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EU  
HEALTH POLICY  
FORUM

Final

**Recommendations on  
Health and EU  
Social Policy**

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## EU HEALTH POLICY FORUM

### RECOMMENDATIONS ON HEALTH AND EU SOCIAL POLICY

#### ABSTRACT

On 22 November 2002, the EU Health Policy Forum conducted a session on health and social policy. Members of the Forum, the European Public Health Alliance, EuroHealthNet, and the European Federation of Public Service Unions, delivered presentations outlining links between health and social policy. These organisations were consequently requested by the Forum to draft a policy paper on the issue of health and social policy. The present paper being the result.

The dynamic of the EU health strategy can be summarised by the inter-relationship between accessibility, improvement of quality, and financial sustainability. The relationship between health and social policy is reflected in the accessibility which deserves more attention. As accessibility is a cornerstone in fighting health inequalities and social exclusion the European Commission should address this.

One important way to address the issue of accessibility is through long-term preventive intervention. Doing this will lessen the financial pressure on health systems. This correlation should be recognized.

Availability, accessibility, acceptability and quality must be taken as a foundation for reconciling national health policy with European obligations.

In the future, the EU Treaty should prioritize citizens' health. The European Commission should provide a coherent health policy through a Commissioner for Health supported by a Directorate General for Health. More resources should be allocated to health and a balance between economics and social policy should be reflected in the European Commission's legislative proposals.

#### ***Keywords***

Accessibility  
Equity in health  
Health promotion  
Resources to health

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## EU FORUM ZUR GESUNDHEITSPOLITIK

### EMPFEHLUNGEN ZUR GESUNDHEITS- UND EU-SOZIALPOLITIK

#### AUSZUG

Am 22. November 2002 befasste sich das Gesundheitspolitische Forum der EU mit Fragen der Gesundheits- und Sozialpolitik. Einige Mitglieder des Forums (European Public Health Alliance, EuroHealthNet und Europäischer Gewerkschaftsverband für den öffentlichen Dienst) unterstrichen in ihren Präsentationen die Bezüge zwischen diesen beiden Politikfeldern. Deshalb wurden diese Organisationen vom Forum aufgefordert, den Entwurf eines Strategiepapiers zum Thema Gesundheits- und Sozialpolitik zu erstellen. Das vorliegende Papier ist das Ergebnis.

Die Dynamik der EU-Gesundheitsstrategie ergibt sich global betrachtet aus der Wechselwirkung zwischen Zugänglichkeit, Qualitätsverbesserung und finanzieller Tragfähigkeit. Ein zentraler Aspekt der Beziehung zwischen Gesundheits- und Sozialpolitik ist die Frage der Zugänglichkeit, der mehr Aufmerksamkeit gewidmet werden muss. Die Zugänglichkeit spielt eine entscheidende Rolle bei der Bekämpfung von sozialer Ausgrenzung und Ungleichheiten in der Gesundheitsversorgung, weshalb sich die Europäische Kommission eingehend mit dieser Thematik befassen sollte.

Ein maßgeblicher Weg, um die Zugänglichkeit zu verbessern, sind langfristige Präventivmaßnahmen, mit denen zugleich der finanzielle Druck auf die Gesundheitssysteme gemildert wird. Dieser Wechselbeziehung sollte mehr Beachtung geschenkt werden.

Verfügbarkeit, Zugänglichkeit, Annehmbarkeit und Qualität – an diesen Pfeilern müssen sich die Maßnahmen ausrichten, um die nationale Gesundheitspolitik mit den europäischen Verpflichtungen in Einklang zu bringen.

Künftig sollte die Gesundheit der Bürger im Vertrag als vorrangiges Ziel festgeschrieben werden. Die Europäische Kommission sollte eine kohärente Gesundheitspolitik betreiben, wofür sie einen Kommissar für Gesundheit benötigt, der durch eine Generaldirektion „Gesundheit“ unterstützt wird. Es sollten mehr Ressourcen für Gesundheitsfragen bereitgestellt werden, und in den Legislativvorschlägen der Europäischen Kommission sollte auf Ausgewogenheit zwischen wirtschaftspolitischen und sozialen Belangen geachtet werden.

#### *Schlagwörter*

Zugänglichkeit  
Gleichheit im Gesundheitswesen  
Gesundheitsförderung  
Ressourcen für Gesundheit

## FORUM UE SUR LA POLITIQUE DE LA SANTÉ

### RECOMMANDATIONS SUR LA SANTÉ ET LA POLITIQUE SOCIALE DE L'UE

#### RÉSUMÉ

Le 22 novembre 2002, le Forum européen sur la politique de la santé a organisé une séance sur la santé et la politique sociale. Des membres de ce Forum - European Public Health Alliance, EuroHealthNet et Fédération des syndicats européens des services publics - ont souligné, dans leurs exposés, les liens entre la santé et la politique sociale. Invitées en conséquence par le Forum à rédiger un document sur la question de la santé et la politique sociale, ces organisations ont produit le présent document.

La dynamique de la stratégie de l'UE en matière de santé peut se résumer comme l'interdépendance de l'accessibilité, de l'amélioration de la qualité et de la viabilité financière. Un élément essentiel de la relation entre la santé et la politique sociale est l'accessibilité qui mérite une plus grande attention. L'accessibilité étant la pierre angulaire de la lutte contre les inégalités en matière de santé et l'exclusion sociale, la Commission européenne devrait se pencher sur cet élément.

Une manière d'aborder la question de l'accessibilité est une intervention préventive de longue durée qui permettra d'alléger la pression financière exercée sur les systèmes de santé. Il faudrait prendre conscience de cette corrélation.

La disponibilité, l'accessibilité, l'acceptabilité et la qualité sont les quatre piliers sur lesquels il faut s'appuyer pour concilier la politique nationale en matière de santé et les obligations européennes.

La santé devrait figurer à l'avenir parmi les priorités du Traité. La Commission européenne devrait mettre en place une politique de santé cohérente, avec un commissaire de la santé qui serait assisté par une direction générale de la santé. Des ressources supplémentaires devraient être consacrées à la santé et les propositions législatives de la Commission européenne devraient exprimer un équilibre entre l'économie et la politique sociale.

#### *Mots clés*

Accessibilité  
Égalité en matière de santé  
Promotion de la santé  
Ressources consacrées à la santé

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## Why a paper on health and social policy?

The highest attainable standard of health is a global public good and a fundamental human right. Healthy populations are economically more productive and socially cohesive. Although throughout the European Union, life expectancies have increased and mortality rates have fallen, significant inequalities in health status exist within countries and across the Union. Individuals from lower socio-economic groups consistently have poorer health status throughout their lives, make the most use of primary and secondary healthcare services, are the lowest users of preventative health services and die as much as 10 years earlier than counterparts in more affluent areas. Furthermore, social exclusion impacts negatively on health as the most marginalised groups in society lack the social support needed to maintain health and well-being. The single largest determinant of ill health due to communicable diseases is poverty, whether defined by income, living conditions or education. In this respect accession countries face specific challenges on HIV/AIDS, TB, Diphtheria.<sup>1</sup> A policy goal should be to reduce the proportion of the population that falls behind and the distance that it falls behind<sup>2</sup>.

Health does not exist in a vacuum. It is dependent on the social and environmental context as well as high quality and effective healthcare systems. The goal of public health measures and the role of public health professionals in ensuring health for all parts of the community and population groups is important. Gains in health have been made in a number of areas such as cardiovascular disease and cancer. Challenges remain in these areas, to which enlargement will add a new seriousness. In addition the future will bring new challenges such as tackling the epidemics of obesity and poor nutrition in Europe and its resulting disease burden. This health problem is essentially a social issue, connected to food poverty, deprivation, access to fresh foods as well as how food products are manufactured and marketed. Furthermore, mental and physical health are closely interdependent, and neuropsychiatric disorders rank among the leading causes of disability adjusted life years (DALYS) in all ages in Europe.<sup>3</sup> In addition, the specific needs of individuals with genetic disorders and rare diseases are not adequately addressed. Tackling these issues effectively will need coherent and concerted action in a number of policy areas.

All healthcare systems in the Union feature common principles of solidarity, equity and universality of access despite their diversity in organisation and structure<sup>4</sup>. The European Social Model, or European social market economy, is recognised as a fundamental tenet upon which the EU is built.<sup>5</sup> In the context of health, the challenge facing EU policy-makers is how to give substance to this tenet. The debate has been shaped by the need to reconcile principles of solidarity with the budgetary pressures that exist in the current economic climate and with future demographic changes. These critical issues have been highlighted by the European Commission in its Communication on the future of health care, which stated that the dynamic

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<sup>1</sup> For detailed overview of health aspects of EU enlargement see 'European Health policy Forum recommendations on health and enlargement', adopted November 2002.

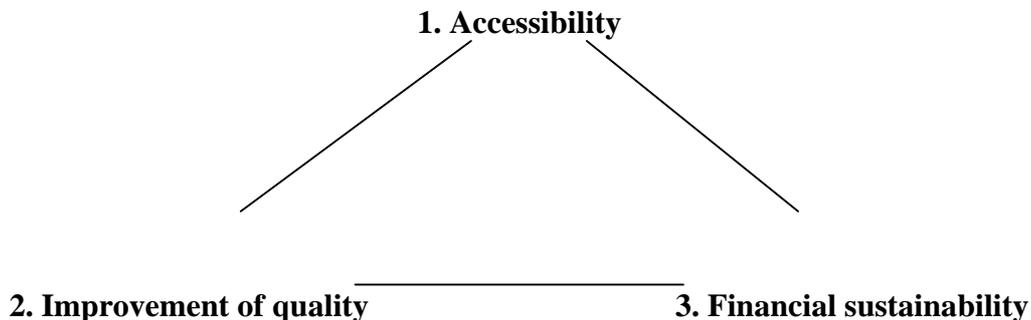
<sup>2</sup> WHO European Health Report 2002, <http://www.who.dk/europeanhealthreport>

<sup>3</sup> WHO European Health Report 2002, <http://www.who.dk/europeanhealthreport>

<sup>4</sup> Conclusions of the Health Council, 26 June 2002, <http://ue.eu.int/pressData/en/lsa/71383.pdf>

<sup>5</sup> Paragraph 22, final report of the European Convention Working Group on Social Europe, CONV 516/03

of the EU health strategy can be summarised by the following relationship<sup>6</sup>. Indeed this has been recently reiterated in the follow-up communication this year.<sup>7</sup>



The relationship between health and social policy is largely reflected in ‘point one’ of the triangle - accessibility. In short, while the European-level debate over the last 2 years has focussed very largely on ‘point 3’ i.e. the financial sustainability of health, in the EU and Member State context, it is important that the fundamental principles upon which the provision of public health, health promotion and health-care systems are based, are adequately articulated. In order to do this, the necessity of a strong link between EU health and social policy must be clearly stated. Public Health and Health Care systems should reflect the following aspects; accountability to every EU citizen; respect for social equity so that universal access is maintained and; efficiency through genuine organisational innovation, rather than through rationalisation of public health and health care personnel or reduction in working conditions. Outlined below are the foundation stones upon which health in Europe is based.

### **Principles of health and the Individual**

- According to the *World Health Organisation*, health is “*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*”.
- The United Nations International covenant on Economic, Social and Cultural Rights recognises; “*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*”.<sup>8</sup>
- The UN Committee on Social and Economic Rights adopted a General Comment on the right to health in May 2000: “*An **inclusive** right extending not only to timely and appropriate health care but also to the underlying determinants of health (safe water, housing, food, environment, living/working conditions, information)*”.
- The 1978 Alma Ata Declaration sets out the principle that governments have a responsibility for the health of their citizens including primary health care and that people have the right and duty to participate individually and collectively in the planning and implementation of their health care.<sup>9</sup>

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<sup>6</sup> “The future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability” COM (2001) 723 final

<sup>7</sup> “COM (2002) 774 final – conclusions state that “ the replies (from the Member States) confirm the usefulness of the three broad objectives of access, quality and sustainability.

<sup>8</sup> Article 12, UN international covenant on Social Economic and Cultural Rights

<sup>9</sup> International Conference on Primary Health Care, <http://www.who.int/hpr/archive/docs/almaata.html>

- The Ottawa Charter for Health Promotion highlights 5 core tasks for reaching health goals: build healthy public policies, create supportive environments, strengthen community actions, develop personal skills, reorient health services.<sup>10</sup>
- The European Social Charter, adopted by the Council of Europe (1961, revised 1996) states that: *“Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable”*.<sup>11</sup>

### Principles of Health and European Union

- Article 152 of the Treaty of the European Union (Amsterdam)<sup>12</sup>
- *“Everyone has the right of access to preventative healthcare and the right to benefit from medical treatment under the conditions established by national law and practices”* Charter of Fundamental Rights of the EU, Adopted in Nice, 12/2000<sup>13</sup>
- In its official submission to the European Convention, the **Health Policy Forum** requested the European Convention Working Group on Social Europe: *“To enshrine as a cornerstone of Social Europe, the unique existing principles of health equity and universality of access to health services in Europe, while respecting the right of the Member States to organise and deliver healthcare systems”*.<sup>14</sup>

Therefore framing health in the context of social policy is required to ensure that the *accessibility – financial sustainability – quality* triangle remains equilateral and indeed equitable.

### Recommendations

- The Intergovernmental Conference (IGC) should include a high-level of human health in Article I-3, Objectives of the Union.
- The EU should commit to implementing the internationally recognised human right to health and the determinants of health.
- The European Commission should identify social policy goals to reduce the proportion of the population that falls behind and the distance that it falls behind.
- The European Commission should address the specific health needs of marginalised and socially excluded groups.

## Outlining health and social policy in public health and health care systems

### Social Policy and Public Health

The correlation between social exclusion and poor health is well established. People’s lifestyles and the conditions in which they live and work strongly affect their health and longevity. The WHO has identified ten aspects of the social determinants of health which include preventing individuals from falling into long-term disadvantage, the impact of work or unemployment, the importance of early childhood, the role of family and social support,

<sup>10</sup> <http://www.who.int/hpr/archive/docs/ottawa.html>

<sup>11</sup> European Social Charter, Article 11 – The right to protection of health  
<http://conventions.coe.int/treaty/en/treaties/html/163.htm>

<sup>12</sup> “A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities”.

<sup>13</sup> Article 35, EU charter of fundamental rights

<sup>14</sup> ‘A Healthy Constitution for Europe’, submitted to European convention on the Future of Europe  
[http://europa.eu.int/futurum/forum\\_convention/documents/contrib/other/0339\\_c\\_en.pdf](http://europa.eu.int/futurum/forum_convention/documents/contrib/other/0339_c_en.pdf)

the need for good nutrition, sustainable transport and smoke free and healthy environments.<sup>15</sup> There is evidence that efforts should be made to raise overall prosperity and relative distribution of health.

The *cycle of poverty – ill health – poverty* is based on the following formulation: factors such as inadequate diet, lost opportunities, illiteracy, physical labour and environmental risks lead to ill health. This ill health in turn causes loss of labour, loss of income, and health-care costs, which result in poverty.<sup>16</sup> This, simplified, synopsis of social exclusion underlines the need for adequate social protection measures. The link between health and employment, income support, welfare, housing and education policies is crucial. In the health context this means preventative health strategies, such as health promotion programmes, to offset health inequalities and aimed at health maintenance and improvement. Specifically this means targeting vulnerable, marginalized groupings within society, particularly women.<sup>17</sup>

In outlining this case, it is important to highlight the positive economic contribution that health promotion strategies can make. In the current EU debate, the potential benefit of investing in public health and promotion is often overlooked or underestimated. Some data exists from the WHO Commission on Macroeconomics and Health<sup>18</sup> and the UK Wanless Report<sup>19</sup> of the return on investment of health promotion. Initiatives to reduce smoking, increase physical exercise and alleviate stress and anxiety have led to higher productivity, less absenteeism and better overall health. Effective and well-implemented health and safety policies can reduce work-related accidents and ill health. The cost of work-related illness reaches almost 4 % of GDP across the Union, 500 million working days are lost due to work related accidents and illnesses and specifically stress, anxiety and depression, the reason for 18 % of workplace health problems, costs the EU economy 20 billion Euros per year<sup>20</sup>. Health promotion goals should include empowering individuals to take greater responsibility for their own health through the provision of appropriate key messages, infrastructure and social support. The long-term impact of proactive health promotion and prevention measures can be very positive in maintaining the solidarity-based nature of health-care system management. In other words taking the long-term preventative approach to health will lessen the financial pressures on health systems.

### **Recommendations**

- The European Union should address the inter-linkage between social disadvantage and poor health.
- The European Union should recognise the positive economic contribution of health promotion strategies

<sup>15</sup> 'Social Determinants of Health: the solid facts' WHO Europe <http://www.who.dk/document/e59555.pdf>

<sup>16</sup> International Council of Nurses, Poverty and Health: Breaking the Link

<sup>17</sup> Article 34 (3) 'Social security and social assistance' of the Charter of Fundamental rights of the European Union makes reference to social protection in case of illness.

<sup>18</sup> WHO Commission on Macroeconomic and Health

[http://www3.who.int/whosis/cmh/cmh\\_report/e/report.cfm?path=cmh.cmh\\_report&language=english](http://www3.who.int/whosis/cmh/cmh_report/e/report.cfm?path=cmh.cmh_report&language=english)

<sup>19</sup> 'Securing our future health: taking a long-term view', an independent review'

[http://www.hm-treasury.gov.uk/Consultations\\_and\\_Legislation/wanless/consult\\_wanless\\_final.cfm](http://www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_final.cfm)

<sup>20</sup> European Agency for Safety at Work statistics

## Social Policy and Health-Care Systems

The link between social policy and health care systems exists on many levels. At European level Regulation (EEC) No 1408/71, is the clearest example of this link<sup>21</sup>. However, reconciling national health policy with European obligations remains the most sensitive aspect of this issue. Article 152, paragraph 5 of the EU Treaty states that “*Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care*”. However subsequent rulings by the European Court of Justice, in particular the Kohll (C-158/96), Decker (C-120/95) Smits-Peerbooms (C-157/99) and Müller-Fauré cases (C-385/99), have challenged the extent to which the *responsibilities of the member states* takes precedent over internal market regulations. Despite the explicit reference to responsibility, National health systems are not immune from internal market rules. In this regard, as the European Court of Justice has constantly reasserted, health care services are covered by the principle of the "Free Provision of Services", one of the European Union's four fundamental freedoms. This has important consequences at a number of levels; for the organisation of health care services; for the future financing plans and for the mobility of patients. Therefore, drawing and redrawing the fine line between ‘economic’ and ‘non-economic’ activity, such as health-care, is what the legal concerns and ECJ judgments are about. Acknowledgements of these ambiguities and attempts to clarify them have started at the European level.<sup>22</sup>

The General Comment to the ‘right to health’ adopted in May 2000 by the UN Committee on Social, Economic and Cultural rights, provides 4 key evaluation criteria on health. These could be usefully integrated into national and European policy as indicators:

**Availability:** functioning public health and healthcare facilities, with sufficient quantity.

**Accessibility:** no exceptions; no physical, economic, information barriers, principle of non-discrimination to apply.

**Acceptability:** culturally appropriate and medically ethical procedures and techniques, which improve health.

**Quality:** medically and scientifically appropriate and of good quality

### Recommendations

- In the debate on reconciling national health policy with European obligations, the European Union and its Member States must take as its foundation the principles of availability, universal accessibility, acceptability and quality.
- The European Court of Justice should not in its rulings, formulate health policy. Policy-making is the competence of the Health Council and the Member States.
- The conclusions of the ‘high level reflection group on patient mobility’, should clearly state that the principle of mobility of patients must not increase/contribute to further health inequalities.
- Recognition at EU level of health care systems as non-economic services of general interest must be forthcoming.

<sup>21</sup> Council Regulation (EEC) No 1408/71 of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community

<sup>22</sup> 2002 has seen the Commission Communication on health care and care of the elderly (and follow up), the European Parliament response (Mantovani report on health care and the internal market PE 316.377) and the establishment of the High Level Reflection Group on patient mobility

## **Future Focus**

### **Convention on the Future of Europe and the Intergovernmental Conference (IGC)**

The future EU Treaty must put an emphasis and priority on citizens' health. This means that the Convention on the Future of Europe and the subsequent IGC, while recognising that the funding and organisation of health care remains a Member State competence, needs to combine the "acquis" already included in the Treaty, in particular the *high level of social protection* and a *high level of human health*, with the right of equal access to health included in the Charter of Fundamental Rights. The goal should be promoting accessible and financially sustainable and high quality healthcare organised on the basis of solidarity. This also means that European policies must measure their impact on national health care systems in order to prioritise the principle of solidarity ahead of competition.

### **Organisation of health in the EU institutions**

The profile of health needs to be raised amongst the institutions and clear leadership provided for a coherent health policy. This means having a Commissioner for Health supported by a Directorate General for Health. The fragmented approach to health issues would end by a re-integration of the policy areas of public health, health and safety at work, social affairs, recognition of health professional qualifications, pharmaceuticals and medical devices and environmental health. These are currently managed by Directorates General SANCO, EMPL, MARKT, ENTERPRISE, DEVELOPMENT, TRADE and ENVT.

In addition, the role of the EU Health Policy Forum should be noted as being particularly relevant, due to the broad range of stakeholders represented. In particular, opportunity should be given to the stakeholders to identify and articulate issues, which may not have been identified within the EU's health strategy.

### **Resources for health at EU level**

The level of funding for health at EU level and particularly the new EU Public Health Programme is inadequate. At 312 million Euros over 6 years, this is the equivalent of less than 14 cents per person per year. In the context of the threat of bioterrorism and communicable diseases, such as the SARS epidemic, it is logical that significant emphasis should go towards a surveillance network and the planned European Centre for Disease Prevention and Control. However, a large proportion of the funds from the new Programme will go towards reinforcing cooperation between Member States on these issues and therefore not be available for activities by civil society and the public health community. Advantage needs to be taken of the bridging role that civil society and the public health community plays, in ensuring that socially excluded groups are given a voice. The local community focus of civil society groups is an element that needs to be given particular emphasis. Strengthening the capacity of NGOs to fully participate in EU policy-making related to health must be a key priority.

There should be recognition by the EU budgetary authorities (Council, Parliament) of the economic savings offered by effective health promotion and prevention and realistic, adequate funding should be allocated for public health programmes as an essential strategic investment. Indeed, the Lisbon goals of becoming the most competitive knowledge based economy in the world with sustainable economic growth can only be met if sufficient investment is made in health prevention and promotion.

The EU Public Health Programme must take into account the needs of Europeans with disabilities, many of whom are socially excluded, and are consequently more vulnerable to related health problems, when setting out its agenda. 2003 is European Year of People with Disabilities so now is the right time to address this.<sup>23</sup>

The human rights of refugees, asylum-seekers and illegal immigrants of access to appropriate and high quality healthcare facilities needs to be safeguarded<sup>24</sup>. Today, certain Member States have remained neutral in an increasing climate of hostility towards immigrants, inviting medical authorities to re-assess policies regarding illegal immigrants.

The Open Method of Co-ordination, including the definition of common objectives determined at European level and implemented at national level, including the introduction of qualitative and quantitative evaluation indicators and a monitoring and assessment procedure is needed for health policy issues. Member States should be supported in developing innovative approaches to health care policy which aim to preserve solidarity in financing health care, informing citizens about their cross border health care rights, supporting European wide training measures for health care professionals, supporting cross border co-operation between health care institutions and establishing binding and non-binding quality standards in health care.

The European Commission should introduce a rigorous health impact assessment mechanism in order to ensure that a 'high level of health protection is ensured in all EU policies'. Furthermore, the introduction and implementation of health impact assessments at national level should be encouraged.

Criteria need to be outlined to ensure that applied and basic research is conducted in a manner, which promotes the widest possible application of, and access to the findings.

The priority given by the European Union to combating poverty and promoting social inclusion should make access to quality care for all one of the key indicators of success.

### **European Policies**

The balancing of Economic and Social Policy in the context of health needs to be reflected in commission legislative proposals (European Commission – Green Paper on Services of General Interest).

The Commission, in the framework of the WTO, must defend in GATS (General Agreement on Trade in Services) the concept of 'health care services' as part of services of general interest, and therefore exempt from WTO GATS rulings.

The '*scoreboard on the implementation of the social agenda for social policy*' should make explicit, annual reference to the health status. Recommendations as to how this can be practically achieved should be tabled by the EHPPF.

Active support for the social dialogue process as a progressive method of insuring a high level of health must be forthcoming.<sup>25</sup>

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<sup>23</sup> This point is valid in the general context of social exclusion and disability, but has been specifically referenced by the European Blind Union, which highlights the need for health campaigns and health information to be in formats accessible for blind and partially sighted people. It details how this can be achieved in its working document 'The Access to Information Principles and Guidelines'.

<sup>24</sup> European social charter (1996) Article 19 <http://conventions.coe.int/treaty/en/treaties/html/163.htm>

<sup>25</sup> A recent NHS study in the UK showed a marked improvement in patient care due to the introduction of partnership mechanisms between staff and employers. This has also been recognised by the International Labour organisation - [www.ilo.org/public/english/dialogue/sector/techmeet/](http://www.ilo.org/public/english/dialogue/sector/techmeet/)

### **Recommendations**

- The Intergovernmental Conference (IGC) must provide the legal basis to combine the “acquis” already included in the Treaty, in particular the *high level of social protection* and a *high level of human health*, with the right of equal access to health included in the Charter of Fundamental Rights. The goal should be promoting accessible and financially sustainable and high quality healthcare organised on the basis of solidarity.
- In order to properly assess the link between health and social policy, a Commissioner for Health supported by a Directorate General for Health should be established.
- The Commissioner for Health should formulate a system to allow that European policies measure their impact on national health care systems in order to prioritise the principle of solidarity ahead of competition.
- The EU Public Health Programme funding should be significantly augmented. The EHPF should work to raise awareness of the contrast with resources allocated at EU level for other policies such as scientific research, CAP and in particular subsidies for tobacco farmers in Europe.
- Recognition should be given to, and advantage taken of the bridging role that civil society and the public health community plays, in ensuring that socially excluded groups are given a voice.
- There should be coherence between internal and external policies of the Union. The European Commission should ensure that as the mandated interlocutor for the World Trade Organisation (WTO) negotiations on the General Agreement on Trade in Services (GATS), all requests to third countries in the field of health respect the right of those countries to exempt health from negotiations, based on the rationale of the specificities of health care delivery as used by EU member states.
- The European Commission should give full support to the development of the social dialogue process in the hospital sector in the EU.

It is recommended that this document be reassessed on a biennial basis to incorporate developments in health and social policy, and to reflect the evolution of the EU Health Policy Forum.

## Annex 1: Position of European Private Hospitals

The European Union of private hospitals (UEHP) welcomes the “**Recommendation on Health and EU Social Policy**”, presented by EPHA, concerning availability, accessibility, acceptability, quality as key evaluation criteria on health. Nevertheless **the UEHP common position is different in regard to the prioritisation of solidarity ahead competition, because solidarity can be guaranteed also in a competitive environment, like required by the general rules of the Internal Market.** In the UEHP opinion, competition is not a principle always contrasting with solidarity. On the contrary, competitive mechanisms of social markets have been implemented by many Member States in their health care reforms, in order to ensure a real equity in access, according to the welfare principles. Effective management, stimulated by competition, provides a better use of resources and by consequent it offers the real possibility of fully respecting human and social rights, by preventing the rationalisation of health expenditure from giving rise to rationing of services.

Free movement of patients aims to avoid serious consequences on health status caused by queues in the access to health services. By consequent **the UEHP cannot share the statement that the European Court of Justice in its rules formulates health policy.** In fact, **the ECJ protects European patients’ rights and it guarantees the respect of Treaty principles, concerning free movement of citizens, goods, services and capitals.**

In the **COMMISSION COMMUNICATION “Internal Market Strategy - Priorities 2003 – 2006”** [COM(2003) 238 final - Brussels, 7.5.2003] it is stated that “**well managed application of Internal Market rules to the health care sector has the potential to help both patients and providers by allowing the most efficient possible use of resources across the EU.**” In the same document it is underlined the necessity “**to develop a shared vision of the ways in which the Internal Market can support national health systems in full compliance with the relevant jurisprudence of the European Court of Justice.**”

Concerning the Recommendation statement, that the “**recognition at EU level of health care systems as non-economic services of general interest must be forthcoming**”, the UEHP underlines that the **European Commission** within the recent “**Green paper on services of general interest**” [COM (2003) 270 final] makes clear that: “**...economic and non-economic services can co-exist within the same sector and sometimes even be provided by the same organisation. Furthermore, while there may be no market for the provision of particular services to the public, there may nevertheless be an upstream market where undertakings contract with the public authorities to provide these services. The internal market, competition and state aid rules apply to such upstream markets.**”

Alberta Sciachi  
PRESIDENT OF THE UEHP



## **Annex 2: List of supporting and abstaining organisations**

AER – Assembly of European Regions  
AESGP – Association of the European Self-Medication Industry  
AGE – European Older People’s Platform  
AIM – Association Internationale de la Mutualite  
ASPHER – Association of Schools of Public Health in the EU Region  
CHANGE – Coalition of HIV and AIDS Non Governmental Organisations in Europe  
CPME – Standing Committee of European Doctors  
EAGS – European alliance of Patients Support Groups for Genetics services  
EATG – European Aids Treatment Group  
EBU – European Blind Union  
ECH – European Committee for Homeopathy  
ECL – The Association of European Cancer Leagues  
EDF – European Disability Forum  
EFA – European Federation of Allergy and Airways Disease Patients  
EFPIA – European Federation of Pharmaceutical Industries and Associations  
EGA – European Generic medicines Association  
EHMA – European Health Management Association  
EHN – European Heart Network  
EHTEL – European Heart Telematics  
EMA - European Midwives Association  
ENSP - European Network for Smoking Prevention  
EPHA – European Public Health Alliance  
EPSU - European Federation for Public Service Unions  
ESMHD - European Society for Mental Health and Deafness  
EUCOMED  
EUPHA – National Associations of Public Health for the European Public Health Association  
EUROCARE – Advocacy for the prevention of Alcohol Related Harm in Europe  
EuroHealthNet – European Network of Health Promotion Agencies  
EUROPA DONNA – The European Breast Cancer Coalition  
EURORDIS - European Organization for Rare Disorders  
GAMIAN-EUROPE – Global Alliance for Mental Illness Advocacy Networks  
GIRP – Groupment International de la Repartition Pharmaceutique  
HAI – Health Action International  
HOPE – Hospitals of EU  
IAPO – International Alliance of Patients’ Organizations  
IPPFEN – European Network Parenthood Federation  
IUHPE – International Union for Health Promotion and Education  
MHE-SME – Mental Health Europe-Sante Mentale Europe  
PCN – Standing Committee of Nurses  
PGEU – Pharmaceutical Group of the European Union  
Red Cross/EU  
UEHP/CEHP – European Union of Private Hospitals  
UEMS/EUMS- European Union of Medical Specialists  
Youth Forum Jeunesse

### **Abstaining:**

BEUC – Bureau Europeen des Unions de Consommateurs  
ESIP – European Social Insurance Partners Association