

The 46th Mid-term Council Meeting of the CMAAO



Le Meridien Hotel, Kuala Lumpur, Malaysia
September 16–18, 2010

This issue of the JMAJ features the 46th Mid-term Council Meeting of the Confederation of Medical Associations in Asia and Oceania (CMAAO) held in Kuala Lumpur, Malaysia, from September 16 to 18, 2010. It provides a brief summary of the meeting, program, the CMAAO contact list, the Sampran Declaration on Tobacco Control in Asia and Oceania Region, CMAAO Declaration on Drug Prescription, Country Reports (the annual activity reports by national medical associations, NMAs) and the Symposium presentations on the theme of task shifting and medical profession.



BRIEF SUMMARY

Of the 18 CMAAO member NMAs, over 40 representatives from 12 NMAs attended the Mid-term Council Meeting. Mr. Shinichi Murata, who was nominated as the CMAAO Legal Advisor by the Japan Medical Association, was officially appointed to assume the office by the CMAAO Council.

With the upcoming General Assembly of the World Medical Association (WMA) in October 2010, Dr. Tai Joon Moon (Korea) made a presentation on WMA policies on drug prescription. CMAAO member countries reaffirmed that the prescribing of medicine has great significance in patients' safety and the patient-physician relationship, and thereby the right to prescribe medicine must be solely the responsibility of the physician. The emergency Resolution on Drug Prescription was signed by all the participating CMAAO Council members and officers, and sent to Dr. Otmar Kloiber, Secretary General of the WMA on September 18.

The Council also deliberated the several drafts of CMAAO policies, among which the Sampran Declaration on Tobacco Control in Asia and Oceania Region

was adopted by the CMAAO Council.

Constitution and Bylaws of the CMAAO are currently undergoing revision in the Constitution and By-Laws Committee, including a proposal for a major change aimed at enabling decisions to be adopted more quickly that Mid-term Council Meetings be abolished and Congresses held every year instead. Dr. Bertha Woon Yng Yng (Singapore) reported work progress of the committee and made proposals for the revision.

The Council approved recommendations for future meetings that the 27th CMAAO Congress not be held before the WMA General Assembly but in November 10–12 in Taipei, Taiwan, linked to the Physician's Day in Taiwan on November 12, and that the 48th Mid-term Council Meeting in 2012 be held in Macao. In view of the importance of the task shifting issue, the ad-hoc committee on task shifting was established and Dr. Dong Chun Shin (Korea) was appointed as the Committee Chair. The first seminar for the committee members is planned to be held in Tokyo, Japan in March 2011.

PROGRAM

DAY 1: THURSDAY, SEPTEMBER 16, 2010

- 18:30 Arrival of the International Guests and Registration
19:00 Welcome Reception at Le Meridien Hotel: Hosted by the Malaysian Medical Association

DAY 2: FRIDAY, SEPTEMBER 17, 2010

- 08:00 Registration
09:00 Call to Order: Dr. Wonchat Subhachaturas, Chair
Roll Call: Dr. Masami Ishii, Secretary General
Opening Remarks: Dr. Wonchat Subhachaturas
Welcome Address: Dr. David K.L. Quek, President of the Malaysian Medical Association
Approval of the Minutes of the 26th CMAAO Congress and the 45th CMAAO Council Meeting Held in Indonesia, November 2009: Dr. Wonchat Subhachaturas
Report of the President: Dr. Fachmi Idris
Report of the Secretary-General: Dr. Masami Ishii
Financial Report of the Treasurer: Dr. Alvin Chan
Future Meetings
i) Briefing of the 27th CMAAO Congress in Taiwan: Taiwan Medical Association
ii) Future Meetings
Membership Applications (if any): Dr. Wonchat Subhachaturas
Any Other Business
10:30 Group Photo and Coffee Break
11:00 **Country Reports** and Q & A
12:30 Lunch Break
13:30 Report from the Committees and Discussion: Dr. Wonchat Subhachaturas
i) Constitution & By-Laws Committee
Proposal of the Revision of the C & B: Singapore Medical Association
ii) Finance Committee: Hong Kong Medical Association
iii) Membership Committee: Taiwan Medical Association
iv) Resolution Committee
Comments on Proposed WMA Policies: Dr. Tai Joon Moon
WMA Resolution on Drug Prescription
WMA Statement on the Relationship between Physicians and Pharmacists in Medical Therapy
v) Draft of the CMAAO Statements: Dr. Dong Chun Shin
17:00 Any Other Business
Summary of the Business Session: Dr. Wonchat Subhachaturas
17:30 Adjournment
18:30 Dinner: Hosted by the Malaysian Medical Association

DAY 3: SATURDAY, SEPTEMBER 18, 2010

Symposium on “Task Shifting and Medical Profession”

- 08:30 Welcome Address: Dr. Dong Chun Shin, Chair of Symposium, co-chaired by Dr. David K.L. Quek
Presentation by NMAs
11:00 Summary of the Symposium: Dr. Dong Chun Shin
11:30 Closing Remarks: Dr. Wonchat Subhachaturas and Dr. Fachmi Idris
12:00 Farewell Lunch: Hosted by the Malaysian Medical Association
14:00 Kuala Lumpur City Tour: Hosted by the Malaysian Medical Association

LIST OF PARTICIPANTS AND STAFF

Dr. Alvin Yee Shing Chan	Hong Kong
Dr. Tse Hung Hing	Hong Kong
Dr. Choi Kin	Hong Kong
Dr. Fachmi Idris	Indonesia
Dr. Ihsan Oetama	Indonesia
Dr. Prijo Sidipratomo	Indonesia
Dr. Gatot Soetono	Indonesia
Ms. Mieko Hamamoto	Japan
Dr. Masami Ishii	Japan
Mr. Shinichi Murata	Japan
Mr. Hisashi Tsuruoka	Japan
Dr. Yoshitake Yokokura	Japan
Dr. Shigeru Suganami	Japan/AMDA
Mr. Shoji Naito	Japan (coordinator)
Ms. Minami Kagiyama	Japan (interpreter)
Ms. Kayu Taguchi	Japan (interpreter)
Ms. Mineko Soeda	Japan (interpreter)
Dr. In Sung Cho	Korea
Ms. Bo Kyung Kang	Korea
Mr. Tae Hag Kim	Korea
Dr. Tai Joon Moon	Korea
Dr. Dong Chun Shin	Korea
Dr. Mary Suma Cardosa	Malaysia
Dato' Dr. Khoo Kah Lin	Malaysia
Dr. Ravindran R. Naidu	Malaysia
Dr. David K.L. Quek	Malaysia
Dato' Dr. Sarjeet Singh Sidhu	Malaysia
Dr. Harvinder Singh	Malaysia
Dr. Kuljit Singh	Malaysia

Dato' Dr. Mohan Singh	Malaysia
Dato' Dr. N.K.S. Tharmaseelan	Malaysia
Prof. Dr. Khin Maung Aye	Myanmar
Prof. Dr. Kyaw Myint Naing	Myanmar
Dr. Jose Sabili	Philippines
Dr. Mary Jane Sabili	Philippines
Dr. Oscar Tinio	Philippines
Ms. Ong Zi Jing Gracia	Singapore
Dr. Chan Teng Mui Tammy	Singapore
Dr. Lee Yik Voon	Singapore
Dr. Chong Yeh Woei	Singapore
Dr. Bertha Woon Yng Yng	Singapore
Mr. Mahendra Amarasekera	Sri Lanka
Dr. Suriyakanthie Amarasekera	Sri Lanka
Dr. Indika Karunathilake	Sri Lanka
Dr. Meng-Chih Lee	Taiwan
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Dr. Chung Shao Lin	Taiwan
Dr. Yung Tung Wu	Taiwan
Prof. Dr. Somsri Pausawasdi	Thailand
Assoc. Prof. Dr. Prasert Sarnivvad	Thailand
Dr. Wonchat Subhachaturas	Thailand
Dr. Nai Chi Chan	Macau

Supporting Staff of the Malaysian MA

Mr. Collin Mathews Anthony
Ms. Matilda Cruz
Ms. Kusalakumari Nagiah
Ms. Hemalatha Sivalingam

(Listed by country, in alphabetical order)



Office Bearers of the CMAAO (2009–2011)

President	Fachmi Idris (Indonesia)	Treasurer	Alvin Yee Shing Chan (Hong Kong)
President-Elect	Ming-Been Lee (Taiwan)	Secretary General	Masami Ishii (Japan)
Imm. Past President	Somsri Pausawasdi (Thailand)	Assist. Sec. General	Hisashi Tsuruoka (Japan)
1st Vice President	David K.L. Quek (Malaysia)	Advisor	Tai Joon Moon (Korea)
2nd Vice President	Dong Chun Shin (Korea)	Advisor	Yung Tung Wu (Taiwan)
Chair of Council	Wonchat Subhachaturas (Thailand)	Legal Advisor	Shinich Murata (Japan)
Vice-Chair of Council	Peter Foley (New Zealand)		

CMAAO Secretariat

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 International Affairs Division:
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 Ms. Mieko Hamamoto, Ms. Mahoko Imamura,
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Confederation of Medical Associations in Asia and Oceania

The Sampran Declaration on Tobacco Control in Asia and Oceania Region

**Adopted by the 46th CMAAO Mid-term Council Meeting
Kuala Lumpur, Malaysia, September 2010*¹**

PREAMBLE

Tobacco use is the leading cause of preventable death, killing more than 5 million people each year worldwide. Second-hand smoke kills about 600,000 people who were non-smokers each year. Most of these deaths are in low- and middle-income countries including countries in Asia and Oceania. Apart from other well-known health hazards, tobacco use also increases morbidities such as malnutrition and subfertility, hence urgent action is needed.

The WMA, representing the medical associations of the world, issued a statement on the health hazards of tobacco products in 1988 at the 40th World Medical Assembly. This was amended at the 49th and 59th WMA general assemblies. The CMAAO adopted the WMA statement in 1988. With the entry into force of the WHO Framework Convention on Tobacco Control (WHO FCTC) in 2005, the global tobacco control community has made considerable progress against the global tobacco epidemic.

According to the WHO Report on the Global Tobacco Epidemic, 2008 and 2009, the majority of the world's smokers are in Asia and Oceania, which makes tobacco control in the region the main challenge. Only a few countries have a national policy on comprehensive tobacco control. Most users are inadequately warned about the extreme addictiveness of tobacco and the full range of health risks. In all CMAAO countries, cessation services are still insufficient to help the 360 million smokers. Although second hand smoke is easily prevented but only few countries having comprehensive smoke-free environment legislation. The health of more than one third of population in the region is at risk from exposure to second hand tobacco smoke and remains unprotected.

In this regard, government and policy makers must play a pivotal role in ratifying and enforcing the WHO FCTC. The medical profession must recognize its role and social responsibility in tobacco control.

At the individual level, doctors should be agents of change in the battle against tobacco use. The medical profession is deeply committed to tobacco control and a smoke-free society. The CMAAO together with all other organizations such as the WHO will partner with the regional and national tobacco control organizations to act decisively against the tobacco epidemic—the leading global cause of preventable death.

The success of this program is going to be wholly dependent on the proactive role of the medical profession in tobacco control and prevention of its health hazards, the cooperation of the general public through the civil societies who will reinforce the medical profession and the

*1 The Sampran Declaration was originally adopted by the 1st International Summit on Tobacco Control in Asia and Oceania Region held in Sampran, Thailand, in February 2010.

commitment of the national government to enact and enforce laws directed towards tobacco control.

RECOMMENDATIONS

The CMAAO urges the CMAAO members to take the following actions to help reduce the health hazards related to tobacco use, at:

I. National Medical Association Level

1. Adopt a policy position opposing smoking and the use of tobacco products, and publicize the policy so adopted.
2. Prohibit smoking at all business, social, scientific and ceremonial meetings of the National Medical Association.
3. Develop, support, and participate in programs to educate the profession about the health hazards of all forms of tobacco use. Convince and help smokers and smokeless tobacco users to cease the use of tobacco products, and develop cessation programmes for tobacco users and avoidance programmes for non-smokers and non-users of tobacco.
4. Strongly urge individual physicians to be role models (by not using tobacco products), healthcare team leaders and spokespersons to campaign and to educate the public about the deleterious health effects of tobacco use, exposure to second-hand smoke and the benefits of tobacco cessation and making a smoke-free home.
5. Mandate all medical schools, hospitals and other health-care facilities to prohibit smoking on their premises.
6. Introduce or strengthen educational programs for physicians to prepare them to identify and treat tobacco dependence in their patients.
7. Strengthen and cooperate with the regional network to develop an effective regional system on tobacco cessation. Support widespread access to effective treatment for tobacco dependence—including identification of smokers in the routine services and provision of counseling, necessary pharmacotherapy and other appropriate means.
8. Develop and endorse a clinical practice guideline on the treatment of tobacco use and dependence.
9. Urge the national authorities to add tobacco cessation medications to the List of National Essential Medicines and Health Security System.
10. Mandate medical schools, research institutions, and individual researchers not to accept any funding or any form of support from the tobacco industry.

II. Individual Physician Level

1. Ask every patient for smoking history and provide brief advice to every patient along with referral to specialized cessation treatment.
2. Do not accept any funding or any form of support from the tobacco industry.

III. Government Level

1. Support MPOWER*² as the main tobacco control strategy released by WHO.
2. Advocate the enactment and enforcement of laws that:



*² M=Monitor tobacco use and prevention policies, P=Protect people from tobacco smoke, O=Offer help to quit tobacco use, W=Warn about the dangers to tobacco, E=Enforce bans on tobacco advertising and promotion, R=Raise taxes on tobacco products.

- a. provide for comprehensive regulation of the manufacture, sale, distribution and prohibit any form of promotion and advertisement of tobacco products. All forms of promotion of tobacco products including sponsoring sports events and entertainment should be banned.
- b. require written and pictorial warnings about health hazards to be printed on all packages of tobacco products.
- c. prohibit smoking in all enclosed public places (including health care facilities, schools, and education facilities), workplaces (including restaurants, bars and nightclubs) and public transport.
- d. prohibit the sale, distribution, and accessibility of cigarettes and other tobacco products to children and adolescents.
- e. prohibit the sale of tax-free tobacco products.
- f. prohibit all government subsidies for tobacco and tobacco products.
- g. prohibit the promotion, distribution, and sale of any new forms of tobacco products that are not currently available.
- h. increase taxation of tobacco products, using the increased revenues for prevention programs, effective cessation programs and services and other health care measures.
- i. curtail or eliminate illegal trade in tobacco products and the sale of smuggled tobacco products.

Confederation of Medical Associations in Asia and Oceania

CMAAO Resolution on Drug Prescription

**Adopted by the 46th CMAAO Mid-term Council Meeting
Kuala Lumpur, Malaysia, September 2010**

Through the discussion at the 46th CMAAO midterm council meeting held in Kuala Lumpur, Malaysia, CMAAO member countries reaffirmed that the prescribing of medicine has great significance in patients' safety and the patient-physician relationship. Thereby, the right to prescribe medicine must be solely the responsibility of the physician.

CMAAO member countries hereby strongly support "The proposed WMA resolution on Drug Prescription" written by Japan Medical Association and Korean Medical Association as attached.*¹

(Official signatures are omitted.)

*1 The attached documents, *Proposed WMA Resolution on Drug Prescription* has since been amended and adopted by the WMA General Assembly, Vancouver, Canada (October 2010). WMA Policies are available on the WMA website for <http://www.wma.net/en/30publications/10policies/index.html>.

HONG KONG MEDICAL ASSOCIATION



CHOI Kin*1

With the continuous efforts of our colleagues, the Association's membership has grown steadily over the past year. With the unfailing support from our members, we continued to speak for the profession and safeguard the health and welfare of the public.

In the past year, Hong Kong has been under the threat of human swine flu (HSI). Our Association worked closely with the Centre for Health Protection ever since. After examining and reviewing international data on the development and the evolution of the pandemic, our Advisory Committee on Communicable Diseases made suggestions on how to contain the disease in the community. We issued guidelines and provided the most updated information to our members. With in-depth discussion on the pros and cons of mass vaccination, we stood by the Government and supported the vaccination programme. We openly addressed the concerns over the adverse effects of the vaccine and re-assured the public its safety. Public health talks were conducted in various districts with the help of our network doctors. We were relieved that the pandemic has not caused serious infection in Hong Kong.

With regard to public health, our Association has been more involved than ever in joining with other professions in fighting drug abuse. Recent study on drug use among students in 2008/2009 indicated that the youth drug abuse problem has permeated over 90% of secondary schools and 80% of primary schools in Hong Kong. Unlike the most commonly abused drug used by the youngsters—Ketamine, primary school age abusers often take cough syrup or organic solvents because these substances are relatively convenient for them. We teamed up with The Law Society of Hong Kong in producing an educational flyer on anti-youth drug abuse. Through

our district partners, the flyers were distributed to students, youth and parents. In the profession, CME programmes on “Management of Drug Abuse Patients” were organised in various districts. This provides a mass of trained doctors that can be mobilized to help the at-risk or young drug addicts in the community. We organized a movie and poster-design competition which was well-received by the community and the government. A Public Education Day and the HKMA Annual Charity Concert were organized in late July. They were dedicated to raising funds in support of the beat drugs efforts. Besides, they were also organized in celebration of the 90th Anniversary of The Hong Kong Medical Association, on top of other sports, cultural and recreational activities, a commemorative publication and the annual ball to be held on New Year's Eve.

Healthcare financing is another hot issue of great concern to the general public. Being a core stakeholder of the health care profession, the Association has been proactively working with the insurance industry on the design of a basic medical insurance policy that is affordable for the majority of Hong Kong people. In this connection, we conducted another round of doctors' fees survey in early 2010 and a report was released in the following April. The result of the survey will be used as a reference in designing the new product.

In the last two years, the development of the various Community Networks was making good progress. As mentioned above, the networks have exerted great efforts in the training of doctors. Apart from organizing CME programmes, the network doctors have assumed a key role in the negotiation and collaboration with the Hospital Authority Clusters in public-private projects. The Diabetes Shared Cared Programme is an example of public-private partnership (PPP).

*1 President, Hong Kong Medical Association, Hong Kong (yvonne@hkma.org).

This article is based on a presentation made as the annual activity report during the Country Report session at the 46th CMAAO Mid-term Council Meeting, Kuala Lumpur, Malaysia, on September 17, 2010.

We shall move along this path to see other PPP projects coming up.

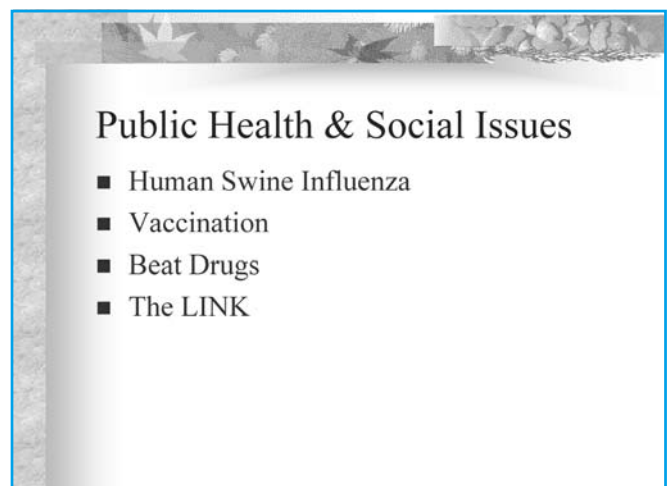
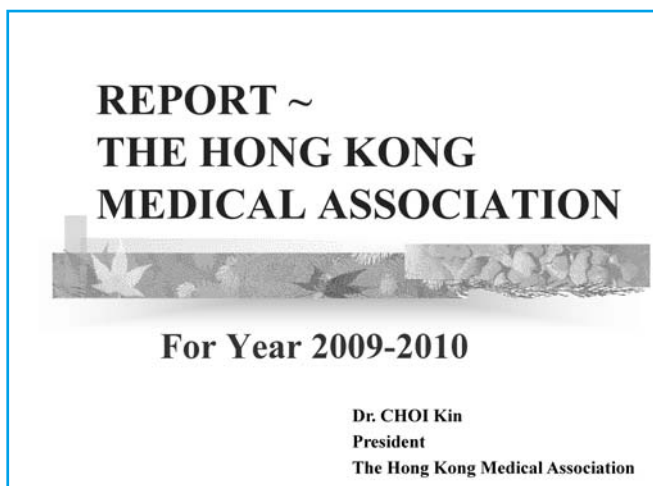
Mediation has been a new trend of solving disputes. The HKMA fully supports this approach and has been exploring on this over the past few years. We believe through this approach, the doctor-patient relationship can be restored. With less cases being brought up to the court, the charges on profession indemnity insurance can be reduced. The HKMA has made its pledge to pursue mediation in front of the Secretary for Justice. We have also sought the support of the Medical Protection Society (MPS). On the other hand, with the aim to teach doctors to prevent conflicts with patients, the HKMA has co-organized with MPS series of “Mastering Your Risk” and “Mastering Adverse Outcomes” workshops. The workshops were very useful and well-received by members. Moreover, a “Practical Handbook on Risk Management for Doctors” will be published towards the end of 2010 for the handy reference of medical practitioners.

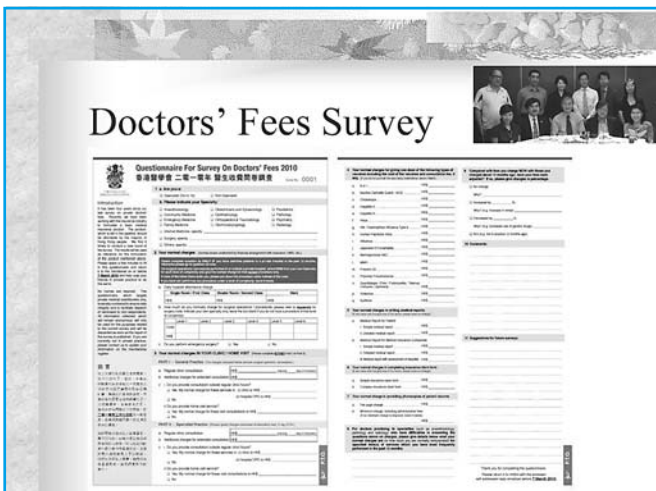
Since the Link took over the management of shopping centers inside public housing estates, repeated sharp increases in rental requests have caused great concerns among our colleagues

renting shops and working inside them. Our negotiations with the Link has thus been lingered for years. With the leadership of our President Dr. CHOI Kin, some agreements have been reached. The Link assured that certain new measures about their leasing policy of medical/dental clinics would be implemented so as to ensure continuity of medical services to the residents. The HKMA will surely keep an eye on the performance of Link to ensure the best benefit of our members.

In the effort to promote fraternity among our fellow colleagues, sports, recreational and cultural activities have expanded largely. There were numerous singing and sports training classes, friendly competitions and short trips. A Youth Committee has been newly formed to tailor-make functions for our younger members, so as to help them lead their own way in the career path, and enhance their sense of belonging to the Association.

Last but not least, we attended the 60th WMA General Assembly held in New Delhi, India in October 2009, and participated in the 45th CMAAO Council Meeting held at Bali, Indonesia in November 2009.







Continuing Medical Education (CME)



Beijing/Hong Kong Medical Exchange

- October 2009 in Chengdu, Sichuan
- Theme: Rehabilitation after Disaster (5.12 Earthquake)



60th Anniversary of Establishment of People's Republic of China



Member Welfare & Activities

- HKMA Choir
- HKMA Orchestra
- Annual Social Function
- Sports
 1. Joint Professional Tournaments
 2. Ball games
 3. Family Sports Day
 4. Swimming Gala
 5. Family hiking
 6. Trailwalker



Charity

- Centralized Organ Donation Register
- Donations for Typhoon Morakot Relief in Taiwan
- Donations for Mainland Flood Relief
- Donations for Haiti Earthquake
- Charity concerts to raise funds for Suicide Prevention Services (SPS) and Beat Drugs Action



General

- Council Meetings
- 45th CMAAO Council Meeting held at Bali, Indonesia in November 2009
- 60th World Medical Assembly held in New Delhi, India, in October 2009
- 12 monthly HKMA News
- 12 monthly CME Bulletins
- bimonthly Hong Kong Medical Journal

END

~ Thank You! ~

INDONESIAN MEDICAL ASSOCIATION



Ihsan OETAMA*¹

Right after the CMAAO Congress in Bali (November 2009) the IMA held its 17th General Assembly in the city of Palembang, South Sumatra.

In this event, Dr. Prijo Sidipratomo was installed as the new president of the IMA, replacing Dr. Fachmi Idris, for the period of 2009–2012.

Dr. Zaenal Abidin, the former Secretary General of the IMA was elected as the President-Elect.

In his inaugural address, Dr. Prijo Sidipratomo explained his program for the coming three years.

One month after the Assembly, Dr. Prijo Sidipratomo announced the composition of the new office bearers of the IMA, with Dr. Slamet Budiarto as the new Secretary General.

In May, the IMA held an event called **INDONESIAN DEDICATED DOCTOR'S DAY**. Programs within this event are:

1. An appeal to doctors throughout Indonesia not to charge patients for their services for one particular day, or to turn their earnings of that day to the IMA to be donated away to those needing aid.
2. Medical Expo.
3. Dedication Safari (Safari Bakti) across the country: Free cataract operations, free cleft palate operations done by IMA members.
4. Seminars.
5. National panel discussions, where the most serious health problems in the country were brought forward.
6. Steps taken in regard of collaborations with the government are:
 - assisting the generic drug campaign, in hospitals and private practices
 - escalating the anti tuberculosis campaign
 - formulating the methods to reach the best results of the MDG program, particularly



items 4 and 5

- training for early detections of cervical and breast cancer
- facing the problems of how to deal with the presence of foreign doctors practicing in Indonesia
- campaign of acceptance to use condoms as a way to prevent the spread of HIV/AIDS
- on the Independence Memorial Day, at the Indonesian National Committee of Tobacco Control gathering, Dr. Prijo Sidipratomo delivered a speech of how pressing tobacco control is for Indonesia (**photo**). According

*1 International Relations, Indonesian Medical Association, Jakarta, Indonesia (pbidi@idola.net.id).

This article is based on a presentation made as the annual activity report during the Country Report session at the 46th CMAAO Mid-term Council Meeting, Kuala Lumpur, Malaysia, on September 17, 2010.

to the WHO, tobacco consumption in Indonesia is number three in the world. Noted in 2008, 240 billion cigarettes, which equals 658 million/day, or IDR 330 billion, are burned daily. This loss could and should be used to promote the health of the people.

- Advertisement make as if smoking is a normal thing, with no risk to one's health. The aim of tobacco control is to protect the following generation of a nation.
- At the end of his speech, he as the president of the Indonesian Medical Association, with

the organization fully backing him, urged the government to pass the Law for Control of the Impact of Tobacco Products to Health.

International

- Attending the First International Summit on Tobacco Control in Asia Oceania Region in Sampran, Thailand
- Invited to attend the General Assembly of the Philippine Medical Association in Manila.
- Invited to attend the General Assembly of the Malaysian Medical Association in Melaka.

JAPAN MEDICAL ASSOCIATION



Yoshitake YOKOKURA*1

Aiming to be “a medical association that is open to the public, protects the public, and advocates for the public,” the Japan Medical Association (JMA) has led the nation to have the highest longevity with best health in the world. This achievement was realized by the firm adherence to Japan’s universal healthcare system. We believe that the most important task for the JMA is to ensure the realization of a healthcare provision system that the people of Japan truly seek by undertaking diverse activities from the perspective of the general public.

Of the JMA activities we conducted in the past year, we would like to report the following five issues to our CMAAO colleagues.

“Placebo Controls in Clinical Trials” Conference, Hosted by WMA

At the World Medical Association (WMA) General Assembly 2008 (Seoul), the WMA made major revisions to the Declaration of Helsinki. In the course of making these revisions, a working group was installed to continue the discussion on the use of placebos, to which our Executive Board Member Dr. Ishii served as a representative of the JMA. He also attended the “The Ethics of Placebo Controls in Clinical Trials” conference held in Brazil this past February, where he opened a very lively discussion.

This conference heard the opinions of national medical associations and relevant international organizations on the human rights of placebo-trial subjects and other relevant issues, with the purpose of providing an opportunity for the WMA to formulate its policies.

About 40 experts participated in this three-day conference in active discussions. The working group intends to continue its discussions via teleconference and other means to have its conclu-

sions adopted at the WMA General Assembly 2011 in Uruguay.

Global Health Committee Report

The JMA’s Global Health Committee compiled a report on “The Involvement of the Japan Medical Association in Global Health” following two years of discussions and deliberations, in which global health experts played a central role.

Upon tracing the footsteps of the JMA’s international activities, the report points out that organizational system of both within and outside the JMA require further strengthening in the future.

The report also recommends utilizing the human resources in the field of global health who have been nurtured through the Takemi Program in International Health at the Harvard School of Public Health in order to expand the role that the JMA plays to more international level.

The report further emphasizes that global health activities imply the spiritual meaningfulness as the starting point of what physicians are for—the pure desire to help people who are ill and to save lives, which significance cannot be simply expressed in numerical figures. In the future, the JMA intends to become even more actively involved in global health activities through CMAAO and the WMA.

Issues Regarding Prescription Rights

The JMA strongly insists that we oppose the introduction of a special nursing qualification that would enable nurses to treat, prescribe and administer medications for chronic and mild diseases. The Japanese Government is attempting to introduce this task shifting as a means of controlling healthcare expenditure, which we briefly

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This article is based on a presentation made as the annual activity report during the Country Report session at the 46th CMAAO Mid-term Council Meeting, Kuala Lumpur, Malaysia, on September 17, 2010.

mentioned in our Country Report last year.

The WMA General Assembly is to be held next month in Vancouver, Canada. This General Assembly will decide whether or not to adopt the two statements, which clearly state that prescription rights belong solely to physicians. These statements are “Proposed WMA Statement on the Relationship between Physicians and Pharmacists,” and “Proposed WMA Resolution on Drug Prescription,” which was prepared jointly by the JMA and KMA. I strongly request the firm and united support of all CMAAO members present here today for the adoption of these statements.

We believe that the most pressing task for the JMA is not the expansion of task shifting, but rather the resolution of the shortage of physicians while ensuring patient safety and quality of care, which are the essence of healthcare. The JMA will continue striving to solve this problem.

Global Warming Countermeasures in Hospitals: Report of the follow-up survey on the Voluntary Action Plan

In August 2008, the JMA formulated a “Voluntary Action Plan for Global Warming in Hospitals.” Then, a follow-up survey was conducted for the duration of almost a year.

In this survey, questionnaires were distributed to 4,632 of the 5,680 hospitals participating in the Voluntary Action Plan, of which 1,513 responded.

The survey results showed a 7.9% decrease for Fiscal Year 2008 over the previous year in basic

emission units for carbon dioxide (CO₂), which is an improvement that greatly exceeded the annual target of 1.0% decrease. Particularly large factors are considered to be the impacts of “reductions in the amount of heavy oil, kerosene, and other fossil energies used” and “energy conversion from heavy oil and/or kerosene to electricity and/or gas” due to the promotion of energy conversion engineering, according to the analysis.

One important future issue is to discuss mechanisms for both new financial resources and systems that ensure stable and sustainable hospital management. The JMA will continue to work on other ongoing environment-friendly activities, as well as this Voluntary Action Plan.

Continuing Medical Education Program

Established in 1987, the JMA’s Continuing Medical Education (CME) was launched as a program for supporting physicians’ learning under the principle of professional autonomy that physicians themselves shall govern their position as physicians. Subsequently the program underwent numerous revisions in efforts to improve its quality. It was again revised in April of this year, and curricula of 84 topics were prepared. Additionally, a “JMA CME Certificate” will be issued to all those who meet the requirement within three years.

This concludes my report on main activities of the JMA over the past year.

1. “Placebo Controls in Clinical Trials” Conference, Hosted by WMA, in Sao Paulo Brazil, Feb. 2010



About 40 experts participated.

2. Global Health Committee Report

“The Involvement of the Japan Medical Association in Global Health”

1. Further strengthening of the organizational system
2. Utilizing the human resources

3. Issues Regarding Prescription Rights

1. Prescription rights belong solely to physicians.
2. “Proposed WMA Statement on the Relationship between Physicians and Pharmacists”
“Proposed WMA Resolution on Drug Prescription”



3

4. Global Warming Countermeasures in Hospitals: Report of the Follow-up Survey on the Voluntary Action Plan

1. 7.9% decrease in 2008 over 2007 in basic emission units for CO₂
2. Reductions in the amount of heavy oil, kerosene, and others
3. Energy conversion from heavy oil and/or kerosene to electricity and/or gas

4

5. Continuing Medical Education Program

1. Established in 1987
2. Physicians professional autonomy
3. JMA Continuing Medical Education Certificate

5

This concludes my report on main activities of the JMA over the past year.

Thank you very much for your attention.

6

KOREAN MEDICAL ASSOCIATION



In Sung CHO*1

Fighting against Tobacco: Building public support for cigarette price increases

Last February, KMA joined fellow CMAAO members at the 1st International Summit on Tobacco Control in Asia and Oceania Region held in Sampran, Thailand. The Sampran Declaration, adopted at the meeting, called on all members to assume a stronger initiative in spearheading each nation's anti-tobacco programs and to bolster efforts to raise public awareness on the need for a tobacco-free society. The Sampran Declaration could be adopted as a CMAAO policy after deliberation following the report by the Resolution Committee. In accordance to the role of NMAs as defined by the Sampran Declaration, KMA announced a statement calling on the Korean government to improve its smoking cessation policies and has been developing more systematic approaches to fight smoking.

According to the OECD, Korea has one of the highest smoking rates in the world, especially among its younger population. Korea's adult male smoking rate is also 15% higher than the OECD average. In August, KMA collaborated with several other health professionals' organization in Korea to announce a joint statement emphasizing the immense harm smoking poses to public health, economic productivity and the national health insurance's finances. The statement strongly called on the Korean government to revisit all existing anti-smoking policies and to devise a much more effective set of programs to eliminate smoking. Given Korea's smoking demographics, KMA believes that higher cigarette prices are the most effective way of reducing tobacco use. Accordingly, in the statement, KMA proposes a double digit increase in cigarette prices because a minor increase would only

add financial burden to the public without forcing many to quit smoking. The statement also calls for non-price policies such as expanding non-smoking areas, banning cigarette advertisement and strengthening the warning labels included in cigarette packaging. The statement has helped build public support for cigarette price increases. KMA will continue to cooperate with other health and anti-smoking groups in its efforts to push for the necessary legal revisions to implement these policies.

Redefining Medical Delivery System and Promoting Primary Care

In Korea, an indistinct division of roles between clinics and hospitals has resulted in an unproductive competition between the two types of medical institutions in both outpatient and inpatient care. This competition often resulted in the financial difficulties of clinics and inefficient distribution of medical resources. Defining clear scopes of practice between medical institutions and adjusting the medical fee structure accordingly are vital to resolving these issues and helping clinics maintain financial viability.

The basic framework being proposed is to have clinics focus on out-patients while hospitals focus on in-patient care. In particular, large-scale hospitals should be allowed to specialize in treating serious diseases and conducting medical education and research. Both KMA and the Ministry of Health and Welfare are determined to make 2010 the year of "redefining the medical delivery system." Currently, a taskforce is defining the different scope of practice to be specialized by each type of institution. Details of the new framework is yet undecided but strict standards on patient referrals and referral-backs, readjustment of fees paid by insurance for outpatient and inpatient treat-

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This article is based on a presentation made as the annual activity report during the Country Report session at the 46th CMAAO Mid-term Council Meeting, Kuala Lumpur, Malaysia, on September 17, 2010.

ments (increase of fees for outpatient treatment by clinics and increase of fees for inpatient care at hospitals) and readjustment of patient co-payments are expected. KMA welcomes the redefining of the medical delivery system and hopes that it will prevent direct competition between clinics and hospitals and help improve the financial conditions of primary health care providers.

Medical Relief Effort in Haiti

On January 13, 2010, a devastating 7.0 magnitude earthquake struck the areas surrounding the Haitian capital city of Port-au-Prince leaving about 220,000 dead, 320,000 wounded and 800,000 homeless. KMA quickly responded by organizing medical relief teams. Over a 2-month period, KMA dispatched a series of 4 medical assistance teams that treated over 5,500 people in Haiti. After completing the mission, KMA published a report based on the field experiences in Haiti to be used as a manual for organizing prompt and effective medical assistance in case of future disasters in Korea and abroad. KMA has also created the Social Cooperation Committee to leverage the lessons learned from Haiti and to act as the expert on providing professional and systematic medical relief to distressed areas.

Death of Mrs. Kim and Debate on Death with Dignity

In last year's national report, KMA had introduced Korea's first court ruling in favor of discontinuing life-sustaining treatment and how that allowed mechanical ventilation to be stopped on an elderly patient identified as Mrs. Kim. Korea's first legally recognized death with dignity case became far more complicated when Mrs. Kim continued to breathe on her own even after the removal of the ventilator. Her ability to survive without life-sustaining treatment triggered another heated debate on the appropriateness of anyone deciding to discontinue life-sustaining treatments. Mrs. Kim did pass away on January 10, 2010, which was 201 days after the ventilator was removed. Her death brought the entire Korean society to deeply contemplate the sincere meanings of death with dignity and helped build a social consensus on the need for better defined social standards and systems. KMA believes the medical profession should play a vital role in pre-

paring any law or system that defines the concept, timing, methods and medical grounds for death with dignity and has been leading discussions on the basic framework. After a half-year deliberation, last July the religious, medical, legal and civic groups were able to agree upon standards on discontinuing life-sustaining treatments. According to this standard, life-sustaining treatment can only be discontinued on patients who are terminally ill or who are in a vegetative state and suffer from a terminal disease. Even when life-sustaining treatments such as mechanical ventilation or cardiopulmonary resuscitation are discontinued, basic treatments such as nutrition and hydration supply cannot be stopped. In addition, the patient himself must have expressed his written wishes to forgo life-sustaining treatment in advance. These standards are expected to be used as a framework in drafting of the final bill on discontinuing life-sustaining treatment.

Drug Treatment for Sex Offenders against Minors

A recent series of repulsive sex crimes against minors in Korea has instigated public outrage. In response to public demands for fundamental measures against such crimes, a law allowing the use of sex-drive inhibiting drugs on sex offenders was enacted and will come into force from July 2011. KMA is concerned that any drug therapy not accompanied with systematic integration therapy or training programs would only become another form of punishment rather than treatment. Accordingly, KMA has been emphasizing the need for developing an integrated treatment and training program for sex offenders before the implementation of the law. In addition, in order for effective implementation of the drug treatment, clinical research is necessary to establish the efficiency and safety of the drug by determining diagnostic standards, dosage, treatment guidelines and side effects. For this reason, KMA believes it is essential to develop an expert group including psychiatrists to verify these questions. KMA plans to play an active role as the medical expert until the new law takes effect. As the first step, KMA delivered its opinion on behalf of Korea's medical professionals at a discussion session held at the National Assembly last July. KMA will continue to play a pivotal role in leading public opinion on this issue based on its expert knowledge.

The 46th CMAAO
Mid-term Council Meeting
September 16-18
Kuala Lumpur, Malaysia

Country Report

Activities of Korean Medical Association
2009-2010

In Sung CHO, MD, PhD
Executive Board Member
Korean Medical Association

 Korean Medical Association

Contents

1. Fighting against Tobacco
2. Redefining Medical Delivery System
3. Medical Relief Effort in Haiti
4. Debate on Death with Dignity

1. Fighting against Tobacco

The 1st International summit on Tobacco Control in Asia and Oceania Region (Sampran, February 2010)

The Meeting adopted "The Sampran Declaration"

- It calls on all CMAAO members a stronger initiative in anti-tobacco programs and efforts to raise public awareness on the need for a tobacco-free society
- In accordance to the Sampran Declaration, KMA announced a statement calling on the Korean government to improve its smoking cessation policies and develop more systemic approaches to fight smoking

⇒ The declaration is to be adopted as a CMAAO Policy

1. Fighting against Tobacco

Smoking situation of Korea

- Korea has one of the highest smoking rates in the world, especially among its younger population
- Korea's adult male smoking rate is 15% higher than the OECD

Reasons for the higher smoking rates

- Lack of efforts by the government and medical society
- Lack of long-term integral plan for reducing smoking
- low price of tobacco

1. Fighting against Tobacco

KMA issued a joint statement with other health professionals' organization in Korea (August 2010)

- Emphasizing the immense harm that smoking poses to public health, economic productivity and the national health insurance's finances
- Strongly calling on the government to revisit all existing anti-smoking policies and to devise a much more effective set of programs
- Proposing a double digit increase in cigarette prices
- Non-price policies such as expanding non-smoking areas, banning cigarette advertisement and strengthening the warning labels

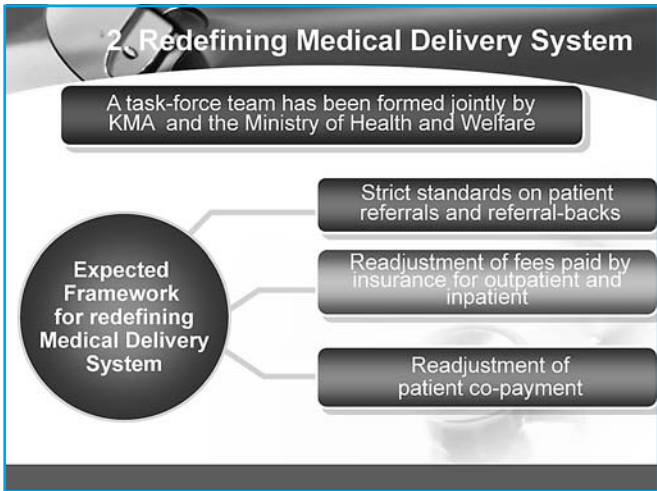
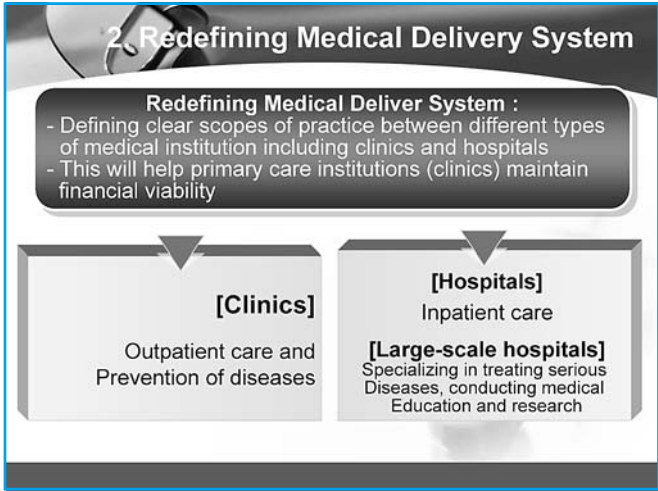
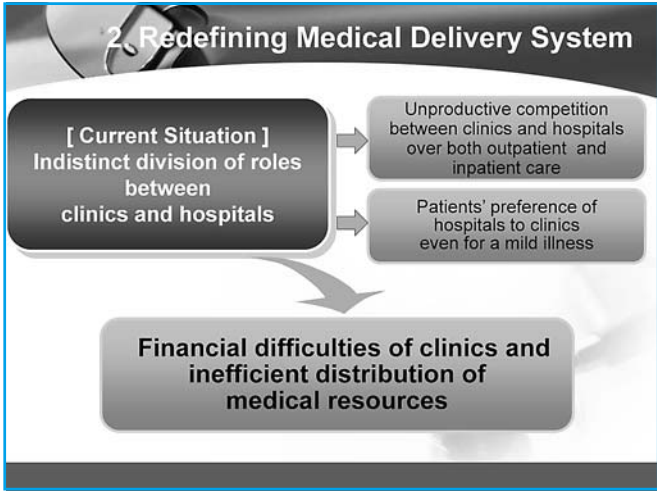
1. Fighting against Tobacco

Impact of the Joint Statement

Building public
Support for cigarette
Price increases

Strengthening ties
of medical societies
and anti-smoking
groups

⇒ KMA will continue to follow up the joint statement and push for the necessary legal revisions to implement these policies



3. Medical Relief in Haiti

Earthquake in Haiti



On January 13, 2010, a devastating 7.0 magnitude earthquake struck the areas surrounding the Haitian capital city of Port-au-Prince:

- About 220,000 dead
- 320,000 wounded
- 800,000 homeless

3. Medical Relief in Haiti

Earthquake in Haiti



3. Medical Relief in Haiti

Dispatch of KMA Medical Team

- KMA dispatched a series of 4 medical teams to Haiti over 2-month period. (Jan. 25~Mar. 7)
- KMA medical teams treated over 5,500 people in Haiti.



3. Medical Relief in Haiti

Dispatch of KMA Medical Team



3. Medical Relief in Haiti

Follow-ups to share experiences

Publishing a report based on the field experiences in Haiti to be used as a manual for future disaster medical relief

Creation of the Social Cooperation Committee to leverage the lessons learned from Haiti and to act as the expert on providing professional and systematic medical relief to distressed areas

4. Debate on Death with Dignity

Korea's first court ruling in favor of discontinuing life-sustaining treatment (May 2009)

- With this ruling, mechanical ventilation was stopped on an elderly patient identified Mrs. Kim
- The situation became complicated as she continued to breathe on her own even after the removal of the ventilator
- Mrs. Kim did pass away on January 10, 2010, which was 201 days after the removal of the ventilator
- Her ability to survive without life-sustaining treatment triggered heated debate on the appropriateness of the ruling and death with dignity

4. Debate on Death with Dignity

KMA has been leading discussion on the basic framework for preparing any law or system defining the concept, timing, methods and medical grounds for death with dignity

4. Debate on Death with Dignity

Agreement among religious, medical, legal and civic groups (July 2010) on standards on discontinuing life-sustaining treatments

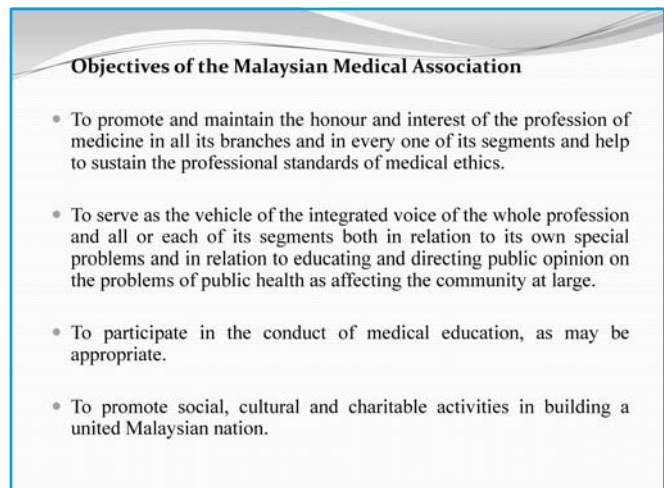
- Life-sustaining treatment can only be discontinued on Patients who are terminally ill or who are in a vegetate state and suffer from a terminal disease
 - Even when life-sustaining treatments are discontinued on patients, basic treatments such as nutrition and hydration supply cannot be stopped
 - The patient himself must have expressed his or her written wishes to forgo life-sustaining treatment in advance
- ⇒ These standards will be used as a framework in drafting of the final bill on discontinuing life-sustaining treatment

Thank you

MALAYSIAN MEDICAL ASSOCIATION



N.K.S. THARMASEELAN*1



*1 Honorary General Secretary, Malaysian Medical Association, Kuala Lumpur, Malaysia (info@mma.org.my).

This presentation was made as the annual activity report during the Country Report session at the 46th CMAAO Mid-term Council Meeting, Kuala Lumpur, Malaysia, on September 17, 2010.

MMA COUNCIL 2010/2011

The MMA Council consists of the following key office-bearers who are also members of the Executive Committee; as well as 21 branch representatives from the 14 states in Malaysia.



We have two Sections in our Association, namely:

The Section Concerning House Officers, Medical Officers & Specialists (SCHOMOS)

- Its objective is to identify, address and seek the cooperation of the government to resolve issues relating to the welfare, pay, and allowances and working conditions of all grades of doctors in government service.
- SCHOMOS over the years has evolved into a powerful Section of the MMA which conducts periodic meetings with the Director General and other top Ministry of Health officers and has achieved many notable successes in its ventures.
- The issues discussed periodically includes: clinical allowance for medical officers, review of specialist allowance, overtime pay, promotion prospects for medical officers and specialists, etc.



The Private Practitioners Section (PPS)

- Private Practitioners Section of MMA was established to look after the needs of the private practitioners.
- PPS continues to be the negotiating arm of the Association in all matters relating to private practitioners, quality of pharmaceuticals, dispensing and labelling, disposal of clinical wastes, FOMEMA, SOCSO, MCOs, Private Healthcare Facilities and Services Act and Regulations, National Health Financing Scheme, Globalisation, to name a few.
- Currently, MMA is working with Primary Care Organisations to address increasing woes of the General Practitioners.

The 4 Societies under the umbrella of MMA are:

- Public Health Society
- Society of Sports Medicine
- Society of Occupational and Environmental Medicine, and
- MMA Society of Medical Students.

We also have 29 Committees and MMA is represented on 36 external bodies – government and non-governmental organisations (NGOs).

MMA Membership

- Currently there are over 30,000 registered medical practitioners in the country and only about 9,500 active MMA members.
- This 30% representation of all doctors in the country is still the largest and we are the oldest and most experienced and engaged.
- The MMA has been in the forefront in promoting and looking after the welfare of doctors including non-members who reap the benefits;
- The MMA believes that we can play an even greater and more meaningful role because we continue to have within our means, very interested members and experts who sacrifice huge personal time and effort to study, research and understand healthcare issues, which we believe we can share with the regulatory authorities.
- 4770 of members are in private practice (GP or specialist), 3250 work in the government and army, 378 are in universities (private and public) and 2028 student members.

We have two Publications



Medical Journal of Malaysia (MJM) Published Quarterly

- Historically, the first medical journal publication in the country originated in 1890 as the Journal of the Straits Medical Association and it is stated that it could be found in the archives of medical libraries in many parts of the world.
- Soon after the founding of the Malayan Medical Association 1960, the Medical Journal of Malaya was recognised as an official publication of the Association.
- The Journal is listed in Index Medicus and continues to enjoy a premier position in the country as a multi-specialty journal with established international recognition, providing a publication medium for Malaysian doctors as well as for contributors from all over the world.
- Since January 2010 the all new articles have been accepted online and recently all published articles are available online.

Berita MMA Published Monthly

- The Berita MMA began as a Newsletter in 1960.
- Since 1969, the Berita MMA made its regular monthly appearance and developed into an important medium to keep members informed of activities of the Association and its various committees, developments in the healthcare services in the country and general news and feature article of professional interest.
- The Berita MMA was given many facelift over the years and we strive to make this magazine attractive and readable to our members.

Continuing Professional Development (CPD) Committee

- The continuing education of doctors is a vital component in the ultimate delivery of quality health care to our people and in recognition of this adage, the MMA launched the CME Committee and in 1994, MMA was appointed by the Malaysian Medical Council (MMC) to administer the MMC-CME Grading System and the accruing of annual credit points by doctors leading to the issuance of a certificate by the President of MMC.
- MMA dedicated itself with enthusiasm on this project and spared no expenses in making it a nation-wide success through purchasing of computer hardware for all state Branches and engaging secretariat staff.
- This service is provided free for all MMA members.

50th MMA National Annual General Meeting

- The MMA National AGM was organised in May 2010 in the historic state of Melaka.
- The AGM was preceded with two Pre-AGM Scientific Sessions namely: "Occupational Health for Healthcare Professionals" and "Orthopaedics (Office Orthopaedics)".



MMA 50th Anniversary Celebration

- The Dinner graced by our Prime Minister, YAB Dato' Sri Mohd Najib Tun Abdul Razak was the culmination and highlight of our 50th Anniversary Celebration which was held in July 2010. About 700 members were present.
- The other activities planned are:
 - printing a coffee table book on the history of MMA,
 - press coverage on MMA's achievements,
 - interviews with Past Presidents who were from the 50's era,
 - blood donation campaign,
 - National Pap Smear Campaign,
 - Dinner with the Prime Minister,
 - 50th Year Stamp and First Day Cover,
 - Health Run & Talk,
 - Golf Competition,
 - National Public Forum, etc.



INTERNATIONAL AFFAIRS

WMA Seminar on Climate Change and Healthcare

- This seminar was held on 1 September 2009 at the Danish Engineers Building, Kalvebod Brygge, Copenhagen, Denmark.
- Dr David K L Quek, President and Dato' Dr Sarjeet Singh Sidhu, Honorary Deputy Secretary, attended this seminar.

World Medical Association (WMA)

- The World Medical Association (WMA) General Assembly was held on 14-17 October 2009 at the Hotel The LaLiT, New Delhi, India.
- The MMA was represented by Dr David Quek, President, Dato' Dr N.K.S. Tharmaseelan, Honorary General Secretary, Dato' Dr Sarjeet Singh, Honorary Deputy Secretary and Dato' Dr Mohan Singh, PPS Chairman.

WMA Leadership Course 2010

- The WMA organized the INSEAD – Leadership Development Programme from 8-13 February 2010, INSEAD, Singapore.
- Dato' Dr Khoo Kah Lin, Dato' Dr N.K.S. Tharmaseelan and Dr Hooi Lai Ngoh attended this course.
- The overall goal of this course was to make the participants more effective in their roles as leaders in their country's medical association, and as team members of the World Medical Association.
- More specifically, the program sought to enhance their competencies as decision makers, leaders and team members, shapers of health policy and spokespersons for the medical profession.

Confederation of Medical Associations in Asia and Oceania (CMAAO)

- The 26th Congress and the 45th Council Meeting of CMAAO was held on 5-7 November 2009 at the Intercontinental Bali Resort in Bali, Indonesia.
- The MMA was represented by Dr David K L Quek, President, Dato' Dr N.K.S. Tharmaseelan, Honorary General Secretary, Dr Hooi Lai Ngoh, Honorary General Treasurer and Datuk Dr Teoh Siang Chin, CMAAO Councilor.

The First Conference on Tobacco Control Among Asian and Oceania Countries

- The Medical Association of Thailand In collaboration with the Confederation of the Medical Associations in Asian and Oceania (CMAAO), The WHO (Thailand) and Thai Health Professional Alliance against Tobacco organized this conference from 25-27 February 2010 at the Rose Garden Hotel and Resort, Thailand.
- The emphasis of this conference was on all aspects of tobacco control, such as health hazards, public awareness, impact of second hand smokers especially in pregnant women, etc.
- Dr David K L Quek, President, attended this conference on behalf of the MMA.

CURRENT NATIONAL PROBLEMS

- MMA have had several dialogue sessions with the Minister of Health and some of the problems discussed were:



1 Malaysia Clinics To Include / Utilise GP Clinics

- The setting up of 1Malaysia clinics by the government in aid of the urban poor in the country is mushrooming;
- These clinics are manned by Medical Assistants and Nurses.



The MMA's Stand Conveyed to the Ministry of Health and the Government

- Have doctors run these clinics;
- Highlight on the safety and quality of healthcare that will prevail in 1 Malaysia Clinics;
- Legal implications of having non-doctors manning 1Malaysia Clinic;
- Double standards by MOH, as GPs cannot employ non-doctors whereas MOH employed paramedical staff to run 1Malaysia Clinic;
- The GPs were not given the opportunity to do locum in the public sector hospital as these locum opportunity was being given to government doctors;
- Rope in existing GP Clinics to help out in this exercise to reach out to the poor;

GP's Play a Critical Part in Our Malaysian Healthcare

- Our National Health and Morbidity Survey (2006), showed that 62% of all Malaysians utilize the widespread GP clinics in towns and cities for their common day to day ailments.
- Disproportionate clustering of urban GP clinics has led to intense competition.

- There is a decline in GP income, affecting some one quarter to one third of GP's, i.e. who work as locums or solo practitioners. Modern healthcare implies a greater and more universal adoption of ICT. Upgrading of amenities and implementation of a common portable form of Clinical or Medical Information System (including Electronic Health Records) is another objective, which should be encouraged and incentivized.
- The MMA urged the government to consider offering such incentives of matching grants and tax breaks to motivate more and more GP's and solo practitioners to upgrade their services and amenities. This also applies to credentialing issues, which is to enhance patient safety and improve standards and delivery of services

General Practitioners' Woes Mounting

- Private sector doctors and GPs are also concerned with many other competing issues such as feeder clinics, wellness health screening centres, pathology laboratories posing as clinics, Managed Care Organisations, third party payer or insurance discounting, capping and selection, harassments' from MOH officers implementing PHCFSA
- The GPs in the country seem to have been assaulted from all angles.

GP SUMMIT 2010



Too Many Medical Colleges, Medical Graduates, Quality & Training Issues

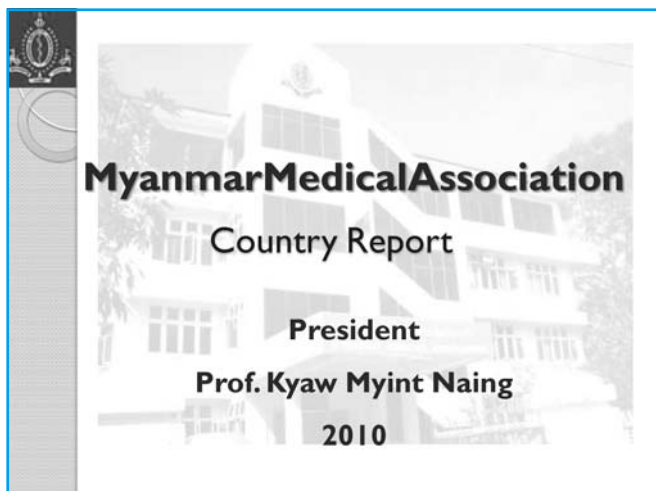
- Recently, we have had overflowing junior doctors crowding our public hospitals. Last year we had some 3,150 House Officers (HO's), and this year more than 3,600 HO's thus far.
- We expect some 4000 to 5000 new House Officers entering service year on year from 2011 onwards. We now have more than 28 operating medical schools with some 37 medical programmes producing close to 2,000 new medical graduates yearly, with more being forecast in the next few years

Glut of Medical Doctors Imminent, Moratorium on Medical Schools Now. What next after 2015?

- By 2020, we expect that we might have as many as 80,000 doctors, which would mean that we cannot sustain their training even for their houseman ship years or retaining them in the public sector.
- The private sector could also be very crowded and doctors could become unemployed, underemployed, and unemployable even.
- This would be a sad scenario because Malaysian parents and the government would have spent so much money sponsoring these students, at huge costs!
- We are urging the government to quickly establish a moratorium on medical schools and programmes and enforce more stringent quality assessment of these schools and beyond.

MYANMAR MEDICAL ASSOCIATION

Kyaw Myint NAING*¹



MYANMAR

AREA

676,578 square kilometers
2200 kilometers from North to South
925 kilometers from East to West

Population = 59 million
Population growth rate --- 1.75



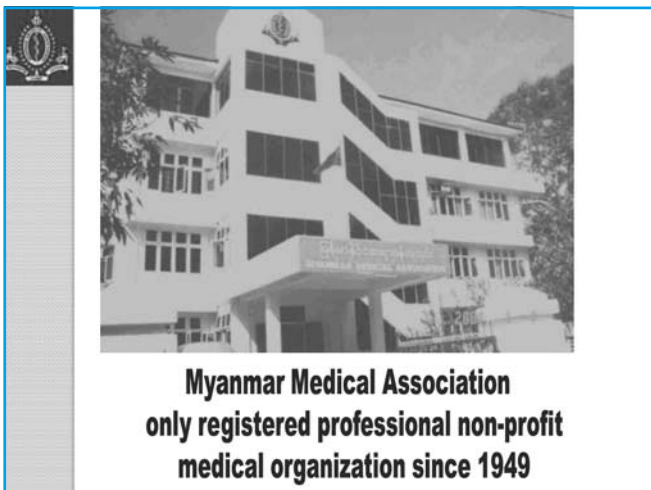
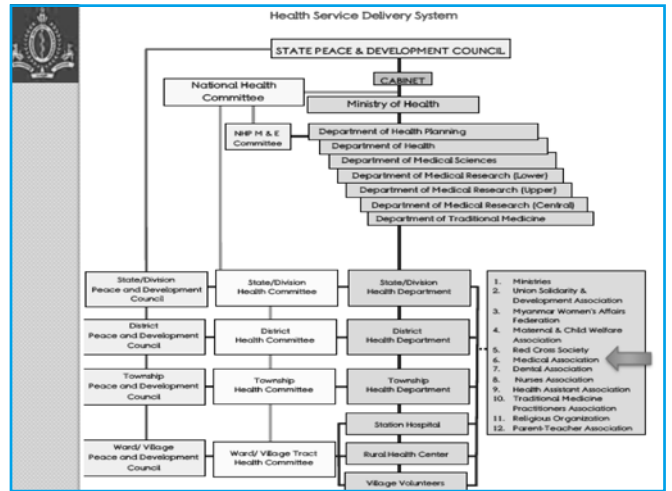
Number of Doctors

Total number of doctors --- 23709 (2008-2009)

• 30,000 in 2010

- Public (in-service) --- 11158 (2009 – 2010)
- Co-operative and private --- 14858 (2009 – 2010)

*1 President, Myanmar Medical Association, Yangon, Myanmar (mma.org@mptmail.net.mm). This presentation was made as the annual activity report during the Country Report session at the 46th CMAAO Mid-term Council Meeting, Kuala Lumpur, Malaysia, on September 17, 2010.



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- Web
 - www.mmacentral.org

Vision

- To be instrumental in promoting the health of the people by enhancing the professionalism of the members

Mission

- Working together, sharing responsibility and experiences with strong commitment towards quality health care

Motto

“ Good Doctors for Quality Service”

Organization Set up



Executive committee of MyMA

- Founded since 1949
- Our 28th President, Prof. Kyaw Myint Naing, is also the Chairman of the Myanmar Medical Council

Capacity Development

- Organization Development Program was initiated last year
- New MyMA building (Headquarters) is now under construction in Nay Pyi Taw
- New MyMA branch buildings have been constructed in three states and regions

Legal Framework of MyMA

- New constitution, by-laws and regulations, was successfully revised in 2009 May including organizational policy and legal protection
- One legal advisor was provided
- Ongoing process for ways and means of medical protection mechanism for member doctors
- Mechanism of ensuring members' rights and responsibilities

Organizational Attitude

- Non-political, non-governmental, non-profit, independent registered medical professional organization
- Stands for professional integrity and loyalty
- To help and serve our people to the utmost

CME

- Annual scientific conferences by Central MyMA
- Annual scientific conferences by major township Medical Associations
- Biennial scientific conferences by specialist societies
- Mid-term scientific conferences by some societies
- Seminars on specific subjects by respective societies
- Advanced refresher courses for junior specialists
- Regular CME courses for GPs

MyMA involvement in MDGs

- To reduce the maternal and child mortality
- Activities
 1. Reproductive health projects
 2. HIV/AIDS projects in maternal and child health
 3. Obstetric and Pediatric emergency trainings for community doctors
- Role in private sector development (e.g. PPM policy)

MyMA involvement in 3diseases

- Malaria projects – QDSTM
- MyMA TB DOTS project
- Reproductive health project including HIV/AIDS
- Collaborated with 3D funds, WHO, UNFPA

Hands-on skill trainingcourses

- Basic surgical skill courses
- Primary trauma care courses by central MyMA in collaboration with Royal Australasian College of Surgeons and PTC foundation
- Imaging courses
- ECG courses

Human resource development

- CPD program for new generation doctors with training allocation and mobilization
- Youth training program
 - Basic ARH training
 - TOT for basic health education
 - Leadership
 - Capacity building
 - Training aids development
 - Peer Education program
 - HIV/AIDS knowledge fair

Social activities

- Women section
- Buddhist section
- Support Group for Elderly Doctors-SGED
- Sport and Recreation section
- Doctor-writer section
- Healthcare volunteer group



Future Interest

- Healthcare financing- (e.g. Health insurance)
- Primary trauma care service leading to pre-hospital care system
- Compulsory CME towards Accreditation Program

THANK YOU

NEW ZEALAND MEDICAL ASSOCIATION



Peter FOLEY*1

Overview

New Zealand is a country of 4.4 million people in the South Pacific. It has now been almost two years since the centre right National Party was elected into Government, headed by Prime Minister John Key.

Health expenditure in New Zealand as a proportion of GDP (nine percent) is similar to that in most other OECD countries. Expenditure on health in real terms has risen consistently over the last decade. In this time there has also been an increase in the number of health professionals, including doctors and nurses, although there are still critical shortages. The Government has strongly stated that the major increases in health funding seen in recent years are unsustainable in the long term and that it is up to the health sector to look at delivering health care in ways that are innovative and more cost-effective. There is a growing focus on value for money, with resources moving from administrative overheads to essential frontline health services.

Life expectancy has risen over the last half century. However, there remain disparities in life expectancy and health status based on ethnic and socioeconomic differences. Though our country is making progress on reducing this 'gap,' this is an area that the New Zealand Medical Association (NZMA) intends to have a greater involvement in, with the recent formation of an NZMA health inequalities sub-committee.

Over the past 15 years, New Zealand's health system has undergone major restructuring—from a purchaser/provider market-oriented model in 1993 to the current community oriented model. Since 2001 New Zealand has had largely autonomous District Health Boards (DHBs). These 20 DHBs are responsible for providing and funding health and disability services in each region.

Primary Health Organisations (PHOs) were set up as local structures for delivering and co-ordinating primary health care services and are funded by DHBs. The Government has stated its wish to have fewer PHOs (there are approximately 80 at present) and we are now seeing PHOs merging throughout the country. It is anticipated the number of PHOs will be significantly reduced by next year.

In recent years we have seen more resources directed towards primary (non-hospital) care. The Government is now looking at how we can better coordinate primary and secondary care, and is looking at integrating health services by shifting some health services, delivered in the secondary sector, to the primary sector where appropriate. This is in line with their policy document "Better, Sooner, More Convenient." The aim is to reduce the number of services that are delivered within a hospital, if they can be better delivered in the community. At the end of last year the Government sought expressions of interest (EOIs) from PHOs to submit proposals to deliver these services to their community. The primary sector responded well with many EOIs submitted. The shortlist of EOIs is now being assessed by a panel within the Ministry of Health.

The Primary Health Care Strategy, released in 2001, aims to improve access to health services and to reduce health inequalities for all New Zealanders. Patient subsidies have been increased over time to make primary health care more affordable. The challenge for general practitioners, most of whom are in private practice, has been to keep fees at reasonable levels for patients, while also ensuring business viability.

About the NZMA

The NZMA is the largest medical pan-professional

*1 Chair, New Zealand Medical Association, Wellington, New Zealand (chairman@nzma.org.nz).

The New Zealand Medical Association was absent from the meeting but submitted the annual activity report to the 46th CMAAO Mid-term Council Meeting, Kuala Lumpur, Malaysia, on September 17, 2010.

organisation in New Zealand with approximately 4,500 members. The NZMA represents member doctors from all disciplines within medicine, including medical students. It was established in 1886.

The key roles of the NZMA are:

To advocate on behalf of doctors and their patients.

To develop health policy initiatives.

To provide services and support to members.

To publish the New Zealand Medical Journal.

To publish and promote the Code of Ethics.

The NZMA has strong and effective working relationships with other medical organisations and often acts as a peak organisation for major issues affecting the profession. The NZMA has a strategic programme of advocacy with politicians and officials which is heard at the highest levels of government. We have strong relationships within the health sector and other government agencies, including the Ministry of Health, Accident Compensation Corporation, Department of Labour, and the Ministry of Social Development.

The NZMA is an organisation with a long and proud history, and is always looking to the future. We are proactive in our efforts to attain a world class health system. The Association has a strong track record for effecting change. Our opinions and input reflect our broad membership base, and are regularly sought at all levels of policy development and review.

Main Issues of Concern to NZMA

Workforce

For more than a decade, the NZMA has advocated for the Government to take a comprehensive and strategic approach to address our medical workforce crisis. New Zealand is facing shortages of doctors (and other health professionals) and difficulties in recruiting and retaining staff. The competitive global health market means many medical practitioners choose to work in other countries which often pay higher salaries. New Zealand has an over-reliance on overseas trained doctors—around 45 percent of doctors working in New Zealand did not train here. The NZMA has long argued that our health workforce needs to be self-sufficient. We are now seeing real progress to boost our workforce with the Government implementing a range of initiatives to improve recruitment and retention.

Workforce initiatives introduced by the

Government include: incremental increases in medical student training places, the Voluntary Bonding Scheme (debt relief in exchange for graduates working in hard to staff areas) and interest free loans for students who stay in New Zealand. There have also been a number of workforce reports released, for example, a report for Senior Medical Officers which makes recommendations to improve working conditions and to ensure clinicians are more valued within their workplace. A common theme of these workforce reports has been the need for a cultural shift to better value doctors where, for example, senior doctors are encouraged to teach and training time is protected for doctors in training.

In 2009 a new organisation, Health Workforce New Zealand (HWNZ), was established to lead and coordinate the planning and development of our country's workforce. Its aim is to have a high quality, self-sufficient and motivated health workforce that can meet the health needs of New Zealand. HWNZ is developing projects which include an enhanced training experience for resident medical officers through more structured career guidance, training and personal support. HWNZ is working in collaboration with training providers and professional bodies to achieve its goals.

The aim now is to take on board the various workforce reports, such as optimising the opportunities for clinical leadership, to enable us to improve recruitment and retention of our medical workforce.

New Zealand's medical workforce has many challenges to overcome—an increasing demand for health services in light of our ageing population, the ageing doctor workforce which is not being adequately replenished, doctor dissatisfaction and morale, general practices closing their books to new patients or not being able to provide timely appointments for patients and doctors leaving New Zealand in high numbers.

The NZMA will continue to be a strong advocate to ensure that progress and momentum on workforce issues is sustained.

Health structure & equitable access to health

The NZMA has been a long time advocate for a less fragmented health structure with a reduction in bureaucracy, duplication and waste. We are now seeing some progress to achieve these goals.

The recommendations of a report released in 2009, the seminal Ministerial Review Group Report, have largely been adopted by the Government. Recommendations focus on creating a more centralised and coordinated health management system to provide a more equitable health service across all regions. At present there is huge variation and inconsistency in the performance of DHBs, which means that the health care a person receives is largely dependent on which part of New Zealand they live in.

A new organisation has been formed called the National Health Board (NHB) whose primary role is to improve frontline health services and to supervise the \$10 billion of public health funding DHBs spend on hospitals and primary health care. It will do this by managing the national planning and funding of all IT, workforce planning and capital investment. The NHB comprises senior doctors and nurses to ensure strong clinical input into the Board's advice and oversight.

The NZMA has been supportive of the NHB's goals. We are however disappointed that the Government does not intend to reduce or at least consolidate the 20 DHBs which are too many for a population of just over four million, and make it difficult to achieve health care that is nationally consistent.

Primary health care

The Primary Healthcare Strategy has led to improvements in general practice and made it more affordable for patients to visit their GP. The focus must now be on strengthening clinical services, particularly in light of Government policy to improve integration of primary and secondary services. The future delivery of healthcare is increasingly in a non-hospital setting. Appropriate funding is necessary to achieve this goal, as well as engagement of doctors from both sectors.

The NZMA's GP Council provides a political voice for GPs and is also a key member of the General Practice Leaders Forum (GPLF), which comprises seven organisations. The GPLF provides a united voice for general practice but still enables individual voices to have an influence. How to best represent the interests of general practice is an ongoing priority for the NZMA. The NZMA also hosts the largest general practice conference in New Zealand, the GP CME, which takes place every year in Rotorua. This year

we added a second conference, the South GP CME in Christchurch, to meet growing demand.

Secondary/Tertiary services

Patients face delays and long waiting lists in many areas, to get access to publicly-funded secondary and tertiary services. This is particularly a problem in relation to first appointments with specialists, and the long waiting times for many elective procedures. Many are unable to access specialist treatment, and are returned to the care of their GP for what is called 'active review.' This lack of timely access to healthcare causes great distress to many New Zealanders and their families. The NZMA is keen to see a more transparent approach to managing the wait for necessary care.

Maternity services

New Zealand's maternity services, while of a very high standard internationally, have been adversely affected by workforce shortages. Since changes to regulations in 1996, the vast majority of general practitioners have given up intrapartum obstetric care and the number of doctors practising obstetrics and gynaecology has decreased dramatically. Most maternity care is now delivered by midwives. Many women report difficulties in accessing midwifery services due to a shortage of midwives. Pressures also exist on other medical disciplines, including anaesthesia, radiology and paediatrics, which have implications for the provision of maternity services. The National Government has indicated it will not make changes to the structure of maternity services in the foreseeable future. However, the NZMA continues to advocate for the reintegration of maternity services into primary care.

Health contracting

The NZMA has strongly advocated for a national policy framework to be implemented for health contracting processes. The switch to a new laboratory provider last year, in our largest city, led to widespread problems which were largely attributable to not having robust national contracting processes in place. There was widespread upheaval due to a diminished standard of service for diagnostics. The NZMA played a significant role in leading the call for immediate redress but most importantly, we highlighted that there had been failings in the contracting process from the

beginning and that we needed to learn lessons from this experience. These included: the need for contestable laboratory services, a national policy framework in health contracting (and indeed in other areas of health), the need for adequate consultation with health professionals and the imperative for separate management of any transition process. At present the Government is undertaking a review of the transition process that occurred and we await with interest the recommendations that will emerge from this review.


On a personal note, I have taken on two new positions—both of which contribute to my inability to attend this years CMAAO gathering.

I am now the Deputy-Chair of New Zealand's Health Quality & Safety Commission, and have recently accepted a position as a district health board chief medical officer. This latter position aims to assist the integration of hospital & non hospital patient care so that we remove siloed medicine from a new seamless patient-focussed health system!

PHILIPPINE MEDICAL ASSOCIATION



Oscar D. TINIO*1




PHILIPPINE MEDICAL ASSOCIATION

CONFEDERATION OF MEDICAL ASSOCIATIONS
IN ASIA AND OCEANIA (CMAAO)

COUNTRY REPORT 2010-2011

OSCAR D. TINIO, MD
PRESIDENT



PMA Leadership Directions (2010-2011)

- Promote the involvement and participation of the membership in organizational affairs;
- For the PMA to serve as a Guardian in protecting the rights, restoring and upholding the dignity, uplifting the pride and mending the difficulties and challenges facing the Filipino physician and the medical profession;
- Tool for connecting people and medium for exchange of views and bridging of ideas to attain unity and harmony;
- Push the standards of the Association to regain the trust, confidence and love of our people and the patients we serve;
- To be conscious and proactively act and respond to prevailing local, global, political, social environments;
- Use the collective wisdom, knowledge, skills, experience of the more than 100 years of the PMA's existence.



Imperatives: Key Areas

1. Membership Development and Benefits
2. Competency Building and Professional Development
3. Organizational, Resource and Infrastructure Development
4. Unification and Networking
5. Fiscal Stability and Financial Independence
6. Socio-Civic, Environmental and Other Advocacies
7. Legislative and Political Agenda



Membership Development and Benefits

- Identify, understand problems and provide solutions to competency, capability, resource availability and environment;
- Philhealth benefit enhancement
- Implementation of Magna Carta for Healthcare Workers
- Salary Standardization
- Mutual Aid Fund

*1 President, Philippine Medical Association, Metro Manila, Philippines (philmedas@yahoo.com).
This presentation was made as the annual activity report during the Country Report session at the 46th CMAAO Mid-term Council Meeting, Kuala Lumpur, Malaysia, on September 17, 2010.



Competency Building and Professional Development

- Observe Medical Ethics and Standard Patient Care
- Strengthen CME
 - CME On Line
 - Referral system must work
 - Define levels of competency of specialties
 - MRA
 - PhilHealth Accreditation
 - PRC Circulars 1 and 2, Series of 2010



Competency Building and Professional Development

- RA 2382 (Medical Act of 1959) and RA 8991 (PRC Modernization Act of 2000), mandate the PRC to:
 - Standardize, Supervise, Monitor, Control and Regulate the practice of the profession;
 - Adopt measures to enhance the profession
 - Reiteration for PMA as APO
 - Mandatory membership to the PMA
 - PMA membership as a requirement for renewal of License
 - License and certificate of registration does not give a physician the blanket license to practice all fields of specialization of medicine, thus the need to undergo training and certification as specialist in the recognized specialization of the PMA



Competency Building and Professional Development

- Develop PMA - CPG Clearing House
- Strengthen and promote research as basis for national consensus guidelines for evidence based medicine
- Recognition of emerging specialties and disciplines, i.e., Division on Public Health Medicine, General Medicine, etc.
- Determination of manpower distribution
- Encourage selective training of specialists based on geographical specialty necessity
- Augment competency of Generalists in the context of specialization
- PMA Constitutional Amendment



Organizational, Resource and Infrastructure Development

- Professionalize manpower staff by training, review of tasks and compensation
- PMA Computerization
 - Database management
 - Electronic Financial Transactions
 - Membership Processing
 - Adjudication of Claims
 - Documentation and Data Retrieval
 - Information Dissemination thru Web Portal
 - Linkage to Local and International Partners and Specialties
 - Interactive CME on-line
 - Public Access to Health Information
 - Electronic Medical Record



PMA Web Address

www.philippinemedicalassociation.org



Unification and Networking

- Streamline Specialty Organizations/Associations
- Enhance local and international recognition of the PMA
- Cooperation, participation in healthcare programs by the DOH, WHO, WMA, CMAAO, MASEAN, USAID, etc
- Recognition, cooperation and coordination with Allied Healthcare Organizations, i.e., PNA, PAMET, Midwifery Org, etc
- Enhance media visibility, cooperation and consciousness



Fiscal Stability and Financial Independence

- Reduce or totally eliminate dependency on sponsorships
- Conversion of PMA property to a Multi- purpose commercial establishment
- Fund raising activities
 - Repertory Phils. Tie-up
 - Manila Bulletin Partnership



Socio-Civic , Environmental and Other Advocacies

- Pursue efforts and involvement in promoting advocacies on health, i.e., Anti-cigarette Smoking, Support DOH-AO on Graphic Presentation of Ill effects of smoking on cigarette packs, AO on Supplements, breast feeding, environmental advocacies, etc.
- Strengthening/Creation of Disaster Management and Preparedness Programs
- Indigency Center



Socio-Civic , Environmental and Other Advocacies

- Tree Planting
- Blood donation program
- Anti-cigarette smoking advocacy
 - PMA Resolution vs Cigarette Smoking for Physicians
- Breast Feeding advocacy
- Seat Belt advocacy
- Anti Drug Program – “Iwas Musmos”
- Patient Safety Advocacy



Political and Legislative Agenda

- Support programs, issuances, orders or bills for a safer, stronger and secured practice of medicine and oppose bills that are detrimental to the practice of medicine and the health of our people.
 - Physicians Act of 2009
 - Patient’s Right Bill
 - PMA Integration



**THANK YOU!
MARAMING SALAMAT
PO!**

SINGAPORE MEDICAL ASSOCIATION



CHONG Yeh Woei*¹

SMA Developments

Membership

As at August 2010, the total membership of the Singapore Medical Association stood at 5,277. This represented 57% of all 9,335 registered practitioners in Singapore.

51st SMA Council

The following are the office bearers for the 51st SMA Council for the year 2010/2011.

President	Dr. Chong Yeh Woei
1st Vice President	Dr. Toh Choon Lai
2nd Vice President	A/Prof. Chin Jing Jih
Honorary Secretary	Dr. Abdul Razak Omar
Honorary Treasurer	Dr. Tammy Chan
Honorary Asst. Secretary	Dr. Wong Tien Hua
Honorary Asst. Treasurer	Dr. Lee Yik Voon
Members	Dr. Noorul Fatha As'art Dr. Chow U-Jin Dr. Lee Pheng Soon Dr. Tan Sze Wee Dr. Tan Yia Swam Dr. Toh Han Chong Dr. Wong Chiang Yin Prof. Wong Tien Yin Dr. Bertha Woon

Conferences & seminars

SMA Lecture, 30 January 2010

Instituted in 1963, themes are centred on medical ethics and related topics. The lecture, "Entrepreneurship in Medicine—Resolving Conflicts of Interest in For-Profit Medical Enterprise" was held at the Health Promotion Board Auditorium, and presented by Dr. T. Thirumoorthy.

SMA House Officers Seminar

168 newly minted house officers attended the House Officers Seminar on 24 April 2010 at the National University of Singapore. Talks during

the seminar included topics such as "Being a Doctor: What it means to be professional," "Morning Ward Round" and "Night Duty."

SMA Annual Dinner 2010

Held on 8 May 2010, the SMA Annual Dinner was organised at the Shangri-La Hotel. The Guest-of-Honour was Senior Minister of State, Ministry of Foreign Affairs, Dr. Balaji Sadasivan. SMA also conferred the SMA Honorary Membership on SMS Balaji Sadasivan, Prof. Tan Cheng Lim, and Prof. Woo Keng Thye. This is the highest honour that SMA can bestow on persons who are distinguished in public life or who have rendered meritorious service to the medical profession or to the association.

SMA 41st Annual Medical Convention, 10 July 2010

The theme of this year's Convention was "20/10 Trends In Eye Care," and it was attended by more than 600 participants. The talk focused on the latest updates on early prevention or treatment of common eye problems, including glaucoma, diabetic retinopathy, cataract, myopia, age-related macular degeneration, as well as LASIK. Free eye screening was also presented to the public, an effort on the part of the SMA and the Singapore National Eye Centre (SNEC) to provide the benefits of early detection, as well as to facilitate timely treatment. The eye screening was an inter-institution collaboration, and doctors conducting the screening came from SNEC as well as three other hospitals.

Other seminars & workshops

Throughout the year 2010, the SMA Centre for Medical Ethics & Professionalism (CMEP) organised an Advanced Specialist Training Course on Medical Ethics, Professionalism and Health Law. The course equips trainees with necessary communication skills and working knowledge of clinical ethics and local health

*1 President, Singapore Medical Association, Singapore (sma@sma.org.sg).

This article is based on a presentation made as the annual activity report during the Country Report session at the 46th CMAAO Mid-term Council Meeting, Kuala Lumpur, Malaysia, on September 17, 2010.

statutes. In addition, trainees develop more systematic and professional approaches to common ethical and medico-legal issues in Singapore.

SMA also helps to co-organise the Medical Protection Society (MPS) “Mastering Your Risk” and “Managing Adverse Outcomes” workshops, an interactive 3-hour workshop presented by doctors on practical communication techniques and skills to assist doctor-patient interactions.

The SMA Guideline on Fees was withdrawn on 1 April 2007 after SMA received indications that GOF might contravene the Competition Act. Arising from recent exchange of correspondence with the Competition Commission of Singapore (CCS), SMA submitted an application for a decision on whether GOF could be excluded from the Competition Act. The application fee of S\$5,000 was paid by Council Members and a well-wisher. The CCS has come to the decision that the GOF cannot be excluded, and will infringe the Competition Act if re-instated.

Country Developments

Division of Singapore’s health facilities into 5 clusters

The public healthcare facilities now fall under 5 broad clusters: Alexandra Health Pte Ltd, Jurong Health Services, the National Healthcare Group, National University Health System, and Singapore Health Services. These integrated net-

works enable comprehensive, and yet affordable quality healthcare services through co-operation and collaboration between public healthcare establishments.

Amendments to the Human Organ Transplant Act (HOTA)

The HOTA allows for the kidney, liver, heart and cornea to be recovered in the event of death from any cause for the purpose of transplantation.

From 1 November 2009, HOTA will cover all Singaporean citizens and Permanent Residents of 21 years and above, who are of sound mind, unless they have opted out. The upper age limit of 60 years has been removed.

Besides deceased organ donation, HOTA also provides for the regulation of living donor organ transplantation (i.e. the removal of organs from a living donor for transplantation into a patient).

Medisave for approved overseas hospitalisation

From 1 March 2010, Singapore residents will be able to use their Medisave to help pay for their hospitalisation overseas under certain conditions, so as to give patients wider choice, and to allow them to take advantage of the lower cost of hospitalisation overseas.

The scheme will start off with two providers: Health Management International and Parkway Holdings Pte Ltd.



SINGAPORE MEDICAL ASSOCIATION COUNTRY REPORT

Presented at the 46th CMAAO MID TERM COUNCIL MEETING

DR CHONG YEH WOEI
President, 51st Council
Singapore Medical Association

Membership

❖ As at August 2010, total membership of the Singapore Medical Association stood at **5,277**.

❖ This represents **57%** of all 9,335 registered medical practitioners in Singapore.

❖ Percentage of doctors who are SMA members has dropped to 60% and below in recent years, mainly due to the influx of foreign-trained doctors which has increased the overall number of doctors in Singapore. SMA is currently working with the public hospitals to reach out to this group.



51st Council 2010-11



51st Council 2010-11

President
1st Vice President
2nd Vice President
Honorary Secretary
Honorary Treasurer
Honorary Asst Secretary
Honorary Asst Treasurer

Dr CHONG Yeh Woei
 Dr TOH Choon Lai
 A/Prof CHIN Jing Jih
 Dr Abdul Razakjr OMAR
 Dr Tammy CHAN Teng Mui
 Dr WONG Tien Hua
 Dr LEE Yik Voon

Members

Dr CHOW U-Jin
 Dr TOH Han Chong
 Dr LEE Pheng Soon
 Dr TAN Sze Wee
 Dr Noorul Fatha AS'ART

Dr TAN Yia Swam
 Dr WONG Chiang Yin
 Prof WONG Tien Yin
 Dr Bertha WOON Yng Yng



Conventions & Seminars



Conventions & Seminars

SMA Lecture

❖ Held on 30 January 2010.

❖ Instituted in 1963, themes are centred on medical ethics and related topics. The lecture, "**Entrepreneurship in Medicine – Resolving Conflicts of Interest in For-Profit Medical Enterprise**" was held at the Health Promotion Board Auditorium, and presented by Dr T Thirumoorthy.



Conventions & Seminars

SMA House Officers Seminar

❖ 24 Apr 2010.

❖ Attended by 168 house officers.

❖ Talks included "What makes a good house officer?", "Being a doctor: What it means to be professional", "Medical indemnity", "Changes", "Night duty", etc.



Conventions & Seminars

SMA Annual Dinner 2010

❖ 8 May 2010

❖ Guest-of-Honour was Senior Minister of State, Ministry of Foreign Affairs, Dr Balaji Sadasivan. During the dinner, SMA also conferred the SMA Honorary Membership on SMS Balaji Sadasivan, Prof Tan Cheng Lim, and Prof Woo Keng Thy.



Conventions & Seminars

41st SMA Medical Convention

- ❖ 10 July 2010: "20/10 Trends In Eye Care". Talks focused on latest updates on early prevention or treatment of common eye problems, with free eye screening.
- ❖ Over 600 participants, including healthcare professionals and members of the public.



Conventions & Seminars

AST Course on Medical Ethics, Professionalism & Health Law



- ❖ Organised throughout the year.
- ❖ Equip trainees with necessary communication skills & working knowledge of clinical ethics & local health statutes.
- ❖ Help trainees develop more systematic & professional approach to common ethical & medico-legal issues in Singapore.

SMA 1958
2009
Years

Conventions & Seminars

MPS "Mastering Your Risk" and "Managing Adverse Outcomes" Workshops

- ❖ Interactive 3-hour workshop presented by doctors.
- ❖ Practical communication techniques & skills to assist doctor-patient interactions:
 - Understand why patients complain & sue;
 - Why certain 'bedside' manners expose some doctors to increased risk;
 - Link between communication skills and patient dissatisfaction.



SMA 1958
2009
Years

Publications & Surveys



Publications & Surveys

SMA Guideline on Fees (GOF)

- ❖ Withdrawn on 1 April 2007 after SMA received indications that GOF might contravene Competition Act.
- ❖ Arising from recent exchange of correspondence with the Competition Commission of Singapore (CCS), SMA submitted an application for a decision on whether GOF could be excluded from the Competition Act. The application fee of S\$5,000 was paid by Council Members and a well-wisher.
- ❖ CCS decision that the GOF could not be excluded, and will infringe the Competition Act if re-instated

SMA 1958
2009
Years

Country Developments



Division of Health Facilities

Division of Singapore's Health Facilities into 5 Clusters

❖ The public healthcare facilities now fall under 5 broad clusters: Alexandra Health Pte Ltd, Jurong Health Services, the National Healthcare Group, National University Health System, and Singapore Health Services. These integrated networks enable comprehensive, and yet affordable quality healthcare services through co-operation and collaboration between public healthcare establishments.

SMA 1953
2009
Years

Human Organ Transplant Act



Proposed Amendments to Human Organ Transplant Act (HOTA)

❖ Proposed changes include lifting of upper age limit of 60 years for deceased donors, paired matching, compensation of living donors, and increasing penalties for organ trading.

❖ From 1 November 2009, HOTA will cover all Singaporean citizens and Permanent Residents of 21 years and above, who are of sound mind, unless they have opted out. The upper age limit of 60 years has been removed.

SMA 1953
2009
Years

Medisave

Medisave for Approved Overseas Hospitalisation

❖ From 1 March 2010, Singapore residents will be able to use their Medisave to help pay for their hospitalisation overseas under certain conditions, so as to give patients wider choice, and to allow them to take advantage of the lower cost of hospitalisation overseas.

❖ The scheme will start off with two providers: Health Management International and Parkway Holdings Pte Ltd.

Thank You

SRI LANKA MEDICAL ASSOCIATION



Indika KARUNATHILAKE*¹

Introduction

The Sri Lanka Medical Association (SLMA) is the oldest national professional organization of medical doctors in Asia and Australasia and the apex body of all medical professionals in Sri Lanka. It brings together a cross-section of the medical fraternity from both the state and private sector, ranging from senior to junior specialists and generalists, postgraduates, grade medical officers and even medical students. It brings together medical practitioners of all grades and from all branches of medicine in Sri Lanka. The SLMA started life as the “Ceylon Branch of the British Medical Association” on 17 December 1887 with 65 members on its roll and Dr. P.D. Anthoniz as its first President. The change of the name to “Ceylon Medical Association” came in 1951 and in 1972 when Sri Lanka became a Republic, the name changed to the “Sri Lanka Medical Association.”

Vision:

To be the most influential and effective apex medical professional organization in Sri Lanka.

Mission:

To lead the medical community to achieve the highest standards of medical professionalism and ethical conduct.

To be an advisory body on health policy to the Sri Lankan government and community.

General objectives

1. Enhance the capacity as an apex professional and scientific organization for all categories of medical doctors as defined in the constitution of the SLMA.
2. Play an advocacy role towards comprehensive curative and preventive health services for the people of Sri Lanka.
3. Promote professionalism, good medical prac-

tice and ethical conduct among doctors.

4. Disseminate state-of-the-art knowledge, clinical practice, technology and emerging concepts in medical sciences among medical and allied health professionals.
5. Provide opportunities for continuous professional development of doctors and allied health professionals.
6. Encourage ethical medical research.
7. Educate the public on health-related issues.
8. Enhancing closer professional and scientific links between medical doctors and allied health professionals.

Activities of the SLMA during the Year 2010

Annual Scientific Sessions 2010

The 123rd Annual Scientific Sessions were held on 31st May-5th June 2010. The Chief Guest was Prof. Sir Michael Marmot, President Elect of the British Medical Association and the Chairman of the WHO commission on Social Determinants of Health. The theme for the 2010 sessions was “Achieving Equity in Health.” There were several overseas and local resource persons who are world authorities in their respective fields. The academic programme included a theme-seminar, 12 symposia, 9 guest lectures, 2 interactive sessions and 3 post congress workshops. From the large number of papers submitted, 62 were selected for oral presentation and 40 were displayed as posters.

Foundation Sessions 2010

The second most important academic activity of the SLMA is the Foundation Sessions. The Foundation Sessions 2010 will be held in Jaffna from 22nd-24th October 2010. Jaffna is the capital of the Northern Province of Sri Lanka, an area

*1 Secretary, Sri Lanka Medical Association, Colombo, Sri Lanka (slma@eureka.lk).

This article is based on a presentation made as the annual activity report during the Country Report session at the 46th CMAAO Mid-term Council Meeting, Kuala Lumpur, Malaysia, on September 17, 2010.

which was badly affected by the recently resolved conflict as well as the 2004 Tsunami. This can be considered as a historic occasion considering the fact that Sri Lanka will be facing major challenges during the post conflict era in rebuilding the health sector in the war-torn areas.

Monthly Clinical Meetings

The educational programme of the Association includes a regular programme of Monthly Clinical Meetings targeting postgraduate trainees.

Regional Meetings

SLMA conducts joint Clinical Meetings with Provincial/Regional Clinical Societies. So far six joint clinical meetings have been conducted for the year 2010.

Orations

SLMA awards 6 prestigious annual orations, namely the SLMA Oration, the SC Paul Oration, the EM Wijerama Oration, the Sir Nicholas Attygalle Oration, the Sir Murugesar Sinnathamby Oration and the Sri Marcus Fernando Oration.

Ceylon Medical Journal

The SLMA publishes the Ceylon Medical Journal (CMJ), the first issue of which came out in August 1887. The name changed to Journal of the Ceylon Branch of the British Medical Association in 1904, but changed to its pristine appellation in 1952. It continues to be published as the CMJ. At 121 years, it is the oldest surviving English medical journal in Asia and Australasia, and the leading scientific journal in Sri Lanka. The CMJ is indexed in BIOSIS, CAB International, EMBASE and the Index Medicus. CMJ's editorial policies and quality are of international standard and it is listed by the International Committee of Medical Journal editors as conforming to their editorial guidelines.

Activities of SLMA Committees

The SLMA functions through its expert Committees. Following are the highlights of these Committees for the year 2010.

Communicable Diseases Committee

The Committee has conducted a seminar on control of Dengue (currently there is an epidemic of Dengue in Sri Lanka).

Central Continuous Professional Development Committee

A national CPD programme has been launched for doctors in Sri Lanka. This is a voluntary programme based on scoring of CPD credit points.

Medicinal Drugs

The Committee has published several newspaper articles and conducted television programmes on drug information.

Working Group on Disabilities

The working group has been actively promoting awareness on disability related issues.

Ethics Committee

The Committee has conducted workshops on Clinical Ethics at scientific meetings of Regional Associations and Professional Colleges.

Health Management Committee

A Career Guidance Seminar was organized for junior doctors in collaboration with Specialist Colleges and Associations. The Seminar was attended by over 200 junior doctors.

Media Committee

Medical journalism is encouraged by awarding of prizes for "excellence in health journalism" for articles published in the print media (in all 3 languages).

Non Communicable Disease Committee

The main activities of the Committee for the year 2010 are;

1. Research into the social and environmental determinants of diabetes
2. Activities to commemorate the World No Tobacco Day
3. Media programme on prevention and control of NCD
4. Advocacy meetings among stakeholder groups related to prevention of NCDs
5. NIROGI Lanka project on prevention and control of NCDs

The Sri Lanka Clinical Trials Registry

The Sri Lanka Clinical Trials Registry, started as recently as 2006, has achieved recognition from the World Health Organization by being approved as a WHO Primary Clinical Trials Registry.

Committee on Snake Bites

The main activities of the Committee for the year 2010 are;

- Notification of snakebite deaths
- Snakebite epidemiology database
- Development of effective snakebite antivenom

Tobacco, Alcohol and Substance Abuse Committee

Members of the committee appeared on television on several occasions in discussions regarding tobacco and alcohol use.

Tsunami Disaster Relief

The CMAAO/SLMA Joint Sponsorship Scheme which was made possible by the magnanimous donation of the CMAAO has been functioning smoothly since November 2006. At present there are 22 children from Galle, Hambanthota, Ambalanthota, Suriyawewa & Tangalle, with ages ranging from 6 to 18 yrs who receive a monthly sum of Rs 2,000/-. Our records indicate that there are at present three children studying in Grade 1, one each in Grade 2 & 3, two in Grade 4, one each in Grade 5, 6 & 7, seven

in Grade 8, two in Grade 9, three in Grade 10. One student has completed secondary school education.

Committee on Women's and Family Health

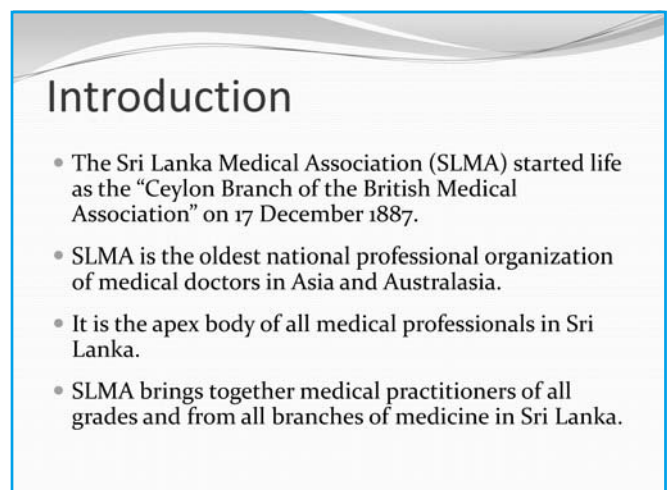
A Post Congress session on "Health Issues in Elderly Women" was conducted during the Annual Scientific sessions. The target audience comprised nursing officers from the curative and preventive sectors, junior medical officers, health administrators and general practitioners.

Equity in Health

The objectives of this recently established committee are;

To raise awareness of the medical profession and general public on issues relating to health equity and social determinants of health (SDH) and to advocate

- conduct of research in relevant areas
- capacity building and translation of knowledge into practice
- networking with local, regional and global partners to take forward the agenda of narrowing health inequalities.



Activities of the SLMA during the year 2010 – Presidential Inauguration



Prof. Narada Warnasooriya receiving presidential medal from Prof. Rezvi Sheriff, immediate past president.

Selection of the gathering



Presidential address

Activities of the SLMA during the year 2010

- The 123rd Annual Scientific Sessions were held on 31st May-5th June 2010.
- The Chief Guest was Prof. Sir Michael Marmot, President Elect of the British Medical Association and the Chairman of the WHO commission on Social Determinants of Health.

Activities of the SLMA during the year 2010 - Annual Scientific Sessions



Minister of Health with President SLMA and chief guest



Chief guest addressing the Annual Scientific Sessions Inauguration

Activities of the SLMA during the year 2010 - Annual Scientific Sessions



Doctors' Concert

Activities of the SLMA during the year 2010



Rehabilitation programmes



Exposition of services available to disable people

- The theme for the 2010 sessions was “Achieving Equity in Health”
- There were several overseas and local resource persons who are world authorities in their respective fields.
- The academic programme included a theme-seminar, symposia, guest lectures, interactive sessions and post congress workshops.

Activities of the SLMA during the year 2010

Foundation sessions

- The second most important academic activity of the SLMA.
- This sessions will be held in Jaffna from 22nd-24th October.

- Jaffna is the capital of the Northern Province of Sri Lanka
- It is an area which was badly affected by the recently resolved conflict as well as the 2004 Tsunami.
- This is a historic occasion considering the challenges during the post conflict era in rebuilding the health sector in the war-torn areas.

Activities of the SLMA during the year 2010



Dr. Samanmali Sumanasena addressing a regional meeting



Orations

- SLMA awards 6 prestigious annual orations
 - SLMA Oration
 - SC Paul Oration
 - Sir Marcus Fernando oration
 - Sir Nicholas Attygalle Oration
 - Murugesar Sinnnetamby Oration
 - E.W.Wijerama Endowment Lecture

Activities of the SLMA during the year 2010 - Ceylon Medical Journal



- The SLMA publishes the Ceylon Medical Journal (CMJ),
- The first issue of which came out in August 1887.
- At 121 years, it is the oldest surviving English medical journal in Asia and Australasia.
- It is the leading scientific journal in Sri Lanka.

Activities of the SLMA during the year 2010

SLMA committees

- Communicable Diseases Committee
- Central Continuous Professional Development Committee
- Medicinal Drugs
- Working Group On Disabilities
- Ethics Committee
- Health Management Committee

- Media Committee
- Non Communicable Disease Committee
- The Sri Lanka Clinical Trials Registry
- Committee on Snake Bites
- Tobacco, Alcohol And Substance Abuse Committee
- Tsunami Disaster Relief
- Committee on Women's and Family Health
- Equity in Health

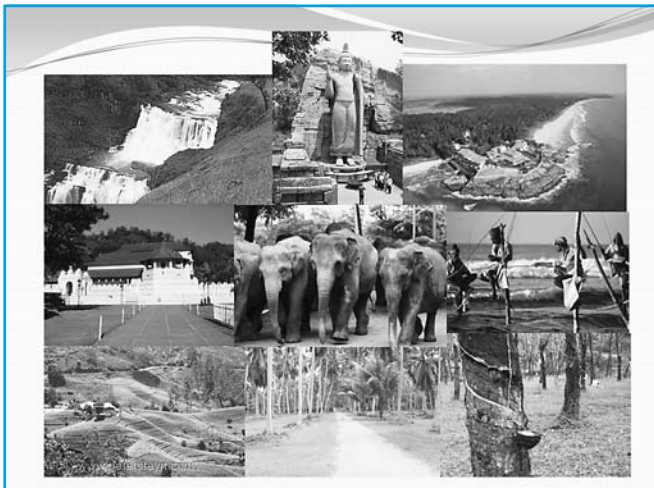
Activities of the SLMA during the year 2010



SLMA Cricket Team



SLMA Ladies Cricket Team soon after winning the Law – Medical championship.



TAIWAN MEDICAL ASSOCIATION



Ming-Been LEE*¹

Impact of Climate Change on Healthcare System and Public Health

In the UN Climate Change Conference held in Copenhagen in December, 2009, governments around the world have reached preliminary consensus to address critical issues such as mitigating the greenhouse effect, environmental protection, clean energy and sustainable development. In addition, a statement was made appealing to national medical associations and physicians to join hands with governments, nongovernmental organizations and communities through health education to the public and participation in disaster response systems. Commitment from medical professionals has profound contribution to the society, including a country's capacity for disaster preparedness.

On 23 January, 2010, the TMA, in collaboration with National Taiwan University Hospital (NTUH) and NTUH Yunlin branch, organized the "Forum on Global Warming and Health," the first formal occasion in Taiwan that highlighted global warming and medicine. We invited leading medical professionals, government officials and experts and participants to analyze the causation, impact and solutions of the crisis from the perspectives of medicine and public health, respectively. Recommendations from policy, medicine, education to the broader environmental awareness were made at the forum. The conference also echoed the appeal of the Intergovernmental Panel on Climate Change to adopt a vegetarian diet to help brake global warming. Effective ways to save energy and reduce greenhouse gas emission were also elaborated to ensure sustainable health for both human species and the earth.

Medical Malpractice Disputes and Physician-Patient Relationship

Physicians and patients have long maintained amiable relationship of mutual trust. However, there is a growing trend of medical malpractice disputes in the recent decade. In case of a medical malpractice lawsuit, both parties are subject to considerable energy, time and cost input. It also casts a heavy load for the justice system in dealing with such cases. Physicians under the pressure of litigation are bound to collect and present evidence in order to self-defense, which distracts them from carrying out routine responsibilities and furthermore, compels them to be conservative with treatment, retreating to so-called defensive medicine. This development produces no benefits to the patients on one hand, and increases the cost of medical care on the other. Many outstanding physicians who wish to avoid civil compensation as well as criminal charges accompanied by medical disputes tend to move themselves to fields involving lesser risks.

Given that medical practice inevitably faces uncertainty and high risks, and in order to prevent defensive medicine and tension between physicians and patients, the TMA urged the government to promulgate or amend legislation concerning disputes and criminal responsibilities. In December, 2009, a workshop, attended by law experts and health professionals with an aim to articulate legal responsibilities in medical malpractice disputes, reached the following conclusion: healthcare institutes and personnel who cause damages to patients due to intention or negligence while performing duties are liable for damage compensation. Healthcare personnel who cause patients' deaths or injuries due to intention or gross negligence while performing duties are liable for criminal responsibilities.

*1 President, Taiwan Medical Association, Taipei, Taiwan, ROC (intl@tma.tw).

This article is based on a presentation made as the annual activity report during the Country Report session at the 46th CMAAO Mid-term Council Meeting, Kuala Lumpur, Malaysia, on September 17, 2010.

Passage of such legislation is expected to effectively resolve medical disputes and enhance harmony between physicians and patients.

Strengthened Community Based Healthcare System for an Ageing Population

To provide continuous holistic care and achieve the goal of “ageing in place,” community clinics and primary care institutes in Taiwan would like to assist the government in the making of a user-friendly healthcare system for senior citizens by utilizing health resources and strengthening healthcare infrastructure in the community in order for the elderly to age in place.

To this end, the TMA proposes the following 6 strategies.

- Introduction of telemedicine,
- Improvement of rural healthcare,
- Implementation of referral system,
- Adjustment of national health insurance payment,
- Establishment of a community centered mid-term healthcare plan, and
- Establishment of DRG-based payment scheme by taking into account patient’s age, disability and disease severity.

We believe this plan will help strengthen community based healthcare system for an ageing population.

Quality of Healthcare in Rural and Off-shore Areas

To enhance emergency and critical care, improve quality of service and promote people’s welfare in rural and off-shore areas, more attention should be paid to problems facing these areas, namely the communication and education divide between rural and urban areas. It is necessary to implement short-term programs that address the situation. To meet the health needs of people living in rural and off-shore areas, especially those in need of emergency and critical care, mid- and long-term programs should also be in place so that problems with healthcare quality in hardship areas could be lessened. Strengthened capability of specialized, emergency and critical care relies on resource input from the public sector able to build up early child care with professional support for rural children suffering from development delay.

Seminars on Safety and Quality of Healthcare

Patient safety issues have received attention from around the world in recent years. Considering that an increasing incidence of medical disputes raises legal and ethical debates, TMA looks into the matter from the perspectives of system, regulation and quality before offering recommendations.

Since 2008, the TMA and partners such as Formosan Medical Association, NTUH, Taiwan Joint Commission on Hospital Accreditation and Taiwan Association of Medical Education jointly organized over 20 nationwide interdisciplinary seminars on safety and quality of healthcare. Experts and scholars were invited to analyze and comment on case studies from different view points including evidence-based medicine, ethics and law. Outside the physical venue in NTUH, health professionals from around the country also enjoyed access to simultaneous participation in all sessions through video conference technology. About 40,000 people joined the forum, making it an event of highest number of participants in a single continuous educational program.

All sessions were videotaped and made available online to provide another option to receive continuous medical education. The multiple channels of participation benefited more than 100,000 people in total, enabling heavily-loaded physicians to quickly update their professional knowledge and become aware of new regulations, as well as exchanging opinions with peers. The goal of barrier-free learning has been achieved.

This forum also successfully established a platform for communication among the medical community, Department of Health and Bureau of National Health Insurance. Case analyses presented in the forum helped health authorities identify problems with regards to the system, laws and regulations and auditing, providing a useful reference for further policy making.

“Cherish Your Life” Concert

Suicide rate is on the rise. Suicide has been one of the 10 leading causes of death for 10 consecutive years. To make the society aware of the importance of this issue, the TMA, along with Taiwan Bar Association, Taiwan CPA Association and National Architect Association, initiated a suicide

prevention campaign by organizing four “Cherish Your Life” concerts in northern, central, southern and eastern Taiwan, respectively. The concerts conveyed heart-warming and encouraging messages with a humanitarian spirit and concern for the vulnerable population. They called for people to value life and hope for the best. They also reminded the society to take suicide prevention seriously. In the concerts, health messages were transformed into powerful and pleasant sound of music, which purified the heart and soul of participants and helped them move toward a life full of hope and worth living.

Publications

Taiwan Medical Journal is a monthly publication. Every month, more than 40,000 copies are delivered to physicians, healthcare institutes of all levels and professional societies around Taiwan, as well as medical associations in other countries. It is Taiwan’s most representative medical journal. Soon after I became president of TMA, TMJ has undergone changes in terms of artistic layout and content. Some of the articles, especially regarding key issues, were solicited from specialists, aiming to present truth, expert opinions, solutions, and to help readers understand the current situation and burning issues. Through this communication tool, there will be less misunderstanding, stronger coherence, better environment to practice medicine, and eventually better care for the people.

In 2010, the TMA published 5-volume Taiwan Medical Series, covering Transparency, Medical Ethics in a Globalized World, Patient Safety-Case Studies, Medical Law—Understanding National Health Insurance, and Arts and Humanities for Physicians. The Taiwan Medical Series compiled excerpts from Taiwan Medical Journals to serve readers by categorized articles.

Active Participation in International Affairs

Since 2007, delegates of TMA attended the course “Caring Physician of the World” organized by the World Medical Association (WMA). We also took part in WMA’s other activities such as assemblies, conferences, declaration making, to name a few. In 2009, with Taiwan finally becoming an observer in the World Health Assembly,

we are able to contribute in health in Asia Pacific as well as the world. Some of our activities last year include:

Conclusions made in the 26th CMAAO Congress suggested progress reports on 3 key issues brought up by the WMA Assembly this year, which are task shifting, prescription writing, and tobacco control. In particular, the Congress designated tobacco control as a routine agenda for CMAAO and decided that tobacco-related resolutions, progress and reports will be delivered at the WMA Assembly. In July this year, the TMA prepared a draft statement “Strengthening of Primary Care” which is to be presented later in this meeting and receive comments from member colleagues.

The TMA was invited by the Medical Association of Thailand to host the third-day session of the first International Summit on Tobacco Control in Asia and Oceania Region with participation from twelve member states. The Sampran Declaration on Tobacco Control in Asia and Oceania Region was made at the conference and endorsed by participating members. The CMAAO Congress will review the declaration to solicit its position in terms of tobacco control.

Furthermore, the 60th WMA Annual Meeting in New Delhi, India announced the Declaration of Delhi on Health and Climate Change, urging governments of the world to pay attention to the impact of climate change on global health. The declaration shows the commitment of the health professionals to combat global warming and prepare ourselves to respond to global health crisis. The TMA plans to organize seminars in Taiwan to address this issue.

Welcome to Taiwan

After a decade, the TMA has the honor again to host the 27th CMAAO Congress and 47th Council Meeting in 2011. We are fully committed to making this event a success. Due to rising suicidal deaths all over the world and to respond to World Health Organization’s endeavor to improve mental health for mankind, a tentative theme has been proposed as “From Suicide Prevention to Health Promotion: The Role of Physicians.” Through this grand gathering, medical organizations in the region will have opportunities to exchange and cooperate. I cordially invite all colleagues to join us in Formosa, and be my guest.



The 46th CMAAO Midterm Council Meeting

- Country Report -

Ming-Been LEE, M.D.
President of Taiwan Medical Association

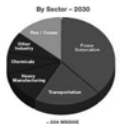
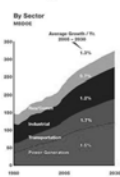
Contents

1. Impact of Climate Change on Healthcare System and Public Health
2. Medical Malpractice Disputes and Physician-Patient Relationship
3. Strengthened Community Based Healthcare System for An Ageing Population
4. Quality of Healthcare in Rural and Off-Shore Areas
5. Seminars on Safety and Quality of Healthcare
6. "Cherish Your Life" Concert
7. Publications
8. Active Participation in International Affairs
9. Welcome to Taiwan

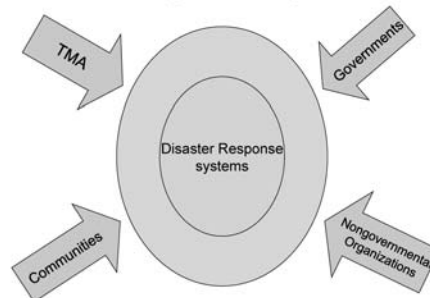
1. Impact of Climate Change on Healthcare System and Public Health

The UN Climate Change Conference held in Copenhagen in December 2009

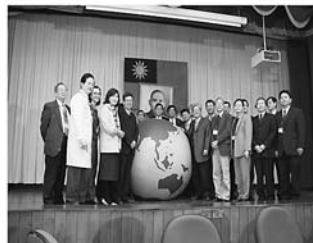
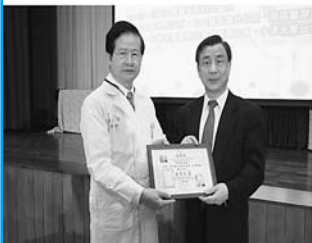
World Energy Demand to 2020



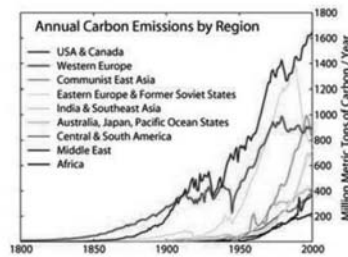
The Statement of the United Nations Framework Convention on Climate Change (UNFCCC)



「Forum on Global Warming and Health」 in Taiwan



To adopt a vegetarian diet to help brake global warming



2. Medical Malpractice Disputes and Physician-Patient Relationship

In Case of a medical malpractice lawsuit, both parties are subject to considerable energy, time and cost input.



Influences

- In order to self-defense, physician distracts their routine responsibilities.
- To move the field involving lesser risks.
- The patients can not get the perfect care.



Solution

- Taiwan Medical Association urged the government to promulgate or amend legislation concerning disputes and criminal responsibilities.



TMA reached the conclusion:

Physician-Patient Relationship

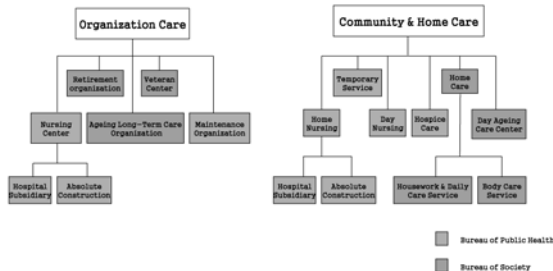
Healthcare institutes and personnel who cause damages to patients due to intention or negligence while performing duties are liable for damage compensation. Healthcare personnel who cause patients' deaths or injuries due to intention or gross negligence while performing duties are liable for criminal responsibilities.



3. Strengthened Community Based Healthcare System for An Ageing Population

Target:

To provide continuous holistic care and achieve the goal of 「ageing in place」



The TMA proposes 6 strategies:

- Telemedicine
- Improvement of rural healthcare
- Implementation of referral system
- Adjustment of national health insurance payment
- Establishment of a community centered mid-term healthcare plan
- Establishment of DRG-based payment scheme by taking into account patient's age, disability and disease severity.



4. Quality of Healthcare in Rural and Off-Shore Areas

Targets:

- emergency and critical care
- Improve quality of service
- Promote people's welfare in rural and off-shore areas



Suggestions:

More support and attention should be paid by government



5. Seminars on Safety and Quality of Healthcare

「Seminars on safety and quality of healthcare」 are organized over 20 nationwide interdisciplinary.



Major Activities:

- To analyze and comment on case studies from different view points including evidence-based medicine, ethics and law.
- Most people also enjoyed access to simultaneous participation in all sessions through video conference technology.



Main Achievements:

More than 40,000 people joined the forum simultaneously.



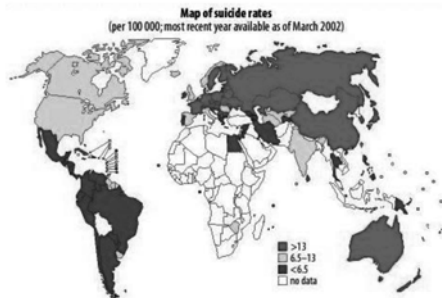
- The goal of barrier-free learning has been achieved.
- To establish a platform for communication successfully.



6. "Cherish Your Life" Concert

Background:

Suicide rate is on the rise and has been on of the 10 leading causes of death for 10 consecutive years.



「Cherish Your Life」 Concerts are organized by TMA.



Goals

- To call for people to value life and hope for the best.
- To remind the society to take suicide prevention seriously.



7. Publications

- Instructions
- 「Taiwan Medical Journal」 is a monthly publication.
- Every month, more than 40,000 copies are delivered to physicians, healthcare institutes of all levels and professional societies around Taiwan, as well as medical associations in other countries.

In 2010, TMA published 5-volume Taiwan Medical Series:

- Transparency
- Medical Ethics in a Globalized World
- Patient Safety – Case Studies
- Medical Law – Understanding National Health Insurance
- Arts and Humanities for Physicians



8. Active Participation in International Affairs

- Attended the Caring Physician of the World, organized by the World Medical Association.
- Attended the WMA's other activities such as assemblies, conferences, declaration making, to name a few.
- Translated the WMA's declaration in Chinese.



In 2009, with Taiwan finally becoming an observer in the World Health Assembly.



TMA joined :

- WMA announced the Declaration on Delhi on Health and Climate Change during the 60th WMA Annual Meeting in New Delhi in 2009.
- TMA Drafted the 「Strengthening of Primary Care in Asia and Oceania Region」



TMA joined:
The first International Summit on Tobacco Control in Asia and Oceania Region」



Endorsement by 18 Countries.



9. Welcome to Taiwan

After a decade,

- Taiwan Medical Association has the honor to host the 27th CMAAO Congress and 47th Council Meeting in 2011.
- The Tentative theme has been proposed as 「The Role of Physicians in Suicide Prevention」.



THE MEDICAL ASSOCIATION OF THAILAND



Prasert SARNVIVAD*1



Country Report 2009-2010



The Medical Association of Thailand Under Royal Patronage

Executive Board

- President: Pol. Lt. Gen. Jongjate Aojanepong
- President Elect: Dr. Wonchat Subhachaturas
- Vice President: Prof. Dr. Saranatra Waikakul
- S .G: Assoc. Prof. Dr. Prasert Sarnvivad
- Treas: Prof. Dr. Teerachai Chantrarojanasiri
- Int. Re: Asst. Prof. Naval Lt. Dr. Manopchai Thamkhantho
- CEO: Prof.Dr. Somsri Pausawasdi

The standing activities of the Association

Continuous medical education and research

- Annual scientific meeting and "Tobacco Control Programme in Asia and Oceania"





Annual Scientific meeting
October 21-24,2009
Krabi Province , Thailand

The standing activities of the Association

Continuous medical education and research

- Annual Meeting and General Assembly of the Medical Association of Thailand .



Annual Meeting
January 23,2010

*1 Secretary General, The Medical Association of Thailand, Bangkok, Thailand (math@loxinfo.co.th).
This presentation was made as the annual activity report during the Country Report session at the 46th CMAAO Mid-term Council Meeting, Kuala Lumpur, Malaysia, on September 17, 2010.

1st International Summit on Tobacco Control in Asia and Oceania Region
February 25-27, 2010
Rose Garden Riverside Hotel, Sampran, Thailand



Continuous medical education and research

- Providing 6 scholarships annually continue postgraduate studies to study in Japan under the collaboration of Takada Science Foundation.
- Research Grant for Thai doctors.
- Lecture tour or special lecture, for continuing medical education

The standing activities of the Association

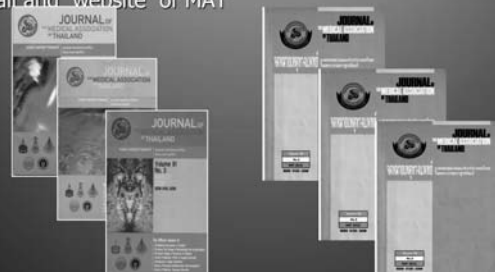
Medical Ethics

- Publications in the Journal of The Medical Association of Thailand concerning medical ethics.
- Special Lectures about medical ethics and matters concerning law and regulation to doctors and final year medical students.
- Publishing regular topics or issues about medical ethics, in the journal of Medical Association of Thailand and other medical journals.

The standing activities of the Association

Academic activities for supporting the members

- Publish a monthly journal of Medical Association of Thailand and distribute to all members by surface mail, electronic mail and website of MAT



Activities for supporting the members

- Up-date and review the member registration.
- Service and Accommodate the members for using medical club house in the office of the association.



Activities for supporting the members

- Distribution of the newsletter, Bulletin to all the members every month.



Activities for supporting the members

- Set up a project to help and support members who has legal problem via legal advisory team.
- Organize " Post-congress Tour" to visit and observe the healthcare management neighbour countries.



The standing activities of the Association

International activities

- Participation in the Medical Congress meetings and activities in the region as council member of CMAAO , MASEAN.
 - 26th CMAAO Congress and the 45th CMAAO Council Meeting Nov 5-7 ,2009 at Bali , Indonesia.
 - 13th MASEAN Mid-term Meeting and 102nd PMA Annual Convention May 19-21 ,2009 at Mandaluyong City ,Philippine

International activities

- Attending the meeting of the other medical associations
 - WMA General Assembly New Delhi 2009, October 14-17 ,2009
 - Annual Meeting of the House of Delegates of AMA June 13-17 ,2009
 - 2009 Australian Medical Association National Conference May 29-31 ,2009



Annual Meeting of the House of Delegates of AMA
June 13-17,2009

The standing activities of the Association

Activities for the Public

- Be the leader in the campaign of Tobacco Smoking Cessation Programme.



Tobacco-Smoking Cessation Conference



Thai Tobacco Cessation Workshop
May 6-8,2010

- Walk-Run Rally on "No Tobacco Day" May 31st Every year.



Activities for the Public

- Produce the television programmes about the health education or health issues for the people, five times a week.

National Health activities

- Organize a special council called "Tri Parties" by screening the law and regulation concerning health and make suggestion to the cabinet about the actual health problems

The standing activities of the Association

Current special activities

- Fund raising programme : Annual Charity Golf Tournament.



[Hong Kong]

Task Shifting

TSE Hung Hing*¹

The WHO Perspective

At the June 2006 General Assembly High-Level Meeting in HIV/AIDS, United Nations Member States agreed to work towards the goal of “universal access to comprehensive prevention programmes, treatment, care and support” by 2010. However, it was found that one of the main constraints is the serious shortage of health workers, especially in low income countries, where HIV and AIDS are taking the greatest toll.

In August 2006, the World Health Organization (WHO) launched the “Treat, Train, Retain” plan to strengthen and expand the health workforce by addressing both the causes and the effects of HIV and AIDS on health workers.

The workforce crisis has no single cause. Public health care systems are not training and recruiting enough people. Then the pool of skilled workers is unevenly distributed, with high concentrations in urban areas and many working in the private sector rather than in public health care. WHO, in collaboration with the Office of the United States Global AIDS Coordinator (OGAC), has therefore launched the WHO/OGAC Task Shifting Project as a key contribution to the “Train” element of the “Treat, Train, Retain” plan.

The WMA Resolution 2009

At the General Assembly in New Delhi, India, October 2009, the WMA adopted a resolution on Task Shifting. The term “Task Shifting” is used to describe a situation where a task normally performed by a physician is transferred to a health professional with a different or lower level of education and training, or to a person specifically trained to perform a limited task only, without having a formal health education. Task shifting occurs both in countries facing shortages of phy-

sicians and those not facing shortages.

The Hong Kong Scenario

The population of Hong Kong by mid-2010 is about 7.06 million. The number of HIV positive cases in Hong Kong in 2009, according to government statistics, is 398 and the number of AIDS disease is 76. The number of registered medical practitioners in Hong Kong by August 2010 is 11,712 (1 doctor per 602 people). We have 2 medical schools with 320 graduates per year. We also have overseas graduates returning to Hong Kong to take the Licentiate Examination of the Medical Council of Hong Kong. In short, there is no overall shortage of registered medical practitioners in Hong Kong.

The healthcare service in Hong Kong is provided by the public sector (The Hospital Authority) and the private sector. About half of the medical practitioners are working in the public sector while the other half is working in the private sector. Yet the public sector is providing more than 90% of the hospital services while the private sector only provides less than 10% of the hospital services. This major discrepancy is the result of the prize differential between the 2 sectors. The public healthcare service is under huge subsidy from the government while the private healthcare service is mainly paid by out of pocket spending unless there is insurance coverage. For out-patient services, the private sector is providing about 70–80% of the market share. So there is an apparent shortage of doctors in the public system only.

To solve this tremendous work load of the public sector, the administration of the Hospital Authority has been trying to “shift” some of the tasks from doctors. Typical examples like suturing of superficial wounds were done by nurses; allow-

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This article is based on a presentation made at the Symposium themed “Task Shifting and Medical Profession” held at the 46th CMAAO Mid-term Council Meeting, Kuala Lumpur, Malaysia, on September 18, 2010.

ing nurses to perform diagnostic protoscopy and sigmoidoscopy; follow up of psychiatric patients by nurses and vaccination of babies performed by some insufficiently trained persons. Last year, the Hospital Authority administration was planning to accept referrals from opticians to their ophthalmology specialist clinics. This was opposed by ophthalmologists from both the private and the public sector because that was in fact shifting the diagnostic role from primary care doctors to the opticians. Shifting the diagnostic role from doctors to insufficiently trained persons is particularly dangerous. Over diagnosis would further overload the workload of specialists while under-diagnosis is detrimental to patients.

In the history of development of healthcare service in China and Hong Kong, we have seen situations when healthcare services had been provided by persons who are insufficiently trained

for the job. Typical examples included the “bare foot doctors” providing healthcare services in the rural areas of China during the Cultural Revolution. And in the early days in Hong Kong when there was a real shortage of doctors, resident doctors were required to do operations without adequate supervision.

So “task shifting” is nothing new to us but should be something in history and definitely is not the way forward. The Hong Kong Medical Association is against “Task Shifting” when there is no real shortage of doctors. We believe there are other ways to solve the problem of uneven distribution of medical practitioners among different sectors or among different regions. We urged our government to buy services from the private market where there are excessive services available instead of delegating the role of doctors to non-doctors.

TASK SHIFTING

DR. TSE HUNG HING
HONG KONG MEDICAL ASSOCIATION

The WHO Perspective

- June 2006 General Assembly High-Level Meeting in HIV/AIDS, UN member states agree to work towards the goal of “universal access to comprehensive prevention programmes, treatment, care and support” by 2010.
- Main constraint is the serious shortage of health workers, especially in low income countries.

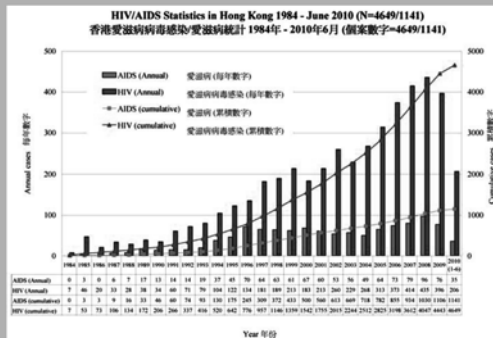
The WHO Perspective

- August 2006, WHO launched the “Treat, Train, Retain” plan to strengthen and expand health workforce by addressing both the causes and the effect of HIV and AIDS on health workers.
- Shortage of healthcare workers in the public system.
- Uneven distribution of healthcare workers among regions and among sectors.

THE WMA RESOLUTION 2009

- October 2009 in New Delhi, India, WMA adopted the resolution on Task Shifting
- “A situation where a task normally performed by a physician is transferred to a health professional with a different or lower level of education and training, or to a person specifically trained to perform a limited task only, without having a formal health education.”

HONG KONG SCENARIO



HONG KONG SCENARIO

- Population (by mid-2010) 7.06million
- HIV positive cases – 398 in 2009
- AIDS disease – 76 in 2009
- Registered medical practitioners in August 2010 - 11,712 (1 doctor per 602 citizen)
- 2 medical schools, 320 graduates/year
- Overseas graduates returning to Hong Kong

HONG KONG SCENARIO

- 2 systems – public sector (the Hospital Authority) and the private sector
- Distribution of medical practitioners – 50% working in HA and 50% working in private
- Public system providing 90% of hospital services while private sector only 10%
- Outpatient service 70-80% provided by the private sector
- Apparent shortage of doctors in the public sector only

TASK SHIFTING IN THE PUBLIC SECTOR

- Suturing of superficial wounds done by nurses
- Allowing nurses to perform diagnostic proctoscopy and sigmoidoscopy
- Follow up of psychiatric patients by nurses
- Vaccination of babies done by insufficiently trained persons
- Accept referrals from opticians to ophthalmology clinics

HISTORY

- Task Shifting did occur during the development of healthcare service both in China and Hong Kong
- “Bare-foot doctors” during Cultural Revolution
- Operations done by resident doctors without adequate supervision

OUR VIEWS

- Task Shifting is nothing new but should be in history and not the way forward
- We are against “Task Shifting” when there is no real shortage of doctors
- Other ways to solve the problems of uneven distribution of doctors
- Buy services from the private market where there are abundant services available

[Indonesia]

Task Shifting in Rural Area

Prijo SIDIPRATOMO*1

TASK SHIFTING IN RURAL AREA

Prijo Sidipratomo
President of Indonesian Medical Association

Presented on CMAAO Meeting
Kuala Lumpur September 18th 2010

Introduction

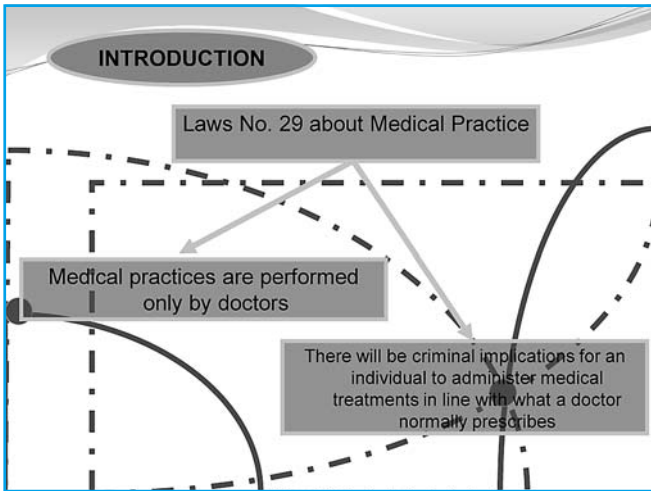
- World Health Organization (WHO) described task shifting as the rational redistribution of tasks among health workforce teams
- When feasible, healthcare tasks are shifted from higher-trained health workers to less highly trained health workers in order to maximize the efficient use of health workforce resources



Introduction

Map of Indonesia showing the distribution of population per doctor across various regions. The map is divided into numbered regions, with a legend indicating the number of inhabitants per doctor for each region. The map shows a high concentration of population per doctor in the Java region (1) and a low concentration in the Papua region (33).

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This presentation was made at the Symposium themed "Task Shifting and Medical Profession" held at the 46th CMAAO Mid-term Council Meeting, Kuala Lumpur, Malaysia, on September 18, 2010.



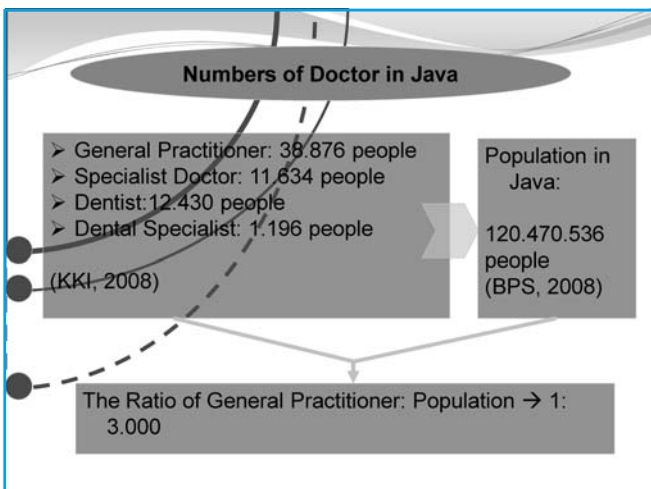
Tenth Provinces with most numerous Medical Doctor In Indonesia

NO	PROPINSI	Specialist	%	cumulative	General Practitioner	%	Cumulative
1	DKI	3884	23,6	23,6	10.383	17,1	17,1
2	Jabar	2416	14,6	38,2	9625	15,9	33
3	Jatim	2418	14,6	52,8	8364	13,8	46,8
4	Jateng	1731	10,5	63,3	6282	10,3	57,1
5	Sumut	942	5,7	69	4111	6,8	63,9
6	Sulsel	627	3,8	72,8	2379	3,9	67,8
7	Banten	506	3,1	75,9	2484	4,1	71,9
8	D.I.Y	679	4,1	80	1738	2,8	74,7
9	Bali	534	3,2	83,2	1726	2,8	77,5
10	Sumbar	328	1,9	85,1	1373	2,2	79,7

Indonesian Medical Councils 31 August 2008

- Total number General Practitioners and Specialist by 2008**
- Total Specialist 16451
 - Total General Practitioners 60413
 - Around 70 % Specialist staying in java island
 - Around 64 % General Practitioners staying in java island
 - In Sumatera Island staying 14,5 % Specialist and 19,1 % General Practitioners
 - Majority Medical Doctors living in Java and Sumatera Island
- Indonesian Medical Councils 31 Agustus 2008

- Distribution of peoples in Indonesia**
- Majority people about 57% live in Java island
 - Around 20 % staying in Sumatera Island
 - The rest 23 % distributes in Kalimantan, Sulawesi, Bali, Nusatenggara, Maluku dan Papua



Province	General Practitioner (n)	Specialist Doctor (n)	Dentist	Dental Specialist	Population	Ratio of doctor and population
West Sumatera	1.373	328	387	7	4.566.126	1 : 3.300
Jambi	504	89	121	1	2.635.968	1 : 9.126
West Kalimantan	444	118	135	11	4.052.345	1 : 3.000
East Kalimantan	931	25	296	1	2.848.798	1 : 3.000

Problem

- Lack of medical doctor in Indonesia
- Disparity of medical doctor in Indonesia
- Still high rate MMR and IMR
- High prevalences of malnutrition in toddler
- Low life expectancy

RECOMMENDATIONS

1. Add doctor's production distribution in rural area with some compensation given. Scholarship-welfare
2. Regulation about working in rural area as an obligation
3. Authority delegation to nurses and midwives in isolated area to do medical action, while giving them some extra medic competency (Task shifting)

Add doctor's production distribution

- Will be fulfilled in 4-5 years
- Awarded by incentive, welfare, and career
- Voluntary

Regulation about working in rural area as an obligation

- Contradict with constitution (amandment), clause 28c ,28d-----judicial review
- ILO ratification: 1. **Anti-discrimination (ILO Convention no. 100 and no.111)** 2. **Anti-forced labor (Konvensi ILO no. 29 dan 105)**
- Can be done if :
 - conscription
 - Official ties agreement

Authority delegation to nurses and midwives in rural area to do medical action, while giving them some extra medic competency (Task shifting)

- Uncommon (especially in other countries)
- Method used in transition time, while waiting for the optimal amount and distribution of doctor
- Temporary regulation
- A lot of conflicts with other regulations
- Keeping time-bomb

TASK SHIFTING

- Requirements :
 - Not enough doctors
 - There must be a doctor who fulfill the requirements to give the authority
 - It's temporary for the time being, until there are enough doctors to handle the cases or situations
 - Supported by regulations and laws
 - Medical officers who received delegation of authority must be competent.
 - Only valid for remote or isolated areas and only in government-owned facilities

TASK SHIFTING PROBLEMS

- It's against government regulations number 29 year 2004 regarding medical practices
- It's against regulations about strong medicines and psychotropics
- There's no desire from the Government to place doctors in remote or isolated areas
- Competency of medical experts vary significantly
- Disciplinary issues present as an obstacle

Burden challenges of TASK SHIFTING

- Medical practice Law
- Drugs Law
- Psychotropics Law
- Health Law

The way in which authority was delegated

- Medical actions or treatments are more associated with individuals who are in the medical profession, hence they are linked to the individual
- Other than doctors, medical actions or treatments can be carried out by a delegation of authority, but with certain conditions that apply
- For midwives and nurses, the methods used is by TASK SHIFTING, which is a limited delegation of authority

Requirements for midwives/ nurses

- Must have competence (has undergone trainings as facilitated by health distric office or IMA)
- Vocational education stage

Place requirements

- Represents medical service facilities owned by the Government
- Rural area is adjusted with regulations (ministry regulations) and agreement between distric health office and IMA
- Outside Java Island
- Adjusted with need

Medical action that can be delegated

- Non-interventional medical action (non invasive)
- Limited interventional medical action (invasive)
- Adjusted with prevalence of diseases in certain area
- Agreement between district health office and IMA

MEDICAL STOCK

- OTC (Over the counter) drugs and restricted OTC drugs
- Except vaccine and contraception
- Order or procurement of medicines can be carried out or done by doctors with the designated authority through health center (Puskesmas).

Time

- Regulations on delegation of medical authority is temporary , or as long as lack of medical doctors and based on agreement between District Health Office and IMA
- Delegation of authority will be cancelled if
 - Doctors are already present in that area
 - Midwives and nurses who gets the delegation of authority move to other area.
 - Midwives and nurses that receive certain authority perform medical actions beyond the authority assigned to them
 - The authority that's been delegated are withdrawn by the person giving the authority

- Thank You

[Japan]

Current Status of Task Shifting in Japan and the Response of the Japan Medical Association

Yoshitake YOKOKURA*¹

The issue of task shifting is currently under discussion by the World Medical Association (WMA) as an important item for consideration. The WMA has already adopted a statement on this theme¹ in 2009. This continuing discussion also involves the issue of prescription rights, which is truly one of the most-focused topics for physicians, and the content is fundamental to physicians' achieving their mission as physicians.

The Japan Medical Association (JMA) holds grave concerns about the movement towards transferring certain tasks of medical diagnosis and treatments that currently only physicians are allowed to perform to non-physicians under the concept referred to as "task shifting" due to worsening of national finance. In this paper, I would like to explain two examples of task shifting in Japan. The response of the JMA to this movement, both measures taken in the past and actions planned for the future, are also discussed.

Two Examples of Task Shifting in Japan — "Nurse practitioner" and emergency life-saving technicians

The first example concerns the introduction of a new type of qualification tentatively called "nurse practitioner"; the second example concerns the duties of "emergency life-saving technicians."

"Nurse practitioner" is an occupational category whose introduction is being proposed by the Japanese Government mainly as a means of compensating for the shortage of physicians in medical workplaces; the qualification would permit nurse practitioners to perform certain medical practices. This occupational category stems from thinking that dispenses with funda-

mental measures for resolving the shortage of physicians and believes that medical practices can be removed from the supervision of physicians. The JMA is adamantly opposed to the introduction of this qualification.

With regard to "emergency life-saving technicians," their actions at the scenes of emergencies are expected to increase rescue rates. There is debate in Japan at the moment about the extent to which emergency life-saving technicians should be permitted to perform medical practices, and if they are permitted to perform certain procedures, under what circumstances they should be permitted to do so.

What Is "Nurse Practitioner" in Japan?

Nurse practitioner is a special occupational category that is for neither physicians nor nurses. The duty includes the performance of certain medical practices. However, medical practices primarily have invasive effects to the human body. Medical diagnosis and treatment involve a high degree of uncertainty regarding a patient's condition. Regardless of whether their condition is mild or stable, there is always the risk of worsening or sudden changes. Accordingly, unless medical practices are performed by qualified physicians who have high-level skills and the ability to make high-level medical decisions, it is impossible to protect patients' safety.

The national government needs to be extremely careful about creating a new professional occupation that expands the duties of nurses, giving the current shortage of physicians as its main reason. Should only the division of duties move ahead, it is clear that the locus of responsibility will

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become vague. This also means that patients' safety will be jeopardized.

JMA's Proposals on "Nurse Practitioners"

In Japan, the Act on Public Health Nurse, Midwives, and Nurses defines that the nurse is a person who holds a license from the Ministry of Health, Labor and Welfare, and engage in providing nursing care to or assisting in the medical treatment of persons with injuries and/or illnesses or postnatal women.

Efforts need to be made under the current laws in Japan—namely, the Medical Practitioners Law and the Public Health Nurse, Midwife, and Registered Nurse Act—to ensure that the people involved in each of these occupations are able to more fulfill their potential skills. Medical care as a team should be promoted while the opinions of physicians, nurses and the general public in communities should be fully collected and reflected to solve the problems with regard to the expansion of nurses' duties.

Although the JMA opposes the creation of a "nurse practitioner" qualification, we agree to the expansion of nurses' "diagnostic assistance" role under the existing laws. This expansion should proceed under the conditions that a wide variety of opinions of the government, medical profession, and local residents are combined and regional healthcare is improved.

There are many measures under the current laws that should be attempted before a new occupational category is created, including resolving the issue of medical fees which may be the major cause of the shortage of physicians. The JMA is strongly opposed to taking shortcuts to resolve the shortage of physicians, such as introducing measures employed in other countries with different social and cultural backgrounds, as well as the easy introduction of qualifications that in due course will lead to medical cost containment.

What Is "Emergency Life-saving Technician" in Japan?

In the area of pre-hospital emergency care in Japan, diagnostic assistance roles are expanding in some medical areas. One example is the duties of emergency life-saving technicians. They are permitted to perform certain procedures under the Paramedic Law, established in 1991.

Emergency life-saving technician is a national qualification, and currently approximately 34,000 technicians are registered.

Their basic duties are: 1) to transport emergency patients to physicians as quickly as possible, 2) to secure patient safety during transportation as far as possible, and, 3) to ensure medical control or physician supervision as far as possible within the overall flow.

Three Specific Actions of Emergency Life-saving Technicians

The three specific emergency life-saving procedures are intravenous infusions to secure venous paths, airway management including endotracheal intubation, and administration of limited medicines. At the scene of emergencies, the technicians are to contact physicians both directly via radio or phone and online via internet, and receive specific instructions to perform these actions.

What Are Necessary to Establish Medical Control (Physician Supervision) in Task Shifting?

As task shifting takes place, the establishment of medical control (i.e., physician supervision) is most important, and the following are most necessary:

- 1) Local medical associations take a leadership role.
- 2) Functional disparities among emergency medical care centers must be corrected. Emergency medical care centers should be the core of medical control system. More acute physicians should be trained and their numbers should be secured. "Ambulance with a doctor" should become more widely used, and methods of transporting physicians to the scenes of emergencies should be improved.
- 3) The technicians must receive specific instructions from physicians for emergency procedures on a case-by-case basis, and the technicians or fire-fighters must record and save the instructions in the national standard format to ensure smooth post-emergency follow-up.
- 4) In the follow-up, the technicians should provide the physician who supervised the initial diagnosis and treatment with the necessary information about the patients.

What Are Important to Establish Off-line Medical Control?

The important items related to off-line medical control are as follows.

- 1) Protocols must be formulated beforehand for determining cases and procedures that emergency life-saving technicians can follow as sufficient pre- and post-emergency medical controls.
- 2) Expansion of duties must begin from emergency rescue squads which have training and post-emergency follow-up systems in place.
- 3) Emergency medicine-related laws that take into consideration emergency medicine overall must be developed.
- 4) When duties are outsourced, appropriate agreements must be concluded with contractors to clarify the legal responsibilities of fire-fighters, emergency life-saving technicians, cooperating physicians, and medical institutions.

Basic Position of the JMA on Task Shifting

In the Declaration of Seoul, the WMA uses

the terms “professional autonomy” and “self-regulation” to describe the ideal form of medical practice by physicians as medical profession. Medical practices, that is to say, medical diagnosis and treatment, are practices traditionally carried out by physicians only. Accordingly, task shifting should be allowed only when certain medical practices must be carried out by non-physicians due to unavoidable circumstances, and must be performed under reliable medical controls or doctor’s supervision, with local medical associations actively taking a leadership role in medical controls and supervision.

There is a trend towards the performance of some medical practices being imprudently shifted to non-physician, using the shortage of medical resources as an excuse. We must take the current situation even more seriously than ever. To ensure that the delegation of one medical practice does not spread little-by-little to others, physicians must remain fully vigilant and unite in making the utmost effort to preserve professional autonomy in order to continue meeting the expectations of patients who require sufficient quality care in the future.

Reference

1. WMA Resolution on Task Shifting from the Medical Profession. Adopted by the WMA General Assembly in New Delhi, India, October 2009. <http://www.wma.net/en/30publications/10policies/t4/index.html>

Current Status of Task Shifting in Japan and the Response of the Japan Medical Association

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46th CMAAO Mid-term Council Meeting
Symposium Topic "Task Shifting"
Kuala Lumpur, Malaysia
September 18, 2010

Two Examples of Task Shifting in Japan

- The introduction of a new type of qualified nurse, "nurse practitioner"
 - The JMA is against this qualification
- The actions of "emergency life-saving technician"
 - Expectations to increase rescue rates
 - Debate about the extent to which they should be permitted to perform medical practices, under what circumstances?

2

What is Nurse Practitioner in Japan?

- A special occupational category
- Neither physicians nor nurses
- Includes the performance of medical practices

JMA's Viewpoints

-Medical diagnosis and treatment involve a high degree of uncertainty and are the duties of physicians.

-The national government needs to be extremely circumspect about creating a new professional occupation

3

JMA's Proposals on Nurse Practitioners

Under the current laws...

- Ensure that qualified people in each occupation are able to fulfill their skills
- Promote medical care as a team
- Expand nurses' duties under conditions combining a wide variety of opinions and improving regional healthcare
- Improve the medical fee schedule first
 - ✓ Measures employed in other countries are not necessarily applicable to Japan
 - ✓ The easy introduction of qualifications will lead to medical cost containment

4

What is Emergency Life-saving Technician in Japan?

- A national qualification
- Permitted to perform certain procedures
- The Paramedic Law (1991)
- Approx. 34,000 technicians are registered (2009)

Basic Duties

- Transport emergency patients to physicians
- Secure patient safety during transportation
- Ensure medical control


5

Three Specific Actions of Emergency Life-saving Technicians

- Intravenous infusions to secure venous paths
- Airway management, including endotracheal intubation
- Administration of medicines permitted only under medical control

6

What are Necessary to Establish Medical Control (Physician Supervision) in Task Shifting?



1. Supervision by local medical associations
2. Measures to correct functional disparities
3. Necessary information for physicians
4. Instructions from physicians

What are Important to Establish Off-line Medical Control?



1. Protocols for medical control
2. Training and follow-up systems
3. Emergency medicine related laws
4. Appropriate agreements

Basic Position of the JMA on Task Shifting



- Professional Autonomy
 - Self-regulation
- (WMA Declaration of Seoul)

[Korea]

Dimensions of Task Shifting: Consideration for further discussion

Dong Chun SHIN*¹

Introduction

The term ‘task shifting’ implicates many aspects: task delegation as a way to alleviate shortage of medical professionals, collaborative care and allied health, scope of practice and so forth. These practices have existed for many years, but discussion on these under the term of ‘task shifting’ started in earnest with the growing problem of shortage in health workers and controversy regarding infringement on scope of practices concomitant to it. Currently, task shifting exists not only in the countries which lack medical professions but also in the countries which don’t suffer such shortage problems. Task shifting has expanded roles of existing healthcare workers and has created new cadre of healthcare workers as well. Controversial in particular among them are community health workers, prescribing pharmacists, nurse practitioners, physicians’ assistants and etc. In attempts to respond to the controversies regarding task shifting and provide guidelines for task shifting, the WMA has adopted the resolution on tasks shifting in 2009. Korean Medical Association (KMA) has participated to the drafting of the resolution as a workgroup member. In advance to the adoption, the WMA has organized a seminar on task shifting which was held in Reykjavik, Iceland in 2009 to collate wide range of opinions from various stakeholders to be reflected in the process of drafting the WMA resolution on task shifting. I would like to introduce some of the conclusions drawn from the seminar and main points of the WMA resolution in this paper as an useful platform for further discussion in CMAAO.

Different Dimensions of Task Shifting

As described in the introduction above, there are various approaches to task shifting depending on countries. In Africa region which suffers from a severe shortage of healthcare workers, task shifting has been instituted very early on to counter the problem. For the patients in the region, failure in task shifting often means no treatment at all. In this region, community health workers and medical assistants have expanded their roles most. They are trained to perform limited specific tasks in the field of healthcare such as HIV treatment.

In North America, task shifting would be incorporated in the direction towards ‘collaborative care.’ Collaborative care is considered as the best condition for achieving the best interests of patients. However, under this concept, independent prescribing by non-physicians is still regarded as controversial and many argue that there should be clear limit on task shifting.

The other dimension is cautious approach to expansion of jurisdiction by non-physicians. Countries like Korea, Japan, Israel and etc. may be enumerated under this category. These countries agree with the necessity of redistribution of tasks only under limited situations, but concern about indiscriminate extension of scope of practice by non-physicians. They also concern that task shifting could be misused as a way of reducing health expenditure and led to infringement on physicians’ clinical autonomy and professional independence.

As an example on this dimension, I would like to briefly introduce the task shifting in Korea.

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Task Shifting in Korea

According to the Medical Act in Korea, prescription lies solely on the responsibility of physicians with only extremely limited situation. Only under emergency situation such as natural disaster, trained nurses can prescribe limited category of drugs.

Another issue is the inconsistent penalty regulations against non-licensed medical practices such as eye examination or lens attachment by optometrists or dermatological peeling and blemish removal by beauticians.

Adding to this, the ‘health education professional’ that is being prepared by the Korean government may pose further complications. Although this new concept of profession is for focusing more energy on disease prevention and health promotion, KMA concerns that unless the role of the health education professional, which is currently stipulated as “health counseling and management” is not clearly defined, it could infringe upon the professional scope of physicians or result in unlicensed medical practices. If not properly managed, this new service may rather harm public health by disseminating inaccurate information.

Conclusions from the Reykjavik Seminar

Situations and philosophies regarding task shifting are so greatly different from country to country that it is almost impossible to consider every aspect in WMA’s drafting of the resolution. Rather, we should sort out the most important directions we should stick to: Patients’ health and safety should be the utmost concern in the discussion of task shifting. Some governments consider task shifting as a cost saving measure, but this kind of approach would be negative as it is unlikely to lead to quality outcome in terms of best interest of patients. Prescribing and diagnosis are the fields that need most prudent approaches in task shifting. Task shifting is a temporary measure to counter shortage in health workers and it should not substitute for efforts to normalize and improve healthcare system of a country. Task shifting is only a way of addressing

health professional shortage problems and other better approaches such as team care under the leadership of physicians should be developed. For improving teamwork, we need training programs for enhancing mutual understanding among different health professions.

WMA’s Resolution on Task Shifting

The WMA workgroup on task shifting was formed in Israel (Chair), Iceland, Korea, Norway and Spain. After two years of discussion, WMA adopted the resolution on task shifting proposed by the workgroup. WMA clearly states the following points:

- The quality of care and patient safety should never be compromised
- Physicians and NMAs should be involved in the discussion and decision-making of task shifting throughout the whole process.
- Task shifting should be viewed as a short-term measure with clear exit strategy in principle and it should not replace full-functioning healthcare system, nor education and training of physicians and other healthcare professionals.
- Task shifting should not be viewed solely as cost saving measures as such approach is not likely to produce quality results in patients’ best interests. Analysis on substantiality of cost-saving effects of task shifting should be conducted.
- Task shifting must be assessed and evaluated independently and other methods such as collaborative practices and team approach should be developed.

Direction of Further Discussion

The WMA resolution on task shifting captures general principles and guidelines from the viewpoint of physicians well-balanced. The ideas of the resolution can be applied to basically all regions. If we make a policy on the level of CMAAO, we need to develop more detailed strategies for conducting and assessing task shifting specified for the Asia and Oceania region, so that it can go hand in hand with the WMA resolution.

Dimensions of Task shifting: Consideration for further discussion



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Introduction on Task shifting

1. Task shifting has many aspects:
 - task delegation
 - collaborative care
 - scope of practice.
2. Task shifting have existed for many years and currently it exists not only in the countries which lack medical professions but also in the countries which don't suffer such shortage problems

Controversies regarding Task Shifting

Task shifting has expanded roles of existing healthcare workers and has created new cadre of healthcare workers

**Infringement of
Physicians'
Scope of practice**

**Prescribing
pharmacists**

**Nurse
practitioners**

**Community
health workers**

**Physicians'
assistants**

Different approaches of Task shifting

[Africa region] - Severe shortage of health workforce - Failure in task shifting means often no treatment at all - Community health workers and medical assistants	→	Task delegation to alleviate shortage of medical professionals
[North America] - Collaborative care as the best condition for achieving the best interests of patients - Independent prescribing by non-physicians are still controversial	→	Collaborative Care
[CMAAO region] - Concern about indiscriminate extension of scope of practice by non-physicians - They concern that task shifting could be misused as a way of reducing health expenditure - Infringement on physicians' professional autonomy and independence	→	Cautious approach on expansion of practice scope by non-physicians

Task shifting in Korea

Korea's Medical Act: extremely limited range of task shifting
 Only under emergency situation such as natural disaster, trained nurses can prescribe limited categories of drugs

Inconsistent regulations against Non-licensed medical practices
 eye examination or lens attachment by optometrists or dermatological peeling and blemish removal by beauticians

Health education professional
 - This new concept that is being prepared by the government is focusing more on disease prevention and health promotion
 - Unless the role of the health education professional is not clearly defined, it could infringe upon the professional scope of physicians or result in unlicensed medical practice

Conclusions from the Reykjavik Seminar

The WMA had organized the seminar on task shifting in Reykjavik in Iceland (2009) to collate wide range of opinions from various stakeholders to be reflected in the process of drafting the WMA resolution on task shifting.

Important Directions for drafting WMA resolution on Task shifting

- Patients' health and safety should be the utmost concern.
- Considering task shifting as a cost-saving measure would be negative as it is unlikely to lead to quality outcome in terms of best interest of patient.
- Task shifting is only a temporary measure and it should not substitute for efforts to normalize and improve healthcare system of a country.
- Other better approaches should be developed

WMA Resolution on Task Shifting

Workgroup: Israel (Chair), Iceland, Korea, Norway and Spain
WMA adopted the resolution in New Delhi General Assembly in 2009.

WMA Resolution on Task Shifting

- The quality of care and patient safety should never be compromised.
- Physicians and NMA's should be involved in the discussion and decision-making of task shifting throughout the whole process
- Task shifting should be viewed as a short-term measure with clear exit strategy in principle and it should not replace full-functioning healthcare system, nor education and training of physicians and other healthcare professionals.

WMA Resolution on Task Shifting

WMA Resolution on Task Shifting (con'd)

- Task shifting should not be viewed solely as cost saving measures as such approach is not likely to produce quality results in patients' best interests.
- Analysis on substantiality of cost-saving effects of task shifting should be conducted
- Task shifting must be assessed and evaluated Independently and other methods such as collaborative practices and team approach should be developed

Direction of further discussion

Directions for policy on the level of CMAAO

The WMA resolution on task Shifting captures general Principles and guidelines from the viewpoint of physicians well-balanced.

On the level of CMAAO, we need to develop more detailed strategies Conducting and assessing task shifting specified for the Asia and Oceania region.

Thank you.

[Malaysia]

Task Shifting Concerns in Malaysia

David K.L. QUEK*¹

MMA Supports Universal Healthcare for All¹

In general, Malaysia has nearly universal access to health for most Malaysians, but this is undeclared and not structurally defined. The government's heavily subsidized public health sector provides most health care to all patients, with minimum copayment, often a token one to five ringgit per outpatient visit. Even hospital admissions and treatment are subsidized to the tune of 98% of all total health expenditure (THE).

Our health expenditure consumes just 4.7% of the GDP, with the government providing just 2.1% (44% of the THE) from tax revenue allocations, amounting to around RM13 billion per year. (Total National Health Expenditure amounts to RM35 billion in 2008.)² This entire sum is spent exclusively for maintaining and providing for the public healthcare sector, which provides 38% of outpatient services and 70% of in-hospital services.

The private healthcare sector is funded predominantly by third party payers (TPP, such as employer health benefits, and health insurance ~14 to 15%), with another 35% from out of pocket payments (OPP). The private sector looks after some 62% of outpatient services, and 30% of in-hospital treatments.³

The MMA respects and acknowledges government measures, which help to bring better access of healthcare to the population, especially the poor, the marginalized, and the underserved, whether in the urban or rural locations.⁴

We fully support every effort to ensure that the poorest among us, as also of every resident of Malaysia, must have easy, affordable and high quality healthcare, as a human right for all.⁵

We fully appreciate that for many decades now, many world authorities, have praised

Malaysia's primary healthcare structure as being among the best among developing countries, the world over. We are proud that nearly every citizen of Malaysia (~90%) has relatively easy access to a healthcare facility under a radius of less than 5 km.

However, while the MMA supports better, affordable and more accessible healthcare facilities to the public, the manner in which so-called "1Malaysia clinics" has been announced, where they are to be sited, as well as the fact that these clinics were to be manned by medical assistants and nurses, took many doctors by surprise.⁶

Paramedic-operated 1Malaysia Clinics Frustrate Doctors

At the last announced national budget 2010, 50 such clinics around the country were set up. Thus, this small number of clinics would probably have little impact on any doctor's rice-bowl. However, the MMA has reservations about opening these in urban areas, because we already have so many GP clinics (>7,500 clinics) in almost every town and suburb in the country.

Dr Mah Hang Soon, Perak State exco member, while visiting the soft opening of these clinics, alluded to the fact that there were already some 319 GPs in the four towns where these 1Malaysia clinics have been sited!

Many GPs are much angered by such arbitrary setting up of these paramedic-manned clinic services. Such was the general impression that they are once again bearing the brunt of perceived one-sided governmental action, following so closely on the heels of the unpopular Private Healthcare Facilities and Services Act and Regulations (PHCFSA).⁷

The major peeve is the manning of these clinics by non-medically registered personnel, i.e.

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medical assistants and nurses rather than doctors. This approach appears to many GPs and doctors as taking many steps backward, despite reassurances that there will be oversight and supervision by some doctors, periodically.

The Prime Minister tried to reassure us that our doctors will not be impacted, and that these clinics are simply basic ones to cater for monitoring diabetes, hypertension and some simple ailments. However, he left the question of expansion of these clinics opened, depending on the success of its popularity... Hence, our concerns remain. Many GPs continue to feel strongly that these clinics should not have been opened and manned in this manner.

Poor Distribution of Doctors, Better Deployment the Answer

MMA believes there is no real shortage of medical doctors, but a misdistribution of resources. As of 2010, we have a doctor-population ratio of 1:900, but in the interiors of Sabah and Sarawak, the distribution is quite disproportionate, 1:2,000 or more.⁸

The public sector primary care clinics (called 'klinik kesihatan') number just over 800 around the country and are severely overcrowded, over-utilized and often understaffed. Many of these are rural- or suburban-based, and most are manned by paramedics supervised by medical officers, on a rotating roster of visiting services.

The MMA feels strongly that more doctors should be deployed to man these clinics.⁹ We understand the logistical problems, which have arisen time and again due to doctor reluctance to be relocated to more rural or remote locations. Yes, despite all the improved perks, retaining doctors in the public service remains a challenge.

Proper and fair deployment with guaranteed career paths for further training or preferred posting after such rostered 'hardship' postings will allow greater participation by ambitious younger doctors.

Also if these 1Malaysia clinics are now to be part of the expanded public healthcare system, then the MMA believes that even more public sector doctors would be willing to be deployed in rotation, or as part of a training initiative for an enhanced family practice/general practice vocation.

Upgrade All Health Clinics, Including the Remote and Rural

The MMA strongly believes that even rural or suburban 'klinik kesihatan's should be upgraded to doctor-manned clinics which would enhance the overall standard and quality of care for everyone, urban and rural. We believe that these services even for the poor, can be made even better with clinics, which are doctor-covered 100% of the time.

Paramedical personnel, whom we all deeply respect and are dependent on, are specifically-trained and have defined scopes of practices, which are as stated quite explicitly, to 'assist' doctors to carry out healthcare services, and never intended to replace doctors.

Thus, the specific roles of allied health personnel will not be eroded, but instead should complement those of doctors. It is a norm that doctors should remain in this day and age, as the minimum standard of care, where indeed possible.

We cannot always look backwards in time and compare the 1960s and 70s, where because of our fledgling healthcare service then, we had to utilize these medical assistants, assistant nurses and midwives to provide very critical services, especially in rural and remote areas around the country. Then, quite obviously some kind of healthcare service is better than none at all, and these have served us very well, indeed.

Our maternal and childhood mortality and morbidity data underscores the success of such a much-lauded program, which are being emulated by many other developing nations. We are rightfully proud of this. But, despite such strides, our health vital statistics still lag behind more advanced countries, which suggest that more improvement can still be achieved.

It is acknowledged that some nurses now have degrees, Masters and even PhDs, but the reality on the ground remains that these are few and far between. Furthermore it is well-known that these better-trained personnel are usually administrative and not deployed to service health clinics. However, it remains incontestable that their training does not equal that of a doctor's.

Nevertheless, we fully support the Malaysian Nurses' Association's call to further upgrade the calibre, responsibilities and training of nurses in the country. This will undoubtedly enhance the

standard of care for all Malaysians.

However, there are also rising concerns that the mushrooming nursing colleges (>120) around the country has also cast a growing cloud of ambiguity as to the average quality and standards of our nurses trained recently. This is also true of our many (30) medical schools!

This is the hard truth, which our health system must learn to address before they become unmanageable. But do we dare ask these difficult questions? Is any one authority seriously looking into this, or are we just too comfortably complacent at simply getting out the numbers?

Thus, the MMA maintains that all of these clinic services are best fully supervised directly by a doctor in proximity, in every healthcare establishment. This practice of having surrogate allied health personnel should always be a stopgap measure, which should be discontinued once sufficient efforts were made to enhance our services.

Using such alternate substitute personnel to replace doctors would never be allowed in any of the private hospitals or private medical facilities. So, clearly because of real life shortages and economic factors, we resort to such practices. But in an ideal world, these would not be the preferred choice.

We should not be stuck in the past; we have to move forwards. The MMA believes that we have sufficient doctors to be deployed to service clinics around the country, notwithstanding logistical problems such as doctor reluctance to be deployed to more remote locations, and the continued attrition of public doctors to private sector ventures.

We are convinced that we are now producing sufficient number of doctors and they can now hopefully function in their true capacity and training to oversee and run these clinics. That is the premise of the MMA and most doctors—we should not compromise on this, simply for economic or other purposes.

Surely if all else are equal, if payment for service is not the concern, who would any one sick person prefer to see, a doctor or another healthcare professional?

This is not to say that there cannot be a complementary assistive role for allied health professionals. Nurses, nurse practitioners, medical assistants, special technicians, physiotherapists, all or some of these, are indispensable and

would enhance the overall healthcare experience.

Our premise is that to each professional, its own tasks and duties based on its specific capacity and training. However, this does not mean we are disparaging or looking down on these very important personnel, whom we work with on a daily basis!

Double Standards & Legal Implications of Clinics

Most doctors believe that this approach of using clinics run by MAs and nurses alone, is wrong in law. Our Medical Act dictates that only registered doctors should operate any health/medical clinic. Yet, while this is the law for the private medical practitioners, there appears to be another law for government-backed facilities where this requirement can be ignored! (It is true that under the Medical Act, the Health Minister can waive or exempt certain regulations.)

That there appears to be one law for private doctors and another for the government or MOH has provoked a sense of injustice and deep anger, especially because quite a number of doctors who had fallen foul of this law had been severely punished recently. Some doctors have openly asked why they too cannot also employ MAs in their clinics, to look after simple basic health issues too, while each doctor can oversee a few clinics without being physically present!

Of course, the MMA does not and will not condone or encourage any doctor to break the law. Therein lies our dilemma of such a perceived differential application of the rule of law. Blatant double standards are badly frowned upon by well-reasoning people, including doctors!

If all these 1Malaysia clinics can be manned by doctors, even house or medical officers (registered medical practitioners) then this degree of unhappiness would be much dissipated. The MMA urges an overall upgrading of these clinics to that manned by at least registered doctors. We believe this will help defuse the situation, and more importantly will enhance the quality of care for patients.

It should not be that if one is poor, then one has no option but would be serviced by whatever is offered at the cheapest mode. Such inequity exacerbates social injustice and is an affront to modern human rights concerns.

Safety & Quality of Care Concerns, Likely to be Better with Doctors

With such a move, there will not only be improving access to the poor but also ensuring safety, higher quality of care, possibly fewer errors, lessen medico-legal mishaps, despite the payment of only RM1! Of course, we can harness the special capabilities of the MAs and nurses to offer quicker access, but one that is supervised by a doctor. With such a move, the question of legality, more appropriate therapies, timely referral and even medical chits can be resolved.

A recent report by a group of doctors in Penang¹⁰ (Dr Jayabalan T and others,) stated that “A study in 2009 revealed that medical assistants at government health clinics and government hospitals were found to be responsible for many medication errors. Of the 1,612 prescriptions generated by medical assistants in a single week, 1,169 errors were noted and some were critical errors, involving the use of at least one medication categorised as Group B medicine, which only medical officers are authorised to prescribe.”

They concluded that “It must be noted that medical assistants are trained to assist medical officers and not to provide treatment in the same manner as medical officers.”

Another study published in 2008 by the (comprising researchers from both University Malaya and MOH doctors), on “**Medical Error in MOH Primary Care Clinics,**” had also found many more errors hitherto unexposed to the public.¹¹ Of 1,753 clinical records reviewed by a team of family medicine specialists, a very high percentage of medical errors were discovered: 57.2% occur in primary healthcare sites, and 93% of medical errors were deemed preventable. The majority of medical errors are related to medication. Medical assistants saw 81% of the total of records assessed, and thus were responsible for the majority of these medical errors.

A lack of knowledge and skills of MOH staff has been shown to contribute to medical errors. They concluded that there is a need to improve the quality of healthcare services provided by MOH health clinics.

Therefore, safety issues must always be considered. This is not to say that doctors cannot make such similar mistakes, but with far more comprehensive training and education, doctors are expected to make fewer of these errors.

Medical protection insurance, when taken up by doctors, also helps to ensure greater patient protection.

MMA shares World Medical Association Concerns about Uncontrolled Task-Shifting¹²

For many of us in the MMA, the delegation of duties in the Malaysia clinics to non-doctors despite its noble intentions of trying to reach out to more of the urban poor, is a form of task-shifting from the medical doctor, which is much feared and roundly cautioned by medical professionals around the world.

While some poorer nations with very short supply of doctors have resorted to task-shifting some of health care to nurse practitioners or health assistants (even encouraged by WHO), this is not the usual exercise for countries aspiring toward a higher standard of care.

This move also contrasts starkly with our vaunted new approach to encourage greater Medical Tourism initiatives, and could lead to questions of uneven healthcare standards, and possibly safety issues. This could unfavourably impact our efforts to promote health tourism from safety conscious foreigners.

Doctors and the MMA have been lambasted as being ‘elitist.’ But this is not true, we respect standards and clear task demarcations, which define one profession from another. Task separations have been mankind’s refining benchmarks for better and more specialized work designations, and we believe this approach is particularly appropriate for the medical and health profession.

Importantly, MAs and nurses **do not** replace the need for doctors, they **assist** them to help free up more time for more consultative, diagnostic or more special therapeutic roles. This exercise should never be an exercise for economic or other purposes. Safety and Quality of healthcare must always be our prime concern.

Utilise our Extensive GP Network¹³

Our GP clinic network is extensive in the urban setting. All towns small and big have perhaps too many GP clinics. In major cities these are now highly competitive, even excessive and oversupplied. Many clinics have concerns of viability and

under-utilisation. Perhaps, some of these are not sufficiently popular because of poor preparation or other reasons, but most can be improved upon with proper distribution or dispersal of patients.

Therefore, many GPs have asked why they have not been roped in to help out in these clinics for the poor, if only the MOH or government can help reimburse these clinics to help out. We understand the differences in expectations, amenities and perhaps problems with reimbursement protocols, but these can be worked out for the benefit of all.

Our GPs stand ready to be incorporated into a partnership, even an integrated system for better primary care for all our citizens.

But MOH concerns that some or most GPs

are of unsure/unsound standards are unfounded and biased. Otherwise how is it that some 62.1% of Malaysians who need medical treatment, seek private primary care consultations in the first instance? (2006 National Health and Morbidity Survey)

The MMA is leading a primary healthcare workgroup to further coordinate measures to raise the standards and quality of patient care among all our GPs and/or family physicians.¹⁴ This will enhance the quality of care even higher for our citizens. We are also working with the MOH to see how we partner or integrate the primary health care system in the country. Again differing standards of expectations, logistics and reimbursement mechanisms need to be sorted out.

References

1. Quek DKL, *The Malaysian Health Care System: A Review*, 2009.
2. Prime Minister & Finance Minister Najib Razak. *Malaysian National Budget 2010*.
3. Ministry of Health, *The National Health & Morbidity Survey 2006*.
4. Quek DKL. *Equitable Access to Health Care for All: Is this still a Pipe Dream for Malaysians? A Medical Professional's Perspective*. Paper presented at Suhakam's "Human Rights & Access to Equitable Healthcare" Dialogue, Kota Kinabalu, Sabah, 08 January 2008.
5. Malaysian Medical Association, MMA. *Health for All: Reforming Health Care in Malaysia*. Academe Art & Printing Services, Selangor, 1999.
6. *New Straits Times*. Urban folk to benefit but private doctors worry, 24 October 2010, p.4.
7. *Private Health Care Facilities and Services Regulations 2006* (P.U. (A) 137/2006). PCNB, Malaysia, 2006.
8. Medical Development Division. *Doctors: Country's requirement by the year 2020*. Ministry of Health, July 2010.
9. Quek DKL. *Obstacles to improving healthcare*. Malaysiakini, 9 April 2010.
10. Dr Jayabalan T and others, *The Star*, 07 January 2010, p.N45.
11. Khoo EM et al. "Medical Error in MOH Primary Care Clinics," Institute of Health Systems Research, 2008.
12. World Medical Association, *WMA Resolution on Task Shifting from the Medical Profession*. <http://www.wma.net/en/30publications/10policies/t4/index.html>.
13. Quek DKL. *The GP Conundrum—Whither the future*, MMA News, Feb 2010, p.4–7.
14. Quek DKL. *A New Deal for Malaysian Healthcare & the MMA*, MMA News July 2010, p.4–9.

[Philippines]

Task Shifting: The Philippine experience

Oscar D. TINIO*¹

Task Shifting
The Philippine Experience



By
OSCAR D. TINIO, M.D.
President

Task Shifting :

“expanding the pool of health human resources in areas where the appropriate health services are needed to meet the health care needs of the affected community or communities”

Universal Objective

“ universal access to comprehensive prevention programs , treatment, care and support”

... or “the health for all objective”

Problems Confronting the Philippine Health Sector

- Low priority given to health by the local and national governments resulting in the deterioration of public health facilities especially in the rural communities after the devolution;
- Growing population and the need to enroll everyone , especially the poor, to the National Health Insurance Program;
- Exodus of highly skilled health manpower resources especially doctors and medical technologist;
- Managing the distribution of the remaining health manpower resources.

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Philippine Health Manpower Resources

UNDER SUPPLY

- Medical Technologist
- Medical Specialists
- Physicians
- Pharmacists
- Dentists
- Bio-medical Technicians
- Medical Records Officers

OVER SUPPLY

- Nurses
- Midwives
- Nursing Aides
- Pharmacy Aides
- Caregivers

The Philippines has adequate supply of other health manpower resources like masseurs, morticians, embalmers

Problems encountered in achieving our “health-for-all” objective

- Shortage of physicians in some parts of the country for various reasons ;
- Low priority given to health by some local governments;
- About 25% of the country’s population are not covered by health insurance;
- Shortage of well trained health workers in some health facilities that were devolved.

Proposed Solutions

- Providing incentives to physicians who choose to work in the rural areas like higher pay;
- Medical Missions by NGOs like the PMA in remote communities with no doctors;
- Enhancing the referral system & the coordination among the inter-local health zones.
- Task Shifting to be managed by the LGU in coordination with the DOH and the PMA.

Medical Profession



Examples of Task Shifting in the Earlier Years

- The sending of medical graduates or interns to rural areas was one of the earliest attempts to do task shifting. The program was later abandoned for various reasons;
- Municipal Health Physicians relied on RHU personnel like nurses, midwives, sanitary inspectors & “baranggay health workers” of the community.

Legal Nuances

Task shifting within a professional health team --- from physicians to other health professionals who have fewer qualifications is generally frowned upon by even those in the rural communities.

Adverse events, which sometimes happen in communities where modern facilities are inadequate, are often blamed to the lack of skills or competency of the health provider. It is understandable, therefore, why many still depend on physicians for their healthcare needs, especially their curative and their surgical needs.

Philippine Laws governing the practice of medicine.

Levels of Competency

(Philippine Setting)

- Medical Specialists
- Physicians with training but have not passed the specialty board
- General practitioners or primary care physicians
- Licensed Nurses and Medical graduates who have not passed the licensure examination yet.
- Midwives
- Under-board Nurses
- Health aides (NC II and NC III)



Up to what level of competency or technical skills should a particular task be carried out?

Examples :

Normal and uncomplicated birth or deliveries --- midwives;

Immunizations & administering medicines ----- nurses, midwives

Dispensing otc (unregulated) medicines ----- pharmacists

Circumcision and simple suturing ----- nurses

i.v. fluid insertions/administration ----- nurses, midwives

Care of the elderly ----- nurses, midwives, licensed health aides

Care of the chronically and terminally ill --- trained health provider.

Other tasks that may be “shifted” :

Health promotion activities

Disease prevention and other public health work

Rehabilitation and care of the ill and infirmed

Some tasks that might have some problems of being shifted to other health providers.

- Medico-legal cases;
- Major surgical operations and even some minor surgical operations;
- Complicated disease conditions (or those with co-morbid conditions);
- Complicated birthing or deliveries;
- Diagnosing and prescribing;
- Complicated fractures;
- Prescribing regulated medicines.

Proposed starting competency level of a nursing graduate, the following training module may be applicable:

Desired Competency or Skill	Minimum Period	Trainor/s
Normal Deliveries	6 months	Obstetricians
Simple Anesthesia (local anesthesia)	6 months	Anesthesiologist
Routine Laboratory Procedures (CBC, Urinalysis, fecalysis etc)	12 months	Pathologist or Registered Medical Technologist
Immunization	3 – 6 months	Internist /Pediatricians
Simple surgical procedures	8 – 12 months	Surgeons and trained physicians
Emergency Procedures (intubation, tracheostomy ,CPR, splinting	10 to 12 months	Anesthesiologist, Surgeons and trained physicians.

Parting words :

In our desire to improve the health status of our people we may find it necessary to delegate some of the tasks which other health providers can render at their own respective levels if only to make health care more accessible and affordable to most , if not all, our countrymen.... This situation should be viewed , however, only as a temporary measure to address the problem of scarcity of physicians and not as a permanent solution in solving the mal-distribution of our precious health manpower resources. The leadership role of physicians in the delivery of health care is a professional call of duty that must be kept and maintained at all times ic33

[Singapore]

Task Shifting

Bertha WOON Yng Yng*¹

Background

Task shifting aims, in the short-term, to ameliorate the issues of a shortage of healthcare human resources, equipment and medications by shifting healthcare tasks from highly-trained to less highly-trained health workers.

In Singapore, there is an under-investment in long-term healthcare capabilities as well as a relative shortage of doctors and trained nurses.

Improving Long-term Healthcare Structure

The Ministry of Health set aside S\$1.5 billion to recruit 7,700 more healthcare personnel over 5 years since 2007. Physical expansion of acute care facilities have commenced such as the setting up of the Khoo Teck Puat Hospital and Jurong General Hospital.

Home nursing care is being improved to cope with patients who need transitional care to aid recuperation. In addition, the number of specialist geriatricians is set to increase by 30–40% over the next three years.

Singapore faces a shortage of doctors in the public sector, in part due to long working hours. Many tend to leave for private practice once their 5-year bond ends.

Singapore's rapidly graying and enlarging population exacerbates the problem of the short-

age of doctors, particularly in less popular specialties such as Geriatrics and Renal Medicine. To counter this, the National University of Singapore's medical school increased the number of places per year, a second medical school—the Duke-NUS Graduate School of Medicine—has been opened, and a third medical school is in the pipeline. The residency programme has also been implemented to streamline specialty training. In addition, the Singapore Medical Council has allowed temporary registration of doctors without registrable qualifications to work under supervision in areas of need. More graduates with foreign medical degrees are being allowed to practice. Advanced Practice Nurses have also been inducted into the system to enhance primary healthcare, patient education and facilitate healthcare in the acute care setting.

Challenges

Professionals are usually hesitant to turn over traditional roles to less highly-trained personnel. It is important to retain patient-centricity. The influx of foreign doctors has resulted in cultural differences in clinical practice and necessitated the use of translators in the care of non-English speaking patients, particularly the elderly. This is not desirable in the long term. There is a pressing need to convince local medical students studying abroad to return home to practice.


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Task Shifting


Presented at the 46th CMAAO Mid-term Council Meeting,
16-18 September 2010, Kuala Lumpur, Malaysia

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The lack of...

- Equipment, medications, and healthcare human resource



What it is...

- Shifting healthcare tasks from higher-trained health workers to less highly-trained workers to deliver healthcare in resource-poor settings
- 4 main cadres are:
 1. Medical doctors
 2. Nonphysician clinicians
 3. Nurses
 4. Community Health Workers




Challenges...

- Professionals may be hesitant to turn over traditional roles to less highly-trained workers
- Emphasis on task shifting has overshadowed the challenges of training
- To retain the importance of being patient-centric in the long term



The Singapore context...

- Under-investment in long-term healthcare capabilities
- Dealing with the shortage of doctors
- The introduction of Advanced Practice Nurses (APNs)




Beefing up healthcare for the future...

- Physical expansions of acute care facilities, such as Khoo Teck Puat Hospital and Jurong General Hospital
- Increasing staff strength, the Ministry of Health has set aside \$1.5 billion to recruit 7,700 more healthcare staff over 5 years in 2007
- Improving nursing home care to cope with the demand of transitional care for patients who require facilities to recuperate → government working with Home Nursing Foundation to ramp up operations and extend services, raising financial support by 7%
- Increasing the number of specialist geriatricians by 30-40% over the next three years, currently at 48

Why the shortage of doctors...

- Shortage in the public sector due to low pay and long working hours – many leave for private practice once their 5-year bond ends
- Certain hospital specialities shunned by Singapore doctors, such as Geriatrics, General Medicine, and Renal Medicine, as well as medical officers in polyclinics
- Rapidly enlarging and aging population



Steps taken...


- Increasing the number of places to 250 at the National University of Singapore for medical students
- More foreign-trained doctors working in Singapore as the number of medical degrees recognised increases, now making up 40-50% of doctors in Singapore polyclinics
- Singapore Medical Council allowing temporary registration of doctors without registrable qualifications to work in areas of need (AON) under supervision e.g. rehabilitation Medicine, with a cap of 40% per AON department
- Second medical school, Duke-NUS Graduate Medical School
- Implementation of the residency programme
- Third medical school to start up

Issues we face...

- Compromise in the quality of medical care, exacerbated by heavy workload, language problems and different training in the case of foreign doctors
- Many have to depend on translators when they see non-English speaking patients, in particular the elderly → local patients prefer local doctors!
- Need to convince local medical students to return from abroad – pre-employment grant for overseas medical students

Why we need Advanced Practice Nurses...

- Small number of expert nurses
- Good clinical nurses promoted to become managers or educators, and moved further away from direct patient care and clinical roles
- Capitalise on nursing strengths, to complement the physician's role




The role of APNs...

- To enhance primary healthcare, and nurse-led follow-up clinic services for patients with chronic diseases
- To conduct patient education and counseling sessions that include reinforcement of self-management skills, emphasising on medication adherence and evaluation of treatment
- To facilitate the flow of healthcare in the acute care setting, as part of the healthcare team


The job scope of APNs...

- 65% of time in direct patient care management
- 15% in teaching
- 10% in research
- 10% in project work




The Outcomes...

- In an appropriate setting, patient care and outcomes were of equivalent quality to that provided by physicians
- Improved quality indicators
 1. greater patient independence
 2. compliance with treatment
 3. decreased length of stay
 4. fewer hospital admissions and re-admissions
 5. decreased healthcare costs
 6. etc.



The challenges...

- New in Singapore's landscape – how will other nurses and the medical profession feel?



The future...

- To map out and expand the scope of APNs, and to measure the impact of APN interventions on the healthcare processes
- The need to reduce role ambiguity and promote understanding through defining, integrating and articulating the role of the APN, as well as emphasise the objectives to relevant stakeholders
- Healthcare should not be profession-centric, but patient-centric to deliver quality care

Resources...

- Task Shifting: A Solution for the Health Worker Human Resource Crisis? Larry W. Chang <http://www.medscape.com/viewarticle/705727>
- International Nursing Conference on Advanced Nursing Practice, 30 Mar 2005
Speech by Prof K Satsunanatham, DMS
- The Quest For Nursing Excellence
C Ang, Singapore Med J, 2002, Vol 43(10): 493
- Advanced Practice Nursing in Singapore
Dr Premarani K
- Expanding Singapore's long-term care capabilities
Claire Huang, http://www.938live.sg/News/Singapore/EDC100309-0000272/Expanding_Singapore_s_long-term_care_capabilities
- Singapore Medical Council, Temporary Registration for Medical Practitioners in Areas of Need
<http://www.smc.gov.sg/html/1278643225066.html>

[Sri Lanka]

Retention of Family Health Workers in Rural Communities as an Important Strategy in Task-shifting—The Sri Lankan experience

Indika KARUNATHILAKE,*¹ Pubudu De SILVA*²

Sri Lanka is an island located in the Indian Ocean south east to India with a population of approximately 20 million. Approximately 72% of the population is living in the rural community (Department of Census and Statistics, 2008). The primary health care system of Sri Lanka is a unique system with family health workers reaching out to these rural communities at grass root level. The Public Health Midwife (PHM) is the key family health worker at the grass root level. Today the services of PHM have evolved into a professional carrier taking a holistic approach in preventive health covering many aspects other than midwifery. Their services are immensely valued in rural setting where health resources are scarce. The success of PHM recruitment, training programme and employment in the rural sector can be seen by its ultimate impact in the health indices. Over the past years maternal mortality ratio (MMR) dropped from 265 in 1935 to 5.3 per 10,000 live births in 2003 and infant mortality rate (IMR) from 263 in 1935 to 11.2 per 1,000 live births in 2003 (Ministry of Healthcare and Nutrition, 2003). These indices highlight the effectiveness of task shifting and delegating the responsibilities to the grass root level health workers. It is important to ensure that PHMs are retained in the most needed areas. The paper discusses the main strategies that have been followed by Sri Lanka to ensure the retention of PHMs in the rural areas of Sri Lanka; need-based recruitment, capacity development as “experts” at the grass root level, Continuous Professional Development (CPD) and providing financial incentives.

Need-based Recruitment

The recruitment criteria for PHM training are based on educational qualifications. The eligibility criterion for enrolment is a minimum of simple passes for all three subjects in the Advanced Level examination. However on several occasions (in 1996, 2000, 2002 and 2009) the educational qualifications for recruitment have been lowered to enable trainees from very rural settings to participate in PHM training course. This decision was taken considering the fact that very rural settings may not have applicants with required educational qualifications for the PHM training course. These recruitments were done mainly for plantation sector in the rural and underprivileged districts of Central, Sabaragamuwa and Uva Provinces and to war-torn areas of the Northern & Eastern Provinces.

The recruitment policy of the country favours recruiting PHM trainees from very rural settings. It is mandatory to recruit trainees from all Provinces proportionate to the population living in each Province. This provides opportunity for those in Provinces with more rural settings to get selected for training. Thus those who are living in the Province can be trained within the Province, resulting in fewer defaulters from the rural settings. Those who are selected from a particular Province will later be enrolled to serve within that Province.

A significant proportion of PHMs was provided for Provinces with poor health indicators. In 2004, more than 90% of the trainees attending the PHM training course were posted to rural

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settings after completion of the training course. It is worth to note that the highest proportion was sent to Northern & Eastern Provinces in 2006, 2007 and 2008 (De Silva, 2009).

Capacity Development as “Experts” at the Grass Root Level

The training courses for PHM consist of 1 year basic training and midwifery, in a Nurses’ Training School and 6 months training in community health management in Regional Training Centers of the National Institute of Health Sciences (NIHS). NIHS is the premier training centre of the country for primary health care workers. The curriculum is designed to ensure that PHMs gain knowledge and competence that enables them to function at a higher capacity than a usual grass root level community health workers of other developing countries. A World Bank report on Sri Lankan PHMs has shown that this had enabled them to gain a high recognition among the rural communities, who identify them as experts in maternal and child health, thus helping to retain these “experts” in rural communities (Pathmanathan & Rajapaksha et al., 2003).

Continuous Professional Development (CPD)

The PHMs are kept updated through various local as well as regional and national programmes. At district level all most all districts in the county has conducted at least one training programme. Even the PHMs from the very rural settings have attended these training programmes. At national level the Family Health Bureau has conducted at least one training programme for the PHMs in each district. A World Health Organization report on the CPD for Sri Lankan PHM has shown high participation for continuous professional development by these PHMs in very rural settings and this was not due to economic gains and neither was it linked to promotions or re-registrations (WHO, 2004). The same report indicates that CPD is a requirement of majority of the health care workers and is one reason for internal migration of health professionals. Therefore it is mandatory to providing CPD facilities to those working in rural settings in order to retain them in the rural areas.

Financial Incentives

Various types of allowances are presently provided for the PHMs to retain in the rural communities. These are:

1. Office allowance – Approximately 1.5 US\$ are given monthly to maintain a office in the respective PHM area (However the present cost for renting an office is approximately ten times the allowance).
2. Field (Transport) allowance – A payment of 1.25 US cents per kilometer is paid with a maximum limit of 10 US\$ (However when considering the present fuel and transport prices this is not adequate).
3. Clinic allowance – An allowance of 1.75 US\$ per clinic sessions (for maximum of 8 clinics per month) is given for conducting community clinics.

Apart from these the availability of good quality schools, transport facilities and good road networks are other non health amenities required by PHMs when retained in the rural communities to provide primary health care. Providing other benefits available for government servants such as the availability of pension schemes, cost of living allowance and subsidized mobile communication facilities will attract more PHMs to work in rural areas (De Silva, 2007).

The Lessons Learnt

The success of the Sri Lankan primary health care system lies on its ability to retain grass root level primary health workers in remote/rural areas. The contributions from the PHM training programmes are immense. However the flexibility of the educational standards has helped to retain PHMs in very rural settings. The PHM training curriculum has given them the confidence to work in rural setting and it has obtained the recognition of the rural communities as well. Conducting ongoing CPD programmes and conducting out reach educational programmes for the most rural primary health care workers helps to keep the staff in rural settings since the opportunity to update the knowledge is given. There is high participation for CPD programmes by rural communities.

The favorable government policies which had been continuously present since the inception of primary health care system in Sri Lanka is one of

the main reasons for its ability to retain PHMs in remote/rural settings. The contribution from the non health factors had been another crucial aspect for the provision of PHM services to rural settings. These include providing equal educational opportunities for girls, high female literacy (87.9%), increasing age at marriage of girls (25.5 years 1994), high health literacy level, and minimal gender discrimination (Department of Census and Statistics, 2008). This provides

the opportunities for the females to achieve the required educational qualifications to apply for the PHM training course.

Conclusion

Strategies to retain grass root level health workers are essential in successful implementation of task-shifting.

References

1. Department of census and statistics (2008) http://www.Statistics.gov.lk/Abstract_2008_PDF/abstract2008/pagesPdf/pdfindex.htm
2. Department of census and statistics (2007/7) Sri Lanka Demographic and Health Survey 2006/7, <http://www.statistics.gov.lk/DHS/dhs1%20index.htm>
3. De Silva AP (2009) A Case Study on Retaining of Family Health Workers in Rural Communities in Sri Lanka, Proceedings of the 3rd AAAH Conference, October 2009, Hanoi.
4. De Silva AP (2007) The Community Health Workers of Sri Lanka, Proceedings of the 2nd AAAH Conference, October 2007, Beijing.
5. Ministry of Healthcare and Nutrition (2003) Annual health Bulletin, Ministry of Healthcare and Nutrition, Government of Sri Lanka.
6. Pathmanathan I, Rajapaksa LC et al (2003) Investing in Maternal Health: Learning from Malaysia and Sri Lanka, The World Bank, Washington DC.
7. WHO (2004) Continuous Professional Development of Health Personnel. Country Perspective—A Study in Sri Lanka, World Health Organization.

RETENTION OF FAMILY HEALTH WORKERS IN RURAL COMMUNITIES -THE SRI LANKAN EXPERIENCE

Indika Karunathilake¹ & Pubudu De Silva²

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Introduction

- Sri Lanka is an island located in the Indian Ocean south east to India.
- The population is approximately 20 million.
- Approximately 72% of the population is living in the rural community.
- The primary health care system of Sri Lanka is a unique system
- Family health workers reaching out to these rural communities at grass root level.

The success story of the Sri Lankan Health system

- Over the past years maternal mortality ratio (MMR) dropped from 265 in 1935 to 5.3 per 10000 live births in 2003
- Infant mortality rate (IMR) from 263 in 1935 to 11.2 per 1000 live births in 2003
- These indices highlight the effectiveness of selective task shifting and delegating the responsibilities to the grass root level health workers.

Role of the Public Health Midwife

- The Public Health Midwife (PHM) is the key family health worker at the grass root level.
- Today the services of PHM have evolved into a professional carrier taking a holistic approach in preventive health
- Their services are immensely valued in rural setting where health resources are scarce.

Strategies to ensure the retention of PHMs

- Need-based recruitment
- Capacity development as “experts” at the grass root level
- Continuous Professional Development (CPD)
- Providing financial incentives.



Need-based recruitment

- The recruitment criteria for PHM training are based on educational qualifications.
- The eligibility criterion for enrolment is a minimum of simple passes for all three subjects in the Advanced Level examination.
- However on several occasions (in 1996, 2000 2002 and 2009) the educational qualifications for recruitment have been lowered to enable trainees from very rural settings to participate in PHM training course.

Need-based recruitment – Contd...

- This decision was taken considering the fact that very rural settings may not have applicants with required educational qualifications
- These recruitments were done mainly for plantation sector in the rural and underprivileged districts

Capacity development

- The training courses for PHM consist of 1 year basic training and midwifery, in a Nurses' Training School.
- And 6 months training in community health management at the National Institute of Health Sciences (NIHS).
- NIHS is the premier training centre of the country for primary health care workers.

Capacity development – Contd...

- The curriculum is designed to ensure that PHMs gain knowledge and competence.
- That enables them to function at a higher capacity than a usual grass root level community health workers of other developing countries.
- This had enabled them to gain a high recognition among the rural communities.
- They identify them as experts in maternal and child health, thus helping to retain these "experts" in rural communities.

Continuous Professional Development (CPD)



- The PHMs are kept updated through various local as well as regional and national programmes.
- At district level all most all districts in the county has conducted at least one training programme.
- At national level the Family Health Bureau has conducted at least one training programme for the PHMs in each district.

Continuous Professional Development (CPD) – Contd...

- There is a high participation for CPD by the PHMs in very rural settings.
- This was not due to economic gains and neither was it linked to promotions nor re-registrations.

Financial incentives

- Office allowance – Approximately 1.5 US\$ are given monthly to maintain a office in the respective PHM area
- Field (Transport) allowance – A payment of 1.25 US cents per kilometer is paid.
- Clinic allowance – An allowance of 1.75 US\$ per clinic sessions

Lessons learnt

- The success of the Sri Lankan primary health care system lies on its ability to retain grass root level primary health workers in remote/rural areas.
- The flexibility of the educational standards has helped to retain PHMs in very rural settings.

Lessons learnt – Contd...

- The PHM training curriculum has given them the confidence to work in rural setting.
- It has obtained the recognition of the rural communities as well.
- Conducting ongoing CPD programmes and Out reach educational programmes for the most rural PHCWs helps to keep them in rural settings

Conclusion

- Strategies to retain grass root level health workers are essential in successful implementation of selective task-shifting

[Taiwan]

Strengthening of Primary Health Care in Asia and Oceania Region

Meng-Chih LEE,^{*1,2} Ming-Been LEE,^{*1,3} Yung Tung WU,^{*1} Tai-Yuan CHIU^{*1,4}

Challenges

Most of Asian and Oceanian countries are now facing the challenges of the inequity of health care as well as a rapid ageing society that should more focus on both establishing the primary care system and taking better care of chronic diseases. In accordance with Declaration of Alma-Ata, we reinforce that health is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal that requires the action of all social, economic, and health sectors. We acknowledge that the promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace. Overall, primary health care is the key to attaining this target as part of development in the spirit of social justice.

Solutions

Firstly, we need create a sense of urgency with the vision: healthy people in a healthy world through prevention.

Strategies

Addressing evidences: What work needs to be done should be based on evaluation and research

Getting effectiveness: Translating the evidence to application and getting better outcomes

Building capacity:

1. Government policy and resources: including priority setting, partnerships and networking

2. Comprehensive educational and training system as well as services system on primary health care

Actions

Medical Association Level

Recommendation 1: Not only focus on quality improvement of healthcare, we should also increase public accountability and greater managed care in the era of new medical technology, computerization of healthcare, as well as Internet technologies.

Recommendation 2: We should continue to advocate that community-oriented primary care is an important aspect of policy to achieve patient-centered, safety, effectiveness, timeliness, efficiency, and equity in health services.

Recommendation 3: Community-oriented medical education cannot be overemphasized in order to attract more physicians devoting to primary care and to provide comprehensive, continuous and coordinate care in the future.

Recommendation 4: Team-based multidisciplinary care and best practices for primary health care should be well established.

Governmental Level

Recommendation 5: Governments should continue to diminish the existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries. Essential health insurance program should be provided to most people in all countries including preventive health services.

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Recommendation 6: Governments have a responsibility to empower people to participate individually and collectively in the planning and implementation of their health care.

Recommendation 7: To build up better integrated health delivery system across the countries, governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors.

Conclusions

Better primary health care can lead to better health outcome, lower cost, and greater equity in health development. Therefore, all countries should continue to cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country.

Strengthening of Primary Health Care in Asia and Oceania Region

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The Millennium Development Goals



- 1 Eradicate extreme poverty and hunger
- 2 Achieve universal primary education
- 3 Promote gender equality and empower women
- 4 Reduce child mortality
- 5 Improve maternal health
- 6 Combat HIV/AIDS, malaria and other diseases
- 7 Ensure environmental sustainability
- 8 Develop a global partnership for development

Millennium Development Goals: 2009 Progress Chart

Goals and Targets	Africa		Asia				Oceania	Latin America & Caribbean
	Northern	Sub-Saharan	Eastern	South-Eastern	Southern	Western		
GOAL 4 Reduce child mortality								
Reduce mortality of under-five-year-olds by two thirds	low mortality	very high mortality	low mortality	low mortality	high mortality	low mortality	moderate mortality	low mortality
Measles immunization	high coverage	moderate coverage	high coverage	moderate coverage	moderate coverage	moderate coverage	low coverage	high coverage

The progress chart operates on two levels. The words in each box indicate the present degree of compliance with the target. The colours show progress towards the target according to the legend below.


- Already met the target or very close to meeting the target.
- No progress or deterioration.
- Progress sufficient to reach the target if prevailing trends persist.
- Missing or insufficient data.
- Progress insufficient to reach the target if prevailing trends persist.





What are other challenges faced

- **A very quick aging society and prolongation of life expectancy**
But do the elderly enjoy a healthy life expectancy or in another word, successful aging/good quality of life ?
- **A huge amount of money have been spent on the medical care**
But very limited resources were used for the disease prevention and health promotion !
- **There have been so many research performed for biomedical sciences**
But inadequate evaluation and evidence across domains have been made for priority setting and effective interventions !

The importance of family medicine/primary care physician has been recognized
But it s still not fully recognized by the authority about the roles of primary care physicians in health care system !




The Historic WHA Resolution 62.12

Primary Health Care , May 22, 2009


The resolution calls for all member nations to reinvigorate their health care systems through a strengthening of primary health care



Historical Documents

However, the development of primary care is still in its young adulthood in most countries of the Asia-Pacific region

- Health for All through PHC by 2000, Alma-Ata Declaration , WHO, 1978
- Primary Care: The key to meet people health needs, Dr. Barbara Starfield, the Johns Hopkins University, 1998
- Healthy People 2000 & 2010, USA: Health promotion and disease prevention and partnership as well as medical care reform focusing on PHC and insurance coverage as the basis
- Improving Health Systems: the Contribution of Family Medicine, WONCA/WHO, 2002



Resolution on primary health care adopted on 61st WHA 22.05.2009

1. URGES member states:...

(5)to train and retain adequate numbers of health workers, with appropriate skill-mix, including primary health care nurses ,midwives, allied health professionals and family physicians, able to work in a multidisciplinary health workers in order to respond effectively to people’s health needs;

Resolution WHA62.12“Primary Health Care including health systems strengthening”

↓

The World Health Assembly,urges member states: ...(6) to encourage the vertical Programmes, including disease-specific programmes, are developed, intergrated and implemented in the contex of intergrated primary health care

What do we need


First create a sense of urgency

•**Vision:**
Healthy people in a healthy world through primary care and prevention

•**Strategies:**
Evidence:
What work needs to be done based on evaluation and research


Effectiveness:
Translating the evidence to application

Capacity:
Government policy and resources: priority setting partnerships and networking
Comprehensive educational and training system on primary care physicians and allied health professionals



Models of Strengthening of Primary Care

1. **Community-oriented primary care (COPC)**
2. **Team-based multidisciplinary care**
3. **Best Practices in comprehensive management of chronic diseases: e.g. DM, Hypertension**



Community-oriented Primary Care in Taiwan-Community Health Centers

1. Community Health Centers (CHCs) has been set up in all townships and a health station in almost each village since 1970s
2. Beginning from 1980s, There are 2-4 trained family physicians working together as a group practice to provide people with both medical and preventive services in CHC with back-ups from the local community hospital
3. Central and local government provide hardware facilities and appreciated rewarding systems to physicians and allied health workers including nurses, pharmacist, medical technologist----
4. National Health Insurance Program was implemented on 1 march, 1995



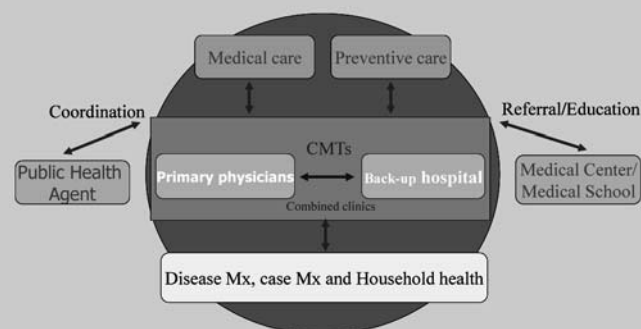
Community Medical Teams (CMTs) Project in Taiwan

Granted by NHIP since 2003

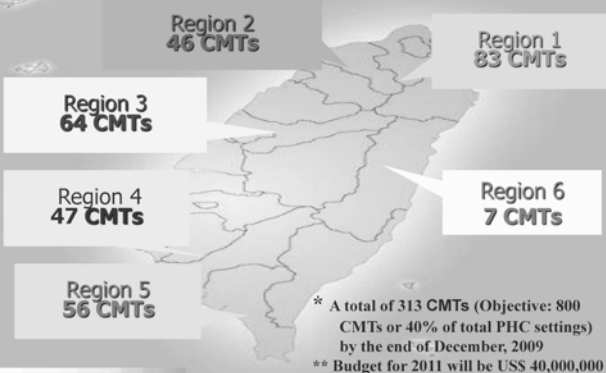
- To strengthen the quality primary health care through multidisciplinary team and comprehensive care, and to establish the family physicians system
- Integration of 5 to 10 primary care settings, back-up hospital and local public health sector to be a functional alliance
- Financial aids for the operation of the Executive Office and Call Center of each CMT
- Additional payment to quality care (NT\$800 or US\$25/per capita per year): e.g. outcomes management, preventive services, referral ----



Combined (Integrated) Care in a Community



The most important project in medical care system- current status of community medical teams (CMTs) in Taiwan (2010)



WHY Team-based multidisciplinary care

- The challenges of healthcare are increasingly complex and subject to frequent change.
- Meeting these demands require health professionals to work in partnership with each other, with other allied medical health professionals and with patients.
- The value of working as a team has already been recognized.



The multidisciplinary team - Roles of Family Physicians in CHCs and CMTs

- Utilize a team approach where a Family doctor acts as the **coordinator and facilitator** working closely with other allied health professionals and specialists providing a continuum of care within a Community Health Center.
- **More detailed consideration would be needed in defining the roles of various healthcare disciplines in different settings (public or private sector) and for management of different health problems**



Best Practices in management of chronic diseases

- Establish Practice guidelines and provide decision support
- Establish Care pathways for prevention and management of chronic disease:
 - consumers access programs
 - services based on systematic assessment and care planning
 - *Provide Coordinated, team based, Multidisciplinary care across a service continuum ranging from risk prevention to complex care*
- Governance and management with informatics of healthcare providers around the needs of consumers
- Empowering the patients in the community



WHO-five star doctor

THE FIVE STAR DOCTOR

- assess and improve the quality of care
- make optimal use of new technologies
- promote healthy lifestyles
- reconcile individual and community health requirements
- work efficiently in teams



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[Thailand]

Task Shifting

Wonchat SUBHACHATURAS*¹

Abstract

Under limited resources, one might be faced with unavoidable difficulty and stress in practicing medicine. There might be an idea to delegate the overloaded work to other professional alliances. In fact, in medical profession, delegation of the physician's duties such as diagnosis, plan of treatment and prescription of medicine as well as surgery to those who had not been well trained is not practicable due to lacking of knowledge background and experience. Diagnosis and treatment in Medicine are integrated procedure and safety

of the patients lies in the hands of physicians.

In Thailand, the code of practice in Medicine does not allow other health professionals apart from physicians to treat the patient or replace the task of a physician.

Only for the specific circumstances such as in health emergency or mass casualties in natural disaster, nurses and paramedics can assist physicians in the field to provide medical treatment but all these activities are needed to be under supervision of physicians who will be the team leader.

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