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**COMMUNICATION FROM THE COMMISSION TO THE COUNCIL, THE
EUROPEAN PARLIAMENT, THE EUROPEAN ECONOMIC AND SOCIAL
COMMITTEE AND THE COMMITTEE OF THE REGIONS**

**Modernising social protection for the development of high-quality, accessible and
sustainable health care and long-term care: support for the national strategies using the
“open method of coordination”**

1. INTRODUCTION

The social protection systems created in the Member States aim to ensure access for all to quality care. Their development has considerably reduced the risk of poverty, which, in the past, was often linked to ill health, old age or accident, and has made a significant contribution to improving the state of health of the people of Europe over recent decades¹. They are therefore an important part of the European social model, and the quality of care provided in Europe is almost unrivalled in the world.

The aim of this Communication, announced in the *Spring Report 2004*², is to define a common framework to support Member States in the reform and development of health care and long-term care, borne by the social protection system, using the “open method of coordination”. The Resolution adopted by the European Parliament on 11 March calls for greater cooperation on health and long-term care and calls on the Commission to present relevant proposals in the spring of 2004, allowing the Council to apply the “open method of coordination” in this field and to adopt common objectives.

This Communication is thus a complement to the one concerning the proposals of the “High-level process of reflection on patient mobility and healthcare developments in the European Union” (hereinafter known as the “Communication on patient mobility”), launched at the initiative of Commissioners David Byrne and Anna Diamantopoulou and involving representatives of the health ministries and the Commission³. These two Communications, adopted together by the Commission, thus present an overall strategy for developing a shared vision for the European health care and social protection systems.

Social protection is a way of distributing, at the level of an entire society, costs which often exceed the means of an individual or his/her family, ensuring that paying for healthcare does not lead to impoverishment and that even those on a low income have reasonable access to care. These results have been achieved using a wide range of systems – based on insurance or the direct provision of services – the prime responsibility for which, under the Treaty, falls to the Member States. The importance of this responsibility and the need for better cooperation at European level were emphasised in the conclusions of the “High-level process of reflection”.

The role of health systems in combating the risk of poverty and disease, their contribution to social cohesion and employment and the consequences of demographic ageing have been acknowledged for some considerable time by the Union. As early as 1992, a Council Recommendation⁴ called on the Member States to “*to maintain and, where necessary, develop a high-quality health-care system geared to the evolving needs of the population, and especially those arising from dependence of the elderly, to the development of pathologies and therapies and the*

¹ For example, between 1960 and 2001, life expectancy for men rose by 8.1 years and for women by 8.7 years.

² COM (2004) 29 final – “*Delivering Lisbon: Reforms for the enlarged Union*”

³ The conclusions of the HLPB are available at:
http://europa.eu.int/comm/health/ph_overview/Documents/key01_mobility_en.pdf

⁴ Council Recommendation of 27 July 1992 on the convergence of social protection objectives and policies (92/442/EEC), Official Journal L 245 , 26/08/1992, p. 0049 - 0052.

need to step up prevention". In 1999, health care was identified by the Council as one of the four fields of social protection⁵ where closer cooperation between the Member States was needed.

Following the Lisbon and Gothenburg European Councils, which highlighted the need to reform and adapt social protection systems, including health care, in order to meet the challenge of demographic ageing and ensure social cohesion, the Commission identified three principles⁶ that could serve as a basis for this reform. These principles were approved by the Barcelona European Council in March 2002⁷:

- **Accessibility of care** for all, based on fairness and solidarity, taking into account the needs and difficulties of the most disadvantaged groups and individuals, as well as those requiring costly, long-term care;
- **High-quality care** for the population, which keeps up with medical advances and the emerging needs associated with ageing and is based on an assessment of their health benefits;
- Measures to ensure the long-term **financial sustainability** of this care and aiming to make the system as efficient as possible.

2. **ACCESSIBILITY, QUALITY, FINANCIAL SUSTAINABILITY: A CHALLENGE FOR HEALTH CARE SYSTEMS, A KEY TO THE SUCCESS OF THE LISBON STRATEGY**

The joint report of the Commission and of the Council "*Supporting national strategies for the future of health care and care for the elderly*" of 10 March 2003 emphasised that technological and treatment innovations, improved wellbeing and patient information, and demographic ageing are raising new problems in terms of the capacity of the national systems to ensure accessibility and high quality and to guarantee their financial sustainability over the long term. Certain problems are common to all the systems: inequalities and ongoing access difficulties, despite the universal access guaranteed in principle; insufficient provision of quality services compared to the needs of the population in some cases, with excessive waiting times; and widening financial imbalances in certain systems.

The new Member States are set to add to this diversity and accentuate current trends in EU-15. Their main health indicators tend to be worse than in EU-15, particularly for men, and they spend significantly less on their health care systems, despite constant growth since the early 1990s. Moreover, the ageing of the health care professions is more marked there than in EU-15. The Lisbon Strategy is therefore a coherent framework for catching up in terms of the level and quality of care, and is supported by a range of instruments, including the "open method of coordination".

⁵ In 2000, health accounted for 27.3% of all social protection expenditure in EU-15, the second largest item after retirement and survivors' pensions (*Source: statistical annex to the draft Joint report on social inclusion 2003*, SEC (2003) 1425).

⁶ COM (2001) 723 final

⁷ §25: "The European Council takes note of the initial Council report on health care and care for the elderly, and invites the Commission and the Council to examine more thoroughly the questions of accessibility, quality and financial sustainability in time for the spring 2003 European Council."

At the same time, European integration entails growing interaction between care systems:

- Health care services have been recognised by the Court of Justice as services within the meaning of the Treaty, and patients, as the recipients of these services, must be able to benefit from the free provision of services that the Treaty guarantees⁸. The updated version of Regulation 1408/71⁹ includes this dimension, and its application is specified in a proposal for a directive presented on 13 January 2004 on services in the internal market, which includes a definition of hospital services¹⁰;
- The citizens of the Union are making increasing use of their right of free movement¹¹ to go and live in another Member State, to move there temporarily or to seek health care there.

This interaction has been accompanied by the development of policies at EU level with an impact on health care systems and, more generally, on the health of Europeans. However, these trends have never been the subject of a global strategy tackling the development and modernisation of the supply and funding of care, patient and health worker mobility in an enlarged Union, cooperation between health care regions and systems, as well as the mainstreaming of the main objective — providing a high level of human health protection — in all Community policies. The “*Spring Report 2004*” therefore calls for the coordination of national policies to be stepped up in order to support the modernisation and development efforts in the sector undertaken by all the Member States, both the current and the new ones. A **global strategy for health care systems** is therefore being proposed now in two Commission communications:

- This Communication proposes common objectives for the development and modernisation of health care provision and funding, which would allow Member States to define their own national strategy and benefit from the experiences and good practices of the other Member States. This coordination of national policies would complement the other three main areas of social protection – pensions, inclusion and “*Making work pay*” — which have been coordinated more closely since 2000.
- A second Communication follows up the recommendations adopted by the “High-level process of reflection”. It presents a set of concrete proposals covering many different areas and providing for the mainstreaming of the objective of providing a high level of human health protection, as stated in the Treaty, in Community policies.

⁸ See *Report on the application of internal market rules in the field of health care services and implementation by the Member States of the Court’s jurisprudence* (SEC (2003) 900).

⁹ Proposal for a Council Regulation (EC) on coordination of social security systems (COM (1998) 779 final); Amended proposal for a Regulation of the European Parliament and of the Council on coordination of social security systems (COM (2003) 596 final); Communication from the Commission to the European Parliament pursuant to the second subparagraph of Article 251(2) of the EC Treaty concerning the common position of the Council on the adoption of a Regulation of the European Parliament and of the Council on the coordination of social security systems (COM (2004) 44 final)

¹⁰ COM (2004) 2 final

¹¹ *Commission’s Action Plan for skills and mobility*, COM (2002) 72 final.

The provision and funding of health and long-term care are key elements of the economic and social modernisation strategy launched in Lisbon in March 2000 for three complementary reasons.

Social cohesion is reinforced by access to quality care based on the principles of universal access, fairness and solidarity. Improving access to care is acknowledged to be a way of mobilising the potential of the EU's workforce in the context of a shrinking active population. Recent studies¹² show that care policy should be seen as an active employment policy tool, as it increases the social and occupational integration prospects of jobseekers. However, the draft *Joint report on social inclusion*¹³ shows that the most disadvantaged groups have more, and more serious, health problems: for example, 16% of those in the bottom income quintile say that they are in poor health, compared to 7% in the top quintile¹⁴. These people often find it more difficult to have access to care, because of long waiting times, high treatment costs in relation to their income, complex administrative procedures and, more generally, insufficient prevention (screening, vaccination).

Secondly, in 2002, health and long-term care¹⁵ represented around 10% of **total employment** in the Union of 15, and between 4.1 and 7.1% in the new Member States. With 1.7 million new jobs created between 1997 and 2002 in EU-15, it is the second largest creator of jobs. To meet the challenges posed by demographic trends and technological progress, it is vital to have a sufficient number of trained professionals and to give them quality jobs. The ageing of the workforce will make itself felt here in particular. In 2002, in EU-15 and EU-25, 11% of the workforce in this sector was aged between 55 and 64, and the proportion was even higher for doctors¹⁶. Above all, a large proportion of workers in this sector (27%, in both EU-15 and EU-25) are in the age range 45 to 54, which could lead to a demographic time bomb in the years to come. These people will retire at a time of general ageing of the population, which means that the health and social services sectors will have to compete with other sectors to recruit new staff.

Improving the quality of jobs will thus be essential to ward off early retirement, in particular of those people with the hardest and most stressful jobs and those aged older than 55, as well as to promote recruitment. Improving the productivity and effectiveness of care providers will also be a key element in the sustainable development of this sector. "E-health", the development of which is promoted by the Plan of action *eEurope 2005*¹⁷, has an essential role to play here, in informing, preventing and improving care provision and in the lifelong training of health care professionals¹⁸.

¹² Brenner, H., "*Unemployment and public health*" – Final report ordered by the European Commission, May 2002

¹³ COM (2003) 773 final

¹⁴ In 2000. Source: *Joint indicators of poverty and social exclusion*, Eurostat, ECHP UDB, December 2002 version.

¹⁵ See *Emploi en Europe 2003*, page 37. The labour force survey includes health care, all 'social' services, including child care, and veterinary services.

¹⁶ In 2001, it ranged from 11.7 % in the UK to 21.7 % in the Czech Republic and 33.2% in Denmark, for example. See also the Commission report on the social situation in 2003.

¹⁷ Commission Communication "*eEurope 2005: an information society for all*", COM (2002) 263 final.

¹⁸ See the Commission Communication "*e-health – improving the health care provided to European citizens: a plan of action for a European e-health area*", COM (2004) XXX

Demographic ageing will have two other effects on the health care and elderly care sector: the increase in the number of people older than 65 years (+ 64% between 2002 and 2050, according to the Eurostat base scenario) and in the number of those aged older than 80 (from 14.8 million to 37.9 million between the same dates). These trends, which testify to improvements in Europeans' state of health, will also mean more age-related illnesses and more people in long-term care. The ageing of the population is accompanied by a growing number of old people living alone, because of greater family mobility, and a higher female employment participation rate, even though women perform the lion's share of informal care work. The response to the needs of this population group will include developing a wide range of services, including care at home, which will be chosen by ever more people, and specialised institutions, as well as closer coordination between care providers often working in isolation (intensive care, primary care and social services).

The social protection systems need to be reformed in an integrated and coordinated way to meet these challenges. The Commission Communication *Strengthening the social dimension of the Lisbon strategy: Streamlining open coordination in the field of social protection*¹⁹ showed that health and elderly care is one of the areas where coordination in the field of social protection should be streamlined. This streamlining will contribute to strengthening the political messages in favour of the modernisation of these systems and to ensuring that they are in line with the other coordination processes under the "Lisbon Strategy".

The results will be:

- Greater consistency with existing social protection processes (pension reform, social inclusion), with which many areas of common interest exist²⁰. As part of the streamlining of these processes, one important task will be to identify issues which could constitute general objectives for all the branches of social protection, such as issues relating to gender, the role of health care in active ageing or the role of social protection systems in employment promotion measures.
- Closer coordination with other political processes, including the European Employment Strategy, in particular with regard to the challenges of the ageing workforce in these sectors, and the broad economic policy guidelines. As a result of the streamlining, issues of health and long-term care should be better reflected in the Lisbon Strategy, in line with their importance to citizens. As provided for in the Spring Report 2004, the Commission will be examining, by 2005, the arrangements for incorporating public health in the Lisbon Strategy, and its contribution to growth and sustainable development.
- In this context, the "open method of coordination" will be a flexible tool, respecting the diversity of the national situations and competences and therefore particularly well adapted to the specific features of health care systems in all the branches of social protection.

¹⁹ COM (2003) 261 final

²⁰ For example, accessibility of care is an important theme of social inclusion policy (see the draft joint report 2003, op. cit.); ageing has an impact on the social and financial sustainability of pension schemes.

- The joint objectives, one pillar of which relates to health care, will offer an overall policy framework for the reforms, making them more transparent and highlighting the issues common to care systems.
- The open method of coordination will contribute to involving the many actors in this sector, particularly the social partners, the health care professions and patient representatives, whose role is becoming ever more important.
- Exchanges of experience will improve the various actors' knowledge of the possible reforms. Joint indicators will support these exchanges.
- Finally, the "open method of coordination" will favour a comprehensive, integrated approach to the problems found today in the different systems, by establishing a close link with the various instruments and policies associated with the field.

3. JOINT OBJECTIVES FOR DEVELOPING CARE SYSTEMS

The lower risk of ill health-, accident- or old age-related poverty and the significant improvement in Europeans' state of health are valuable achievements of Europe's social protection systems. They must continue to provide high-quality care based on the principles of universal access – i.e. covering all the population – and solidarity – i.e. based on collective contributions, not on individual wealth – and which is financially sustainable. Accessibility, quality and financial sustainability are therefore **all important and mutually dependent**. Moreover, a key to the development and reform of the systems is their ability to implement **effective governance based on involving and giving responsibility to the players concerned – including the social partners, regional and local authorities, patients and civil society – and coordinating care providers, financial organisations, NGOs and the public authorities**. At European level, it would be desirable for the sectoral social partners to make a tangible contribution to the reform efforts.

On the basis of the guidelines approved in March 2002 by the Barcelona European Council and the Joint Report adopted by the Commission and the Council in March 2003, the Commission is therefore proposing the following joint objectives to support the development of these systems in the enlarged Union.

3.1. Ensuring access to care: universal access, fairness, solidarity

One real success of European care systems has been to make high-quality care accessible to all. They must continue to provide a safety net against ill health-, accident- or old age-related poverty, for both the beneficiaries of care and their families. Universal coverage must be based on solidarity, according to the structure of each system, benefiting in particular those on low incomes and those whose state of health requires intensive, long or expensive care, including palliative and end-of-life care. However, access difficulties still exist for certain groups and individuals, compromising their social and occupational integration ability. Moreover, inequalities in the regional distribution of care facilities or inadequate supply compared to need can lead to abnormally long waiting lists. Staff recruitment and management difficulties can cause similar problems. Care systems must therefore

develop a care package which is sufficient and well adapted to the needs of the population.

Objectives:

Ensuring access to high-quality care based on the principles of universal access, fairness and solidarity.

Providing a safety net against poverty or social exclusion associated with ill health, accident, disability or old age, for both the beneficiaries of care and their families.

In particular, and in accordance with the specific nature of their own system, the Member States agree to:

- offer all the population high-quality care adapted to their needs. Particular attention will have to be paid to persons requiring long-term or expensive care, to those with particular difficulties accessing care – such as ethnic minorities and migrants – and those on low incomes;
- ensure the financial and physical accessibility of care systems for disabled persons;
- offer specific care for elderly people, based in particular on closer coordination between the social services, primary carers, hospital services and specialised institutions;
- promote palliative and end-of-life care;
- reduce, where necessary, regional inequalities in the provision of care;
- develop, where necessary, suitable structures with trained staff to increase the supply of care and cut waiting lists, in particular where these waits are at the expense of patients' health and quality of life. Support could be provided for the development of infrastructure, particularly hospitals, under economic and social cohesion policy: the bodies responsible for the Structural Funds, in particular the ERDF and the Cohesion Fund, should look at how this support can be fully used in the eligible regions;
- promote human resources management that meets the challenges of demographic ageing in the health care and long-term care sector, in particularly by anticipating or reducing shortages of certain categories of staff, thanks to sufficient investment in basic and continuing training and an improvement in the quality of jobs, including their health and safety at work aspects. The ESF contribution must be used to the full in this area. The Communication on patient mobility also complements this objective by proposing the promotion of cross-border mobility for health care workers and more research into these flows;
- take into account in all these measures the specific problems that men and women can face, especially in human resources policy and the promotion of high-quality jobs.

3.2. Promoting high-quality care

Offering accessibility and high quality must remain a fundamental objective of the European systems. However, achieving this objective has become much more difficult than it was when these systems were created, for two main reasons:

- The impact of technological progress is still uncertain, in particular in the context of an ageing society. It may indeed make systems more effective, raise healthy life expectancy and increase costs, particularly for new drugs. Furthermore, the high standard of education, particularly for those of the baby boomer generation who are now reaching retirement, may have a similar impact, with more healthy behaviour and greater prevention but also a growing demand for care, particularly innovative care.
- The range of care available today is richer, more varied and complex than when the care systems were created. Investment in health is a political choice and will have a positive impact on the economy in the long term. Nevertheless, given the limited public funds available, investment in any sector will automatically affect the other sectors²¹. The mainly public funds invested in health must therefore be used as efficiently and effectively as possible in order to improve the overall health situation.

These trends, intensified by the ageing of the population, mean that the real quality and benefit for individuals and for overall health of the drugs, treatments or billing methods available will have to be audited more and more. This calls for a preventive approach in order to improve overall wellbeing and effective management of the care system, on the basis of closer coordination between all the players and making them more responsible for the management of resources and the supply of care.

Objective:

Promoting high-quality care in order to improve people's state of health and quality of life.

In particular, depending on the specific nature of their system, Member States should:

- promote practices and treatments providing real benefits for health and quality of life, based on an appropriate scientific assessment. The costs and benefits of drugs, equipment and treatments must be evaluated, in accordance with the procedures of each national system and with the development of European cooperation in this area;
- mainstream the gender dimension in the development of prevention and health policies, in order to better take into account the specific problems of men and women and make their care more effective;

²¹ According to *OECD-Healthcare 1996*, health spending increases by 0.5 % with every 1% increase in wealth. Moreover, according to a study by the EU Economic Policy Committee published in 2001, the 'spontaneous' effect of demographic ageing could increase the share of public expenditure earmarked for health and long-term care by between 1.7 and 4 GDP points.

- ensure a high level of basic and continuing training of health care workers, in the context of lifelong learning;
- develop health and safety at work policies based on risk prevention and creating better-quality jobs for all workers, especially older workers, in order to reduce premature death (at younger than 65 years) and raise healthy life expectancy;
- earmark financial and human resources to the regions, services and different types of care depending on actual need, in order to obtain the best possible results for the health and quality of life of beneficiaries. The Communication on patient mobility complements this objective by proposing the identification of “reference centres” and the promotion of their networking;
- promote governance that encourages the systems’ adaptability to changing needs, in particular thanks to effective coordination between the players concerned (the public purse, insurance funds, health care professions, hospitals, prevention institutions and organisations, including educational establishments, regional and local authorities involved in health care systems, patients and citizens);
- define the rights of patients and their families and the arrangements for the involvement of organised civil society. The Communication on patient mobility complements this objective by proposing that the information available on individual rights and the European and national rules on billing for care should be brought together and enhanced.

3.3. Guaranteeing the financial sustainability of accessible, high-quality care

Continuing to offer accessible, high-quality care without taking funds away from other sectors or political priorities is a major challenge for all the Member States, both the existing and the new ones. They are faced with the need to ensure proper funding for their care system in order to offer quality services while adapting to new needs, especially those associated with ageing, and to technological progress. A large proportion of health and elderly care spending is paid for from public funds, which are subject to the requirements of the Stability and Growth Pact. To ensure that sufficient public funds are available to meet the needs of the care system, Member States must have healthy and sustainable budgetary situations. Cutting the public debt rapidly and raising employment rates are important ways of making public funding more sustainable.

In this context, the Member States have long been implementing measures or reforms designed to ensure the financial equilibrium of the systems, based on various instruments: reimbursement rates, in order to encourage responsibility or guide demand in a particular direction; prices and volumes of treatments, in order to control certain products or prescriptions; the fixing of budgets, particularly in the hospital sector; the development of steering tools based on health objectives, the results obtained and the diseases treated, and on giving more responsibility for the management of resources to people working in the sector and financial backers; the establishment of new ratios between the various financing possibilities, particularly to reinforce the responsibility of the players concerned. There is no single way of meeting this challenge — research into financial sustainability should therefore continue to be based on a combination of these instruments.

In general, the Member States should take appropriate measures to ensure sound management of public funding for health care and long-term care, concentrating on the need to improve the quality and effectiveness of public expenditure.

Objective:

Ensuring the long-term financial sustainability of high-quality care accessible to all.

In particular, and depending on the specific features of their national system, Member States should:

- develop prevention and guidance policies at treatment entry points, so as to reduce the need for expensive treatments, particularly hospital and intensive care, and to this end strengthen the coordination between the various care providers (primary care, hospitals, local social services). This objective complements the work undertaken under the Community action programme for health²², which supports prevention measures in order to improve health and reduce future health care expenditure;
- achieve a sustainable rate of expenditure development, using measures adapted to the situation and the specific features of each system, e.g. incentive measures for providers and patients or measures to promote new treatments or new products that reduce costs whilst providing the same service;
- ensure that their system is properly funded, in order to meet the new challenges posed by ageing, changes in society and technological progress;
- offer the most cost-effective care possible, thanks, in particular, to an audit of the health benefits of certain drugs, procedures or types of billing and to activity-based and real-need-based funding;
- improve the effectiveness of the system, based in particular on decentralisation, involving the various players (local and regional public authorities, social security institutions and other suppliers of funding, the health care professions and hospitals, patients) in and making them responsible for the management of resources and the provision of care.

4. THE NEXT STEPS

Responsibility for the organisation and funding of the health care and elderly care sector rests primarily with the Member States, which are bound, when exercising this responsibility, to respect the freedoms defined and the rules laid down in the Treaty. The added value of the “open method of coordination” is therefore in the identification of challenges common to all and in support for the Member States’ reforms.

²² Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008) - Commission Statements OJ L 271 , 09.10.2002

Pursuant to this Communication, it would be desirable to come to an agreement on the joint objectives in 2004. Member States, including the new ones, should present 'preliminary reports' covering the challenges facing their systems at national level, current reforms and medium-term policy objectives by the next Spring Summit in March 2005. These reports would include statistical data and, where relevant, quantified objectives. At this preliminary stage, they would be concise.

They would then be analysed by the Commission, so that the views and contributions of the Member States can be taken into account when the joint objectives of the streamlined social security process are established. This streamlining will lead in 2006 to an initial series of "development and reform strategies" in health care and long-term care for the period 2006-2009. The conclusions of the assessment of these strategies will be presented in the *Joint report on social protection and social inclusion* in 2007.

Given the wide range of topics and issues tackled by the joint objectives, the Social Protection Committee and the other competent bodies (the Employment Committee, the Economic Policy Committee, the future High Level Group on Health Services and Medical Care created in parallel by the Commission) should forge close links, including the establishment of a work programme to identify the topics relevant to each.

With regard to the indicators, the Commission proposes starting work in 2004 to identify possible indicators for these objectives. The interim reports due in the spring of 2005 will contribute by submitting national data, facilitating the drawing up of an initial comparison table of the different national situations and the assessment of progress compared to the stated objectives. This work will have to be based on activities undertaken over several years in the context of the action programme on health monitoring²³, then the action programme on health, to create a prototype for a future Community health monitoring system. It will also be based on Eurostat's health statistics work. Cooperation with international organisations, such as the OECD and the WHO, will also be necessary.

²³ Decision No 1400/97/EC of the European Parliament and of the Council of 30 June 1997 adopting a programme of Community action on health monitoring within the framework for action in the field of public health (1997 to 2001) OJ L 193 , 22.07.1997