REPORT

on the Commission communication to the Council, the European Parliament, the Economic and Social Committee and the Committee of Regions on the future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability (COM(2001) 723 – C5-0163/2002 - 2002/2071(COS))

Committee on Employment and Social Affairs

Rapporteur: Mario Mantovani
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By letter of 5 December 2001, the Commission forwarded to Parliament a communication to the Council, the European Parliament, the Economic and Social Committee and the Committee of Regions on the future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability (COM(2001) 723 – 2002/2071(COS)).

At the sitting of 11 April 2002 the President of Parliament announced that he had referred the communication to the Committee on Employment and Social Affairs as the committee responsible and the Committee on Budgets, the Committee on Economic and Monetary Affairs and the Committee on the Environment, Public Health and Consumer Policy for their opinions (C5-0163/2002).

The Committee on Employment and Social Affairs had appointed Mario Mantovani rapporteur at its meeting of 24 January 2002.

It considered the Commission communication and the draft report at its meetings of 10 September, 1 October, 12 November and 9/10 December 2002.

At the latter meeting it adopted the motion for a resolution by 22 votes to 2, with 6 abstentions.

The following were present for the vote: Theodorus J.J. Bouwman (chairman), Marie-Hélène Gillig, Winfried Menrad and Marie-Thérèse Hermange (vice-chairmen), Mario Mantovani (rapporteur), Jan Andersson, Elspeth Attwooll, Philip Bushill-Matthews, Chantal Cauquil, Alejandro Cercas, Harald Ettl, Jillian Evans, Carlo Fatuzzo, Ilda Figueiredo, Lisbeth Grönfeldt Bergman, Richard Howitt (for Enrico Boselli), Stephen Hughes, Karin Jöns, Ioannis Koukiadis (for Elisa Maria Damião), Arlette Laguiller, Elizabeth Lynne, Thomas Mann, Manuel Pérez Álvarez, Bartho Pronk, Lennart Sacrédeus, Giacomo Santini (for Regina Bastos pursuant to Rule 153(2)), Amalia Sartori (for Luigi Cocilovo pursuant to Rule 153(2)), Herman Schmid, Miet Smet, Helle Thorning-Schmidt, Claude Turmes, Ieke van den Burg and Sabine Zissener.

The opinions of the Committee on Economic and Monetary Affairs and the Committee on the Environment, Public Health and Consumer Policy are attached; the Committee on Budgets decided on 17 April 2002 not to deliver an opinion.

The report was tabled on 17 December 2002.

The deadline for tabling amendments will be indicated in the draft agenda for the relevant part-session.
MOTION FOR A RESOLUTION

European Parliament resolution on the Commission communication to the Council, the European Parliament, the Economic and Social Committee and the Committee of Regions on the future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability (COM(2001) 723 – C5-0163/2002 - 2002/2071(COS))

The European Parliament,

– having regard to the Commission communication (COM(2001) 723 – C5-0163/2002),

– having regard to Articles 13 and 152 of the EC Treaty amended as a result of the Amsterdam Treaty,

– having regard to the Charter of Fundamental Rights of the European Union, in particular Articles 21 and 25, and 34, 35 and 38,


– having regard to its resolution of 15 December 2000 on the Commission communication entitled ‘Towards a Europe of all ages’ (COM(1999) 221),


– having regard to its resolution of 9 March 1999 on the report from the Commission on the state of women’s health in the European Community (COM(1997) 0224),

– having regard to its resolution of 16 November 2000 on supplementary health insurance,


– having regard to Regulation No 1408/71/EC on the application of social security schemes to employed persons and their families moving within the Community and Regulation No 574/72/EEC fixing the procedure for implementing it, which is currently being revised,

8 OJ L 149, 5.7.1971, p. 2.

- having regard to the Commission communication entitled ‘A concerted strategy for modernising social protection’ (COM(1999) 347),

- having regard to the European Parliament and Council decision concerning the sixth framework programme of the European Community for research, technological development and demonstration activities, contributing to the creation of the European Research Area and to innovation (2002 to 2006)\(^4\),

- having regard to the relevant conclusions of the Lisbon, Göteborg and Barcelona European Councils, the initial Council report on health care and care for the elderly and the conclusions of the Health Council of 26 June 2002 on free movement of patients,

- having regard to the objectives and indicators agreed by the Laeken and Nice European Councils with a view to combating poverty and social exclusion,

- having regard to the conclusions of the two UN World Assemblies on Ageing and, in particular, the new Plan of Action adopted by the Second World Assembly on Ageing\(^5\),

- having regard to Rule 47(2) of its Rules of Procedure,

- having regard to the report of the Committee on Employment and Social Affairs and the opinions of the Committee on Economic and Monetary Affairs and the Committee on the Environment, Public Health and Consumer Policy (A5-0452/2002),

A. whereas the demographic trend towards an ageing population is a worldwide phenomenon, the significant and complex implications of which cannot find an effective response at exclusively national level,

B. whereas the European Community strategy and action programme in the field of public health (2003 – 2008) provides an integrated approach to health policies and health care, which is based inter alia on health promotion and primary prevention, on obviating sources of danger to health, on the inclusion of a high level of health protection in the definition and implementation of all sectoral policies and on tackling inequalities in health,

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\(^1\) OJ C 175, 24.5.1999, p. 135. \\
\(^2\) OJ C 337 E, 28.11.2000, p. 122. \\
C. whereas various estimates concerning demographic change in the Member States show divergences of up to 60%, which shows us that forecasts of social developments over a period of fifty years should be treated with caution and can under no circumstances be considered as 'established findings',

D. whereas the Charter of Fundamental Rights of the Union recognises the right of the elderly to lead a life of dignity and independence and to participate in social, cultural and working life and the right of everyone to have access to preventive health care and to benefit from medical treatment,

E. whereas the European Union has affirmed on various occasions the need to draw up a global European strategy covering the economic, employment and social implications of an ageing population, by harnessing the full potential of people of all ages and strengthening solidarity between generations,

F. whereas health care in the European Union is based on the principles of solidarity, fairness and universal access, and whereas health care systems, which have evolved on the basis of historical factors, will remain the responsibility of the Member States in the future, both as regards the way in which they are organised and financed,

G. whereas the ageing of the population, developments in medical technology and rising demand for health care services have led to a significant increase in the costs of health care and care for the elderly, which means that all of the Member States are today faced with the problem of how to control, and cover, the costs of health care,

H. whereas prevention is a cornerstone of a foresighted health policy, and whereas systematic preventive measures will increase general life expectancy, gradually remove differences in health expectancy according to social class, prevent the development of chronic diseases and enable costs of treatment to be saved,

I. whereas the Barcelona European Council in March 2002 stressed the need to launch and develop, during 2002 and 2003, cooperation between the Member States in the area of social protection, by an exchange of good practice and information, and set a guaranteed high and sustainable level of health protection as one of its priority objectives,

J. whereas the Barcelona European Council also took note of an initial Council report on health care and care for the elderly and requested the Commission and the Council to examine more thoroughly the issues of accessibility, quality and financial sustainability in time for the Spring 2003 European Council,

K. whereas the Laeken European Council in December 2001 called on the Council to adopt, in the area of health care and care for the elderly, a similar approach to that taken in relation to the modernisation of pension systems, when preparing the joint report on health care and care for the elderly, namely to take account in a balanced way of the aspects of accessibility, quality and financial viability; whereas the Social Protection Committee is currently considering this joint report, which is being drawn up on the basis of the national reports forwarded by the Member States in July 2002,
L. whereas Article 152 of the EC Treaty stipulates that "a high level of health protection shall be ensured in the definition and implementation of all Community policies and activities" and that actions shall not only aim at improving health and preventing diseases but shall likewise aim at "obviating sources of danger to human health",

M. whereas the Commission communication on the future of health care emphasises that the European Union’s health care systems and public health policies must tackle severe challenges, and whilst the provision of health care and care for the elderly remain essentially the responsibility of the Member States, these issues nevertheless must be included in a framework of broader European cooperation, in order to achieve effective results, and must strongly take into account the principles and objectives of the Community action programme in the field of public health and the specific objectives laid down by the United Nations Plan of Action (such as reducing the cumulative effects of risk factors and the development of prevention policies, universal and equal access to health services, the continuing improvement of health services and promoting the social inclusion of disabled persons and persons in the most vulnerable categories),

N. whereas, not least as a result of rulings by the European Court of Justice, there will be an increase in patient mobility and use of cross-border health care service provision, and whereas this trend, together with the development of the internal market, will have an increasing impact on national health care systems,

O. whereas, in the light of increasing patient mobility, the Council has agreed that initial areas for cooperation should be the setting up of highly specialised reference centres in which patients from the whole of the Union can receive treatment for specific diseases, the use of available capacity for patients on waiting lists in other Member States, the strengthening of cooperation in border regions and care of patients who settle for a longer period of time in another Member State, for example retired persons,

P. whereas the state of health of women is determined to a greater extent by socio-economic differences and women represent the majority of elderly people in view of their higher life expectancy,

Q. whereas the Commission Communication is entitled "the future of health care and care for the elderly",

R. whereas the Ecofin Council of 6 November 2000 stipulates in its conclusions: "Member States' strategies for addressing the economic and budgetary challenges posed by an ageing population should be presented in conjunction with stability and convergence",

1. Considers that the Commission’s Communication is a good basis for discussion on the future for Member States’ health care and long-term care systems as a result of demographic ageing in view of the fact the all of these EU care systems are confronted with similar core challenges, although to varying degrees;

2. Considers that Community cooperation in drawing up policies to tackle ageing must be stepped up, in particular in the field of developing and improving health services and care for all elderly people, and that support for a policy for an active old age requires greater
coordination of national social security and public health systems and measures to combat discrimination;

3. Criticises the fact that the European Community strategy and the Community action programme in the field of public health (2003-2008) based on health promotion and primary prevention is not taken into account in the Commission's approach on the future of health care and care for the elderly;

4. Calls on the Greek Presidency to make this issue of health care and care for the elderly a priority, in accordance with the conclusions of the Laeken and Barcelona European Councils;

5. Stresses the need to present an accurate image of the elderly as not merely a liability for the health service but also as a resource and potential asset to society; points out in particular that it is extremely important to avoid discriminatory terms such as ‘ageing’ in legal texts and explanatory memoranda;

6. Points out that the well-being and health of the elderly require a global response, not only in the sphere of health but also in the social and economic spheres;

7. Reminds Commission and Council in this respect of the recommendations of the WHO European Health Report 2002, which should be implemented in European and Member States’ policies alike: “Health is best served in more socially cohesive, egalitarian societies with a smaller burden of relative deprivation. (…) Thus the link between health policy and other policy sectors such as employment, income maintenance and social welfare, housing and education is crucial in all European Member States. To reduce socio-economic inequality, it is necessary to reduce both the proportion of the population that falls behind and the distance it falls behind. Evidence suggests that greater income equality and the improved social environment that comes with it, act by enhancing the population’s psychosocial welfare”;

8. Warns against the risk of overemphasising the importance of the goal of financial viability at the expense of accessibility and quality; points out that forecasts relating to the anticipated rise in costs are difficult to make and depend to a very great extent on the underlying assumptions;

9. Believes that the crucial issues raised in the Communication require detailed consideration. Due to the wide diversity of health care and long-term care needs and systems across the European Union and in candidate countries, solutions should be defined at the earliest opportunity and be based both on studies and on proper political and economic debate. The whole problem of health care and long-term care for the elderly should also feature in any future Commission work programme;

10. Considers that the achievement of the objectives of sustainability, accessibility and quality of health services requires, inter alia:

    (a) the safeguarding, and further improvement, of high quality social protection and health care provision in the Member States, based on the principle of solidarity and accessibility to all concerned;
(b) accurate and impartial information for the population regarding the opportunities for care,

(c) the creation of an internal market in health services and products, which must first and foremost guarantee high quality health care accessible to, and affordable for, all, taking into account the viability and capacity of the Member States’ systems, and which will also guarantee free movement of citizens and access to services in all the countries of the Union, which must be compatible with the abovementioned principles underlying national health care systems and which must not jeopardise the health policy objectives of the Member States,

(d) ensuring greater freedom of choice for the patient and real participation by the players in the social sphere;

11. Recommends that the broader principles and objectives of the European strategy on public health become the central reference point for guidelines, exchange of best practice etc. in the proposed OMC on health care and care for the elderly, which implies:

- the need to consider promotion of good health, disease prevention, medical treatment, care and rehabilitation as equally important areas of concern for the coordination process;
- a strategic involvement of the Commissioner for Public Health and Consumer Protection and his services in the envisaged OMC process in order to establish coherence with the aims of the public health strategy;
- the implementation of an integrated intersectoral approach to health policies at Member State, regional and local level in the coordination process (e.g. contribution of social, employment, environment, economic and other policies to improving public health and thus inter alia reducing pressures on spending for health care);

12. Considers the long-term objectives of accessibility, quality and financial viability proposed by the Commission as too narrowly conceptualised and too strongly biased towards a mere cost-cutting strategy in the framework of the stability pact; recommends therefore to:

- consider the removal of inequality in health as a long-term objective, which would both encompass tackling socio-economic, gender, age etc. biased inequality in health and equal access to high quality health care;
- consider the improvement of quality and transparency as a long-term objective covering all elements of the “health policy chain”, from promotion of good health, prevention, medical treatment to care and rehabilitation;
- consider financial viability as a long-term objective that has to be tackled along the whole “health policy chain” and to be consistent with the principle of solidarity;

13. Believes, however, that in order to control spending, be it funded from taxation revenue or contributions, healthier lifestyles and means of prevention ought to be promoted,
while at the same time raising awareness among service providers and consumers as to the costs involved in therapy and the health care consumption;

14. Calls on the Commission and the Social Protection Committee to take account of the following recommendations:

(a) Community cooperation should be stepped up in the sphere of improving health services in order to tackle the ageing of the population, not least by means of the contribution which may be made by the action plan for public health now being adopted, covering:

- the exchange of information on the population’s state of health and risk factors,
- the exchange of good practice,
- the establishment of indicators and an analysis of needs,
- the drawing up of common qualitative and quantitative standards to monitor the health services,
- the drawing up of strategies for developing health services and for the systematic analysis of needs with a view to the planning, execution and assessment of health programmes carried out at national and local level;

(b) a data bank should be established covering the social and health care sector, and containing statistical analyses and projections, both at European and national level, to enable anyone involved in planning and setting up services to understand the situation in the sector;

(c) on the basis of proven practices used in the Member States, the Commission should, to a greater extent, draw up specific scientific guidelines for health care and care for the elderly and submit these to the Council with a view to adoption as a Council recommendation;

(d) the Commission should carry out a general assessment of patient mobility and submit a study on experience in the border regions to date;

(e) provisions should be made for organising, at national and Community level, training and information campaigns for operators and prevention and promotion campaigns in the field of health, such as on age-related macular degeneration, including recognising that the future health of older people requires a lifelong approach and educating young people as to the consequences of their actions in later life;

(f) elderly people should be guaranteed access to health services not only as regards long-term care and hospitalisation, or strictly medical services, but also as regards preventive care, physiotherapy, rehabilitation and any other service designed to ensure their independence for as long as possible, in order to prevent and delay the onset of diseases and to support disabled people in a way which improves their quality of life;

(g) particular attention should be devoted to studying multiple risk factors, in particular those linked to social or economic conditions, such as the physical and
geographical environment, and in particular pollution, smoking, level of education, profession, income, social support, culture, gender, nutrition, etc.;

(h) whilst bearing in mind that the provision of health care services cannot be delegated to families, NGOs or local communities, it is necessary to identify measures designed to encourage, facilitate and support the care activities provided by such bodies or individuals, by means of:

- training and informing the persons providing the care,
- the creation of specialised services for elderly people at local and Community level,
- the participation of NGOs and users themselves in the planning and improvement of health services,
- the development of cultural and social activities to prevent the isolation of elderly people,
- psychological, economic, legal and social support for families or individuals caring for an elderly person;

(i) healthcare staff are of fundamental importance in ensuring the maintenance and development of efficient and functional health facilities, and a high standard of care and health, while the nursing shortage is a phenomenon experienced by all the Member States – albeit to varying degrees;

(j) the European Union should fund campaigns to raise awareness of the care professions needed to develop services and maintain a high standard of care and health in the Member States;

(k) the Commission should therefore propose a specific programme to fund training projects to enable people to gain access to and attend nursing courses and undergo specialised higher training in important areas (transplants, oncology and heart surgery, geriatrics, emergency medicine, rehabilitation, telemedicine, telecare and neuroscience);

(l) particular attention should be given to ongoing training in geriatrics and gerontology for healthcare and social service professionals, to include not only doctors, but also nurses and, more generally, care workers;

(m) possible responses to the problem of mental illness in the old, which affects women in particular, should be analysed, in particular as regards prevention, detection and early treatment, the establishment of protocols for diagnosis, pharmaceutical treatment and psychotherapy, the devising of programmes aimed at self-help and home care for people suffering from Alzheimer’s or other forms of senile dementia;

(n) measures are needed aimed at delaying the onset of disabilities in elderly people and providing solutions to allow disabled elderly people to maintain their autonomy (accommodation, transport, etc.); to this end, "one-stop shops", where multidisciplinary teams could look at the needs of the older person in a holistic
approach, taking on board all aspects of his/her life in a close consultation with
the person can be very useful;

(o) efforts should be made to devise solutions and instruments - including economic
ones - aimed at assuring the safety, dignity and quality of life of people unable to
live self-sufficiently with a view to ensuring that the burden does not fall solely on
the families involved;

(p) Community research aimed at ensuring the welfare and maintaining the health and
autonomy of elderly people should be developed and maintained and educational
approaches and information technology should be developed and improved so that
prevention and education help achieve improved life expectations;

(q) provision should be made for coordinating a vast range of services in a
comprehensive framework covering disease prevention and health promotion,
primary health services, intensive care, rehabilitation, long-term care and
palliative care;

(r) particular attention should be devoted to combating the maltreatment, physical,
psychological, sexual and financial abuse and neglect of elderly people in their
own homes, in residential care and in hospital, by family members, carers and
health or social care professionals, both by means of awareness-raising campaigns
aimed at the general public and those working in the health and social services,
and by creating services specifically designed for victims of maltreatment and
programmes to re-educate those guilty of such acts; welcomes the research being
carried out into elder abuse and calls on the Commission to ask the European
Agency for Living and Working Conditions to co-ordinate the sharing and
dissemination of knowledge and policies in this area; believes there is an urgent
need to establish a network of vetting systems in the respective Member States so
that a person who moves to another Member State, and seeks a job with elderly
people, can be subject to security checks with the Member State from which he or
she has come;

(s) particular attention should also be paid to the care needs of those in rural
communities;

(t) adequate account should be taken in all health-related measures of aspects specific
to women;

(u) the future of health care and care for the elderly should from now on form a
permanent part of the Commission’s work programme;

15. Stresses that increased quality in health care and long-term care systems must go hand
in hand with increased capacity and high-quality supply, as waiting times for care also
have a negative impact on the quality of life of the elderly and their relatives, and thus
on productivity and overall economic output; substantial public and private investment
is necessary in order to maintain and improve quality and diversity while at the same
time expanding capacity;
16. Calls on the Commission and Council to:
   (a) improve and harmonise European and national health monitoring and data
collection systems, in order to enable the strengths and weaknesses of systems of
health care and care for the elderly to be determined, possibilities for
improvement identified and proven practices established;
   (b) encourage the development of general preventive services in schools and
companies and among the general public and the introduction of national
prevention programmes for the major diseases;
   (c) initiate an exchange of experience relating to the issue of information for
patients and patients’ rights and to develop common criteria;
   (d) undertake a fundamental review of the legal framework for cross-border access
to health care services in the European Union, which should lead to
systematisation of the reimbursement of costs, quality standards and the
provision of information to patients, welcoming in this connection as a first step
the review of Regulation 1408/71 and the proposal, planned for spring, to
introduce a European health insurance card;
   (e) involve the applicant countries as far as possible now in EU health policy
programmes and to make available further funding for cross-border cooperation;

17. Welcomes the fact that the Council has agreed on closer cooperation, the exchange of
information and experience and the identification of national best practice in the area
of health care and care for the elderly, and calls for the Council, at the time of the
Spring 2003 European Council, to adopt a proposal from the Commission and the
Social Protection Committee, to adopt in principle the use of the open method of
coordination, to lay down a precise timetable for further action and to agree on
common targets and indicators by the Spring 2004 European Council;

18. Calls for an interinstitutional agreement under which rules are to be adopted
concerning the involvement of Community institutions in all stages of the open
method of coordination (setting of targets, defining of indicators, consultation on
reports), including rules on access to documents and participation in meetings;

19. Calls for the Social Protection Committee to conclude by the start of 2003 its work on
the examination of means of measuring quality-adjusted life expectancy, premature
mortality dependent on socio-economic position and access to health care, and calls on
the Council to agree on appropriate indicators during 2003;

20. Calls on the European Convention to include a high level of health protection as a
general goal in the draft Constitution and to define health policy as an area in which
competence is shared between the European Union and the Member States, in order to
enable the European Union to continue, as previously, to take action complementing
Member States’ policy, including the adoption of legislation;

21. Calls on the Commission and Council to take account of the decisions adopted in the
joint report currently being prepared when drawing up the Broad Economic Policy
Guidelines and when preparing the joint synthesis report for the Spring 2003 European
Council;
22. Calls on the Commission and the Social Protection Committee to keep the European Parliament regularly informed, in a timely manner, of their activities;

23. Stresses that, within the objective of achieving closer coordination of existing EU models, account should be taken of the future needs of European pensioners, one such need being for them to maintain the rights they have acquired during their working lives, regardless of the Member State in which they reside once they have retired: this will require the adoption of arrangements under which the implementation of such rights is compatible with the structure of the various pension systems currently in place in the EU;

24. Recalls in that context its call for the European Parliament to be involved in the production of the Broad Economic Policy Guidelines;

25. Stresses the need to take account of the challenges of EU enlargement when discussing policy on health care and long-term care for the elderly;

26. Instructs its President to forward this resolution to the Council, the Commission, the Social Protection Committee and the parliaments of the Member States.
EXPLANATORY STATEMENT

1. Introduction

Global demographic trends show a gradual ageing of the population: according to European Union estimates the proportion of the European population over the age of 65 will rise from 16.1% in 2000 to 22% in 2025 and 27.5% in 2050. At the same time people over the age of 80, who made up 3.6% of the population in 2000 are likely to make up 6% in 2025 and 10% in 2050.

This phenomenon all too frequently provokes two diametrically opposed but equally unjustifiable responses: on the one hand, to view the situation as a disaster, and on the other, to attempt to evade the issue altogether. Although an ageing population is an inescapable fact with which political decision-makers will have to come to terms, the presence of so many elderly people in our society undoubtedly offers a wealth of opportunity and potential. The ageing of the population is essentially a triumph for our civilisation, brought about by the improvements in medical treatment and general living conditions in our countries. We should therefore not bemoan this achievement or view it as a burden, but should meet the challenge through cultural adjustment and a coherent socio-economic development plan.

The Commission communication dealt with in this report specifically concerns the future of health services and care for the elderly. Any health policy must, however, be seen in the overall context of the international and Community strategy for improving the quality of life of the elderly.

Before going any further, we should point that people over 65 do not form a homogenous group with similar needs. Apart from the 'horizontal' distinction between the so-called 'third' and 'fourth' ages (elderly and very elderly), a 'vertical' distinction is clearly needed between people who are in good health and self-sufficient and those who are not. These two variables are the most immediately relevant as regards health and care services, although there are other factors involved (urban or rural environment, level of education, etc.). However, the boundaries between the two groups (self-sufficient and others) are not always clear-cut and depend on society's ability to guarantee an autonomous existence for as long as possible.

2. The international and Community approach

The European Union has supported the United Nations initiatives on ageing (the two world assemblies, the International Year of the Elderly and the plans of action), in particular the new Plan of Action adopted by the second World Assembly, which identifies three main priorities:

- full involvement by older people in the process of social development and equitable participation in the benefits of economic and social growth (active old age, empowerment, solidarity between generations, combating social exclusion, etc.);
- advancing health and wellbeing into the third and fourth ages;
- creating an appropriate support framework for older people (environment, housing, transport).
The Commission Communication 'Europe's response to world ageing', drawn up on the occasion of the second World Assembly on Ageing, stressed the need to frame an overall European strategy, taking into account the economic, employment and social implications of ageing.

This approach is designed fully to mobilise the potential of persons of all ages through policies and practices geared to active ageing and the involvement of all those concerned in drawing up policies in the field of social protection, inclusion and employment1.

With this in view, the Community has identified a number of key challenges: managing the economic implications of ageing in order to maintain growth and sound public finances; adjusting well to an ageing and shrinking workforce; ensuring adequate, sustainable and adaptable pensions; and reforming health care systems.

These are the conclusions that have so far been reached from the Community's consideration of this matter. A first step was the Commission's 1999 Communication "Towards a Europe of all ages", which opened a debate at European level on the subject of ageing, stressing that all Member States would benefit from closer European cooperation on this matter. It should be borne in mind that in 2025 one in 14 people in Italy will be more than 80 years old and this demographic trend will have an impact on the labour market, pension and health care schemes, economic and commercial processes, fiscal policies – in short on a whole range of policies which, despite the reform efforts made by the Member States, have global repercussions.

A second essential step was the inclusion in the EC Treaty of measures to combat discrimination on grounds of age and the adoption of the Charter of Fundamental Rights, which, as well as prohibiting discrimination on grounds of age, recognises 'the right of the elderly to lead a life of dignity and independence and to participate in social and cultural life'.

In adopting the social policy agenda outlining the Union's strategy on employment and social affairs for the period 2000-2006, the Nice European Council stressed the need to address the broader social and employment implications of ageing through policies which bolster one another in the field of employment, social protection and the economy.

Bearing in mind the need to ensure a response to ageing that will ensure both economic growth and financial sustainability, the Stockholm European Council in March 2001 adopted a strategy based on three priorities, which were subsequently incorporated into the general economic policy guidelines and involved increasing employment rates, reducing public debt to offset increased spending on pensions and health care, and reforming pension systems.

In November 2000, on the basis of this strategy, the Council adopted a directive and a plan of action on combating discrimination at the workplace, seeking inter alia to overcome negative attitudes to elderly workers.

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1 Separate mention should be made of the Madrid Declaration of March 2002 on disabled people and their integration, which also concerns the elderly. The declaration, adopted at the European Congress on Disability as a result of the agreement between the European Disability Forum, the Spanish presidency of the EU and the European Commission, provides a conceptual framework for action in this field.
The Göteborg European Council (June 2001) introduced the open method for coordinating pensions policy, laying down three major common principles, namely the need to ensure adequate pensions for all, to maintain the financial sustainability of the system and to adapt pension systems to changing social needs, particularly the demand for a more flexible retirement age.

3. European strategy on health care

European cooperation on public health is relatively recent. Article 152 of the Treaty, which requires a high level of human health protection to be ensured, was first applied through the Commission's 1998 Communication on the development of public health policy in the European Community and in its communication on the health strategy of the European Community, including a proposal for a programme of action in the field of public health. At the same time, ensuring a high and sustainable level of health protection has been seen as one of the main objectives of European cooperation in the field of social protection.

The Commission documents emphasise the increased incidence of age-related illnesses, particularly mental illnesses (around one quarter of people over 85 suffer from some form of senile dementia), and the corresponding increase in demand for long-term and specialised health care services.

In the light of these considerations, the plan of action focuses on improving information and knowledge for the development of public health and the strengthening and maintenance of efficient health systems, enhancing the ability to respond rapidly and in a coordinated fashion to threats, and disease prevention and health promotion measures and the need for synergy between measures in the field of health and those relating to the single market in pharmaceutical products, consumer protection, the environment and research.

With this in view, the fifth framework research programme made provision for a specific action on 'the ageing population and disabilities' and a series of other specific measures relating to health and ageing. The sixth framework research programme has confirmed these priorities. Parliament has placed particular emphasis on research related to cancer, cardiovascular diseases, degenerative diseases of the nervous system (Alzheimer's, Parkinson's, etc.), diabetes and, more generally, all diseases linked to the ageing process or to social exclusion.

For its part, the European statistical system has launched major projects in the health sector, in particular as regards state of health, health services and risk factors.

Finally, it should be borne in mind that legislation on pharmaceutical products, environmental protection, social security and taxation have a significant impact on people’s health. For this reason, a European health policy strategy must take account of the health implications of the regulation of the market in goods and services, legislation on professional qualifications and technical standards, cross-border cooperation, etc., and aim to remove the barriers to the right of establishment of legal persons and the free movement of people within the territory of the Union.

4. The Commission communication
The present communication on the future of health care services was adopted by the Barcelona European Council in March 2002, which stressed the need to launch and develop cooperation between Member States in these sectors during 2002 and 2003 through exchanges of best practice and information and discussion of the common challenges facing them at European level.

In its communication, the Commission points out that health care systems in the European Union face the three-fold challenge of securing access to health care for all, a high level of quality in health care and the financial viability of health care systems. The document concludes that: 'if these objectives are to be attained, it is essential that all the players of the health systems cooperate, be they local authorities, health care professionals, social protection bodies, supplementary insurance companies, consumers or their representatives.'

Both the Commission's conclusions and the objectives it sets can certainly be endorsed. However, insufficient attention seems to have been paid to the strategy needed to achieve these objectives, the actual instruments to be used, and the role to be played by the Union.

On the one hand, the goals of accessibility, quality and sustainability for the health care system set by the Commission should be seen as part of the broader objective of promoting a society for all ages where longevity is accompanied by health, defined by the WHO as 'a state of complete physical, mental and social wellbeing'.

On the other hand, it should be borne in mind that whilst the improvement of health care systems in order to tackle the ageing of the population remains essentially the responsibility of the Member States, effective results can be achieved only as part of broader European cooperation, taking into account the specific objectives set forth in the United Nations plan of action:

- reducing the cumulative effects of factors (social exclusion, dependence, etc.) that increase the risk of disease among the elderly and developing preventive policies;
- ensuring universal and equal access to health care services;
- developing primary health care services for the elderly and promoting their integration in society;
- improving health services to meet the needs of the elderly (developing quality standards for health care and rehabilitation, coordination between different services and creating specialised centres for the elderly);
- ensuring involvement by interested parties in the development of services;
- training health care professionals;
- developing services for the prevention, treatment and management of mental health problems in older people;
- maintaining maximum functional capacity throughout life and promoting full social involvement of older persons with disabilities.

The proposals contained in the resolution therefore point in this direction and stress in particular the need for enhanced Community cooperation in the field of exchange of information and best practice, research, the definition of health indicators and qualitative and quantitative standards for services, and also draw attention to potential ways of developing
health care and social services for the elderly, such as the treatment of mental illnesses affecting the elderly, preserving autonomy, social inclusion, access to rehabilitation and prevention, assistance and support for families caring for elderly people and combating maltreatment and neglect.
6 November 2002

OPINION OF THE COMMITTEE ON ECONOMIC AND MONETARY AFFAIRS

for the Committee on Employment and Social Affairs

on the Commission Communication to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions on the future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability

Draftsman: Mary Honeyball

PROCEDURE

The Committee on Economic and Monetary Affairs appointed Mary Honeyball draftsman at its meeting of 19 March 2002.

It considered the draft opinion at its meetings of 10 July, 27 August, 7 October and 5 November 2002.

At the latter meeting it adopted the following conclusions by 22 votes to 13, with 0 abstentions.

The following were present for the vote: Christa Randzio-Plath, chairwoman; Philippe A.R. Herzog and John Purvis, vice-chairmen; Mary Honeyball, draftsman; Generoso Andria, Pervenche Berès, Roberto Felice Bigliardo, Hans Blokland, Hans Udo Bullmann, Carles-Alfred Gasoliba i Böhm, Robert Goebbels, Lisbeth Grönfeldt Bergman, Christopher Huhne, Othmar Karas, Giorgos Katiforis, Piia-Noora Kauppi, Christoph Werner Konrad, Astrid Lulling, Hans-Peter Mayer, Fernando Pérez Royo, Alexander Radwan, Mónica Riduejo, Olle Schmidt, Peter William Skinner, Helena Torres Marques, Bruno Trentin, Theresa Villiers, Luis Berenguer Fuster (for David W. Martin), Harald Ettl (for Bernhard Rapkay), Wilfried Kuckelkorn (for a full member to be nominated), Werner Langen (for Ingo Friedrich), Peter Michael Mombaur (for Renato Brunetta), Karla M.H. Peijs (for Ioannis Marinos), José Javier Pomés Ruiz (for Jonathan Evans), Marcelino Oreja Arburúa (for José Manuel García-Margallo y Marfil, pursuant to Rule 153(2)).
**CONCLUSIONS**

The Committee on Economic and Monetary Affairs calls on the Committee on Employment and Social Affairs, as the committee responsible, to incorporate the following points in its motion for a resolution:

1. Considers that the Commission’s Communication is a good basis for discussion on the future for Member States’ health care and long-term care systems as a result of demographic ageing in view of the fact the all of these EU care systems are confronted with similar core challenges, although to varying degrees.

2. Welcomes the three common objectives for EU health care and long-term care systems, namely accessibility, quality and financial viability.

3. Recalls that the stability and convergence programmes show that ageing populations will have a considerable budgetary impact causing public spending to grow between 4% and 8% of GDP in most Member States, and in some States even more. Member States must, therefore, take urgent measures in relation to the growth in age related spending.

4. Stresses that increased quality in health care and long-term care systems must go hand in hand with increased capacity and high-quality supply, as waiting times for care also have a negative impact on the quality of life of the elderly and their relatives, and thus on productivity and overall economic output. Substantial public and private investment is necessary in order to maintain and improve quality and diversity while at the same time expanding capacity.

5. Emphasises that public investment can help build up additional sources of complementary private investment to develop and enhance care provision. The system of health care and care for the elderly affords a number of opportunities for private investment in additional goods and services for the elderly. Hence the challenge posed by health care also offers new potential that can be harnessed in order to raise employment and social welfare levels in a system in which public and private services complement one another to the extent required.

6. Believes that the crucial issues raised in the Communication require detailed consideration. Due to the wide diversity of health care and long-term care needs and systems across the European Union and in candidate countries, solutions should be defined at the earliest opportunity and be based both on studies and on proper political and economic debate. The whole problem of health care and long-term care for the elderly should also feature in any future Commission work programme.

7. Welcomes the acknowledgement in the Communication that the diversity of funding and organisational arrangements is one of the main characteristics of health care systems in Europe. As such the organisation of health care and long-term care systems, their funding and planning are a matter for Member States who are able to
assess the needs of their populations. Although there is undoubtedly scope for increased and better co-ordination, in view of this diversity and variety, any harmonisation of health care systems is not an option.

8. Believes, however, that in order to control spending, be it funded from taxation revenue or contributions, healthier lifestyles and means of prevention ought to be promoted, while at the same time raising awareness among service providers and consumers as to the costs involved in therapy and the health care consumption; in the same vein, considers that consumers ought to be encouraged, through tax relief and other arrangements, to make an appropriate contribution to care provision and/or take out supplementary health insurance cover and long-term care insurance.

9. Stresses that, within the objective of achieving closer coordination of existing EU models, account should be taken of the future needs of European pensioners, one such need being for them to maintain the rights they have acquired during their working lives, regardless of the Member State in which they reside once they have retired. This will require the adoption of arrangements under which the implementation of such rights is compatible with the structure of the various pension systems currently in place in the EU.

10. Agrees, as regards the co-ordination of economic policies, that it is necessary to take account of the effects of the ageing population within the framework of the EU Broad Economic Policy Guidelines.

11. Recalls in that context its call for the European Parliament to be involved in the production of the Broad Economic Guidelines.

12. Stresses the need to take account of the challenges of EU enlargement when discussing policy on health care and long-term care for the elderly.

13. Calls for an interinstitutional agreement laying down rules governing the participation of Community institutions in all steps of the open method of co-ordination (formulation of objectives, definition of indicators, consultations on the report), including rules on access to documents, participation in meetings and the procedure for moving from the open method of co-ordination to the Community approach.
3 October 2002

**OPINION OF THE COMMITTEE ON THE ENVIRONMENT, PUBLIC HEALTH AND CONSUMER POLICY**

for the Committee on Employment and Social Affairs


Draftsman: Antonio Mussa

**PROCEDURE**


It considered the draft opinion at its meetings of 9 September 2002 and 2 October 2002.

At the last meeting it adopted the following conclusions by 35 votes to 3, with 2 abstentions.

The following were present for the vote: Mauro Nobilia, acting chairman; Alexander de Roo and Anneli Hulthén, vice-chairmen; Antonio Mussa, draftsman; Per-Arne Arvidsson, María del Pilar Ayuso González, Hans Blokland, John Bowis, Philip Bushill-Matthews (for Martin Callanan), Dorette Corbey, Avril Doyle, Anne Ferreira, Marialiese Flemming, Karl-Heinz Florenz, Pernille Frahm, Cristina García-Orcoyen Tormo, Robert Goodwill, Françoise Grossetête, Christa Klaß, Eija-Riitta Anneli Korhola, Bernd Lange, Peter Liese, Torben Lund, Jules Maaten, Minerva Melpomeni Malliori, Eryl Margaret McNally (for Catherine Stihler, pursuant to Rule 153(2)), Jorge Moreira da Silva, Emilia Franziska Müller, Giuseppe Nisticò, Ria G.H.C. Oomen-Ruijten, Marit Paulsen, Dagmar Roth-Behrendt, Guido Sacconi, Karin Scheele, Inger Schörling, Maria Sornosa Martinez, Nicole Thomas-Mauro, Antonios Trakatellis, Kathleen Van Brempt and Phillip Whitehead.
SHORT JUSTIFICATION

Introduction

In accordance with the request made by the European Council in Göteborg in June 2001, a preliminary report on the principles governing health care for the elderly was submitted at the European Council meeting in Barcelona of 15/16 March 2002, calling on the Commission and the Council to examine in greater detail the aspects of accessibility, quality and financial sustainability, with a view to the European Council meeting in spring 2003.

The Communication we are examining is the Commission’s contribution to the current debate on the implementation of the Göteborg mandate, and was the basis for the report drawn up by the Council with a view to the Barcelona summit.

The health sector in general and health-care systems are of a very high standard in the European Union, thanks not only to improvements in the standard of living and health education, but also to the fact that risks of illness and invalidity are now generally covered by insurance. Public expenditure on health, in the European health systems, therefore accounts for a significant proportion of total health expenditure, and has, in the last 30 years, especially before 1990, grown more rapidly than GDP.

Long-term objectives

It is therefore extremely important for Europe to maintain the health systems developed in the last 30 years and adapt them to the challenges of the new millennium, in particular the ageing of the population. The aim must be, as the Commission points out, to combine access to care for all with the provision of high-quality care and financially sustainable care systems. These are the three long-term objectives approved by the European Council in Barcelona, which form the reference framework for the debates on the future of health care.

The organisation of national health systems, the funding details and the types of care and treatment on offer are the responsibility of the individual Member States of the European Union and are characterised by profound and long-standing differences; nevertheless, it is obvious that the exchange of information and knowledge is bound to have a positive impact on the quest for appropriate responses to the new demands of national health systems.

Finally, the recent judgments of the Court of Justice of the European Communities concerning the freedom of movement of patients, enabling them to obtain treatment in a Member State other than the one in which they live are also relevant to the debate on the future of health care.

The problems involved

Increased life expectancy, with the resulting increase in the proportion of old people in the total population, may have considerable consequences - albeit difficult to quantify at the moment - on health systems, because of the higher rate of morbidity among the elderly, the combination of several illnesses and the more serious and chronic nature of age-related diseases, which may lead to dependence on others. Added to this is the probable increase in
expenditure on long-term care - either in out-patients departments, long periods of hospitalisation or psychiatric care – not least due to the weakening of family structures, traditional networks of assistance and care for old people in need of help.

This probable twofold development highlights the problem of human resources and qualified staff in a sector - health and social services – in which employment has already increased more than twice the average in the last five years. In this context the Member States and the European Union more than ever need to take steps to raise young people’s awareness of paramedical professions, to fund projects for higher training in nursing and to draw up a legislative framework enabling qualified young people from outside Europe to be employed in the health structures of the Member States.

The development of medical technologies and therapies is the second challenge which the health care systems will have to tackle in the coming decades. Technological progress leads not only to increased productivity - whether in terms of reducing the duration of health care or reducing the risks of serious diseases - but often also to the possibility of treating new diseases and using more intensive treatment. In an atypical sphere of activity such as health, in which demand is to a great extent determined by supply - of medicines or therapies - and in which patients - who are now better educated and better informed - pressurise doctors to use the latest discoveries, clear, transparent and efficient mechanisms for assessment must be devised, in order to ensure accessibility of new products and new therapies.

Greater prosperity and an improved standard of living have important consequences for the development of health-care systems: educational and preventive measures mean, as time goes on, that intensive and expensive forms of treatment are used to a lesser extent; access to information entails a need for greater quality and efficiency in the health systems, but also the possibility of comparing the practices of other countries and hence greater cross-border mobility; patients are asking for greater involvement and greater transparency as regards the quality and functioning of health services.
CONCLUSIONS

The Committee on the Environment, Public Health and Consumer Policy calls on the Committee on Employment and Social Affairs, as the committee responsible, to incorporate the following points in its motion for a resolution:

Paragraph 1

1. Agrees largely with the analysis made by the Commission, according to which increased life expectancy entails an increase in the demand for qualified care, because of morbidity and the tendency towards a combination of illnesses;

Paragraph 2

2. Backs the long-term and equally important objectives identified in the Communication (accessibility, quality and financial viability);

Paragraph 3

3. Points out that any forecast about the trend in costs in the health sector is subject to great uncertainty;

Paragraph 4

4. Considers that a sustainable social protection system presupposes concerted action between Community policies and strategies;

Paragraph 5

5. Considers that support for a policy for an active old age requires greater coordination of national social security and public health systems and measures to combat discrimination;

Paragraph 6

6. Considers that healthcare staff are of fundamental importance in ensuring the maintenance and development of efficient and functional health facilities, and a high standard of care and health, and stresses that the nursing shortage is a phenomenon experienced by all the Member States – albeit to varying degrees;

Paragraph 7

7. Points out that the health and care sector constitutes a growing labour market and can therefore help to meet employment policy targets; however, above all, adequate pay must be guaranteed, if this sector of employment is to be developed appropriately;
8. Considers that recruitment of staff from outside the EU may be an appropriate short-term solution if it is carried out in accordance with ethical guidelines. In the longer term, however, the European Union should aim to be self-sufficient in healthcare staff;

Paragraph 9

9. Proposes that the European Union should fund campaigns to raise awareness of the care professions needed to develop services and maintain a high standard of care and health in the Member States;

Paragraph 10

10. Calls, therefore, on the Commission to propose a specific programme to fund training projects to enable people to gain access to and attend nursing courses and undergo specialised higher training in important areas (transplants, oncology and heart surgery, geriatrics, emergency medicine, rehabilitation, telemedicine, telecare and neuroscience);

Paragraph 11

11. Considers that priority should be given to making available the resources needed for the training of qualified nurses in the following fields: geriatrics, oncology, first aid, transplants, heart surgery, nephrology and psychiatry, in order to make young people more interested in taking short degree courses in nursing and to provide qualifications and incentives in specialised areas in which work is more demanding both intellectually and psychologically (‘burn-out’ in the case of oncology and stress in the case of transplant surgery). It would also be appropriate to provide for the introduction of differentiated training courses which devote particular attention to the psychological aspects affecting nursing staff, since they are more exposed to emotional pressure in connection with the serious nature of a patient’s symptoms;

Paragraph 12

12. Considers that guidelines should be laid down for the training of staff in any capacity who deal with illnesses exclusively affecting the elderly;

Paragraph 13

13. Believes that networks should be set up to provide information on new methods of treatment and support for anyone caring for elderly people suffering from neuropsychiatric or degenerative disorders;

Paragraph 14
14. Considers, on grounds of financial sustainability, that care for the elderly should be provided not only by the paramedical professions but also by the family and more general social environment of the elderly after appropriate training;

Paragraph 15

15. Points out that as regards the objective of accessibility, the situation of marginalised people must be given particular consideration;

Paragraph 16

16. Suggests that the problem of nurse and doctor shortage is compounded in certain Member States as many nurses leave the profession early and many doctors seek early retirement: calls on the Commission to spur Member States to provide data in this regard for comparative purposes;

Paragraph 17

17. Agrees that the organisation of health care systems, their funding and planning are a matter for the individual Member States, but considers that Member States have much to learn from one another and should seek to exchange ideas and best practice much more vigorously;

Paragraph 18

18. Notes especially that a minority of Member States finance a national health service solely from taxation, and commends consideration of other funding options in addition;

Paragraph 19

19. Agrees with the Commission that funding of healthcare should take more into account the specific needs of people above 65 years of age;

Paragraph 20

20. Stresses that in recent years there has been a substantial increase in waiting lists, a direct consequence of a not insignificant increase in demand for healthcare for long-term treatment and chronic diseases. Proposes, therefore, that in cases in which it is possible to provide care ‘at home’ all the necessary means should be made available. Care at home must be organised using qualified nursing staff, doctors and itinerant services;

Paragraph 21
21. Calls for employees to be entitled to continue to receive their salary up to the equivalent of the maximum for the regular weekly working hours within a working year, if, after being taken on, they are demonstrably prevented from working because of having to care for someone close to them who lives in the same household and has fallen ill. This person may be a spouse or direct relative, or the person with whom the employee is living in a long-term relationship;

Paragraph 22

22. Points out that the practice of geriatrics requires a multi-dimensional approach, taking into account a large number of acute and chronic pathologies, as well as the psychic and social difficulties of people who are weakened by both a loss of autonomy and by the disintegration of the family;

Paragraph 23

23. Considers it essential to foster a strategy of preventing and detecting risk factors linked to ageing, such as undernourishment, the effects of polypharmacy, osteoporosis, urinary incontinence, Alzheimer’s disease and related illnesses and the problem of the seriousness and frequency of falls among the aged;

Paragraph 24

24. Is aware of the growing problem of the physical, psychological, sexual and financial abuse of vulnerable older people in their own homes, in residential care and in hospital, by family members, carers and health or social care professionals; welcomes the research being carried out into elder abuse; and calls on the Commission to ask the European Agency for Living and Working Conditions to co-ordinate the sharing and dissemination of knowledge and policies in this area;

Paragraph 25

25. Believes there is an urgent need to combat elder abuse by establishing a network of vetting systems in the respective Member States so that a person who moves to another Member State, and seeks a job with elderly people, can be subject to security checks with the Member State from which he or she has come;

Paragraph 26

26. Points out that increased life expectancy should be seen as a triumph of health and drug policies; it is therefore extremely important to avoid discriminatory terms such as ‘ageing’ in legal texts and explanatory memoranda.