# A European Community health policy for older people


EUROLINK AGE

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## Acknowledgements

This report is based primarily on the results of a meeting in Athens in March 1992, 'An EC Health Policy for Older People', sponsored by DGV, the Commission of the European Communities and organised by Eurolink Age in association with the Hellenic Association of Gerontology. The report has been produced as a contribution to the debate on older people in society during the 1993 European Year of Older People and Solidarity between Generations.

We are grateful to Liz Mestheneos and Judy Triantafillou from Sextant, (Social-Economic Research and Consultancy) who prepared the background paper for that meeting.

In addition, it draws on preparatory and follow up work of the conference 'Ageing Well - a call for European action', a Eurolink Age event under the UK Presidency of the European Community, as well as a wide range of published sources.

Eurolink Age is particularly grateful to Moya Denman, consultant to Eurolink Age and author of this final report.

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# Introduction

This report surveys European Community policies which affect the health of older people and makes recommendations for future policy developments in the light of enlarged Community competence under the Maastricht Treaty.

Good health in later life is a key factor in promoting individual well being and personal growth. An improvement in the health of the older population is essential to enable older people to contribute socially and economically. Both maximising the contribution older people can make and minimising calls on health services could help offset the escalating costs associated with an ageing population. Eurolink Age believes that policies should be designed in such a way as to enable older people to maximise their functional capacity, to postpone or prevent the onset of disease and to lessen the effects of debilitating conditions.

Healthy ageing is the shared responsibility of individuals, non-governmental and voluntary organisations, health professionals, academics and researchers, health service institutions, industry, the media, and of governments at local, national and international levels.

The introductory chapter of this report describes the historically unique demographic situation of the EC: a high and increasing proportion of older citizens, the majority of whom are still active. The importance to us all of their good health is recognized by the World Health Organisation, which provides a framework of principles for healthy ageing. Health and care needs are addressed in diverse ways by Member States.

The EC has no coordinated health policy, but the Treaties do provide a basis for some action. Chapter II outlines EC competence underpinning any health policy for older people, both existing competence and the new competence post-Maastricht, and the development of EC health policies.

Chapter III looks at the future possibilities for EC health policy post-Maastricht, and makes particular recommendations with respect to the priorities for older people.

Chapter IV outlines existing EC policies and programmes in the field of health and makes recommendations for ways in which they could be better oriented to take account of the needs of older people. These relate to pharmaceuticals and other directly health-related products; the coordination of research into diseases, health resources and new technologies; freedom to provide services and freedom to work within the EC, which may lead to undesirable distortions in the quantity and quality of health care services available to older people.

It is widely acknowledged that a broad range of policies have implications for the health of older people. EC policies affecting health in a broader sense are sketched out in Chapter V. The First EC Programme for Older People validates the contribution they make to society. Health and safety at work is a necessary pre-condition for good health in later life. High long-term unemployment rates among older workers may have an adverse effect on their health; poverty, which can be linked to unemployment, is also directly linked to ill health. Suitable housing and public transport, good nutrition and consumer protection are other factors in a total health environment for older people. We make specific recommendations in this range of policy areas.

# Main Recommendations

The EC Action Plan on healthy ageing (see Annex I) lays out Eurolink Age's framework for policies and programmes for healthy ageing. In addition, we believe that the EC should both build on existing programmes and policies and use its new powers to develop coordinated health policies, working in cooperation with the World Health Organisation which, by contrast, has policies but no powers. In particular, Eurolink Age proposes the following:

## 1 Europe for Healthy Ageing

There is a role for the EC in the stimulation and coordination of research into accident and disease prevention, health information and education, and in the collection and dissemination of materials on good practice. We propose a multi-year campaign, Europe For Healthy Ageing, to promote health education and disease prevention for older people, both within the workplace (accidents at work and occupational diseases due to unhealthy working conditions are major factors affecting health in later life) and in the wider world (see Chapter III).

## 2 Major health scourges

The Maastricht Treaty states that "Community action shall be directed towards the prevention of diseases, in particular the major health scourges". There is already ample evidence of what constitutes threats to the health of all older people: what have been referred to as 'the geriatric giants' of immobility, instability, incontinence and intellectual impairment. These are often the result of disabling diseases such as cardiovascular and cerebrovascular diseases, arthritis, osteoporosis, Alzheimer's and other mental diseases, particularly depression. A simple accident, a fall for instance, resulting indirectly from one of these diseases, can transform an independent older person into a frail, dependent person overnight, with consequent demands on expensive medical and care facilities (see Chapter III).

## 3 Health education

The benefits of promoting healthier lifestyles in later life are significant. For example, physical activity and exercise can help prevent the onset of osteoporosis, coronary heart disease and related disorders; reducing alcohol intake and stopping smoking show beneficial results at any age.

Wide variations between Member States in terms of culture, lifestyle, nutrition and economic development are further complicated by differences in attitude between generations. However, even if health education for older people must be appropriately designed and targeted at regional or local level, the challenges are common to all Member States.

EC policies to date have been developed to support and regulate new pharmaceutical and medico-technological developments, but these are expensive solutions to problems that would be better avoided in the first place. The EC could take a lead, by supporting the development of grass-roots health education programmes, such as 'Health Mentor' schemes, whereby senior volunteers are trained to act as peer health counsellors (see Chapter III).

## 4 Access to health care

Throughout the EC health care costs are escalating. Insurance policies for health and long term care are in the process of changing; private policies usually discriminate against older subscribers. Affordable access to insurance and to health care should be a right of all EC citizens, no matter what their age or place of residence within the EC. Clause 25 of the Community Charter of Fundamental Social Rights states that 'any person who has reached retirement age but who is not entitled to a pension or does not have other means of subsistence, must be entitled to sufficient resources and to **medical and social assistance** specifically suited to his needs' (see Chapter IV).

## 5 Formal and informal care

All European countries aim to keep older people in need of care as long as possible in their established social environment. Residential care facilities vary markedly in capacity, quality and staffing between Member States. The 'Female Care Taker Potential' in EC Countries (women aged 45-69 in proportion to population 70+) has reduced by some 68.5% between 1960 and 1990. The necessary consequential policy changes are under consideration at national level, but the EC could play a role in encouraging training schemes for geriatric health care professionals, in drawing up codes of good practice for residential care and nursing homes, and in encouraging employer good practice and support schemes for workers with elderly dependents (see Chapter IV).

## 6 Research

Existing EC-sponsored research into **health services delivery** is a small step in the right direction of improving cost-effectiveness and efficiency, but much more effort needs to be put into this area, even at the expense of other programmes of laboratory-based, fundamental research (whose outcome is uncertain and for the long term). EC-funded research directed towards the **prevention and cure of disease** needs to concentrate more on diseases that lead to serious disablement. More attention must also be given to the **dissemination of research results** (see Chapter IV).

## 7 Other EC policies

Article 129 (1) of the Treaty on European Union states that 'Health protection requirements shall form a constituent part of the Community's other policies'. It is widely acknowledged that there are social, psychological, emotional and physical components to health. In all age groups, ill health and poverty are closely related. Sound policies on income, housing, energy, transport and the environment are important contributory factors to healthy ageing. There is a need for all existing EC programmes and policies (eg disability, poverty, consumer affairs, transport and the environment) to consider and target the health needs of older people (see Chapter V).

Older people have the right to be impatient to see a coordinated health policy developed at European Community level - and it is in the interests of us all, now and in our futures.

# I Background

## 1 The Demographic Challenge

Europe has the highest proportion of older people in the world. There are 100 million older people (50+) in the EC today. Declining mortality rates in the very young and older populations have led to an unprecedented increase in life expectancy. The total population of Europe will increase between 1970 and 2000 by 17.5%; the number of people aged over 60 will increase in the same time by 30.7% and those over 80 by 62.4 %. A century ago the proportion of people aged 75+ to those in the 'active age group' (i.e. 20-60 year-olds) was 1:38; today it is 1:7 and increasing.[1]

While medical care is important in increasing life expectancy, the vast majority of older people are fit and active. An extension of the life span should not be identified with an extension of the period of disability. The greater incidence of mental and physical disability and ill health among older people, especially the oldest old, however, together with escalating costs of health care in all Member States of the European Community, have led to widespread concern.

Older people are not only a significant proportion of the EC population in terms of numbers but also as consumers of health products and services. Increases in medical costs (put at 0.5% per annum in France[2]) and in consumption of prescription pharmaceuticals is directly related to increases in the numbers of older people (new drugs for elderly people accounted for 96% of the increase in consumption of prescribed medicines in the UK 1980-1990[3]).

## 2 The Importance of Good Health for Older People

Good health is essential to enable older people to contribute socially and economically. Maximising the contribution older people can make and minimising calls on health services can help offset the escalating costs associated with an ageing population. The attitude of society towards older people is a major factor in the maintenance of psychological and physical good health, as experts have recognized. Important contributory factors are also sound policies on income, housing, energy, transport and environment.

## 3 The World Health Organisation - Healthy Aging

WHO (European Region) has set a new Health for All in the Year 2000 target 6, Healthy Aging, from 1994. "By the year 2000, life expectancy at birth in the Region should be at least 75 years and there should be sustained and continuing improvement in the health of all people aged 65 years and over." WHO health targets have four dimensions:

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1 Source: Eurostat

2 de Kervasdoue, Jean, "Why is Health Promotion a Sound Proposition for Governments?" Presentation to Eurolink Age's 'Ageing Well' conference, London November 1992

3 *The Times*, London 29.3.93

- **ensuring equity in health** by reducing gaps in health status between countries and between groups within countries;
- **adding life to years** by helping people achieve, and use, their full physical, mental and social potential;
- **adding health to life** by reducing disease and disability;
- **adding years to life** by increasing life expectancy.

## 4 The Diversity of Health Policy Approaches in the EC

Health and care systems in the Member States of the European Community vary greatly, having evolved in response to local social, cultural and economic requirements or conditions. They are financed in different ways (national health systems, insurance funds). They consist of different mixes of public and private services. The total amount spent on health care varies considerably between countries, as well as the proportions spent on different services, e.g. the percentage devoted to acute hospital facilities rather than primary health services.

Systems of care for dependent elderly people also vary widely between EC countries: thus the percentage of older people in institutional care (e.g. residential care, long term hospital care, long stay convalescent homes) varies from 1 to 10 per cent. Some Member States have well developed public, commercial or voluntary home support systems e.g. home helps, carers' support services, nursing services, meals on wheels, while in others dependence is primarily on family, informal networks and domestic help. There is far from universal agreement on minimum standards of care for residential accommodation for elderly people even in the public services.

## 5 EC Competence for the Health of Older People

Until now, older people's health has not specifically been addressed in EC policy making, but many existing EC policies with a health aspect do affect older people.

However, **Article 129 of the European Treaty on Political Union** will for the first time give the Community some competence in the field of Public Health.

# II A Health Policy for older people - EC legal framework

This chapter outlines the existing legal basis for EC policy on health and policy for older people and the progress towards development of an EC health policy. The Maastricht Treaty will have implications for the future of EC health policy (see Chapter III). However, under the current legal basis, a wide range of policies have been developed with implications for the health of older people. These are fully explored in Chapters IV and V.

## 1 Existing Legal Basis

### *1.1 The Treaty of Rome*

The original **Treaty of Rome** of 1956 did not mention health (apart from allowing (in Article 36) restrictions for the protection of health and life of humans on movements of goods), although Article 117 states: "Member States agree upon the need to promote improved working conditions and an improved standard of living for workers, so as to make possible their harmonisation while the improvement is being maintained."[4] Article 118 adds that "the Commission shall have the task of promoting close cooperation between Member States in the social field, particularly in matters relating to:... social security; prevention of occupational accidents and diseases; occupational hygiene...."

### *1.2 The Euratom Treaty*

The **Euratom Treaty**, signed at the same time as the Treaty of Rome does contain articles relating to the health of workers in the atomic energy industry and to the general public in relation to radiation (Title II, Chapter 3, Health and Safety).[5]

### *1.3 The European Coal and Steel Community*

The **European Coal and Steel Community,** the Treaty for which was signed in 1951, has also provided a legal basis for work related to the health and safety of workers.

### *1.4 The Single European Act*

The **Single European Act** of 1986 amended the above treaties. Its Article 100A(3) strengthens the purpose of the Treaty of Rome to create a single market in which "The Commission, in its proposals ... concerning health, safety, environmental protection and consumer protection, will take as a base

[4] See Annex II
[5] See Annex III

a high level of protection." Using Article 100A as its basis the Commission has been able to develop legislation to raise standards beyond the workplace, although always linked in principle to the operation of the Single Market with free movement of people, goods and services.

## 2 The European Treaty on Political Union

The **European Treaty on Political Union**, signed in December 1991 (the Maastricht Treaty) includes a new title on public health (Article 129)[6]. The new Treaty will open for the first time a new EC competence in the health field. The Title identifies three areas for Community action:

- disease prevention and research
- health information and education
- "To make health protection requirements a constituent part of the Community's other policies."

However, it specifically excludes "harmonization of the laws and regulations of the Member States." The implications of this Treaty article for older people are fully explored in Chapter III.

## 3 The Development of EC Health Policies

Older people's health has not specifically been addressed in EC policy making, but many policies with a health aspect do affect older people. Since older people are such a significant proportion of the EC population, both in terms of numbers and as consumers of health products and services, more attention needs to be given to how they fit into existing policies and policies under development.

### *3.1 Responsibilities of Member States*

A Council Resolution of 11 November 1991 concerning fundamental health-policy choices emphasizes that it is a matter for the Member States to determine the organisation and funding of their health-care systems and to make fundamental health-care policy choices.[7] Despite the new competence agreed in the Maastricht Treaty, current political indications are that Member States will use the argument of subsidiarity to resist any attempt by the Commission to establish a comprehensive public health policy at Community level on the grounds that health policy objectives can better be attained at the level of the individual Member States.

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[6] See Annex *II*

[7] Ministers for Health meeting within the Council of 11 November 1991 (OJ C 304 23.11.91) concerning fundamental health policy choices.

## 3.2 EC Actions

However, on the basis of the legal framework already in place, the Community has undertaken a wide variety of actions in the health field. Unfortunately, the lack of specific competence has resulted in a fragmentary approach, with the result, for instance, that EC action to discourage smoking on the one hand (including campaigns against cancer)[8] is more than offset by subsidies to EC tobacco growers on the other.

## 3.3 Division of Responsibilities

There is no one directorate-general within the Commission to coordinate health policy. Existing EC policies affecting health are diffused between DG III (Industry and the Single Market) for pharmaceuticals, DG V (Social Affairs) for health and safety legislation, and DG XII (Science, Research and Development) for research programmes. Environmental (DG XI), agricultural and consumer policies also influence health in an important way, as well as poverty, housing and transport.

At the European Parliament and at the Economic and Social Committee health affairs are among the responsibilities of the committees which also cover environmental and consumer affairs.

# 4 Legislation for Older People

Little legislation of any kind is specifically addressed to the needs of older people as a separate category within the EC.

## 4.1 Right of Residence

One exception is a Council Directive providing for the right of residence of older people in any Member State of the European Community after retirement. This right is conditional on their retirement income being "sufficient to avoid becoming a burden on the social security system of the host Member State during their period of residence and provided they are covered by sickness insurance in respect of all risks in the host Member State."[9]

Any citizen travelling within the EC is entitled to reciprocal emergency medical assistance in another EC country, on the same conditions as nationals of that country, by using the form E111. In addition, in some EC countries, the 'European emergency health card' can be used to give details of personal

[8] Council Directive of 13 November 1989 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the labelling of tobacco products (OJ L 359 8.12.89).
Resolution of the Council and the representatives of the Governments of the Member States meeting within the Council of 7 July 1986 on a programme of action of the Euro Communities against cancer (OJ C 184 23.07.86).
90/238/Eurotom, ECSC,EEC. Decision of the Council and the representatives of the Governments of the Member States meeting within the Council on 17 May 1990 adopting a 1990 to 1994 action plan in the context of the 'Europe against Cancer' programme (OJ L 137 30.05 90).

[9] 90/365/EEC Council Directive of 28 June 1990 on the right of residence for employees and self-employed persons who have ceased their occupational activity (OJ L 180 13.7.90).

health conditions. Older travellers are among those who find both these schemes are of particular use.[10]

## 4.2 *The Community Charter of Fundamental Social Rights for Workers*

The 'Social Charter' was adopted in December, 1989 by the European Council. Clauses 24 and 25 of the Charter specifically refer to the needs of older people, including appropriate medical and social assistance in need.[11] The Charter does not have legal force, but is intended to spur action at Community level.

[10] Council Resolution of 29 May 1986 concerning the adoption of a European emergency health card (OJ C 184 23.07.86)

[11] According to the arrangements applying in each country:
24. Every worker of the European Community must, at the time of retirement, be able to enjoy resources affording him or her a decent standard of living.
25. Any person who has reached retirement age but who is not entitled to a pension or who does not have other means of subsistence, must be entitled to sufficient resources and to medical and social assistance specifically suited to his needs.

# III Provisions and recommendations for EC Health Policy post-Maastricht

## 1 New Health Competence

Article 129 of the European Treaty on Political Union (the Maastricht Treaty), fully reproduced in Annex IV, gives the Community new competence in public health. For the first time the Community will gain competence in three specific areas, each of which provides distinct possibilities to consider health issues affecting older people:

- disease prevention and research
- health information and education
- "To make health protection requirements a constituent part of the Community's other policies".

### *1.1 Subsidiarity*

Once the Treaty is ratified, Community action under the Title will be subject to the doctrine of subsidiarity - that action will be taken at Community level "only if and in so far as the objectives of the proposed action cannot be sufficiently achieved by the Member States and can therefore, by reason of the scale or effects of the proposed action, be better achieved by the Community". The scope of the new Article is still unclear and a top-level Committee of EC health civil servants is currently working on definitions.

### *1.2 Priorities for Health of Older People*

There is already ample evidence of what constitutes threats to the health of all older people: what have been referred to as 'the geriatric giants' of immobility, instability, incontinence and intellectual impairment.[12] These are often the result of disabling diseases such as cardiovascular and cerebrovascular diseases, arthritis, osteoporosis, Alzheimer's and other mental diseases, particularly depression. A simple accident, a fall for instance, resulting indirectly from one of these diseases, can transform an independent older person into a frail, dependent person overnight, with consequent demands on expensive medical and care facilities.

There is as yet no precise definition of 'major health scourge' as mentioned in the new Treaty, but cardiovascular disease is generally taken to be covered. If the EC is to improve the living and working conditions of *all* its citizens, it is important that its policies address the major scourges affecting *all* segments of the population, including older people. This means focusing as well on dis-

[12] Isaacs, B. The Giants of Geriatrics. Inaugural lecture, University of Birmingham, 1975, quoted Duursma, S.A. and T.M.J.J. olde Scheper, "Healthy Ageing: The Importance of Research", at Ageing Well conference, London, November 1992.

eases affecting morbidity as well as mortality. Because mortality data is more readily available, there is a tendency to underestimate the importance of diseases that - while not leading to a rapid end to life - severely impair the quality of the remaining life of their victims, a large majority of them older people.

Among these diseases are:
- arthritis
- osteoporosis
- diabetes mellitus
- cardiovascular disease
- cerebrovascular disease
- multiple sclerosis
- Parkinson's disease
- dementias including Alzheimer's disease
- eye diseases including glaucoma/cataracts
- lung diseases including emphysema.

Other problem areas for the health of elderly people are:
- drug dependence
- depression.

## 2 Disease Prevention and Research

Existing EC-sponsored research into health services delivery is a small step in the right direction of improving cost-effectiveness and efficiency, but much more effort needs to be put into this area, even at the expense of other programmes of laboratory-based, fundamental research (whose outcome is uncertain and for the long term). EC-funded research directed towards the prevention and cure of disease needs to concentrate more on diseases that lead to serious disablement. More attention must also be given to the dissemination of research results (see also Chapter IV Section 2).

In addition, the EC Action Plan on Healthy Ageing[13] highlights the need to:

- prepare a baseline document highlighting the breakthroughs and improvements which have had a major impact on current health status and life expectancy of older people in the last fifty years

- support both short- and long-term research programmes in the fields of basic science, epidemiology and clinical research, including therapy, both pharmacological and non-pharmacological; research should be cross-country and comparative as well as taking into account particular regional needs

- foster a favourable research climate in European and devote adequate resources to the understanding, prevention, alleviation and cure of age-related diseases, including the provision of training schemes and scholarships

[13] See Annex I

- coordinate age-related research by the European Community, governments, research-based pharmaceutical companies and charitable foundations, and ensure full consultation with patients and patient societies.

## 3 Health Information and Education

Health education is needed if healthy ageing is to be maximised. Four lifestyle factors - smoking, alcohol consumption, exercise and diet-weight control - are well established risk factors and should be addressed. The benefits of promoting healthier lifestyles in later life are significant. For example, physical activity and exercise can help prevent the onset of osteoporosis, coronary heart disease and related disorders; reducing alcohol intake and stopping smoking show beneficial results at any age. EC policies to date have been developed to support and regulate new pharmaceutical and medico-technological developments, but these are expensive solutions to problems that would be better avoided in the first place.

Health education for older people must be designed in an appropriate way, involving older people in their planning and development. Until recently older people have been largely excluded from health education/promotion activities, reflecting the negative and ageist view that there was little which could be done to improve their health.

Wide variations between Member States in terms of culture, lifestyle, nutrition and economic development are further complicated by differences in attitude between generations. However, even if health education for older people must be appropriately designed and targeted at regional or local level, the challenges are common to all Member States.

There is a clear role for the EC in the stimulation and coordination of research into accident and disease prevention, health information and education, and in the collection and dissemination of materials on good practice. Eurolink Age believes that a multi-year campaign, Europe For Healthy Ageing, should be implemented to promote health education and disease prevention, both within the workplace (accidents at work and occupational diseases due to unhealthy working conditions are major factors affecting health in later life) and in the wider world. The EC could take a lead, by supporting the development of grass-roots health education programmes, such as 'Health Mentor' schemes, whereby senior volunteers are trained to act as peer health counsellors.

### *3.1 Specific Actions and Campaigns against Disease*

Europe Against Cancer was the first coordinated programme in the health field mounted by the Commission, targeted at a reduction in the rate of cancer-related deaths. Under pressure from the European Parliament, the Community instigated in 1987 a two-year coordinated programme subsequently

extended into a four-year (1990-94) action plan.[14] Actions focus on the prevention of cancer by means of information and health education, the training of personnel employed in health care as well as cancer research.

Some cancers (such as cancer of the colon and breast cancer) are more likely to occur in older people than younger, and are more likely to prove fatal in a frail older person. Tobacco misuse and AIDS are other targeted areas for coordinated Community action. The Maastricht Treaty will give the Commission power to take further action to combat 'major health scourges', and possibly to implement further such programmes.

Following the continuing success of the Europe Against Cancer campaign, and bearing in mind the importance of good general health for the quality of life for older people, the Commission should consider further campaigns for healthy living habits and against major health scourges such as cardiovascular disease. These campaigns must be properly structured to include effective evaluation, monitoring and cost-control.

Specific campaigns should be backed up by a positive action programme, otherwise issues raised by a campaign may be quickly forgotten.

## 4 Health Protection to be Part of the EC's Other Policies

Several directorates-general include some aspect of health protection among their responsibilities, but many divisions within the same DGs are oblivious to the implications of their work for human health.

Chapter IV, V and VI of this report track the full range of EC policies and their implications for the health of older people; they also make some recommendations as to how these policies could be strengthened to take account of the health needs of the ageing population. It is to be hoped that with this new competence will encourage consideration of these health needs across the range of EC policies.

## 5 Cooperation with Third Countries and the Competent International Organisations in the Sphere of Public Health

The European Community is already cooperating with the World Health Organisation on programmes such as European Nervous System and the Healthy Cities programme; the latter is an ideal vehicle for community health participation by older people. Since health policy covers everything from competition policy at global level to a small-town general practice, cooperation with other bodies can save a lot of time and money if effectively carried out. Close cooperation with WHO would avoid duplication of expensive research.

The EC should both build on existing programmes and policies and use its new powers to develop coordinated health policies, working in cooperation with the

[14] see above

WHO which, by contrast, has policies but no powers. In particular, it should focus on the principles already identified by the WHO (European Region) and its new 'healthy ageing' target.

The many non-governmental specialist groups set up to campaign on specific health issues, including those concerning older people and the diseases to which they are particularly susceptible, have valuable expertise to contribute in the fields of research and implementation, as well as in areas such as good practice and regional conditions.

# IV Existing EC legislation and programmes in the field of health with implications for older people

This chapter reviews existing EC policies and programmes in the field of health, which may have implications for older people. To date however, their focus has not particularly considered the implications of the ageing population; we make some recommendations for a reorientation of these policies.

## 1 Health Care Products

### *1.1 Pharmaceuticals*

Europe is the world's largest market for pharmaceutical products, and older people are the largest consumer group for pharmaceuticals. This market is expanding as the population ages[15]. Older people often require daily medication to maintain adequate functional health.

EC pharmaceuticals policy is conducted within DG III (the directorate-general for industry and the single market). Extensive EC legislation covers a wide range of aspects relating to the approval, testing, marketing, advertising, labelling and pricing of pharmaceutical products.[16]

The interests of older people are particularly affected when:

- there is difficulty in obtaining medicines, whether over the counter (OTC) or on prescription when moving within the EC (due to availability or different pricing policies).[17]

- there are adverse reactions from a combination of drugs.

- there is overconsumption or inappropriate consumption of medicinal products.

Evidence suggests that much apparent ill health among older people is due to inappropriate drug consumption. Better training of doctors, pharmacists and health care workers and education of patients is required, as well as the supply of appropriate information on product leaflets.

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[15] In Britain, the number of prescription items per person has grown from 7 in 1980 to 8.4 in 1990 but 96 per cent of the increase is in new drugs for the elderly. *(The Times, 29.3.93)*

[16] For instance, 75/318/EEC, 75/319/EEC (OJ L147, 9.6.75), 81/852/EEC (OJ L317, 6.11.81) and 87/22/EEC (OJ L015, 17.1.87) approximation of Member States' laws for various types of medicines; 89/105/EEC (OJ L040, 11.2.89) price transparency for medicines and their inclusion in national health insurance systems; 92/25/EEC, 92/27/EEC and 92/28/EEC (OJ L113, 30.4.92) wholesale distribution, labelling and package leaflets, and advertising of medicines.

[17] BEUC/112/89, March 1989, updated 1992.

### 1.1.1 Single European Market

In order to create a single market for pharmaceutical products, the EC has adopted several legal measures to harmonize Member States' pharmaceutical legislation. EC legislation aims to combine free circulation of medicine with a high level of protection for patients. However:

i) Drug prescription patterns are influenced by medical cultures and therefore vary widely between Member States of the EC. Following a recent EC Directive[18], newly authorised drugs will be classified by Member States between those subject to medical prescription and those which are not. Further harmonisation of national practices would ensure that access to drugs for all travellers within the Community, including older people, is not restricted beyond reasonable bounds of safety.

ii) Although patterns of consumption vary, older people are major consumers of pharmaceutical products in all Member States. In alternative medicine, divisions between pharmaceuticals, foodstuffs and cosmetics are drawn differently within the EC, often making it difficult to obtain a product in another Member State. Homoeopathic medicines have been brought within the ambit of EC legislation,[19] but Member States have until the end of 1995 before they must permit the sale of products registered elsewhere. Cosmetics, including skin care products with therapeutic uses such as may be used for dermatological problems affecting older people, are also covered.[20]

### 1.1.2 Recognition and approval

The Committee for Proprietary Medicinal Products (set up in 1975)[21] will shortly be superseded (together with a similar Committee for veterinary products) by a new European Agency for the Evaluation of Medicinal Products, whose main tasks will be to coordinate the technical pharmaceutical assessment and surveillance activities of the Member States.[22] It will also be responsible for the approval of innovative and biotechnology drugs and the reporting and follow-up of adverse drug reactions.

If there are serious objections by Member States, the European Agency will issue a binding opinion. Once in place, the new procedure may ensure that all

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[18] Council Directive 92/26/EEC of 31 March 1992 concerning the classification for the supply of medicinal products for human use (OJ L 113 30.4.92) (also 92/25/EEC on the wholesale distribution of medicinal products for human use, 92/27/EEC on labelling of medicinal products for human use, and 92/28/EEC on the advertising of medicinal products for human use.

[19] Council Directive 92/73/EEC of 22 September 1992 widening the scope of Directives 65/65/EEC and 75/319/EEC on the approximation of provisions laid down by law, regulation or administrative action relating to medicinal products and laying down additional provisions on homeopathic medical products (OJ L 297 13.10.92).

[20] Council Directive 76/768/EEC of 27 July 1976 on the approximation of the laws of the Member States (amended ten times) relating to cosmetic products (OJ L 262 27.9.76).

[21] 75/320/EEC Second Council Directive of 20 May 1975 on the approximation of provisions laid down by law, regulation or administrative action relating to proper medicinal products (OJ L 147 9.6.75).

[22] Com (90) 283 Proposal for a Council Regulation (EEC) laying down Community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Agency for the Evaluation of Medicinal Products (OJ L 330 3.12.90).

new biotechnology products will in future be recognised under the same names throughout the EC.

## *1.2 Medical Mechanics*

Older people suffer from a high incidence of medical conditions such as kidney malfunction, cardiac irregularity, various cancers and brittle bones. Technical medical treatments include kidney dialysis and radiation therapy and technical devices such as heart pacemakers. A non-binding Council resolution sets standards for the exposure to aluminium of dialysis patients[23]; there are also EC directives for the radiation protection of patients undergoing medical examination or treatment[24] and standards for active implantable medical devices.[25]

# 2 Research

Every type of Community research activity (which includes research into aspects of some diseases that are important to older people and into health services delivered to them) is now funded within a five-year research Framework Programme. EC funds under the Programme are used to help meet the costs of coordination of research networks or "Concerted Actions", which are usually basic research projects or laboratory-based fundamental research simultaneously in progress at different universities or research institutes in more than one Member State. Continuity is assured by overlapping programme years, and funding towards research into major health scourges such as cancer and AIDS is continued from one Programme to another.

Appraisers of the fourth Medical and Health research programme strongly recommended the refocussing of research within the programme to health rather than narrow biomedical research.[26]

## *2.1 Biomedical Research*

The EC Commission's directorate-general for Science, Research and Development, DG XIII, has been responsible for EC Biomedical and Health Research programmes since 1978. The research programmes range from prevention to pure medicine and related fields such as biotechnology and the application of advanced informatics to medicine (AIM).

Biomedical and Health Research 1990-94 (BIOMED 1) comes within the Third Framework Programme.[27] There is a section on age-related health problems (in-

[23] Council Resolution of 16 June 1986 concerning the protection of dialysis patients by minimizing the exposure to aluminium OJ C 184, 23.07.86

[24] 84/466/Euratom Council Directive of 3 September 1984 laying down basic measures for the radiation protection of persons undergoing medical examination or treatment

[25] 90/385/EEC Council Directive of 20 June 1990 on the approximimation of the laws of the Member States relating to active implantable medical devices (OJ L189, 20.7.90).

[26] Fracchia & Theofilatou, 1993 (see Bibliography)

[27] Third Framework Programme 1990-94, 90/221/EEC (OJ L117, 8.5.90); Decision adopting specific research and technological development programme in the field of biomedicine and health 1990-94, 91/505/EEC (OJ L267, 24.9.91)

cluding research with relevance to specific aspects of the ageing process and diseases to which older people are particularly susceptible: osteoporotic fractures, diabetes mellitus, chronic arthritis, and kidney malfunction).[28]

## 2.2 Technological Research

Certain technological programmes have included research related to the development of new technologies relevant to the special needs of older people. For instance, there is interest in pursuing concepts of telehealth and telemedicine to handle degenerative diseases among an independently living ageing population with a scarcity of carers. The research, though, is often of a very academic nature and broad-based practical results cannot be expected for a long time. Programmes include

- COST (new technologies for increased autonomy, elderly consumers, social technology for the home, services, relations between elderly people and the labour market, adaptation to rapid technical change, special needs of elderly people with respect to learning, pension systems and social security) 1990-94;
- TIDE (Technology Initiative for Disabled and Elderly people) 1990-94;
- DRIVE, including DRIVAGE, investigating factors in elderly people's driving activities, such as capabilities, attitudes, performance and problems of older drivers 1990-94.

## 2.3 Health Resources

This is a separate area of research. It is "concerned with how health services work, are managed, financed and planned, with a view to deciding priorities in health care."[29] Older people are major consumers of health services; increasing demand from the growing population of older people is already straining health resources to the limit in many Member States.

Coordinated research includes
- assessment of health needs, focused on specific groups of the population, in particular the emergency dependency groups: elderly people, handicapped and the chronically ill.
- research on prevention and primary care.
- the determinants of mortality, leading to the publication of an Atlas of "avoidable" deaths.[30]

## 2.4 Drug Research

This appears as a new chapter in the Third Framework Programme, and a development of clinical and pharmaceutical research is proposed for inclusion

[28] Biomedical and Health Research Programme, Area 2.5
[29] Quoted Fracchia and Theofilatou, 1993
[30] Holland, 1991

in the Fourth Framework programme, to run 1994-98. Innovative drugs can do much to enhance an older person's ability to cope with age-related disability; however this type of research requires very high developmental costs and long time-frames.

## 2.5 *Nutritional Research*

The EURONUT Concerted Action on nutrition and health included one study, SENECA, which paid special attention to the nutrition of elderly people.[31] It has provided baseline data necessary for the appraisal of the nutrition and health situation of elderly people in Europe. It also provides a solid basis for a longitudinal study in which specific hypotheses of healthy ageing can be tested. It had been proposed to name 1994 the European Year on Nutrition and Health,[32] but this proposal has so far failed to gain sufficient political support to be put into action.

## 2.6 *The World Health Organisation*

The EC cooperates with WHO on a number of WHO initiated research programmes with which the EC cooperates, including ENS (European Nervous System) which looks to improve the delivery of personal social service benefits 'to groups such as the elderly' through a European telematics programme.

# 3 Health Professionals

Freedom of movement and freedom to provide services within the Single Market mean that doctors, nurses, dentists, pharmacists, etc. are free to practice in any Member State since mutual recognition of their qualifications has been agreed,[33] but in reality it is not very easy for someone to set up in practice in another country except in unpopular areas or specialties[34] (Member States may require evidence of knowledge of the local language and some initial top-up training to meet local standards).

Geriatric medicine is notoriously unattractive to medical students and doctors. Throughout Europe there is a shortage of nurses, partly due to the decline in the birth rate. These shortages may be particularly noticeable in some occupational settings (e.g. hospitals rather than primary care), and in some specialities (e.g. geriatrics and psychiatry). Nurses may increasingly choose to move to another Member State in search of better salaries and working conditions, thus aggravating shortages in less prosperous areas.

[31] Resolution of the Council of the representatives of the Governments of the Member States meeting within the Council of 3 December 1990 concerning an action programme on nutrition and health (OJ C 329, 31.12.90). SENECA stands for Survey in Europe on Nutrition and the Elderly: A Concerted Action.

[32] Conclusions of the Council and the Ministers of Health of the Member States meeting within the Council on 15 May 1992 on nutrition and health (OJ C148, 12.06.92).

[33] Medicines 75/362/EEC and 75/363/EEC (OJ L167, 30.6.75); nurses 77/452/EEC and 77/453/EEC (OJ L176, 15.7.77); dentists 78/686/EEC and 78/687/EEC (OJ L233, 24.8.78); pharmacists 85/433/EEC and 85/432/EEC (OJ L153, 24.9.85).

[34] It is estimated that since the 1970s about 12,000 doctors out of a total 900,000 (1.3 per cent) have moved to practise in another Member State *(The European Citizen no.4, p.9.)*

Current Commission proposals for guaranteed periods of leave and for prescribed rest periods to minimise the effects of shift work are likely to affect workers in the health care services who provide night time care for elderly people, e.g in hospitals, nursing homes, residential homes, etc., with the result that essential services may become more expensive and/or more difficult to staff.

## 4 Health Care Services

Throughout the EC health care costs are escalating. Insurance policies for health and long term care are in the process of changing; private policies usually discriminate against older subscribers. Affordable access to insurance and to health care should be a right of all EC citizens, no matter what their age or place of residence within the EC. Clause 25 of the Community Charter of Fundamental Social Rights states that 'any person who has reached retirement age but who is not entitled to a pension or does not have other means of subsistence, must be entitled to sufficient resources and to **medical and social assistance** specifically suited to his needs'.

In the Single Market, financial services - including pensions and health insurance companies - are able to operate across national borders. But at the moment EC consumers are not automatically entitled to medical care in all other Member States except in the case of an emergency.

There has been a noticeable increase in private medical insurance schemes that supplement limited statutory health insurance. In the future multinational insurance companies could choose to control costs by requiring a patient to go for covered treatment to a hospital in an adjacent Member State, or at least offering lower premiums to clients who declare their willingness to receive treatment at a hospital designated by the insurance company.

Health is not a straightforward market commodity. Hospitals should not be able to compete for patients at the expense of good service and care. The workings of the Single Market may promote centres of excellence in Europe (for instance hip replacements, an operation needed by many old people), but uncontrolled market mechanisms could distort and restrict the provision of fundamental health care for the bulk of the population, of whom older people are major consumers: for instance, if a hospital in a border area lost its accident and emergency centre because the orthopaedic surgeons preferred to work at a specialist centre in a neighbouring country.

# 5 Recommendations

The range of policies and programmes in the field of health already in existence will have considerable implications for the health of older people; however, these policies have not always taken into account the particular implications of an ageing population and increasing numbers of older people. In particular, we would like to see a role for the EC in the following areas:

## *5.1 Pharmaceuticals*

Legible, informative leaflets for all pharmaceutical products, reinforced by advertising that encourages people to read them, are essential for their proper use, whether or not they are sold on prescription. The Commission should continue to develop measures encouraging good practice in this area.

The European Commission should consult widely to draw up labelling information guidelines that ensure information on drug ingredients and side effects is given in an accurate form, and accessible to older people, the same in all Member States.

While the recent directive on the classification of medicines is a small move towards market transparency, much more needs to be done to improve access for older consumers to the drugs they need as they move freely in the EC.

Every effort should be made to allow those who need them to have access to appropriate drugs. A suitable balance must be struck between the administration of generic and innovative medicines. Rational use of the latest therapies - many of which are still employed - would greatly increase their cost-effectiveness.

## *5.2 Research*

The Fourth Framework Programme offers an opportunity to take into account older people's involvement in and use of health services, by greater support for research into health services delivery, preventive measures and the coordination of medical and social research so that research might be carried out, for instance, on the impact of a patient's condition on his environment, including his carers. Research into ageing and age related diseases should start with the social and medical needs of older people themselves and make provision for its practical application.

The Commission should do more to publicize in an accessible way the results from research projects with which it is involved. The new competence under the Maastricht Treaty offers scope to develop relevant research (see Chapter III).

## *5.3 Health professionals*

There is a need for more high level specialised training in medical fields such as geriatricians, gerontologists and geriatric social or rehabilitation workers, espe-

cially in the southern Member States, as well as training in basic geriatrics for general practitioners.

Community action within the structural funds could encourage the necessary professional and vocational education, especially in the less developed regions of southern Europe, where health services are poorer than in the north. Training of all health care professionals should be extended and reoriented towards health promotion and the health needs of older people.

## *5.4 Services*

Access to medical care services would seem an integral part of a single market. The EC must act to ensure equality of access, clarity of costs and guaranteed insurance cover if a consumer of health care voluntarily chooses to seek medical care in another Member State.

Older people from northern Europe who retire to the sun in the south need to be aware of the shortage of health resources.

The EC has a responsibility to develop codes of good practice for the provision of adequate hospital care. It should encourage independent monitoring to maintain minimum performance targets.

# V EC Social and Related Policies with a health impact

It is widely acknowledged that there are social, psychological, emotional and physical components to health. In all age groups, ill health and poverty are closely related. Sound policies on income, housing, energy, transport and the environment are important contributory factors to healthy ageing. A wide range of EC policies have therefore indirect implications for the health of older people. This chapter reviews this range of policies and makes recommendations for their future orientation.

## 1 EC Programme for Older People

How older people perceive themselves and how the society around them supports and approves of their behaviour can have a major effect on their health standing. Stereotypes may inhibit the full development of an older person's potential, and an expectation that old age is synonymous with ill-health and disability is likely to be self-fulfilling.

The first **EC Programme for Older People** (1991-93),[35] and especially activity within the framework of the European Year of Older People and Solidarity between Generations (1993), mark a step in the right direction of validating the contribution of older people to society and of their right to be seen as full members of that society.

## 2 Disability

70% of disabled people are over 60 years of age.[36] Two specific action programmes for disabled people have been implemented by the EC;[37] the third one, (HELIOS II (1992-96), which was approved in February 1993, identifies for the first time the specific target group of 'older disabled people'.

## 3 Employment and Health

### *3.1 Health and Safety at Work*

Preventive measures must be taken in mid-life in order to avoid health problems in later life. For instance, health in older age may be affected by:

- exposure to radiation, toxic chemicals and biological agents that affect morbidity and mortality in later life

- accidents at work, an important cause of disability in later life

- ergonomic factors (repetitive strain injury, unrestricted work with visual display units) that can cause permanent disability.

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[35] 91/49/EEC Council Decision of 26 November 1990 on Community actions for the elderly (OJ L 28 2.2.91).
[36] Eurolink Age publication, *Age and Disability.*
[37] Council Resolution of 27 June 1974 establishing an initial Community action programme for the vocational training of handicapped persons (OJ C 80 9.7.74). 88/231/EEC Council Decision of 18 April 1988 establishing a second Community action programme for disabled people (HELIOS) (OJ L 104 23.4.88).

A considerable body of legislation covers the health and safety of workers, especially under the Euratom and the European Coal and Steel Community Treaties. For the Single Market, Council Directive 89/391/EEC[38] provides a framework for measures of safety and health at the workplace.

The European Year of Safety, Hygiene and Health Protection at Work, ending February 1993,[39] laid special emphasis on actions promoting safety in small and medium sized industries and workshops.

## 3.2 Unemployment

The consequences of unemployment are well known in terms of health outcomes, with particular implications for health in retirement:

- stress and depression increase, leading to ill health;

- long term unemployment is often accompanied by low income, with an established relationship between poverty and ill health; the subsequent implications for income in retirement are quite considerable.

In the current recessionary climate, once an older worker loses a job, s/he is more likely than younger workers to stay unemployed. Many redundant older workers do not easily adapt to or even consider learning new skills; employers often do not consider it worthwhile to recruit and train older workers. Measures to maintain or restore older workers' participation in the workforce contribute at the same time to the maintenance of their health.

## 3.3 Carers

All European countries aim to keep older people in need of care as long as possible in their established social environment. The vast majority of community care for frail elderly in the EC is informally provided by family members, usually women in the 40-65 age range. In providing this care, the women may lose the opportunity to work in the market place and thus fail to build up adequate pension or social insurance rights. Without adequate support services both at home and at the workplace, there can also be an important cost to the carers' own health. The 'Female Care Taker Potential' in EC Countries (women aged 45-69 in proportion to population 70+) has reduced by some 68.5% between 1960 and 1990[40]. The necessary consequential policy changes are under consideration at national level in some member states but there has been little coordinated EC approach.

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[38] 89/391/EEC Council Directive of 12 June 1989 on the introduction of measures to encourage improvement in the safety and health of workers at work (OJ L 183 29.6.89).

[39] 91/388/EEC Council Decision of 25 July 1991 on an action programme for the year of Safety, Health and Hygiene at Work 1992 (OJ L 214 2.8.91).

[40] Alber, Jens, "Health and Social Services", in *Older People in Europe: Social and Economic Policies*, the 1993 Report of the European Observatory. Published by the Commission of the European Communities, Directorate General V, Employment, Social Affairs, Industrial Relations.

## 4 Anti-Poverty Programmes

There is a two-way relationship between health and poverty - bad health may be a cause of poverty, while poverty may cause bad health. Older people - especially older women and people who are frail and dependent - can be particularly vulnerable to poverty. Unemployed older workers who have not yet qualified for a full statutory retirement pension may be in receipt of unemployment or disability benefit that can be interrupted or reduced due to national budgetary pressures. Changes in behaviour and attitudes affecting health are unattainable if the target group has inadequate material resources with which to change lifestyle.

The EC has implemented a series of programmes to combat poverty. Within the second EC Programme to Combat Poverty, a number of pilot projects aimed at combatting poverty amongst older people.[41] The third programme, Poverty 3, does not provide for special categories of interest.

## 5 Housing

Decent housing is one of the basic requirements for a healthy life. Older people make up a high proportion of those in substandard or inadequate housing. There is no specific EC competence for housing action, but annual meetings of Housing Ministers within the Council are held, and the Commission has prepared studies in response to concern expressed in the European Parliament.[42]

The 1993 Report of the European Observatory, a group of academics studying EC policies affecting older people within the framework of the Action Programme for Older People, examines housing and living standards in depth. An EC-wide network of Innovative Projects of Care/Housing which stimulate autonomy and the integration of older people into society has been set up within the EC Programme for Older People.

## 6 Transport

Transport falls under the responsibility of DG VII (Directorate-general for transport). Access to public transport is essential to enable older people to remain healthily integrated in society and is often important in enabling them to have access to health services and treatment.

A Resolution of the EC Council of Transport Ministers in December 1991 called on the Commission to submit an action programme to help people with reduced mobility. It acknowledged the need to address the likely increase in numbers of people with reduced mobility as a result of longer life expectancy.[43]

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[41] Final report on the second European poverty programme Com(91)29 final, 13 February 1991.

[42] See *Social Europe* supplement 3/92 for a full description of EC housing activities.

[43] Resolution of the Council and the representatives of the Governments of the Member States meeting within the Council of 16 December 1991 concerning a Community action programme on the accessibility of transport to persons with reduced mobility (OJ C 18 24.1.92).

## 7 Environmental Policy

The Commission's directorate-general for the Environment is DG XI. The competence first given to the Commission by the Single European Act in 1986[44] will be enhanced by the Maastricht Treaty. Any health policy must take account of environmental factors, as the Council acknowledged in a recent Resolution.[45] Due to age-related changes in biological functioning, older people may be particularly susceptible to toxicity in the air and in bathing and drinking waters.

A number of Directives have been adopted, requiring monitoring of atmospheric pollution and setting standards for air[46] and drinking water[47] quality as well as noise pollution from various sources, although these directives are notoriously more honoured in the breach than in the observance in some countries. There is a specific research and development programme for the environment.[48]

Collaboration also takes place on environmental matters between the EC and other international bodies, for instance with the World Health Organisation in the Healthy Cities Programme.

## 8 Consumer/Industrial

Healthy food products, safe medicines and safe consumer products are as important to older people as to anyone else. The Consumer Protection Service is a special division of the Commission of the EC; legislation for consumer protection has so far been introduced on the basis of the need to inform and protect consumers in a single market with free movement of all products. Article 129a of the Maastricht Treaty[49] will give the Commission power to take "specific action ... to protect the health, safety and economic interests of consumers and to provide adequate information to consumers", without the need to justify their action on the grounds of the single market; Member States are, however, reluctant to allow the Commission to develop wide powers.

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[44] See Annex V.

[45] Resolution of the Council and the Mins. for Health meeting within the Council of 11 November 1991 concerning fundamental health policy choices (OJ C 304 23.11.91).

[46] 82/884/EEC (amended OJ L377, 31.12.91) Lead pollution 85/203/EEC (amended OJ L377, 31.12.91) Nitrogen dioxide pollution
87/217/EEC (amended OJ L377, 31.12.91) Asbestos pollution.

[47] Council Directive of 15 July 1980 relating to the quality of water intended for human consumption (OJ L 229 of 30.9.80); 79/869/EEC Council Directive of 9 October 1979 concerning the methods of measurement and frequencies of sampling and analysis of surface *water* intended for the abstraction of *drinking water* in the Member States (OJ L 271 of 29.10.79).
91/689/EEC Council Directive of 12 December 1991 on hazardous waste.
91/692/EEC Council Directive of 23 December 1991 standardising and rationalising reports on the implementation of certain Directives relating to the Environment.
76/160/EEC Council Directive of 8 December 1975 concerning the quality of bathing water (OJ L 31 5.2.76).

[48] Council Decision of 7 June 1991 adopting a specific research and technological development programme in the field of the environment (1990 to 1994).

[49] See Annex VI.

## 8.1 Consumer Safety

There is a specific Community System for the Rapid Exchange of Information on products that present a *serious and immediate danger,*[50] but there is currently no arrangement in place for the exchange of information on products of a hazardous nature that circulate freely in the single market.[51]

The general product safety directive[52] will come into force on 29 June 1994. It will include provision for a Community system for the exchange of information on certain consumer products likely to endanger the health and safety of consumers. The Commission's efforts to construct interim arrangements have run into political difficulties with the Council of Ministers.

A directive on liability for defective products[53] covers a range of products including medicines, but it excludes the liability of health care professionals as suppliers.

EHLASS (European Home and Leisure Accidents Surveillance System) was set up in 1986 as a 5-year demonstration project, to collect information at Member State level on home and leisure accidents involving consumer products, with a view to taking preventive action in the Community. Participation and results have been uneven. The project will be continued but much more work needs to be put into standardizing procedures of recording and sharing data at hospital and national levels for it to become a useful tool.

## 8.2 Food

Access to safe, affordable and appropriate food is essential for the maintenance of good health, not just for older people. Food is a principal budget item for most older people. Increasingly, food sold for consumption throughout the European Community is processed food. Legislation is spread between DG III (Directorate-general for the Internal Market) and DG VI (Directorate-general for Agriculture).

Numerous advisory committees assist the Commission's work on food questions, and there is an ever-increasing body of Community legislation in force affecting the preparation and packaging,[54] contents,[55] labelling and distribution[56] of foodstuffs. Questions have been raised about the cost/benefit relationship of

[50] 89/45/EEC Council Decision of 21 December 1988 on a Community system for the rapid exchange of information on dangers arising from the use of consumer products.

[51] Proposal for a Decision concerning the institution of a Community system for the exchange of information in respect of certain products which may jeopardise consumers' health and safety. COM(92) 429 final, transmitted to Council 23 November 1992.

[52] Council Directive 92/59/EEC on general product safety. (OJL 228 of 11.8.92).
tions and administrative provisions of the Member States concerning liability for defective products (OJ L 210 7.8.85).

[53] 85/374/EEC Council Directive of 25 July 1985 on the approximation of the laws, regulations and administrative provisions of the Member States concerning liability for defective products OJ L 210 7.8.85).

[54] 89/109/EEC (OJ L 11.2.89) and 90/128/EEC (OJ L075, 21.3.90) Materials and articles intended to come into contact with foodstuffs.

[55] 74/63/EEC (OJ L ) Undesirable substances and products in animal nutrition.
89/107/EEC (OJ L040, 11.2.89) Food additives for use in foodstuffs intended for human consumption.
89/398/EEC (OJ L186, 30.6.89) Foodstuffs intended for particular nutritional uses (PARNUTS).
89/397/EEC (OJ L186, 30.6.89) Official control of foodstuffs.

[56] 90/496/EEC (OJ L276, 6.10.90) Nutrition labelling for foodstuffs.

some of these measures, as the gap between the price paid to the primary producer (the farmer and fisherman) and the price paid by the consumer steadily increases.

Good food for good health is not the prime motivation for the Common Agricultural Policy, whose subsidies encourage the over-production of meat and dairy products and the use of high-fat dairy products as ingredients in manufactured foods, while healthier foods such as fresh vegetables and fruits are disproportionately highly priced (and large quantities are regularly destroyed).

# 9 Recommendations

## *9.1 EC Programme for Older People*

A new EC Action Programme for Older People should be launched after 1993, working to change social norms and setting targets for the better economic and social integration and empowerment of older people, while identifying the risk factors. Health should be a major theme of this programme.

## *9.2 Disability*

The new target of on disabled older people under the HELIOS II programme should be warmly welcomed; the success of EC action in this field should be closely followed and evaluated and it is hoped this should provide a focus for future EC disability policy.

## *9.3 Employment and Health*

More attention should be given to older workers' needs within programmes for retraining and reinserting marginal groups, which often include older workers, that receive support from the EC structural funds.

### *9.3.1 Carers*

The EC could play a role in encouraging training schemes for geriatric health care professionals, in drawing up codes of good practice for residential care and nursing homes, and in encouraging employer good practice and support schemes for workers with elderly dependents.

## *9.4 Anti-Poverty programmes*

Older people must be included as an integral and targeted part of future EC action on poverty. In addition, there should be a guarantee of a minimum income, at an appropriate level for local conditions, in keeping with the recommendation of the Social Charter.

## 9.5 Housing

Although no decision has yet been taken, consideration is being given to an EC-wide carbon tax. This could have adverse effects on older people's access to affordable and essential energy.

Improvement in the quality of housing for the elderly and disabled would have a marked effect on the health status of older people. The European Community should continue actively to promote the exchange of information about successful housing projects within the Anti-Poverty and HELIOS programmes and any future EC Programme for Older People.

## 9.6 Transport

The Commission should develop Community-wide standards for improved access to public areas and the provision of affordable and accessible public transport as a priority.

## 9.7 Environmental Policy

Enforcement of environmental standards is essential. All necessary means should be used towards this end. But legal and fiscal controls, taxes and subsidies, must not act to the disadvantage of vulnerable groups, such as elderly people. A carbon energy tax should not affect their costs for domestic heating or public transport.

A stronger base for EC citizen action in relation to health protection in the context of environmental actions will lie in Article 130r on the Environment in the Maastricht Treaty,[57] which requires protection of human health in relevant EC environmental measures such as air, water pollution which may also affect older people. Decisions based on this Article will be taken via the new conciliation procedure for legislation, which gives the European Parliament a potential right of veto. The Treaty also strengthens the power of the European Court of Justice by giving it the right to impose fines on Member States that flout EC law.

## 9.8 Consumer/industrial

Using the new Maastricht competence, the Community must address

- the lack of access for older people to certain categories of goods and services, for example, housing, energy, health services and financial services such as insurance;

- the older consumer as a 'user' instead of a 'subject' of public services, such as transport, post, telecommunications and energy;

[57] See Annex VII.

- the need for higher service standards and effective EC-wide protection and safeguards for consumers of all ages.

### *9.8.1 Consumer safety*

The EC should set up an interim system for the exchange of information on hazardous products without further delay. Access to justice for consumers of defective products in the Single Market must be improved. EHLASS results from Member States, however imperfect or incomplete, should be released. This would help indicate those areas where accidents are more frequent and enable the highest safety standards to be maintained.

### *9.8.2 Food*

The EC should set up an independent committee to examine the Common Agricultural Policy in relation to diet and nutrition and report on the conclusions.

The proposed European Year of Health and Nutrition, with an effective Action Plan to include a directive on labelling, should be made a priority. Clear labelling of nutritional content would enable older people to follow recommended diets more easily.

Research should continue into what constitutes a good diet appropriate to different ages and stages.

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## ANNEX I

## AGEING WELL

### an EC Action Plan

Recommendations from the Ageing Well Conference, London 30 November and 1 December 1992, call on -

- governments at local, national and European level
- non-governmental and inter-governmental organisations
- older people's groups
- the health professions
- industry
- research bodies
- the media

to take action during 1993, European Year of Older People and Solidarity Between the Generations, and beyond to stimulate and support policies and programmes for healthy ageing and in particular to:

## *I Priorities for Public Policies*

1 Take account of older people and the ageing of the population in all areas of public policy development and establish mechanisms for their representation and consultation on health.

2 Recognise the economic and social benefits of health promotion and disease prevention for older people, developing policies that build on existing health policies and draw on examples from other sectors.

3 Support and promote research into ageing and age-related diseases, starting with the social and medical needs of older people themselves and making provision for its practical application.

4 Instigate specific EC action on health and ageing including a second, broader EC programme for older people, research programmes, information exchange and data collection; stimulate member states to formulate policies with regard to a decent standard of living and medical and social assistance.

## *II Quality of Health Care - Reorienting Services*

1 Develop effective strategies to counter negative attitudes of health and care workers to working with older people through wider understanding of normal ageing, evidence of the benefits of positive approaches and appropriate status and conditions.

2 Extend and reorient training of all health care professionals towards health promotion and the health needs of older people, through national and EC led initiatives.

3 Ensure health care is patient centred, age related, multi-disciplinary, non-discriminatory and responsive to the needs of all older people, acknowledging that many illnesses and disabilities are not currently preventable by healthier practices; it should be relevant, accessible and include a system of audit.

4 Establish policies for collaboration between health professionals and locally based formal and informal networks of support for older people and their carers, and ensure commensurate practical, social and financial support.

## III Research

1 Prepare a baseline document highlighting the breakthroughs and improvements which have had a major impact on current health status and life expectancy of older people in the last fifty years.

2 Support both short- and long-term research programmes in the fields of basic science, epidemiology and clinical research including therapy, both pharmacological and non-pharmacological; research should be cross-country and comparative as well as taking into account particular regional needs.

3 Foster a favourable research climate in Europe and devote adequate resources to the understanding, prevention, alleviation and cure of age-related diseases, including the provision of training schemes and scholarships.

4 Coordinate age-related research by the European Community, governments, research-based pharmaceutical companies and charitable foundations, and ensure full consultation with patients and patient societies.

## IV Self-Help and Local Community Action

1 Acknowledge the right of, and create opportunities for, every older person to take decisions on the issues that affect his/her health and well-being.

2 Recognise and promote the key role of local community action and self-help initiatives, including the contribution of families and social networks.

3 Provide information and technical, organisational and social support encouraging self-help to both individuals and groups of older people, taking into account the needs of the most disadvantaged.

4 Create partnerships between government, for-profit and non-profit sectors at local, national and European level for practical and financial support of self-help and local community action initiatives.

## V Health Education, Information and Networking

1 Develop health education programmes in cooperation with the diverse target groups to ensure their relevance to all older people, who should themselves be seen as an important part of the education process (peer education).

2 Work with the media to ensure they have informed perspectives on health and ageing and a ready supply of positive role models.

3 Ensure health professionals are trained to communicate effectively with older people and that information on the use and effects of medical treatments is accessible in both language and presentation.

4 Establish a European clearing house for materials and information about healthy ageing initiatives and examples of the 'old wisdom' from different cultures, such as stories and proverbs.

EC Member States, the European Community, the Council of Europe and the World Health Organisation are all encouraged to cooperate to implement this plan.

## ANNEX II

### Single European Act

**Article 100A**

1. The Council shall, acting by a qualified majority on a proposal from the Commission in cooperation with the European Parliament and the Economic and Social Committee, adopt the measures for the approximation of the provisions laid down by law, regulation or administrative action in Member States which have as their object the establishment and functioning of the internal market.

2. Paragraph 1 shall not apply to fiscal provisions, to those relating to the free movement of persons nor to those relating to the rights and interests of employed persons.

3. The Commission, in its proposals laid down in paragraph 1 concerning health, safety, environmental protection and consumer protection, will take as a base a high level of protection.

## ANNEX III

**Excerpts from the Treaty establishing the European Atomic Energy Community:**

**Title Two, Chapter III**

**Health and Safety**

### Article 30

*Basic standards shall be laid down within the Community for the protection of the health of workers and the general public against the dangers arising from ionizing radiation.*

The expression *"basic standards"* means:
(a) maximum permissible doses compatible with adequate safety;
(b) maximum permissible levels of exposure and contamination;
(c) the fundamental principles governing the health surveillance of workers.

### Article 31

The basic standards shall be worked out by the Commission after it has obtained the opinion of a group of persons appointed by the Scientific and Technical Committee from among scientific experts, and in particular public health experts, in the Member States. The Commission shall obtain the opinion of the Economic and Social Committee on these basic standards.

After consulting the Assembly the Council shall, on a proposal from the Commission, which shall forward to it the opinions obtained from these Committees, establish the basic standards; the Council shall act by a qualified majority.

### Article 33

measures for teaching, education and vocational training (in basic standards)

### Article 35

Monitoring level of radioactivity in the air, water and soil.

## ANNEX IV

## European Treaty on Political Union

## Title X Public Health

### Article 129

1. The Community shall contribute towards ensuring a high level of human health protection by encouraging cooperation between the Member States and, if necessary, lending support to their action.

Community action shall be directed towards the prevention of diseases, in particular the major health scourges, including drug dependence, by promoting research into their causes and their transmission, as well as health information and education.

Health protection requirements shall form a constituent part of the Community's other policies.

2. Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination.

3. The Community and the Member States shall foster cooperation with third countries and the competent international organizations in the sphere of public health.

4. In order to contribute to the achievement of the objectives referred to in this Article, the Council:

- acting in accordance with the procedure referred to in Article 189b, after consulting the Economic and Social Committee and the Committee of the Regions, shall adopt incentive measures, excluding any harmonization of the laws and regulations of the Member States;

- acting by a qualified majority on a proposal from the Commission, shall adopt recommendations.

## ANNEX V

### Single European Act

### Title VII Environment

**Article 130R**

1. Action by the Community relating to the environment shall have the following objectives:

(i) to preserve, protect and improve the quality of the environment;
(ii) to contribute towards protecting human health;
(iii) to ensure a prudent and rational utilization of natural resources.

2. Action by the Community relating to the environment shall be based on the principles that preventive action should be taken, that environmental damage should as a priority be rectified at source, and that the polluter should pay. Environmental protection requirements shall be a component of the Community's other policies.

3. In preparing its action relating to the environment, the Community shall take account of:
(i) available scientific and technical data;
(ii) environmental conditions in the various regions of the Community;
(iii) the potential benefits and costs of action or of lack of action;
(iv) the economic and social development of the Community as a whole and the balanced development of its regions.

4. The Community shall take action relating to the environment to the extent to which the objectives referred to in paragraph 1 can be attained better at Community level than at the level of the individual Member States. Without prejudice to certain measures of a Community nature, the Member States shall finance and implement the other measures.

5. Within their respective spheres of competence, the Community and the Member States shall cooperate with third countries and with the relevant international organi-

zations. The arrangements for Community cooperation may be the subject of agreements between the Community and the third parties concerned, which shall be negotiated and concluded in accordance with Article 228.

The previous paragraph shall be without prejudice to Member States' competence to negotiate in international bodies and to conclude international agreements.

## ANNEX VI

## European Treaty on Political Union

## Title XI Consumer protection

### Article 129a

1. The Community shall contribute to the attainment of a high level of consumer protection through:

(a) measures adopted pursuant to Article 100a in the context of the completion of the internal market;

(b) specific action which supports and supplements the policy pursued by the Member States to protect the health, safety and economic interests of consumers and to provide adequate information to consumers.

2. The Council, acting in accordance with the procedure referred to in Article 189b and after consulting the Economic and Social Committee, shall adopt the specific action referred to in paragraph 1(b).

3. Action adopted pursuant to paragraph 2 shall not prevent any Member State from maintaining or introducing more stringent protective measures. Such measures must be compatible with this Treaty. The Commission shall be notified of them.

## ANNEX VII

### European Treaty on Political Union
### Title XVI Environment

**Article 130r**

1. Community policy on the environment shall contribute to pursuit of the following objectives:

- preserving, protecting and improving the quality of the environment;
- protecting human health;
- prudent and rational utilization of natural resources;
- promoting measures at international level to deal with regional or worldwide environmental problems.

2. Community policy on the environment shall aim at a high level of protection taking into account the diversity of situations in the various regions of the Community. It shall be based on the precautionary principle and on the principles that preventative action should be taken, that environmental damage should as a priority be rectified at source and that the polluter should pay. Environmental protection requirements must be integrated into the definition and implementation of other Community policies.

In this context, harmonization measures answering these requirements shall include, where appropriate, a safeguard clause allowing Member States to take provisional measures, for non-economic environmental reasons, subject to a Community inspection procedure.

3. In preparing its policy on the environment, the Community shall take account of:

- available scientific and technical data;
- environmental conditions in the various regions of the Community;
- the potential benefits and costs of action or lack of action;
- the economic and social development of the Community as a whole and the balanced development of its region.

4. Within their respective spheres of competence, the Community and the Member States shall cooperate with third countries and with the competent international organizations. The arrangements for Community cooperation may be the subject of agreements between the Community and the third parties concerned, which shall be negotiated and concluded in accordance with Article 228.

The previous subparagraph shall be without prejudice to Member States' competence to negotiate in international bodies and to conclude international agreements.

*Produced by Eurolink Age with the support of the Commission of the European Communities, DGV*

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