Fédération Européenne des Médecins Salariés
European Federation of Salaried Doctors

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Title:	**Meeting with EU Commissioner for Health, 31 May 2017**		
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FEMS delegation consisted in:

- Enrico Reginato, FEMS president
- Bojan Popovic, FEMS secretary general
- João de Deus, AEMH president, delegate to FEMS of the Portuguese Medical Chamber
- Diana Voicu, AEMH-FEMS secretariat

EC delegation:

- Commissioner Vytenis Andriukaitis
- Balázs Lengyel, Legal Officer, Healtchare systems
- Annika Nowak, Assistant to Commissioner Vytenis Andriukaitis

Background information

Before the meeting, the Commissioner team requested a list of topics that FEMS delegation wished to tackle. Below is the information Bojan Popovic sent before the meeting:

- ***Inequalities in EU health systems and the connected inequalities in the working conditions of doctors;***
- ***What the European Commission can do to reduce these inequalities;***
- ***FEMS request to join the Working Group on Health workforce.***

The "inequalities" are meant in a broad sense. The field where we would like to draw the European Commission's attention are those inequalities that make the free movement of physicians in the EU a one-way drive in the direction east-south -> west-north. If the inequalities didn't exist, the migration of physicians would follow a more or less chaotic pattern without such a distinct trend, at least from one metropolitan area to another. We could still observe the drain of doctors from peripheries into larger metropolitan areas (which is not a EU-wide, but a local concern), but no particular one-way drain from eastern and southern metropolitan areas into western and northern ones.

The consequence are the distortions of the single EU labor market where nobody is happy: the countries of immigration have difficulties to integrate such a huge number of physicians and their families and maintain the same standards for domestic and immigrating doctors, while the countries of emigration face the lack of doctors and the problems to maintain minimum standards required for the public healthcare to function properly. Migrations by themselves are a positive movement as long as they are due to the optimization of the systems (e.g. make one central hospital instead of numerous smaller ones in each town, provided that the logistics challenges are solved) or when they happen in a random/symmetric pattern due to the natural desire of professionals to move, to exchange experiences etc. But when they become a one-way trend without any particularly desired effect on healthcare optimization, they are not positive anymore, rather a symptom that somewhere something is wrong. EU, and even most of EU member states internally, go for a more decentralized public healthcare (in organizational and budgetary terms), which is good for the local population, but it poses major challenges if the labor market is disbalanced. A disbalanced doctors labor market eventually causes disbalanced healthcare standards across EU which converts people, otherwise in favor of the European integration process, into its opponents.

*The measure of inequality on the EU level should be the doctors' **migrations asymmetry** among various EU member states. It may be true that Slovenia or Czech Republic, but also Austria, Germany or Italy can maintain or even increase the net number of physicians despite emigration, but not because the systems are stable, but because they*

are geographically on the way between poorer and richer EU member states. The doctors' deserts become apparent in the least developed EU countries first just because they are the starting point of the journey, not because they are the only ones with inequalities. And on the destination side of the journey, the countries make economies to educate physicians because they can take the advantage to absorb more immigrants - at the expense of education budgets of poorer countries - another symptom of the same problem.

It seems that the main inequalities that require more concern are the following:
- the disproportionate level of salaries, even when adjusted with purchasing power parity (PPP);
- a confused way of the implementation of the EU working time directive in various states, partly due to the lack of doctors and partly due to low levels of basic salaries;
- no equalization schemes between the budget which pays for the doctors' education and the budget the doctors later pay taxes to;
- no maximum standards on workload in terms of number of patients' visits, number of patients a doctor is responsible for in the hospital departments, number of hours spent in emergency departments etc.
- poor hospital governance: no obligation of member states to increase budgets and introduce non-pecuniary measures to improve the overall working environment in healthcare facilities (like reducing stress) if a non-symmetric personnel drain is detected.

In conclusion, FEMS would like to define the way of communication with the EC directorate for health and to find a way to promote the topic in the frame of EU health policies.

Meeting with the EU Commissioner, 31 May 2017, Berlaymont building

The meeting lasted 1h30 minutes, 30 minutes more than initially foreseen. The Commissioner listened carefully to the FEMS delegation and proved quite informed and willing to engage in a process aimed at improving the healthcare situation.

Enrico Reginato pointed out the existing huge inequalities in the working conditions of doctors across Europe, which impact on the quality of the healthcare provided. He emphasized the paradox of granting free circulation of goods and labour as opposed to the autonomy in the organisation of healthcare systems; therefore, supranational rules are needed to regulate the movement of doctors, with direct consequences on the organisation of the national healthcare systems. He suggested the Commission should set up a system that overcomes the autonomy of the Member States in organizing their health systems.

As a consequence of this autonomy of the Member States in regulating their healthcare systems, João de Deus mentioned the existence of 3 situations with respect to healthcare in the EU member states:

- Countries with high GDP, of which a high ration is allocated to healthcare;
- Countries with lower GDP, of which a reasonable ratio is allocated to healthcare;
- Countries with low GDP and a low ratio allocated to healthcare.

He further pointed out the issues of doctors' burn-out as well as task shifting which are dangerous for the safety of patients.

He suggested that the Commission should emphasize more the fact that health is not an expense, but an investment.

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Bojan Popovic said that FEMS can assist the Commission by means of providing information on the working conditions and salaries in the Member States. FEMS is trying to identify the in-depth reasons behind the circulation of doctors across Europe – i.e. not necessarily what makes doctors leave their countries, but what makes them stay. It proves that it is mainly working conditions and not primarily the salaries that make doctors chose their workplace. What came out of the FEMS research is that there are inequalities not only among countries, but also among the regions of the same country when it comes to working conditions.

Despite its capacity to provide significant input as to doctors' working conditions, Enrico Reginato pointed out that FEMS was left out of the Working Group on European Workforce for Health.

The Commissioner said that, as provided in the Lisbon treaty, health organization falls under the competences of the Member States, according to the principles of subsidiarity and proportionality. The powers of the Commission in this area are limited to "cooperation, encouragement and assistance". Nevertheless, he proved more than willing to overcome this limitation, provided that the Commission is given support by the EMOs in 2 ways:

- Lobby at the national level, so that their national representatives raised healthcare issues with the Council of Minister of the EU; once such issues become more visible at the EU level as voiced by the Member States themselves, the EU institutions will mobilise to take action – if not for all MS, at least for clusters of MS sharing the same problems.
- Maintain a close contact with the Commission in order to explore ways of cooperating and assisting when dealing with various problems; sharing best-practice models (i.e. on developing community-based models in practice from social budgets, recruiting and retaining health workforce, creating management of comunity-based healthcare, etc.)

Besides the provisions of the Lisbon treaty, the Commissioner pointed out the difficulty to achieve consensus among the Member States as well as within the European Parliament, the resistance of the National Governments which would rather feed social dumping, as well as the difficulty to address healthcare education, given the university autonomy.

He concluded that the solution to overcome this autonomy would be to establish clusters of cooperation function of the different issues. In point of good examples of such cooperation, he mentioned the establishment of the European Reference Networks, the National Contact Points, e-health and the Joint Action on Healthcare Workforce. The tools to be also made use of are the European Social Fund, the Structural Funds and Horizon 2020, as the resources available to DG Santé are very limited and could not possibly feed the development of more systematic approaches.

He invited FEMS to stay in close contact with feeding information on its work as well as to get further involved in the Joint Action on Healthcare Workforce, whose second phase is expected to unfold shortly.