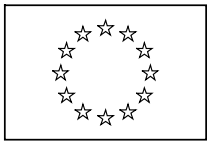
EN



COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels, 05.12.2001
COM (2001) 723 final

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

The future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability

TABLE OF CONTENTS

Introduction

For Europeans, a high level of protection against the risk of illness and dependence is a vital asset that must be preserved and adapted to the concerns of the modern world, particularly demographic ageing.

This prompted the Lisbon European Council of March 2000 to stress that social protection systems needed to be reformed in order to be able to continue to provide good quality health services. Subsequently, in June 2001, the Göteborg European Council called on the Council, "*in conformity with the open method of coordination and on the basis of a joint report of the Social Protection Committee and the Economic Policy Committee (...) to prepare a progress report for the Spring 2002 European Council on guidelines in the field of health and care for the elderly. The results of the work will be integrated into the Broad Economic Policy Guidelines*". (§ 43)

Accordingly, and in the spirit of the conclusions of the Lisbon European Council, which define the open method of coordination as being based on partnerships between different actors, within their respective powers, the Commission hopes that this communication will contribute to achieving the task conferred upon it by the Göteborg European Council.

The EU has an overall health situation and health care systems among the best in the world. The widespread extension of cover against sickness and invalidity, along with other factors such as the rise in the per capita standard of living, improved living conditions and better lifestyles, not to mention better health education, is one of the main reasons for this.[1]. It is what has made it possible to shield people from the financial consequences of ill-health and at the same time to sustain the rapid, ongoing progress in medicine and treatments. It therefore represents an essential part of the operation of health systems in general and the substantial share it represents in overall health expenditure makes this branch of social protection the largest behind retirement and survivors' pensions.

Total health care spending rose from around 5% of GDP in 1970 to over 8% in 1998, with most of this increase occurring before 1990. Public health care spending followed the same trend, growing faster than GDP from 1970 to 1990 (rising from 3.9% of GDP to some 6%), and at a slightly lower rate since 1990, in particular as a result of efforts to rein in public spending in all Member States. Since 1999, however, health expenditure has returned to a level of growth higher than GDP in several countries[2].

---

[1] The overall performance of health care provision does not depend directly on the volume of expenditure on health and therefore on the care system. While in Germany, for instance, this expenditure care amounted to more than 10% of GDP in 1999 (the highest in the European Union) compared with 7% in Spain, people in Germany can expect to live two years less than people in Spain; life expectancy in Germany is lower than that of British men and equal to that of British women, although the United Kingdom spends considerably less on health care (6.8% of GDP).

[2] See graph 1, Annex 3.

Health care systems in the European Union face the challenge of attaining at the same time the three-fold objective of access to health care for all, a high level of quality in health care and ensuring the financial viability of health care systems.

COMMON ISSUES

1 The impact of demographic ageing on health care systems and expenditure

The ageing of the population involves two aspects:

- People *live longer*[3]. Since 1970, life expectancy at birth has risen by 5.5 years for women and almost five years for men. Despite substantial differences — men in Sweden and women in France had a life expectancy three years higher than their Finnish and Irish counterparts in 1997 — average life expectancy in the EU is one of the highest in the world and is continuing to rise. In 2000, it was 74.7 years for men born in that year and 81.1 years for women: in 2050, according to Eurostat's base scenario, it will be 79.7 and 85.1 years respectively. This higher life expectancy at birth also means higher life expectancy in "good health" and in the absence of disability.

- There are *more elderly people*. The share of the total European population older than 65 is set to increase — from 16.1% in 2000 to 22% by 2025 and 27.5% by 2050; the share of the population aged over 80 years (3.6% in 2000) is expected to reach 6% by 2025 and 10% by 2050[4].

While these trends are difficult to ascertain with accuracy, they may have major consequences on developments in *health care systems*. The fact is that per capita health expenditure increases sharply after the age of 65 and even more sharply after the age of 80. Old people's greater morbidity (often as a result of a combination of illnesses), the seriousness and more chronic nature of age-related diseases, which can lead to dependence on others, are just some of the factors that explain this distribution of expenditure by age group. The health information system envisaged in the proposal pending for a public health action programme will enhance knowledge on these issues.

It is nevertheless difficult to predict the state of health that old people will experience in the future, or the life expectancy "in good health" of the generations due to turn 60 in around 2030. The first difficulty is that health care expenditure is concentrated during the last year of life, whatever age the person is, and that intensive care costs during this last year of life are lower if the person is very old. Moreover, improved standards of living and better education (which, alongside the health system, are the main determinants of health) may help to improve the overall health of the population by encouraging people to adopt healthier lifestyles and a prevention-based attitude. This could postpone the age at which health care consumption increases, and reduce the risk of high dependence among the oldest people. But, conversely, these older

---

3 See graph 2, Annex 3.

4 See graph 3, Annex 3.

persons, more accustomed to a high level of health care, may demand the latest treatments, which are probably more costly.

It is also clear that the increase in the numbers of elderly people will increase the pressure on the public sector for long-term care. Age-related illnesses, which may be serious enough to make sufferers completely dependent on others, require long-term care (outpatient care, in long-stay units or in psychiatric units). Such care is not a matter for the "conventional" health system, but for the medical-social sector. The increase in the number of smaller and more unstable family structures could undermine the family networks of solidarity and make the provision of health and care within families more difficult to continue. Consequently, if the number of people requiring long-term care increases, and given the rise in employment rate for women (the primary informal care providers), specific measures will have to be taken. The factors related to how provision is organised are thus crucially important in this context.

This nature of the effects of ageing is reflected in the estimates of its impact on public expenditure carried out by the Economic Policy Committee of the European Union by national correspondents in the working party on ageing, using a simple methodology but one which is not without its uncertainties[5]:

- If the basic scenarios showing population trends are confirmed, public expenditure on *health care* could increase for the period 2000-2050 by between 0.7 GDP points (low hypothesis for DK) and 2.3 GDP points (IRL). While public health expenditure in 2000 ranged from 4.6% (UK and FIN) to 6.2% of GDP (F), the same range is expected to be 5.6% (UK and NL) to 8.2% (IRL) of GDP in 2050. Expenditure on the 0-64 year age group in all countries is expected to rise (from 0.2 to 0.7 GDP points). The overall rise for most Member States for this half century ranges from 1 to 1.5 GDP points, not a substantial increase in relation to the level reached today, and only three Member States are expected to record a rise of over 2 GDP points (D, IRL and A).

- The impact of demographic trends on long-term care (according to the same scenarios), would be greater in countries which already have structured methods of covering costs and consequently high levels of expenditure even now (between 1.5% and 3% of GDP). Sweden, Finland, Denmark, the Netherlands, which fall into this group, would thus see demographic ageing generate a spontaneous increase in long-term care expenditure of approximately 1.7-2.5 GDP points, i.e. an almost twofold increase. Six other countries - which, with the exception of the UK, all spent less than 1% of GDP on this care - would record more moderate increases (between 0.2 and 1 GDP point). However, these countries could experience changes in their cost coverage structure with a move towards greater formalisation driven by the increase in the population groups concerned and by social changes, which could generate a rise in the proportion this care represents in public expenditure and GDP. These foreseeable trends would bring the need to define

[5] The structure of expenditure on health care and long-term care by age group was combined with demographic projections in order to arrive at estimated future public expenditure. As shown in the working party report, it is thus more of a "snapshot" of the incidence of demographic trends than of "actual" public expenditure.

appropriate funding arrangements within the sickness-invalidity branch, or specifically (creating a specific "dependence" risk, sharing of expenditure between the health care and the social assistance systems, use of private insurance schemes).

Overall, the "spontaneous" effects of demographic ageing could increase the proportion of public expenditure on health and long-term care from 1.7 to almost 4 GDP points, i.e. a level of public expenditure representing between 7.5% (low hypothesis for I) and 12.1% of GDP (high hypothesis for S), compared with 5.5% (I) and 8.8% (S) of GDP in 2000.

Generally speaking, developments in health care and long-term care of this kind raise the question of ***human resources***, inasmuch as this care is *per se* labour-intensive in skilled manpower. Yet, the need to recruit people would come at a time when the number of people in work is stabilising or falling, and when the "health-social" sector is already experiencing a growth in employment which is well above average: between 1995 and 2000 in the Union, overall employment rose by 6.8%, but the same increase was 12.6% in the "health-social" sector[6].

2 The growth of new technologies and treatment

Developments in medical technology — whether the use of miniature robots for surgery, genetic therapies, growing replacement organs and tissues, new medicinal substances — constitute the second issue as regards the national systems, particularly as regards health care[7].

Technical progress will bring us new products and treatments involving more R&D and technology. Whilst this may lead to productivity gains, e.g. shorter hospital stays for a given disease, or reducing the risks of serious illness by means of preventive treatment, any increase in the effectiveness of treatments is likely to offer the feasibility of treating new diseases but at the same time lead to greater intensity of treatment and thus higher overall spending.

In fact, supply and demand will contribute to this higher spending. Health is an atypical economic sector, because the supply side — i.e. doctors — largely determines the demand, sometimes to the detriment of systematic evaluation of the real health benefits of innovations and their cost to the general public. Today's patients are, moreover, better educated and informed than ever before and are demanding the very latest molecules and treatments, or products such as food supplements which are supposed or claimed to be beneficial to health. They thus exert a pressure on doctors which is particularly keenly felt in countries where patients are free to 'shop around' for health care. This pressure on the demand side has a specific, measurable impact for medicines, as the most recently developed molecules are almost invariably the most expensive.

---

6 2001 Labour Force Survey, distribution of employment by sector of activity.

7 The projections by the EU's Economic Policy Committee take account of the effect of technologies and their developments indirectly through a range of different hypothetical patterns of per capita cost trends.

Technical progress thus raises the question of funding and of who is to bear the burden of expenditure, for it could have the same - or even greater - effect as demographic ageing. In a context of prudent budget management, clear, transparent and effective evaluation mechanisms must be developed, as this is the only way to guarantee accessibility to these new products and treatments.

However, they should take more into account the specific needs of people above 65 years of age, who still make for a fraction of patients entered into clinical trials.

New information technologies allow for collaborative work of health professionals on a European-wide basis and thus open fresh opportunities to improve assessments.

3 Improved wellbeing and a better standard of living

Demand and supply of health care is heavily dependent on the standard of living and the level of education. This also determines the lifestyles adopted by people. Thus, for half a century, it has been observed that the demand for health care tends to increase more than proportionally to the per capita income.

This has three main consequences.

- Patients are better educated and are able to adopt healthier lifestyles and a prevention-based attitude which in the long run makes it possible to avoid the use of intensive and costly care. Health care systems are thus prompted to increase their drive on the education and prevention side within the overall context of public health policy.

- In addition, patients expect ever better quality and efficiency from health care systems. The spread of the new information technologies offers greater opportunities for seeking medical information, but also of locating services (e.g. health counselling) and obtaining products, with the risks such practices may involve. The fact that it is now easier to access information — irrespective of quality — also makes it easier for people to make comparisons with procedures in other countries. As a result, there is greater mobility of people, goods and services across national borders. This has a direct impact on the way in which health care systems operate, both in terms of what they supply and with regard to how they cover their costs.

- Lastly, health care consumers feel that they need to be considered as fully-fledged partners and players in health care systems, not only by health professionals but also by the public authorities. This can be seen from the emergence of “patients’ charters” in hospitals and the consolidation of patients’ rights in national law. They also expect greater transparency on the performance and quality of care services.

THE DIVERSITY OF NATIONAL SYSTEMS AND THE CONTRIBUTION OF COMMUNITY POLICIES

While the organisation of health care systems, their funding and planning as a function of the needs of the population are a matter for the Member States, this responsibility is pursued increasingly in a general framework on which many

Community policies have a bearing[8], a situation which is an argument for strengthening European cooperation.

1 The diversity of national systems

The diversity of funding [9] and organisational arrangements is one of the main characteristics of health care systems in Europe and sets the context for reform for adjusting to ageing and the other factors whereby expenditure on health care and on care for the elderly evolves.

It is nevertheless clear that public-sector funding makes up a significant proportion of health expenditure in all the EU Member States: this proportion being lowest in Greece although it still represents 56% in that country, and rising to nearly 84% in the United Kingdom. There are two aspects to this diversity:

- Some systems — essentially those that constitute a national health system — are financed through tax revenue; in some countries (NL, P, S UK, DK, IRL) this is their sole source of financing. Other systems are financed through social security contributions, although there is evidence of a trend towards reducing the proportion of such contributions in favour of tax revenue (as in France and Germany).

- The second aspect of diversity, unrelated to the first, is the way in which the financial burden is shared by the public authorities and private individuals: i.e. the share of overall health expenditure borne by households and, in certain cases, covered by voluntary supplementary insurance. It accounts for between a fifth and a quarter of overall expenditure in most Member States, but less than 5% in the UK and Luxembourg, and as much as 42% in Italy and Portugal.

However, the consumers' share of the costs often varies according to the type of care provided. While the bulk of the cost of hospital care is often covered by basic insurance, this is not the case for medication, dental care, or optical appliances, to mention only the most common types of care. The fact that consumers have to shoulder part of the cost of financing health care is often justified by the endeavour to make people more aware of the cost of health care. However, this also strengthens the role of supplementary insurance in making health care more accessible, including for the most deprived members of society, for whom arrangements must be found for bearing the supplementary costs involved.

2 The contribution of Community policies

Three policies are particularly relevant as regards adaptations and reform.

- The public health policy and the promotion of a high level of human health (Article 152 of the Treaty). The Commission communication on the "health strategy of the European Community" (COM(2000) 285 final) emphasised that health services must meet the population's needs and concerns, in a context characterised by the challenge of ageing and the growth of new medical techniques, as well as the more

---

8 See Annex 1.

9 See graph 4, Annex 3.

international dimension of health care (contagious diseases, environmental health, increased mobility of persons, services and goods).

- Improving the quality and viability of public funds. Health care accounts for a large proportion of public spending, which means that this sector is vital for the implementation of quality and viability strategies, which must respect the principles laid down in the Broad Economic Policy Guidelines for 2001 ("promoting the accumulation of physical and human resources" and "improving the effectiveness of expenditure through institutional and structural reforms").

- The growing impact of the internal market. Organising and funding social security systems is the responsibility of the Member States. Under the oft-reiterated jurisprudence of the European Court of Justice[10], while Community law does not impinge on the responsibility of the Member States when it comes to organising their social security system, the Member States must respect Community law in the exercise of this responsibility[11].

Since 1999, and following the communication from the Commission entitled "A concerted strategy for modernising social protection" (COM(99)347 final) European cooperation on social protection has been increasing, with the participation of the players concerned. In its conclusions of 29 November 1999 the Council makes guaranteeing a high and sustainable level of health protection one of the four priority objectives of European cooperation in the field of social protection, reiterating that Community action must be supported and the reform drive by the Member States encouraged as part of their national priorities.

THREE LONG-TERM OBJECTIVES: ACCESSIBILITY, QUALITY, VIABILITY

1 Accessibility

For Europeans, access to health care is a fundamental right and an essential element of human dignity; it must therefore be guaranteed for all. The European Union's Charter of Fundamental Rights states that "*everyone has the right of access to preventive health care and the right to benefit from medical treatment*"[12] and that "*the Union recognises and respects the entitlement to social security benefits and social services providing protection in cases such as maternity, illness, industrial accident, dependency or old age*".[13]

Under the Council Recommendation of 27 July 1992 on the convergence of social protection objectives and policies[14], access to health care and the grant of replacement income at a sufficient level for people who have been obliged to interrupt their work for health reasons are established as key objectives of social protection systems.

---

10 Judgements of 7 February 1984, Duphar and others C-238/82, ECR p 523, point 16; of 17 June 1997, Sodemare and others C-70/95, ECR p.I-3395, point 27; and of 28 April 1998, Kohll, C-158/96, ECR p.I-1931 point 17

11 Cases C-157/99 (Smits/Peerbooms) and C-368/98 (Vanbraeckel)

12 Article 33.

13 Article 32.

14 92/442/EEC, OJ No L245 of 26/08/1992, p. 0049-0052.

However, mortality rates show that in all the Member States there is sometimes a very close link between people's health and their position in society[15]. This is a reflection of low income levels, which mean that some people restrict their consumption of health products; this is particularly true when a large share of the cost has to be borne by patients, as in the case of dental or optical care, or when patients have to pay all or part of the cost of the services concerned themselves and seek reimbursement afterwards. However, the link between health and social position also reflects several other factors, e.g. living and housing conditions, job quality, standards of education, lifestyle and eating habits.

The issues of access to health care for disadvantaged groups and for the poorest members of society, and of the linkage between the health care system and the other players in the fight against exclusion are therefore recognised as part of the "common objectives" adopted by the European Council in Nice with a view to combating social exclusion. The joint report to evaluate the national action plans for social inclusion describes three broad categories of measures in this area:

- Measures to develop disease prevention and promote health education which, although they do not relate exclusively to the most vulnerable in society, can make it possible to reach them more easily. Examples are measures relating to mother and child care, medical care at school and medical care at work.

- Measures to improve access to care by providing less expensive and even free care for those in low-income brackets but also by improving the coordination of social services and health services.

- Measures aimed at disadvantaged groups, e.g. the mentally ill, migrants, the homeless, alcoholics, drug-addicts and prostitutes.

2 Quality

Good quality health care is an essential requirement for all Europeans. It is a major public health objective.

Moreover, the significant share of the cost of care which comes from public funding gives this quality requirement a second dimension, namely how to achieve an optimum balance (which is acceptable without jeopardising the public health objective) between the health benefits and the cost of medication and treatment. The development of information resources accessible to the public, the growing impact of the internal market and increased mobility, give this quality issue a cross-border dimension hitherto unknown.

But ascertaining quality in this way is made particularly complex and tricky by two factors:

- The diversity of patterns of provision. For instance, there were 465 hospital beds per 100 000 inhabitants in Denmark in 1997, compared with 708 in Germany and

---

[15] The mortality ratio of male manual and non-manual workers between 45 and 59 years of age ranges from 1.71 in France to 1.33 in Denmark [*Inégalités sociales de santé*, Inserm-La Découverte, 2000].

877 in France. In 1999, the ratio of doctors per head of population ranged from 226 doctors/100 000 inhabitants in Ireland to almost 405 doctors/100 000 inhabitants in Belgium. In 1997, there were 46.4 pharmacists (working in dispensaries) in France compared with only 17.5 in the Netherlands[16]. The variation is even more marked in long-term care structures, depending on the extent to which cost coverage is institutionalised. However, the structure and level of health care is often the decisive factor in determining demand for health care (and consequently the level of expenditure).

- The heterogeneousness of medical treatment. This is the case, for instance, with regard to childbirth. The perinatal mortality rates in France and the Netherlands are fairly similar (8.2% and 8.4% respectively in 1996); yet, while in France most children are born in a hospital, almost a third of births in the Netherlands take place at home (although hospital births have become much more common in the last 30 years). It is therefore difficult to draw the *a priori* conclusion that one of these methods is "better". There can also be regional differences within the same country, not only with regard to the methods or protocols adopted but also in terms of the apparent efficiency of health care services or techniques (which can, for example, be measured in terms of the post-operative mortality rate).

There have been many studies which show that quality improvement policies, particularly in hospitals (which are the main recipients of health care expenditure), make it possible to reduce the costs resulting from poor quality care[17]. In order to explain and remedy these variations and thus improve the overall quality of health care, action must be taken to evaluate costs and performance, conduct surveys on patient satisfaction, and evaluate and grant accreditation to health care services[18]. Such steps must involve all the partners concerned (supervisory authorities, health care professionals, "disbursing" agencies and supplementary insurance agencies).

Comparative analysis of health care systems and medical treatment, making it possible to identify "best practice", will therefore be particularly useful in improving the quality of health care systems and optimising the use of resources in the context of social protection. The future public health action programme, now being examined by the Council and the European Parliament, will help to promote quality and "best practice" in health care systems.

3 Financial viability

A certain level of financing is required to ensure the availability of high-quality health care that keeps pace with scientific and technical progress and is accessible to the population at large.

---

16 Eurostat data, in Key Data on Health 2000.

17 Report by the French Health Accreditation and Evaluation Agency (ANAES) *Le coût de la qualité et de la non-qualité à l'hôpital* — (The cost of quality and poor quality in hospital) (September 1998).

18 See, for example "A First Class Service: Quality in the new NHS" (UK), which makes provision for the creation of a "National Institute for Clinical Excellence"; implementation of the French Health Accreditation and Evaluation Agency (F).

The pressures on the unit costs of care and on the demand for health care make themselves felt irrespective of the way in which health care systems are organised, but the effect they have depends on the nature of the systems in question. In the case of health care systems that take the form of "national health services", it is theoretically easier to control expenditure (which is naturally budget expenditure) but the pressure of demand results in longer waiting lists[19] which can show that the supply of health care is inadequate. When it comes to insurance-based systems, where the health care providers are often independent of the "financing entity", a rise in demand and/or costs leads to an increase in expenditure, which can become unsustainable in the long term for public financing. All that the authorities can do in such a situation is to increase tax revenue or take steps to control expenditure, which are often opposed by the professions concerned and, above all, involve the problem of deciding which needs should be met.

Up until 1999 at least, a substantial slowdown in the rate of increase in expenditure in relation to the growth of GDP was observed in this context. However, since 1999 health expenditure has overtaken the rate of growth of GDP in many countries. Many reforms have been introduced since the early 1990s[20]. These reforms have traditionally involved two methods, either separately or sometimes in combination, and implemented to a greater or lesser extent according to the specific situation:

- Regulation of demand, which can be achieved by increasing (tax or social security) contributions or by ensuring that the final consumer bears an increasingly large share of the costs (through de-listing or co-payments).

- Regulation of supply, which can take place at macro-economic level (particularly by determining budgets or resource envelopes for health care providers) or be achieved by seeking to improve the efficiency of supply at micro-economic level: this is the objective of the measures introduced to create a competitive market among the bodies responsible for financing and/or providing health care (Germany) or to create a contractual relationship between "buyers" and "providers" of health care (UK).

The point is to be able to distinguish between the economic and structural effects of these measures, i.e. their ability to ensure that spending develops at a sustainable pace without compromising the quality and effectiveness of the health care system. Exchanges of experience which would make it possible to keep track of the policies introduced over several years would be a useful way of comparing health care systems and encouraging progress.

A different kind of challenge is faced by most of the candidate countries in this regard. Many have made an effort to overhaul both the structure of their health care systems and the methods used to finance them, particularly as regards the balance between public and private financing, in order to improve the efficiency and quality of the service they provide. However, the success of reforms of this kind depends largely

---

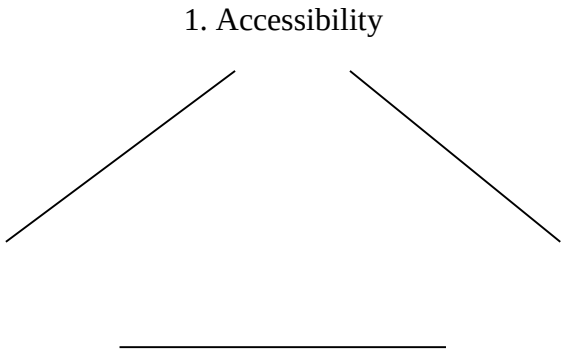
19 The "NHS High-Level Performance Framework" (UK) includes an indicator measuring the length of waiting lists ("percentage of those on waiting list waiting 12 months or more").

20 See Annex 2 for an overview of health care systems and recent reforms.

on whether the financial viability of health care systems, which, in turn, depends on economic reform and a successful transition to a market economy.

CONCLUSIONS

The systems of health care in the European Union and the candidate countries face the challenge of attaining simultaneously the three-fold objective of access to care for everyone, a high level of quality in the care provided and the financial viability of health care systems.



1. Ensure that everyone has access to good quality health care. The elderly require long-term care, which presents a special challenge both in terms of financing and as regards making the necessary adjustments on the supply side, particularly as regards institutionalisation of long-term care.

2. Improve the transparency and quality of health care systems, particularly by developing ways of evaluating medical treatment, health care products and the structure of health care systems.

3. Continue the reforms already introduced so that spending evolves at a viable pace, as part of policies that seek to improve the quality of public financing and ensure that adequate financing is provided for health care.

If these objectives are to be attained, it is essential that all the players of the health systems cooperate, be they local authorities, health care professionals, social protection bodies, supplementary insurance companies, consumers or their representatives. This is often a difficult task, given the different and sometimes conflicting interests and viewpoints of those involved.

Annex 1: the contribution of Community policies

FREE MOVEMENT OF GOODS (ARTICLE 28)

Health products are goods, the free movement of which may be restricted only for overriding reasons of public interest resulting from the need to protect public health or preserve the financial equilibrium of health care schemes, which is considered essential to the maintenance of high-quality health care. Such restrictions, particularly the refusal to reimburse the cost of a health care product purchased in a Member State other than the one in which the person concerned has health insurance cover, must be well-founded and in proportion to the desired objective.

FREE MOVEMENT OF PERSONS (ARTICLES 18, 39, 42 AND 43)

In order to promote the right to the free movement of persons, Regulation 1408/71 coordinates the statutory social security systems in the Member States, including health care schemes. Moreover, with regard to the free movement of employed and self-employed persons, which also applies to the health care sector, a large number of directives make provision for mutual recognition of qualifications for doctors and other health care professionals by laying down the essential requirements for initial training in such areas.

FREE MOVEMENT OF SERVICES (ARTICLES 49 AND 50).

The Court of Justice has ruled that inpatient and outpatient health care constitutes a service. This means that the cross-border provision of such services may be restricted only for overriding reasons of public interest resulting from the need to protect public health or preserve the financial equilibrium of health care schemes, which is considered essential to the maintenance of high-quality health care. Such restrictions, particularly the refusal to reimburse the cost of a health care product purchased in a Member State other than the one in which the person concerned has health insurance cover, must be well-founded and in proportion to the desired objective.

FUNCTIONING OF THE INTERNAL MARKET (ARTICLE 95)

The Treaty lays down the rules for the approximation of the laws, regulations and administrative provisions that relate to the establishment and functioning of the internal market, particularly with regard to health products (pharmaceutical products, medical devices) and supplementary health insurance.

COMPETITION (ARTICLES 85 AND 86)

The health insurance funds and the bodies that help manage the provision of social security services in the public sector fulfil a purely social function if their activities are based on the principle of national solidarity, if they are non-profit making and if the services they provide are defined by law and are independent of the level of contributions. Hence, their activities are not of an economic nature and the bodies responsible for such activities therefore do not constitute undertakings within the

meaning of Articles 85 and 86 of the Treaty[21]. However, if activities in the health care sector can be described as economic activities within the meaning of the Treaty, these rules should be applied.

COORDINATION OF ECONOMIC POLICIES (ARTICLE 99)

The economic and budgetary effects of an ageing population are examined as part of the multilateral monitoring procedure. In this context, the *Broad Economic Policy Guidelines* for 2001, adopted at the Göteborg European Council on 15 June 2001, stress that "*Member States need to develop comprehensive strategies for addressing the economic and budgetary challenges posed by ageing populations. Strategy measures might include reform of pension and health care systems, and care for the elderly*". The work on the economic and budgetary aspects of ageing populations is being supported by the Economic Policy Committee.

COOPERATION BETWEEN THE MEMBER STATES AND COORDINATION OF ACTION ON SOCIAL PROTECTION (ARTICLE 140)

Article 2 of the Treaty states that "*The Community shall have as its task, by establishing a common market and an economic and monetary union and by implementing common policies … to promote throughout the Community …a high level of employment and of social protection …*" In this regard, the Communication from the Commission "*A concerted strategy for modernising social protection*" (COM(99)347 final) makes guaranteeing a high and sustainable level of health protection one of the four priority objectives of European cooperation in the field of social protection. In its conclusions of 29 November 1999, the Council approved the objectives contained in the Communication and requested that European cooperation be developed in this field, where health care systems and their methods of financing are a matter for national governments.

PUBLIC HEALTH (ARTICLE 152)

The Treaty stipulates that the objective of ensuring a high level of human health protection must be incorporated in the definition and implementation of *all Community policies and activities*. With regard to public health, the Community's role is to complement national policies, to encourage cooperation between the Member States and to lend support to their action when it comes to improving public health, preventing human disease and reducing risks to human health. The Commission Communication on the Community's health strategy[22] describes how the Community intends to respond to the main challenges facing care systems and cater for people's concern for effective protection of their health. A new Community Action Programme will support this strategy over the period 2001-2006. Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisations and delivery of health services and medical care.

RESEARCH AND TECHNOLOGICAL DEVELOPMENT (TITLE XVIII)

---

21 Joined cases C-159/91 and C-160/91 (Poucet and Pistre).

22 COM (2000) 285 final of 22 May 2000

One of the 23 key actions of the Fifth RTD Framework Programme focuses on the medical and social challenges posed by an ageing population and the disabilities associated with old age. One of the research areas targeted by this key action is the effective and efficient delivery of health and social care services to older people, including comparative research on the financing of long-term care and pensions. Furthermore, the 4th and 5th FPs have supported the development of electronic tools for clinical trial management and remote data entry, for literature review and guideline development as well as for quality assurance. Research on the adaptation of these products to the special needs of the elderly are being taken up in the 5th Framework Programme.

Annex 2: Health care systems and health policies within the Union

	Total health expenditure	Public expenditure	General government expenditure	Social security expenditure	Private expenditure	Out-of-pocket expenditure	Private health insurance	Recent trends
A	8.2	72.1	39.4	60.6	27.9	16.6	7.1	No overall fixed health care budget
B	8.8	71.3	n/a	n/a	28.7	n/a	n/a	Budget set annually by Government
D	10.3	75.8	8.4	91.6	24.2	12.8	7.1	No overall fixed health care budget
DK	8.4	82.2	100	0	17.8	16.2	1.6	Budget negotiated annually and set by central and local governments
E	7	76.8	88.3	11.7	23.2	n/a	n/a	Budget set annually
EL	8.4	56.3	n/a	n/a	43.7	n/a	n/a	Budget set annually
F	9.3	76.2	3.3	96.7	23.8	10.1	12.6	Target budget set by Parliament since constitutional reform in 1996;"Universal Health Coverage" for low-income households
FIN	6.8	75.7	80.2	19.8	24.3	20	2.6	No overall fixed health care budget
I	7.9	76.8	99.9	0.1	27.7	24.1	n/a	Budget set annually
IRL	6.8	72.3	91	9	23.2	11.4	8.3	Expenditure is cash-limited and set by Government
L	6.1	92.9	11.5	88.5	7.1	7.1	n/a	Target budget since 1994
NL	8.7	68.5	6	94	31.5	8	17.5	Target budget set for a 4-years period
P	7.7	66.9	n/a	n/a	33.1	n/a	n/a	Budget set annually on an historical basis

S	7.9	83.8	n/a	n/a	16.2	n/a	n/a	No overall fixed health care budget
UK	6.9	83.3	88.2	11.8	16.7	11.2	3.4	Expenditure is cash-limited and set by Government

as % of GDP (1999 data. 1998 for D.S.UK.IRL.E.EL) | *as % of total health expenditure (1999 data. 1998 for P.S.IRL.E.EL.D)* | *as % of public expenditure on health (1999 data for A.DK.F.FIN.I.L;1998 for D.E.IRL.NL.UK)* | *as % of public expenditure on health (1999 data for A.DK.F.FIN.I.L;1998 for D.E.IRL.NL)* | *as % of total health expenditure (1999 data for A.DK.F.FIN.I.L.UK; 1998 for D.IRL.NL)* | *as % of total health expenditure (1999 IRL.NL.D)* | *as % of total health expenditure (1999 data for B.DK.F.FIN.UK;1998 for*

Source: *OECD Health Data 2001*, *Health care & Cost Containment in the EU*, edited by Elias Mossialos & Julian Le Grand, Ashgate, 1999

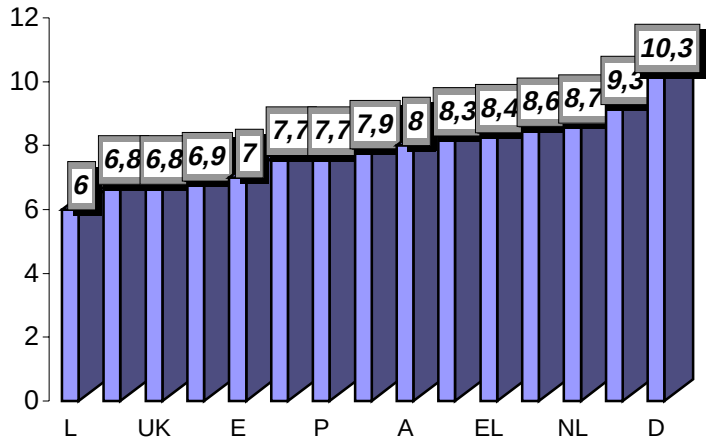
	Organisation		**Recent trends and reforms**		
	Contracted services	***Integrated services***	***Hospitals***	***Doctors***	***Pharmaceutical products***
Most countries			*Co-payments; prospective budget setting; development of activity-based funding*	*Co-payments; restriction on the number of doctors*	*Co-payments; price controls; positive and negative lists of products;*
BE	All services		Prospective budgets for hotel and biology costs	Fee for service; free choice of doctor	Expenditure targets
DK	Most hospitals, GPs and specialists outside hospitals, dentists, pharmacies	Some counties hospitals	Prospective budgets	Fee for service and capitation	Expenditure targets; reference prices
DE	All services		Prospective budgets	Fee for service; free choice among sickness funds doctors; indicative budget	Reference prices
GR	Pharmacies, private hospitals, most dentists, private doctors	Doctors and hospitals	Prospective budgets	Fee for service (private doctors) and salary (NHS)	
ES	Specialist doctors, hospitals, 60% of GPs	Pharmacies, dentists and private hospitals	Prospective budgets combined with activity-based payments	Salary payment or capitation	Fixed budget; ceilings on promotion expenditures
FR	All services		Prospective global budgets, with phasing-in of activity-based payment	Fee for service; free choice of doctor; expenditure global targets; non-binding medical guidelines (RMO)	Expenditure targets; revenue target for companies; taxes on promotion expenditure; development of generics; practice guidelines
IE	Private hospitals, GPs, pharmacies	Public hospitals, specialists	Prospective budgets and diagnosis-related group measures	Capitation plus fee for service (for special service);referral; indicative budget	
IT	Private hospitals, GPs and specialists, pharmacies	Public hospitals, specialists	activity-based payment	Salary payment or capitation, plus fee-for-service (for special services);referral	Fixed budget; reference prices
LU	All services		Prospective budgets combined with activity-based payments	Fee for service; free choice of doctor	
NL	All services		Prospective functional budgets based on activities	Capitation (low income) or fee for service (high	Pharmacists paid on a flat rate; reference prices

				income);referral; prescription auditing;	
AT	All services		Prospective budgets combined with activity-based payments	Fee-for-service combined with capitation; free choice among sickness funds doctors	
PT	Private hospitals, doctors in rural areas, pharmacies, most dentists, labs	GPs, some specialists, public hospitals	Prospective global budgets based on activities	Salary; referral	
FI	Hospitals, pharmacies, private outpatient care	Health centres	Purchasing of packages of hospital services, phasing-in of DRG-based prices	Salary payment or capitation; referral	
SE	Hospitals, pharmacies, private hospitals, dentists	Health centres, pharmacies, dentists	Prospective payments based on DRGs, complemented by price, volume and quality controls	Salary payment; fee for service for private doctors	Reference prices; taxes on promotion expenditure
UK	Public hospitals, GPs, most dentists, pharmacies	Community care services	Activity-related annual contracts between purchaser and provider	Fixed budgets (fundholding GPs);salary payment or capitation for first-contract doctors; referral; prescription auditing;	Pharmacists paid on a flat rate; promotion of generics; profit control; ceilings on promotion expenditures

Source: *Health care & Cost Containment in the EU*, op.cit.; European Commission

Figure 1: Total expenditure on health

as a % of GDP



1998 data - Source: OECD Health Data

Figure 2: A rising life expectancy at birth

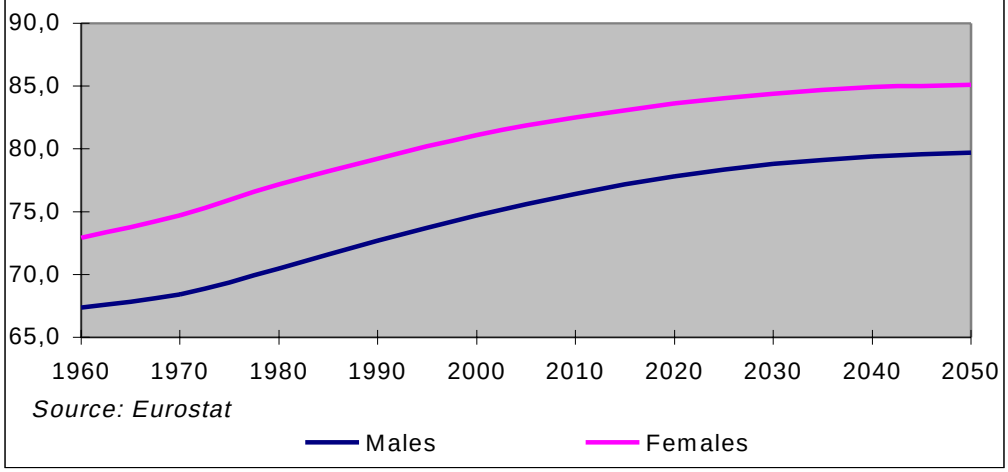


Figure 3: The ageing EU population

Source: Eurostat, population structure indicators (1960-1990), baseline scenario projection (2000-2050)

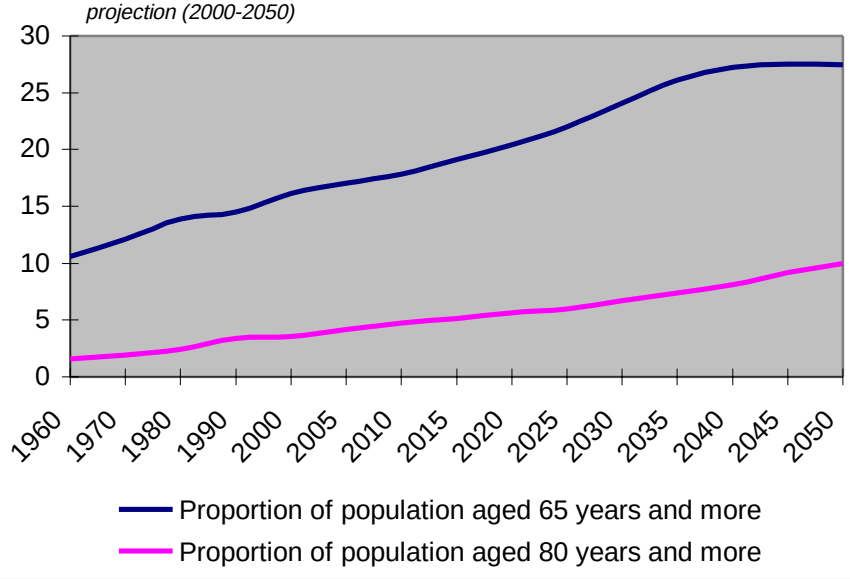
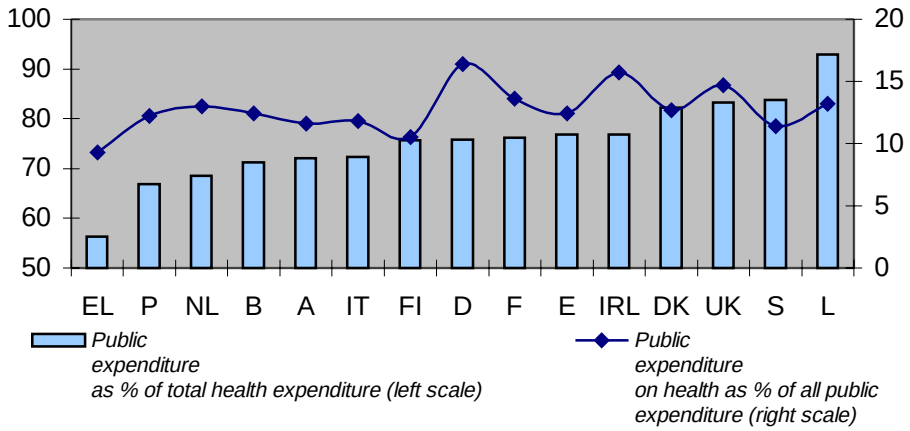


Figure 4: Public expenditure on health



Source: OECD Health Data 2001