

Healthy ageing: keystone for a sustainable Europe





Health & Consumer Protection
Directorate-General

Healthy ageing: keystone for a sustainable Europe -

EU health policy in the context of
demographic change

Discussion paper
of the Services of
DG SANCO, DG ECFIN and DG EMPL

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“Healthy ageing, a keystone for a Sustainable Europe” EU Health Policy in the Context of Demographic Change

Draft working paper of the Services of DG SANCO, DG ECFIN and DG EMPL¹

1. Introduction

A keystone is the central stone in an arch which prevents the structure from falling apart. A healthy population is the keystone for economic growth and prosperity in Europe for at least two clear reasons; it will limit strain on health and social care systems and it will allow people to remain active in society longer. Policy action at EU level, with its perspective across the Member States and its ability to share experience and collect information, is a valuable addition to the work done at national and local level to prepare for an ageing population in Europe.

The predicted trend towards demographic ageing, resulting from low birth rates, and increasing longevity, is now well established on political agendas across Europe. Several Member States have taken on reforms of the social system, in particular pensions, health and long term care, in order to prepare for the ageing populations of Europe. It is clear that measures to promote individuals' health across the lifespan are important in limiting ill health in old age and increasing active, healthy life expectancy.

Health has been shown to be a “robust and sizeable predictor of subsequent economic growth” in many studies looking at differences in growth between poor and rich countries.² In 2001, The Commission on Macroeconomics and Health made a strong economic case for investing in health for low and middle income countries³ and later work by the European Commission confirmed its relevance to Europe's higher income countries. Policy to improve population health and to increase healthy life years (HLY) must therefore be a key concern for governments at all levels.

This paper examines current trends in life expectancy, how they relate to healthy life years, and what this could mean for EU Member States. It then sets out factors which affect healthy life expectancy, and the policy response at EU level to increase HLY, both specifically within the health sector, and elsewhere. It shows how both policies that are

¹ The information contained in this paper does not necessarily reflect the opinion or the position of the European Commission. The European Commission does not guarantee the accuracy of the data included in this project nor does it accept responsibility for any use thereof. The paper has been prepared by Clare Siddall and Guri Kjaeserud (DG SANCO), with contributions from Wojciech Dziworski (DG SANCO), Bartosz Przywara (DG ECFIN), Ana Xavier (DG EMPL), and other Commission colleagues.

² Suhrcke, McKee et al, The contribution of health to the economy in the European Union, European Commission 2005, p.12

³ Macroeconomics and Health: Investing in Health for Economic Development Report of the Commission on Macroeconomics and Health, Chaired by Jeffrey D. Sachs, 20 December 2001

narrowly focused on specific health issues and cross-cutting policies can contribute to a healthier population which will underpin European society in the future. It concludes by looking at future challenges for policy to support healthy ageing.

2. Trends in Healthy Life Expectancy

Life expectancy in Western Europe has increased consistently since the 1950s by around 2.5 years per decade (see graph 1), and it is expected to continue to increase. The fact that people are living longer is a clear trend. Life expectancy at the age of 65 and even at 80 years has increased, and it has increased even more than life expectancy at birth.

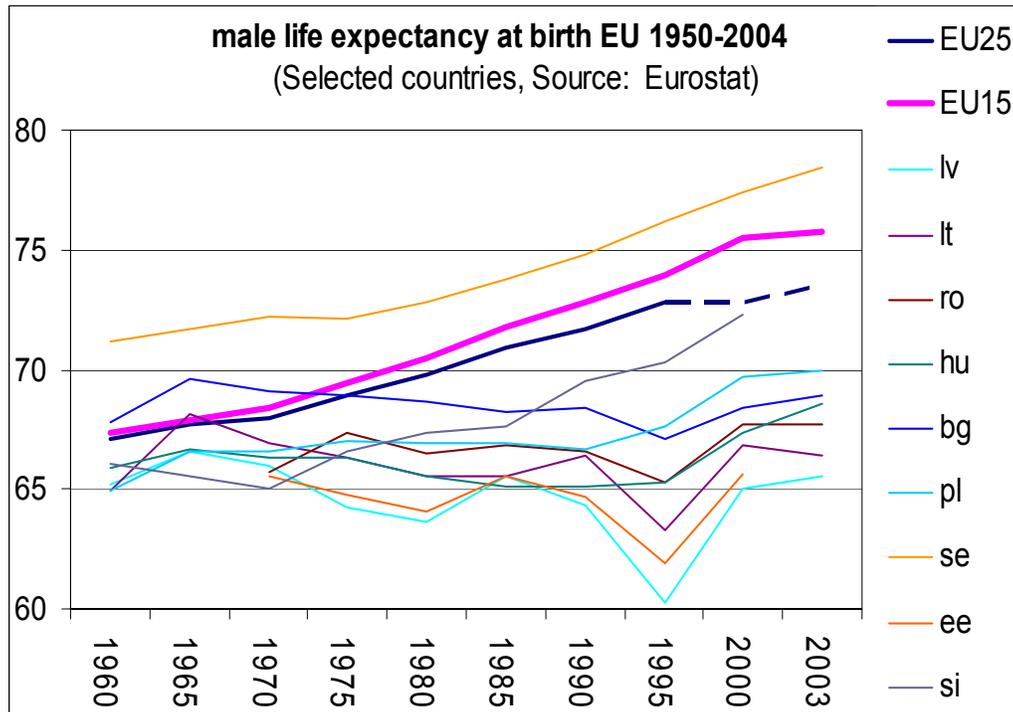
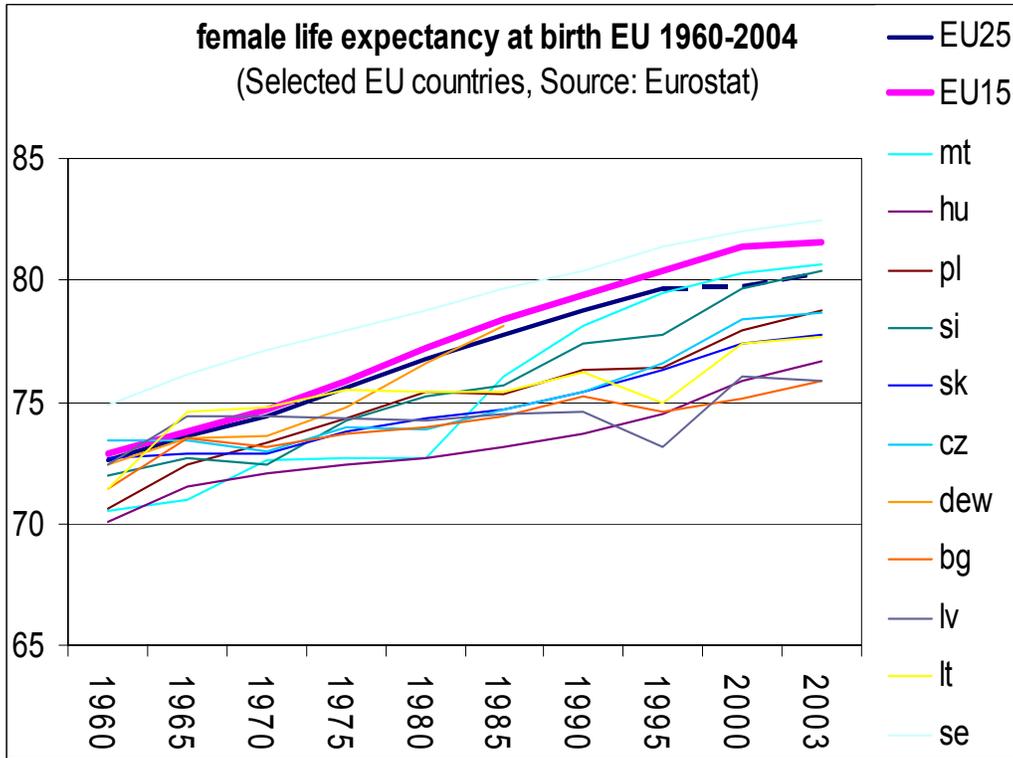
At the same time, within the EU, Eurostat predicts an 11.7% decrease in population for the 10 most recently joined Member States (the EU10) by 2050, due to migration patterns and low fertility rates. A combination of these factors, as well as the ageing of the 'baby boom' generation, will lead to dramatic changes in the demographic make-up of Europe in the next fifty years (see graph 2).

The greatest challenge for future economic prosperity given the changing composition of the population may lie in the decline of the number of people of working age. The European Commission Green paper "Confronting demographic change: a new solidarity between the Generations"⁴ suggests that by 2009 will the size of the youngest cohort of the working age population will already be lower than the size of the oldest cohort. In 2050 there are expected to be 66 million people aged 55-64 and only 48 million aged 15-24. This means that the working age population will start declining soon after 2010 and that the labour market will increasingly have to rely on older workers.

Although most predictions assume that life expectancy will continue to increase, this assumption can be challenged; risk factors such as smoking, obesity and lack of physical activity increase the risk of life expectancy leveling off (see part 3). Independent of whether life expectancy continues to increase or not, it is likely that these growing risk factors will increase the time people spend in poor health. Measuring healthy life expectancy is therefore important. An ageing population in good health will limit the pressure on health systems and on carers and will increase the contribution to society made by older people through paid or voluntary work. Therefore reducing morbidity, or ill health, in the ageing population is a vitally important aim for health policy.

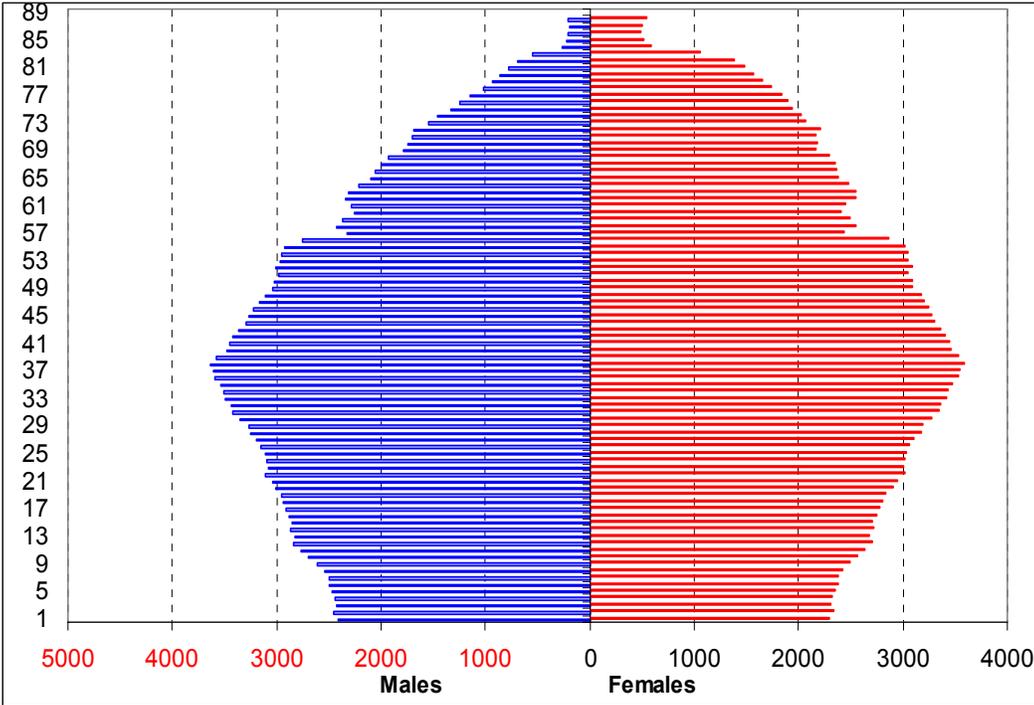
The Healthy Life Years indicator (also called Disability Free Life Expectancy), developed by the Commission along with other partners, measures the number of years that a person of a certain age can expect to live without ill-health, and can be used to monitor health as a factor in productivity and economic prosperity, to support health prevention and promotion policies.

⁴ COM(2005)94

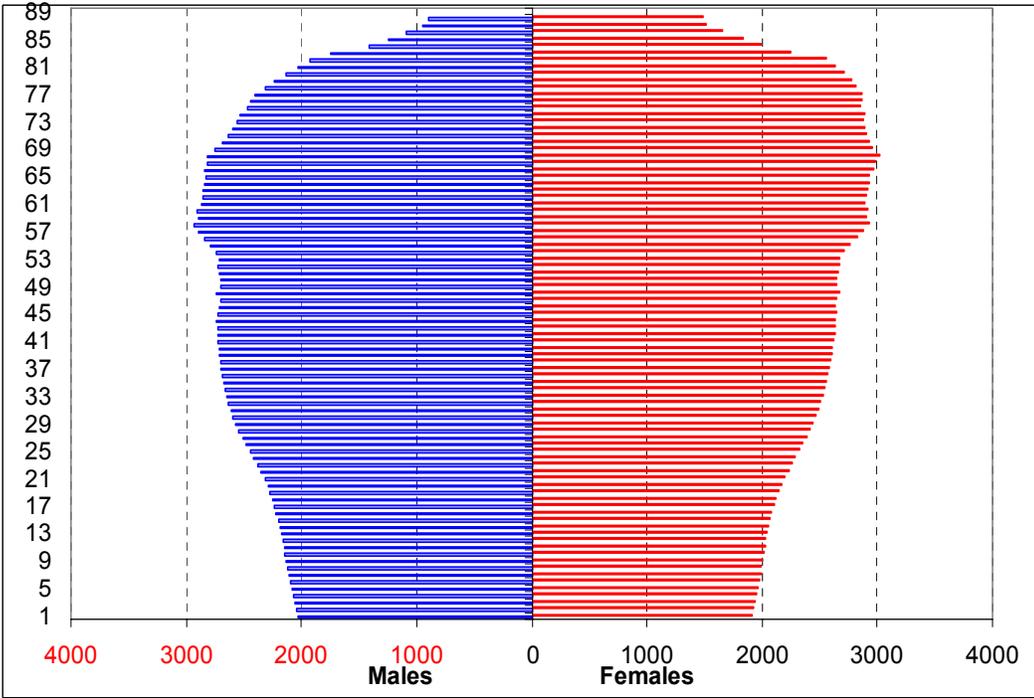


Graph 1: Life expectancy at birth in selected EU Countries from 1960 to 2003

2004



2050



Graph 2: Population Projections of Age Structure in the EU25 in 2004 and 2050 (source: Eurostat) graphs made for the Ageing Working Group, of the Economic Policy Committee.

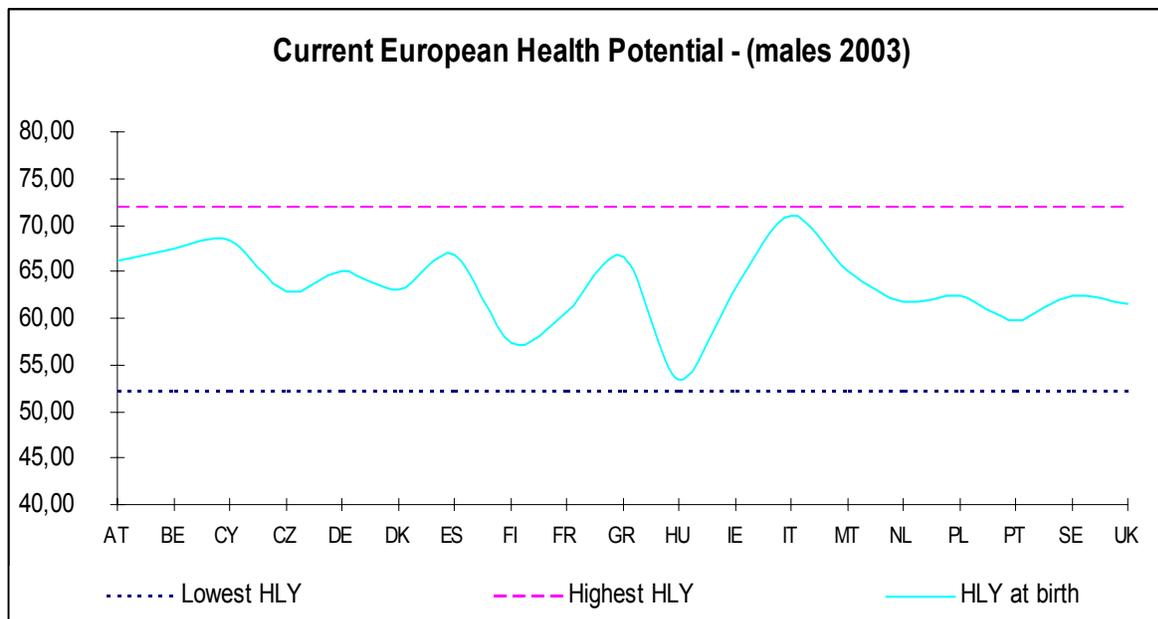
It can also be a better indicator than life expectancy data of the success of health policies. Key crosscutting EU policies such as the Lisbon agenda and the Sustainable Development Strategy include Healthy Life Years within their list of indicators (see part 3), and the Commission's Communication to the Spring European Council in January 2005 said that 'increasing Healthy Life Years is crucial in attracting people into the labour market'.⁵

The two components of the calculation of the HLY in the EU are mortality tables and self-perceived disability assessed by health surveys. Life tables which give mortality data for calculating life expectancy are available as a demographic long-term series based in the standard causes of death registration harmonised at EU level. Regarding self-perceived disability, from 1995 to 2001, data from the Eurostat European Community Household Panel (ECHP) survey has been used for the EU-15 Member States. The successor of the ECHP, the Eurostat EU-Statistics on Income and Living Conditions survey (EU-SILC) has been used from 2005 for the EU-25. Self reported health does not always correlate with objective health status and using self-perceived health in cross-country comparisons means that cultural differences in health reporting come into play. For example we see some northern countries like Finland reporting fewer healthy life years than we would expect according to objective health status. Cultural differences in reporting are an issue which the EU continues to work on as it further develops the Healthy Life Years Indicator.

Today in 2006, women in the EU15 are expected to live about 80% of their lives in good health, while men are expected to live a larger share of their lives in good health, close to 85%, (although total life expectancy for men continues to be shorter than for women) (see graph 4, and figures 5a and 5b). Healthy life expectancy is much shorter than life expectancy, and it is clear that more can be done at a European level to improve health. Comparing the statistics of the best-performing countries with the others, we can estimate a 'European Health Potential' (see graph 3). For example, if southern European citizens live a large part of their lives in good health, why should other European Citizens not expect to live the same share of life in good health? If a Swedish citizen has a high life expectancy why should other European citizens not expect the same?

To illustrate what is at stake, European Health Potential can be calculated at country level. To estimate the potential for health improvement in each country (for men) it is assumed that the life expectancy of the current best performer, (Sweden 78 years) can be achieved by all Member States. It is also assumed that all Member States are able to realise the share of good health that is achieved in the best performing country, (Italy where currently 93% of life expectancy is in good health). This implies that by improving the performance of the Member States to level of the best performer, all Member States would have a population living on average 72 years in good health (Healthy Life Years), i.e. 93% of 78 years. Graph 3 therefore shows that raising standards to the level of the best performing EU country would increase healthy life expectancy by an average of 8.3 years for men. The area above the line is the potential health gain to be made.

⁵ COM(2005)24



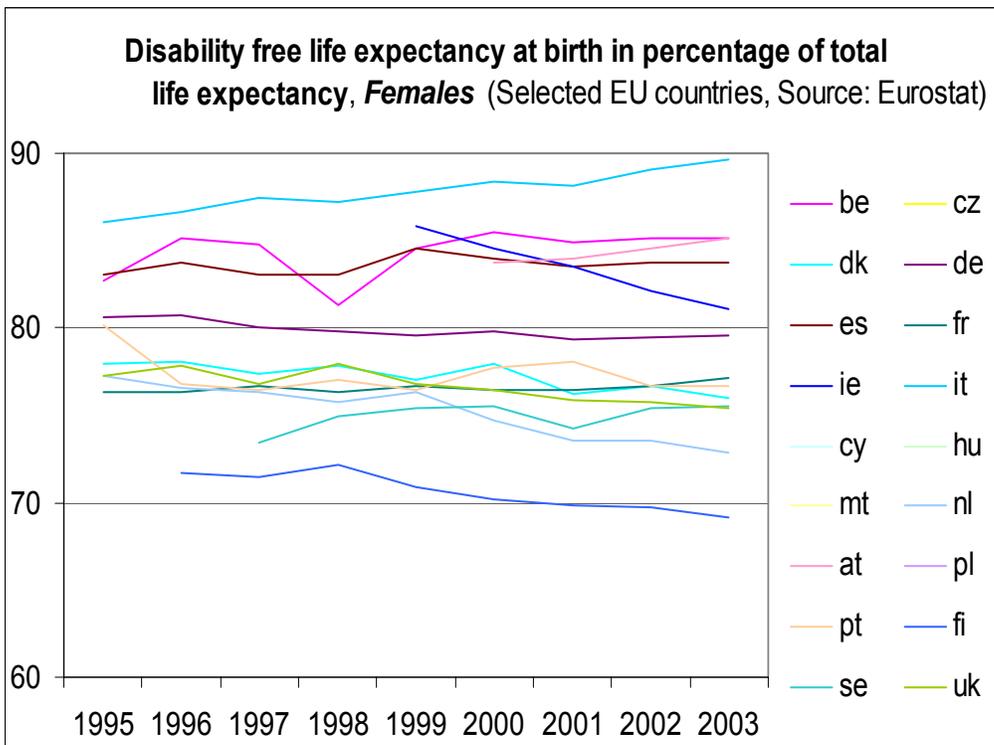
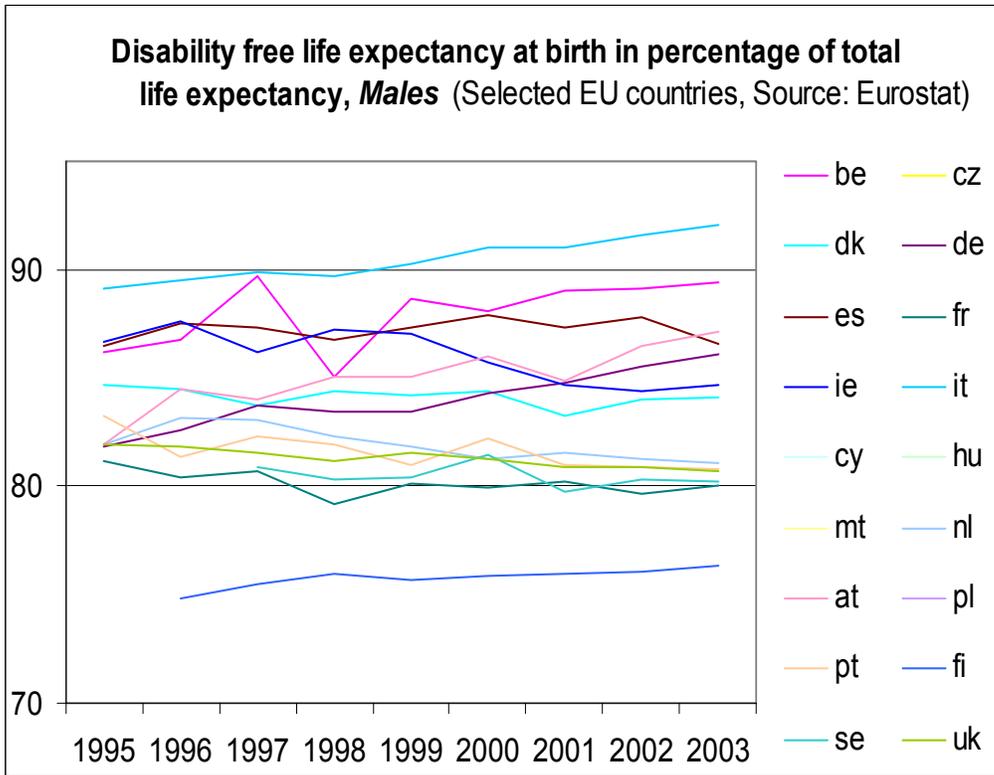
Graph 3: Current European Health Potential – Males 2003 (Source: Eurostat)

The area below the line shows the potential for a drop in health if each country's life expectancy fell to the level of the lowest performer. On average each EU Member State would lose 6 years of healthy life expectancy. Taking Hungarian Life Expectancy (68 years) and combining it with the lowest share of life in good health (Finland, 76.3%) leads to a result of 52.2 years, i.e. 76.3% of 68 years. This shows the gains that have been made in improving health, but also what is at stake if no policy action is taken to support life expectancy or the share of life in good health.

For women, the upper boundaries would be defined by the life expectancy in Spain of 83.7 years and the share of healthy life years in relation to life expectancy in Italy of 89.7%. This suggests that an average increase in healthy life years of 10.6 years can be achieved. Again the lower boundaries are defined by the Hungarian life expectancy, (76.7 years) and the Finnish percentage of healthy life years in relation to life expectancy (69.1%). For women there is a risk of a reduction in Healthy Life Years of 8.4 years. The data above give a picture of Europe as it is today, and show that Member States could improve their health considerably by converging towards the level of the best performers. However, the Health Expectancy Monitoring Unit has clearly shown that the European trends in the development of the Healthy Life Years are not converging (see graph 4) Taking the figures for males as an example:

- HLY increases in Austria, Belgium, Italy, Finland and Germany
 - HLY is stable in France, Greece, Ireland, and Spain
 - HLY decreases in Denmark, Portugal, Netherlands, Sweden, and UK
- Similar trends are also present for females although for different countries.

This illustrates that our current efforts are not yet leading to a concerted increase of Healthy Life Years across Europe.



Graph 4 : Trends in healthy life expectancy for selected EU Countries from 1995-2003, Source: Eurostat.

The figures also show clear gender differences in health status and health developments across Europe. The need to increase men's life expectancy, and women's participation in the labour force, at the same time as providing for a balance between work and family life are issues which continue to be discussed at European level following the recent Green Paper on confronting demographic change.⁶

Conclusion

It is clear that within the next fifty years the population of Europe will contain a much greater share of older people. What is less clear is whether people will age in good health or in poor health. Given emerging threats to health such as obesity, we cannot take for granted that life expectancy will continue to increase as it has done, while at the same time population levels are dropping in some parts of Europe. The next section sets out the economic case for more policy action to increase Healthy Life Years.

3. The Economic Consequences of More Healthy Life Years

This section sets out the positive consequences of more healthy life years in terms of both workforce health and working longer, and in terms of expenditure on health services.

Health and the Workforce

Health policymakers have long argued that 'health means wealth'; that a healthy population is necessary for a sustainable future. Poor health is a factor in early retirement and worker absenteeism - in Germany, the probability of leaving the workforce at the earliest possible age is four times higher for men with disabilities, and in Ireland, the proportion of labour participation is 61% lower for men with chronic diseases.⁷ The Commission pointed out in its report to the 2006 Spring European Council that Member States need to reduce the high numbers of people who are inactive because of their ill-health⁸ and that Europe cannot afford to have people drop out of the labour market when they are in their fifties⁹. Healthy people are also likely to be more productive at work.¹⁰

Recent figures are encouraging. The 2005 European Union Labour Force Survey found that the employment rate for older people (i.e. those aged 55-64) reached 42.5%, up from the 36.6% registered in 2000.¹¹ This positive trend must rely on the health of the

⁶ COM(2005)94

⁷ The contribution of health to the economy in the EU, European Commission, 2005.

⁸ Annex to COM (2006) 30 of 25.1.2006

⁹ 2006 Commission Communication to the Spring European Council, COM(2006) 30, 25.1.2006

¹⁰ The contribution of health to the economy in the EU, European Commission, 2005. p.20-22

¹¹ EU Labour Force Survey - Principal results 2005 - Issue number 13/2006

older workforce. Table 1 shows the reasons given for retiring by males in the EU-15 in 1995. Illness or disability, although very variable across the Member States, accounts for up to 25% of retirements. The effect of cultural differences relating to the role of ill health on retirement needs to be studied further.

Retired males aged 55-64¹⁾, Main reasons for leaving last job or business in the EU, 1995 (share of total) (Source: The European Union Labour Force Survey, 1995)

	AT	BE	DK	FI	FR	DE	EE	IE	IT	LU	NL	PT	ES	SE	UK
Dismissed or made redundant	5.1	3.7	23.4	24.1	10.7	9.5	2.5	8.8	2	0	7.9	1	10.2	30.2	22
Job of limited duration has ended	0.2	0.7	7	3.8	1.5	0.7	1.7	3.1	1.7	0.5	0.1	0.4	11.1	8.2	3.6
Personal or family responsibilities	0.2	1.3	0.2	0	0.4	0.6	0.5	1.4	1.2	0.2	1.9	0	0.2	2	1.6
Own illness or disability	2.6	7.7	9.5	25	7.3	22.9	4.1	15.1	5.2	16.6	15.6	2.1	18.3	7	22.8
Early retirement	49	30.6	37.2	0	16.9	33.1	5.1	15.9	9.2	29.1	42.9	2.3	13	25.9	14.7
Normal retirement	30.2	19.6	2.3	11.7	38.6	10.9	52.2	12	53.4	31.7	0	1.2	17.8	12.5	4.8
Other reasons ²⁾	12.8	36.4	20.3	35.5	24.5	22.3	33.9	43.7	28	22	31.6	93.1	29.5	14.2	30.6
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

1) Refers to persons aged 55-64 who are not in the labour force, but who had been in the labour force in the 8 years preceding the survey.

2) Other reasons include: education and training, compulsory military or community service and other reasons

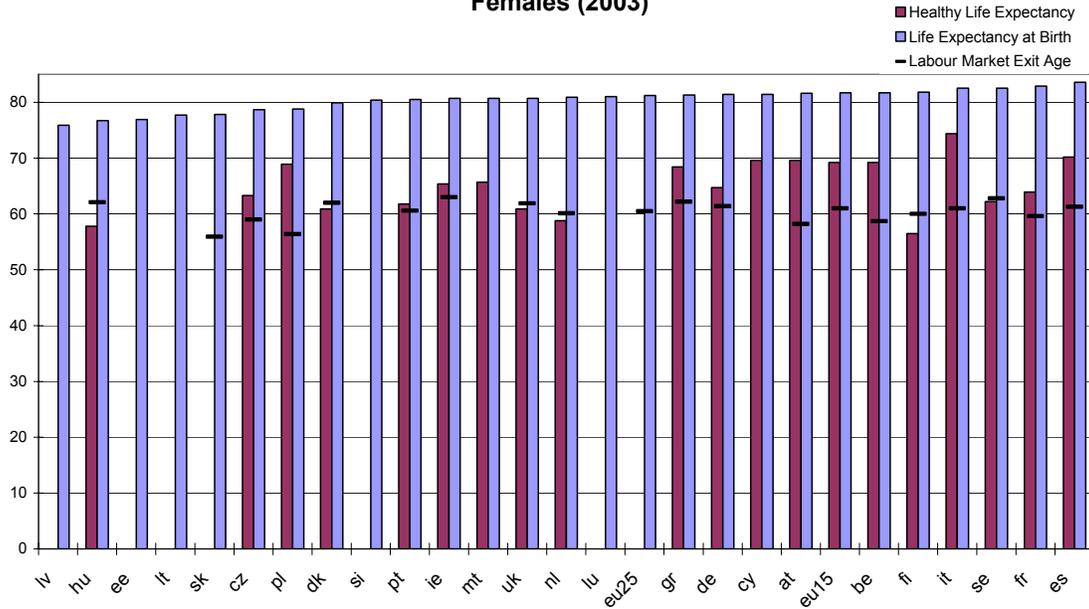
Table 1. Main reasons for leaving last job or business in the EU, 1995, retired males 55-64 (Source: The European Union Labour Force Survey, 1995)

Graph 5 shows life expectancy in the EU25 ranked from lowest to highest, measured against Healthy Life Expectancy for the EU15, also showing labour market exit age. There is a clear variation in life expectancy in EU 25 from 66-78 years (a gap of 12 years) for men and 76-84 years (a gap of 8 years) for women. They show that, even in the EU15¹², the average difference between life expectancy and healthy life expectancy is 11 years for men and 16 years for women. The difference between EU countries is wider for healthy life expectancy than for life expectancy. Healthy life expectancy ranges from 57-75 years (18 years) for women, and from 54-71 years (17 years) for men.

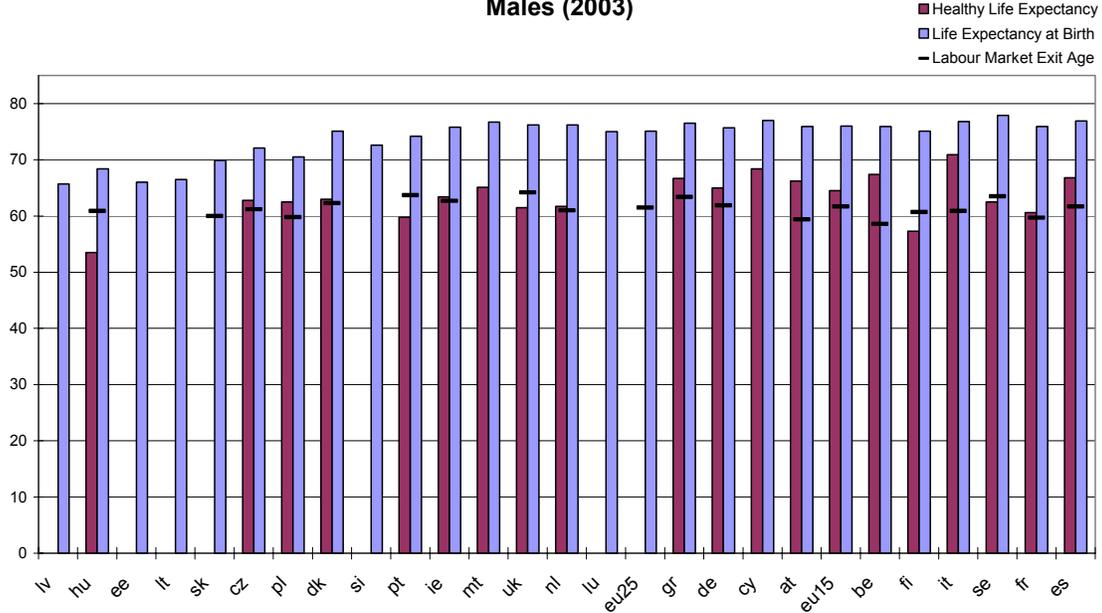
In graph 5, the average labour market exit age appears to reflect the limit of healthy life years. Although health is not the only factor in retirement from work, it is clearly an important factor. Further work is needed to identify the role health plays in relation to pension provision and age limits in triggering exit from the labour force. The graphs illustrate the substantial amount of time that older people currently spend in poor health in the EU. If health can be improved, there is great potential for achieving the two aims of reducing pressure on health and social care systems and increasing economic prosperity.

¹² The Healthy Life Years indicator is relatively new and no data exists yet for the EU10.

**Total and Healthy Life Expectancy and Labour Market Exit Age:
Females (2003)**



**Total and Healthy Life Expectancy and Labour Market Exit Age:
Males (2003)**



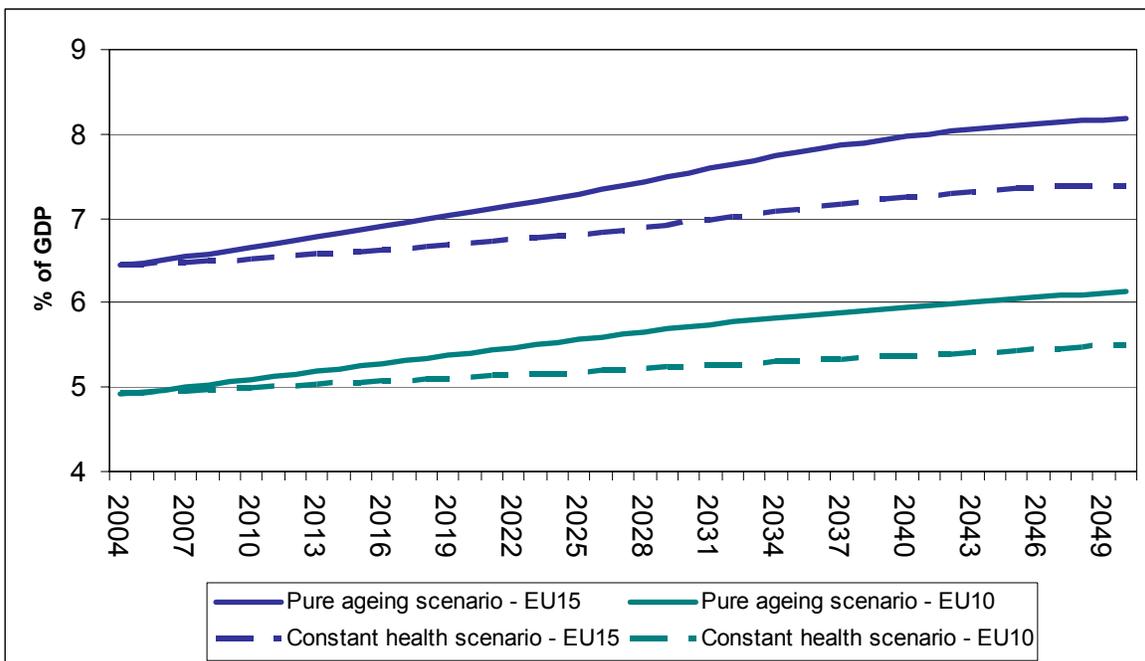
Graph 5 - Source: Eurostat, National data, Labour Force Survey and European Household Panel

a. Expenditure on Health Services

Expenditure on health has been increasing gradually over the past decades and is expected to continue growing in the decades to come (see graph 6). As health expenditure increases in the last years of life it is expected that health expenditure will increase as a result of demographic change.

Summarising the results of the long-term projections of public expenditure on age-related items, DG ECFIN has concluded that the pure demographic effect of an ageing population is projected to push up (public) health care spending by between 1 and 2% GDP in most Member States.¹³ One key challenge for the EU is to demonstrate to Member States, through dissemination of research and best practice, how to invest in health through health systems and health promotion in order to avoid future increases in health expenditure by reducing preventable disease and therefore enabling people to remain active and participate in society for a longer period of time.

Graph 6 shows the projected increases in public health care expenditure as a share of GDP. The cost of the increasing need for health and long term care staff is a key element of this increased expenditure, and is under further pressure due to the shrinking proportion of people of working age. However, to properly assess the pressure that will be put on the working population it is important to focus on total health expenditure. Health technology is also an important driver.



Graph 6: Projected increases in public health care expenditure (in % of 2004 level)

¹³ The impact of ageing on public expenditure: projections for the EU25 Member States on pensions, health care, long term care, education and unemployment transfers (2004-2050) DG ECFIN 2006, p.133

The continuing rise of new technologies is a factor that may drive future health expenditure relating to demographic change. Although technology can lower unit costs of providing more efficient treatment, it also increases the availability of treatments and makes new treatments available for more people. Technology can lower the demand for health care if early or less invasive interventions improve health and lower future health care needs, and technological improvements are also often associated with improvements in quality. Alternatively, technology can increase future health care needs by increasing the lifespan of people with chronic or multiple health conditions. Therefore, the impact of technology on future health care spending is not clear cut. Evidence to date suggests that technology has pushed up overall spending as increased demand appears to have outweighed unit cost savings.

b. Conclusion

Increasing Healthy Life Years may be a way to reduce the economic risks associated with demographic change. More Healthy Life Years means a healthier workforce, and less retirement on the grounds of ill health. It may lead to less strain on public finances and contribute to the sustainability of health systems as the population ages. The next sections offer some approaches towards increasing Healthy Life Years in order to support these outcomes.

3) How Is EU Health Policy Supporting Preparation for Demographic Change?

The EU's health policy works to increase Healthy Life Years through ageing policy, through a lifecycle approach, and through pursuing the goal of Health in all Policies. Alongside this work EU health policy assists Member States in preparing health systems for the consequences of an ageing population.

3.1 Increasing Healthy Life Years

Healthy Life Years can be increased through policies directed at the ageing population, through promotion and prevention across the lifecycle, and through strategic work across sectors to raise the profile of health and to emphasise the importance to population health, and to future sustainability, of increasing Healthy Life Years.

a. Healthy Ageing Policy

The Commission's modified proposal for a Programme for Community Action in the Field of Health contains an aim to 'promote initiatives to increase healthy life years and promote healthy ageing' and to 'support measures to promote and explore health's impact on productivity and labour participation.'¹⁴ Ageing is therefore clearly identified

¹⁴ COM(2006)234, Annex

as an area on which health policy should concentrate, and the Commission is co-funding a 3 year study on healthy ageing, coordinated by the Swedish National Institute of Public Health, due to complete in 2007.¹⁵ This project aims to develop an integrated approach to health in later life by analysing the different methods used by Member States at the national level to promote healthy ageing, and will make recommendations for action at both Community and national level. The EC has also focused on ways that Information and Communication Technology can support older people to remain independent longer.¹⁶ However, as health in old age is very often linked to health earlier in life, a focus on ageing alone is not sufficient – promotion and prevention policy across the lifespan is necessary to achieve a healthier, more active ageing population.

b. EU Policy on Promotion and Prevention

The most common risk factors for disease in the EU are high blood pressure, smoking, overweight, poor diet and alcohol abuse. Many of these risk factors lead to diseases in older age, which are typically long lasting chronic conditions which occur in combination. Poor health in old age is often the result of the accumulation of a lifetime of these risk factors, particularly for the biggest killers, cardiovascular disease and diabetes. Additional factors like reduced mobility and eyesight can make a huge difference to how active older people can be. Mental health problems are very common in older people and can be partly attributed to social values that typify old age as a time of uselessness and isolation.

The Commission takes action at EU level on many of these key issues. Commission proposals for strategies on alcohol, and on mental health, are due to be adopted soon. The Commission co-funded a recently-published 'Alcohol in Europe' report which states that even for chronic diseases, such as liver cirrhosis and depression, reducing or stopping alcohol consumption is associated with rapid improvements in health.¹⁷ Three examples follow of actions on key issues that are important elements of a lifecycle approach to health. Health policy action in these areas ultimately impacts on the health of the ageing population.

Mental Health

An EU mental health strategy is being developed following a Green Paper¹⁸ which focused on possibilities to promote mental health and to prevent mental illness in population groups and through relevant settings such as schools and workplaces. It also focused on the social inclusion and the rights of those with mental illness, and discusses the need for better data on mental health. Depression affects 10-15% of people over 65, and older people with depression are 2-3 times more likely to have 2 or more chronic illnesses, while there are 5.5 million cases of Alzheimer's disease in Europe.¹⁹ As the Green paper pointed out, encouraging physical and social participation in older age can

¹⁵ see www.healthyageing.nu

¹⁶ http://europa.eu.int/information_society/activities/health/docs/events/indep-living-nov2005/24-25nov-report-final-draft-june2006.pdf

¹⁷ written by the Institute for Alcohol Studies, 2006, available at www.ec.europa.eu/health-eu/news_alcoholineurope_en.htm

¹⁸ COM(2005)484

¹⁹ International Longevity Centre UK and Merck Company Foundation, The State of Ageing and Health in Europe, June 2006

positively influence mental well being. The forthcoming EU strategy will take into account the importance of action in relation to the mental health of older people.

Tobacco

Over recent years, the Community has passed legislation banning tobacco advertising, and has also run a number of campaigns to discourage smoking. The most recent 'HELP' campaign was considered to be a success as evaluation figures showed that the campaign triggered 61% of EU smokers to think about their smoking.²⁰ Despite considerable progress, the number of smokers is still high at around one third of the Community population, and there are around 650,000 smoking-related deaths per year in the Community. Almost half of these deaths are of persons aged between 35 and 69, and the remainder are older. Smoking combined with other risk factors such as overweight is particularly dangerous. Research in the Netherlands has found that people who are overweight at the age of 40 are likely to die at least three years earlier than healthy adults, the same risk as for smokers.²¹ In this study, obese female smokers were found to lose 13.3 years, and obese male smokers lost 13.7 years compared with normal-weight non-smokers. Among a wide range of EU actions on tobacco, the Commission recently adopted a Decision offering a library of coloured warning pictures which Member States can use on tobacco packs to help smokers quit and dissuade young people from starting to smoke.²²

Nutrition

The EU is taking innovative steps to tackle poor nutrition, engaging public and private partners to support promotion of healthy lifestyles. The European Platform for Action on Diet and Physical Activity is a Commission initiative bringing together key EU-level representatives of the food, retail, catering, and advertising industries, consumer organisations and health NGOs. It aims to catalyse voluntary actions across the EU by business, civil society and the public sector. Members have compiled their current and future activities aimed at promoting healthy diets and physical activity. 333 "baseline" activities have been submitted to a publicly available Platform database, along with 98 commitments for new work starting in 2006.

In order to define priorities, and to identify actions that could be taken at European Union level, the Commission launched a major public consultation exercise with the Green Paper *Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases* that ended in March 2006. Over 250 responses have been received from a wide range of stakeholders advising on which actions could complement, support and coordinate existing national measures. A summary will be published on the Commission's public health website. Ultimately, the Green Paper responses will feed into the development of a comprehensive and coherent Community strategy, which is foreseen for adoption in Spring 2007.

²⁰ <http://en.help-eu.com/pages/index-2.html>

²¹ Study by Erasmus Medical Centre and the University of Groningen in the Netherlands, published in the journal 'Annals of Internal Medicine', January 2003

²² C(2005)1452

Policy action on health promotion and prevention aims to increase the health of individuals, but it could also save health systems and the economy money in the long term. Chronic disease such as that linked to obesity and poor nutrition is costly. Recognising that the cost of illness is particularly difficult to quantify accurately, it has been estimated that approximately €74 billion is spent each year on treating Cardiovascular Disease in the EU and about another €106 billion a year is incurred due to the lost production of goods and services²³. 80% of all cardiovascular diseases are considered to be preventable by reducing the well known risk factors like smoking, unhealthy diet, physical inactivity and psychological strains.

In England it was estimated that in 1998 obesity accounted for 18 million days of sickness absence and 30,000 premature deaths, equivalent to €715 million per year to treat obesity (not counting the indirect costs).²⁴ Although these figures are estimates rather than facts, it is clear that the costs of illness are significant.

c. Health in all Policies

To increase Healthy Life Years a focus is needed on all sectors, not just on health. Many policy areas have traditional links with health and important role in supporting health improvements. Article 152 of the Treaty establishing the European Community states that “A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities”. The European Commission proactively works to ensure that health issues are taken into account in all EU proposals which may affect health, from wine reform to pharmaceutical policy to patient mobility. There are clear links with employment in relation to health in the workplace, with environment in relation to issues like air quality, and to education. On the other hand, for some other sectors, notably financial and economic policies, the link has not always been so well-recognised. Recently the profile of health has been raised in some key cross-sectoral EU policies, including the Lisbon Agenda, the Sustainable Development Strategy, and the Structural Funds.

The heads of state and government at the Lisbon European Council in 2000 agreed that “People are Europe’s main asset and should be the focal point of the Union’s policies. Investing in people and developing an active and dynamic welfare state will be crucial both to Europe’s place in the knowledge economy.”²⁵ However it was not until 2005 that the Healthy Life Years indicator was included as one of the Lisbon Agenda indicators²⁶, a first clear indication of the importance of health as a contributor to meet the targets of the Lisbon agenda, that EU should become the ‘the most competitive and dynamic knowledge-based economy in the world, capable of sustainable economic growth with more and better jobs and greater social cohesion.’²⁷ Progress in highlighting the role of health in preparing for demographic change was confirmed when Member States

²³ Liu et al, *Heart* 2002;88:597-603

²⁴ National Audit Office (England) 2001

²⁵ Point 24. European Council Conclusions, Lisbon 23-24 March 2000.

²⁶ Brussels, 3.2.2005, SEC (2005) 192, Lisbon Action Plan Incorporating Eu Lisbon Programme And Recommendations For Actions To Member States For Inclusion In Their National Lisbon Programmes, Companion document to the Communication to the Spring European Council 2005 {COM (2005) 24}, Working together for growth and jobs.

²⁷ Point 5, European Council Conclusions, Lisbon 23-24 March 2000

submitted their National Programmes for implementation of the Lisbon strategy to the Commission in 15 October 2005. Several Member States included the need for reform of the health sector. For example, the “Estonian National Action Plan for Growth and Jobs²⁸” notes that “Estonia annually loses 6–7% of its potential labour force due to the premature morbidity and disability”.²⁹ The action plan suggests a specific priority to “Improving the health of the population and ensuring better working environment” as a way to increase the labour supply.

The EU’s Sustainable Development Strategy, initially adopted at the Gothenburg European Council in 2001, is to be updated in 2006 with a greater emphasis on health including the promotion of healthy and active ageing. The strategy covers a range of issues including demographic change, public health, climate change, transport and global poverty, and reinforces the general principles of integrated policy-making and long term competitiveness. The EU Structural Funds are now able to be used for health-related projects, which could lead to the reduction of inequalities within Member States at regional level, including helping health systems prepare to support an ageing population.

This progress in including health in overall EU economic policy, highlighting it as a factor in economic prosperity including in relation to preparing for demographic change, is therefore leading to actions at the national level which will lead to health policy aimed at supporting an ageing population. Increasing Healthy Life Years is not just the domain of health departments at any level of government. Health administrations working on their own, without the cooperation of other sectors, will always have limited success. The recognition that health underpins economic prosperity, and therefore that investing in health and health systems is an investment, is a vital step forward for EU and national policy.

3.2 Preparing for the Consequences of an Ageing Population

a. EU Policy on Health Systems

Tackling lifestyle-related disease through health promotion and prevention is important and needs to be better integrated within the running of the wider health system. Health systems include ‘all activities whose primary purpose is to promote, restore, or maintain health’.³⁰ This includes formal setting like hospitals, primary care units and clinics, their workforce, infrastructure, purchasing and catering, as well as home care of the sick, health promotion and disease prevention. The Health systems also encapsulate policy planning and management by government and other bodies.

It is clear that an ageing population in poor health can generate additional costs for healthcare budgets, but evidence shows that improved population health can greatly

²⁸ Republic of Estonia, Action Plan for Growth and Jobs 2005–2007, for implementation of the Lisbon Strategy. Tallinn 2005.

²⁹ Ibid, Pg 50

³⁰ WHO World Health Report 2000: Health Systems – Improving Performance

reduce projected increases in spending. ECFIN projections have shown that if healthy life expectancy can be increased proportionately as life expectancy increases, then the projected increase in health care spending due to ageing alone can be halved.³¹ The impact of this could be substantial. A study by Grammelos, one of the Walter Studies commissioned by the EU in relation to work in the field of demographic change, states that health care expenditure for the elderly currently amounts to about 30% - 43% of total health expenditure across the EU, and that disability among the elderly accounts for around 50% of health care budgets in the current EU-25 countries and is projected to rise with the increase in the elderly population.³² This emphasises the importance of increasing the number of healthy life years, as an effective means of tackling the challenge of rising health care costs for the ageing population.

Integrated health care

The greatest burden of disease in older people is chronic disease like cardiovascular disease and diabetes. In the UK, 50% of hospital bed day use is accounted for by only 2.7% of all medical conditions, most of which are chronic diseases.³³ Efficient healthcare spending means continuity of care and good management of chronic disease, and integrated provision of services provided at home as well as in care institutions and hospitals. This is not only a more efficient use of funding, but a paradigm which respects patients' rights and dignity. In general, effective, low cost, public health based interventions, such as providing stop-smoking programmes, systematic identification of cardiovascular risk factors, can have a significant impact on the biggest killers, and can save health systems money in the long run. Examples such as Sweden's 'Preventive Home Visits' have been identified as good practice in promoting healthy ageing, by a 3 year study of healthy ageing policies across the EU. Initial findings by the study based in Nordmaling, Sweden, found that the group that received home visits from a health professional showed a decrease in indicating pain and anxiety, a decrease in GP visits and lower mortality than the control group.³⁴ The EU has a role to play in encouraging such policies and in fostering exchange of good practice across the EU.

Pharmaceuticals and Medical Devices

The development of innovative pharmaceuticals raise issues about efficient spending by health systems, as illustrated in the recent court cases in the UK around prescription of the breast cancer drug Herceptin. It is important that decisions about the use of these drugs are based on evidence about whether they are more effective or more efficient than existing ones, for example through relative effectiveness assessments. Of course, the primary responsibility for making such assessments and taking the consequent decisions rests with the Member States. Nevertheless, European cooperation can help to develop shared methodologies and to avoid duplication of effort in evaluating new technologies and techniques. The Commission's Pharmaceutical Forum and the European Network for Health Technology Assessment (EUnetHTA) are both initiatives aiming to facilitate exchange and to build on the experiences of Member States and the

³¹ The impact of ageing on public expenditure : projections for the EU25 Member States on pensions, health care, long-term care, education and unemployment transfers (2004-2050) DG ECFIN Special Report no 1/2006, p.133

³² Grammelos, S, Centre for European Social and Economic Policy (CESEP), Implications of Demographic Ageing in the Enlarged EU in the Domains of Quality of Life, Health Promotion and Health Care, 2005 – of the DG EMPL 'Walter Studies'

³³ Chronic Disease management – a compendium of information, UK Department of Health May 2004

³⁴ A cost-utility analysis of preventive home visits in Nordmaling, Sweden, Umea University, project ongoing

industry to develop further the promising field of relative effectiveness assessments.

What can the EU add?

The significant changes to the population mean that planning ahead is vital, and although each health system at national and local level across the EU is unique, the EU has a key role to play in sharing good practice to improve efficiency in particular in relation to elderly care. The Employment, Social Policy, Health and Consumers affairs (EPSCO) Council took an important step for EU action in the field of health systems by agreeing a set of “Common Values and Principles in EU Health Systems” in June 2006³⁵

The Commission’s High Level Group on Health Services and Medical Care brings together Member States together with other stakeholders to help facilitate practical cooperation on healthcare issues. It has been active since July 2004 on issues such as health professionals, cross border healthcare purchasing and provision, networks of centres of reference, health technology assessment, e-health, patient safety, and health systems impact assessment. Although these issues are not directly aimed at older people, improving efficiency in all these areas will make health systems better prepared for demographic ageing.

In 2004 the Council decided to extend the Open Method of Coordination (OMC) to healthcare and long-term care. The OMC is an EU policy tool whereby EU countries exchange information and identify best practice while remaining fully responsible for the organisation of their services. In 2005, EU countries submitted national statements regarding access, quality and sustainability in the fields of health and long-term care, which led to the identification of common challenges faced by EU Member States in those fields. EU countries have now agreed on the common policy objectives for healthcare and long-term care based on the analysis exercise, in the areas of access, quality and financial sustainability of health and long term care.³⁶

The Commission is also preparing a proposal for a Community framework for safe, high-quality and efficient health services, by reinforcing cooperation between Member States and providing clarity and certainty over the application of Community law to health services and healthcare.

b. Conclusion

Policy to increase Healthy Life Years incorporates policy directed at ageing, but also wider policy actions including a focus on promotion and prevention across the lifecycle, and work across all sectors of government. This public health-focused work needs to be better incorporated into health systems planning, where low cost preventative interventions can lead to significant savings on hospital care, for example. EU level actions can support national governments in increasing healthy life expectancy and preparing their health systems for demographic change.

³⁵ available at www.consilium.europa.eu

³⁶ http://ec.europa.eu/employment_social/social_protection/docs/spc_ltc_2005_en.pdf.

4. Conclusion

This paper has given an overview of current demographic trends including life expectancy and healthy life expectancy. It has argued that, without active policy intervention, there is uncertainty as to whether healthy life expectancy will increase as the overall population gets older. It has set out the policies that are being developed to support a continued increase, which is necessary to sustain Europe in the face of demographic ageing.

Much has been done, and is in progress, but important challenges remain. Work to move towards a culture of investment for the future in terms of health needs to continue. Monitoring of policies and research in the field is vital, and EU initiatives must continue to increase the focus on health across all sectors.

a. A Culture of 'Investment'

This paper has argued that improving the health of the population will lead to a healthy workforce and a healthy and active older population. Carefully monitored health investments are therefore a necessary tool to ensure sustainable public finances. Unfortunately, these investments are often substantial, and the time between investment and results, for example tackling childhood obesity with the aim to support healthy ageing, is often so long that it exceeds the possible commitments of any single individual working on the topic. An institutionally-based 'long view' must be taken to ensure Europe is financially sustainable in 2050 and beyond. This culture of investment must focus on the inequalities which continue to exist within and between Member States, particularly in rural areas and in the new and accession Member States. Health policy clearly needs to be linked to funding mechanisms like the Structural Funds and the European Social Fund.

b. Monitoring and Research into Healthy Ageing

If we are to increase the number of healthy life years of the population, we must have a means to measure successful outcomes, both in terms of collectable data to give comparisons between Member States, but also good quality research to identify best practice. The Healthy Life Years indicator is one useful official measure as included in the Lisbon strategy. The SHARE survey³⁷ is producing valuable data as a baseline for a longitudinal study on ageing, alongside other projects funded by the Commission under framework programmes for research and technological development and other funding sources, as well as other research. However, it will still take time before the dynamics of ageing populations are fully understood. Increasing migration within the European Union is a factor which will make it increasingly hard to follow and measure the impacts of policies aimed to improve healthy ageing.

c. Future Initiatives

A number of initiatives which will support policy on healthy ageing are currently under development. The Commission plans to publish a Communication on Demographic

³⁷ Survey of Health, Ageing and Retirement in Europe, first results published 2005 by MEA

Change following the Green Paper of 2005 on Confronting Demographic Change: a New Solidarity Between the Generations³⁸ to set out the key challenges for the coming years. The Commission's proposal for a new programme for community action in the field of health will be considered by European Parliament and Council. An overarching Health Strategy, pulling together EU work on Health with a view to setting objectives for the future will follow. The Lisbon Agenda continues until 2010. The EU must continue to consider demographic ageing as it moves forward.

In conclusion, this paper has shown how health policy can support active ageing, and how this must continue to be a central focus of concern at both EU and national level in the future, as the keystone for a sustainable Europe.

³⁸ COM(2005)94