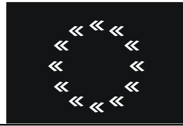
EUROPEAN PARLIAMENT

2004  *2009*

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REPORT

on modernising social protection and developing good quality healthcare
(2004/2189(INI))

Committee on Employment and Social Affairs

Rapporteur: Milan Cabrnoch

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MOTION FOR A EUROPEAN PARLIAMENT RESOLUTION

on modernising social protection and developing good quality healthcare (2004/2189(INI))

The European Parliament,

- having regard to the Commission Communication on modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care : support for the national strategies using the "open method of coordination" (COM(2004)0304),

- having regard to its resolution of 16 February 2000 on the communication from the Commission on a concerted strategy for modernising social protection[1],

- having regard to its resolution of 15 January 2003 on the Commission communication to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions on the future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability[2],

- having regard to the meetings of the European Council of 20 to 21 March 2003 in Brussels and the conclusions of the preceding European Council meetings in Lisbon, Göteborg and Barcelona on health care and long-term care,

- having regard to the Commission White Paper on services of general interest (COM(2004)0374),

- having regard to the Commission Communication on 'Strengthening the social dimension of the Lisbon strategy: streamlining open coordination in the field of social protection' (COM(2003)0261),

- having regard to its resolution of 11 March 2004 on the proposal for a joint report on 'Health care and care for the elderly: Supporting national strategies for ensuring a high level of social protection' [3],

- having regard to Rule 45 of its Rules of Procedure,

- having regard to the report of the Committee on Employment and Social Affairs and the opinion of the Committee on the Environment, Public Health and Food Safety (A6-0085/2005),

A. whereas the right to health is a basic social right, as enshrined in Article II-95 of the Treaty establishing a Constitution for Europe[4], now subject to ratification, and whereas the Charter of Fundamental Rights of the European Union recognises the right of each person to have access to health care and medical treatment and the right of the elderly to

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[1] OJ C 339, 29.11.2000, p. 154.
[2] OJ C 38 E, 12.2.2004, p. 269.
[3] OJ C 102 E, 28.4.2004, p. 862.
[4] OJ C 310, 16.12.2004.

lead a life of dignity and independence and to participate in social, cultural and working life,

B. whereas health is a value inherent to each individual at all stages and in all situations in life and is one of the basic prerequisites enabling him or her to make an active contribution to society, and whereas public health is one of society's values and maintaining it is one of society's most important tasks,

C. whereas health is affected by many factors including genetic predisposition, lifestyle and social situation, and whereas health care contributes only to a limited extent (the figure of 10% is often mentioned) to an individual's overall state of health,

D. whereas confidence that health care will be available if it is needed is essential to the successful functioning of any individual in society, at all stages and in all situations in life,

E. whereas the free movement of persons (including workers) is one of the EU's basic principles and is also at the same time essential to the further development of the individual Member States and of the Union as a whole, and people's confidence in the availability and the quality of health care as a result of their movement between Member States can be strengthened through the open coordination of health systems,

F. whereas, in line with the jurisprudence of the European Court of Justice, there will be an increase in patient mobility and the use of cross border services, and this development, combined with a deepening of the internal market, will have an increasing impact on national health systems whose principles and objectives must not be jeopardised thereby;

G. whereas the European sickness insurance card is an appropriate instrument for ensuring freedom of movement within the EU in terms of health care, even if the structures of national social systems vary very substantially,

H. whereas the European Court of Justice has repeatedly recognised claims by patients for the reimbursement of the costs of medical treatment in another Member State, although it has made a distinction between in-patient and out-patient treatment, attaching certain conditions to the assertion of such claims which are intended in particular to ensure a balanced approach and social security, always with the objective of ensuring a high standard of health protection,

I. whereas in its report for the June 2004 Council, the European Parliament urged the Member States to strengthen their public and private care and assistance institutions by using the full range of supply available in patients' countries of origin,

J. whereas health systems in the Member States are founded on the principles of equality and solidarity, which dictate that high-quality health care and long-term care should be available and accessible to all, tailored to their needs and irrespective of their age or means,

K. whereas it is a constant objective of the Union to promote a high level of social protection and whereas more effective cooperation in the field of health care and long-term treatment will contribute to the sustained modernisation of the European social model and greater social cohesion; whereas health care and long-term treatment are services of general

interest in which the principle of solidarity should be given priority,

L. whereas health systems, as part of Member State' social security systems, are confronted with the challenges posed by new investigative and therapeutic technologies, an ageing population (i.e. an enormous increase in the number of the very old and frail in need of tailored health assessment and appropriate care), the general public's increasing expectations and the guarantee of universal access for all citizens to these systems,

M. whereas the ageing of healthcare workers presents a challenge in some Member States, as does the ageing of many who provide unpaid care,

N. whereas new diagnostic and therapeutic technologies not only jeopardise the financial stability of health systems, they also - and in particular - introduce fresh options and inject new hope into mankind's constant fight against disease and old age; whereas, however, increasing poverty amongst the elderly must also be borne in mind,

O. whereas prevention is the most effective and most efficient form of health care and whereas affordable high-quality preventive care, which is accessible to all, leads to an increase in average life span, a reduction in the frequency of illness and lower expenditure on health care, and helps to ensure that health-care financing is sustainable on a long-term basis,

P. whereas although the vast majority of older people live healthy and independent lives, a significant number of them still suffer from illnesses and disability and therefore need access to high-quality highly-integrated social and health services providing appropriate geriatric (i.e. multidisciplinary and holistic) assessment, which is the only intervention able to reduce disability as well as prevent unnecessary long-term care for members of this group,

Q. whereas the focal point of everything relating to health is the individual - the patient; he or she is provided with health care and pays for it either directly or in the form of insurance or taxes; ordinary people have the utmost interest in the availability, accessibility, appropriateness and quality of care, and must therefore be fully informed and have full rights and choice as regards decision-making in respect of health-care options and consumption,

R. whereas the quality of health care is affected in particular by the educational level and continuing training of health workers, by appropriate working and labour protection conditions, by the availability of high-quality investigative and therapeutic technologies, by the level of organisation of health services and by the quality of communication and information-sharing between health-care providers and patients,

S. whereas, given the enormous increase in the number of frail older people, there is an urgent need for the development and promotion of gerontological and geriatric education, both in undergraduate and postgraduate training programmes, in order to equip all health professionals with the specific knowledge and skills that are needed to provide better and more appropriate care to this group,

T. whereas the European programme of Community action in the field of public health (2003-2008) provides an integrated approach to health policies and health care, based inter

alia on health promotion and primary prevention, on obviating risks to health, on the inclusion of a high level of health protection in the definition and implementation of all sectoral policies and on tackling social inequalities as a source of health problems,

U. whereas health - like economics - is a very important field of science and research – it constitutes an extremely large area for scientific development and research and at the same time for the practical everyday application of the results of research and scientific investigation; whereas, as a sector of the economy, health creates large numbers of jobs and a great deal of economic value,

V. whereas, in addition to basic research, there is a strong need for clinical research, which addresses the health problems currently encountered by the growing number of frail older people and aims at developing new interventions to provide the most effective and efficient care, contributing to a high quality of life,

W. whereas the health sector is closely linked to economic growth and sustainable development and should not therefore be considered solely in terms of its costs, but also as a productive investment that can be made by means of effective health policies,

X. whereas cooperation in the health care sector is an element in the creation of a healthier Europe whose organisation essentially lies within the responsibility of the Member States; whereas, in order to improve and develop high-quality, accessible and sustainable health care, it is important for there to be an exchange of experience between the Member States; whereas health care should play a significant role in the Lisbon strategy;

Y. whereas there is an increasing demand for home care which enables a patient to be treated in his or her familiar home environment and whereas this type of care provides a useful complement to in-patient treatment and constitutes an important service with great employment potential,

Z. whereas the Commission's Communication on the Social Policy Agenda (COM(2000)0379) states that the introduction of social health insurance has been an essential element of health care reforms, highlighting the fact that seven of ten new Member States prefer an insurance-based to a tax-based system,

1. Notes that the Commission intends to support - inter alia within the framework of the open method of coordination - national (and, where appropriate) regional governments in the development and reform of health care systems and demands that the absolute sovereignty of national (and where appropriate, regional) governments in the field of healthcare organisation in particular the various funding systems be fully respected, so that they may attain jointly defined objectives for the modernisation of the social protection systems;

2. Points out that in the process of the open method of coordination neither the competences of the Member States may be eroded nor the principle of subsidiarity undermined; points out that in future each Member State must continue to decide for itself how jointly defined objectives for the modernisation of social protection systems are to be attained;

3. Calls on the Commission and the Member States to take more account of the importance of prevention and health in establishing Community objectives and indicators;

4. Criticises the fact that the open method of coordination, as intended to apply to health, in particular computerised data collection, clearly overstretches the administrative capacity of the Member States; proposes that data collection should initially apply only to especially relevant areas;

5. Welcomes the Council decision to use the open coordination method in the field of health care and long-term treatment; confirms its endorsement of the three basic objectives - universal access independent of income or wealth, high quality and long-term financial sustainability; calls upon the Member States to make those priorities explicit and to ensure universal access without undue waiting lists and points out that sustained efforts must be made to ensure that those objectives are consistent with each other; considers that citizens' rights to equivalent health care in every Member State need reinforcing; calls on each Member State to take the necessary steps to ensure that these rights are respected, and that tourists in particular are not propelled into costly private health treatment against their wishes and in contravention of their rights;

6. Urges Member States to consider active steps to deal with the health needs of the poorest members of society and their access to health care;

7. Regrets that the Commission views the modernisation of social protection with regard to health care essentially in terms of the requirements of the Stability Pact; regrets that the Commission makes no reference in its text to the trends in spending on the various sectors of health care (treatment, hospital care etc.) or to the impact of prevention in the individual Member States;

8. Agrees that health systems in the Union are confronted with common challenges, owing to medical and technical progress together with increasing costs, demographic developments, in particular the growing number of frail older people, suffering from multiple illnesses which are often compounded by unfavourable social circumstances, the increasing demand for health services and medical products and an increasingly mobile Community population;

9. Takes the view that the ageing of the population constitutes a challenge and should also be taken as an opportunity to involve people with long and valuable experience more closely in society and enterprises as part of active ageing;

10. Points out that for the further development of social infrastructures, increasing life expectancy requires better coordination between medical services and care services;

11. Recognises that an increasingly mobile Community population and immigration from other countries can represent an administrative challenge;

12. Emphasises the importance of prevention and of affordable care for one's own health as the most effective courses of action in the fight against disease, and calls upon the Member States' governments to encourage the coordination of health prevention programmes aimed at different age groups which include health promotion and health education amongst their priorities and give prevention a perceptibly higher priority in the actual use of services, including regular preventive medical examinations and vaccination in accordance with scientific knowledge and to ensure universal access to these measures; also recommends appropriate geriatric screening for frail older people with a view to

improving their quality of life and avoiding unnecessary long-term hospitalisation and nursing home care, which will in turn make a huge contribution to cutting expenditure on health;

13. Remarks that the 'big killers' (e.g. cancer diseases, cardiovascular diseases) and the 'big cripplers' (e.g. musculo-skeletal disorders and other work-related chronic diseases, health problems resulting from e.g. unhealthy diets, drug abuse, environmental degradation and reduced physical activity) could be considerably reduced by general intersectoral policies and individual preventive policies and improved measures to address factors in people's working and living environment which cause disease; stresses, therefore, the importance of developing occupational health care with a view to the prevention and early detection of diseases and health problems;

14. Emphasises the fact that the main role in any system of health care and long-term care must be played by the individual as a beneficiary of services and a care consumer; his or her rights are paramount and first and foremost amongst them is the right to comprehensive information concerning his or her own health, concerning health care and long-term care options and concerning the choice of care which is offered on the market by individual providers;

15. Calls on the Member States and the Commission, in particular with the help of the health action programme, to ensure the approximation of data gathering and an improvement of the data situation and to enable citizens and service providers to access information on the health care and health policy of other Member States through the EU health portal which is currently under construction;

16. Welcomes the emphasis which the Commission places on improving interdisciplinary and interagency communication and cooperation between individual health care and long-term care providers in prevention, diagnosis and treatment; the doctor responsible for dispensing primary care plays a key role in such communication and cooperation and the sharing of existing information leads to higher quality and efficiency of the care provided, a reduction in the risk that patients will be harmed and greater effectiveness in the use of manpower and resources;

17. Is concerned about the substantial differences between the old Member States and most of the new Member States in terms of the health status of their population and access to, quality of, and resources deployed in the field of health care and long-term care; calls on the Commission and the old Member States to support the new Member States in their efforts to improve health care and long-term care with the aid of the health action programme and other appropriate instruments, in particular the open method of coordination;

18. Stresses the importance of health care, long term care and social care in national economies, thanks to the large number of people which they employ at present and their potential to create an abundance of jobs with various care providers, thus creating increased competition and hence increased growth potential for national economies; points out that the gradual ageing of the EU population will require the deployment of more financial and human resources to help older people; and also considers that in many Member States there is an urgent need to take active steps to recruit and retain health care workers;

19. Points out that the increasing demand for services in the health and care sector is creating additional jobs of an increasingly high quality;

20. Calls on Member States' governments to adopt effective measures to improve the situation of individuals in their consumption of health care and long-term care, to support improved availability of information for the general public and to enhance the conditions under which individuals can take decisions freely regarding the consumption of health care and long-term care; considers that to make this possible there is a need for a variety of care providers and for availability of information on healthy lifestyles and preventive, diagnostic and therapeutic options, and access to such information must not be restricted, especially not for the purpose of saving public resources;

21. Points out that some Member States are increasing the share of health costs to be borne by patients and calls in this connection for disadvantaged groups to continue to have access to adequate health care;

22. Is concerned that, in many Member States, waiting times for certain urgent and non-urgent forms of treatment are too long; calls on these Member States to make targeted efforts to reduce waiting times; calls on the Member States, whenever long waiting lists exist and a comparable or equally effective treatment for patients cannot be undertaken in time domestically, to work together closely to ensure a high level of health protection and social security for all EU citizens, while duly respecting the principle of subsidiarity, the balance of national systems and a financial equilibrium;

23. Calls on Member States' governments to provide practical support for the sharing of information (including among the various agencies and disciplines involved in the care of individual patients) and the use of electronic communications technologies in health care and long-term care; calls on the Commission and the Member States' governments to provide greater and more systematic support for the development of so-called electronic health care;

24. Is concerned that in many Member States there is an increasing lack of well trained doctors, medical and care personnel- albeit to varying degrees; urges Member States to make targeted efforts to improve the quality of work, to make these professions more attractive and to eliminate existing staff shortages; stresses the need to promote the training and further training of volunteers and employees already qualified employees in this area;

25. Regrets that in matters subject to greater coordination no particular value has been attached to feedback from grassroots actors; points out that the flow of information from the bottom up plays a prominent role within the management models in use;

26. Regrets that, in general, greater emphasis is not placed on a scientific analysis of needs; recalls that scientific data from other organisations cannot be accepted without prior verification; recommends that the processing of internal data should be effected to a greater degree through existing research programmes;

27. Calls on Member States' governments to bring the systems for educating and training health workers closer into line, to advance the mutual recognition of professional qualifications, thereby facilitating the mobility of health professionals, and both to

coordinate to a greater extent and to bring closer into line the requirements relating to the equipping of health-care facilities and the use of new investigative and therapeutic technologies, and thus to promote comparable health-care quality in all Member States;

28. Emphasises that financial sustainability can only be secured in the long-term if existing resources are optimally used; points out that this objective can only be attained if the quality of health care is made more transparent than is presently the case, if Member States introduce systematic programmes to ensure quality and evidence-based treatment guidelines and if they use public funds only for medical products and technologies with proven benefits;

29. Stresses the need for Member States increasingly to scrutinise medical and medico-technical progress in the light of effectiveness, benefit and economic viability; calls upon the Commission to examine the possibility of networking and coordinating the evaluation of health technology and medical guidelines undertaken in the Member States;

30. Urges the Member States to present national preliminary reports in time for the next European Council;

31. Considers that the healthcare of the frail elderly is an appropriate area for research at the European level;

32. Calls on the Commission to submit proposals by the end of 2005 presenting policy orientations, common objectives, working methods and a detailed timetable, while also stressing that citizens' health care is the responsibility of the individual Member States;

33. Emphasises that a very careful approach must be adopted in drawing up indicators and in interpreting the results and that existing differences between health systems must be respected; urges in particular that indicators should be drawn up to measure equitable access, the quality of care and effectiveness;

34. Calls on the European Council, with a view to rationalising the open method of coordination, to adopt in the spring of 2006 an integrated framework in a field of social protection and to adopt a standard list of common objectives in the areas of social integration, pensions, health care and long-term care;

35.Calls on the Commission and the Council to inform the European Parliament of their proposals;

36. Calls on the Member States and the Commission to involve patients' organisations more than hitherto in health policy decisions and to give them appropriate support in their work;

37. Calls on the Commission and the Member States to pay appropriate attention to aspects specific to women in all health care matters; calls on the Commission to submit a new report on the health situation of women in the European Union;

38. Instructs its President to forward this resolution to the Council, the Commission, the Social Protection Committee and the Parliaments of the Member States.

EXPLANATORY STATEMENT

1. INTRODUCTION

The social protection system is a component part of the European social model. Its four strands are:

- pensions
- social integration
- making work pay
- health care and long-term care

In the field of health-care and long-term-care provision, the aim is to provide access to high-quality health care for all people, irrespective of their age, sex, nationality or means.

2. BACKGROUND

In 1992 the European Council issued a recommendation calling upon the Member States to establish and develop high-quality health-care systems appropriate to the needs of the population - needs which would increase in particular with the ageing of the population, developments in diagnosis and treatment and the requirements of prevention.

In 1999 the European Council included health care as one of the four areas in which closer cooperation between countries was required.

In December 1999 the European Council adopted a resolution on modernising and improving social protection.

In its June 2000 decision the European Council established ‘high-quality sustainable health care’ as one of the four broader aims to be pursued in the modernisation and improvement of social protection.

In the March 2000 Lisbon European Council conclusions the creation of ‘greater social inclusion’ (including the modernisation of social protection systems) was established as a strategic objective.

At the June 2001 European Council in Göteborg a call was issued for greater efforts to be made in order to provide adequate, sustainable pensions which would cover the cost of both health care and long-term care.

At the March 2002 Barcelona European Council, three principles established by the Commission were adopted. They serve as a basis for the development and the reform of health care and long-term care: (1) care to be universally available, (2) care to be of high quality and (3) care to be sustainable on a long-term basis.

On 10 March 2003 the Commission and the European Council adopted a joint report on support for national strategies relating to the future of health care and care for the aged. In that report, (1) innovations in technology and care, (2) the increase in patients' expectations and awareness and (3) demographic ageing were highlighted as new problems which threatened to undermine national health-care and long-term-care systems. At the same time three general objectives were laid down in the report and are now being proposed as the basis for the open method of coordination: (1) availability of care, (2) high quality and (3) financial sustainability.

The Commission report was submitted together with a report concerning the movement of patients and the development of health care within the European Union. That report stemmed from an initiative launched by the former Commissioners David Byrne and Anna Diamantopoulou and their respective health ministers. The two reports were adopted jointly by the Commission and they set out a joint strategy for the development of health care and social protection systems in Europe.

3. SUBSTANCE OF THE REPORT

The Commission report was published in the Spring Report 2004. Its purpose is to define a common basis for Member-State support for the development and reform of health care and long-term care by means of the 'open method of coordination'.

In the report, (1) accessibility, (2) quality and (3) the financial sustainability of health-care and long-term-care systems are established as the main objectives to be pursued through the development and reform of those systems in the Member States. Those objectives are closely interconnected and interdependent.

The report identifies as the main threats to the national systems (1) new diagnostic and therapeutic technologies, (2) the general public's increasing awareness and growing expectations and (3) the ageing of the population, to which may be added (4) the increasing age of medical workers, especially in the new Member States, and (5) an increasingly mobile Community population.

Both Commission reports call for coordination of the Member States' health policies and the Commission proposes a global strategy for the development of health-care systems. The Commission report proposes joint objectives for the development and the reform of health-care and long-term-care systems. Those joint objectives enable individual countries to establish their own national strategies and to exchange their experiences with other countries. The joint objectives should underpin further development in health care and long-term care and they should provide political support for reforms.

Improving health care is a means of tapping the potential of the labour force and health policy is an active instrument of employment policy, since it is improves an individual's chances of finding and remaining in a job.

The ageing of health workers constitutes a time bomb, since many such workers are retiring just at the time when a general ageing of the population is taking place - hence at a time of increasing demand for health care and long-term care.

A fundamental role in raising awareness, in preventing illnesses and in improving the quality of health care is played by the exploitation of information technologies - 'eHealth'. This also plays an important role in the training of health workers. Communication plays a fundamental role in the coordination of the health care and the long-term care made available by a variety of providers who often work in isolation.

According to the Commission the key to the development and the reform of health-care and long-term-care systems is the effective running of systems based on the linking of responsibilities and the transfer thereof to the individuals involved in the systems, including the social partners, local and regional authorities, patients and non-governmental organisations. At the same time health-care providers, financial organisations, non-governmental organisations and public authorities must be coordinated.

The Commission proposes the following joint objectives:

(1) Availability of health care and long-term care

- Ensuring access to high-quality health care for each individual in accordance with his or her needs, based on universal access, fairness and solidarity,
- Providing a safety net against poverty or social exclusion associated with ill health, disability or old age for both the beneficiaries of care and their families.

The Member States should agree to:

- offer high-quality care to persons requiring long-term or expensive care, to those with particular difficulties in accessing care, to persons with disabilities and to the elderly,
- concentrate on the coordination of social services, primary care, hospital services and the services of specialised institutions,
- promote palliative and end-of-life care,
- reduce regional inequalities in access to health care,
- support action to shorten waiting lists,
- promote human-resources management and the training of health workers.

(2) High-quality health care and long-term care

Providing high-quality health care and long-term care is still a priority which is becoming ever more difficult to achieve. The reason is rapid technological development together with a rapid increase in costs and the general public's growing demands and expectations.

Increasing the quality of health care and long-term care must result in a genuine improvement in people's state of health and quality of life, and public resources must be spent effectively.

The Member States should agree to:

- promote practices and treatments based on scientific assessment and to evaluate the costs and benefits of treatment, equipment and drugs,
- promote prevention and a healthy lifestyle,
- promote the quality of the undergraduate, postgraduate and life-long training of health workers,
- improve the legal arrangements for protecting health and safety at work, with an emphasis on prevention,
- promote the adaptability of systems to changing needs, with a view to providing the best possible conditions for health and quality of life by means of better coordination between the players concerned,
- define the rights of patients and their families.

(3) Financial sustainability

The Commission assumes that it will be possible to maintain access to high-quality health care and long-term care without drawing on financial resources from other areas of the public budget. Much of the cost of health care and long-term care is reimbursed out of public funds which are currently under pressure from the demands of the Stability Pact.

In the report the Member States are advised to carry out reforms designed to increase the financial stability of health-care and long-term-care systems. The tools to be used for that task should include the introduction of partial reimboursement of care costs out of public resources or the requirement that patients pay some of their own costs, in order to promote responsibility on the part of care consumers. Furthermore, the report mentions the setting of budgets (particularly in the hospital sector), the introduction of steering tools designed to improve the population's state of health and the results of treatment, and the transfer of greater responsibility for public spending to health workers. The report places particular emphasis on increasing the responsibility of the players concerned: care providers, financial backers and care consumers.

The Member States should agree to:

- improve prevention and thereby reduce the consumption of expensive medicinal products,
- strengthen coordination and the exchange of information between individual providers of health care, long-term care and social care,
- achieve a sustainable rate of expenditure on development by means of incentive measures for care providers and consumers,
- offer more effective care by more effectively monitoring the way in which resources are used,
- make the provision of health care and long-term care more effective through the

decentralisation of the providers of such care and in particular by increasing those providers' responsibility for the use of public resources.

4. JUSTIFICATION FOR PARLIAMENT'S MOTION FOR A RESOLUTION

In Parliament's motion for a resolution on the Commission report I emphasise health as a basic value of each individual and the protection of public health as one of society's basic tasks.

It must be borne in mind that health is by no means affected only by health care and hence that in efforts to maintain and improve health, attention must also be paid to factors other than health care and long-term care.

The confidence that health care will be available if it is needed is essential to the functioning of each individual in society and in the context of an increasingly mobile Community population, efforts must be made to provide comparable availability of health care throughout the Community.

New preventive, diagnostic and therapeutic technologies, the general public's growing awareness and expectations and the increase in life expectancy - which are considered in the Commission report to constitute problems or threats - are in fact achievements on the part of our society. Hence we do not intend to combat them but, rather, to promote them and to seek a way of making health-care and long-term-care systems financially sustainable, even if people's life expectancy, awareness and expectations continue to increase and greater use is made of new technologies.

In the motion for a resolution, emphasis is placed on the fact that prevention and health care are important not only to health but also to the long-term financial sustainability of care systems.

In the motion for a resolution the individual - the patient - is placed at the heart of health-care and long-term-care systems. Everything that is done in the context of health care and long-term care is done in the interests of the patient; the availability of care is in his interest, as are the quality and the financial sustainability of care systems. For this reason the individual must have maximum access to information and extensive rights as regards decision-making, and at the same time he must assume responsibility (including financial responsibility) for the decisions he takes.

In the motion for a resolution I make the point that the quality of health care and long-term care is conditional upon the level of health workers' education and training and upon the extent to which the latest preventive, investigative and therapeutic technologies are made available.

Last but not least, health care and long-term care are presented as significant sectors of a country’s economy and as scientific and research fields. They create a large number of stable, high-quality jobs and generate a great deal of economic value.

I propose that in its resolution, Parliament should back the Commission report, endorse the

main objectives laid down in the report and acknowledge the main causes of the problems facing the Member States' health-care and long-term-care systems.

I propose that in its resolution, Parliament should call on the Member States' governments to devote more attention to promoting a healthy lifestyle, to creating and maintaining healthy living conditions and to encouraging prevention. Furthermore, I propose that the Member States' governments should be called upon to promote the position of the individual - the patient - within health-care and long-term-care systems. The general public should be given better access to information, greater rights and greater responsibility. At the same time I propose that the Member States' governments should be called upon to promote better-quality communication and the sharing of information amongst all providers of social, health and long-term care, and to promote all forms of education and training for health workers.

5. CONCLUSION

The Commission report is a contribution designed to support the Member States as they develop and reform their health-care and long-term-care systems.

Of fundamental importance are the acknowledgement that the Member States' governments have full sovereignty in the field of health care and long-term care and the promotion of development and reforms in that field on the part of all Community bodies.

The growing need for development and reforms to be coordinated is accentuated by the increasing mobility of the general public and hence of patients within the Community. It is right that the Commission report has been drawn up and is being considered in conjunction with the report on the movement of patients and the development of health care in the EU.

16.3.2005

OPINION OF THE COMMITTEE ON THE ENVIRONMENT, PUBLIC HEALTH AND FOOD SAFETY

for the Committee on Employment and Social Affairs

on modernising social protection and developing good quality healthcare
(2004/2189(INI))

Draftsman: Thomas Ulmer

SUGGESTIONS

The Committee on the Environment, Public Health and Food Safety calls on the Committee on Employment and Social Affairs, as the committee responsible, to incorporate the following suggestions in its motion for a resolution:

1. Welcomes the fact that the European Union is supporting the Member States in the modernisation and development of their health care systems; notes that the priorities of access to care, quality and financial sustainability seem to be well chosen;

2. Stresses that guaranteed access to a high-quality health care system is the recognised right of all citizens and an essential condition for their integration into society; emphasises that health care cannot be treated as a simple market service;

3. Regrets that the Commission views the modernisation of social protection with regard to health care essentially in terms of the requirements of the Stability Pact; regrets that the Commission makes no reference in its text to the trends in spending on the various sectors of health care (treatment, hospital care etc.) or to the impact of prevention in the individual Member States;

4. Regrets that the Commission does not express more strongly in its communication the Member States' responsibility for their respective health care systems; notes that there is no explicit reference to the complementary nature of the open method of coordination;

5. Criticises the fact that the open method of coordination, as intended to apply to health, in particular computerised data collection, clearly overstretches the administrative capacity of the Member States; proposes that data collection should initially apply only to especially relevant areas;

6. Stresses that the concept of patient mobility should not undermine the principle of locally available health care and should primarily concern the occasional treatment of citizens

travelling within the Union or crossborder agreements;

7. Regrets that in matters subject to greater coordination no particular value has been attached to feedback from grassroots actors; points out that the flow of information from the bottom up plays a prominent role within the management models in use;

8. Regrets that, in general, greater emphasis is not placed on a scientific analysis of needs; recalls that scientific data from other organisations cannot be accepted without prior verification; recommends that the processing of internal data should be effected to a greater degree through existing research programmes.

PROCEDURE

Title	Modernising social protection and developing good quality healthcare
Procedure number	2004/2189(INI)
Committee responsible	EMPL
Committee asked for its opinion Date announced in plenary	ENVI 18.11.2004
Enhanced cooperation	No
Draftsman Date appointed	Thomas Ulmer 20.9.2004
Discussed in committee	3.2.2005 15.3.2005
Date suggestions adopted	15.3.2005
Result of final vote	for: 43 against: 5 abstentions: 0
Members present for the final vote	Irena Belohorská, Johannes Blokland, John Bowis, Frederika Brepoels, Martin Callanan, Dorette Corbey, Chris Davies, Avril Doyle, Mojca Drčar Murko, Edite Estrela, Jillian Evans, Anne Ferreira, Norbert Glante, Françoise Grossetête, Mary Honeyball, Marie Anne Isler Béguin, Caroline Jackson, Dan Jørgensen, Christa Klaß, Holger Krahmer, Urszula Krupa, Aldis Kušķis, Marie-Noëlle Lienemann, Linda McAvan, Roberto Musacchio, Riitta Myller, Dimitrios Papadimoulis, Vittorio Prodi, Frédérique Ries, Dagmar Roth-Behrendt, Karin Scheele, Carl Schlyter, Richard Seeber, Kathy Sinnott, Jonas Sjöstedt, Bogusław Sonik, María Sornosa Martínez, Thomas Ulmer, Anja Weisgerber, Åsa Westlund, Anders Wijkman
Substitutes present for the final vote	Alfonso Andria, Christofer Fjellner, Kartika Tamara Liotard, Ria Oomen-Ruijten, Bart Staes, Claude Turmes
Substitutes under Rule 178(2) present for the final vote	Anne Laperrouze

PROCEDURE

Title	Modernising social protection and developing good quality healthcare
Procedure number	2004/2189(INI)
Basis in Rules of Procedure	Rule 45
Committee responsible Date authorisation announced in plenary	EMPL 18.11.2004
Committee(s) asked for opinion(s) Date announced in plenary	ENVI 18.11.2004
Not delivering opinion(s) Date of decision	
Enhanced cooperation Date announced in plenary	
Motion(s) for resolution(s) included in report	
Rapporteur(s) Date appointed	Milan Cabrnoch 10.11.2004
Previous rapporteur(s)	
Discussed in committee	31.1.2005 16.3.2005 31.3.2005
Date adopted	31.3.2005
Result of final vote	for: 39 against: 1 abstentions: 3
Members present for the final vote	Jan Andersson, Roselyne Bachelot-Narquin, Jean-Luc Bennahmias, Emine Bozkurt, Philip Bushill-Matthews, Milan Cabrnoch, Mogens N.J. Camre, Alejandro Cercas, Ole Christensen, Derek Roland Clark, Luigi Cocilovo, Jean Louis Cottigny, Proinsias De Rossa, Harald Ettl, Richard Falbr, Ilda Figueiredo, Roger Helmer, Stephen Hughes, Ona Juknevičienė, Karin Jöns, Jan Jerzy Kułakowski, Raymond Langendries, Bernard Lehideux, Elizabeth Lynne, Mary Lou McDonald, Thomas Mann, Jan Tadeusz Masiel, Maria Matsouka, Ana Mato Adrover, Ria Oomen-Ruijten, Csaba Őry, Jacek Protasiewicz, José Albino Silva Peneda, Jean Spautz, Anne Van Lancker, Gabriele Zimmer.
Substitutes present for the final vote	Mihael Brejc, Marian Harkin, Jamila Madeira, Marianne Mikko, Elisabeth Schroedter, Marc Tarabella, Claude Turmes, Anja Weisgerber.
Substitutes under Rule 178(2) present for the final vote	
Date tabled – A6	6.4.2005 A6-0085/2005
Comments	