Czechoslovakia revisited

ABSTRACT—The previous totalitarian régime has left the economy in chaos, and has adversely affected support services for the physically disabled and care in the community. Medical education structured on the Soviet model is currently under review. Collaboration with the West is the only hope scientists, academics and professionals have for playing a more useful role in the mainstream European scientific community.

I had last visited Czechoslovakia in 1986, and was delighted to return there in June 1990 as a Visiting Professor at the invitation of the Faculty of Medicine, University of Bratislava. As my hosts put it to me with a sense of pride, ‘We won our freedom by Ahimsa (non-violence) in true Gandhian style’.

The previous totalitarian régime had left the economy in chaos which had adversely affected support services for the physically disabled with mobility problems, and for the care of the elderly in the community. My remit was to make an on-the-spot assessment of these two areas of health care and to make recommendations to health professionals on the reorganisation of support services. The Postgraduate Medical Institute, Bratislava, was buzzing with activity. There were Visiting Professors from North America, Sweden, and West Germany. There was also a Visiting Professor from the Faculty of Medicine, Department of Ayurvedic Medicine, University of Poona, India, who gave a paper on ‘Ayurvedic medicine in the 20th century’. Seeds of Fenugreek (Indian-Methi) have been found to control diabetes as well as to reduce cholesterol and triglyceride levels in blood. One aspect of this system in the context of the economic situation in the East European countries is that Ayurvedic drugs are relatively inexpensive. The general opinion among professionals was that Ayurvedic medicine would find a foothold in Czechoslovakia and its neighbouring countries in Eastern Europe.

Czechoslovaks like spas, not only those with a glamorous cosmopolitan tradition like Marianske Lazne and Karlovy Vary, but also the lesser-known ones like Piestanai, Trencinska and Teplice. They are visited for ‘curing’ incurable conditions if recommended by a doctor and are like a holiday at State expense.

After the revolution there came a surge in Slovak nationalism, and the country now consists of two separate federatives—Slovak and Czech. It has a population of 10 million, of which 5 million live in Slovakia; Bratislava, the capital of Slovakia, is the second largest city in Czechoslovakia, and has a population of half a million. More people could now communicate with ease in English than on my last visit.

Acute medical services

 Provision of acute medical care in major centres in both Slovakia and Bohemia is excellent and comparable to that in West European countries, but in most hospitals there is a serious shortage of beds in the acute specialties [1], as shown in Table 1.1. I visited Klinika Geriatrie. This is a high-technology department of geriatric medicine affiliated to the school of medicine in Bratislava. It has access to diagnostic and imaging facilities such as ultrasonography, two-dimensional echocardiography, Doppler echo, etc, and also has an endoscopy service, a well-equipped coronary care unit, and an intensive care unit.

Demographic changes and care in the community

Community-care support services are poorly developed. The vast majority of elderly people are looked after in their own homes by their carers, often with inadequate domiciliary support services. The elderly population is increasing and varies between 12.8% and 17% in different parts of Slovakia and the Czech country [2]. Because of harsh economic realities, the number of young working couples is increasing in parallel with the number of people aged 75 years and over. The birth rate, however, is falling in Czechoslovakia, except in the ethnic Hungarian population in southern Slovakia. This will put a tremendous strain on the State, as a shrinking population of working age will have to cope with increasingly large numbers of elderly in the late 1990s and beyond (Table 2).

In Czechoslovakia the pendulum has now swung far away from State enterprise. Health professionals and bureaucrats alike are deliberating modelling their system of care in the community on the North American model to ‘hedge against’ the rising tide of elderly, and over the next decade a substantial number of private residential-care and nursing homes will be competing

Table 1. Comparison of number of beds in hospitals and the number of elderly people

|                | 1959  | 1984  | Change  |
|----------------|-------|-------|---------|
| 1. Number of beds | 82,114 | 100,857 | +22.8%  |
| 2. Number of elderly | 1,747,000 | 2,504,000 | +43.33% |
| Ratio 2:1        | 21.27 | 23.82 |         |

Y. P. SURI, DTMH, FRCP
Consultant Physician, Department of General/Geriatrie Medicine, Darlington Memorial Hospital

124 Journal of the Royal College of Physicians of London Vol. 25 No. 2 April 1991
with the State-run institutions. In a State-controlled economy there was no charge for any of the services, but from 1991 charges for various services, eg dental, ophthalmic, and some social services will be introduced.

Physically disabled people

The number of physically disabled people is not known, so that any meaningful planning of support services is almost impossible. However, physicians with an interest in disability medicine reckon that there are as many physically disabled people with moderate to severe disability in Slovakia as in the North of England; ie 69 per thousand population [3]. There are probably over 1 million physically disabled people (of all ages) in Czechoslovakia; figures for the different categories of disability are not available. In the past, bureaucrats had turned a blind eye to this area of health care. Physically disabled individuals with mobility problems are housebound. There is a serious shortage of mobility aids, eg wheelchairs, Zimmer frames, etc. Adaptations of public transport for use by the physically disabled is a pressing need throughout the country [4-6].

Morbidity and mortality trends

East European countries have a 40% higher age-standardised death rate than West European countries. Deaths from ischaemic heart disease and poisoning are 70% higher among men in East Europe [7] (see

Table 2. Changes in selected groups of population in Czechoslovakia

| Age group | 1959          | 1984          | Increase |
|-----------|---------------|---------------|----------|
|           | % Total       | % Total       |          |
|           | population    | population    |          |
|-----------|---------------|---------------|----------|
| 60-69 years M | 483 (3.55)    | 542 (3.51)    | 12.2     |
|           | W 631 (4.64)  | 682 (4.41)    | 8.1      |
| 70-79 years M | 226 (1.66)    | 385 (2.49)    | 70.4     |
|           | W 333 (2.45)  | 593 (3.84)    | 78.1     |
| 80 yrs and over M | 65 (0.48) | 90 (0.58) | 38.5 |
|           | W 96 (0.71)   | 212 (1.37)    | 120.1    |
| 60 yrs and over together | 1,747 (12.84) | 2,504 (16.19) | 43.33 |
| Total population | 13,607 | 15,495 | 13.6 |
Table 3). Patterns of morbidity due to alcohol-related problems in Czechoslovakia are more or less similar to most West European countries, although the incidence of drinking is rising rapidly and poses a serious public health problem. The nutritional status of the people is generally well below that of West European countries for comparable socio-economic groups [8]. The higher mortality from osteoporotic fracture of the proximal femur is more likely to be due to early discharge from hospital because of a shortage of acute beds and because of inadequate domiciliary support services than to the poor quality of immediate post-operative care or other peri-operative causes [9,10].

Geriatric medicine

The specialty of geriatric medicine is in its early stages. Over the past 10 years or so, Professor Litomeresky, Professor of Geriatric Medicine in the postgraduate department of geriatric medicine, and Professor Cernak, Klinika Geriatrie, School of Medicine, Bratislava, have been pioneers in organising geriatric services and raising the standards of geriatric medicine in Slovakia.

Medical education and training

Undergraduate medical education and training is structured on the Soviet model, leading to the MD after five years’ training. The whole medical education system is at present under review. It is hoped that the proposed changes will result in a new system more in line with the education and training in West European countries.

Postgraduate medical education.

There are two institutes of postgraduate medical education, one in Bratislava and the other in Prague. The current review will make radical changes in the present system. It is proposed that, after a period of three years of postgraduate training, a doctor will receive accreditation for general professional training. He/she will then be able to decide on specialisation, and further specialty training will last for three to five years; a further two years will then be spent in subspecialty training: eg, cardiology, neurosurgery, etc. Geriatric medicine is not a popular (first) career choice among young Czech medical graduates, unlike the trend in the 1970s in the UK [11]. There are three teaching/academic departments of geriatric medicine in Slovakia, two in the capital Bratislava, and one in Goshitsa, the second largest city, and there are six other departments of geriatric medicine [12].

Research

Funds for research are inadequate, and the number and quality of publications is poor, because of the limitations on research work imposed on the scientists by the previous régime. Some of them even find it difficult to subscribe to an international journal of repute [13]. Scientists and academics are free to travel abroad to Western countries to attend scientific meetings, but the foreign travel allowance set by the Czechoslovak government is only about $100 a year, and this makes it very difficult for them to attend any scientific meetings. At present this can only be achieved through sponsorships, albeit with difficulty. It is heartening that the European Spine Society at its meeting at the University of Zürich has agreed, for the first time, to allow a trade exhibition to be held, on the understanding that the income from it be used to bring East Europeans to the meeting [14]. British geriatrians have also drawn the attention of the British Council to the difficulties experienced by academics and professionals wishing to attend scientific meetings in the UK [15].

A rather sad and grim consequence of 40 years of totalitarian régime is the profession’s loss of self-esteem because of systematic denigration. They were poorly paid, often less than semi-skilled workers; they had little job satisfaction, and what little research was carried out was of poor quality by Western standards. One welcome post-revolution change would be for academics and scientists not to have to compete for their jobs every five years, a requirement the previous régime used for political blackmail of intellectuals.

The future: East–West collaboration

President Vaclav Havel’s government has inherited a health service which is inefficient, over-manned, riddled with bureaucracy, and ineffective. It faces a very difficult task. The Czech and Slovak health-care planners, bureaucrats and professionals need expertise from the West, especially from Britain; and it will take patience and time for the reforms to work and to get the economy on course. Our Czech and Slovak medical colleagues would like to see increased opportunities for collaboration with their British colleagues in areas of medical education and training, in research, and in joint ventures in preventive medicine, especial-
ly coronary heart disease, hypertension, and stroke. The head of the department in Bratislava is in regular touch with British geriatricians for advice on organising geriatric services and to establish medical exchange programmes.

It is good to hear that in 1991, for the first time in 45 years, Slovak gerontologists will have a joint symposium with fellow gerontologists in Vienna. The XV IAG International Congress of Gerontology will be held in Budapest in 1993, and a post-congress satellite symposium will be held in Bratislava.

There are opportunities for collaboration and investment in the field of bio-engineering; eg the manufacture of prostheses, mobility aids, and appliances, as well as nursing aids such as hoists, and manufacture of appliances for the management of urinary incontinence. Discussions are already in progress with West European manufacturers for the manufacture of mobility aids, and negotiations are going on with some pharmaceutical companies to produce some drugs locally.

Bureaucrats will take their own time to adapt to the changing climate. I was pleasantly surprised to learn that the Faculty of Medicine was able to obtain clearance for my visit from the External Affairs Ministry within four weeks; this would have been unthinkable only a few months ago. Under the previous régime, the Dean of the Medical Faculty and Director of Postgraduate Medical Studies had to be interviewed by the Statman Dezechost (the Czech equivalent of the Soviet KGB) on more than one occasion, and be further vetted by officials of the External Affairs Ministry, a process lasting several months.

A mixed mood of despair and optimism prevails among scientists, academicians, and health professionals. But they are optimistic that, with co-operation from the West and in particular from Britain, they will be able to integrate with the scientific mainstream and play a more useful role in a larger European scientific community.

Acknowledgements

Thanks are due to Mrs Elaine Jemmott for painstakingly preparing the manuscript and to Mr Philip Neally and Mrs Sheena Crawford in the clinical photography department for help with the illustrations.

References

1 Krajcik S, Nouzovska M. The Elderly People and Changing Conditions of their Life in Czechoslovakia: Paper presented at the European Symposium on Behavioural & Social Gerontology: Gdansk, Poland. August 1990.
2 Ibid.
3 Report of the Advisory Committee on Disability. Services for people with a physical disability. Northern Regional Health Authority, April 1989.
4 Royal College of Physicians of London. Physical disability in 1986 and beyond. J Roy Coll Physicians 1986;20:160–94.
5 Office of Population, Censuses & Surveys: OPCS Surveys on Disability in Great Britain 1. The prevalence of disability among adults. London: HMSO, 1986.
6 Royal College of Physicians of London Report The young disabled adult. London: 1986.
7 World Health Statistics Quarterly 1990;43:91–104.
8 Warendorf J, Boeing H, Honemann I, et al. Results from a comparative dietary assessment in Europe: II—Feasibility of pooling individual based dietary data between countries. European J Clin Nutrition 1989;43:379–90.
9 Suri Y. Osteoporosis: European orthogeriatric epidemic. Paper presented at Slovak Medical Society meeting, June 1990; Bratislava; Czechoslovakia.
10 Office of Population, Censuses & Surveys. OPCS Surveys. Deaths from fractured neck of femur in England and Wales. London: HMSO, 1984.
11 Parkhouse J, Ellin J. Medicine as a career among 1974 and 1977 British medical qualifiers. J Roy Coll Phys London 1990;24:178–81.
12 Krajcik S (1990) Personal communication.
13 Darozynski A. Research struggle in Eastern Europe Br Med J 1990;301:305
14 Sullivan M. Research in Eastern Europe: Br Med J 1990;301:537
15 Dall J (1990) Personal communication.

Address for correspondence: Dr Y. P. Suri, Memorial Hospital, Hollyhurst Road, Darlington, Co Durham DL3 6HX

Czechoslovakia revisited

Journal of the Royal College of Physicians of London Vol. 25 No. 2 April 1991 127