



European Economic and Social Committee

SOC/437
Health for Growth
Programme

Brussels, 23 February 2012

OPINION

of the

European Economic and Social Committee

on the

Proposal for a Regulation of the European Parliament and of the Council on establishing a Health for Growth Programme, the third multi-annual programme of EU action in the field of health for the period 2014-2020

COM(2011) 709 final - 2011/0339 (COD)

Rapporteur-General: **Ms Ouin**

On 30 November 2011, the European Parliament, and, on 21 December 2011, the Council decided to consult the European Economic and Social Committee, under Article 304 of the Treaty on the Functioning of the European Union, on the

Proposal for a Regulation of the European Parliament and of the Council on establishing a Health for Growth Programme, the third multi-annual programme of EU action in the field of health for the period 2014-2020
COM(2011) 709 final - 2011/0339 (COD).

On 6 December 2011 the Committee Bureau instructed the Section for Employment, Social Affairs and Citizenship to prepare the Committee's work on the subject (rapporteur-general: Ms Ouin).

Given the urgent nature of the work, the European Economic and Social Committee appointed Ms Béatrice Ouin rapporteur-general at its 478th plenary session, held on 22 and 23 February 2012 (meeting of 23 February 2012) and adopted the following opinion by 169 votes to 1 with 4 abstentions.

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1. **Conclusions and recommendations**

- 1.1 The EESC welcomes the Commission's initiative: the existence of this third programme, in this period of crisis, is a positive message to the people of Europe. The Committee welcomes a programme specifically dedicated to health with an increased, albeit modest budget.
- 1.2 The EESC welcomes the focus on a limited number of priorities and the increase in the ceiling for subsidies for Member States whose gross national income per inhabitant is less than 90% of the Union average¹.
- 1.3 The EESC shares the view that efforts should be made to improve the use of human and financial resources and warns against the temptation to cut budgets and public health services during this period of crisis.
- 1.4 The EESC considers that, where health is concerned, European added value consists of encouraging exchanges of best practice and disseminating the principles of mainstreaming health in all policies and combating health inequalities, poverty and social exclusion.

¹ e.g. EE, HU, LV etc.

- 1.5 The EESC stresses the importance of prevention for maintaining a healthy population: health education, improved living, working and housing conditions. Healthy ageing needs to be prepared for throughout life.
- 1.6 The EESC argues that, as there is a general shortage of labour in this sector, common solutions need to be sought: professional equality, re-evaluation of skills and pay, recognition of the high level of technical skills required, recognition of know-how acquired from informal work in the family, a better gender balance in the sector, improving conditions of work and organisation of working time, lifelong training, end-of-career arrangements taking account of the physical and psychological strain on care staff.
- 1.7 The EESC considers it preferable to train the unemployed in these vocations rather than bringing in already trained workers from third countries and other EU countries, so as to prevent these countries from being deprived of their skills.
- 1.8 The EESC stresses the need to give families and the community (friends, neighbours etc) the means to look after the sick and dependent persons, with a better distribution of working time over a person's life.
- 1.9 The EESC encourages exchanges of experience in the use of online health systems both by professionals and private individuals, and calls for European frameworks to be established:
- to protect confidential data in the event of cross-border exchange of patient files or prescriptions,
 - to ensure that information disseminated on public websites is accurate via a system of accreditation operated by competent health authorities.
- 1.10 The EESC considers that, in addition to the existing priorities (smoking, alcohol, obesity and HIV), new risks should be added, related to:
- climate change, pollution, the spread of chemical products, nanotechnologies,
 - the safety of medicines and prostheses, and the over-consumption of medicines,
 - changing ways of life and eating habits and their effect on human reproduction,
 - mental health problems, such as stress, depression, Alzheimer's disease.
- 1.11 The EESC finds that new technologies in healthcare need to be further encouraged to reduce the workload of healthcare staff, to improve quality of care and support to patients, and to improve and sustain mobility of the elderly.

2. **Background**

- 2.1 Over the last two years the European Economic and Social Committee has adopted numerous opinions on health issues, ranging from combating health inequalities to the campaign against

alcoholism, from Alzheimer's disease to cancer, from action against smoking to patient safety².

- 2.2 Although the healthcare sector can make a valuable contribution to economic growth, there is more to health than this. The best way of improving the viability of health schemes, which come into play when someone falls ill, is to maintain the population in good health by preventive and public health measures. It would be useful to have more statistics on the activities of the care systems.
- 2.3 The economic crisis is leading to worrying cuts in budgets which endanger the quality of public health services and universal access to care. Maintaining the health of the population against a background of demographic and climate change requires that sufficient resources be devoted to this aim.
- 2.4 Remaining in good health requires health education from childhood onwards (provided by the family, educational institutions and the media), a healthy diet at all ages, limiting exposure to dangerous substances, decent living and working conditions etc. Particular emphasis should be placed on healthy ageing, as older people are - apart from new-borns - the largest consumers of care services. Healthy ageing needs to be prepared for early.
- 2.5 Improving living and working conditions and preventing the onset of illness are the best ways of safeguarding the health of the population and thus of reducing workplace absenteeism and healthcare costs.
- 2.6 The main scourges needing to be tackled are poverty and social exclusion: cold, hunger, an unbalanced diet, poor hygiene, unhealthy living conditions, often in combination with loneliness, lack of preventive medicine etc. promote the development of diseases, in particular chronic diseases, which impose a very heavy cost on social security schemes, i.e. for all those who contribute to their financing.

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See the following EESC opinions:

[OJ C 18, 19.1.2011, p. 74.](#)

[OJ C 339, 14.12.2010, p. 1.](#)

[OJ C 255, 22.9.2010, pp. 72 and 76.](#)

[OJ C 128, 18.5.2010, p. 89.](#)

[OJ C 228, 22.9.2009, p. 113.](#)

[OJ C 318, 23.12.2009, p. 10.](#)

[OJ C 306, 16.12.2009, p. 64.](#)

[OJ C 317, 23.12.2009, p. 105.](#)

[OJ C 218, 11.9.2009, p. 91.](#)

[OJ C 175, 28.7.2009, p. 116.](#)

[OJ C 77, 31.3.2009, p. 115.](#)

[OJ C 224, 30.8.2008, p. 88.](#)

[OJ C 77, 31.3.2009, p. 96.](#)

- 2.7 The Committee supports the objective of contributing to innovative and viable health systems, which requires common tools and mechanisms to tackle the lack of human and financial resources. It is essential to boost investment in home care and non-emergency or surgical care by redirecting the money spent on hospital care; it will thus be possible to recognise the key role of the family in maintaining the health of the population and improving the sustainability of the care system.
- 2.8 Health education begins at the earliest age, in the family, and includes hygiene, a balanced diet and behaviour as well as a stable emotional environment. It is in the family that people first learn the rules for staying healthy and it is also the family which takes care of the sick, partly because many sick people do not require hospitalisation and remain at home, with their families, and also because, when someone is hospitalised, visits from family and friends provide the patient with psychological and material support, complementing the work of hospital staff. This essential function of the family and those close to the patient must be preserved, because when a person is diminished by illness, what he or she needs above all is the presence and support of the family.
- 2.9 Changes in the structure of the family do affect mental and physical health and the problem needs to be tackled at source by helping the family to remain a secure environment.
- 2.10 *The decline of informal care in the family environment* is not inevitable. Sick people do not want to be cared for mainly by professionals. Where care requiring specialised technical skills is needed, the family cannot replace the professionals. But sick people and their families must have a choice where all other home-care tasks are concerned. Hence the need to allow employed people leave of absence from work when a family member requires care.
- 2.11 The need for an overhaul of pension systems should be seen as an opportunity to rebalance working time throughout an individual's life. Since longer life expectancy makes it possible to work longer, men and women should be entitled throughout their working lives to take extended periods of leave, either full or part-time, financed in the same way as pensions, to take care of sick family members or dependent elderly relatives. Greater freedom of choice is needed for employees to organise the time financed by their work in accordance with their needs, not only when retired. The European social partners, who have already negotiated parental leave, could now focus on these periods of leave and the accounts/time required to respond to the need to reconcile family and professional life more effectively.
- 2.12 If the family is to remain the primary source of solidarity, it has to have the means. Time spent caring for sick or dependent relatives should already be taken into account when calculating social security and pension benefits.
- 2.13 Services also need to be developed to help dependent persons cope with the demands of everyday life alone: assistance with hygiene, household tasks, preparation of meals, night-time care. The family assistance employment sector is developing rapidly, with the creation of jobs. In too many countries work in the home is still informal, undeclared,

unprotected work without recognised qualifications, often carried out by female migrant workers. This is a key area in the context of gender equality, where stereotypes are commonplace, technical skills are not recognised, contracts are insecure or non-existent and wages very low, although these jobs are essential for the operation of the economy. The convention recently adopted by the ILO on decent work for domestic workers should help to establish the sector on a firm moral and professional basis, providing that methods of financing are developed, as the services cannot be financed by the sick or their families on their own.

3. Objectives of the programme

- 3.1 The programme proposes innovative solutions to tackle the shortage of workers. During this period of massive unemployment in Europe questions need to be asked about recruitment difficulties in the healthcare sector. This employment sector is very much dominated by women and does not attract enough young people or men, and the causes of this are: insufficient recognition of qualifications and skills, difficult hours and working conditions and low pay. Professional equality will require improved pay and greater recognition of technical skills, as well as access to lifelong training.
- 3.2 One major innovation would be to increase the number of men working in the sector. This would require measures. The social partners should promote policies to encourage the participation of under-represented groups. Vigilance is needed to ensure that self-employed status does not cause care workers to neglect rest periods and to work to the point of exhaustion. All technical, organisational and social innovations should be encouraged which help to improve working conditions and make them less difficult.
- 3.3 In the healthcare sector, where demands are heavy, patients need care 24 hours a day, seven days a week. It requires night-time working and hours which are difficult to reconcile with family life. Making working conditions satisfactory requires close involvement of staff in decisions. The social partners, in the framework of the sectoral social dialogue, must envisage the application of innovative concepts of the workplace, such as individual management of working time (self-rostering), which could benefit from the support of information and communication technology (ICT) instruments.
- 3.4 The social partners must work together with government in order to support lifelong learning, internal mobility of posts and the acquisition of management and organisational skills. In order to make it easier to combine work and training, they should give consideration to a number of options, including secondment, in-service training and online learning. It is essential to broaden career opportunities in order to retain staff.
- 3.5 Responding to labour shortages by training the unemployed and offering appropriate pay seems a better solution than attracting already trained workers from third countries: doctors, nurses, physiotherapists etc. from Africa, Asia or Latin America will be missed in the countries which financed their training. The European healthcare sector social partners have

drawn up a code of conduct for ethical cross-border recruitment and retention in the hospitals sector. This should be applied and extended. And for professionals from third countries wanting to move to Europe anyway, the Committee, in a 2007 opinion on Health and Migrations, proposed the setting-up of a Special Compensation Fund to finance the training of other professionals in their countries³.

- 3.6 The first objective of the programme is to "*foster European cooperation on Health Technology Assessment (HTA) and explore the potential of e-Health and ICT for Health*". European frameworks need to be established to protect confidential data in cases of cross-border exchange (e.g. patient files or prescriptions).
- 3.7 The second objective of the programme is "*to increase access to medical expertise and information for specific conditions also beyond national borders and to develop shared solutions and guidelines to improve healthcare quality and patient safety in order to increase access to better and safer healthcare for EU citizens*". Heavily used public healthcare websites disseminate medical information and contribute to health education. For minor ailments consulting these sites can make a visit to the doctor unnecessary. By providing information on the benefits of traditional medicine as well as on complementary therapies like herbal remedies, thermal cures, massage etc, these sites help people to remain in good health. Helping people to better understand themselves and their psychological and physiological needs helps to keep the population healthy and limit overconsumption of care and medicines. Exchanges should be organised and European frameworks established to ensure the accuracy of information made available to the general public (accreditation) in order to prevent a proliferation of sites interested only in profit and exploiting the credulity of the sick.
- 3.8 The exchange of best practice should be encouraged on the mechanisms introduced in specific regions in order to improve access to care and to enable doctors and qualified healthcare professionals to remain in or move to rural or economically deprived areas, and on the planning of health systems and policies and personal services.
- 3.9 The third objective is "*to identify, disseminate and promote the up-take of validated best practices for cost-effective prevention measures by addressing the key risk factors, namely smoking, abuse of alcohol and obesity, as well as HIV/AIDS*". A programme which places great emphasis on innovation should also promote exchange of information on new risk factors which are just as important for the future.
- 3.10 New health problems and chronic illnesses are appearing which will pose major problems in the 21st century as a result of climate change, increased pollution, changing ways of life (sedentary lifestyles, time spent in front of a screen etc.) and the widespread use of chemical agents, the long-term health effects of which are unknown.

³ EESC opinion, OJ C 256, 27.10.2007, p. 123.

- 3.11 Between the end of the 19th century, when it was first used in industry and construction, and its prohibition at the end of the 20th century, asbestos killed tens of thousands of workers.
- 3.12 Agriculture uses pesticides and other chemical products, the damaging effects of which on the organism only come to light in the long term. Studies are being carried out into the incidence of cancers among farmers. These substances spread in the air, in water and in foodstuffs. The agrifood industry also uses additives to make foodstuffs keep longer and to modify their taste.
- 3.13 In addition to this there are domestic and workplace cleaning products, as well as numerous substances used in industry, and medicines. Over-consumption of medicines is already giving rise to antibiotic resistance. Antibiotics given to farm animals also find their way into the water supply. Other substances, gases, soot etc are spread in the air. Together, these substances form a "chemical soup", present in the environment, one of the consequences of which seems to be a rapid increase in allergies and cancers. Electromagnetic radiation is also a problem.
- 3.14 Another worrying question concerns the impact of exposure to products, radiation and changed lifestyles on human reproductive capacity. Although the causes of the falling birth rate are above all sociological, the increasing physiological difficulties encountered by many couples wishing to start a family should not be neglected.
- 3.15 Among the new risks, workplace stress is one of the causes of depression, sometimes even leading to suicide. Stress experienced by the unemployed, and more generally by all those who feel useless to society, also needs to be tackled. Mental health is an essential component of public health.
- 3.16 Ageing well requires lifelong preparation. Working conditions play a decisive role, and life expectancy is not the same for white-collar office workers, seconded workers or agricultural workers. Improving difficult working conditions, limiting night-time working and reducing stress levels are ways of preparing for a healthy old age.
- 3.17 In order to enjoy good health in old age, it is essential to continue to feel socially useful, to have a network of friends and intellectual curiosity, to continue working, either professionally or as a volunteer, to practise sport and to look after oneself.
- 3.18 Another subject, the end of life, ought to be discussed at European level, because it concerns every individual and is connected with the concept of personal dignity. Today the vast majority of people die in hospital, which makes the end of life an important issue.
- 3.19 It is essential to develop palliative care services to prevent suffering for the terminally ill for whom no treatment is possible. Services of this kind are not available in all hospitals or to all those who need them.

- 3.20 The fourth objective of the programme is "*to develop common approaches and demonstrate their value for better preparedness and coordination in health emergencies in order to protect citizens from cross-border health threats*". Epidemics know no frontiers and cooperation in this area is essential. Lessons should be learnt from the measures taken in order to prevent wastage in the future. A distinction should be drawn between preventive measures which involve education and can be made permanent, and those involving the purchase of products with a limited lifespan. Exchange of information on costs and results could make it possible to establish methods appropriate to the objectives.

Brussels, 23 February 2012

The President
of the
European Economic and Social Committee

Staffan Nilsson
