General Assembly Minutes

Minutes of the UNEPSA General Assembly Meeting, June 15th, 2002,

Prague, Czech Republic

The General Assembly of UNEPSA was called to order by President Jan Janda on June 15th, 2002 at 8:45 to 13:30 hrs. A quorum was declared, with 15 voting National delegates present (see list of participants) and 4 members of the board of UNEPSA (Janda, Katz, Olàh, Schmitz).

Prof. Janda read greetings and letters from countries, which are not present in Prague. They support the further UNEPSA activities. Messages were received from Presidents of the following countries: Albania, Austria, Luxembourg, Macedonia, Norway, Poland, Portugal, Slovenia, Ukraine, United Kingdom. All members of UNEPSA had been invited to the meeting, nevertheless, some addresses changed do to new representatives and several countries did not answer at all.

* All participating persons signed the list of participants.
* The auditors for the financial report were Mehmet Vural and Kevin Connolly.
* The minutes of the General Assembly were taken by the Secretary General Manuel Katz.
* Prof. Jane Schaller, President of IPA, was the special guest invited to the General Assembly.

The agenda was unanimously approved by the GA.
Jan Janda informed to the General Assembly that according with the constitution one hour before the election, members have to suggest two members for 2 vacancies in the Board (Secretary General and treasurer).

The minutes of the General Assembly of 19th March, 2000 in Rome were unanimously approved by the GA. The amended constitution was unanimously approved by the GA.

President's report
The past (2000-2002)
Scientific activities of the board:

1. Demography of Primary care in Europe: An article was published in Pediatrics Vol. 109 No 5

May 2002, pp. 788-796
The paper was presented by Manuel Katz and discussed.

Demography of Pediatric Primary Care in Europe: Delivery of Care and Training
Manuel Katz, MD[1], Armido Rubino, MD[2], Jacqueline Collier, PhD[3], Joel Rosen, BA[4] and Jochen H. H. Ehrich, MD[5]

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Objective. The Union of National European Pediatric Societies and Associations recognized the lack of information regarding demography of delivery of care and training for the doctors who care for children in Europe. Therefore, the Union of National European Pediatric Societies and Associations studied factors and explanations for the variation between countries regarding pediatric primary care (PPC) and community pediatrics (CP) as well as the extent of formal training provided for those who take care of children at the community level.

Methods. An explanatory letter and a questionnaire with 12 questions regarding delivery of PPC and CP and training was mailed to the president of each of 41 national pediatric societies in Europe. Statistical data about population, country's income, and infant mortality rate (IMR) were also obtained from World Health Organization data. Statistical analysis using multivariate and linear regression was conducted to ascertain which variables were associated with IMR. Descriptive statistics regarding demography and training are also reported.

Results. In 1999, a total of 167 444 pediatricians served a population of 158 million children who were younger than 15 years and living in the 34 reporting European countries. The median number of children per pediatrician was 2094; this varied from 401 to 15 150. A pediatric system for PPC existed in 12 countries; 6 countries had a general practitioner system, and a combined system was reported from 16 countries. Pediatricians did not work at the primary care level at all in 3 countries. In 14 of 34 countries, pediatricians worked in various aspects of community medicine, such as developmental pediatrics, well-infant care, school physicians, and so forth. IMR was lower in countries with a higher income per capita. In addition, a pediatric system of primary care had a protective effect when looking at IMR as the outcome. In 75% of the countries, some form of training in pediatric care for pediatricians was reported; the corresponding data for general practitioners was 60%. Community-based teaching programs were offered to pediatricians and general practitioners in a minority of countries only.

Conclusions. At the end of the century, Europe showed a considerable variation in both delivery of PPC and training for doctors who care for children. This study identified 3 different health care delivery systems for PPC, as well as 2 types of pediatricians who work in community-based settings. Formal training in PPC or CP for both pediatricians and general practitioners varied from established curricula to no teaching at all. Economic and socio-political issues, professional power, and geographical and historical factors may explain the differences in pediatric care among European countries.

2. Demography of renal care in Europe: A draft of a manuscript was presented by Jochen Ehrich and was discussed. The paper will be sent for publication to PEDIATRICS.

Demography of Pediatric Renal Care in Europe: Organization and Delivery of Care.
Jochen H. H. Ehrich, Anita Amina ElGendi, Alfred Drucker, Jan Janda, Constantinos Stefanidis, Kate Verrier-Jones, Jacqueline Collier, Manuel Katz

Objective. The European Society for Paediatric Nephrology (ESPN) recognized the lack of information available regarding demography of delivery of care and training for the doctors who care for children with kidney diseases in Europe. Therefore, ESPN stimulated its members to study factors and explanations for the variation between countries regarding demography and policy of pediatric renal care.

Methods. An explanatory letter and a questionnaire with 16 questions regarding demography and policy of pediatric renal care was mailed to the president or secretary general of each of 43 national pediatric societies or working groups in Europe. Statistical data about population, country's income and Infant Mortality Rate (IMR) were obtained from WHO data. Descriptive statistics were carried out including linear correlation, linear and multivariate regression in order to define predictive values; T-Test, ANOVA, Mann-Whitney-U-Test and Kruskal-Wallis-H-Test were used to compare means and medians.

Results. In 1998, 842 pediatric nephrologists worked in 42 European countries with a median number of 9 pediatric nephrologists per country, ranging from 0 to 150. The median number of pediatric nephrologists per million child population was 4.9, with a range from 0 to 15. The mean number of children per pediatric nephrologist was significantly higher in countries with the General Practitioner Care System, namely 370,747 versus 169,456 in the Pediatric Care System, respectively 191,788 in the Combined Care System. In addition to the fully trained pediatric nephrologists there were 1087 pediatricians with a part time interest/activity in pediatric nephrology taking care of children with kidney diseases in 34 European countries. Eastern European countries had significantly more of these pediatricians with nephrological activities than countries belonging to the EU (16.7 versus 6.6 pediatricians pmcp). The mean ratio of specialized pediatric nephrologists to all general pediatricians was significantly lower (1:276) in countries with the Pediatric Care System than in countries with the Combined (1:150) and the General Practitioner System (1:147).

In 1998, 92% of all European countries offered pediatric dialysis for acute renal failure, 90% for chronic renal failure and 55% offered pediatric transplantation. The availability of pediatric dialysis for ARF and CRF was significantly associated with the size of the child population. The availability of pediatric transplantation was also significantly associated with the Gross National Product, the geographical and political situation. Only 30% of Eastern and Central European countries offered pediatric transplantation versus 87% of EU countries. The median number of hospitals offering dialysis for CRF was 1.5 ranging from 0 to 5.0 pmcp and the median number of pediatric hospitals offering renal transplantation pmcp was 0.4 ranging from 0 to 3.5 pmcp. Fewer children were dialyzed or transplanted in Eastern European countries than in the European Union. Eastern European countries provided more often a screening program for renal diseases in children. Seventy-one percent of all answering pediatric nephrologists stated that their country would need more pediatric nephrologists and 50% asked for more dialysis nurses.

Conclusions. At the end of the 20th century, Europe showed a considerable variation in delivery of pediatric renal care for children with kidney diseases. This study identified different types of pediatricians working in pediatric nephrology. In some Eastern European countries, dialysis and transplantation care for children were not in the hand of pediatric nephrologists. Our data analysis indicates that differences throughout Europe concerning pediatric renal care are related to factors such as size of the population, geographical and political situation, the type of primary pediatric care system and the economic situation. The spectrum of pediatric renal care offered by pediatricians ranged from basic nephrology only to highly specialized renal replacement therapy. This may

explain the unexpected result of almost equal numbers of doctors caring for children with kidney diseases in Eastern Europe and in Western European countries. The goal number for specialized pediatric nephrology centers per country is estimated to be in the order of approximately 1.2 to 1.6 centers pmcp having a minimum of four pediatric nephrologists per center who can provide a 24 hours service.

According to our data there seem to be enough pediatric nephrologists both in Western and Eastern European countries in order to meet the demands of a high standard of renal care. In countries with a small child population co-operation with local adult nephrologists or with pediatric nephrologists from neighboring countries remains an effective alternative to specialized national pediatric nephrology centers.

Europe at the end of the 20th century is far from equal access to renal replacement therapy for children. Concerning dialysis for ARF or CRF the question is not anymore the pure availability but the extent of availability. According to our data about 90% of European countries provided pediatric dialysis for CRF in 1998 but only 55% pediatric renal transplantation which is unsound considering the clinical and financial long term superiority of renal transplantation. The challenge is therefore to identify the reasons for the low transplantation rate and to overcome this paradoxical situation.

The importance of registered data on children with renal replacement therapy in order to define the costs of pediatric renal care is self-explanatory. However, only 50% of countries of Eastern Europe were reporting to a registry. In these days of globalization, co-operation is one of the basic conditions in order to promote equity in health care. In fact the lack of scientific co-operation during the Cold War can be made responsible for discrepancies encountered throughout Europe concerning the quantity and the quality in health services. Co-operation consisting of solidarity and scientific collaboration will therefore also play an important role in the context of European pediatric renal care today in order to provide equity of care for all children.

3. Financial report: Jochen Ehrich reported about the UNEPSA finances

In April 1998 the UNEPSA account balance was 0 DM

In March 2000 12,501.18 DM

By the end of 2001 19,060 DM

Jochen Ehrich emphasized that there is a positive change in finances of UNEPSA, however, UNEPSA continues to have a serious problem in collecting the money from different countries. As an example only 4 countries already paid their dues in 2001 (Israel, Spain, Turkey and Norway) and 5 countries did so in 2000 (Norway, Czech Republic, Spain, Germany, Turkey).

Manuel Katz suggested a new initiative to collect dues based on country income per capita, and number of pediatricians. According to this proposal countries will pay 800, 500, 300 or 100 Euro per year. It was suggested that UNEPSA will need at least 10,000 Euro per year in order to accomplish part of the goals.

The General Assembly voted unanimously that the delegates don't have the mandate to decide about the proposition and that it has to be approved by each country individually. Manuel Katz will send by mail to each representative the proposed dues payment to be

approved by each country. The dues payment system was proposed: 800 Euro: Austria, Belgium, France, Italy, Spain, Netherlands, Sweden, Turkey, United Kingdom Germany, Norway, Switzerland, 500 Euro: Denmark, Finland, Israel, Portugal, Czech Republic, Greece, Hungary, Poland 300 Euro: Ireland, Luxembourg, Slovakia, Croatia, Slovenia, Russia, 100 Euro: Bulgaria, Cyprus, Estonia, Latvia, Macedonia, Ukraine, Lithuania, Romania, Jacques Schmitz suggested that the same type of calculation may be used by IPA.

4. Europaediatrics 2003

Manuel Katz (President of Europaediatrics) and David Branski (Co-Chairman of the Scientific and Organising Committees reported about the congress.

See enclosed PowerPoint presentation (venue, hotels, program, suggested topics, etc.).

Manuel Katz asked the members of the GA participant to be supportive and active in stimulating the participation of paediatricians. EUROPAEDIATRICS 2003 should be advertised during National Congresses. He reported about the possibility to have 200 Mexican paediatricians in the congress. Andria Generoso proposed to publish the information throughout the official journals and national paediatric newspapers.

It was suggested to share with the organising company the mailing list from paediatricians in order to spread the information as widely as possible.

5. The UNEPSA Website

Jan Janda and Jan Vejvalka reported about the UNEPSA website www.unepsa.org. This was developed during the last 6 months having link to the major international paediatric sites, the Europaediatrics 2003 and all the information about UNEPSA (constitution, aims, etc).

6. Further mission of UNEPSA

The possibility was discussed again to have the Europediatric Society, suggested by Ehrich and Katz in 1998. The idea is to have an umbrella society bringing all the European Paediatric organisations together. Jacques Schmitz suggested to have a meeting in this matter in Paris very soon and discuss this proposal.

7. Election of two members

Manuel Katz informed to the General Assembly that Jochen Ehrich and Manuel Katz have finished their 6 years mandate at the UNEPSA council and should to be replaced. According with the constitution a quorum of 2/3 of the members was needed for council election. Unfortunately the number of participating members was less than permitted. Jacques Schmitz suggested to allow Katz and Ehrich to stay ex officio until the next General Assembly in October 2003 in Prague during the Europaediatrics 2003. The proposition was approved unanimously.

Jan Janda	**Dr. Manuel Katz**
President	**Secretary General**