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Preliminary Opinion
of the German Hospital Federation (DKG)
on the
Communication from the Commission
concerning the re-exam of
Directive 93/104/EC

Directive 93/104/EC of 23 November 1993 (Council Directive concerning certain aspects of the organization of working time – called here “the Directive”), in liaison with the jurisdiction of the European Court of Justice concerning on-call duty has far-reaching implications for the hospital sector in several Member States. The German hospitals are confronted with sizeable cost increases for personnel and with serious staff shortages. The employees will have to change their established patterns of working time organization, in particular for the periods of duty spent on call (“Bereitschaftsdienst”). Against the background of increasing costs and competition (budget restrictions, introduction of the DRG system) and the shortage of skilled staff in German hospitals, a revision of the Directive has become a necessity. For this reason, the German Hospital Federation (DKG) as the representative of the German hospital bodies welcomes the widespread consultation procedure launched by the European Commission, as it enables stakeholders to contribute to the eventual modification of said Directive.

The DKG’s opinion comes in three parts. Part One treats the five core elements of the Communication: Definition of working time, reference periods, opt-out agreements, compatibility between work and family, integration of all aspects into a comprehensive approach. Part Two concerns further important aspects of the Directive, and Part Three highlights the specific problems of “trainee doctors” in Germany.

I. Part One: The five core elements of the Communication

The modification of the German Law on Working Time (ArbZG) by the Law on Reforms of the Labour Market of 24 December 2003 (BGBl. I 2003, p.3002) represented the last step towards the full application of Directive 93/104/EC. The modification of the ArbZG of 6 June 1994 (BGBl. I 1994, p.1170 as amended in BGBl. I 2003, p.2340) was the result of the European Court of Justice’s jurisdiction (cases SIMAP and Jaeger) concerning the legal definition of periods spent on call. The German law is now more restrictive than the EU Directive. For example, § 3 of this Law limits the working time on weekdays to eight hours, against a maximum of 48 hours weekly working time as laid down by Article 6 Nr.2 of the Directive.

I.1. The definition of working time

Legal aspects

Art. 2 Nr.1 of the Directive defines *working time* as any period during which the worker is working, at the employer’s disposal and carrying out his activity or duties, in accordance with national laws and/or practice. On the other hand, Article 2 Nr.2 provides that *rest period* shall mean any period which is not working time.

In the Jaeger Case (C-151/02, 9 September 2003), the European Court of Justice was requested to give an opinion on the definition of time spent on call by doctors in Germany. Until then, the rule in Germany was that on-call duty was time performed at the employer's request outside the regular working time in a place determined by the employer in order to be able to provide services on call. Only those times in which these services were actually provided counted as working time. The Court decided (points 63 and 64) that any period of duty spent by a doctor on call, where presence in the hospital is required, must be regarded as constituting in its entirety working time for the purposes of the Directive, even though the person concerned is permitted to rest at his place of work during the periods when his services are not required.

The German legislation has now taken account of this judgment by modifying the German Law on Working Time. The periods spent on call by an employee are now considered as working time for the purposes of the Directive in their entirety.

Implications for the hospital sector in Germany

This modification of the German legislation has far-reaching consequences for the economic situation of the hospitals and the working conditions of their staff. The distinction alone between working time and rest period does not take into account the specific task of hospitals and their highly specialized employees. In view of the shortage of skilled personnel, it is impossible to recruit supplementary part- or full time medical staff of which some 15.000 to 20.000 would be needed. The ensuing additional costs, estimated at 0.7 to 1.7 billion € per year, would represent a heavy burden on the hospitals and the German health care sector in general.

Working time in hospitals is unevenly distributed over a 24h period. During evenings and nights, working requirements in specific services and functions are only sporadic and limited. Until now, these requirements could be met through the on-call duty. During rest periods, the employee was present at a different place than the one of work; most hospitals provided sleeping facilities in doctors' rooms. There, the employee could relax, pursue private activities, or sleep; and the call for his services was made by telephone or personally by another employee. During the times in which these services were not required, and compared to his normal work or his work during on-call duties, the hospital doctor did not only have to perform gradually lesser services, but indeed he did not have to work at all.

The abolition of on-call duties in hospitals will cause a number of serious problems, and introducing different organizations of work can only provide limited compensation.

From an economic point of view, the costs will rise out of proportion and the quality of treatment, services and training will deteriorate .

Doctors are highly specialised, and internal organization of work in hospitals cannot easily be standardized. The high degree of specialization renders

mutual substitution, for example a coverage of several sections at once during the night, difficult: Legal and professional standards would hardly allow it. Smaller specialized services or administrative units in particular would require too many additional staff, should the on-call duties be abolished. This, and the significantly increased salaries and incidental charges will result in labour costs which the hospitals can not finance any more; already now, labour costs represent 70% of the hospitals' expenses. The internal repartition of tasks and procedures between the different services and the diversity of services makes standardizations difficult. New working time models will require substantial time-consuming and expensive communication efforts between services, should the quality of treatment and services be maintained. Moreover, the quality of training will deteriorate, as the skilled doctors would have to spend more time treating patients and less for giving young doctors training or specialization. Also, the latter would not be able to gather the necessary experience in the field. These nexes are recognised by the majority of doctors concerned (1).

Hospital doctors want to maintain on-call duty. According to a recent study by the German Hospital Institute, most of them, including assistant doctors without specialization, are against its abolition (2). This is understandable for several reasons: The treatment of patients and the doctors' training maintain their high level, additional income remains possible, and the working time organization flexible. Therefore, the on-call duty is a means of making work and family compatible.

By stipulating that a doctor must be regarded as at work as soon as he is at his employer's disposal, regardless of whether he indeed performs work, the European jurisdiction seriously restricts the possibility for flexible working models and creates indefensible discriminations against alternative forms of work. A doctor who has worked for 30 minutes during his on-call duty and slept for the rest of it will be treated like his colleague who has actually worked for eight hours. An integrated approach should better take account of the volume of work rendered and the health implications.

Proposal for the revision of the Directive

For all those reasons, the German Hospital Federation (DKG) proposes a modification of Article 2 of the Directive. The definitions of working time and rest period should be supplemented by a specific definition of periods with less intensive work requirements. There should be no detailed rules on the place of presence and the number and duration of services provided. Such rules should be agreed decentralized between the social partners on the basis of collective agreements or individual agreements based on such. Thus, the sector-specific needs and the interests of the employees will be better satisfied.

The German experience shows clearly that such agreements are being applied in a responsible way and are able to secure the employees' health protection. The collective agreement applicable for the public hospital sector (BAT) provides in § 15 para.6a, subpara.1.2 that the employer can require on-

call duties only if it is expected that the time of actual work will be exceeded by the periods of inactivity. According to special agreements (SR Nr.8.2c BAT), the working time in the context of on-call duty is calculated on the basis of the actual work performed.

It must in principle remain possible that the maximum weekly working time of 48 hours is exceeded in cases of lesser work intensity.

As an alternative, instead of amending article 2 of the Directive, Article 17 could provide for a derogation which takes into account the economic necessities of the hospitals and their employees' request for maintaining on-call duty.

I. 2. Reference periods

Legal Aspects

The reference periods for the application of Article 5 (weekly rest period) and Article 6 (maximum weekly working time) are laid down in Article 16 of the Directive. For the maximum average weekly working time of 48 hours, these reference periods are staged. Article 16 para.2 provides for a normal reference period of four months which, according to Article 17 para.4 can be extended to six or 12 months under certain conditions.

In the German Law on working time, the point of departure is not the weekly, but the daily maximum working time, limited to eight hours (§ 3 ArbZG). It can be extended to up to 10 hours, if within six calendar months or 24 weeks the average of eight hours per working day is not exceeded. Extensions or derogations on the basis of collective agreements (§ 7 ArbZG) are possible on the basis of a reference period of 12 calendar months and a weekly maximum of 48 hours (§ 7 para.8 ArbZG).

Implications for the hospital sector in Germany

The reference period of four or six months respectively restricts unnecessarily the flexibility for hospitals and their employees. The present staged provisions should be replaced by a standard reference period of 12 months. This would allow for the flexibility which is vital for all concerned.

Further to the introduction of this standard reference period, hospitals would be able to react in a flexible way to mid- or short term needs for additional services. This is economically very important in view of the personnel-intensive character of hospital services. Such a reference period would also meet the requirements of flexible working time models for the employees. For example, the introduction of accounts for yearly working time would ensure better compatibility between work and family and allow for more rest periods.

Proposal for the revision of the Directive

For the reasons outlined above, the DKG proposes to amend article 16 para.2 and article 17 of the Directive by introducing one standard reference period of 12 months for the maximum weekly working time.

I. 3. The Opt-out Rule

Legal Aspects

This rule is laid down in Article 18 para.1(b)(i) of the Directive. A Member State shall have the option to allow for more than 48 hours average weekly maximum time, provided the general principles of the protection of the safety and health of workers, collective agreements, voluntary consent, non-discrimination, record keeping and information on request are respected.

The new German legislation endorses this opt-out rule and its conditions (§ 7 para. 2a and para. 7, 6 16 para.2 ArbZG). Its application is only possible on the basis of a collective agreement or other agreements based on such.

Implications for the hospital sector in Germany

Given that the opt-out rule has only been transferred into German legislation as of 1 January 2004, it has not been applied yet. However, in view of the present obligation to consider on-call duty as working time in its entirety, and the short reference periods, it would be in the best interest of the hospitals and their employees to make use of this option by concluding collective agreements to this end.

Within the framework laid down by law or collective agreements, the hospitals would be able to improve existing working time models (e.g. on-call duty) and to introduce new ones, like accounts for yearly working time. This additional flexibility will benefit the economic situation of hospitals and give employees more options. The abolition of unflexible rules will also enable further rationalization.

The Commission's assessment of the opt-out practice in the United Kingdom cannot be transferred to the situation in Germany. The conditions laid down in the Directive are fully implemented by German legislation and controlled. It is guaranteed that any individual agreements are indeed voluntary. The above-mentioned study of the German Hospital Institute indicates clearly that 52 % of all participating doctors and 64 % of all doctors doing on-call duties would be ready to opt for a working time above the one fixed in the collective agreement, i.e. 38.5 or 40 hours respectively (3).

Proposal for the revision of the Directive

For these reasons, the DKG firmly demands that the existing opt-out clause be maintained. The present legal framework, the commitment to collective

agreements and the hospitals' specific interests guarantee the respect of the principles of the protection of the safety and health of workers, individual agreements, voluntary consent, non-discrimination, record keeping and information on request..

I. 4. Compatibility between work and family

Legal aspects

The EU Directive contains no explicit provisions concerning better compatibility between working and family life, whereas § 6 para.4 of the German Law (ArbZG) entitles employees to request the transfer from night to day work. Further provisions to this end can be found for example in the German Law on part-time and short-time employment.

Implications for the hospital sector in Germany

Legal provisions aiming at better compatibility between family and work by restricting the working time, are in the end counterproductive. In particular, the labour market situation of working women with children would probably deteriorate.

In view of the demographic change and the obvious shortage of skilled workforce in this sector, hospitals have to offer their employees working conditions which ensure the right balance between work and family. To this end, childcare facilities and family-friendly working time models are being developed.

Compatibility between working and family life means more flexible working time models which are tailored to the individual needs of the employees. In particular the on-call duty, longer reference periods and the possibility for opt-out facilitate such conditions and provide different options. Modern models, such as flexible working hours based on demand or working time accounts already exist in hospitals or are being developed, the central point being the participation of staff in determining the best conditions.

Proposal for the revision of the Directive

The new Directive should not introduce any elements which further regulate working time under the pretext of better compatibility between work and family. The existing legal framework and the interests of the hospitals and their staff would not warrant this. Instead, the present provisions of the Directive (in particular the definition of working time and the reference periods) should be re-drafted in order to allow for more flexibility and modern working time models.

I. 5 Integration of these aspects into a comprehensive approach

The EU Directive lays down the framework for the organization of working time in the hospitals by all concerned. In addition to the Commission's aim to improve safety and health at work, the economic impact and the needs of the employees must become part of a comprehensive approach. As already demonstrated above, the sector-specific characteristics are especially important in this context.

The inevitable correlation between excessive working time and its negative effect on the employees' safety and health is obvious and scientifically established. However, the relation between different working models, surrounding factors and their results is not universally accepted; the empiric studies in this area arrive at sometimes contradictory conclusions (4) which, in view of the complexity of this subject, is no surprise. Further studies, in particular concerning the specific working conditions in hospitals, are therefore indispensable.

The sector-specific characteristics of hospitals are totally different from those in an enterprise; the highly skilled staff must be employed in the most flexible way possible.

Hospital staff are highly specialized, especially in the medical services. The working requirements are very diverse in terms of the nature of the activities and the required working times. Utmost flexibility of work and working time is therefore elementary, and the industry's models for shift work are hospitals economically not viable for hospitals. Productive work is characterized by repetitive and identical work processes, and the workers' specialization is not particularly high. The hospitals' employees request, as shown above, more flexible working time models and the continuation of on-call duty.

These requirements are best met by way of framework regulations. The hospital bodies in Germany and their federations are open to every real improvement of the working conditions in hospitals. Hospitals promote a number of projects for innovative working models which prove the necessity of, and the potential for, alternative models. This way, more rationalization can be achieved, to the benefit of both the hospitals and their staff.

II. Further important aspects of the Directive

These are in particular the provisions on rest period (Article 3), the derogation under Article 17 para.2 Nr.2.1.c, and the scope of the directive (Article 1 para.3).

Daily rest period (article 3)

According to Article 2, *rest period* shall mean any period which is not working time. Article 3 requires a daily rest of at least 11 consecutive hours per 24-

hour period. This is reflected by the German law which adopts the minimum requirement of 11 hours (§ 5 ArbZG).

As already explained above, times of lesser working intensity should become a separate category. Periods in which the employee is permitted to rest at his place of work when his services are not required, should be regarded as rest periods. Either Article 2 of the Directive should be amended in this sense, or a new derogation should be introduced into Article 17. The German experience shows that this will have no negative impact on safety and health of hospital staff. On the contrary, a new margin for modern working time models will be created which will be beneficial to all concerned.

Derogation according to Article 17 para.1 and para. 2 Nr.2 (1) (c)

According to this provision, Member States may derogate from the main provisions of the Directive in the case of services relating to the reception, treatment and/or care provided by hospitals, when the continuity of service is guaranteed and equivalent periods of compensatory rest are afforded.

The German legislation allows for an equivalent derogation on the basis of collective agreements (§ 7 para.2 Nr.3 ArbZG).

The legal framework which determines minimum requirements, together with the European Court's jurisdiction which treats alternative working models differently, do not reflect the hospitals' economic interests and their employees' needs. In order to introduce further flexibility, Article 17 could provide for a new derogation for on-call duty in hospitals, should an amendment of Article 2 in this sense be refused. In this context, interrupted periods of inactivity during on-call duty should also be regarded as equivalent periods of compensatory rest.

The scope of the Directive (Article 1 para.3)

Teaching and research activities performed in universities, university hospitals and equivalent institutions are equally covered by the Directive and the German legislation.

Such activities are characterised by a high degree of independence and the fact that they are not performed at a determined place of work. Working time at home cannot be recorded in the same way as other working time, and a limit of 48 hours weekly working time is unrealistic in view of the international competition among scientists, constitutes a serious disadvantage for the competitors located in Europe and finds little acceptance by those concerned.

The DKG therefore requests the exclusion of such activities from the scope of the Directive.

III. Doctors in Training

Legal aspects

Originally, Directive 93/104/EC excluded a number of sectors of activity from its scope, amongst others, doctors in training (Article 1 para. 3). As of 2 August 2004, Directive 2003/88/EC stipulates that doctors in training will now also be covered by said Directive. For these cases, Article 17 para. 3 (c)(i) allows for certain derogations, and Article 17 para. 5 for longer transitional periods.

In the final step towards implementation, the German legislation has not considered “doctors in training” as a specific category. The German Ministry for Health and Social Security is of the legal opinion that the term “doctors in training” can only refer to medical staff which are not yet qualified to carry the title “doctor”. According to the Federal Regulation on Doctors (“Bundesärzteordnung”, § 2a, BGBl I, page 1218 of 16.4.1987, as last modified on 4.12.2001, BGBl I, page 3324), these are only the doctors in training who have not yet received their official approbation.

This restrictive interpretation does not take into account the specificities of the medical qualification. Further to the basic training, several years of continued training in the different specialized areas follow, on the basis of Regulations issued by the Regional Medical Chambers (“Landesärztekammern”). Only then, a successful exam opens the way for an independent activity as an established doctor or a specialised hospital doctor. De facto, the approbation does not imply that the doctor’s training has actually ended.

Implications for the hospital sector in Germany

The fact that at present there is no specific derogation for doctors in training or in continued training, together with the definition of call-on duty being regular working time, bears negative implications for all concerned.

In fact, this results in additional costs, a deterioration of treatment and services, and an extension of the training periods for hospital doctors. During these periods, the doctors in training have to deliver proof of the knowledge, experience and skills they have acquired, on the basis of a pre-defined number of examinations, operations etc. If they could work only on regular duty, it would take them much longer to be able to assemble the number of interventions required. Hospitals consider this as very serious: They estimate the future period of overall training at up to eight years, which would also be unacceptable to the doctors concerned.

Proposal for the revision of the Directive

For these reasons, the DKG proposes to re-draft Article 17 para.3 and 5 of Directive 2003/88/EC in a way that “doctors in training” should refer to all doctors whose training for specialization is not yet concluded.

For these persons, it should remain possible to exceed the 48 hours maximum weekly working time even after the transitional period provided for by the Directive. As a result, an acceptable length of overall training and a high quality of specialised doctors will be ensured. To this end, Article 17 should provide a general derogation.

- (1) Study by the German Society of Surgeons, H. Schrem: "Law on Working Time: Falsified documentation, no shorter working time", in: Hospital management and keeping, 2003, pages 562-565. See also: German Hospital Institute, "Implications of alternative working time models", final report (not yet published), 2004-04-28
- (2) Cf. German Hospital Institute, above
- (3) Cf. German Hospital Institute: Implications of alternative working time models (not yet published), 2004-04-30
- (4) Cf. references in Beswick, J. et al. "Working long hours", Working Paper of the Health & Safety Laboratory, HSL/2003/02, 2003; Kodz, J. et al. "Working long hours: A review of the evidence, Volume 1 – Main report", Working Paper of the Institute for Employment Studies, Employment Research Series No. 16, 2003
- (5) See above, chapter I. 1.