Opinion of the European Economic and Social Committee on 'The impact of population ageing on health and welfare systems' (exploratory opinion)

(2011/C 44/02)

Rapporteur: Ms HEINISCH

In a letter dated 18 September 2009, Ms Margot Wallström, Vice-President of the European Commission, asked the European Economic and Social Committee, under Article 262 of the Treaty establishing the European Community, to draw up an exploratory opinion on

The impact of population ageing on health and welfare systems.

The Section for Employment, Social Affairs and Citizenship, which was responsible for preparing the Committee’s work on the subject, adopted its opinion on 16 June 2010.

At its 464th plenary session, held on 14 and 15 July 2010 (meeting of 15 July), the European Economic and Social Committee adopted the following opinion by 89 votes with 5 abstentions.

1. Recommendations

1.1 The Committee believes that the following measures are needed to deal with the impact of population ageing on health and welfare systems.

1.1.1 At national level:

— Mainstreaming of ‘healthy ageing’ as a horizontal issue.

— Strengthening of preventive healthcare, health promotion and education across all age groups.

— Improving the quality of health and social care for older people.

— Inclusion of palliative care in care services.

— Developing and adapting age-appropriate types of therapy, by including older people in clinical studies and comorbidity studies.

— Developing health and care institutions suitable for older people, and alternative housing.

— Evaluation through Health Technology Assessment (HTA) of telecare and technology-based solutions including Ambient Assisted Living (AAL) and other health technologies (care environment), which aim to support independent living and improve the efficiency and quality of care for older people.

— Creating a comprehensive, decentralised infrastructure near to where people live that facilitates direct contact between older people and members of the medical and caring professions (deinstitutionalisation).

— Support for regional and local stakeholder networks to implement the Ageing and health aims.

— National legislation introducing mandatory schemes to ensure care in old age (e.g. care insurance).

— Opening of national health and social care systems to model tests with subsequent evaluation in order to enable systems to evolve.

— Making systems for additional payments and complementary insurance more flexible.

— Drafting and implementation of national strategies and policies for lifelong learning (LLL) at national, regional and local level.

— Ensuring that work, family and care can be reconciled.

— Encouraging volunteering.

— Recognising the importance of carers and their needs.

1.1.2 At European level:

— With reference to the conclusions of the EPSCO council on 30 November 2009, drawing up an action plan for healthy and dignified ageing.

— Prioritising the issue of active, healthy and dignified ageing in the EU 2020 strategy.

— The need to harmonise terminology, definitions, assessment tools, guidelines, criteria, procedures, etc. It is now 20 years since this problem first arose and yet there has been no significant progress to date.
— Emphasising active, healthy and dignified ageing as a key theme in the European Years 2010 (European Year for Combating Poverty and Social Exclusion), 2011 (European Year of Volunteering) and 2012 (European Year of Active and Healthy Ageing and Intergenerational Solidarity) and during the corresponding Council presidencies.

— Inclusion of demographic change in the European Commission’s joint research programming.


— Establishment of a specific inter-service working party in the Commission on Ageing and health (including healthcare, personal care, pensions and financial sustainability).

— Creation of a Round Table, a Category or a Permanent Study Group on Active, healthy and dignified ageing – intergenerational dialogue in the EESC to draw up an interdisciplinary strategy in these areas.

— Inclusion of gerontology and demographic research as a priority in the Eighth Research Framework Programme.

— Establishment of a project entitled Older people and knowledge transfer as part of the Science and society sub-programme.

— Listing and comparing the health aims of Member States and how binding these are.

— Supporting the Member States in the implementation of the above-mentioned measures through funding from the Structural and Cohesion Funds and the Open Method of Coordination.

— Support for the exchange of good practice regarding tailored information and communication technology (ICT) solutions, for example in the context of the INTERREG programme, with support from the Structural Funds.

— Support for multinational Health Technology Assessments (HTAs) for evaluating new ICT solutions to the care needs of older people.

— Continuous awareness-raising of lifelong learning (LLL) and the exchange and coordination of European education and training programmes with Ageing and health as key themes: from lifelong learning to ‘learning for a long life’.

— Creating a new image of old age – including in the media.

— Drawing up European guidelines on reconciling family, work and care.

2. General remarks

2.1 Introduction

2.1.1 Society in the European Union is ageing because of increasing life expectancy. Eurostat forecasts suggest that the proportion of people aged 65 or over in the population will rise from 17.1% in 2008 to 30% in 2060. The average ratio between people of working age (15-64) and people aged 65 and over will change from 4:1 now to 2:1 in 2050.

2.1.2 A large proportion of the economically active population will exit the labour market between 2026 and 2030. This means that, at a time of lower birth rates, the proportion of people not working will increase in relation to the working population.

2.1.3 A recent Commission Communication (1) states that governments have only a short window of opportunity to implement measures to address the issues relating to the ageing population before the baby-boom cohorts enter retirement. In this context, the Commission asked the EESC on 18 September 2009 for an exploratory opinion to look at how the efforts of the Member States to tackle this problem could be supported by Community initiatives in the area of health. This opinion is based on a number of EESC opinions (2).

2.1.4 The Council presidencies held by the Czech Republic (first half of 2009), Sweden (second half of 2009) and Spain (first half of 2010) have included healthy, dignified and active ageing as a priority in their work programmes.

2.1.5 Society and leaders in healthcare need to develop a new image of ageing that is appropriate to demographic change and is conducive to the dignity of older people.

2.1.6 It is not the ageing of the population per se that causes greater expense, but unhealthy ageing. For this reason, the main recommendations in this opinion relate to measures to promote healthy ageing.

2.2 Further development and innovation of healthcare systems, welfare systems and health services

2.2.1 Demographic change requires healthcare and welfare systems, healthcare services and other related services be developed as regards their organisation and capacity, i) to meet the needs of older people, ii) to ensure that all those in need of care receive those services that are necessary to uphold their autonomy and dignity, and iii) to ensure that all sections of the population, regardless of age, gender, financial situation or place of residence, have equal access to high-quality health services (including health promotion, preventive healthcare, treatment, rehabilitation and palliative care).

2.2.2 In this context, not only older people's expectations of health and welfare systems should be taken into consideration, but also people's timely, preventive responsibility for their own ageing – in other words, society's expectations of people who are growing older.

2.2.3 To support healthcare provision and long-term care for all older people with the help of EU policy, the EU should list and compare the healthcare aims (1) of the Member States and the extent to which they are binding. Similarly, a scoreboard should be drawn up of the extent to which prevention and health promotion are already integrated within healthcare systems.

3. Specific comments

3.1 Areas of specific concern

3.1.1 Prevention

3.1.1.1 People start ageing the moment they are born. It is therefore important for them to have – as far as possible – good conditions in which to live their whole lives. What is at stake is a good start in life and a dignified end to life. Healthy ageing starts long before retirement and is influenced by, amongst other things, living and working conditions and the availability of resources. If people realise this, the need for people to grow old responsibly follows logically (2). Responsible ageing calls for lifelong learning. To this end, new strategies and policies for lifelong learning (LLL) need to be drawn up at national, regional and local level in the health education sector. They must include all types of learning (formal, non-formal and informal). This includes every stage of learning, from pre-school to adult learning. Taking responsibility for keeping themselves healthy through active participation in preventive measures (nutrition, sport, healthy lifestyles, avoidance of risk factors, etc.), health promotion and health education help older people to remain at home and in their habitual social environment for as long as possible. In addition, the role of technology in this context should be kept under continuous review and evaluation.

3.1.1.2 Health systems need to place more emphasis on prevention. This could not only allow people to remain active in the labour market for longer, but could also enhance their ability to adapt to the labour market. High quality occupational health and safety systems and more ergonomic workplaces could play a significant role in making it possible to extend healthy working lives, thus also engaging with the demographic challenge.

3.1.1.3 By adapting what people do to their abilities and needs as they get older (e.g. moving away from implementing activities towards preparatory but also advisory, support, training and planning activities), such an extension of working lives can be made possible. This also means that older people will be integrated in social and socio-economic contexts for longer and will thus continue to receive helpful performance stimuli. In this way, longer healthy lifetimes can be reflected in longer fulfilled, productive lifetimes. This does of course mean that appropriate training and support measures must be available in order to initiate and continue the processes outlined above (lifelong learning, vocational training including certification of skills learned on the job, etc.). Businesses should offer health promotion, and illness and accident prevention, so as to develop healthy working conditions.

3.1.1.4 Once people have left professional life, social integration into society and into the socio-cultural environment is of the utmost importance. To prevent social isolation is to prevent cases of depression. Older people are particularly well-placed to put their social skills and experience to use, for example through voluntary work. However, people should be encouraged from an early age to get involved in voluntary work.

3.1.2 Health services

3.1.2.1 Emphasis is increasingly being placed on the provision of patient-centred healthcare services and on ensuring that patients are involved in developing and planning healthcare services.

3.1.2.2 Chronic illnesses (diabetes, rheumatism, heart disorders), degenerative illnesses of the nervous system (dementia and Alzheimer's), the musculoskeletal system and the eyes, and also cancer, increase with age. This poses particular challenges to the healthcare professions, diagnostics, treatments and healthcare provision itself.

3.1.2.3 Health services for integrated, personalised care that put the patient at the centre must be developed.

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(2) 'Teach us to number our days aright, that we may gain a heart of wisdom.' (Psalms 90:12). English translation from the New International Version, copyright © 1973, 1978, 1984 by Biblica.
3.1.2.4 Better and more specific training of healthcare professionals should be encouraged: the members of these professions (doctors, pharmacists, nurses and carers) and researchers must be made more aware of the specifics of geriatric medicine and receive more training in this area. Healthcare professionals should also be given specific training in the importance of health promotion and preventive measures for the elderly (e.g. avoiding falls, healthy eating).

3.1.2.5 Development and adaptation of age-appropriate types of treatment: comorbidity, changed metabolism in old age and, in many cases, multiple treatments, require precise knowledge of interactions between organs and systems in the bodies of older people. This requires specific medication management and the selection and adaptation of medication and dosage to the metabolism of older people. The availability in public pharmacies of personalised advice involving interaction tests, along with good ICT providing information on drugs and their interactions, may help to minimise the undesired side-effects of medicines and to optimise the success of treatments.

3.1.2.6 Promoting direct, continuous contact between older people and medical and care professionals: The more dependent on care older people become, the more important such contact is to ensure successful treatment outcomes and to prevent isolation and depression.

3.1.3 Care services

3.1.3.1 Standards should be set so that the quality of care services can be guaranteed, made verifiable and evaluated. A European Charter on the Rights of Persons in Need of Assistance and Care should be developed, which should include protection from violence in care. New technologies (e.g. AAL) that enable independent living could help here. However, potential new technologies must be assessed properly and must certainly not lead to new inequalities in healthcare and care provision at national level.

3.1.3.2 ‘Rehabilitation before care’ should be the motto where older people are concerned. Institutionalised care must not become a one-way street: there must be way out of care and back home. The healthcare and care institutions that currently exist do not yet sufficiently fulfil this requirement.

3.1.3.3 Development of age-appropriate medical and care institutions, and alternative housing: what is needed is a smooth and reversible transition between health and sickness, care and social life, backed up where needed by good medical and personal care, enabling older people to remain in a ‘normal’, i.e. multigenerational, environment for as long as possible. This requires good coordination between healthcare and personal care. At the same time, provision needs to be made, alongside long-term care institutions, for more inpatient and out-patient hospices and palliative care institutions. A ‘hospice culture’ should be fostered.

3.1.3.4 For this purpose, a comprehensive, decentralised, local infrastructure for care at home needs to be set up (deinstitutionalisation). Non-institutional care infrastructure including all the necessary services (outpatient care, home care, help with odd jobs) should be promoted. This must be reflected in organisation at regional level and improved structural financing in order to ensure that there are adequate institutions and structures not only in cities, but also across the board in rural areas.

3.1.3.5 How a society treats its older people says much about that society. Voluntary work has taken on a particular significance when it comes to looking after and caring for older people. In future, every citizen must do all they can to take responsibility for the sick, disabled people and elderly people – but also be rewarded for what they do.

3.1.3.6 Promoting work and making it accessible: Effective work organisation and recognition of work can support the self-confidence of older people. The same applies to paid and unpaid work. Adequate recognition of work and true social and economic participation should be promoted.

3.1.3.7 How can people be motivated to age responsibly and take responsibility for their own health? (Promoting healthy behaviour, incentives for older people to use the measures and facilities available to them to maintain their health).

3.1.3.8 How can people be motivated to change their behaviour in order better to fit in with the social environment?

3.1.3.9 How can people be motivated to become carers?

3.1.4 Research into the above-mentioned areas

Demographic change should be included in the European Commission’s joint research programming. Following on from the WhyWeAge and Futurage projects under the seventh framework programme, gerontology (research into old age and ageing) and demographic research should be priorities in the eighth framework programme. It would also make sense to include a thematic area of Older people and knowledge transfer in DG Research’s Knowledge and Society programme. This also needs to include the following areas of research:

3.1.4.1 Research into prevention

— What is the outlook for preventive healthcare in the workplace?

— What are the long-term effects of particular lifestyles on general health and particular illnesses?

— How do various gender, culture and migration-related lifestyles impact on health ageing?

— What can be done to prevent falls and bone fractures?

— What preventive measures are useful in maintaining physical, sensory and cognitive functions, and social skills?

— How can people be motivated to age responsibly and take responsibility for their own health? (Promoting healthy behaviour, incentives for older people to use the measures and facilities available to them to maintain their health).

— How can people be motivated to change their behaviour in order better to fit in with the social environment?
3.1.4.2 Research into illnesses and treatments

— relating to the epidemiology and aetiology of age-related illnesses, to enhance the scope for prevention;

— relating to the biological ageing process from the cradle to the grave;

— relating to comorbidity, chronic illnesses, cancer, heart conditions, rheumatism and illnesses of the musculoskeletal system, visual impairment (e.g. cataracts), neurodegenerative illnesses such as Alzheimer’s disease, etc. This should also include improving diagnostics so that problems can be diagnosed, and treatment started, at an early stage;

— relating to treatments for older people as regards age-specific illnesses: the biochemical processes that affect absorption, metabolism, the efficacy of medicines, medication and dosage, must be better understood and be taken into account during treatment. In many cases the therapeutic basis for this is lacking, as clinical trials and the testing of medicines often only involve young adults.

3.1.4.3 Care research

— How can we develop new technologies that meet the needs of older people?

— What are the optimum environments and formats for providing care?

— How can improvements in the skills and working conditions of care workers be achieved, also in connection with new technologies?

— What contribution can technical solutions (e.g. robotics) make to relieving the burden of caring relatives and improving the working conditions of professional carers without impairing the integrity and dignity of the person being cared for?

— How can care provision be adapted to the needs and expectations of older people who are in need of care?

— What new ideas could contribute to the development and support of care at home? This also includes economic support and societal recognition of caring relatives (e.g. the possibility of temporarily reducing working hours by agreement between employer and employee, for care-related reasons, work done as carers being recognised by pension schemes, care allowances, etc.).

— What new ways are there of arranging care, pain relief and end-of-life care for dignity in dying?

3.1.4.4 Research into healthcare systems

— Research in public healthcare should look at healthcare systems and long-term care, and at the integration of services, and develop a roadmap for research into ageing. An evaluation is needed as to whether the healthcare and welfare systems in the Member States are prepared for the challenges of demographic change. For example, how much emphasis is placed on prevention? What proportion of healthcare spending goes on prevention? How many people are being cared for at home or in institutions?

— How much does voluntary work and care save in terms of resources, and how much unpaid work is carried out at home, particularly by women?

— Research into health outcomes and Health Technology Assessments are needed particularly as regards the use of new technology and eHealth in the treatment and care of older people before such technologies are introduced. Do these technologies live up to their promises when tested in practice? Do the most vulnerable groups benefit from these technologies?

— In cooperation with the Member States, a clinical and socioeconomic research project into the effectiveness and efficiency of investments in improving health and care provision for older people should be carried out.

3.1.5 Developing new technologies

3.1.5.1 However, as well as causing problems, demographic change also provides considerable potential, particularly in terms of new goods and services for an ageing society. Age as an economic factor can act as a driving force for the economy, increasing growth and employment in the area of health services, new technologies, pharmaceuticals, medicinal products, medical technology, and tourism and wellness. According to Commission estimates, the impact of demographic change on healthcare spending will be considerable: the projections suggest that public healthcare spending in the EU will increase by 1.5 percentage points of GDP by 2060. New products and services should be developed and put on the market. The amount of value they create will be influenced by market volume, the price and their added value.

3.1.5.2 Whilst possible cost savings are a priority for the ‘first health market’ and will thus determine whether Ambient Assisted Living (AAL) will be provided by statutory sickness and/or care insurance funds, the ‘second health market’ is in a position to act much more freely and flexibly in this regard. There is a need here to develop sustainable, affordable business models paid for through sale, rental or leasing. At the same time, it is important to ensure that the ‘second health market’ avoids creating inequalities.
3.1.5.3 The collation and exchange of social and economic knowledge about the consequences of introducing care-related technologies should be encouraged, for example by building on the pilot projects that have been started as part of the Competitiveness and Innovation Programme and are currently ongoing. At the same time, the exchange of tried and tested ICT procedures relating to solutions for enhancing older people’s quality of life should be supported, for example as part of the INTERREG programme, with funding of the Structural Funds. This research should evaluate the opinions of technology users, particularly with regard to the user-friendliness and benefits of the technologies.

3.1.5.4 Technological progress and newly-developed early diagnosis and treatment methods are on one level a key factor in the increase in spending, but, on the other, technical advances can, when applied sensibly, certainly achieve cost savings in the long term. A greater role should be given to Health Technology Assessment (HTA) to establish the scope of health and care services and the extent to which they are funded. The effective introduction and management of technology is therefore a major determinant of future spending. However, new technologies cannot and must not replace direct contact between older people and healthcare and care professionals. They must also be affordable.

3.1.6 Financial sustainability

3.1.6.1 In almost all Member States, care services for older people are funded by welfare systems, which means that each of these systems need to have sustainable, secure funding.

3.1.6.2 The need for care is still a poverty risk, particularly for pensioners with small pensions or low incomes. Many people in Europe cannot afford decent care in their old age. Therefore, systems to cover care costs must be set up in all EU countries, in line with the way their social security systems are run (social insurance system or tax-funded system), and existing provisions need to be adapted to the challenges of demographic change over the coming decades in order to ensure that all citizens can access care services in accordance with Community law, national legislation and practices and individual needs. This coverage of care costs should apply not only to in-patient, but also out-patient services.

3.1.6.3 The transfer of some long-term care services to private health insurance must be thought out properly, in consultation with the parties concerned, so as to ensure that this trend does not complicate access to these services. Member States should continue to ensure that older people have universal access to primary care and prevention. This ambitious objective will require the deployment of all available financial instruments: statutory social security schemes and complementary mechanisms.

3.1.6.4 New structures for reimbursement of costs should also make it possible for more distant relatives to receive a care allowance for looking after people who need care. However, the quality of care must also be ensured in these cases. In addition, by analogy with maternity leave, care leave should be introduced. At political level, ways of reconciling family, work and care need to be worked out as a matter of priority, in consultation with the social partners as part of social dialogue (as in the case of parental leave, for example).

3.1.6.5 The financial pressure on social security schemes could be reduced by means of a number of measures at national level, e.g. greater use of generics, reductions in VAT on medicines and price negotiations with the pharmaceutical industry.

3.2 Local networks – The smallest unit is the most efficient and the closest to the individual

3.2.1 Older people can, depending on their constitution, offer much to society. Personal or professional circumstances mean that multi-generational households are becoming increasingly rare in modern families. Private or municipal providers with local networks can close a gap here, as bodies providing services of general interest need to be adapted at regional and local level if a decent level of support and assistance is to be provided.

3.2.2 Examples of such local networks are platforms of municipal providers, social partners, NGOs and healthcare leaders that work to coordinate service provision. Such initiatives offer good opportunities for support from the structural and cohesion funds. Europe should recognise models of good practice such as initiatives on ways to foster civic involvement and self-help in the area of care at home.

3.2.3 Multi-generational centres are also a new form of inter-generational relations outside the family: the work of nursery schools, youth clubs and day centres for the elderly is brought under one roof (5).

3.2.4 Further services such as day and night care (particularly for dementia patients) need to be added.

3.3 European health policy

3.3.1 The Member States' healthcare systems must meet the challenges of demographic change and be strengthened with this in mind. That said, it is important to remember that the organisation and management of healthcare systems remains, even under the Lisbon Treaty, the task and responsibility of the Member States, and that the EU institutions merely support the Member States in this task. Because of the way they are organised (private insurance operates alongside state-backed systems under the Beveridge or Bismarck models, or a hybrid model), their development, the differing strength of the respective economy, and the needs and expectations they face, national healthcare systems vary enormously from one Member State to another. However, as the European Charter of Fundamental Rights states, the right to access healthcare must be ensured.

(5) http://www.mehrgenerationenhaeuser.de.
3.3.2 The Open Method of Coordination (OMC) could be used to organise and manage health policy more efficiently. Such cooperation should focus on sharing experience and describing practical examples in the three key areas of access, quality and long-term affordability.

3.3.3 The organisation of social policy also remains primarily the competence of the Member States, in accordance with the subsidiarity principle. However, the EU can help them through supporting measures such as complementing or promoting cooperation between Member States. The OMC has proven to be a useful means of improving social policy in accordance with the principles of access, adaptation and sustainability.

3.3.4 The issue of active, healthy and dignified ageing must become a priority in the EU 2020 strategy. An action plan should be drawn up to this effect. This requires still more intensive and continuous cooperation between the Commission’s Directorates General. A specific inter-service working group on ageing and health should therefore be set up to look at the issues of healthcare provision, care, pensions and financial sustainability. The principles of more prevention, health promotion and education should be mainstreamed across all policy areas and serve as an example to the Member States.

3.3.5 The EESC should continue, by means of a Round Table, a Category or a Permanent Study Group, to examine the issue of Active, healthy and dignified ageing as part of inter-generational dialogue with a view to drawing up an interdisciplinary strategy on demography.

3.3.6 EU policy should support the Member States in the implementation of national measures through grants from the structural and cohesion funds.

3.3.7 Beyond this, the EESC again calls for continuing support for lifelong learning in the area of ageing and health at European level and the development of a specific strategy for implementing this principle at national, regional and local level.


The President
of the European Economic and Social Committee
Mario SEPI