CONCLUSIONS OF THE SECOND MEETING

30 YEARS OF SPAIN IN THE EUROPEAN UNION. REPERCUSSIONS ON HEALTHCARE SYSTEMS AND THE MEDICAL PROFESSIONAL. FUTURE CHALLENGES

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TABLE I: TRANSLATLANTIC TRADE AND INVESTMENT PARTNERSHIP (TTIP) AND EU-CANADA COMPREHENSIVE ECONOMIC AND TRADE AGREEMENT (CETA)

1. The declared purpose of that agreement is to improve trade between European countries and the USA, eliminating barriers imposed on the sale of products and services. We are not opposed to free trade and the creation of employment and progress for small business and users between continents / countries, but we demand an informed public debate with total transparency and the protection of essential public services and the rights of users and consumers.

2. We reject the procedural aspects used, which have to do with NON-transparency in established regulatory cooperation mechanisms, technical councils and ad hoc arbitration mechanisms. The mechanisms for protecting investors present in the TTIP - CETA must not supersede the regulatory standards of Governments within the EU framework. The right of regulation must achieve the public health objectives

3. We ask for the express exclusion of essential public services (education, health, food and phytosanitary products) from the scope of application of the TTIP – CETA because we consider that the regulation standards applied in EU member states are more demanding and offer additional guarantees; and environmental and social standards that are expressly defined and protected from all kinds of privatisation.

4. Public health regulations (competence of member states) may be considered "barriers" for the marketing of products and services, and so the Agreement would force their production or prevent the implementation of new provisions aimed at improving health protection.

5. With respect to medicines, the Agreement could limit the right of transparency and information for patients in relation to clinical trials and medicinal products, information which is currently guaranteed by European legislation.

6. Spanish and European legislations establish the right to public health assistance and the obligation of member states and the EU to ensure that all Union policies guarantee and maintain a high degree of protection for human health.

7. Medical Orders must have a single voice within the EU scope in the defence of theses premises by the medical profession and they must be present, take part in and be heard in debates related to the

TTIP, in order to defend the protection of citizen health and public health systems as we know them in the EU.

TABLE II: DIRECTIVE 2011/24/EU ON PATIENTS' RIGHTS IN CROSS-BORDER MEDICAL ASSISTANCE

1. Directive 2011/24/EU is an exercise in transparency regarding patients' rights in cross-border medical assistance. It also constitutes an opportunity for States and Health Systems in harmonising, guaranteeing and consolidating those rights within the scope of the EU itself.

2. Within the framework of the European right to the unrestricted movement of services, medical professionals and patients, mutually-recognised policies in the area of professions, their training standards, best practices in exercising profession tasks, safe identification and (with regard to development and implementation), aspects related to the homologation and recognition of FMC/DPD activities and recertification and revalidation process are extremely important.

3. Information about qualifications, competence, migratory flows of physicians, alarm mechanisms regarding disciplinary records/professional qualification states are crucial elements in the EU that provide safety for citizens and for healthcare systems.

4. Likewise, cooperation in Health Technology Evaluation and e-Health (on-line health/telemedicine) and European Reference Networks (rare diseases) is very important.

5. The need to belong to a professional body for the professional exercise of medicine in EU member states is a guarantee for citizens and healthcare systems, and an essential tool in communication / collaboration between professional corporations, competent authorities and governments through the IMI system.

6. The European Commission becomes the guarantor in observing compliance with the Directives by member state, through (1) the systematic review of transpositions of Directives into national legislations, (2) the verification of the integrity and correction of the sections of the Directive itself, (3) infringement procedures and (4) potential individual and generic claims.

7. European and national laws have shown that the Organisation of Medical Colleges (OMC) as a whole is an essential and necessary collaborator in the social and healthcare field. We cannot depend on well-meaning commendations, and we demand the explicit recognition (given that implicit recognition already exists) of our status as a Competent Authority (CA), which we understand must be "shared" with the State Authorities, as is the case with all countries within the EU scope.

8. The OMC has a fundamental competence in 2 essential aspects of Directive 2011/24/EU that constitute safety and quality, namely, (1) information on the physician's right to exercise his professional, the NCP (National Contact Point) and (2) the safe identification of the prescribing physician in continuing treatment and in the recognition of prescriptions.

9. Bringing Medical Colleges and the medical profession closer to society and to patients, identifying their needs and cooperating with patient associations even within the scope of information and understanding of the explicit rights of European and national legislations is a professional and ethical obligation of the physician.

TABLOE III: 30 YEARS OF SPAIN IN THE EU: ACCOMLISHMENTS AND CHALLENGES FACING HEALTH SYSTEMS AND THE MEDICAL PROFESSION.

1. 30 years ago, in what was then the European Economic Community, activities existed related to health, mainly in the area of medicinal legislation and occupational safety and hygiene, but there was no real concern for health as there is today.

2. The European Union is based on the Rule of Law, which means that all actions are based on the Treaties approved voluntarily and democratically by all the member states. Health was incorporated into the EU Treaties for the first time in 1993. The General Directorate for Health and Consumer Affairs was set up in 1999 and the First Public Health Action Programme was implemented in 2003, while the European Agency for Medicines was set up in 1995 and the European Centre for the Prevention and Control of Diseases in 2005

3. The Agreement currently indicates that all EU activities must be focused at achieving an improvement in health, and legislation is in place on medicines, blood, cells and tissues, transplants, tobacco products, threats to health, cross-border medical attention, recognition of professional qualifications, best practice exchange networks and programmes such as Erasmus or Marie Curie.

4. The EU is an area of freedom and social and economic development like no other in the planet. However, there are great differences in health indicators and in the organisation, planning and funding of health services among the different states and threats continue to exist such as the lack of knowledge of real research costs, the excessive commodification of health services and medicine and patent policies.

5. Spain's incorporation into the EU has meant an important momentum in all areas, including the political, social, economic and health-related fields. Furthermore, experiences related solely to Spain, such as the National Transplant Plan, are regarded as important milestones in the progress made in health assistance services offered to European citizens.

6. Physicians need a single European organisation that defends their professional interests, guarantees the rights of citizens and reduces the current atomisation in professional representation.

7. To that end, they propose the creation of a professional democratic organisation, a Medical Parliament, to guarantee health care and control in exercising the medical profession with responsibility and safety.

8. It is necessary to reduce the exercise of defensive medicine, a direct consequence of the increase in litigations and the absence of guarantee mechanisms, such as medical damage evaluation tables for adverse effects, within the scope of the EU.

9. Medical inequalities exist between EU member states and inside those states. The activity of the European Union is aimed at eliminating those inequalities and at achieving Health Systems with greater quality that are sustainable and efficient, through activities such as evaluating medical technologies, e-Health, health projects, reference networks and others.