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Subject : **Joint report by the Commission and the Council on supporting national strategies for the future of health care and care for the elderly**

Delegations will find attached the Joint Report by the Commission and the Council on supporting national strategies for the future of health care and care for the elderly, as approved by the Council (EPSCO/ECOFIN) on 6/7 March 2003.

1. Introduction

Social protection systems not only provide cash benefits to replace earned income in the event of unemployment, sickness, invalidity or retirement, or for people without sufficient resources. They also enable people to obtain appropriate medical and long-term care services, the costs of which often exceed the financial resources of a patient and his or her family. A communication issued by the Commission in 1999 on “A Concerted Strategy for Modernising Social Protection”¹ consequently identified **ensuring high quality and sustainable health care** as one of the key issues for closer co-operation among the Member States.

This initiative was endorsed by the Lisbon European Council of March 2000, which stressed that social protection systems need to be reformed, *inter alia* in order to be able to continue to provide quality health services. In June 2001, the Gothenburg European Council, in its consideration of what is needed to meet the challenges of an ageing society, asked the Council, in conformity with the open method of co-ordination, to prepare an initial report for the Spring 2002 European Council on orientations in the field of health care and care for the elderly. This report was based on a Commission Communication of December 2001² which examined the demographic, technological and financial trends that may represent challenges to our future ability to maintain high levels of social protection in this field. The Communication concluded that health care and long-term care systems in the European Union face the challenge of ensuring at the same time the three objectives of:

- Access for all regardless of income or wealth.
- A high level of quality of care.
- Financial sustainability of care systems.

¹ COM(1999) 347 final

² COM(2001) 723 final: The future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability.

These three broad goals were endorsed by the Council in an initial orientation report on health care and care for the elderly to the Barcelona European Council which also stressed that all health systems in the EU are based on the principles of solidarity, equity and universality. The Barcelona European Council invited **the Commission and the Council to examine more thoroughly the questions of access, quality and financial sustainability**. For this purpose, a questionnaire was submitted to the Member States. This report draws the main conclusions from the analysis of the Member States' responses and proposes future steps.

2. Common challenges and issues

Our future ability to maintain a high level of social protection for those in need of health and long-term care is influenced by societal and technological developments and will, in the future, be particularly driven by population ageing. These developments were identified in the Communication of December 2001.

(1) New technologies and treatments

New technologies, treatments and techniques offer enormous opportunities for improving and expanding health care and can also improve cost efficiency. However, integrating new technologies and treatments into health care systems nonetheless poses an important challenge. On the one hand, they can reduce the costs of treating diseases, but may also raise expenditure by allowing treatment of conditions not previously possible. The net effect on costs of progress in medical technologies and treatments appears to have been an increase in costs over the past decades. It is impossible to predict what the aggregate impact of technological progress on future health care expenditure will be. A more systematic assessment of health interventions, treatments and technologies could help improve decision making, *inter alia* to ensure that increased expenditure goes only to genuine technological advances and that opportunities for savings are not missed. Such assessment is crucial for the three goals of access, quality and sustainability.

(2) Improved well-being and patient information

The cost of providing health and long-term care tends to rise as individuals and society becomes richer. The reasons behind this are not very clear and are likely to include a mix of demand and supply-side factors. One aspect of this reflects the positive development that people are better educated and have more direct access to information about medical treatments and the quality of care. As a result, they become more demanding vis-à-vis professional care providers and institutions that finance access to care. Under current approaches to the provision of health care, increased consumer awareness is likely to continue to be a factor that increases costs in the future.

It also seems clear that the future demand for long-term care will increase due to a combination of economic and social factors. The increased labour market participation of women; higher levels of geographical mobility; a lower ratio of working age people to frail elderly and changes in family structure may limit the extent to which traditional in-family care is possible.

(3) Demographic ageing

The fact that greater numbers of people are living longer is a huge achievement for our societies and our health systems. Life expectancy has risen much in the last fifty years, and will continue to do so also in the coming decades. However, demographic changes will also pose new challenges for our health and long-term care systems.

As a result of low birth rates and increasing life expectancy, Europe's population has been ageing progressively. In addition, large cohorts born in the 1950s and 60s will reach old age in the next 10 to 15 years. Thus the number of elderly people will rise sharply over the coming decades. One projection is that the number of people aged 65 and over in EU15 will increase from 61 millions in 2000 to some 103 millions in 2050. The number of those aged 80 and over is projected to increase from almost 14 millions in 2000 to some 38 millions in 2050. At the same time the working age population is projected to decrease significantly. (See annex 1, graphs 1a, 1b and 1c). These projections by Eurostat are based on specific assumptions, concerning e.g. the fertility rate. There are alternative projections, using different assumptions, and thus yielding different sizes of for instance the working age population groups.

In terms of the impact on health and long-term care systems, the main effect of demographic ageing will be related to the increase in the numbers of elderly persons demanding care in the coming decades. This is because in general elderly persons require more health care than prime age individuals due to a higher incidence of severe illness. The age profiles of public expenditure on health and long-term care show that spending is significantly higher for the older than for the younger age groups (see graphs 2a and 2b). Health-care systems will also have to adapt to the different pattern of illness linked to the change in the age-profile of patients – age-related diseases are likely to become more prevalent. For health care, however, the scale of this increased demand is likely to be mitigated by improvements in the health status of elderly persons, in continuation of the trend which has accompanied increases in life expectancy in recent decades. Some theories suggest that this is because severe illness requiring intensive health interventions only tends to affect persons at the end of their lives, and as lives are being extended, this need for intensive health is also postponed. If confirmed, this could imply that health expenditure might not rise in the same proportion as the number of old persons. For long-term care, there are also grounds for optimism: in countries where data is available, such as the US, it suggests that disability rates among elderly people are declining over time, although this is not necessarily related to a lengthening of life spans. On the other hand, irrespective of increases in life expectancy, very old persons tend to be frail and in need of long-term care.

Ageing will also lead to a need for health and social services to adapt to changing patterns of illness (rise in chronic diseases) and client structures. Systems should also give a new importance to the objective of enabling older people to live active, healthy and independent lives further into old age. An emphasis on preventive strategies including healthier nutrition and physical and mental activity is needed, starting with the lifestyles of the young and the middle-aged.

Coping with these challenges: policy responsibilities

The organisation and funding of health care systems remains a matter of national competence and it will be a task for the Member States to adapt their very diverse systems to the common challenges identified above. However, several other Community policies have a bearing on national social protection systems for health and long-term care:

– National policies have to comply with the rules of the **Internal Market**, including competition rules and the principles of free movement of persons, of goods and of services. The jurisprudence of the European Court of Justice³, acknowledges the responsibility of Member States for organising their social protection systems, but any restrictions to the freedoms of the Internal Market must be duly justified⁴. A high-level reflection group is currently being established to examine the issues arising from increased patient mobility and greater interaction between health systems.

³ 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

⁴ Cases C-157/99 (Smits/Peerbooms) and C-368/98 (Vanbraeckel)

- In accordance with Article 152 of the Treaty on **Public Health**, the EU seeks to ensure a high level of human health. The Commission communication on the “health strategy of the European Community”⁵ 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 international dimension of health care (contagious diseases, environmental health, increased mobility of persons, services and goods).
- The EU also monitors the long-term **sustainability of public finances**. Since health care accounts for a large proportion of public spending, this sector is vital for the implementation of the recommendations laid down in the Broad Economic Policy Guidelines and the Stability and Convergence Programmes.

Thus at present, the three goals of access, quality and sustainability are considered as aspects in the above policy areas in a rather fragmented way at EU level. The aim of the present exercise, in full respect of the principle of subsidiary, is to facilitate a more integrated co-operative exchange with a view to benefiting from each others’ experiences and good practices.

3. Member States' policy responses to the common challenges

In response to the conclusions of the Barcelona European Council, the Social Protection Committee, in co-operation with the Economic Policy Committee, submitted a questionnaire to the Member States with a view to gathering information on the ways in which the three objectives identified in the orientation report – access, quality and sustainability – are addressed by Member States.

This section synthesises the main issues and policy approaches that can be identified in the Member States' replies to the questionnaire.

⁵ COM(2000) 285 final

3.1. Access to health care

Mechanisms for guaranteeing access

All Member States offer universal, or almost universal, rights to health care for persons residing in their territory. Member States fall into two broad groups in terms of how systems are funded and in terms of how people become entitled to healthcare. One group of systems is financed through tax revenues, with entitlement based either on citizenship or residence criteria. A second group can trace their origins to occupational health insurance systems for employees and their families, where the primary method of financing is via social insurance contributions levied on earnings. In practice, the difference between the two approaches has become less significant as the employment-based systems have often been gradually extended to cover the whole population, and with insurance contributions playing a reduced role for funding in favour of tax revenue.

The essentially universal rights to health care across the EU means that the vast majority of the population is covered; the extent of coverage varies. Where the system is based on labour market participation there can, for example, be a difference in the way that systems treat different occupational groups, e.g. between employees and the self-employed; however, these differences are being reduced. More fundamentally, all systems limit the extent to which they cover the full cost of treatments or in their coverage of different types of treatment. Thus, the share of overall health expenditure borne by households, either directly or with private supplementary insurance, amounts to some 20 – 30 % in most Member States.

As a result of rising health costs, Member States have tended to increase the level of costs borne by patients, either directly through introducing charges or co-payments for services, or indirectly through reducing the range of services covered. Thus, some countries have established a list of eligible treatments and fixed the terms of fees and/or reimbursements. Others define eligibility criteria according to the "basic" levels of health care needed, or they leave it to the patient to pay for the care required with subsequent reimbursement. In several countries patients are charged a fixed amount for various health services, while in other countries they must pay any difference between the price of a service or product and the corresponding fixed or variable rate of reimbursement. The rates of reimbursement may vary according to type of service (list of eligible services), or according to purchaser (e.g. income level, annual health expenditure, and age). Complementary private insurance may cover such contributions. The role of co-payments in the context of the sustainability of systems is addressed further in section 3.5.

The fact that systems demand some financial participation creates the risk that vulnerable groups may not be able to afford such charges and may thus not be able or willing to access appropriate healthcare. The issue was discussed in the Joint Report on Social Inclusion agreed at Laeken in December 2001 and features again as a fundamental policy concern in the replies of several Member States who tend to have provisions which ensure that people facing particularly high health costs will have their total contribution capped or that people on low incomes will pay a lower share of the treatment cost or receive free treatment.

Thus all Member States in one form or another refer to the solidarity features of their systems which aim both to ensure that poor health does not lead to impoverishment and that low income does not diminish people's access to healthcare. There is also acknowledgement of a further dimension to health inequalities in the clear evidence that people in vulnerable groups are likely to lead less healthy lifestyles.

Some countries target elderly people as a group at risk of not sufficiently accessing health care and preventive care. This can take the form of specific provisions to ensure that healthcare does not become unaffordable or measures to ensure that older people take up medical services in a way which reflects their need for such services. Some countries encourage regular housecalls to older people by health professionals. This aspect is of particular relevance for ensuring a good co-ordination of health care and long-term care for the elderly.

The national replies say little about some other potential dimensions of inequality in access, such as regional inequalities. In response to the question whether access to new treatments gives rise to inequalities, they report no particular inequalities, while acknowledging that managing access to such treatments does pose an important, ongoing and, in the light of the rapid pace of technological development, ever-increasing management challenge in the context of controlling costs.

Systems for monitoring and evaluation

Several Member States have established or proposed various indicators to monitor access. Such indicators may be based on measures of supply, e.g. number of nights spent in hospital; numbers of particular interventions; rehabilitation by population categories. These are aimed at measuring efficiency, delivery or performance gaps. There are waiting lists for various treatments in many countries, but their extent differs considerably depending on the system. Countries with insurance-based health care seem to have fewer problems with waiting lists.

Challenges

The demographic and epidemiological trends represent major challenges to the existing health care systems. Systems need to be continuously adapted in order to respond to the envisaged demand for care and to take account of technological and medical progress. Other important challenges are:

- review the range of new treatments and medicines provided or reimbursed;
- shorten waiting times for non-acute hospital care;
- establish more and new types of health care services which cater to the particular patterns of illness linked to ageing, and which could help to maintain the independence of the elderly;
- develop preventive strategies aimed at enabling older people to live active, healthy and independent lives further into old age;
- ensure the availability of sufficient and appropriately trained medical staff.

Planned policy changes

Member States outline the following priorities:

- Improve access for certain categories of the population (self employed, elderly, people on low income);
- Improve the speed of access (reduce waiting times);
- Address distribution of appropriate health care services across the country (urban/rural areas, prosperous/poor regions).

– Improve the recruitment and training of qualified staff (physicians, nurses and other staff) in view of the ageing of existing staff, difficult working conditions and emerging staff shortages.

In relation to the particular health needs of older people the following issues are cited:

– The need to provide alternative geriatric or post-acute facilities for rehabilitation outside hospitals in order to free up space in hospitals and to enable active and independent living for the elderly as far as possible.

– The establishment or re-activation of local health centres in order to facilitate access to care and, through a multidisciplinary approach, to appropriate treatment.

In general, Member States acknowledge that the ageing of the population will pose new problems and challenges if they are to maintain the type of general and comprehensive forms of access to healthcare to which citizens have become accustomed. Nevertheless, several Member States express a determination that this very basic objective of systems should be maintained, even in the face of increasing costs, while others refer to the fact that they are proposing further refinements and improvements to their access mechanisms. Thus Member States are likely in future to have to place a greater emphasis on policies to increase cost-efficiency and effectiveness as discussed in section 3.5.

3.2. Access to long term care

Unlike health care, the need for long-term care is only now being recognised as a major social risk that needs to be covered by social protection systems. Long-term care consists of assistance to persons who are unable to live autonomously and are therefore dependent on the help of others in their everyday lives. Their needs for assistance can range from facilitating mobility, shopping, preparing meals and other household tasks to washing and feeding in the most extreme cases. Providing such long-term care does not necessarily require medical skills. This type of care is therefore often left to relatives, usually spouses and descendants who continue to be the main providers of long-term care.

For reasons presented in section 2(2) above, relatives can no longer be expected to provide care to the same extent as they used to. An increasing number of frail elderly people therefore depend on professional carers who may deliver their care services in the dependent person's home or in specialised institutions. The cost of long-term care, just like medical care, very often exceeds the current income of the person in need of care and may rapidly consume any wealth of this person. Thus the need for long-term care is a major social risk and there is clearly a need for social protection mechanisms.

Such social protection mechanisms take very different forms in the Member States. In some countries, families remain responsible for providing care or financing it. Public support, in the form of social assistance, through social services or a placement in a care institution will only be available if there is no such family support. After the death of the dependent person the cost of publicly supported care may be recouped from the estate of the deceased person. This is the most basic form of social protection, which requires families to bear most of the risk of long-term care and only intervenes if families are no longer able to provide care. In other countries, no legal obligations for descendants vis-à-vis their elderly parents exist, but the risk may still be borne mainly by individuals who have to pay for their care needs from their income and wealth.

More and more countries are moving towards a broader sharing of risks. This can be achieved through the direct provision of care services at home or in institutions or through insurance mechanisms. Such public provision is usually the responsibility of local authorities, often in partnership with non-profit organisations. The alternative approach to risk sharing is an insurance system. In some cases, long-term care needs are covered by statutory health insurance schemes; some countries recently introduced long-term care insurance as a new branch of their social protection system. The financing of direct provision of care services is typically through taxation, whereas insurance-based systems tend to be financed through social insurance contributions. However, at least one country uses inheritance taxes as a source of funding; this appears justified insofar as mutualising the cost of long-term care also avoids descendants having to forego a significant proportion of their inheritance.

Long-term care can be provided in different ways. Apart from family support, professional care can be delivered at home, in day-care centres, in special long-term care institutions or in hospitals. Social protection mechanisms will affect the way of providing care. If more support is available for long-term care institutions than for care at home, then it is likely that more people will live in institutions.

Some Member States consider that freedom of choice between different providers combined with competition between such providers can in general foster quality and efficiency in both health and long-term care.

Some Member States have tried to make their social protection mechanisms neutral with regard to the way in which care is provided. This requires in particular offering support for informal carers. People in need of care can be given the choice between benefits in kind or a cash grant that can be used for family carers. Informal care may also be encouraged through tax advantages, pension and social insurance entitlements for care givers, training, a right to leave from one's employment to care for a relative, the provision of substitute carers during rest periods for the care giver and the provision of day-care centres so that carers can be relieved. The rights and duties of informal carers may even be defined in contracts. Support for informal carers has the advantage of being cost-effective (the allowances paid to informal care givers are typically lower than the cost of professional carers) and of allowing care to be provided by a trusted and familiar care giver. Moreover, the dependent person can stay at home.

All countries have an infrastructure for professional long-term care, but the importance of such institutions varies depending on the role of families, on social protection mechanisms and on the supply of care services and facilities. A lack of facilities and services can lead to dependent persons having to remain longer in hospitals or in the care of relatives.

Challenges

Social protection mechanisms to guarantee access to long-term care are fairly new in many Member States and have yet to be developed beyond social assistance mechanisms in others. As demand for long-term care increases, there may be shortages of professional staff.

Staff shortages may also explain to some extent the lack of capacity in institutional long-term care, which leads to elderly people occupying beds for acute care in hospitals for longer than necessary. Institutional care is particularly important for people suffering from Alzheimer's disease and other forms of dementia who require intensive care and continuous supervision.

Another challenge is the need to co-ordinate different care providers. Dependent people usually need a range of medical and non-medical support, which requires a good co-operation between families, professional carers and medical staff. It may be useful to define a co-ordinator that could also have overall responsibility for managing the costs of different types of care.

Planned policy changes

For several Member States the main priority is to implement the major policy changes that have been introduced recently. Others plan new measures, notably to provide better support for care at home. Some countries are planning new structures aimed at providing integrated and continuous care. This involves addressing the complex needs for health care and social support of people who lost their autonomy or from chronic diseases.

3.3. Quality - Health care

Ensuring quality in the organisation and delivery of health care and long-term care is identified as a key policy concern of all Member States.

It seems useful to distinguish between different contexts in which quality criteria are introduced. First, there are structural quality criteria, which refer to the way a service is staffed and equipped, and to the cases it treats. Process quality criteria apply to the operation of the service and how specific interventions are performed. Finally, outcome criteria seek to measure service quality by looking at the outcome of specific interventions – for example at long-term survival rates or complications.

In almost all Member States, *structural quality criteria* have been developed for the in-patient sector, e.g. for hospitals. These cover, for example, staff (staffing levels, training and experience), equipment, number of cases, building standards, etc. These standards are usually binding and are set by public bodies or the social insurance providers. In the out-patient sector, however, setting structural standards seems to be more difficult. Generally, they cover only basic requirements, e.g. formal training requirements for medical staff.

The situation for *process quality criteria* is more diverse. While many health professionals would regard following standards and guidelines set by medical associations and other formal bodies as standard practice, the development of formal guidelines for treatments and procedures as a matter of policy is lagging behind. However, Member States are putting considerable effort into this area and are making important progress, mostly as regards in-patient care. Some Member States consider that the importance of clinical independence and freedom of medical practice also needs to be considered in this context.

In this area, the degree of formality with which standards are applied differs widely. Often, central governments set a legal framework or issue recommendations to be used to develop more specific guidelines at local and regional level, by health and social insurance institutions, medical associations or other bodies.

Some guidelines and standards are introduced on a voluntary basis, through pilot projects, general recommendations, or using financial incentives. In general, national health systems, such as in the UK, can introduce more binding standards using the central regulatory instruments at their disposal and can apply sanctions to ensure compliance. It is clear that the application of quality standards in clinical practice is the crucial element of a quality policy in health care. This has been pursued in many Member States. Monitoring of process quality in Member States in a comparable way would require the output of the health care system to be systematically described by medical procedures performed and diseases treated, and it would require these disease-procedure combinations to be linked to respective quality assessment efforts. Efforts in this direction are not yet very advanced currently.

A systematic approach to evaluating health *outcomes* as part of the quality agenda can only be found in some Member States. While health outcomes may in principle be a good way to measure the quality of interventions, there are a number of practical difficulties involved. They include scant or unreliable data, and the political difficulties of involving the government in an area that is regarded as a core competence of medical professions. For example, only a few countries are running ranking systems of hospitals by quality of service rendered.

The growing interest in quality issues has lead Member States to create specific institutions or bodies in charge of promoting quality work, running assessments, developing guidelines or accreditation systems. Central bodies now exist in almost all Member States.

Often, the central government can create only framework legislation, which must then be implemented at regional or local level. One noteworthy trend in Member States' responses is the focus on the role of patients. In nearly all countries, efforts have been made to introduce measures to safeguard the rights of patients, in particular in the hospital sector. Empowering patients to take informed decisions, providing adequate information and transparency about health services, treatment options and access to medical records are important aspects in this context. There are now specific patients' rights laws in a number of Member States.

Finally, it is essential to understand how access and quality considerations are linked. Deficiencies and inequalities in access to health services are also an important quality issue, and it is crucial to take access and equity considerations into account when developing quality standards. Addressing these challenges requires actions across different policy areas.

3.4. Quality - Long term care

Most Member States have national quality standards for the care of the elderly. However, there are differences in terms of whether these are legally binding, or merely recommendations. Moreover, it can be deduced from a number of the responses to the questionnaire that, compared to health care, the long-term care sector operates in a very decentralised way, and regional and local authorities have a large degree of discretion in the standards they apply. It is interesting to note, however, that the UK has taken back this responsibility to the national level by establishing an independent national body, the National Care Standards Commission (NCSC) to regulate social care and independent health care services. The aim of this new arrangement is to increase the quality of services and improve the level of protection for vulnerable groups while safeguarding and maintaining good quality homes for the elderly.

There seem to be difficulties related to decentralisation in several Member States; for example, programmes are poorly targeted, with uneven monitoring and lack of quality enhancing initiatives.

For institutional care, most Member States have set structural quality criteria, for instance on staff qualifications and building standards. In such countries respecting these standards is a condition for reimbursement by the social insurance system.

Some countries have also developed process quality criteria for homes for the elderly. This quality approach to residential care includes specific quality targets and the establishment of a “facility strategy” with reference to specifications that set objectives for the main quality criteria. Other countries refer to the lack of standardised systems to guarantee minimum levels of care as a basic challenge for the system of long-term care.

Most Member States indicated in their responses that there is a lack of standard setting in relation to home care, but some examples were given. Some quality standards pilot schemes were conducted in Belgium, while in Denmark, a system of local quality assurance has been introduced. France has established a “Home Service Standard” which aims to ensure quality services. It has also established a procedure whereby an external organisation will ensure compliance with these standards. In terms of training of caregivers, Austria has legislation regarding training of care providers to the elderly, including home-helpers.

At the same time, demand for home care has increased due to demographic developments and as the issue has increasingly been covered by social security systems. As mentioned earlier, in some Member States care for the elderly is considered a family matter. However, as family structures are changing, one example to approach this is giving attention to the development of Home Care Programs.

Most Member States state that recipients’ rights are covered in the quality criteria or the protection of patients rights, while in some case there are specific acts aiming at the promotion of users/clients rights.

A number of Member States have identified staff shortages, high turnover and increasing work pressure as particular areas of concern in this sector. Several countries state that the demographic changes occurring in the older population demand an increase in trained and educated personnel in the field as well as new approaches to increase the attractiveness of the profession.

Measures also have to be taken in order to reduce work-related fatigue among personnel in institutional care. Member States which are facing difficulties in recruiting health care personnel, are looking at salary increases, an increase in staff density, “on-the-job-training” programs and work environment improvements for staff in long term care.

Some Member States note that there is a lack of adequate quality indicators and controls and see the development of these as immediate challenges. To address some of the issues, a Member State will launch a new policy for older people in 2003 including tools for needs assessments of care for older people, which will also operate as a tool for monitoring and evaluating care results. Another country intends to develop a general model for better practices, follow-up procedures and entrenching quality standards in local authorities.

3.5. Financial sustainability - Health care

The structures of financing of health care systems in the EU

The way in which health care systems are financed in the EU varies considerably between Member States, broadly in line with the various different models employed for structuring health care systems. In general, health care systems in the EU tend to be mixed systems, comprising public financing (which is predominant) with some element of private financing. Most systems, although not all, include a (mandatory) sickness insurance, and almost all are in some part financed directly by general taxation. Often resources to finance health care systems are raised at the regional level. All systems have some element of user charges for patients which contribute to the financing of public health care - the primary role of these, however, is often to attempt to control demand for health care goods and services.

Common challenges for the financial sustainability of public health care systems

In terms of ensuring the financial sustainability of public health care systems, Member States outlined a number of challenges faced by their systems. Despite the differences among health care systems across the EU, a number of common challenges can be identified.

With regard to *long-term challenges* for the financial sustainability of health care systems, Member States highlighted the key developments in society, already described in section 2:

- There are important pressures in the health system, both from health professionals as well as from patients, for *the increased diffusion of new and expensive medical technology*.
- *The long-term tendencies of populations to consume more as they become wealthier* over time as being a source of increased costs in health systems.
- The demographic changes linked to *ageing populations*.

In the responses to the questionnaires, Member States noted the following urgent *short-term challenges* for financial management of public health care systems:

- Some Member States point to the need to address the perceived *over-consumption* of health care goods and services beyond that which is effective in improving health outcomes, including the issue of who decides what is over-consumption.
- In some Member States there is a pressing need to deal with immediate *cost overruns*, which are jeopardising the financial balance of sickness insurance funds and/or making the overall management of public finances rather difficult.
- In other Member States, the pressure is rather different, and is more directed towards the need *to increase the volume of services*, *inter alia* by reducing waiting times, but without jeopardising the financial management of the system.

In the face of these short and long-term trends for the financial sustainability of their health systems, many Member States point to challenges they face in readapting their health systems. For example they list the following challenges:

- Finding means of using resources more effectively, for example by improving incentive structures including the use of market mechanisms.
- Involving doctors and health professionals more actively in managing resources.

Recent trends in health care expenditure

While many of the responses of Member States to the EPC/SPC questionnaire discussed recent developments in health expenditure, the responses did not systematically provide quantitative indications of the trends in overall levels of expenditure for health care expenditure. Moreover, where expenditure numbers are provided they are not necessarily consistent or comparable across Member States. As a result, this information cannot readily be used to compare expenditure for health care systems across the EU. Instead in Annex 1, Table 4, the latest information from the OECD health database is provided for illustrative purposes.

The responses to the questionnaire do allow for some qualitative comparison to be made – subject to the limitations resulting from insufficient consistency and comparability mentioned above. From this information it seems that Member States differ in terms of the recent trends in health expenditure, and in their policy responses:

- In a number of Member States rapid expenditure growth is causing concern, with public expenditure often growing faster than GDP and health sectors thus expanding as a share of GDP. Often cost overruns in the health sector are a cause of concern for the wider management of public finances. In some Member States, these cost overruns persist despite the existence of numerous cost control mechanisms. In other countries, resources for health care were increased without loosening cost control. It should be noted, however, that in a few countries rapid expenditure growth has occurred in a context of relatively low levels of overall public expenditure on health care.

- In some other Member States, expenditure growth has also been rapid, but this has been the result of *explicit policy measures to target more resources to the health sector* with a view to improving the quality of care
- In a third group, the questionnaire responses indicate that *expenditure levels are relatively stable*, and thus cost containment is a less pressing challenge.

In terms of the key components of rapid expenditure growth, many Member States highlighted rapid growth in expenditure on pharmaceuticals.

Long-term financial sustainability of public health care

Again, not all Member States provided quantitative information about the likely evolution of health expenditures over the long-term. Where quantitative estimates were provided, often Member States provided a summary of the projections carried out under the remit of the EPC in 2001⁶. Some countries also provided information based on other long-term projections. In most cases, other national projections gave estimates of long-term increases in health expenditure above the estimates of the EPC. This is not surprising, as the EPC estimates aimed to measure only the impact of demographic changes under neutral assumptions for other cost drivers. However, it can be expected that these other factors, including notably the diffusion of new and expensive medical technology, would lead to additional upward pressure on overall levels of expenditure. The EPC projections are summarised in Annex 1, Table 3. Such long-term projections must however be read with caution, as noted in the EPC report.

⁶ Report by the Economic Policy Committee on budgetary challenges posed by ageing populations: the impact on public spending on pensions, health and long-term care for the elderly and possible indicators of the long-term sustainability of public finances. http://europa.eu.int/comm/economy_finance/epc/epc_ageing_en.htm

The EPC projections, together with the other national projections cited above, suggest that future increases in expenditure on health care and long-term care could be significant, thus implying an important additional burden for the public finances over the long-term. The EPC projections for public health care expenditure reveal that the impact of demographic changes over the fifty year period would be in the range of 0.7 to 2.3 percentage points of GDP over the fifty year projection period. Some Member States are expected to see increases in expenditure of around or above 2 percentage points of GDP over the projection period. (Austria has revised their projections in 2002. The revised projections are shown in a note after Table 3.)

In summary therefore, over the long-term, significant additional expenditure pressures can be expected in health sectors. Some Member States note that there will be a need for explicit policy measures to prepare for the financial consequences of ageing populations, particularly given expected increases in other age-related expenditures, such as pensions, over the long-term.

Cost control mechanisms

In general, the questionnaire responses provided a large amount of qualitative information on cost control measures in Member States. However, the responses did not always indicate which measures were effective. A broad overview of the types of measures taken in different Member States is included below, based on a categorisation used by the OECD.⁷

⁷ OECD (1994), Economics Department Working Paper No. 149, H. Oxley & M. MacFarlan, "Health Care Reform: Controlling Spending and Increasing Efficiency"

(1) Measures to shift costs to consumers

Almost all Member States have some type of user charge for health care goods and services - while charges can include a contribution towards the costs of hospital stays or visits to practitioners, most often they concern contributions to the purchase of medicines prescribed in primary care. Cost shifting measures have two aims: firstly to directly shift the burden of financing away from the public finances to private sources. Secondly, they are intended to help control the demand by consumers for services and thus indirectly bring down public (as well as total) expenditure. However, user charges will not play a role in controlling consumer demand if they are reimbursed by supplementary health insurance.

(2) Price and volume controls on both supply and demand

In some Member States, national agreements exist to fix prices between providers of health goods and services (e.g. producers or organisations representing health care professionals) and health care funders. In particular, in almost all Member States, specific agreements exist covering pharmaceuticals products. Agreements often set prices for pharmaceutical products, require the use of generic rather than branded products, and in some cases even include maximum spending levels on these products at the aggregate level.

In some countries, there are direct barriers to access to some health care services. There access to certain specialist health practitioners requires a referral from a general practitioner. Experience has shown that this mechanism is effective in controlling health costs.

(3) Reforms to encourage the efficient use of resources

In some cases, health care funders impose direct top-down controls on expenditure - these include fixed budgets for regional health boards or for hospitals. Increasingly health systems in the EU are using contracts between health care purchasers (either funders or third party purchasers such as insurance companies) and service providers in order to ensure the more efficient use of financial resources. In some cases, these contracts require any cost overruns to be taken out of the following year's budget. The approach appears to be rather effective in encouraging efficiency. In other countries, the allocation of financial resources is increasingly related to performance measures, or to the case-mix of hospitals. These measures also seem to be rather effective in encouraging efficiency improvements - this has been the case in a Member State where the introduction of such contracts has led to a marked decline in the average length of hospital stays.

3.6. Financial sustainability - Long-term care

The structure of financing of long-term care in the EU

The situation in terms of the financing of long-term care systems in the EU is even more difficult to categorise than that of health systems. The reason for this is that long-term care is often divided between various different public structures and budgets, most often between the health budget and the budget for social services. Moreover, long-term care provided in the health system is often difficult to distinguish from more traditional health interventions. Finally, long-term care social services are often provided at a very local level - for this reason it is sometimes difficult to discern national trends. In some Member States there are insurance systems for dependency, and in others such an insurance system is being developed.

Challenges

The most common challenge for the financing of long-term care highlighted by Member States in the questionnaire responses has been ageing. Firstly, ageing will lead to a much greater number of elderly and very elderly persons. Secondly, long-term care is an extremely labour-intensive sector. It is noted in some Member States that the sector is likely to suffer from acute labour shortages (also related to ageing), which in itself will also drive up wage costs. One report notes that the pressure on long-term care systems from ageing will in large part be fuelled by the sharply increased incidence of chronic conditions such as dementia, which do not necessarily demand much in terms of traditional health care interventions but imply a heavy burden in terms of care and assistance. In addition to ageing, some reports note that if past trends continue, there may be increased demand for formal care services as a result of reduced provision of informal care due to changes in society.

Two southern Member States cite a number of challenges that they face in the drawing together of a coherent system of care for elderly persons. One of the key challenges is to provide integrated solutions for patients covering the full range of care services required, including health care. Another is to develop the provision of care services in the home of the elderly person, which are both more in line with the wishes of the elderly person and are more cost effective.

Recent expenditure trends

Information in the national reports is somewhat patchy on this issue, partly reflecting the difficulty in quantifying the costs of long-term care services, which are financed by numerous different budgets. Among the Member States that do provide some quantitative information, it is difficult to see clear cross-country trends. In Denmark, the resources devoted to the sector have been growing in real terms, although at a rate below that of real GDP growth. These cost increases have been promoted by both increases in the number of the elderly as well as increases in costs per head.

Long-term expenditure projections

Again, the information provided on the long-term outlook for long-term care expenditure is very patchy. Of those Member States that do provide some information on the outlook, the projections are essentially based on those carried out with the EPC. For further information see Annex 1, Table 3.

Cost control mechanisms

In some Member States an integrated policy for long-term care is still being developed. As such, there is not yet a need for explicit measures to control costs.

In other Member States, financial allocations are made on the basis of national plans and objectives. For France the objectives are integrated with those set for health care as a whole. These allocations and objectives are set with a view to limiting expenditures a priori, In Germany, cost control is to some extent the responsibility of the nursing care insurance schemes.

In some countries, the services to be provided are defined upfront – thus to some extent limiting the scope for increases in expenditure. Some Member States make the services provided dependent on an individualised care plan based on needs. There are also Member States with policy directions to provide care in the home, which costs less and is usually in line with the wishes of the elderly person.

4. Conclusions

The replies from Member States confirm the usefulness of the three broad objectives of access, quality and sustainability as a basis for looking at policies for health care and long-term care for the elderly. All Member States are trying to find the best ways of advancing these three goals in an integrated manner: how to raise enough funding to secure adequate care for all, with high quality; how to provide services more cost-effectively? These challenges are further increased by the ageing of the populations in all Member States. The Member States' replies show that seeking this balance poses a major challenge for the overall management of systems. Thus, many national replies refer to the need to ensure good decision making at the interface between their health care and the emerging long-term care sectors and a better co-ordination of health care provisions and long-term care services for the elderly. Achieving the best balance also raises governance issues; there needs to be a balance between the focus on quality, standards and cost control which are often centrally driven on the one hand, and local management and delivery, on the other.

While it was not an explicit objective of the questionnaire, some Member States' replies point to the large employment challenges and opportunities in the care sector. The challenges include: how to retain staff under sometimes rather difficult working conditions; how to recruit and train new staff as demand increases over the next decades; and how to develop the quality of work, by providing skill development and career progression, in the sector. There will clearly be opportunities to increase employment. The health and social services sector is already a large employer with 9,7 % of total employment in the European Union in 2001.⁸ In relation to access, Member States express their determination to maintain general and comprehensive access as a cornerstone of their systems, even in the face of increasing costs, with several proposing to further refine and improve their access mechanisms.

⁸ Employment in Europe 2002, page 32.
http://europa.eu.int/comm/dgs/employment_social/key_en.htm

In the area of quality, the replies reveal that there is scope for greater co-operation between Member States in the area of quality of service delivery regarding both health and long-term care. This is particularly true in the perspective of greater cross-border mobility of patients and enlargement. The Community's action programme in the field of public health, which will come into force in January 2003, will help in developing tools for quality assessment. Regarding financial sustainability, Member States point to the challenge of ensuring that resources and in particular new technologies can be deployed in the interest of efficiency and cost effectiveness and of ensuring that health professionals and patients integrate cost considerations into their decisions.

Recommended next steps

The Commission invites the Council, on the basis of this Communication, to adopt the joint report requested by the Barcelona European Council and to submit it to the Spring 2003 European Council.

A process of mutual learning and co-operative exchange should be continued on the basis of the issues identified in the joint report. The Commission will present in autumn 2003 further proposals for pursuing this co-operation. That Communication should also cover the specific aspects of these issues related to the enlargement of the European Union. This will be all the more important as it is likely that many of the challenges discussed in the present report are more severe in most applicant countries.

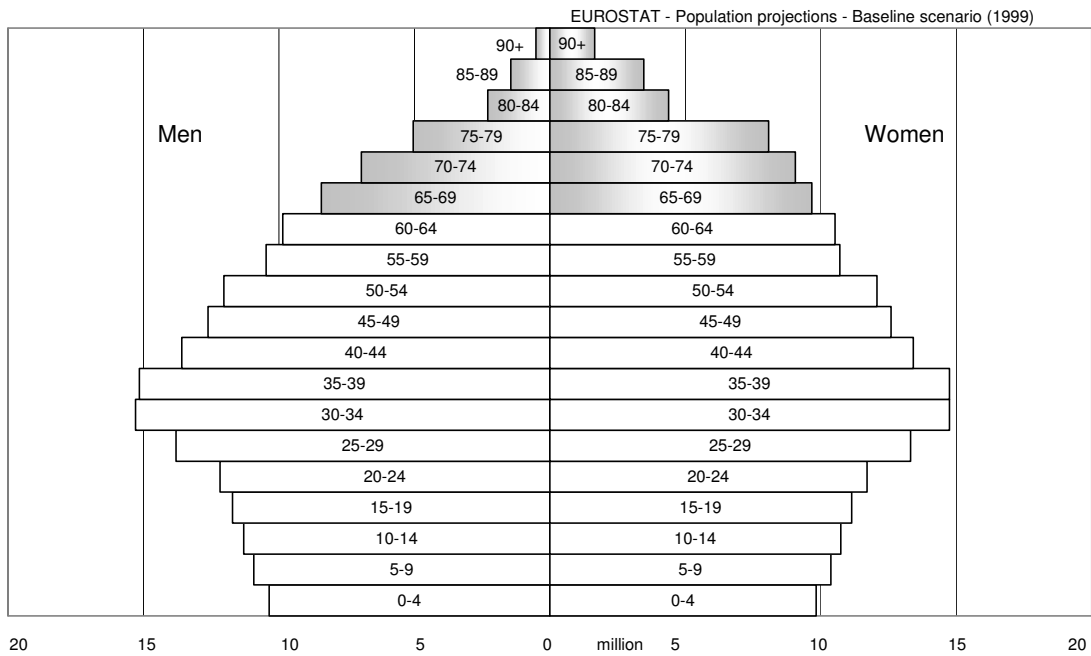
Further work will also take account of discussions in the High Level Process of Reflection on patient mobility and health care developments which will consider the future role of the Union in a wide range of aspects of healthcare. It is recognised that carrying forward the work of this report should not pre-empt the outcome of that reflection process. Co-operation between Member States could concentrate on exchanging experiences and good practices with regard to the three broad objectives. The co-operation will take place in full respect of Member States' competencies in the field of health care. There could be a particular focus on improving the information base and on discussing ways of carrying on this co-operation, drawing inter alia on the existing close co-operation with Eurostat, the OECD and the WHO in this area. It would also be useful to pay particular attention to employment issues.

ANNEX 1

ANNEX 1: TABLES AND GRAPHS

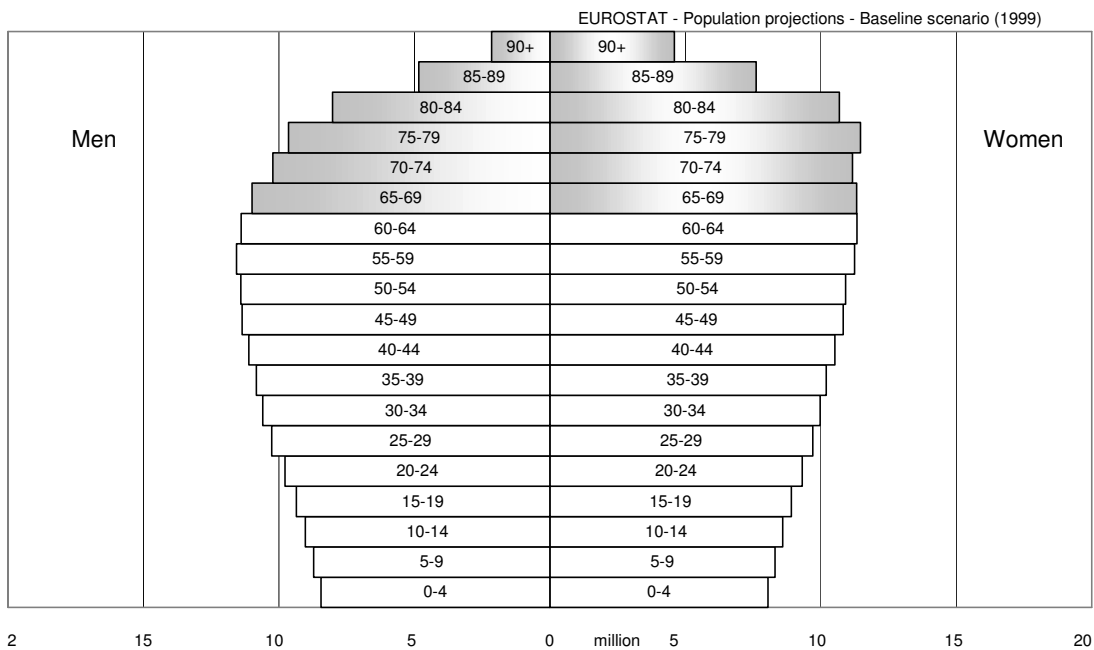
Graph 1a:

Population Pyramid in 2000 - EU15



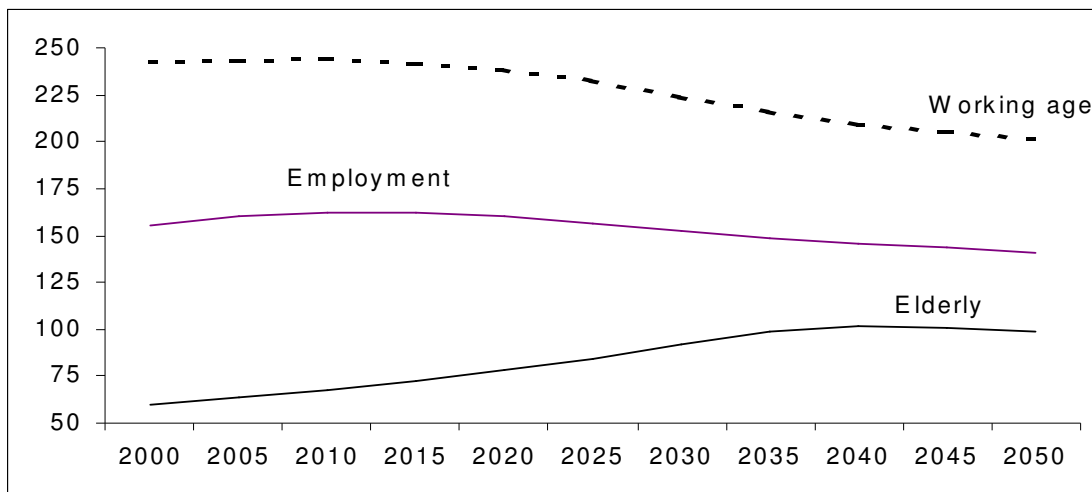
Graph 1b:

Population Pyramid in 2050 - EU15



Source: EUROSTAT

Graph 1c: Projected size of the EU working-age and elderly population (millions)

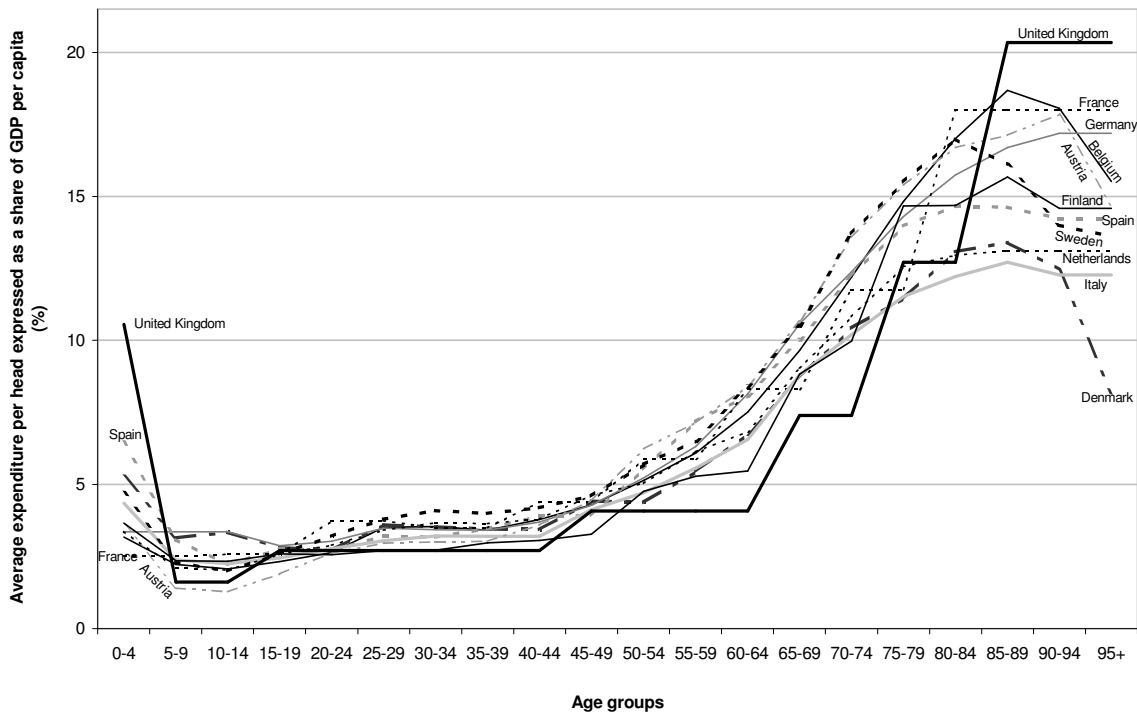


Note: Working age population refers to persons aged 15 to 64.

Elderly population refers to persons aged 65 and above

Source: Economic Policy Committee (2001) “Budgetary challenges posed by ageing populations”, Eurostat and projections of the EPC working group on ageing populations.

Graph 2a: Age profiles for public expenditure on health care

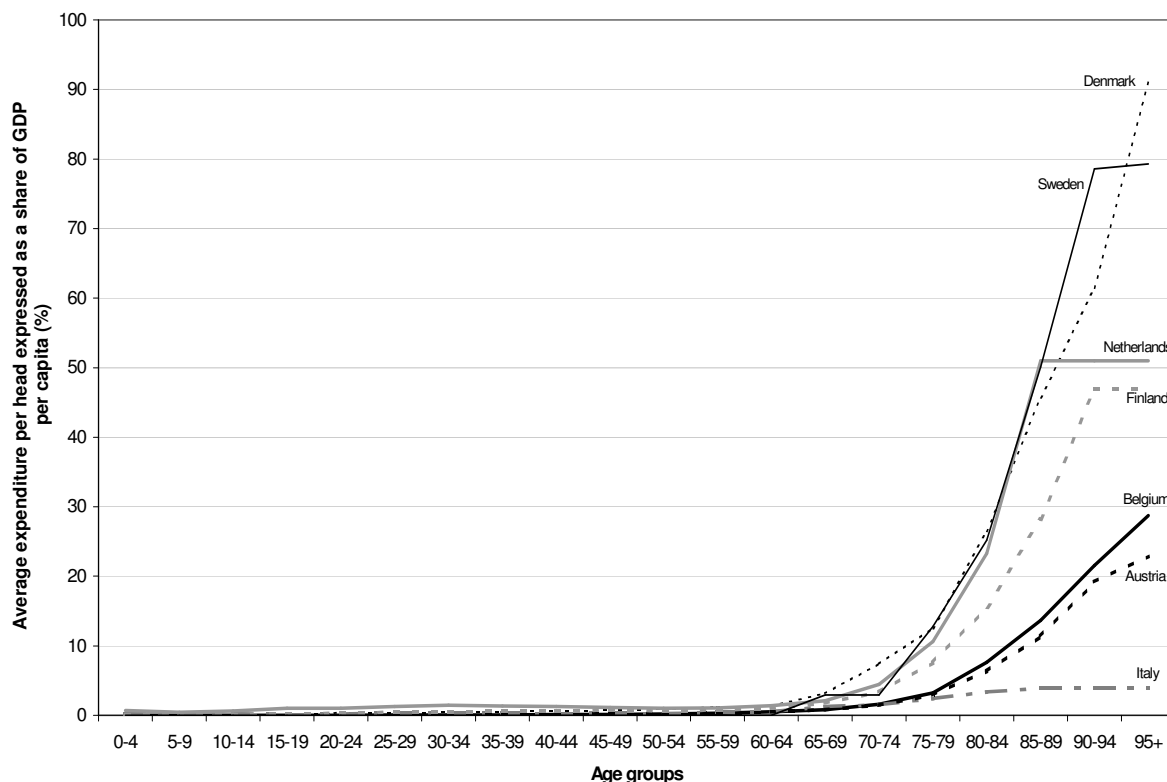


Notes:

- (1) The age-related profiles expressed as a share of GDP per capita, were those used for running the projections of health care expenditure. The base year used for the projections varies slightly across Member States and so the profiles in the graph above refer to different years for different Member States: 1997 for France, 1998 for Belgium, Denmark, Spain and the United Kingdom; 1999 for Italy; and 2000 for Germany, Finland, Netherlands, Austria, and Sweden. (Profiles for Portugal are not presented here as a different age classification is used.)
- (2) The expenditure profiles here relate to public expenditure on health care only. Notably, they exclude private expenditures and public expenditure on long-term care. See definition of expenditures for projections in Annex 4.
- (3) Where the age-profile is flat at the tail-end of the age-distribution, this is generally because a breakdown across age-groups was not available at the highest ages in those Member States.

Source: Economic Policy Committee (2001) "Budgetary challenges posed by ageing populations"

Graph 2b: Age profiles for public expenditure on long-term care



Notes:

- (1) The age-related profiles expressed as a share of GDP per capita, were those used for running the projections of long-term care expenditure. The base year used varies across Member States, and hence the profiles in the graph above refer to different years for different Member States: 1998 for Belgium, Denmark; 1999 for Italy; and 2000 for Austria, Finland, Netherlands, and Sweden.
- (2) The expenditure profiles here relate to public expenditure on long-term care only. Notably, they exclude private expenditures.
- (3) Where the age-profile is flat at the high-end of the age-distribution, this is generally because a breakdown across age-groups was not available at the highest ages in those Member States.

Source: Economic Policy Committee (2001) "Budgetary challenges posed by ageing populations"

Table 3: Total public expenditure on health care and long-term care

Expressed as a share of GDP. Central demographic variant.

	TOTAL HEALTH AND LONG-TERM CARE			HEALTH CARE			LONG-TERM CARE		
	Expenditure as a share of GDP in 2000	Increase in expenditure in per cent of GDP between 2000 and 2050		Expenditure as a share of GDP in 2000	Increase in expenditure in per cent of GDP between 2000 and 2050		Expenditure as a share of GDP in 2000	Increase in expenditure in per cent of GDP between 2000 and 2050	
		per capita	per worker		per capita	per worker		per capita	per worker
B	6.1%	+2.1	+2.4	5.3%	+1.3	+1.5	0.8%	+0.8	+0.8
DK	8.0%	+2.7	+3.5	5.1%	+0.7	+1.1	3.0%	+2.1	+2.5
D (1)				5.7%	+1.4	+2.1			
EL (1)				4.8%	+1.7	+1.6			
E (1)				5.0%	+1.7	+1.5			
F	6.9%	+1.7	+2.5	6.2%	+1.2	+1.9	0.7%	+0.5	+0.6
IRL (2)	6.6%		+2.5	5.9%		+2.3	0.7%		+0.2
I	5.5%	+1.9	+2.1	4.9%	+1.5	+1.7	0.6%	+0.4	+0.4
NL	7.2%	+3.2	+3.8	4.7%	+1.0	+1.3	2.5%	+2.2	+2.5
A	5.8%	+2.8	+3.1	5.1%	+1.7	+2.0	0.7%	+1.0	+1.1
P (1)				5.4%	+0.8	+1.3			
FIN	6.2%	+2.8	+3.9	4.6%	+1.2	+1.8	1.6%	+1.7	+2.1
S	8.8%	+3.0	+3.3	6.0%	+1.0	+1.2	2.8%	+2.0	+2.1
UK	6.3%	+1.8	+2.5	4.6%	+1.0	+1.4	1.7%	+0.8	+1.0
EU (weighted average) (3)	6.6%	+2.2	+2.7	5.3%	+1.3	+1.7	1.3%	+0.9	+1.0

Such long-term projections as the above must be read with considerable caution and respect to the underlying assumptions, as noted in the original report by the Economic Policy Committee (2001) “Budgetary challenges posed by ageing populations” which is available at

http://europa.eu.int/comm/economy_finance/epc/epc_ageing_en.htm

Notes: (1) Results for public expenditure on long-term care are not yet available for a number of Member States.

(2) Results for Ireland are expressed as a share of GNP.

(3) Weights are calculated according to the Member States for which results are available. Therefore for health care it is a weight for the EU-14, and for long-term care, and total expenditure on health and long-term care, the average is for 10 Member States.

Source: Economic Policy Committee (2001) “Budgetary challenges posed by ageing populations”

Note 13/11/2002: New projection, based on new demographic forecasts, by the Austrian Statistical Office in 2002.

Austria (2002)	5,6%	+2.4	+2.5	4.9%	+1.5	+1.6	0,7%	+0.9	+0.9
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Table 4 a: Total expenditure on health care as a share of GDP (%)

Table	Total expenditure on health - % GDP													
	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Austria	7.6	6.6	7.1	7.1	7.5	7.9	7.9	8.6	8.7	8	8	8.1	8	
Belgium	6.4	7.2	7.4	7.7	7.9	8.1	7.9	8.7	8.8	8.5	8.5	8.7	8.7	
Denmark	9.1	8.7	8.5	8.4	8.5	8.8	8.5	8.2	8.3	8.2	8.4	8.5	8.3	8.4
Finland	6.4	7.2	7.9	9	9.1	8.3	7.8	7.5	7.7	7.3	6.9	6.9	6.6	
France			8.6	8.9	9.1	9.5	9.4	9.6	9.6	9.4	9.3	9.4	9.5	
Germany	8.8	9.3	8.7		9.9	9.9	10.2	10.6	10.9	10.7	10.6	10.7	10.6	
Greece	6.6		7.5	7.8	7.2	8.1	8.9	8.9	8.9	8.7	8.7	8.7	8.3	
Ireland	8.4	7.6	6.6	7	7.6	7.5	7.5	7.2	7	6.9	6.8	6.8	6.7	
Italy			8	8.3	8.4	8.1	7.8	7.4	7.5	7.7	7.7	7.8	8.1	8.1
Luxembourg	5.9	5.9	6.1	6	6.2	6.4	6.1	6.4	6.4	5.9	5.8	6		
Netherlands	7.5	7.3	8	8.2	8.4	8.5	8.4	8.4	8.3	8.2	8.1	8.2	8.1	
Portugal	5.6	6	6.2	6.8	7	7.3	7.3	8.3	8.5	8.6	8.3	8.4	8.2	
Spain	5.4	5.4	6.6	6.8	7.2	7.5	7.4	7.7	7.7	7.6	7.6	7.7	7.7	
Sweden	9.1	8.7	8.5	8.4	8.6	8.6	8.2	8.1	8.4	8.1	7.9			
United Kingdom	5.6	5.9	6	6.5	6.9	6.9	7	7	7	6.8	6.8	7.1	7.3	
Czech Republic			5	5.2	5.4	7.2	7.3	7.3	7.1	7.1	7.1	7.2	7.2	
Hungary				7.1	7.7	7.7	8.3	7.5	7.2	7	6.9	6.8	6.8	
Poland			5.3	6.6	6.6	6.4	6	6	6.4	6.1	6.4	6.2		
Slovak Republic										6.1	5.9	5.8	5.9	
Turkey	3.3	2.2	3.6	3.8	3.8	3.7	3.6	3.4	3.9	4.2	4.8			
United States	8.7	10	11.9	12.6	13	13.3	13.2	13.3	13.2	13	12.9	13	13	
Canada	7.1	8.2	9	9.7	10	9.8	9.5	9.1	8.9	8.9	9.1	9.2	9.1	9.3
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Table 4 b: Public expenditure on health care as a share of GDP (%)

	Public expenditure on health - % GDP													
	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Austria	5.2	5	5.2	5.2	5.5	5.9	5.9	6.1	6.1	5.6	5.7	5.6	5.6	
Belgium								6	6.4	6	6	6.2	6.2	
Denmark	8	7.4	7	7	7	7.2	7	6.8	6.8	6.8	6.9	7	6.8	6.9
Finland	5	5.6	6.4	7.3	7.3	6.3	5.9	5.7	5.8	5.6	5.3	5.2	5	
France			6.6	6.7	7	7.3	7.2	7.3	7.3	7.2	7.1	7.1	7.2	
Germany	6.9	7.2	6.7		7.7	7.6	7.8	8.1	8.4	8.1	7.9	8	8	
Greece	3.7		4.7	4.7	4.2	4.7	4.7	4.8	4.9	4.8	4.7	4.7	4.6	
Ireland	6.8	5.8	4.8	5.2	5.5	5.5	5.5	5.3	5.1	5.3	5.2	5.2	5.1	
Italy			6.4	6.6	6.5	6.2	5.9	5.3	5.4	5.6	5.6	5.7	5.9	6.1
Luxembourg	5.5	5.3	5.7	5.6	5.8	5.9	5.6	5.9	5.9	5.4	5.4	5.6		
Netherlands	5.2	5.2	5.4	5.7	6.1	6.3	6.1	6	5.5	5.5	5.5	5.4	5.5	
Portugal	3.6	3.3	4.1	4.3	4.2	4.6	4.6	5.1	5.5	5.5	5.6	5.9	5.8	
Spain	4.3	4.4	5.2	5.3	5.6	5.8	5.6	5.5	5.5	5.4	5.4	5.4	5.4	
Sweden	8.4	7.9	7.6	7.4	7.5	7.4	7	6.9	7.1	6.8	6.6			
United Kingdom	5	5	5	5.4	5.8	5.9	5.9	5.8	5.8	5.4	5.5	5.7	5.9	
Czech Republic			4.8	5.1	5.2	6.8	6.9	6.8	6.5	6.5	6.5	6.5	6.6	
Hungary				6.4	6.8	6.7	7.2	6.3	5.9	5.6	5.5	5.3	5.1	
Poland			4.8	5	5.1	4.7	4.3	4.4	4.7	4.4	4.2	4.4	4.2	
Slovak Republic										5.6	5.4	5.2	5.3	
Turkey	0.9	1.1	2.2	2.4	2.5	2.5	2.5	2.4	2.7	3	3.5			
United States	3.6	4	4.7	5.2	5.5	5.7	5.9	6	6	5.9	5.8	5.7	5.8	
Canada	5.4	6.2	6.7	7.2	7.4	7.2	6.8	6.5	6.3	6.2	6.5	6.5	6.5	6.8
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