European Economic and Social Committee

SOC/140
Healthcare

Brussels, 16 July 2003

OPINION

of the European Economic and Social Committee

On

Healthcare

(Own-initiative opinion)

____

ADMINISTRATOR: **STEFANIA BARBESTA**

Rue Ravenstein 2, B-1000 Brussels. Tel. +32 (0)2 546 90 11 Fax +32 (0)2 513 48 93 Internet http://www.esc.eu.int

EN

On 21 January 2003, in accordance with Rule 29(2) of the Rules of Procedure, the Economic and Social Committee decided to draft an own-initiative opinion on:

Healthcare.

The Section for Employment, Social Affairs and Citizenship, responsible for preparing the Committee's work on the subject, adopted its opinion on 30 June 2003. The rapporteur was **Mr Bedossa.**

At its 401st plenary session of 16 and 17 July 2003 (meeting of 16 July 2003), the European Economic and Social Committee adopted this opinion by 61 votes in favour, 5 votes against and 6 abstentions.

1. Introduction

1.1 The Commission Communication of December 2001[1], the follow-up to the initiative approved at the Lisbon European Council of March 2000, and the initial report for the 2002 European Council boldly address one of the most difficult aspects, after pensions, involved in building a social Europe in accordance with the values enshrined in the Charter of Fundamental Rights.

1.1.1 Health is often defined as a fundamental asset for society. This is equally applicable to each individual citizen, family, and nation.

– Naturally, the approach taken by each individual differs, as does the approach taken by EU Member States, both in terms of organising healthcare and in terms of responsibility.

– However, the EU as a whole must tackle a series of challenges. A solid basis of understanding is needed to find common, appropriate responses to such challenges, whilst respecting existing diversity.

– The definition given by the World Health Organisation (WHO) states that health is a state of complete physical, mental and social well-being of each individual.

– Healthcare is not limited to treating pathologies, but must more generally encompass individual and collective efforts at prevention and promotion of aptitudes and conditions.

– Being a fundamental asset, health cannot be considered solely in terms of social expenditure and latent economic difficulties.

---

1 COM(2001) 723 final on the Future of healthcare and care for the elderly: guaranteeing accessibility, quality and financial viability.

It is an investment and represents a vital, efficient and constructive sector of the economy generating significant value added in societal development, as well as fostering growth.

1.1.2 Access without discrimination, quality and the financial viability of healthcare systems – especially those intended for the elderly and socially disadvantaged groups – present a series of challenges and problems common to all EU Member States, pre- and post-enlargement (a fortiori). Their responses to these have differed, but the principles of solidarity, equality and universality have been upheld by all of them.

1.1.3 It is true that the demand in Europe on healthcare systems and available services has continued to grow over the last two decades. Responding to this demand has always been a matter for each individual country, acting against an increasingly and at times overly sensitive political backdrop. Whilst the challenges to develop healthcare systems apply to all Member States, they will be even more pronounced in the candidate countries in 2004. Undoubtedly, the issues at stake are considerable for all Member States and, more importantly, have become inter-connected.

1.2 This draft opinion aims to achieve several objectives:

- to promote initiatives to boost knowledge, exchanges and comparison between the various European healthcare systems;

- to support the steps taken by the EU institutions, notably by the European Commission, to pursue specific, more effective initiatives in the field of healthcare;

- to encourage initiatives by EU socio-professional interest groups and to enhance their joint policies.

At all events, this draft opinion is intended to support and complement the action taken by the European Commission in its 2003-2008 public health programme.

1.3 Since the Treaty of Rome, the proportion of healthcare consumption expressed in terms of national wealth has risen at an annual average of 2.2% more than GNP in the developed countries as a whole, especially in the European Union, increasing from 4% of GDP in 1960 to over 8% of GDP today (Source: OECD, 2002), even if this rise appears to have slowed down recently.

1.3.1 However, it should be noted that whilst the rate of growth of the health expenditure/GNP ratio has slowed down, the budget for this sector remains high and continues to rise. Public opinion has forced an examination into whether this continuous growth tallies with actual results for consumers, i.e. whether it translates into the benefits of better public and individual health that they expect. The continued increase in spending is nowhere accompanied by a reduction in inequalities, especially socio-occupational, with respect to quality of life and life expectancy. The objective of reducing these inequalities should become the main indicator for healthcare policies in Europe and the stimulus for the changes in strategy that it will require.

1.4 At present, there are many key factors determining health, which vary between the Member States.

Approximately ten essential factors exert a decisive influence on policy:

1.4.1 **Demographic effects**

1.4.1.1 Age and the ageing population inevitably impact on health expenditure.

1.4.1.2 Many recent studies carried out in seven industrialised countries appear to confirm that, over the last decade, demographics have had an impact on the trend in spending equivalent to 1% in volume terms. This rise is due to in equal measure to the overall increase in population and ageing.

1.4.1.3 Therefore, although the breakdown of this impact differs between countries, its influence is clear. However, traditional demographic values should not be the only aspects to be taken into account.

1.4.1.4 Consideration should be given to factors such as that dubbed the "generation effect" by experts, whereby recent generations of healthcare users are accustomed to higher levels of healthcare provision than previous generations who did not always have access to healthcare equivalent to that on offer today.

1.4.1.5 It is quite conceivable that these factors may lead to a multiplier effect on healthcare expenditure occurring as these generations get older if people begin life with proper access to healthcare and continue to benefit from it throughout their active life .

1.4.2 **Perceptions of healthcare**

1.4.2.1 Different attitudes to health exert a considerable influence on the expectations and behaviour of healthcare users. Health is perceived as an absolute good, a citizen’s right which the relevant authorities must safeguard, and this entails a rise in costs to meet these expectations, and the risk of losing political consensus whenever it is planned to reduce the scope of free or almost free healthcare for budgetary reasons.

1.4.3 **Epidemiology**

1.4.3.1 Healthcare is currently facing new challenges associated in part with new pandemics of certain contagious diseases and new manifestations of known illnesses that are no less difficult to treat. The impact of these on costs and healthcare organisation is not easy to quantify.

1.4.4 **Economic growth**

1.4.4.1 Several studies have demonstrated the link between economic growth and healthcare expenditure, i.e. the disproportionate increase in healthcare expenditure that accompanies rising income levels. This correlation at macroeconomic level is not matched where cyclical trends are concerned: there has not been a significant decrease in healthcare expenditure, even at times of economic slowdown.

1.4.4.2 This shows a degree of disassociation between demand for healthcare provision and the state of the economy. It contributes to the difficulties in reducing health spending encountered by countries that are seeking to place greater responsibility on the medical profession and consumers.

1.4.5 **Social organisation**

1.4.5.1 Changing lifestyles, the organisation of family life, changes in the workplace and the increase in precarious employment are drastically changing the shape of traditional healthcare systems.

1.4.5.2 Thus, there has been a growing trend to treat social problems as medical problems. Whilst the approach to this factor is complex and necessitates further examination, it should not be overlooked, especially since European society is increasingly demanding the use of the precautionary principle. All types of social insecurity (unemployment, precarious situations, stress, discrimination, pollution etc.) increasingly affect the state of health and healthcare spending, and create a growing demand to apply the precautionary principle.

1.4.6 **Environmental and dietary needs**

1.4.6.1 The key role played by the environment, in the broadest sense of the term, on health expenditure is no longer questioned.

1.4.6.2 However, it is already clear from a Europe-wide study carried out as part of the programme on atmospheric pollution and health that even a very modest reduction in atmospheric pollution levels has a beneficial effect upon public health and justifies implementing preventive measures.

1.4.6.3 Similarly, the effects of consuming high-risk products, such as tobacco, drugs and alcohol, must be taken into account.

1.4.6.4 The quality of food is a crucial factor – poor eating habits are at the root of a series of processes that lead to increased sickness and even mortality rates; they are for instance the prime cause of death from cancer. This is of particular concern since it affects the whole population, especially young people (obesity).

1.4.7 **Technical progress**

1.4.7.1 Technical progress is an ambivalent factor, as it can have positive or negative effects on healthcare expenditure. Nonetheless, technical progress is an inescapable fact.

1.4.7.2 It should be noted that new treatments often highlight ailments which were previously "unheard of" because no treatment was available.

1.4.7.3 This phenomenon occurs especially with innovations, whether in drugs or examination techniques.

1.4.7.4 Of course, it is important to ensure that new diagnostic or treatment techniques do not duplicate old techniques.

1.4.7.5 Therefore the use of appropriate techniques and replacement of old techniques should be encouraged, whilst noting that this is often hindered by socio-cultural considerations, sometimes generated by restrictive behaviour on the part of the healthcare profession.

1.4.7.6 Radiology techniques can be taken as an example. At present, traditional radiography is still used alongside scans, MRI (magnetic resonance imaging) and, most recently, PET (position emission tomography).

1.4.8 **Socio-cultural behaviour patterns**

1.4.8.1 Socio-cultural behaviour patterns have a considerable influence on healthcare expenditure.

1.4.8.2 Collective and individual actions in this domain mostly concern primary prevention.

1.4.8.3 The results, while undoubtedly leaving room for improvement, have been much better in recent years, in line with progress in evaluation procedures.

1.4.8.4 Besides smoking, drugs, excessive alcohol consumption and excess weight, traffic accidents, domestic accidents and suicide among young people are significant factors, as are accidents at work and employment-related diseases.

1.4.8.5 Such behaviour patterns are linked to a combination of individual, family and social factors. They often cause a degree of premature mortality and therefore are particularly important to identify so that strategies can be adopted to eliminate risk factors and costs that can easily be avoided.

1.4.8.6 Education and prevention are essential areas for investment. If work in these areas is conducted with the full involvement of target groups, especially the most sensitive groups and the groups most exposed to risks, the benefits in economic and health terms are proven.

1.4.9 **Healthcare supply and demand**

1.4.9.1 These are undoubtedly influential factors, but their impact varies between Member States.

1.4.9.2 Moreover, whilst the demand for healthcare continues to grow, it does not always represent objective need and is influenced by the quality and quantity of healthcare supply.

1.4.10 **The impact of social welfare**

1.4.10.1 The increasing demand for social and medical cover puts constant pressure on social welfare systems. This factor, closely linked with the previous one is concerned more with healthcare demand, which it more or less meets, than healthcare supply.

1.4.10.2 Each Member State organises its welfare system according to its own criteria.

1.4.10.3 The increase in internal EU travel raises questions which require in-depth knowledge of each welfare system and which, like it or not, inevitably lead to comparisons.

1.4.10.4 Many questions have arisen as a result of the free movement of patients. First we need to know what the present situation is and how it might evolve.

2. **General comments**

2.1 On the basis of the points raised in the previous section, the European Economic and Social Committee calls for an urgent and serious debate on the various aspects of healthcare policy. It considers that the need to boost knowledge and find common aims in this field should supplement the debate on the European Convention and take into account the enlargement of the Union.

2.2 The Committee is in favour of an ambitious and necessary work programme on the following broad-based topics:

– assessment of the impact of various factors on health;
– health in the candidate countries;
– inequalities in access to healthcare;
– ageing and health;
– promoting good practices and efficiency in the health sector.

To this end, the Committee supports the approach taken by the European Commission.

2.3 The topics raised by the Commission and the public health programme are of particular interest for the forthcoming debates on inter-sectoral policy, patient mobility and the future of healthcare for the elderly.

2.4 The Committee notes that a comparative analysis of healthcare systems involves complex strategic considerations, such as the issue of ageing. In all Member States, this issue is tackled according to family structure, the mobility of elderly persons, the typology of medical consumption and the increased costs of technology.

2.5 Safeguards must be put in place to ensure the quality of healthcare systems, their universal accessibility as far as possible and their financial sustainability.

2.6 The Committee also considers that all policy areas are affected, especially economic and social policies, where particular attention must focus on the link between health and employability as well as age and pensions, and that expectations are not always met.

These expectations are threefold: the support of a well informed organised civil society, the principle of solidarity – an essential European value – and an intelligent and effective prevention policy.

2.7 Coordination of healthcare policies like pension and retirement policies raises several questions:

– definition of healthcare system;
– the role and importance of supplementary healthcare schemes;
– the need to differentiate between care, health and comfort.

2.8 The Committee also lists the following reasons:

– Some people feel that the issue of healthcare, which involves services of general interest, inevitably entails a debate on whether healthcare should be defined as a "service of general interest" and to identify the practical consequences of this.

– Healthcare provision requires trained staff with high qualifications. The importance of care work, especially for the elderly, necessitates the introduction of life-long training programmes.

– The financial viability of such healthcare policies is an issue that inevitably means expanding the scope of the debate, on an ongoing or regular basis, over the coming years, particularly on resource allocation and provision.

2.9 Each country experiences these issues in different ways, according to their social, cultural and political traditions. Recognising that these differences exist does not detract from the

scale of the challenge faced by all Member States and the need to find common approaches involving exchanges, knowledge and solutions.

3. **Challenges and problems**

It is worth stressing the importance of the subject - "Healthcare and care for the elderly; supporting national strategies for ensuring a high level of social protection".

It is clearly very topical and therefore merits strategic discussion by EU institutions.

3.1 The case for engaging in such discussion now is supported by several strategic needs:

– The recurring difficulties faced by national public authorities in reducing inequalities in healthcare between the different population groups and in coping with health expenditure, whatever the nature, organisation or operation of healthcare systems.

– The lack of any actual Community competence as regards the social security systems (except for coordination regulations 1408/71 and follow-ups) and healthcare policies conducted in each Member State does not mean that the Community should remain indifferent to conceptual and policy debate on these issues, bearing in mind the abovementioned comments.

– The prospect of enlargement in 2004 to take in 10 new Member States should encourage the 15 existing members to further analyse and monitor healthcare problems.

– The development of EC Court of Justice case law has over time encouraged wider access to healthcare under supra-national criteria.

– The increase in the free movement of people, patients and professionals due to economic development and the increasing integration of national markets into the European Single Market also justifies this discussion.

3.2 New Article 137 of the EC Treaty (Treaty of Nice) only authorises EU bodies to adopt Community directives setting minimum requirements in the field of health and social protection, and requires unanimity.

In the face of the crucial issues which health problems raise for the European Union, its cohesion and its ability to become the most competitive knowledge-based economy in the world, it is the role of the European Economic and Social Committee to promote increased awareness of these issues.

3.2.1 Concerning the problem of the free movement of patients, CoJ case law has made significant progress over time in paving the way for practical implementation of the right of free movement of patients and the sick based on the fundamental freedoms listed in the Community

Treaties, and overcoming the major differences between national healthcare and health-insurance systems.

3.2.2 This rationale is illustrated by the fact that more than three years ago, the European Community launched a review of EC Regulation 1408/71 (Article 22) with a view to including health in Articles 49 and 50 of the EC Treaty on the freedom to provide services.

3.2.3 Another example of this new state of affairs is the recent judgement of the EC CoJ (case C-326/00 IKA v. Vasileios Ionnidis). This concerned a Member State's duty to pay the medical expenses of a pensioner visiting another Member State, without payment being made subject to authorisation and conditions. The reasons adduced for this judgement are clear: a patient suffering from even a chronic illness must be able to receive care whilst visiting another Member State.

3.3 Mobility applies not only to patients but also to health professionals. As healthcare systems develop, there is the threat of a shortfall of medical and paramedical health professionals.

3.3.1 This threat is growing. Some Member States manage to maintain healthcare provision by relying increasingly on professionals (doctors, nurses) from countries where there is still a surplus of such labour.

3.3.2 Current developments suggest that the balance is precarious and that a crisis is looming in the present EU as regards the number of healthcare professionals.

So far, the question of how things will stand in this respect in an enlarged 25-member Europe has hardly been touched upon.

3.4 Against this backdrop, there is an urgent need for a concerted and organised strategy to examine and pre-empt the problems and to promote the mobility of such professionals without destabilising the national systems of the new Member States.

However, under no circumstances will it be possible to make up for the anticipated shortage of qualified healthcare staff just by promoting cross-border mobility. In order to meet labour demand in the health sector on a sustainable basis, flanking measures are needed to make the caring professions more attractive and to make it possible for people to stay in such professions, including job quality, training and promoting the interchangeability of career paths.

3.4.1 There is a risk that EU enlargement may lead to healthcare problems if certain Member States do not treat developing their healthcare systems as a national priority.

3.4.2 There is also a risk that social and healthcare guarantees will be eroded. This could lead to an exodus of professionals and patients to those Member States with the best organised healthcare systems. Examples of this abound; without standing in the way of the principle of free movement, Member States with the least developed or efficient healthcare systems should make the

budgetary, organisational and qualitative commitments needed to ensure that their national health policy meets the general standards set by the rest of the Community.

3.5 Faced with such challenges, public authorities and healthcare managers seem overcome by the enormous complexity of the issues at stake and the financial pressures.

3.5.1 No EU country can claim that it has resolved these problems. All Member States must pursue the common aim of defining a method of managing and assessing healthcare needs based on consistent principles making use of flexible methodologies.

3.5.2 It is an irreversible fact that the population is ageing. According to experts, it accounts for an unavoidable annual rise in health expenditure of between 0.7 and 1.5% depending upon national situations and the provisions for healthcare for the elderly. Specific policies must be formed to tackle the risk of sections of the population becoming incapacitated and dependent.

3.6 The consumption of medical products and services will gradually increase placing an ever-greater financial burden on aggregate costs.

This is why future healthcare reforms must focus on prevention, promoting good health and developing community medicine.

3.6.1 In view of these complex and costly organisational and economic problems, efforts must focus on a more rational use of resources and on new approaches to healthcare. Multifunctional and coordinated local services must be promoted in all regions. A culture of coordination between healthcare players and operators is essential. Home care (nursing care, geriatrics, home hospitals) should also be one of the priorities.

3.6.2 Traditional hospital structures must be reformed. A graded spectrum of services should be promoted, ranging from general hospitals to more specialised care. To this end, inter-regional and cross-border cooperation are essential. Pilot schemes are already underway and should be encouraged.

3.6.3 Lastly, skills and professions are another aspect in the development of healthcare systems. A rationalisation of medical disciplines and an assessment of paramedical professions must take place before new medical specialities can be recognised.

3.7 Concerning the problem of the financial viability of healthcare systems, it should be noted that there continue to be significant differences in the design, quantity and quality of systems.

3.7.1 Framing and applying the concept of a guaranteed core of medical goods and care is gradually becoming a reality in the policies of EU Member States.

3.7.2 As a result, a European approach could be promoted to identify the services, healthcare products and standard treatments linked to the main known illnesses with a view to forming assessments and mutual recognition. This would be a way of prioritising public funding and making healthcare systems more effective.

3.7.2.1 The need to guarantee broad access to healthcare for all citizens, a core of rights and services implies going beyond a simple reform of the minimum standards currently referred to by European legislation. It has implications for the credibility of the development of the EU, its enlargement and the stability of national systems.

3.7.3 This method of assessment for healthcare provision would be compatible with the principle of solidarity and would demand a greater degree of direct responsibility of professionals and patients.

3.7.4 Concerning lower priority forms of care which are not matters for public health policy, there has been a rise in supplementary insurance schemes[2].

3.8 We believe that the European Economic and Social Committee should recommend establishing a method of observation, analysis and exchange on national health policies in view of the multitude of challenges that healthcare systems face. This approach fully respects the fundamental principles laid down in the Treaties, in particular the principles of subsidiarity and national competence. This would supplement the initiative recently unveiled by the European Commission.

3.9 Benchmarking could be a valid approach to improving the quality of healthcare. The majority of reforms carried out within the EU reveal the concern of public authorities and managers to boost efficiency in hospitals and to set up procedures to accredit and certify the quality of care.

3.9.1 This approach transcends the conceptual and organisational differences in national healthcare systems.

3.9.2 The use of Community tools for labelling, measures to improve quality and the promotion of innovative technology and treatments on the basis of medico-economic criteria could be encouraged.

3.9.3 Equally, the Union must be able to ensure its citizens have access to centres of health and hospital excellence, which are not simply the privilege of the richer nations.

4. **Political responsibilities**

4.1 Although the organisation and funding of healthcare systems are a matter for the domestic policies of Member States, three issues are apparent at EU level:

---

2 See EESC Opinion on supplementary health insurance, rapporteur **Mr Bloch-Laine**, OJ C 204 of 18.7.2000

4.2 Article 152 of the EC Treaty on public health ensures a high level of public health protection. However, despite the fact that this Article concerns public health and in particular all questions of prevention, it is weak in policy terms.

4.3 Although the internal market rules oblige national policies to respect internal rules, there are restrictions, often justified, in those Member States that have not yet recognised the free movement of people, goods and services in this domain.

4.4 The viability of public finances and the impact of healthcare expenditure on national public spending are covered in the stability and convergence pact.

5. EESC proposals

5.1 With due regard for the respective competences of the Member States and of the EU, the problems raised and the contributions made by numerous players, the European Economic and Social Committee proposes a series of measures which are the result of using the Open Method of Coordination, detailing the objectives and principles in an approach to healthcare and long-term care for the elderly:

5.1.1 Ongoing exchange of information and keeping tables of the activities, objectives and principles of all the EU Member States.

5.1.2 A strong and sustained employment policy: medical professionals are unevenly distributed, therefore initiatives must be taken at local and national level to boost supply without waiting for demand. In particular there is an urgent need to complete the final draft of the directive on the mutual recognition of diplomas and skills.

5.1.3 General promotion of healthcare quality indicators: good practices in techniques, staff certification and accreditation of facilities.

5.1.4 Support for a general information and communication policy on existing systems, available facilities and the policies currently pursued.

5.1.5 Establishing a European health insurance card to ensure free movement and promote awareness of established rights, aimed in particular at disadvantaged persons and the elderly (see the Commission Communication concerning the introduction of a European health insurance card – COM(2003) 73 final).

5.2 In this case, the Open Method of Coordination is not yet provided for in the field of healthcare.

5.2.1 It must be put in place as a matter of urgency, and could have the following objectives:

- to modernise national systems by developing a quality healthcare programme;
- to improve cooperation between Member States.

Cooperation must enable **common objectives** to be identified, if possible for healthcare and care for the elderly. These objectives could then form part of national action plans, and regular updates could be produced.

5.2.2 In this context, relevant indicators should be selected to assess policies. The challenges posed in 2001 – accessibility, quality and financial viability – must take into account demographic forecasts, the increase in the number of the elderly and the progressive reduction in working time.

5.2.3 If the Open Method of Coordination is well organised, it should respond to the impact of Community legislation on national health insurance systems, and in particular take into account new advances in case-law which may be handed down by the European Court of Justice on a day-to-day basis with regard to pending cases.

5.2.4 The Open Method of Coordination will have to provide answers to the following questions:

a) How to proceed in this process in the field of health insurance?

b) Is it feasible to set up an exchange of good practices in accreditations, evaluations or prescriptions, defining quality standards, defining the conditions for truly equivalent skills and mutual recognition of practices?

c) Concerning cost reduction, what benefits could be reaped from exchanging good practices, given the diversity of national systems?

d) What progress has been made on identifying a quality indicator for structures and practices?

e) How can policies governing the provision of healthcare products be improved, giving greater emphasis to the need for innovation, preventing wastage and the need to give developing countries access to vital products to combat diseases such as AIDS (see future WTO discussions and implementation of the Doha Agreements)?

f) Coordination of national provisions governing cross-border trade in medicinal products must not lead to a reduction in standards of distribution and advice in the individual Member States.

5.3 In order to establish this Open Method of Coordination, to make it visible and credible and to give it a solid basis, the Committee considers it essential to set up a simple, flexible, efficient structure responsible for a series of priority actions as set out in this opinion.

6. **Conclusion**

The European Economic and Social Committee intends to make healthcare issues an area for action, whilst respecting the existing Community political and legal framework. The Committee feels there is a need to develop tools at European level which draw on the collective European intelligence beyond discussions on the future of national social security systems. The Committee perceives a need for political will to promote awareness of the realities of healthcare and to foster excellence in innovative practice in the medical and social domain. This is why it proposes creating effective bodies to guarantee EU citizens the fundamental right of access to better health for all.

Brussels, 16 July 2003.

The President of the European Economic and Social Committee	The Secretary-General of the European Economic and Social Committee
Roger Briesch	**Patrick Venturini**

____