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The right to access to healthcare is acknowledged by the Charter of fundamental rights of the European Union and the free movement of people and goods of the founding Treaty of the Union applies to health services, but it is with the Treaty of Maastricht (1992) that Health enters the Community rules.

Launched in March 2000 under Portuguese Presidency, the Lisbon strategy aims "to make Europe, by 2010, the most competitive and the most dynamic knowledge-based economy in the world". It promotes a model of development based on balance between economic, social and environmental dimensions. It is the reign of free enterprise and non-regulation including in the field of health. The European Parliament itself asked in 2005 the European Commission to work on the mobility of patients and the widening of the co-operations between the healthcare systems.

In November 2005, the European Commission (DG SanCo) organized in Brussels a Forum on the future Community strategy in the field of Health. The recent interest of the European authorities of health is better understood when considering that this sector accounts for 7,25% of the GDP of the Union and 6 million employment.

Although the organization of the health systems and social protection is under national responsibility (principle of subsidiarity), Community legislation exerts its influence for a long time.

ED 1993-16 of mutual recognition of the professional qualifications was replaced by **ED 2005-36** which will have to be integrated in the national legislations by October 20, 2007, at the latest. It organizes free movement of the professionals and sets up a questionnaire (IMI) for each professional, allowing the exchange of information between organizations of control (the Medical Chambers for Medicine), in the event of installation in another country of the UE than the one of obtaining the diploma.
This text, which relates to the validity of the university courses, is followed by a WG of the FEMS (coordinator B Popovic), integrated into the WG of the CPME, in close cooperation with the European Union of Specialists (UEMS), which gathers the specialists and teachers of Medicine.

For 15 years, one has observed a migration of the healthcare professionals, doctors and nurses, trained with large expenses by the Central and Eastern European countries,

towards Western Europe and North America. This evolution, supported by the European regulation, poses a serious problem of public health and equal opportunity in these countries. Everyone knows also the difficulties of admission of these professionals in our Western countries, with unfair statutes. **The movement of healthcare professionals in Bulgaria, which gathered 10,000 doctors and nurses in Sofia on 15 February 2007**, organized by the Bulgarian Medical Association in partnership with the FEMS, showed to the whole world the strong mobilization of this country to evolve its healthcare system and the working conditions of its doctors rapidly in order to offer to the population a quality of care comparable with the other EU countries. **A mission in the Slovak Rep.** in April 2006 had given the support of the FEMS to the doctors in strike, on the initiative of the trade union LUP/LOZ, member of the FEMS. A new mission, on invitation of the Medical Chamber, is planned for mid-October 2007.

In the logical continuation of the protocol of Lisbon, the Commission launched the **33th Sectoral Committee for Social Dialogue** in the hospitals. Two privileged partners were chosen by the European Commission: the European Trade union of Public Services EPSU and the European Association of Healthcare Employers HOSPEEM. The first meeting of this Social Dialogue in the Hospitals was held in Brussels, September 20, 2006. It is to be noticed that for the moment the European hospital doctors missed this process. They wish to integrate the group of the negotiation partners and the FEMS has in this view deposited an application for adhesion in the EPSU, which did not succeed. Therefore, the FEMS requested to integrate the group of the CPME (coordinator FU Montgomery), established based on a convention signed by EPSU/CPME. This participation was approved by the General Assembly of the CPME in Mondorf-les-Bains (L) in June 2007.

The President of the FEMS also takes part in the informal meetings of the Presidents and Secretaries-general of **the European Healthcare Institutions and Professional Organizations (EHIPO)** which meets three times per annum in Brussels. Working in this group allows very profitable exchanges between employers and employees on the most significant subjects for the future of the Healthcare system in Europe.

ED 2003-88 concerning certain aspects of the working time (EWTD) is under revision process for 2 years. The 4 subjects of political tensions are ***the opt-out*** (possibility for the employee of exceeding the 48h weekly work in over-time, based on voluntariness), ***the reference period*** (currently the four-monthly period), ***the time of compensation*** (currently immediate) and a new proposal of the Commission with the definition of ***"inactive periods" during resident on-call duty at the hospital***, not to be counted in the working time.

The United Kingdom, supported by Germany and Poland, wishes to maintain the possibility for the employee of working over-time, in the sake of flexibility and liberalization of the labour market. France does not subscribe to this request for maintenance, opposite to the engagements taken by the United Kingdom 13 years ago, during the drafting of the 93-104 original ED. The European Parliament, by a vote of May 11, 2005, asked for the abrogation of this possibility of over- time, estimating that its maintenance, in addition to harming workers' health (*and safety of patients{editor's note}*), introduces a possibility of unfair competition and a risk of social dumping.

During the Council of the Union of November 7, 2006 which studied the proposal for a 2nd reading of the Commission worked out by the Finnish Presidency, France allied with Spain, Italy, Greece and Cyprus to form a blocking minority, preventing the United Kingdom and its allies to obtain satisfaction on the maintenance of the opt-out.

The definition of "inactive periods" during the resident on-call duty, at the request of the European Federation of Hospitals HOPE and Germany, is against the jurisprudence of the Court of Justice of Luxembourg (SiMAP, Jaeger, Pfeiffer, Dellas cases). One can understand that the hospitals do not wish to pay doctors in on-call duty for sleeping in the hospital. Under these conditions this on-call duty is neither necessary, nor justified! It left to the health authorities to clearly define the missions of hospitals, in particular their obligation of permanence of care, and to organize the hospitals consequently, rather than penalizing the hospital doctors who ensure this permanence of great arduousness (F07-073, F07-75, F07-076, F07-080). It is incomprehensible to see the Commission launching on one side with large expenses an ambitious strategy on patients' safety in Europe (SIMPATIE), with partners like the French HAS, AVMA association (Action against the medical accidents), ESQH association of promotion of Quality in Healthcare and HOPE, whereas on the other side it will weaken the patients' safety in the medical circumstances that the experts recognize as the riskiest for the patients: emergency services.

The European hospital doctors, united within the European Federation of Salaried Doctors (FEMS), are conscious of the stakes for their patients and support the text of May 11, 2005 of the European Parliament: they will not accept the establishment of "inactive periods" of on-call duty.

If the political decision makers of the European governments which have a seat on the Council of the Union do not want to listen to reason, this subject will be the occasion of the first great European strike. The political price to pay will be very heavy, with the dimension of a movement at the scale of the continent…

In front of the political situation of blocking the process of revision of **2003-88 ED**, the Commission launched a consultation **to modernize the labour law to meet the challenges of the XXIth century – New Labour Law– the Green Paper**. This consultation finished at the end of March 2007. The concept of "flexicurity" (F07-093) involves a statutory risk of instability of the salaried doctors, by introducing a contractualisation between the hospital employer and the salaried doctor. It is also the end of the national negotiations by collective agreements, which will isolate the doctors during the negotiations on their working conditions (statute, wages…).

The FEMS specific WG (coordinator C Amaya) follows **the file of ED 2003-88 and new Labour Law**. A FEMS survey was launched (F07-008) and the results were included in the policy statement FEMS 07-13, sent end March 2007. President C Wetzel and the Vice-president C Amaya are in permanent liaison with the rapporteur of the European Parliament A Cercas and the European Commissioner in charge of the file V Spidla. Appointments are planned in the weeks to come to point out the position of the salaried doctors.

During the preliminary works for the adoption of the European Directive on Services in the Internal Market, known as "Bolkestein Directive", Healthcare had been withdrawn from it. But the Council, the Parliament and the Court of Justice of Luxembourg, wearied by the juridical gap in the matter (Watts case), expressed a keen request to the Commission to launch a consultation for the drafting of a future **European Health Services Directive**. The ED will organize free movement of the patients and establish a co-operation between the healthcare systems (of very different structure), while ensuring a greater transparency on their services and their performances. This consultation is now finished and the Commission will publish its proposal at the end of November 2007. A

FEMS WG (coordinator Mr. Kubek) follows this matter and will study the draft prepared by the Commission at the end of the year.

The patients mobility will be accessible only to the patients who will have financial means to exert it! Organized "medical tourism", in addition to free movement of healthcare professionals, is likely to generate paradoxical migratory flows, which is the cause of true medical deserts in the Central and Eastern European countries. What would happen to the patients with modest incomes in these countries, in a system of degraded health care with the rare health professionals who will not have migrated towards countries with more favourable working conditions?

The FEMS is worried about this evolution for years and adopted a clear motion (F 06-27), during its General meeting of Paris (F) in May 2006. In the same spirit, during the last General meeting of Pula (HR) in May 2007, the FEMS adopted a motion (F 07-051) defending the legitimate claims of the Polish doctors in strike, to obtain better working conditions and decent wages. These motions were adopted then by the Standing Committee of European Doctors CPME and transmitted to the European Commission.

The risk of **privatization of the public services** is obvious, with the example of the evolution noted in the Netherlands, in Czech Republic, Slovak Republic and Bulgaria. The FEMS Board went beginning of September 2007 to Sofia to study the example of a Japanese private hospital of the Tokuda trust (F07-083). This non-for profit hospital, accepts all patients in its emergency unit and will accept medical students for their training, thanks to a convention with the University. The FEMS created a WG on this subject (coordinator M Engel) during its GA in Pula May 2007 and launched a consultation to its members (F07-061) on the tendency of privatization in Europe.

The access to quality care is a base of the human rights. This is why the FEMS applied for **the participatory status of INGO to the Council of Europe (CoE)**. This application was recorded on August 7, 2007 and our organization will take part in work of the Health group in 2008.

To guarantee the coordinated expression of "one medical voice", the President of the FEMS takes part in **the Presidents' Committee** of the CPME and the other EMOs. The President and the Vice-presidents of the FEMS take part regularly in the General Assemblies of the other EMOs: CPME, AEMH, UEMS, PWG and UEMO.

The threat on the public Healthcare services in Europe, with privatization as future, the increasing administrative and regulation constraints, the priority of the economic strategies on the needs for public health, the arduous constraints of the permanent care, insufficient remunerations in spite of an exaggerated medical working time in many member states, the precariousness of the statute and the medical demography which is degraded, are subjects of major concern for the salaried doctors, members of the FEMS. The Council of the Union however recently pointed out a certain number of common values which must prevail in the evolution of the medical systems of the European Union: compassion, equity, solidarity and fraternity. We will add social justice, necessary to social cohesion in the European framework.