Working paper

July 2004

Advancing Integrated Care for Older People through EU Policy

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EHMA
European Health Management Association

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CARMEN is the acronym for the 'Care and Management of Services for Older People in Europe Network' . This thematic network has been managed by the European Health Management Association (EHMA) and has been funded by the European Commission under the RTD programme 'Quality of Life and Management of Living Resources 1998-2002, Key Action: Ageing', project number QLK6 -2000-00584.

The views expressed in this publication do not necessarily reflect those of the European Commission.

The Author has written this document on behalf of the CARMEN network.

The **European Health Management Association** is a membership organisation committed to improving healthcare in Europe by raising standards of managerial performance in the health sector.

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Published in 2004 by
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Contents

Executive summary

This publication focuses on ways for EU policy to contribute to the advancement of integrated health and social services for older people across the EU. The publication builds on the outcomes of the CARMEN project.[1] As such, it is an attempt to inform EU policy by cross-national expertise generated through its own research and development programme.

Its potential added value to the ongoing policy debates is grounded in the fact that CARMEN was concerned with the management of integration across sectors, professions and administrative boundaries. This has been a broad and pragmatic framework to analyse how different policy areas can mutually reinforce each other.

Financially sustainable, good quality and accessible long-term care is a key challenge within the framework of the broader EU social policy agenda. At the same time, the consequences of the EU Internal Market are echoed in the mobility of patients and other healthcare developments. The recommendations are mainly concerned with these two policy areas.

Overall comments

- A shared vision for European health care and social protection services should include perspectives on empowerment, prevention, social values such as equity and solidarity, and the role of informal carers.
- Such a vision should appreciate the contribution of all elements of the health and social care system to the improvement of services for older people, and should be supportive of mechanisms for integration that contribute to client-centred service provision.
- Older people's positive contribution to society should be promoted and reinforced. They should be seen as assets to society and not as a social burden.
- European economic and social objectives should be in balance to protect vulnerable citizens and to achieve a positive outcome for older EU citizens in all Member States.

[1] CARMEN brought together 40 European organisations from 11 European countries between March 2001 and June 2004. The project was co-ordinated and managed by the European Health Management Association (EHMA).

Social policy issues

- National Action Plans (NAPs) set up by EU Member States to deliver common social policy objectives should also allow for the implementation of activities that enable the positive contribution of health and long-term care to other social policy areas, and vice versa.
- EU economic and social policy instruments, such as the Structural Funds, should support further development of the whole system of integrated care provision, including the development of services outside hospital and residential settings.
- Solutions should focus on establishing a coherent system of services with a range of attractive and suitable options for all older people, including vulnerable people with multiple needs, regardless of socio-economic status, ethnicity, gender or lifestyle.
- Accessible, good quality domestic services and other forms of care provided in the home setting should be available to ensure older people can continue to live independently.
- NAPs should stimulate co-ordinated policy and action across local, regional and national levels, maximising the potential of approaches at each of these levels, and guarding against the detrimental effects of compartmentalisation.
- Structural support for informal carers is an essential element in achieving overall objectives with regard to accessible, good quality and financially sustainable long-term care. It should include practical, emotional as well as financial measures.
- Measures designed to support longer working lives should take the position of older family carers into account. Their socio-economic position should be protected against repercussions in terms of pension rights, income and/or social isolation.
- Active measures need to be taken to improve the image, status, remuneration and work pressures in the care sector, to stimulate employment and career opportunities in this sector and to encourage a sustainable workforce.
- Measures should be taken to prevent poorer health among older people leading to impoverishment and low income which may restrict access to care.
- Accumulation of co-payments and/or means testing in health and social care should not lead to poverty, social exclusion, unequal access, or an increase in health inequalities.
- Member States should be encouraged to co-ordinate pensions and other forms of financial social security on the one hand, and co-payment arrangements on the other.
- EU programmes aimed at tackling social exclusion should facilitate projects that encourage social participation and independence of older people and their informal carers.

- Measures should be taken to protect older women's health, financial and social resources, and independence from being disproportionately affected by adverse effects of cost-shifting and the reduction of publicly funded standard care packages.

Internal Market issues

- The follow-up of the High Level Process of Reflection on Patient Mobility and Healthcare should focus on the whole system of health and social care, not only on acute and hospital care. This should also be reflected in the broad range of experts and stakeholders to be consulted in this process.
- Access to good quality continuity of care should be ensured for patients who receive their treatment or care partly abroad and partly in their home country.
- New Community legislation with regard to services in the Internal Market should not encourage further health system compartmentalisation, nor should it discourage integration and innovation across sectors.

Information Society, Research and e-Health programmes

The potential for innovative ICT applications in the home setting to alleviate capacity problems in professional and informal care should be mirrored in more specific support measures through the EU's Information Society, Research and e-Health programmes.

Introduction

CARMEN is the acronym for 'Care and Management of Services for Older People in Europe Network'. This thematic network has been supported by the European Commission's 'Quality of Life and Management of Human Resources' Programme, which is part of DG Research's Fifth Framework Programme. CARMEN brought together 40 European organisations from 11 European countries between March 2001 and June 2004. The project was co-ordinated and managed by the European Health Management Association (EHMA). A list of participants is included in the Appendix.

Over a period of more than three years, the CARMEN project has thus brought together a broad range of different stakeholders including professionals, purchasers, informal carers, and representatives of older people themselves. The network enabled them to reflect on the improvement of integrated care for older people from policy, practice, management and academic perspectives. Grounded in practice as well as theory, the insights acquired through the CARMEN project[2] can provide solid building blocks for policy.

Indeed, strategic management of services at national and European policy level was an explicit focus of the project. The results of these efforts are reflected in the CARMEN Policy Framework[3], which offers a checklist for policy makers at national and regional level. An analysis of relevant implications for policy development at EU level is presented here, following an initial exploration with invited experts at the final CARMEN project meeting on policy issues in spring 2004 and based on the many cross-national experiences shared by the CARMEN participants over the course of the project.[4]

Recommendations for the EU research agenda are not included here, as a reflection on the needs for future research on integrated care is published separately.[5]

[2] Nies, H and Berman, PC (2004). *Integrating Services for Older People: A resource book for managers*. Utrecht: NIZW.

[3] Banks, P (2004). *Policy Framework for Integrated Care for Older People*. London: King's Fund.

[4] The editor and author are solely responsible for the views expressed in this publication, which does not represent the opinion of the Commission. The Commission is not responsible for any use that might be made of any data appearing in this publication.

[5] Nies, H (2004). *A European Research Agenda on Integrated Care for Older People*. Dublin: EHMA.

This publication is aimed at anyone committed to the advancement of integrated care for older people within and across the EU. It is particularly targeted at the three main 'pillars' of EU policy development and implementation: the Council (i.e. the representatives of Member States' governments), the Parliament, and the Commission. Member States are also addressed within the context of collaborative frameworks that increasingly emerge as a way to tackle common challenges across the EU, e.g. through the open method of co-ordination.

EU policy areas and developments with specific relevance to integrated care

Subsidiarity

Under the principle of subsidiarity, the organisation and delivery of health and social care services are the responsibility of Member States. The EU has no specific competency in this field. Consequently, there is no such thing as an EU policy on health care, never mind a policy on long-term or integrated care. There are, however, many EU policy areas that do impact more or less indirectly on the further advancement of integrated care, such as Internal Market and social policy (including employment, social inclusion, pensions and social protection).

Developing agendas

When the CARMEN project was still on the drawing board, it was therefore anticipated that any recommendations addressing EU frameworks would not have one obvious 'niche' in the Brussels policy dynamic. Instead, they would have to target various policy processes that the Council, Parliament and Commission are involved in. At that time, it could not have been foreseen how many new developments would emerge from various EU policy frameworks over the project period (spring 2001– 2004) that could have implications for the whole system of services involved in integrated care, for carers, and for older people themselves. These new developments made CARMEN's aspirations to be able to provide an input into EU policy even more relevant.

Tackling common challenges in social policy

The most immediate link to CARMEN's key concerns emerged from the Lisbon European Council in 2000 and more particularly from the social policy agenda. This roadmap for modernising and improving the European social model is very much based on co-operation between Member States as a way forward, respecting the principle of subsidiarity.

In response to a Communication issued by the Commission,[6] the Council stressed that social protection systems needed to be reformed in order to continue to provide quality health services in light of an ageing society.

First orientation on health care and long-term care for older people

Subsequent to the Lisbon meeting, the Gothenburg Council (2001) asked for an orientation on the field of health care and care for older people, against the backdrop of the so-called 'open method of co-ordination'. Building on the principle of subsidiarity, this is a method of working that allows Member States to tackle common challenges and problems, while at the same time continuing to define their own national strategy and benefiting from experiences and good practices of the other Member States.

The request from the Gothenburg Council resulted in a report based on another Commission Communication[7] (December 2001), suggesting EU Member States were to ensure three broad objectives:

- access for all regardless of income or wealth
- a high level of quality of care
- financial sustainability of care systems.

Since then, Member States have provided information on how they deliver the three suggested objectives. Their information was reflected in a joint report from the Commission and the Council on supporting national strategies for the future of health care and care for the elderly (March 2003). The European Parliament confirmed the validity of the three key objectives for the modernisation of health care and long-term care as well as the importance of further structured co-operation between Member States.[8]

[6] COM (1999) 347 final: A concerted strategy for modernising social protection.
[7] COM (2001) 723 final: The future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability.
[8] EP Committee on Employment and Social Affairs, Report A5-0098/2004 final, rapporteur Karin Jöns.

Towards a common framework for national strategies

As a next step, the Commission presented a Communication to define a common framework to support Member States in the reform and development of health care and long-term care using the open method of co-ordination.[9] The Communication proposes common objectives for health care provision. The co-ordination of this area of social protection would complement similar co-ordinating processes that are already ongoing in three other social policy areas: pensions, social inclusion and employment. The four processes could well be streamlined through the delivery of the Lisbon agenda. This could also provide an opportunity for further links to other social policy themes, such as gender equality and the organisation of working time.

Internal Market policy

The EU Internal Market policy incorporates the freedom of individuals, goods, services, and capital. Numerous rulings of the European Court of Justice (ECJ)[10],[11] have clarified that the application of Internal Market rules does impinge on health care and integrated care provision. The ECJ rulings led to the publication of two different proposals from the Commission dealing with services, respectively with patient mobility.

Services

The proposed Directive on services in the Internal Market[12] is to provide a legal framework to eliminate obstacles to the freedom of establishment for service providers and the free movement of services. The proposal covers a wide variety of services that the Commission considers as 'economic service activities' and includes an article on the assumption of health care costs.

[9] COM (2004) 304 final: 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 co-ordination'.

[10] See case law European Court of Justice on the free movement of patients: Kohll (C-158/96), Decker (C-120/95), Smits and Peerbooms (C-157/99), Vanbraekel (C-368/98) and Müller-Fauré (C-385/99).

[11] SEC (2003) 900: Commission Staff Working Paper. Report on the application of internal market rules to health services: implementation by the Member States of the Court's jurisprudence.

[12] COM (2004) 2 final/3: Proposal for a directive of the European Parliament and the Council on services in the internal market (presented by the Commission).

In recognising the right of patients to benefit from reimbursement in the case of medical treatment dispensed in another Member State, the European Court of Justice (ECJ) has made a distinction between hospital and non-hospital care. In an attempt to translate the ECJ rulings into secondary Community legislation, the Commission's proposal for a directive on services in the Internal Market would reinforce this distinction in all Member States, and would provide a universal definition of hospital care across the EU.

Patient mobility

Parallel to the Communication on modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care, the Commission published another Communication presenting a set of concrete proposals to address patient mobility as a consequence of the EU internal market.[13] The two Communications complement each other. Together, they present an overall strategy for developing a shared vision for European health care and social protection systems.

The Communication has evolved out of the High Level Process of Reflection on Patient Mobility and Healthcare set up under the remit of the Commission's Directorate General for Public Health and Consumer Protection. The Communication addresses the following four themes:

- European co-operation to enable better use of resources
- information requirements for patients, professionals and policy-makers
- the European contribution to health objectives
- responding to enlargement through investment in health and health infrastructure.

[13] COM (2004) 301 final: Communication from the Commission 'Follow-up to the high level reflection process on patient mobility and healthcare developments in the European Union'.

CARMEN recommendations for EU policy

The recent developments towards a shared vision for European health care and social protection services have great potential to enhance integrated care for older people. This potential should be maximised by a broad focus that includes perspectives on empowerment, prevention, social values such as equity and solidarity, and the role of informal carers. Such a broad focus should also appreciate the contribution of all elements of the health and social care system to improving services for older people. A vision on whole systems service provision should be encouraged throughout the two key strategic elements[14] presented by the Commission. A narrow focus on acute care would be a missed opportunity.

1 The Community process on ensuring a high level of social protection with regard to health care and long-term care for older people

The position of older people

'Older people should be seen as assets and not just as a "burden" '.[15] Demographic developments will inevitably bring about more demand for health and social care, presenting considerable social and financial challenges to society. Nevertheless, care should not only be perceived as a social burden: it is also a life-span resource. Most people rely on care later, rather than earlier in life, which sets it apart from other life-span resources, e.g. education. Emphasising the need for good quality and accessibility is as crucial as the need for financial sustainability.

Older people's positive contribution to society should be promoted and reinforced. A stronger focus is needed on prevention instead of on crisis-driven

[14] COM (2004) 301 final and COM (2004) 304 final.
[15] Commission DG Employment and Social Affairs. Guidelines to Call for proposals VP/2004/006.

patterns of helping older people. Policies should address the challenges of integrated care within a broader positive context which promotes health, active life and independence, combats age discrimination, and sees older people as individuals, not as a uniform group.

Supporting national strategies

Mechanisms to work across sectors

Across Member States, administrative, financial and organisational compartmentalisation of care service systems stands in the way of finding sustainable solutions for delivering care for older people. Country-specific problems tend to follow the dividing lines of these system compartments, with the division between social and health care being particularly prominent and the problems in the acute health care sector often taking centre-stage.

Member States should be encouraged to establish mechanisms and incentives to work across these two main pillars and their sub-sections, and to stimulate policy developments that encourage joint working and innovation at sector interfaces. Similarly, Member States should stimulate clear and co-ordinated policy responsibilities across local, regional and national levels.

Future work on good practices, indicators and benchmarks should pay particular attention to integrated care approaches and to the contribution of integrated service provision to improving access, quality and financial sustainability of services. They should also be concerned with improved outcomes for older people and their carers.

Embracing a whole system approach

In designing and delivering long-term services for older people, national policies should incorporate a whole systems approach, including perspectives on:

- client-centred design and provision of services
- seamless service delivery within and across all relevant settings
- collaboration across sectors, including families and informal carers
- provider pluralism (statutory, voluntary, private, etc.)
- local, regional and national responsibilities for provision and funding
- support measures for carers
- streamlining care policies with other policy areas, such as housing and transport, employment, social security and pensions, and education.

Values and principles

In developing national policies, Member States should be encouraged to build on values and principles that promote older people's control and independence, equitable access, and long-term rather than short-term solutions. National policies should also reinforce active ageing, citizenship and inclusive and non-discriminatory approaches. Older people, carers, and organisations representing them should be directly involved in the development of policies at local, national and European levels.

CARMEN's policy framework as a frame of reference

CARMEN's policy framework on integrated care for older people[16] builds on these values and principles. Respecting national responsibilities and systems, it offers a guide or checklist for the development of national policies and action plans on integrated care. It could be used as a frame of reference and source of inspiration for further co-operation between Member States in developing long-term integrated care for older people with complex needs.

Carers

The contribution of informal carers to the provision of long-term care arrangements is considerable. Informal carers provide the lion's share of care. Structural support for informal carers is essential in ensuring that older people can remain independent in the setting of their own choice. Against the backdrop of the demographic developments in the EU and the growing pressure on informal carers to participate in the economic workforce, support for informal carers is also essential to avoid further pressures on the professional care system and on carers themselves.

Support for carers should include practical, emotional and financial measures. This includes employment policies that allow for flexible arrangements enabling people to combine caring responsibilities with paid employment. If the ageing workforce of Europe is to stay in employment until a later age, as well as to be able to provide informal care and support for their partner or friend, it is particularly important to address this issue.

[16] Banks, P (2004). *Policy Framework for Integrated Care for Older People*. London: King's Fund

Support for carers should also include adequate social security policies to financially compensate carers. Policy for informal carers should be coherent with other policies relating to health and long-term care.

Human resources

It is vital to have a sufficient number of trained professionals and to give them quality jobs in order to meet the challenges posed by demographic trends and technological progress.[17] However, the low status and poor payment of care work, shortage of personnel, lack of training or inadequate training, work pressures, etc. all put a strain on care provision. Tackling these issues may well result in more people opting for a professional career in care work. It may also motivate qualified professional care workers who have previously turned away from work in the care sector to re-enter the caring profession.

Integrated and holistic approaches to service provision should be encouraged, making more effective use of scarce resources, offering new roles which combine professional skills and stimulating better job satisfaction.

Similarly, further development of 'e-Health' should be encouraged to improve the productivity and effectiveness of care provision, but also to support informal carers and older people themselves. The potential contribution of ICT to assist older people and carers in the home setting deserves more attention (see also section 'Information Society').

Specific comments with respect to the proposed broad objectives of access, quality and financial sustainability

As the Commission has already pointed out,[18] the three proposed objectives for developing care systems in the EU (accessibility, quality and financial sustainability) are mutually dependent. This is also reflected in the comments presented below.

[17] COM (2004) 304 final. 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 co-ordination'.

[18] idem.

A good balance between the three objectives

European economic and social objectives should be in balance to protect vulnerable citizens and to achieve a positive outcome for older EU citizens in all Member States. Whilst recognising the relative importance of economic drivers within the EU framework, the challenge posed by financial sustainability should not be met at the expense of key European social values such as fairness and solidarity, or of quality of care. Also, short-term financial gain should not prevail over solutions that will lead to more sustainable economic and health gains in the longer term.

The Commission's views support this need for a longer-term, balanced perspective: 'For European citizens, access to affordable high-quality health care is one of the benchmarks of successful modern governance. In many ways, the long-term health of the European economy will depend on the health and longevity of its citizens. In political terms the broad subject of health is all too often seen in a negative light. We need to fundamentally challenge this thinking. A new perspective on health as a productive force in economic prosperity needs to take hold in Europe. Well-managed health systems are positive, forward looking investments.'[19]

Empowerment for everyone?

The current debate about empowering clients tends to focus on developing instruments that seem better suited for clients with more social, intellectual and physical resources befitting the role of critical consumer. A disproportionate percentage of services, however, are needed by frail, very old people with multiple needs.

Within Member States, solutions should therefore focus on establishing a client-centred system with a range of attractive and suitable options for all older people, including vulnerable people with multiple needs, regardless of socio-economic status, ethnicity, gender or lifestyle.

Policies that seek to increase choice by encouraging older people to become purchasers need to go hand-in-hand with mechanisms that provide them with the necessary information and support to take on this role. If this does not happen these policies may lead to increased inequalities in access. People with less education, verbal skills, assertiveness, or socio-economic resources may be particularly vulnerable in this respect.

[19] EU Commissioner David Byrne: speech delivered at the European Health Forum, Gastein, 2003.

Co-payments and access

The introduction and/or the increase of co-payments as a method to reduce demand or reduce public expenditure should not block people from accessing the care they need. It should also not lead to unequal access or an increase of health inequalities. Measures should be taken to counter possible adverse effects to this regard.

Limited care packages: effects on independence, access and longer-term costs

In an attempt to reduce public expenditure on health, some countries reduce the range of services their citizens are entitled to within social health insurance or tax-funded structures. Domestic services and other forms of social care provided in the home setting are particularly at risk of either being scrapped entirely from the basic package or only being provided through the introduction or intensification of co-payment arrangements.

This may undermine older people's wish and ability to continue to live independently and could lead to unnecessary and more expensive in-patient or residential care. Also, more people may have to take supplementary health insurance or purchase private services to cover the care and support they need. This puts a great financial burden on older people in need of health and long-term care. Every person, irrespective of his or her age or state of health, should have the right to insurance cover.

Increasing burden of costs for living and housing

Costs for health and social care are becoming increasingly separated from costs for housing and living, the latter being perceived as the individual's own responsibility. This 'great divide' resonates in the systems of most countries and certainly in the concerns of many older people. With increasing pressure to deliver services outside residential or acute hospital settings, urgent steps need to be taken to ensure older people do not fall into this financial gap.

Evaluating direct purchasing

Across Member States, the objective of increasing choice is predominantly implemented through the introduction of various forms of 'benefits-in-cash' or 'direct purchasing' schemes. Most of these still have an experimental status and only apply to a limited range of services. Thorough evaluation is needed to establish whether these mechanisms indeed contribute to more choice in accessible, high-quality care provision for older people in all socio-economic strata.

Need for quality measurement tools

In most countries, quality policies and assessment tools are much more developed in the acute health care sector than in social services and the long-term care sector. This imbalance needs to be addressed, particularly in areas such as consumer involvement and client information, and should also include planning, monitoring and evaluation of quality of life. More attention should be paid to the implementation of standards and accountability of those involved in that process.

Involvement from CARMEN

CARMEN has been pro-active in linking with the Commission following the publication of their December 2001 Communication[20] and continued the dialogue at the final CARMEN project meeting on policy issues. The strategy proposed by the Commission and the CARMEN project have some obvious common denominators as they both:

- support accessible, high-quality and affordable services for older people
- encourage mutual learning
- identify problems relevant across the EU
- seek to find ways to tackle them
- respect national responsibilities and system differences.

The expertise and experience of CARMEN from across 11 Member States should contribute towards current and future discussions concerning policies relating to social protection systems for older people and their family carers. The multi-stakeholder views on trends, problems and challenges identified through CARMEN add cross-national perspectives to the national responses provided by the Member States. The same holds true for the wide range of innovative solutions and good practices the project has assembled.

Through EHMA, the CARMEN network aspires to function as an instrument for the involvement of key stakeholders in further progress made within the EU social protection agenda both at national and EU level, and as a testing ground for common objectives and indicators should these be developed through future collaboration processes between Member States.

[20] COM (2001) 723 final.

2 The broader social policy agenda: relevant perspectives for integrated care

All three main objectives suggested by the Commission in their report on health care and long-term care for older people can be linked to other elements of the EU social agenda, such as social inclusion, employment, social protection and pensions, and gender equality. With the exception of gender equality, these social policy areas are already subject to collaborative mechanisms through the open method of co-ordination. Further elaboration on streamlining co-operation between Member States across these policy areas, including health care and long-term care for older people, provides a unique opportunity to support a mutually reinforcing policy framework.

National Action Plans (NAPs) set up by Member States to deliver common social policy objectives need to reflect an awareness of these mutually reinforcing mechanisms. NAPs need to address how the social policy areas that are, or will be, subject to the open method of co-ordination will support each other, and they should include specific objectives to this regard. Consequently, NAPs should also allow for the implementation of activities that enable the positive contribution of health and long-term care to other social policy areas, and vice versa.

Compartmentalisation and decentralisation can pose considerable challenges to the achievement of key social policy objectives, and particularly to the delivery of integrated services (see also section 'Supporting national strategies' above). This may be further complicated by the streamlining of policy areas. By their very nature, NAPs can accommodate for the specificity of health and social care systems in Member States. They should stimulate co-ordinated policy and action across local, regional and national levels, maximising the potential of approaches at each of these levels.

Support for further development of the whole system of integrated care provision through EU economic and social policy, for instance through the Structural Funds, would be extremely welcome. This is particularly relevant for the development of services outside hospital and residential settings, and for the encouragement of integrated care arrangements.

Social inclusion

As pointed out in the recommendations with regard to common objectives for developing care systems in the EU, several policy instruments to reduce public

health care expenditure and increase the costs borne by individual citizens themselves could have a negative impact on access for people with less socio-economic resources. They also pose a danger to social inclusion objectives, as older people in need of long-term support or care may have to spend a disproportionate amount of their resources on care, similar to people with disabilities or chronic illness. Older people may also be forced to sell their house or move away from their own neighbourhood, putting them at risk of social isolation.
Measures should be taken to prevent poorer health leading to impoverishment and low income, restricting access to care.

Older people in long-term care could be at risk of social exclusion, as could their informal carers. EU programmes aimed at tackling social exclusion should facilitate projects that prevent this from happening and that encourage social participation and independence.

The EU Internal Market policies are creating new dimensions to the quest for sustainable solutions for high-quality, accessible and financially sustainable health and long-term care. Providing opportunities for mobility of services, people, professionals and capital, the Internal Market could be instrumental in alleviating increasing friction between service demand and supply that exists in many countries.

In earlier research funded by the EU,[21] EHMA has highlighted the tension between social policy objectives and market forces and the potential negative effect of market forces on equity and access. While, through the Internal Market, the EU framework may create positive opportunities for care systems, through its social policy the EU should also safeguard against potential negative effects.

Employment

Improving access to and quality of care is instrumental in mobilising the potential of the workforce. Hence, care policy should be acknowledged as a tool for active employment and as a key contributor to economic development. It increases the social and occupational integration prospects of jobseekers.[22]

Health and social care are major employment sectors, representing around

[21] The Impact of Market Forces on Health Systems. EHMA, March 2000.
[22] Brenner, H (2002). *Unemployment and public health*. Final report ordered by the European Commission.

10 per cent of total employment in the EU 15. Member States should actively stimulate employment and career opportunities in these sectors and encourage measures aimed at sustaining the workforce. This would include further education and training, accrediting prior learning or caring skills, and improving the attractiveness of professional caring as an area of work.

The Lisbon agenda, aiming to create a competitive and dynamic knowledge economy, has put considerable emphasis on the importance of 'high-tech' means to achieve this and on stimulating education and employment in ICT, industry and research. However important, this approach should be balanced by an equally important effort to encourage people to choose a career in a profession that has less of a high-tech image, such as social care.

Whilst the implementation of the Working Time Directive[23] can contribute to better working conditions and a more sustainable workforce in the health and social care sectors, it is also bringing about more pressure on existing staff shortages.

In a society that combines an ageing population with a modern workforce, most potential carers will not be freely available as they are engaged in employment, education or both. A system that fosters the role of carers thus needs policies in place that enable people to combine work and caring responsibilities.

Measures designed to support longer working lives should take the position of older family carers into account and protect them from pressures to meet both caring and economic responsibilities.

When in employment, carers need to be able to work part-time, take carer's leave, or at least be allowed to work flexible hours. The professional care sector should provide respite services to support informal carers participating in paid employment.

Social protection and pensions

Many Member States are increasing co-payments in their health systems to reduce demand and public expenditure. The Commission should call on Member States to co-ordinate pensions and other forms of financial social security on the one hand and co-payment arrangements on the other. Accumulation of co-payments in health and social care should not lead to poverty (see also 'Social inclusion' above): if health systems require older people to contribute more towards the costs of their care, they should be enabled to so.

[23] WTD 93/104/EC (5188/04).

Informal carers should not have to face repercussions in terms of pension rights, income and/or social isolation if they take on caring responsibilities. One way to facilitate this is through a carer's allowance that is not earmarked as social benefit but as income.

Gender equality

Compared to men, the life-expectancy of women is higher and women can also expect to live more years in ill-health. Consequently, their need for health care and long-term care services will be higher. At the same time, their pensions and other financial resources are often less than those of men. The financial position of older women may therefore make them particularly vulnerable to adverse effects of cost-shifting from public to individual budgets and reduction of publicly funded standard care packages.

Insofar as women also form the majority of informal carers, their financial resources may be particularly endangered if no arrangements are made to ensure their income position and employment rights.

3 Internal Market policies

Patient mobility

In following up the various recommendations that emerged from the High Level Process of Reflection on Patient Mobility and Healthcare, the focus should be on the whole system of health and social care, not on acute and hospital care only. A limited focus will lose sight of many challenges posed by Internal Market opportunities, including the increasing flow of older people seeking semi-residential services abroad, and the increasingly diverse group of people moving across borders to offer their services in privately purchased home care arrangements.

The proposed High Level Group on Health Services and Medical Care should include experts and stakeholders from the social care sector as well as the health care sector in order to oversee the whole range of services that citizens can now access abroad as a consequence of rulings from the European Court of Justice (ECJ). It might also include representatives of older people, patients and carers.

For patients who have received part of their treatment abroad, measures have to be taken to ensure sufficient quality, access, and continuity of care. Case-management and communication issues deserve particular attention. Patients should not be denied access to post-hospital care in their home country as a result of having received treatment in another country.

Services

In recognising the right of patients to benefit from reimbursement in the case of medical treatment dispensed in another Member State, the ECJ has made a distinction between hospital and non-hospital care. In an attempt to translate the ECJ rulings into secondary Community legislation, the Commission's proposal for a Directive on services in the Internal Market would reinforce this distinction in all Member States, as well as provide a universal definition of hospital care across the EU. Measures should be taken to guard against negative effects of Community legislation on health system compartmentalisation, and on opportunities for integration and innovation across sectors.

4 Information Society

The EU's Information Society policy and programmes are an example of how integrated care objectives can be advanced through targeted efforts within other policy areas.

Until now, the 'e-Health' label has primarily been applied to look at the promotion of ICT applications in the health care sector, in patient education, and citizen information on health issues. Innovation and application of ICT in the social care sector and more particularly in care provision in the home setting deserves more attention. Developments with respect to telemedicine, telehealth, telemonitoring and smart housing could help alleviate capacity problems in both professional and informal care and could also be instrumental in supporting older people to live independently in their own homes.

Furthermore, information technology with standard performance indicators should be provided to facilitate the planning, monitoring and evaluation of integrated care and should assist benchmarking between and within Member States.

Appendix: CARMEN participants

During the course of the CARMEN project, the following participated as members of the network. Those marked with an asterisk (*) were members of the management committee:

Eirini Agapitou, Kapi Neos Kosmos, Greece

Bengt Åhgren, Bohlin and Strömberg, Sweden

Tiina Autio, Association of Care Giving Relatives and Friends, Finland

Penny Banks*, King's Fund, United Kingdom

Brigid Barron, Caring For Carers Ireland, Ireland

Judith Bell, Moorlands Primary Care Trust, United Kingdom

Philip C Berman*, European Health Management Association, Ireland

Cinzia Canali, Fondazione Emanuela Zancan, Italy

Jan Coolen*, Netherlands Institute for Care and Welfare, The Netherlands

Pip Cotterril, Manchester Health Authority, United Kingdom

Mia Defever*, School of Public Health, Catholic University of Leuven, Belgium

Christopher Drinkwater, Centre for Primary and Community Care Learning, University of Northumbria, United Kingdom

Marie Faughey, South Western Health Board, Ireland

Stelios Fragidis, Greek Alzheimer's Association, Greece

Annemiek Goris, Netherlands Institute for Care and Welfare, The Netherlands

Pieter Huijbers*, Netherlands Institute for Care and Welfare, The Netherlands

Swanehilde Kooij, Netherlands Institute for Care and Welfare, The Netherlands

Penny Lamprou, Grevena State Hospital, Greece

Paula Lawler, South Western Health Board, Ireland

George W Leeson, DaneAge Denmark

Gunnar Ljunggren*, Karolinska Institute, Sweden

Del Loewenthal, Centre for Therapeutic Education, School of Arts, University of Surrey, United Kingdom

Kent Lofgren, Svenska Kommunfoerbundet, Sweden

Carmen Martin Loras, Instituto Migraciones y Servicios Sociales, Spain

Christine Marking, AGE, Belgium

Eddie Matthews, Northern Area Health Board, Ireland

Milla Meretniemi, National Research and Development Centre for Health and Welfare (STAKES), Finland

Mónica Morán Arribas, Consejería de Sanidad Madrid, Spain

Ingrid Mur-Veeman, University of Maastricht, The Netherlands

Henk Nies*, Netherlands Institute for Care and Welfare, The Netherlands

Niall Ó Cléirigh, East Coast Area Health Board, Ireland

Elisabeth Petsetakis, National School of Public Health, Greece

Richard Pieper*, University of Bamberg, Germany

Marja Pijl, Eurolink Age, The Netherlands

Janice Reed*, Centre for Care of Older People, University of Northumbria, United Kingdom

Sari Rissanen, Dept of Health Policy and Management, University of Kuopio, Finland

Francisco Sanchez del Corral, Equipo de Soporte y Apoyo en Domicilio (ESAD), Spain

Nicoline Tamsma*, Netherlands Institute for Care and Welfare, The Netherlands

Enrique Terol Garcia, INSALUD, Spain

Michel Tombeur, University Hospitals, Catholic University of Leuven, Belgium

Judith Triantafillou*, National School of Public Health, Greece

Magda Tsolaki, Greek Alzheimer's Association, Greece

Marja Vaarama*, National Research and Development Centre for Health and Welfare (STAKES), Finland

Jaakko Valvanne, City of Helsinki Social Services Department, Finland

Arjen van Ballegoyen, Boer and Croon Strategy and Management Group, The Netherlands

Babs van den Bergh, Boer and Croon Strategy and Management Group, The Netherlands

Paul van Rooij, Zorgverzekeraars Nederland, The Netherlands

Tiziano Vecchiato*, Fondazione Emanuela Zancan, Italy

Erwin Winkel, Arcares, The Netherlands

Yvonne Witter, Coordinatie-orgaan Samenwerkende Ouderenbonden, The Netherlands