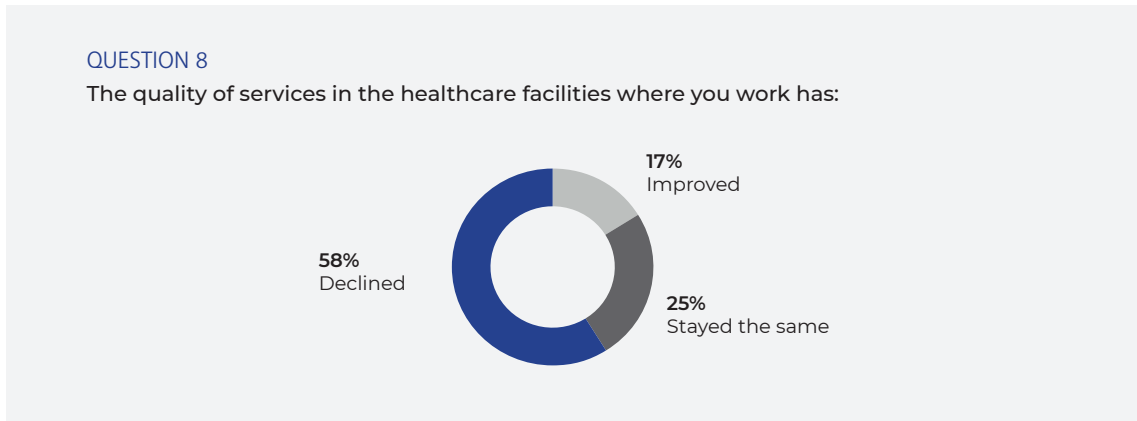
- Declined 59% (Austria, France, Germany, Italy, Portugal, Spain, Sweden)
- Improved 16% (Northern Cyprus, Romania)
- Stayed the same 25% (Slovenia, Slovakia, Croatia)



QUESTION 8

The quality of services in the healthcare facilities where you work has:

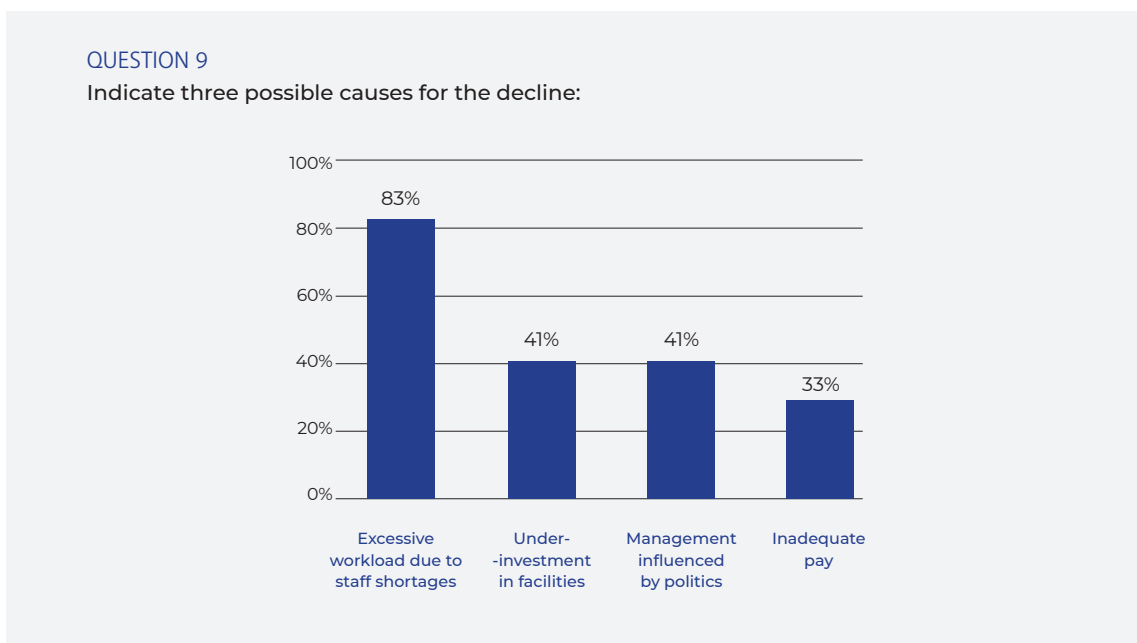
- Declined 58%
- Stayed the same 25%
- Improved 17%



QUESTION 9 M

If it has declined, indicate the main reasons in your view (three answers possible)

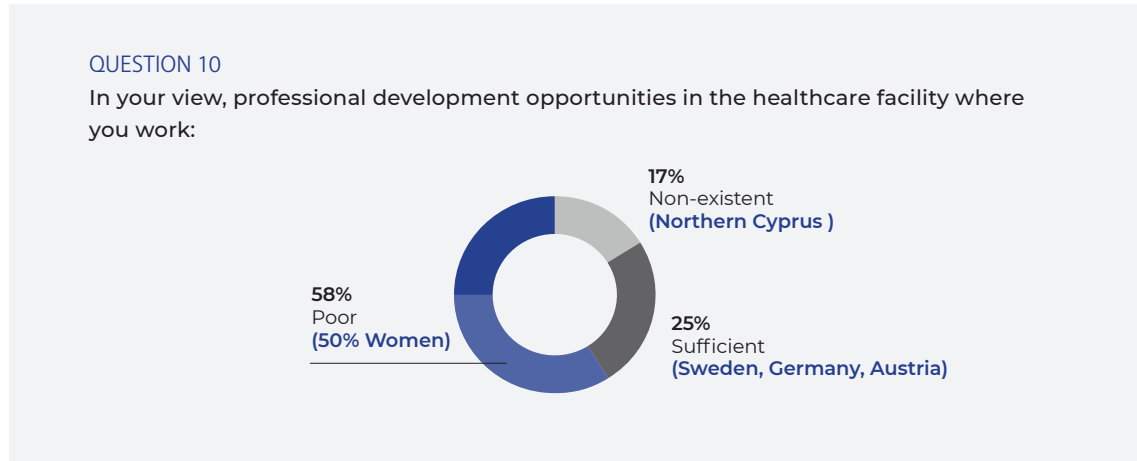
- Excessive workload due to staff shortages 83% (30% women).
- Underinvestment in facilities 41%
- Management influenced by politics 41%
- Inadequate pay 33%



QUESTION 10

In your view, professional development opportunities in the healthcare facility where you work are:

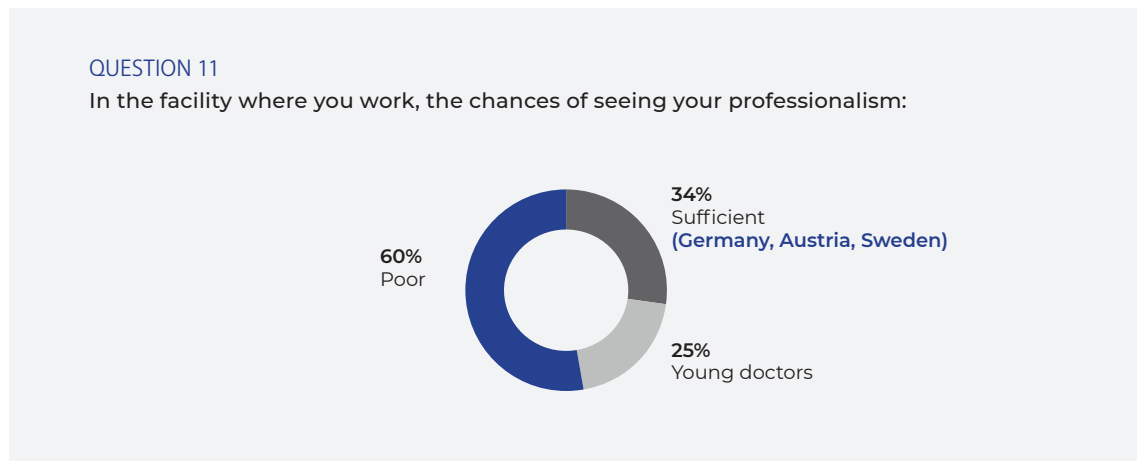
- Poor 58% (women who complain about it: 57%)
- Sufficient 25% (Sweden, Germany, Austria)
- Non-existent 17% (Northern Cyprus)



QUESTION 11

In the healthcare facility where you work, the chances of seeing your professionalism recognised are:

- Poor 66% (25% of these are the youngest)
- The remaining 34% answered sufficient (doctors in Germany, Austria and Sweden)



QUESTION 12 M

If you had to rate each of the following aspects in relation to how it affects the quality of healthcare services, what score would you give?

(1 = has little impact on the lack of quality; 10 = has a huge impact)

Excessive workload due to staff shortages; Excessive workload due to organisational problems; Underinvestment in facilities; Underinvestment in research; Lack of flexibility in the organisation of work; Less preparation for doctors; Less dedication among doctors; Excessively frequent shifts and on-call duties; Inadequate pay; Relations with management; Management influenced by political factors; Manager competence.

58% of respondents answered that their workloads are excessive due to staff shortages, giving it the maximum score of 10.

33% answered that inadequate pay affects the quality of healthcare services (again with a maximum score).

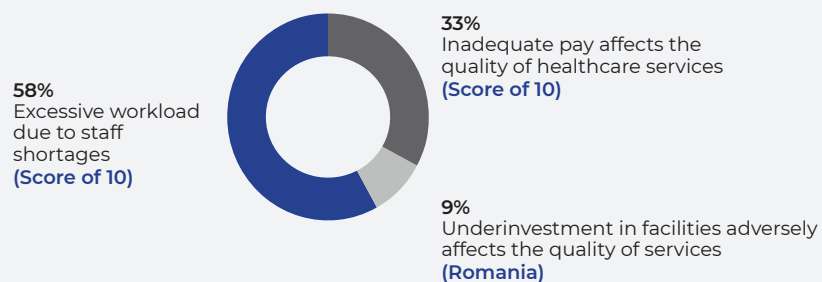
Finally, 9% felt that the quality of services is adversely affected by underinvestment in facilities.

QUESTION 12

If you had to rate each of the following aspects in relation to how it affects the quality of healthcare services, what score would you give?

1 = has little impact on the lack of quality

10 = has a huge impact



QUESTION 13.1

Please indicate to what extent you agree with the following opinions expressed by other doctors working in healthcare facilities:

Financial compensation is not commensurate with the commitment required of salaried doctors.

- Totally agree 83%
- Agree 9% (Sweden)
- Disagree 8% (Germany)

QUESTION 13.2

Working in a healthcare facility means giving up your private life.

- Agree 50%
- The remaining 50% disagree

QUESTION 13.3

The role of the salaried doctor has little recognition in society.

- Agree 33%
- Fully agree 41%
- Disagree 26% (Germany, Austria, Sweden)

QUESTION 13.4

Salaried doctors have little involvement in health and management policy.

- Agree 50%
- Totally agree 50%

QUESTION 13.5

Individual doctors are too dependent on professional and administrative hierarchies.

- Totally agree 59%
- Agree 33%
- Disagree 8% (Austria)

QUESTION 13.6

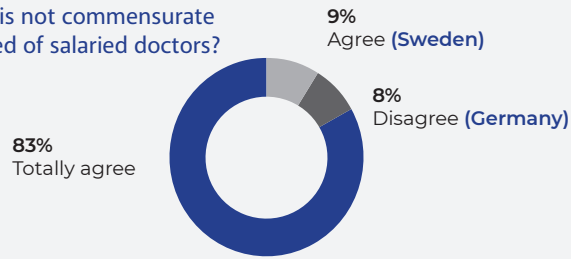
Many regulations aimed at improving safety and quality of care are means of reducing costs.

- Totally agree 66%
- Agree 25%
- Disagree 9% (Slovenia)

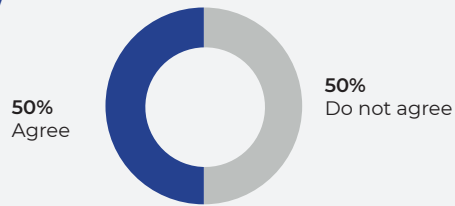
QUESTION 13

Do you agree with those who say that:

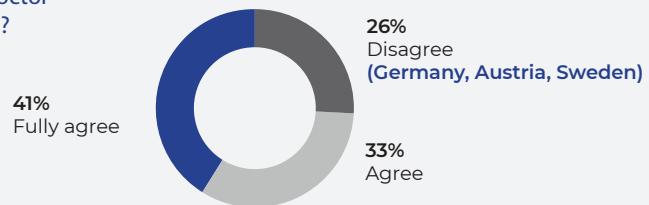
13.1. Financial compensation is not commensurate with the commitment required of salaried doctors?



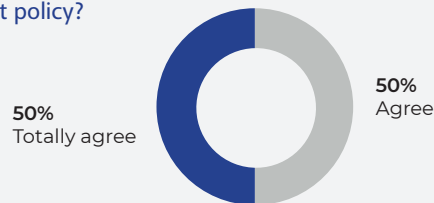
13.2. Working in a healthcare facility means giving up your private life?



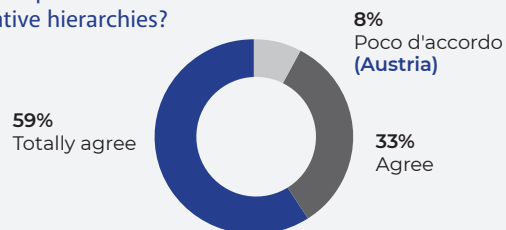
13.3. The role of the salaried doctor has little recognition in society?



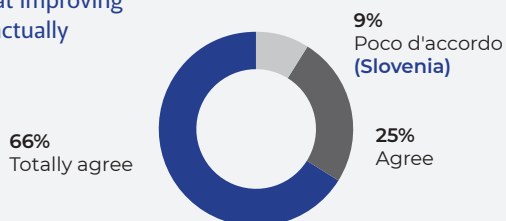
13.4. Salaried doctors have little involvement in healthcare and management policy?



13.5. Individual doctors are too dependent on professional and administrative hierarchies?



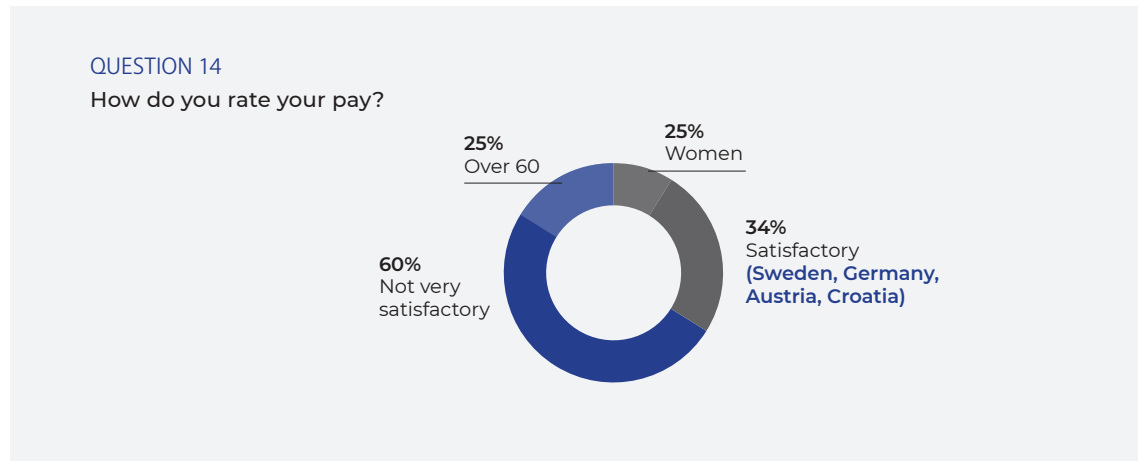
13.6. Many regulations aimed at improving safety and quality of care are actually means of reducing costs?



QUESTION 14

How do you rate your pay?

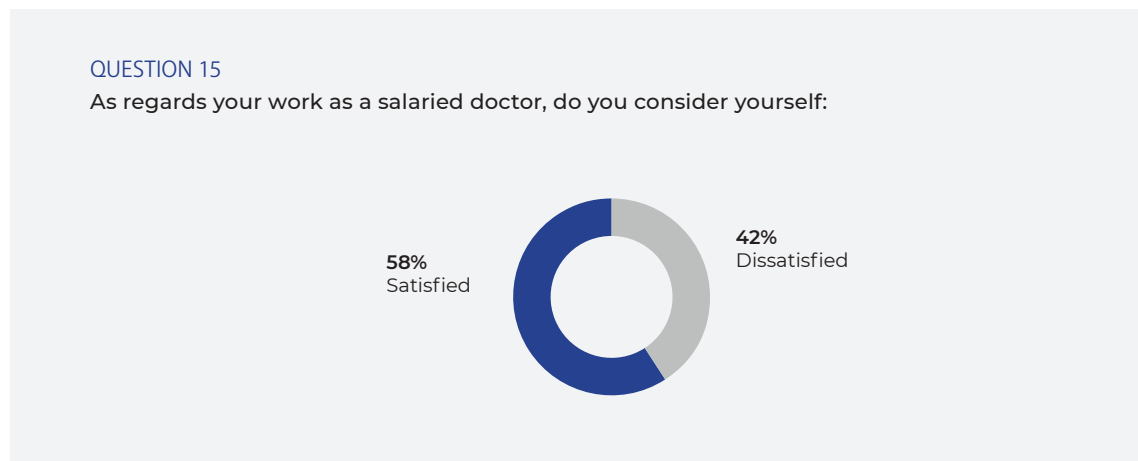
- 33% consider it satisfactory (25% of these are women), particularly in Sweden, Germany, Austria and Croatia
- The remaining 66% consider it not very satisfactory (25% of these are over 60, especially in Northern Cyprus and Spain)



QUESTION 15

As regards your work as a salaried doctor, do you consider yourself

- Satisfied 58%
- Dissatisfied 42%



QUESTION 16.1

Please indicate how satisfied you are with each of the following aspects of the job:

Distribution of workload

- Satisfied 43%
- Dissatisfied 57%

QUESTION 16.2

Job prospects

- Dissatisfied 41%
- Satisfied 59% (28% of these are over 60; 14% are in the 25-35 age group)

QUESTION 16.3

Career prospects

- 58% are dissatisfied (37% are women)
- 42% are satisfied (40% are over 60 and 20% are among the youngest)

QUESTION 16.4

Organisation of work

- Dissatisfied 75%
- Satisfied 25% (particularly in Germany, Slovakia and Sweden, where however 37% of women are less satisfied)

QUESTION 16.5

Work flexibility.

- Dissatisfied 75%
- Satisfied 25%

QUESTION 16.6

Possibility of going part-time

- Very satisfied 10%
- Satisfied 33%
- Dissatisfied 33%
- Extremely dissatisfied 16%
- Don't know 8%

QUESTION 16.7

Training and continuing education

- Dissatisfied 58% (including Sweden)
- Satisfied 42%

QUESTION 16.8

Quality of healthcare facilities

- Satisfied 42% (Austria, Germany, Sweden, Slovenia)
- Dissatisfied 58%

QUESTION 16.9

Relations with the management

- Dissatisfied 50%
- Satisfied 41%
- Extremely dissatisfied 9%

QUESTION 16.10

Relations with patients

- Satisfied 83%
- Very satisfied 17%

QUESTION 16.11

Technological equipment

- Satisfied 58%
- Dissatisfied 33%
- Extremely dissatisfied 9%

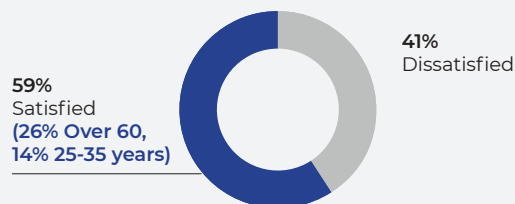
QUESTION 16

Please indicate how satisfied you are with each of the following aspects of the job:

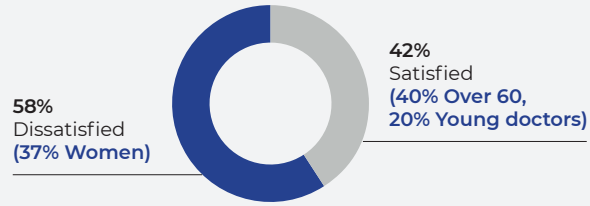
16.1. Distribution of workload



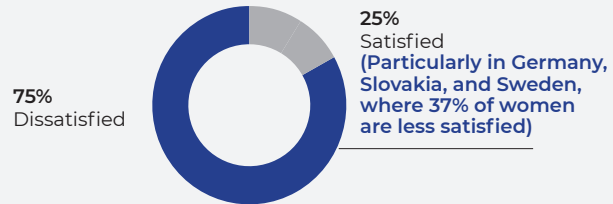
16.2. Job prospects



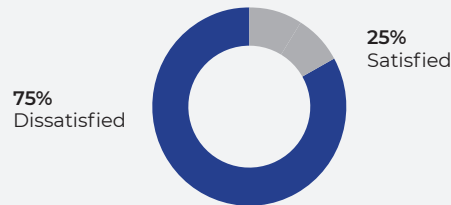
16.3. Career prospects



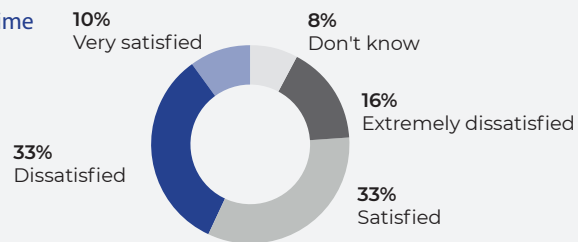
16.4. Organisation of work



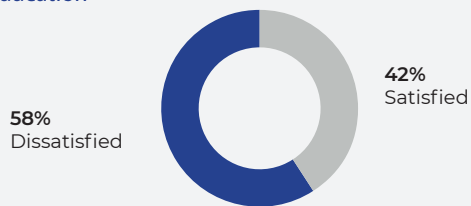
16.5. Work flexibility



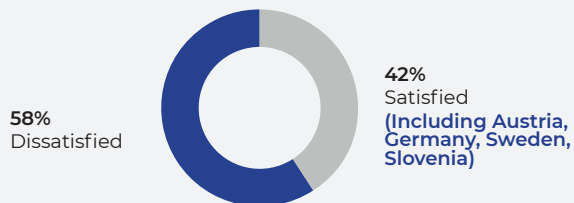
16.6. Possibility of going part-time



16.7. Training and continuing education



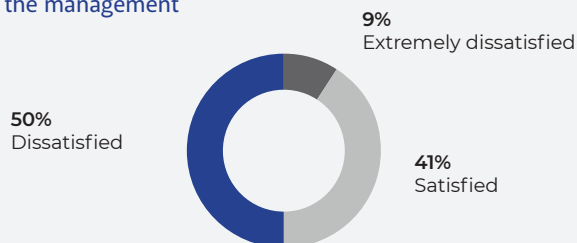
16.8. Quality of healthcare facilities



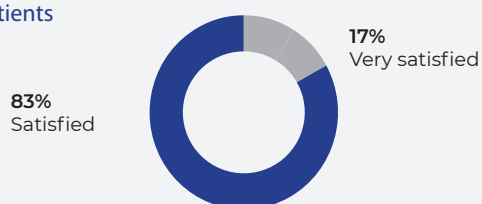
QUESTION 16

Please indicate how satisfied you are with each of the following aspects of the job:

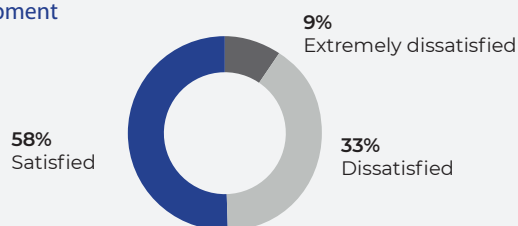
16.9. Relations with the management



16.10. Relations with patients



16.11. Technological equipment



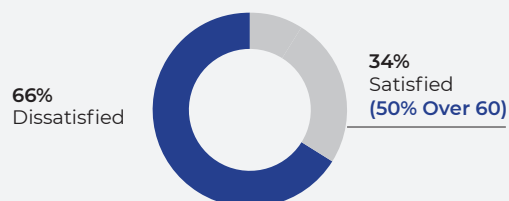
QUESTION 17

As regards the possibility of a work/life balance, would you say you were...

- Dissatisfied 66%
- Satisfied 34% (among these, 50% are over 60)

QUESTION 17

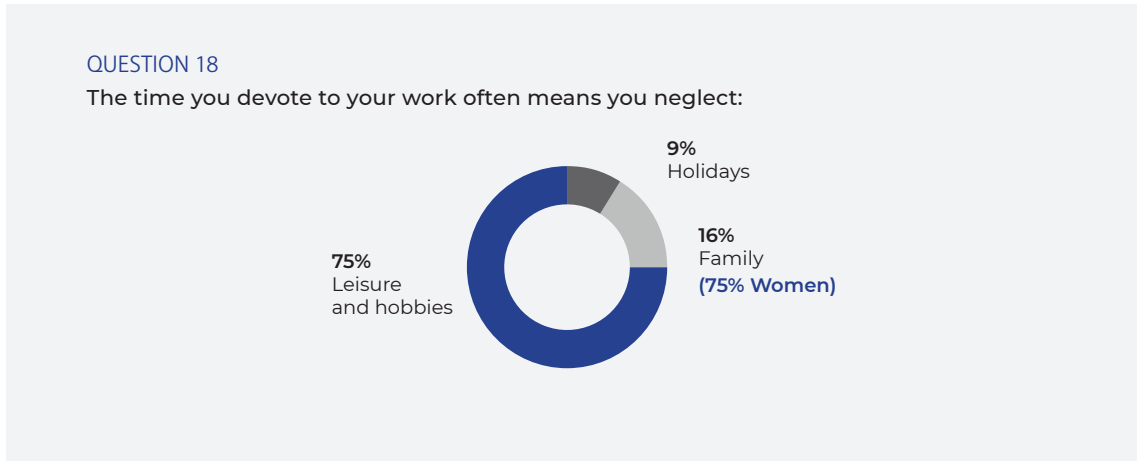
As regards the possibility of a work/life balance, would you say you were...



QUESTION 18

The time you devote to your work often means you neglect.

- Leisure and hobbies 75%
- Family 16% (specifically, 75% of women complain about this)
- Holidays 9%



QUESTION 19.1

Now evaluate certain aspects of your work and indicate for each one how feasible and easy it is to implement changes:

Change hospital.

- Difficult 41%
- Very difficult 34%
- Easy 25% (Germany, Austria and Sweden)

QUESTION 19.2

Change type of job or role

- Difficult 67% (particularly for German women, 70%)
- Very difficult 33%

QUESTION 19.3

Be transferred to another department.

- Difficult 50%
- Very difficult 40%
- Very easy 10% (Austria)

QUESTION 19.4

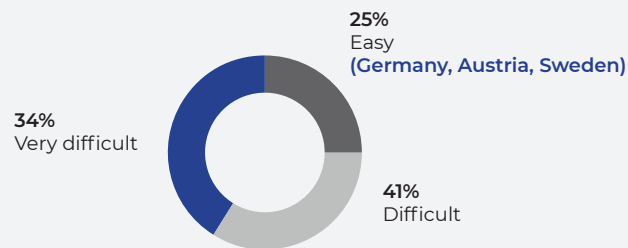
Switch from employment to private practice.

- Easy 40% (Austria, Italy, Portugal, Romania, Sweden)
- Difficult 41%
- Very difficult 19%

QUESTION 19

How feasible is it to:

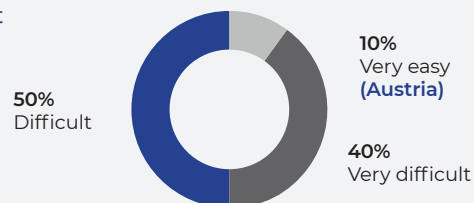
19.1. Change hospital



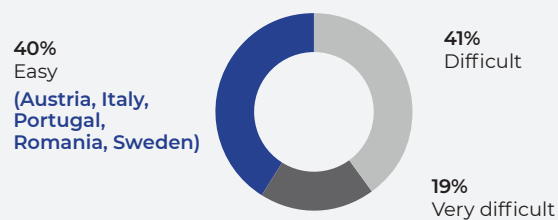
19.2. Change type of job or role



19.3. Change department



19.4. Switch to private practice



QUESTION 20.1

You would define your relations with your work colleagues in terms of working environment as

- Good 84%
- Very good 8%
- Moderate 8%

QUESTION 20.2

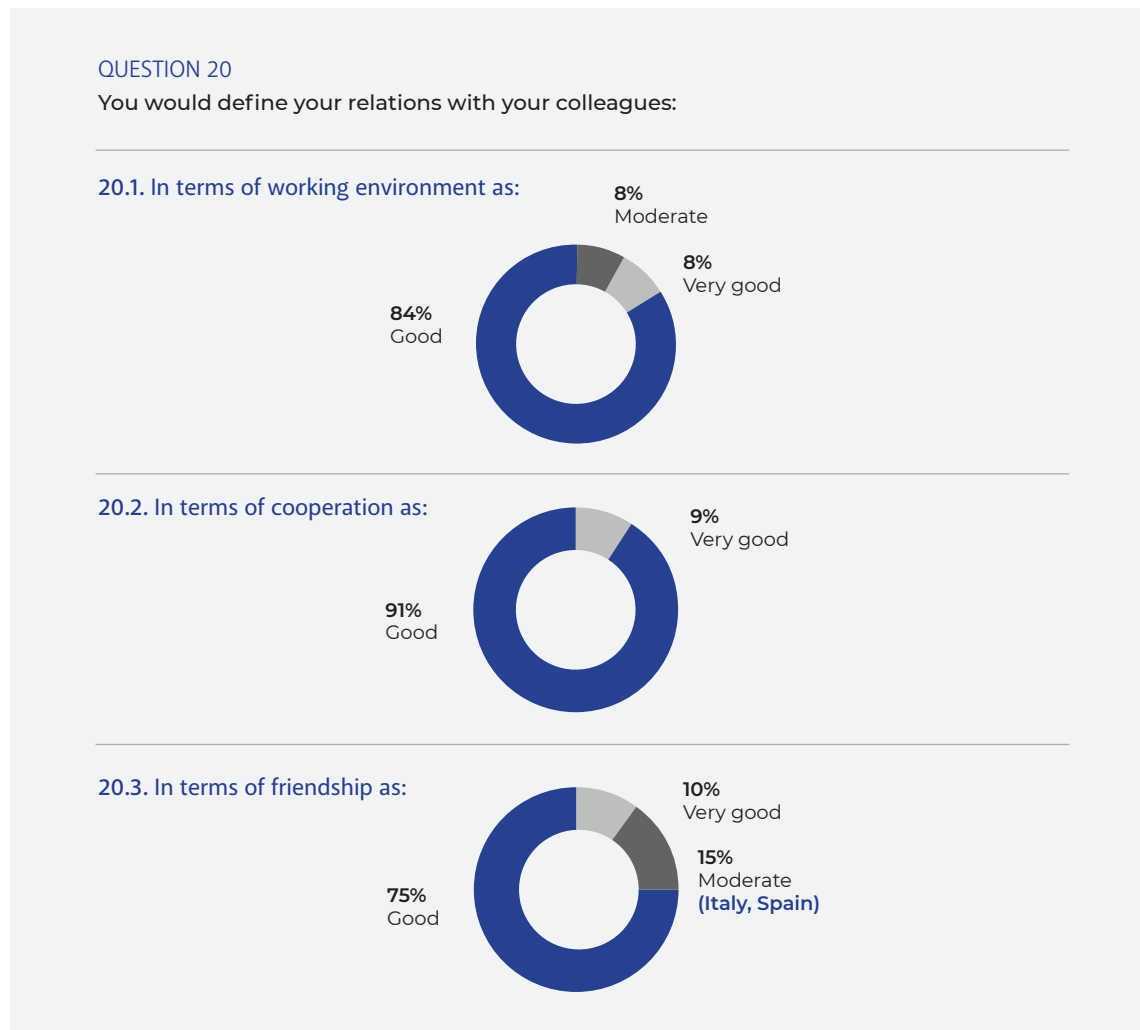
You would define your relations with your work colleagues in terms of cooperation as:

- Good 91%
- Very good 9%

QUESTION 20.3

You would define your relations with your work colleagues in terms of friendship as:

- Good 75%
- Moderate 15% (Italy and Spain)
- Very good 10%



QUESTION 21.1

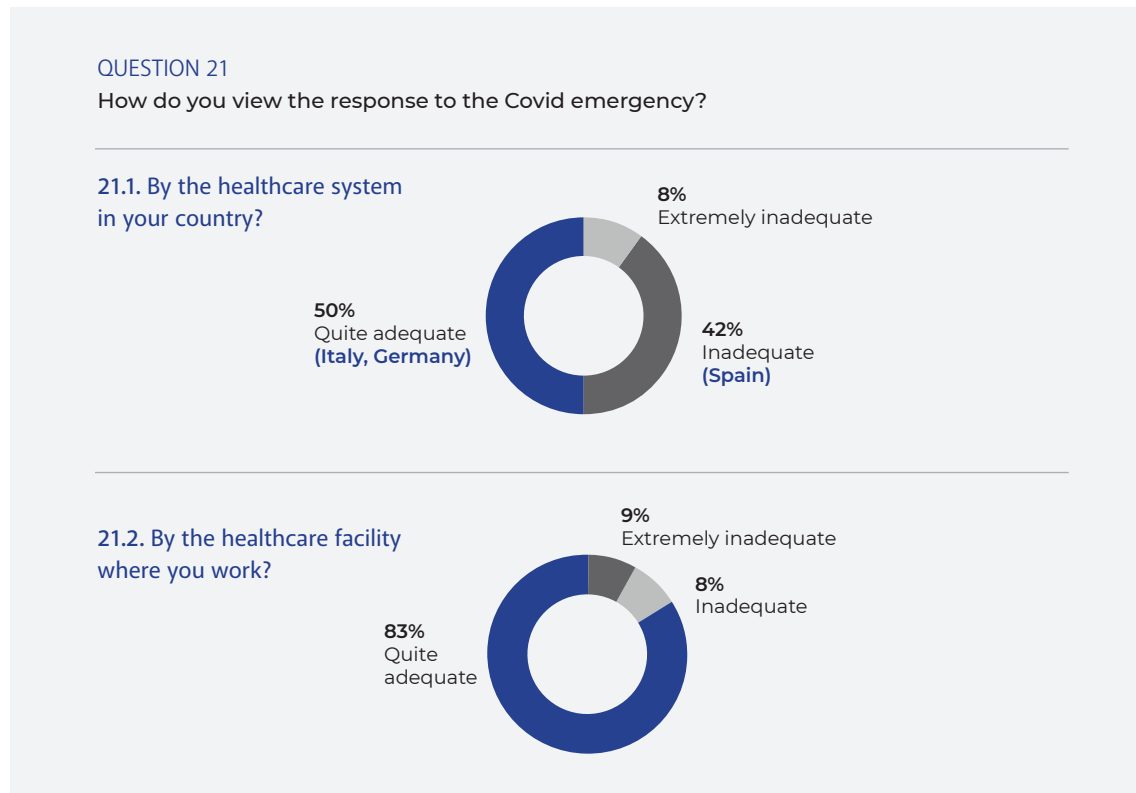
Do you believe that the healthcare system in your country responded to the Covid-19 emergency in a manner that was...

- Inadequate 42% (Spain)
- Quite adequate 50% (including Italy and Germany)
- Extremely inadequate 8%

QUESTION 21.2

Do you believe that the healthcare facility where you work responded to the Covid-19 emergency in a manner that was...

- Quite adequate 83%
- Extremely inadequate 9%
- Inadequate 8%



QUESTION 22.1

During the Covid-19 emergency, do you feel...

that your work played an important role

- Quite important 75%
- Very important 17%
- Not very important 8%

QUESTION 22.2

That your work was valued

- Not really 50%
- Not at all 25%
- Quite a lot 16%
- A lot 9%

QUESTION 22.3

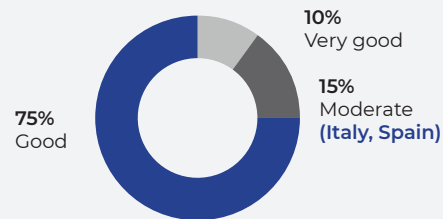
That your opinions were taken into consideration in the decision-making process

- Not at all 66%
- Not really 34%

QUESTION 22

During the Covid emergency, do you feel:

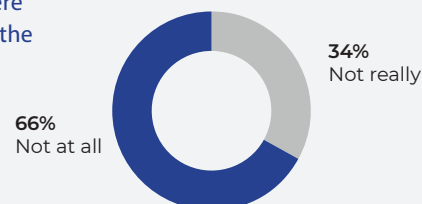
22.1. That you played an important role:



22.2. That your work was valued:



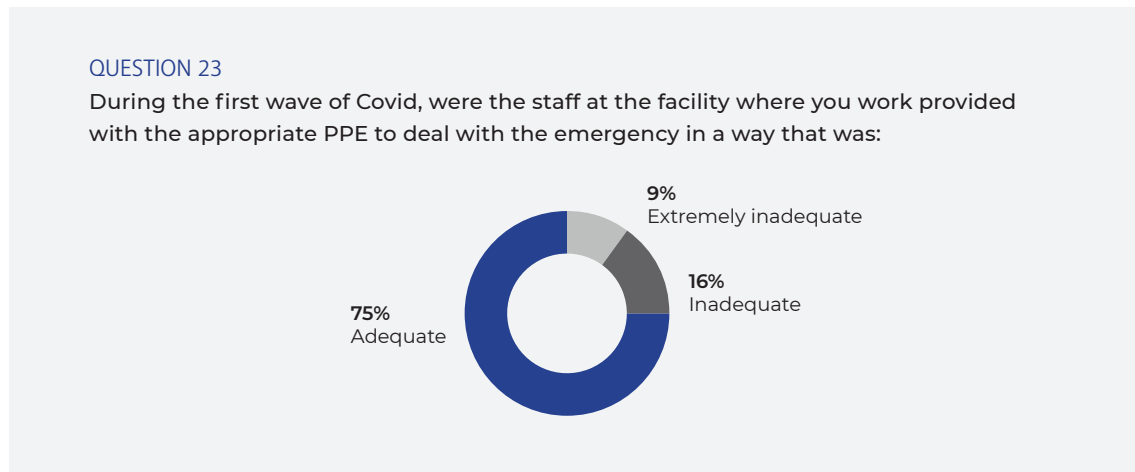
22.3. That your opinions were taken into consideration in the decision-making process?



QUESTION 23

During the first wave of Covid, were the staff at the facility where you work provided with the appropriate PPE to deal with the emergency in a way that was.

- Adequate 75%
- Inadequate 16%
- Extremely inadequate 9%



QUESTION 24 M

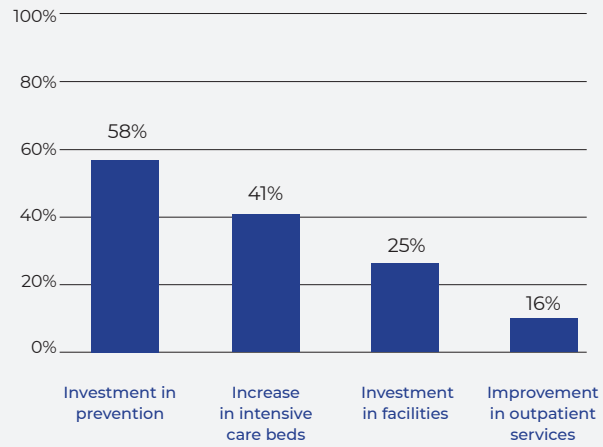
In the event of another public health emergency, which aspects do you think should be improved?

As this is a multiple-choice question, the responses are different. However, it is clear that in most countries, survey respondents expressed the need for more healthcare staff, i.e. nurses (75%) and doctors (66%). In addition, 58% believe it is necessary to invest in prevention and 41% call for an increase in intensive care beds.

- 25% recommend investment in facilities
- 16% call for outpatient services to be improved

QUESTION 24

In the event of another public health emergency, which aspects do you think should be improved?



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**European Federation of Salaried Doctors /
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