clinics, practices and medical institutes, creating budgetary constraint and a detrimental effect for patients.

The Standing Committee of Doctors in Europe demands that the Council of Ministers and the EC Commission develop and apply a reasonable and scientific definition on "hazardous waste". The CP is willing to provide the necessary expert support for this task.

10.4 Resolution on the Agency for Safety and Health

Curia, 1994 (CP 94/53)

Resolution

The Standing Committee of Doctors in Europe (CP) met in Curia, Portugal, on the 16th of April 1994:

- noting the existence of an Agency for Safety and Health
- noting its working programme 1994-2000.
- asks the Agency to direct attention to the implementation of the existing legislation before considering new initiatives and wants to be involved in achieving the Agency's objectives.

10.5 Standing Committee of European Doctors (CP) Proposals for Inclusion in second EU public Health Framework Programme

(CP 97/1010 Rev 1)

The Standing Committee of European Doctors (CP) is an umbrella organisation representing all branches of the medical profession in Europe. Founded in 1959, it now has medical organisations from 17 European Economic Area (EEA) countries as full members, and others from European countries outside the EEA as observers. One of its principal aims is to promote the highest standard of medical training, medical practice and health care within the European Union, in order to achieve the highest possible standard of public health. It works closely with many organisations representing different sectors of the medical profession at European level.

The CP welcomes the opportunity to contribute to the shaping of future public health policy in the EU and expresses its support for the Commission in drawing up the second public health framework programme. Its members are willing to cooperate in any way which would be helpful. We acknowledge that defining "public health" is not easy, given the diversity of approaches across the EU, but wish to use the broadest possible interpretation, to enable the European Union to act as necessary to protect and improve the health of its citizens.

We set out below some areas which we consider to be particularly important. These do not constitute a finite list, and we are happy to advise on any other areas which the Commission identifies as important. While we understand the many different pressures facing policy makers, we wish to see an integrated approach to health, i.e. an approach where policy in all areas is scrutinised to ensure that it has a positive impact on health. We have tried to focus on quality of life, i.e. ways of adding life to years as well as years to life. Thus, as well as concentrating on the promotion of healthy lifestyles, we have also singled out chronic conditions which, even if not immediately life-threatening, undermine the quality of life over long periodes for large numbers of people and have a significant impact on professional activity and health care spending.

1. Common Agricultural Policy (CAP)

We realise that this is an area where there are many conflicting interests, but we believe that it is time to re-examine the CAP. Doing so would be entirely consistent with the Commission's work in other areas, as the current policy has an impact on nutrition, smoking, alcohol consumption, and the environment, which in turn have an impact on many medical conditions. There is also increasing concern about the use of anti-microbial drugs on farm animals, and the potential link with the development of drug-resistant organisms.

We should like to see a commitment to the provision of healthier crops at accessible prices, produced with minimal environmental damage – ending, for example, the anomaly whereby large quantities of surplus fruit and vegetable crops are destroyed while many EU citizens are unable to afford those which reach the shops. We wish this adjustment – which is particularly important if the EU is to enlarge further to include the countries of Central and Eastern Europe – to be made in a manner which safeguards the livelihoods of farmere and agricultural workers.

By taking an approach such as this, we believe that it should be possible to harmonise the objectives of the CAP as set out in Article 39 of the Treaty with the Maastricht requirement to assess the health impact of all policy areas.

1.1 Nutrition

This overlaps to a large extent with our proposal to review the CAP. We note that the Commission has already identified nutrition as a priority for its 1997 health promotion programme and welcome the fact that it has done so.

Diet is an important subject both for education and research for a number of reasons. It has an influence on a range of conditions, such as cardiovascular and metabolic diseases; its influence on some cancers needs further exploration, and for this reason we should also like to see it linked to the Europe Against

Cancer programme. Obesity and eating disorders are becoming increasingly prevalent. We believe that the diversity of dietary habits within the EU should provide significant opportunities for epidemiological research and that these opportunities should be exploited to the full.

Another important aspect is the increasing concern about the microbiological contamination of food and food products. We welcome the recent transfer of responsibility for the technical committees on food safety to the Directorate-General for Consumer Policy.

1.2 Tobacco Control

Again, this overlaps with our proposal to review the CAP. We are opposed to subsidies for a product which is a major cause of mortality and morbidity and gravely concerned by the export of tobacco to developing countries. We welcome the efforts made by the Commission as part of the Europe *Against Cancer* campaign to reduce tobacco consumption and express our strong support for the stance taken by Commissioner Flynn against subsidies.

2. Care of the Elderly

The CP produced a report on this topic in 1990 and is currently working on an updated policy paper. We consider this a very important area for both health and social policy, in the light of demographic changes across Europe. Attention should be paid to living conditions and to social as well as health needs.

One chronic condition which is most prevalent among the elderly, and which we believe merits speciel attention, is *dementia*. This might be defined as a group of illnesses which *cause a progressive decline in intellectual, physical and memory functions, along with changes in personality and a deterioration in social functioning.*

Two common types are recognised: Alzheimer's disease, which accounts for more than half of all cases and as yet has no clear cause or pattern, and multi-infarct or vascular dementia.

While this problem might appear to the best dealt with under the BIOMED research programme, it also has significant social consequences. Caring for patients with dementia constitutes an increasing part of the health care budget of many European countries, but there are also hidden costs which are not taken into account in economic, mostly family members, for whom care-giving represents a considerable economic, social and emotional burden. This burden may be modified by the degree to which ambulatory care services are developed, available and accessible and by the degree of financial support available.

The patterns of care for demented patients vary widely between different countries, and there is a need for improvements in education, training and research. More focused studies are needed on the impact of dementia on patients themselves and on their carers and on the requirements for appropriately designed residential care. Work in this area would be a positive means of adding life to years, and the CP would be delighted to supply more detailed material.

3. Enviroment and Working Conditions

"Health" does not exist in a vacuum, and many of the subjects which we have chosen illustrate the importance of external factors. Additional topics, which would overlap other areas of Commission policy, would include occupational diseases and asthma and allergic conditions caused by environmental factors. Attention could also be given to the participation of the disabled at work.

The Commission has already identified the organisation of working time as a health and safety issue. The working conditions of health professionals are important not only for the individuals concerned, but also because of the impact which they may have on the safety of patients. The CP would like to draw attention to the work already carried out in conjunction with the Commission by the Permanent Working Group of European Junior Doctors (PWG) and to the conference on future medical work with will take place in Köln in October 1997.

The CP would welcome the opportunity to discuss these ideas further with the Commission and to offer help and advice on any other health-related issues to which the Commission wishes to give priority.

11. Working Conditions

11.1 CP Statement on Working Hours of Doctors in Training

Adopted, April 1996 (CP 96/67)

Following the conference on working hours of doctors in training – organised by the PWG (Permanent Working of European Junior Hospital Doctors) with the support of DG V of the European Commission – in Brussels in December 1995, the CP states the following:

The problems which have resulted from doctors in training having been excluded from the scope of DIR 93/104 – the working hours directive – cannot be solved through negotiation between social partners due to the absence of a body representing European employers of Doctors in training.

The CP therefore urges the Commission to take legislative steps to secure that Doctors in Training are included in the scope of Directive 93/104 or have their Working Hours regulated by similar European legislation.