ASSOCIATION EUROPÉENNE DES MÉDECINS DES HÔPITAUX
EUROPEAN ASSOCIATION OF SENIOR HOSPITAL PHYSICIANS
EUROPÄISCHE VEREINIGUNG DER LEITENDEN KRANKENHAUSÄRZTE
EUROPESE VERENIGING VAN STAFARTSEN
DEN EUROPÆISKE OVERLÆGEFORENING
ΕΥΡΩΠΑΪΚΟΣ ΣΥΛΛΟΓΟΣ ΝΟΣΟΚΟΜΕΙΑΚΩΝ ΙΑΤΡΩΝ ΔΙΕΥΘΥΝΤΩΝ
ASSOCIAZIONE EUROPEA DEI MEDICI OSPEDALIERI
DEN EUROPEISKE OVERLEGEFORENING
ASSOCIAÇAO EUROPEIA DOS MÉDICOS HOSPITALARES
ASOCIACIÓN EUROPEA DE MÉDICOS DE HOSPITALES
EUROPEISKA ÖVERLÄKARFÖRENINGEN
EVROPSKO ZDRŽENJE BOLNIŠNIČNIH ZDRAVINIKOV
EUROPSKA ASOCIACIA NEMOCNICNÝCH LEKAROV
EUROPSKA UDRUGA BOLNIČKIH LIJEČNIKA
ЕВРОПЕЙСКА АСОЦИАЦИЯ НА СТАРШИТЕ БОЛНИЧНИ ЛЕКАРИ

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AEMH-President's Report 2008 – 3 -

Since my last report presented in Zagreb at the plenary meeting the internal problem of the CPME and the relation between the CPME and the other European Medical Organisations has caused some turmoil. The AEMH cannot feel unconcerned by the first and reacted officially on the second.

CPME internal affairs

France, Italy and Spain have requested consequent changes of the functioning of the CPME, which are summarized here after.

On 20th December 2007, the CPME President received a letter from the Presidents of Spain, France and Italy, who expressed major concerns about adopted decisions of the CPME General Assembly concerning especially weighted voting, and raised issues relating to the governance of the organisation. They jointly proposed that:

- The decision-making processes shall be applied as by the European Parliament, i.e. proportional to the size of a country;
- The multilingualism should be "respected". English and French, which are the two working and decision-making languages in the CPME should be "systematically treated" in the same way;
- the executive committee of the CPME should be strengthened, by:

(i) increasing the political role of the (four) Vice-presidents
(ii) amending the statutes to allow for a two-year mandate, renewable once, for the President, the Vice-presidents, the Treasurer and the Secretary-General
(iii) redefining the role of the Secretary-General as administrative only and with "no political function."
In this same letter the presidents of these three associations raised the question of their future non-participation in CPME work and the suspension of their contributions until these matters were resolved to their satisfaction.

Although the subsequent CPME GA in June supported weighted voting for the budget, the need to maintain the practice of multilingualism, and a redefining of the relationship between the Secretary General and the Executive Committee, the three countries did not feel their requests being taken sufficiently into consideration.

The divergences and miscommunication growing, the three countries sent their official resignation to become effective by June 2009. Under the Statutes there is obligation to pay contributions for 12 months from the date of resignation.

The last CPME meeting took place 24-25 October in London without the three countries, which represent one third of European Doctors. This poses the question whether the Standing Committee of European Doctors can be representative towards the European Institutions for the whole profession (2 million) without these three countries being active members.

Besides the political aspect, the financial consequences of a decrease of one third of the contribution income needed cuts in the budget.

As a direct consequence the executive body of the CPME decided to rethink the whole structure. A brainstorming of the four past and the current presidents and the secretary general resulted in a profound self-critical challenging of the organisation, its statutes, its governing bodies and its working procedures. One of the significant proposals is the abandon of the current four sub-committees in favour of issue-related working groups. It was also reminded that at the 2005 Conference on the Future of EMOs 75 % of the CPME members expressed in favour of a single European Medical Organisation.

The overarching goal of the CPME is to unite all doctors in Europe. A strategy working group will be launched to reflect on the future of the CPME, collect and assess proposals.
The other medical organisations are invited to take part in this process, which presumes that a closer involvement is considered.

EMOs

The EMOs will hold a common meeting Thursday, 12 June 2009 in Brussels, which will gather the Executive bodies of all European Medical Organisations, followed the two consecutive days by the working sessions of CPME, FEMS, UEMO and PWG. AEMH and UEMS decided not to change their annual calendar. A dinner with all delegates will be organized on Friday.

Main subject of the common meeting will of course be the future collaboration of European Medical Organisations. The AEMH-Board has to define the standpoint of AEMH, which should be approved by the plenary meeting 8-9 May 2009 in Sofia.
EMOs are invited to propose other topics. I am coordinating these proposals together with CPME President Michael Wilks and UEMS President Zlatko Fras.

FEMS President Claude Wetzel and myself as President of the AEMH, felt important to protest on some unfortunate communication problems of the CPME at the occasion of the common statement on the EWTD, which in its final version quoted the inappropriate expression “The CPME and the other EMOs, which resulted in a wave of protest from “the other EMOs”. Claude Wetzel and I took the opportunity to request a profound re-organisation of our collaboration, which happens to be quite in line and in time with the potential restructuring of the CPME.

AEMH and FEMS are anxious to keep their specificities and autonomy but defend by all means the “one-voice” policy in the respect of all organisations and without any kind of discrimination and interference.

AEMH Internal

The preliminary report on the **accounts 2008** drafted by the accountants shows for the first time in many years again a positive result. This is of course mainly due to the effort of all national delegations to pay the one-off additional contribution for which the Board and I are very grateful.

Furthermore, the participation of **PricewaterhouseCoopers** in the conference in Zagreb laid a milestone in the concept of external collaboration, which I strongly recommend to continue and to enhance. We hereby broaden our image and influence and furthermore strengthen our financial situation.

I had the opportunity to discuss future collaboration within a project of the Health Research Institute of PwC which covers medical demography, research and financing of healthcare systems.

The statement defining the **Core values, aims, means and action plan of the AEMH** has been adopted in Zagreb and must be completed by a time table and followed up constantly. It is not a fixed statement but the kick-off of an evolving process.

Political Review

EWTD - The Revision Process of the EWTD

The EU Council of Ministers of Labor and Social Affairs (EPSCO) ended on 9 June 2008 several years of renegotiation of the European Working Time Directive(EWTD) 2003/88/EC by adopting the EU Commission's revision proposal by qualified majority.

The agreement confirms the maximum weekly working time of 48 hours, but stipulates that this can be increased up to 60 or 65 hours on an individual basis ("opt-out").
The agreement of the 27 Member States has also introduced for the first time, "inactive periods" of on-call, which no longer count as working time, in opposition to the rulings of the European Court of Justice in the cases SIMAP, Jaeger, etc.

On 14 June 2008 all European Medical Organisations expressed their opinion in a common statement, which despite the expression “the CPME and the other EMOs” demonstrated unity in a common position:

- There should be a maximum average working week of 48 hours
- All time spent at the premises should be counted as working time
- The reference period should be a maximum of 6 months
- The individual opt-out for doctors in training should be abolished
- Short-term contracts should not be excluded from the Working Time Directive
- Compensatory rest should be taken immediately after the period worked

According to the co-decision procedure of the EU legislative process, the revision process (Council and Parliament share equal legislative power) is now in the phase of the second reading in Parliament.

The 5th November the Employment and Social Affairs Committee of the European Parliament adopted a co-decision report from Mr. Alejandro Cercas (PES, ES), the rapporteur, with 35 votes for, 13 against and 2 abstentions. Hereby the committee made clear its disagreement with the Council notably regarding the “opt-out”, and on on-call time.

An absolute majority (i.e. 393 votes in favour) is required at the plenary session 16-17 December 2008 to confirm the amendments proposed by the Employment Committee – or indeed to adopt any other amendments to the Council’s common position.

The Presidents of the EMOs will meet Mr Cercas and other MEPs in Strasbourg 19th November in order to get their feed-back and lobby in favour of the position of the medical profession,

which is unanimously fighting for the maintain of on-call duties being considered as active working time, the drop of the opt-out clause and the retain of the reference period..

On 16-17. December 2008 the plenary of the Parliament will vote in second reading on the revision proposal. FEMS calls for a demonstration in front of the EP in Strasbourg the day before, i.e. 15 December 2008.

Proposal for a Directive on Patients' Rights in cross-border healthcare

Healthcare was excluded from the scope of Directive 2006/123/EC on services in the internal market. The Council and the Parliament asked therefore the Commission to address issues relating to cross border healthcare in a separate instrument.

The Commission carried out a public consultation to clearly identify the problems in the field of cross-border healthcare. The majority of the 280 contributions favoured some form of Community action on healthcare, combining both legislative elements and practical support for cooperation between European health systems. On that basis, the Commission developed the draft directive on “Patients Rights in Cross-border Healthcare”.

The proposal is also born out of legal uncertainty. Since 1998, the ECJ has constantly ruled that patients have the right to have their healthcare costs reimbursed when it has been received abroad even if they could have received the same care at home. Nevertheless, the principle of country of origin is retained as regards to cost reimbursement (limited to the domestic rate and maximum actual costs), and the State of treatment principle in all other respects (e.g. regarding safety and quality standards or liability issues).

Although EU healthcare systems differ considerably across the 27 member states, healthcare provision should be equal for all EU citizens regardless of whether they have the ability to travel abroad for treatment or not. Acces to healthcare and free movement are fundamental rights of all European citizens. Patient mobility must not just be for the wealthy and educated: equality of access must be guaranteed. Whether the directive can achieve this, or rather widens the existing inequalities within countries is difficult to predict.

It should be reminded that the possibility of seeking healthcare abroad is already covered by Regulation No 1408 of 1971 on the application of social security schemes. This Regulation coordinates national social security legislation in order to protect the social security rights of persons moving within the European Union and ensures reimbursement of healthcare up to the domestic rate.

Information will be one of the keys of success if the directive is adopted and implemented, and as John Bowis, the Rapporteur in European Parliament suggested, it might generate a new profession of “health brokers”, who would offer advice on travelling for care.

Greenpaper on the European Workforce for Health

A inter-service working document of the Commission circulates, entitled "Green paper on the European Workforce for Health – Promoting a sustainable Workforce for Health in Europe". The official document is expected soon.

The issues the Green Paper covers can be grouped as follows: the challenges such as demography, managing mobility, recruitment and retention strategies and what data we need for evidence based policy-making.

The aim of the Green paper is to open a broad-based consultation process and to launch an in-depth discussion to identify what action is needed, both at Member State and at EU level. The Commission calls on all interested organisations to submit responses to the issues raised in this Green paper.

CPME has launched a working group, in which AEMH and FEMS will participate. The topics Migration of health workers, Health Care Training Capacity, the European Working Time Directive are topics we should address and give constructive ideas. The survey of Dr Sanchez-Garcia on Labour Conditions might also be a valuable input.