

CONSULTATION ON THE GREEN PAPER ON HEALTHY AGEING AIM'S ANSWER

This paper gathers AIM's full answer to the European Commission consultation on the Green Paper on Ageing. Some examples of best practices from the mutualist sector have been listed under some of the questions in the sections "Some inspiration from mutuals". They provide concrete examples on the type of action that can be taken. Annexes have been added at the end of the document for more details on some specific aspects covered by the Consultation.

Note that not all questions have been answered.

The answer to this consultation is based on AIM recommendations on the Green Paper (amongst others), which can be found in Annex 1 of this paper (p.15).

CONSULTATION

1. How can healthy and active ageing policies be promoted from an early age and throughout the life span for everyone? How can children and young people be better equipped for the prospect of a longer life expectancy? What kind of support can the EU provide to the Member States?

Health literacy and risk factors: Active and healthy ageing requires a health in all policies approach, involving a wide variety of actors – like national, regional and local governments, service providers, civil society, the private sector, organizations for older people, academia and older people, their families and friends – from a wide range of sectors - including health, finance, long-term care, social protection, education, labour, housing, transport, information and communication. Actions to prevent disease, to promote health, to maintain intrinsic capacity and to enable functional ability should take place throughout the life cycle of a person and start from a very early stage. Raising levels of health literacy, aiming specific target groups (e.g. age groups) starting in schools, and acting on risk factors (healthy diets, physical activity, alcohol, tobacco, etc.) are key to achieve healthy ageing. The proper implementation of the EU Cancer Plan can be a game changer in that respect.

Health-promoting environments: Achieving health-promoting environments should be another key priority. By acting on its internal market and regulating aspects such as food reformulation, marketing, labelling, and taxation, the European Commission can truly make a difference in improving the health of its citizens. Its role goes thus far beyond supporting Member States. In the same vein, promoting age-friendly environment should also become a priority, notably when it comes to EU funding programmes. Urban planning, labour market integration, the creation of collective spaces to encourage meetings and forge social relationships, encouraging healthy mobility... Those actions contribute to break solitude, boost intergenerational solidarity and "demedicalise" social problems by focussing on the key role environments play. Health, well-being, autonomy, and dignity should be cornerstones of such environments.

The social determinants of healthy ageing: Health inequities, education, employment and income are factors which influence each other and have a tremendous impact on an individual's health and well-being. The reduction of those inequities through a proper implementation of the principles of the Pillar of Social Rights is a sine-qua-non condition to healthy ageing. The European Commission has a key role to play in supporting Member States in the implementation of the Pillar through its financial instruments and via the exchange of best practices. It also has the responsibility to monitor their progress through the European Semester process and the Social Scoreboard.

Some inspiration from mutuels

Ageing well: FNMF takes action

Every year, the Mutualité Française devotes more than a third of its prevention activities to the elderly and to ageing well.

The main objectives of these awareness-raising and primary prevention actions are to keep ageing people in good health, to limit the consequences of loss of autonomy and to maintain social links. Their prevention network deploys several actions whose objective is to promote social ties in order to combat the isolation of the elderly. (Many examples are included in this paper)

In this context, the "Mutualité Française Occitanie" has developed its action: "Tales and Lands". This action is proposed in isolated territories (rural or white zone). The aspects of storytelling around culture and social ties are implemented during a walk. This "storytelling walk" format makes it possible to raise awareness of the benefits of walking among people with a profile other than that of hikers, or walkers who practise a regular physical activity. Finally, the context of a friendly meeting allows the promotion of a preventive discourse on physical activity (during the walk) and diet (during the snack). The objectives of that action are to promote social links and exchanges through the enhancement of the department's heritage, to develop the ability to construct psychosocial representations, and to promote the practice of physical activity for health.

2. What are the most significant obstacles to lifelong learning across the life-cycle? At what stage in life could addressing those obstacles make most difference? How should this be tackled specifically in rural and remote areas?

Lack of resources for reskilling and upskilling: AIM encourages the European Commission to mobilise the necessary investments for reskilling and upskilling the EU workforce in its Recovery Plan and multi financial framework for 2021-2027. AIM also invites the European Commission to ensure a clear correlation between the Semester and the Multi-Financial Framework in to make sure that investments meet the goals set in its Programme and, amongst others, its Pillar of Social Rights which promotes "the right to quality and inclusive education, training and life-long learning in order to maintain and acquire skills that enable them to participate fully in society and manage successfully transitions in the labour market."¹

AIM encourages also the European Commission to deliver on the actions listed in its Skills Agenda for Europe. The digital skills of younger generations need to be improved and education systems should adapt to emerging technologies. Education systems need to be in constant evaluation and adaptation

¹ [European Pillar of Social Rights](#), p. 11.

to upcoming changes. Improving skills and allowing life-long learning will also be key in bridging the digital divide and making thus sure that technological development does not exacerbate inequities.

EU education and training programmes for all: An enormous attention and budget goes to programmes like Erasmus, which focus mostly on youth. While those are highly valuable programmes for younger generations, continuous investment in programmes targeting older generations is also necessary. In addition, some EU grants and funding like the European solidarity corps could be open to older people. More general attention should also be devoted to for instance citizenship education.

3. What innovative policy measures to improve participation in the labour market, in particular by older workers, should be considered more closely?

Inclusion of people with disabilities: All EU and national level legislation must guarantee that there is no form of discrimination based on health or disability status, concerning all forms of employment, including recruitment, hiring, employment, career advancement and safe and healthy working conditions. AIM encourages the implementation comprehensive and coordinated health and safety policies both at EU and national level to implement the active inclusion of people affected by mental illness and chronic diseases in the labour market. Those policies include measures enabling those with failing health or disabilities to participate and contribute, encouraging employers to offer flexible working practices in order to help workers to remain in employment for longer, and strengthening the knowledge of employers in supporting work ability and return to work after sick leave. The Employment Equality Directive must be fully implemented with targeted support via EU funds, appropriate legislative frameworks, and exchange of practices to support the labour market integration of groups in disadvantaged situations as part of active labour market policies.²

4. Is there a need for more policies and action at EU level that support senior entrepreneurship? What type of support is needed at EU level and how can we build on the successful social innovation examples of mentorship between young and older entrepreneurs?

Some inspiration from mutuals

SVLFG seminars on business handover

For years, the SVLFG, a German “Krankenkasse” covering farmers, has been successfully conducting so-called business transfer seminars (now also as online events). With the handover of a business, the course is set for the future of a company, but also for the satisfaction and health for the older and younger generation. A poorly regulated business handover can lead to emotional stress for the whole family and, in the worst case, to illness. The seminars include legal information, family processes during the handover, expectations and communication, performance in old age, and answers to the question of how things could continue after the handover. It is also designed to be interactive. There is a dialogue with new handovers as well as a roundtable discussion with former seminar participants who have successfully completed their handover. There is also the opportunity for individual consultation with the speakers.

² [RECOMMENDATIONS FROM THE RARE 2030 FORESIGHT STUDY THE FUTURE OF RARE DISEASES STARTS TODAY ACTIVE SUPPORT TO EMPLOYMENT](#)

5. How can EU policies help less developed regions and rural areas to manage ageing and depopulation? How can EU territories affected by the twin depopulation and ageing challenges make better use of the silver economy?

[See Annex 2 for our full recommendations on medical deserts – p.29]

When it comes to healthcare, a key challenge for certain rural areas is the lack of access, also called medical deserts. To tackle that challenge:

The EU should encourage the establishment of more integrated and collaborative care models by providing recommendations and guidelines to Member States. AIM suggests to propose an Action Plan for the EU healthcare and long-term care workforce. Better coordination between healthcare professionals is part of the solution to medical deserts, through for example the development of multi-professional medical centres, the transfer of competences, or the creation of new care roles. The EU funding mechanisms like the Regional Funds could contribute to establish those centres.

The European Commission and Member States should ensure that both the general population (especially older generations) and healthcare professionals acquire the necessary skills to properly use innovative tools and make the most of innovation. In the same vein, rising the levels of health literacy of individuals in order to achieve higher levels of empowerment is essential. eHealth and telemedicine can contribute to bring care to remote areas, allow for care to happen at home if wished, improve efficiency and to support carers in their tasks. However, to be able to rely on innovation, problems of infrastructure need to be solved and the digital divide must be bridged.

The European Commission and Member States should improve cross-border collaboration and involve both local and national authorities in the implementation of any solution. They should also ensure that citizens are properly informed on their rights. On the one hand, rural areas sometimes are located in border areas and coordination of care delivery is then beneficial. Improving the recognition of and the support to care professions, as already done for healthcare professionals³, is necessary to facilitate a cross border mobility (for both training and later career). On the other hand, collaboration between healthcare professionals in the same spirit of the European Reference Networks can be an added value. The dynamic of collaboration within these ERN's and lessons learned up to know should allow the Commission to investigate whether this tool could be used on exchange on non-communicable diseases.

On top of ERNs, the Interreg funds should encourage those type of exchanges at the "local" level.

The EU should put its Funding Instruments, its EU4Health programme but also its Rural Development Programme and Cohesion funds at the service of the improvement of accessibility to healthcare and long-term care services in rural areas and to the development and implementation of concrete solutions. The Rural Development Programme is key in making rural areas more attractive to younger generations and to contribute to their economic development. Ensuring access to essential services should be another of its core objectives. Cohesion funds contribute to develop cross border projects (which guarantee access to essential services), and to stimulate potential for development of cross border rural areas.

³ See Directive 2005/36/EC on the recognition of professional qualifications

7. Which services and enabling environment would need to be put in place or improved in order to ensure the autonomy, independence and rights of older people and enable their participation in society?

Fighting Ageism: Ageism affects both young and old. Ageism can cause isolation, inappropriate care and medication or abuse. It also imposes barriers in policies and programmes in sectors such as education, labour, health and social care and pensions, as it influences the way problems are framed, the questions asked and the solutions offered. Ageism therefore marginalizes older people within their communities, reducing their access to services. The pandemic has shown that there is still a lot to do when it comes to fighting stigma and negative attitudes related to ageing.

To contribute to tackling ageism, AIM encourages the European Commission to propose a Mental Health Strategy for the Union, taking into account the cross-sectoral impacts of different policies on mental health. This strategy should follow a life-cycle approach, and include older age needs and concerns.

Empowerment of older people and involvement in decision-making processes: AIM believes that older people should be involved in any decision-making processes which direct- or indirectly have an impact on their lives. Older people should have opportunities to contribute to society and the labour market if they wish to. They should remain in control of their own life and care as long as possible. To achieve proper integration and involvement, there is a clear need for a change of mind-set from all sectors in society, which should consider the many strengths of older generations rather than their weaknesses and limitations.

eHealth and Telemedicine: eHealth and telemedicine can contribute to bring care to remote areas (ensuring people's right to qualitative care); allow for care to happen at home if wished, supporting people's autonomy. However, to be able to rely on innovation, problems of infrastructure need to be solved and the digital divide must be bridged. Most rural areas lack a stable and fast internet connection. The next generation broadband access can help bridge the urban-rural divide in the digital area. Healthcare concerns but also data privacy and ethics must remain at the centre in the development of those infrastructures and of innovative tools and technologies. The European Commission should take responsibility in ensuring those concerns are a priority while encouraging the development of innovative tools for care delivery and involving healthcare payers and patients in the process.

Regarding the digital divide, the European Commission and Member States should ensure that both the general population (especially older generations) and healthcare professionals acquire the necessary skills to properly use innovative tools and make the most of innovation. At the same time, rising the levels of health literacy of individuals in order to achieve higher levels of empowerment is essential.

Some inspiration from mutuals

OKRA : an Association of, for and by people over 55

[OKRA](#) is an association of, for and by people over 55. It gives people opportunities to meet people of your own age and to participate in activities together, allowing them to develop their talents, remain active and be able to participate in the ever-changing world. The ultimate goal is to achieve a warmer society for all. OKRA (which stands for Open, Christian, Respectful and Active) is based on the following values: solidarity, justice, equality and solidarity. Vulnerable groups receive extra attention. Volunteers organise the majority of activities at OKRA.

Individuals can also come to OKRA for questions and advice about their pension and healthcare. It also provides information and support regarding mobility, et. It also ensures to make the voices of the 55-plussers heard in decision-making. The EESC awarded OKRA with the Citizens' Solidarity Prize for its original initiative "Resilience", designed to encourage older people during the COVID-19 pandemic and to ensure that they are not forgotten.

The Christelijke Mutualiteit is a partner of the Association.

Better care at home: FNMF's project

Since September 2019, the "Fédération Nationale de la Mutualité Française" (FNMF), in cooperation with French Red Cross and *Hospitalité Saint Thomas de Villeneuve*, has developed a [project](#) aimed at providing adapted care to older people at home, in a safe environment and with the assistance of trained professionals. The project, developed with the various departments of the Ministry of Health, aims to experiment with enhanced home support services for the frail elderly. It is based on a common model which relies on three principles:

- Coordination of the actors and systems involved in home care: The operational coordination of the players working with the elderly (home help service, doctor, physiotherapist, nurse, etc.) is a major aspect of the system. This coordination very often relies on a carer, or even on the elderly person themselves. The aim is to reproduce what is done in EHPADs (nursing homes- by the professionals in charge.
- The contribution of geriatric expertise from the EHPAD to the home: Under the impetus of the coordinating doctor and with the support of a multidisciplinary team of experts from the EHPAD, a geriatric assessment is carried out. On that basis, an adaptation of the home is proposed and a care plan established, which focusses on the maintenance of the capacities (cognitive, motor, social, etc...) of the elderly person.
- Securing the elderly person at home: The lack of security at home is one of the main reasons for entering an EHPAD. The scheme therefore provides for the installation in the home of connected objects adapted to the person's needs. These tools can be used to alert people to unusual situations (which may be a sign of danger to the person) and to trigger an intervention in their home 7 days a week, 24 hours a day.

Putting older people at the centre: "Mutualité française Hauts de France": Seniors in motion

The objective of this action is to fight against social isolation and improve the quality of life of seniors.

Several surveys have highlighted the need for information on health protection factors related to ageing pathologies, but also and above all their need to be listened to and recognised, their need for self-esteem, their desire to feel useful and the importance of feeling free in their thoughts to improve their quality of life. With those challenges in mind, a participatory programme was set up, which encourages seniors to think about long-term actions around ageing well. In this respect, a "Lunch Quiz" is organised. During a meal, participants answer questions on health issues that interest them, and then workshops are offered to think about actions to improve their quality of life. These workshops also aim to empower seniors but also local stakeholders to sustain health projects.

"Trittsicher durchs Leben" (Surefooted through Life): courses offered everywhere in Germany

SVLFG has a special offer for elderly in rural areas, which tens of thousands of senior citizens have already taken advantage of. Independence requires physical and mental mobility. The important prerequisites for mobility and safe walking in everyday life are physical fitness, strength and balance. During the training in the "Trittsicher durchs Leben" (Surefooted through Life) courses, precisely these areas

are strengthened by appropriate exercises. In addition, after the last course date, the participants are advised about safety around the house and company. Through this offer, the health and participation of older people in particular is to be preserved until old age. The programme was developed in cooperation with the *Deutscher LandFrauenverband* (German Rural Women's Association), the *Robert Bosch Krankenhaus* in Stuttgart and the *Deutscher Turner-Bund* (German Gymnastics Federation). The programme is sponsored by the Federal Ministry of Education and Research. It is scientifically evaluated.

9. How can the EU support Member States' efforts to ensure more fairness in the social protection systems across generations, gender, age and income groups, ensuring that they remain fiscally sound?

Promoting Social Economy Actors: A clear role the European Union is to promote systems based on solidarity and social economy actors like mutuals. Mutuals make no risk selection on basis of age, gender or health status; they empower their members and adapt to the needs of their affiliates, who are also part of their governance. Their members are from all income groups, gender types, generations and age. Through participation in their governance, a higher degree of trust of the affiliates in the mutual model is achieved. The mutual model is highly resilient and faithful to the principles of the Pillar of Social Rights. Mutuals seek to provide access to healthcare and LTC for all, tackling inequities at their root and carrying out their social mission within and from communities.

10. How can the risks of poverty in old age be reduced and addressed?

Tackling inequities from an early stage: Poverty does not solely depend on financial resources and income. It is a multidimensional phenomenon which includes the notion of precariousness, lack of opportunities, denial of rights, vulnerability. It is dependent on many factors and includes access to heating, housing, employment, social participation but also access to education, to healthcare, long-term care or medicines, etc. The proper implementation of the principles of the Pillar of Social Rights, through an approach across the life-span, would greatly contribute to reduce the risks of poverty in old age.

Adequacy of pensions and minimum income schemes: While the financial aspect is not the only aspect to take into account, the adequacy of pensions plays a key role in alleviating poverty among the elderly, just as adequate minimum income schemes for those unable to work, temporarily or permanently - often because of care responsibilities towards children or elderly family members (mostly women). When it comes to pensions, their adequacy could be assessed more systematically in the European Semester. Inequalities in pension systems as well as the effects of pension erosion over time should be evaluated as well, which requires to analyse the situation of the oldest pensioners as well as on a gender basis.

Minimum income schemes can be strong potential social protection instruments to reduce poverty and social exclusion, decrease inequalities and increase labour market participation. They can constitute social protection safety nets of the last resort, particularly relevant in the period of economic crisis due to COVID-19. Reflections on minimum income should include aspects such as minimum wage in order to tackle the growing number of “working poor” and make work a viable prospect for those distant from the labour market. Such schemes could be considered as social investments that produce more advantages than disadvantages, both for Europe and for its nations, even at the economic level.

11. How can we ensure adequate pensions for those (mainly women) who spend large periods of their working life in unremunerated work (often care provision)?

Maternity leave and incapacity to work taken into account in pension calculation: The 15th principle of the European pillar of social rights (EPSR) is the right to a pension and equal opportunities for women and men to acquire that right. Unfortunately, the EPSR Action Plan does not set any objective regarding this principle.

More specifically, mutual health funds encourage the recognition of caregiver status. For example, in Belgium, each caregiver saves the community 1197€/month and 30% had to leave their job. Legal dispositions, such as thematic leaves with allowances considered for pension rights, should be encouraged, and supported by the European Union. European legislation should ensure that maternity leave, incapacity to work and disability periods are taken into account for the right to legal pension.

12. What role could supplementary pensions play in ensuring adequate retirement incomes? How could they be extended throughout the EU and what would be the EU's role in this process?

Strong statutory pension systems: Supplementary pensions, as the name suggests, should remain "supplementary". They are not the solution to ensure universal access to a decent pension for the entire population. It should be noted that when they are encouraged by tax deduction, they also have a cost for public finances. The European Union should support a strong statutory pension system part of social security.

Social economy actors to be supported: Pension systems are far from granting that necessary access at the moment. AIM therefore sees a role for supplementary pensions in contributing to cover the current gaps. Yet, not all supplementary pensions are the same. AIM believes that social protection, be it pensions, healthcare or long-term care, should not be marketized as it would leave most vulnerable groups with unmet needs. AIM believes that social economy actors, like mutuals, are perfect actors to take over those tasks as they are truly inclusive and based on solidarity. AIM therefore see a clear role for the European Union to promote systems based on solidarity and social economy actors like mutuals.

13. How can the EU support Member States' efforts to reconcile adequate and affordable healthcare and long-term care coverage with fiscal and financial sustainability?

The Pillar of Social Rights as a Steering Wheel: The revision of the social scoreboard and the proposal to deepen the analysis and extend the scope of the Joint Employment report can make a real difference in helping MS achieve qualitative, more efficient and sustainable LTC and healthcare services.

Changes in the labour market, demographic developments and the pandemic call for adaptations in the way social protections systems are financed and organised. The announced study on the future of the welfare state is a starting point in the discussions on how to reconcile adequate and affordable healthcare and long-term care coverage with fiscal and financial sustainability. The EU as a key role to play in steering that debate and ensuring that all stakeholders are involved.

Systems based on solidarity: There is a trend towards more and more privatisation and a market-driven approach to LTC in Europe. Private for-profit providers are increasingly contracted to deliver public services. Such a trend could exacerbate inequities, leaving the most vulnerable groups with unmet needs due to a lack of affordability and the potential implementation of systems which rely on risk selection.

As already mentioned above (question 9), a clear role the European Union is to promote systems based on solidarity and social economy actors like mutuals.

Health and personal assistance, a public good that must be managed outside the sphere of commerce: Health and personal assistance should be excluded from the competition rules of the internal market. A European directive on social services of general interest must clarify the concepts and their scope and confirm the social objectives of healthcare and assistance to people. Privatization of healthcare institutions for commercial purposes is contrary to the objectives of accessibility.

Ensure access to medicines: Access to pharmaceuticals is a key aspect of healthy ageing. Medicines represent at least 17.6% of the healthcare budget expenditure in Europe⁴. In addition, high-cost medicines represent a risk for patients, who might be exposed to out-of-pocket payments, as well as for social security systems' financial viability. To ensure sustainable access to pharmaceuticals for all, the European Union must work to improve the transparency of underlying medicines costs, as a way to ensure fair prices of medicines and medical devices on throughout Europe. AIM's [model for fair pricing describes our recommendations](#).

EU as a Knowledge Broker of eSolutions: Information and technology services can contribute to strengthen prevention interventions, reach more efficient LTC delivery, improve the coordination of care, and provide support to LTC users and their carers and families... Yet, to be a real added value to people's lives, those solutions are to be developed together with users. Payers are also to be included in the process. Not only will they bear the costs but they are also aware of the needs of their affiliates and can help set priorities which would contribute to guaranteeing the sustainability and accessibility of services. The EU should play a role in boosting the development of those technologies while ensuring that all stakeholders are included in the process, that the rights of individuals are safeguarded and that their literacy is boosted.

14. How could the EU support Member States in addressing common long-term care challenges? What objectives and measures should be pursued through an EU policy framework addressing challenges such as accessibility, quality, affordability or working conditions? What are the considerations to be made for areas with low population density?

[See annex 3 for our complete recommendations regarding long-term care challenges – p.34]

The EU should:

Ensure that data on LTC gathered across Member States is comparable: An initial measure in achieving comparable data is the establishment of EU indicators for LTC.

Establish common needs assessment and eligibility criteria: AIM would welcome EU guidelines on needs assessment and eligibility criteria for LTC. They could support Member States in the establishment of public national standards. Such an initiative is key, in our view, to fight inequities between and within Member States.

Set minimum quality requirements for providers and develop European outcome indicators for the assessment of LTC: Minimum quality requirements for providers should be set at European level to contribute to guarantee high quality levels of care. These requirements have to be developed outside commercial goals by public authorities and scientific societies. Developing outcome indicators at European level could encourage objective and standardised assessment of LTC, which in turn would

⁴ <https://data.oecd.org/healthres/pharmaceutical-spending.htm>

allow the collection of comparable data across MS. Those indicators would also allow to better integrate the monitoring of LTC systems within the European Semester process.

Establish a Steering Group on LTC: There is a clear added value in discussing challenges at European level. The European Commission could establish a Steering Group on LTC, similar to the existing one on health promotion and disease prevention. It would facilitate the exchange and the implementation of best practices. It could also contribute to ensuring better integrated care and look into new care roles.

Propose a new Action Plan for the EU Health and LTC workforce: AIM calls for a proposal of new Action Plan for the EU Health and LTC Workforce. The Action Plan should ensure a proper integration and funding of workforce-related issues in the new EU4Health Programme and in other funding, call for the establishment of an EU Joint Action on forecasting health and LTC workforce needs for effective planning, and have a clear link to the Updated Skills Agenda. It would establish an EU-wide collaboration on updating skills of both the health and LTC workforce.

The plan should support Member States in training healthcare and assistance professionals. It should also encourage proper working conditions across the EU in order to avoid massive mobility which empties some MS from their workforce and reinforces inequalities within the EU.

Ensure a clear working status and proper working conditions for informal carers: It is key to guarantee that carers enjoy proper working conditions and a better work-life balance. This would benefit both carers' and LTC beneficiaries' health, which in turn will be beneficial to healthcare and LTC systems as a whole. AIM calls for a comprehensive Strategy which would both address carers' needs and ensure comprehensive support to informal carers.

Encourage task shifting, including in legislation on health professions: In order to take into account a series of recent developments and to anticipate future trends in care such as patient autonomy, integrated care and multidisciplinary collaboration, the arrival of new specialities and professions, new treatment methods, new communication tools, etc., the regulation of health professions should be adapted so as to encourage the delegation of tasks. To allow that shifting of tasks, a modification of legislation is indeed necessary in some Member States (e.g. law on health professions in Belgium) as certain acts are sometimes reserved to specific professions. The regulation of delegated acts should focus on skill profiles (experience-based) rather than on competence profiles (diploma-based). In principle, all acts can be delegated to the lowest possible profiles, including close carers. Only if there are medical reasons to do so, a detailed and justified regulatory prohibition of delegation may be introduced.

15. How can older people reap the benefits of the digitalisation of mobility and health services? How the accessibility, availability, affordability and safety of public transport can options for older persons, notably in rural and remote areas, be improved?

User-friendly and qualitative digital services: Technology and innovations, if put at the service of people, have a clear potential in supporting healthy ageing by improving prevention, supporting rehabilitation, allowing individuals to live better longer lives at home should they wish and supporting both formal and informal carers in their tasks. To unleash that potential, technology should be designed so as to take into account the needs, skills and limitations of older people and attention needs to be paid to bridging the digital divide. Patient safety, non-discrimination, patient-centeredness, data protection, privacy and dignity are other key aspects which should remain at the centre of discussions in this field. The main

objective of technologies should be to increase access to good-quality health and social services and to improve individuals' health and quality of life.

Health and Digital Literacy: High levels of health literacy strengthen the impact of health promotion and disease prevention actions on elderly. It empowers people to make the right choices for their health and well-being, to use healthcare services adequately while adopting healthier behaviours. In a world where many services turn digital (eGovernment and agencies, counters of many essential service providers like electricity or water, eBanking, etc), high levels of digital literacy are necessary to enable societal barrier-free participation and inclusion of older generations. No matter the services which are made available, people do need the necessary skills to use them adequately and in a timely manner.

Training of the workforce: It is vital to analyse the labour market and conduct needs-based planning to optimize current and future workforces. That would allow the development of a sustainable, appropriately trained, deployed and managed health workforce with competence in ageing, as well as more comprehensive person-centred assessments and the integrated management of chronic or complex health conditions. Improving the recognition of and the support to care professions, as already done for healthcare professionals⁵, is necessary to facilitate a cross border mobility (for both training and later career).

Some inspiration from mutuals

Digital literacy and the digital divide: Mutualité française Centre Val de Loire: on the road to digital!

The project "En route vers le numérique!" is part of the general fight against the isolation of the elderly through a reduction of the digital divide. The workshop is divided into five 2-hour sessions with about ten participants. The objectives are to promote digital access for people aged 60 and over, to be able to carry out research on the Internet; to know the tools of exchange (messaging, social networks), their interests and their limits with a view to combating isolation; to know the institutional websites of the social sector, in particular those concerning prevention and ageing well (CARSAT, Retirement Insurance, CPAM, MSA, Departmental Council, etc.); to be initiated into the use of the Internet to carry out certain administrative procedures; to acquire vigilance reflexes on the potential risks linked to the Internet: Relative reliability of certain articles / sites, advertisements and commercial offers, personal data, purchases on the Internet...

VyV: A service platform to tackle isolation and encourage intergenerational contact

As part of the health crisis, the VYV group, a union of several French mutualist actors, has launched a service platform called "[Objectif Autonomie](#)", which aims to reduce isolation. It is not only dedicated to older people, but there are specific sections for them (e.g. COVID19 senior service) and the services offered are also adapted to life situations outside covid: isolation, mutual aid between neighbours, bereavement support, personal services, mobility (car accompaniment), etc.

⁵ See Directive 2005/36/EC on the recognition of professional qualifications

French mutuals and remote assistance

Digital technologies, and in particular tele-assistance, are good tools for breaking the isolation and facilitating the maintenance of elderly people at home. It is, in fact, very useful for people leaving hospital, but also more generally for people losing their independence.

Tele-assistance aim is to enable a person living alone to benefit from a reassuring call system that works on two levels. First, in the event of an accident or sudden health problem, such as a fall, the person can be helped or rescued after the alarm is triggered. Second, if the person feels lonely and needs contact, the system can offer a social listening role. Some service providers include a regular discussion time when an employee of the platform calls.

The service requires a subscription. The cost, which gives entitlement to a 50% tax reduction, is generally between €20 and €30/month depending on the scope of the services selected. The duration of contracts varies according to needs: when leaving hospital or in the event of illness, remote assistance can be set up for a few days or weeks.

Some mutual insurance companies work through partner assistance providers (e.g. IMA) while others create their own solutions (e.g. *Novaxès* created by Harmonie Mutuelle, RMA and Harmonie Services Mutualistes).

16. Are we sufficiently aware of the causes of and impacts of loneliness in our policy making? Which steps could be taken to help prevent loneliness and social isolation among older people? Which support can the EU give?

Action throughout the life-span: The pandemic has made more evident than ever that loneliness and social isolation affect all individuals, regardless of their age. Preventive interventions should take place throughout the life-span, starting at a very early age. Promoting healthy habits, lifting the stigma on mental health issues and loneliness, tackling ageism... are actions that should be started in schools.

Access to high quality care: Risk factors of loneliness in old age include hearing loss, sight problems, cognitive impairment, depression... Access to mental healthcare is, as already mentioned, a key area in which the EU can play a role (see question 7). Access to quality and person-centred health and social care is another. Ensuring access to qualitative preventive and curative care contributes to prevent or slow down physical decline, which is a risk factor to isolation. Training physicians and social service providers to identify and deal with loneliness is also vital. In addition to care, hearing and vision aids should be made accessible to all.

Age-friendly environment: House design, public space planning, transport... Interventions on the environment play a decisive role in promoting social interaction. Member States should support communities to tackle isolation at the local level by mobilising all generations. The EU should encourage the development of age-friendly communities which promote healthy ageing and the inclusion and participation of individuals in society throughout their lives.

Technologies: Innovation can connect people and tackle isolation. To that end, it is key to improve the digital literacy of individuals, especially older generations, who might not be familiar with new technologies. Another important aspect is the digital divide and ensuring access for all to that innovation, especially vulnerable groups. In any case, technologies alone cannot solve the issue and should be used in combination with the other measures mentioned.

Evidence-based interventions: The EU should allow the exchange and identification of evidence-based best practice interventions across Member States. Along that process, the EU should build the necessary evidence to better understand the risk factors and the psychology of loneliness. As a second step and on basis of that exchange, the EU could develop a framework for loneliness interventions, with a specific focus on vulnerable groups at higher risk (disabled, people with long term conditions...).

Some inspiration from mutuals

Lifting the stigma: "Mutualité française Nouvelle Aquitaine": Séniors et alors!

The "Seniors et alors? cafés" are meetings organised in a café, which aim to fight against the isolation of the elderly. In a friendly setting, seniors are invited to express themselves around readings proposed by an artist and to exchange on their experiences, their emotions linked to the texts read

A [3-minute film](#) produced by Mutualité Française Nouvelle-Aquitaine shows that local action, relayed by mutual health insurance companies in the territories, which can help combat the isolation of the elderly.

MUTAC's foundation fights isolation

In 2013, the [French MUTAC](#) (funeral insurance mutual) created a foundation under the aegis of the Fondation de l'Avenir, whose sole purpose is to fight against the loneliness and isolation of the elderly in two ways: by supporting on the one hand medico-social studies and research (public survey on the French perception of isolation of the elderly, identification of indicators of psychological fragility of the elderly in a situation of isolation) and on the other actions in the field (Mutac Foundation Prize). The idea is to support researchers, to enlighten society on the consideration of this societal issue, while promoting the active forces that lead this struggle on a daily basis.

17. Which role can multigenerational living and housing play in urban and rural planning in addressing the challenges of an ageing population? How could it be better harnessed?

Some inspiration from mutuals

Vivagora: positive health and ageing

Taking into account that housing and social ties are determinants of health, the [Vivagora](#) project by the Christian Mutuality (MC) aims to develop a non-institutional and non-medicalised place to live: an alternative to the classic formulas of accommodation for elderly people. The project also meets other expectations: accessible housing for families, people in precarious situations, disabled people, etc.

The Vivagora project implements the concept of positive health for the development of an intergenerational housing project. It aims to break the solitude in which many people find themselves after the age of sixty whether they are single or in a couple, the project aims to enable them to choose a new habitat in which they find a neighbourhood based on the sharing of activities, tasks and mutual support. It is part of an intergenerational housing complex that ensures a mix on several levels: age, social, cultural, disability, etc. The project allows, in addition to the objective relating to the elderly, to provide favourable and accessible housing solutions for families, single-parent families, young couples, disabled people (children and adults)... The housing offer developed in the form of cohabitation mixes private and common spaces, thus allowing each person to keep his or her self-determination and to

participate in the community life (services, activities...) according to his or her own resources and commitments. It is a place where residents can have projects, participate in civic life independently, despite losses, dependencies and health problems that may arise, while preserving, until their last day of life, all their prerogatives of self-responsibility.

The concept aims to be integrated into the neighbourhood or village where it is harmoniously established. Wherever possible, the project develops spaces for social economy activities (leisure, shops, culture, health) representing an added value for the extended community.



AIM Healthcare and social benefits for all

The International Association of Mutual Benefit Societies (AIM) is an international umbrella organisation of federations of health mutuals and other not-for-profit healthcare payers. It has 56 members from 28 countries in Europe, Latin America and Africa and the Middle East. 31 of its members, from 18 countries, are based in the European

Union. AIM members provide compulsory and/or supplementary health coverage to around 240 million people around the world, including close to 200 million people in Europe, on a not-for-profit basis. Some AIM members also manage health and social services. Collectively, they have a turnover of almost €300 billion.

AIM members are either mutual or health insurance fund.

They are: private or public legal entities; solidarity based; not-for-profit oriented organisations: surpluses are used to benefit the members; democratically-elected members play a role in the governance of the organisation.

Info: www.aim-mutual.org - Contact: jessica.carreno@aim-mutual.org

ANNEX 1

AIM Recommendations for the Green Paper on Healthy Ageing

AIM welcomes the European Commission's intention to publish a Green Paper on Healthy Ageing. AIM believes people's health and well-being should be at the centre of that paper, just as of any EU initiative. Europeans who gain in healthy life years can contribute to society for longer on the one hand and reduce the impact of ageing on healthcare systems on the other, two aspects which in turn will be beneficial to European economies. According to AIM, the main question the Green Paper should answer is the following:

“How can the EU contribute to healthier and happier older people?”

In order to answer it, AIM proposes to take the positive health model as a basis.

The Positive health model⁶

AIM is convinced that the Green Paper should adopt a health in all policies approach, breaking silos and encouraging cross-sectorial collaboration. The approach is already reflected in the new functioning of the European Commission and the way President Von der Leyen has organised cooperation on portfolios between Commissioners. AIM wishes for the Green Paper to follow the same approach.

The positive health model⁷ understands “(...) health as the ability to adapt and to self-manage, in the face of social, physical and emotional challenges”. The model allows for a broader and more in depth understanding of the concept of health and well-being according to six dimensions: bodily functions, mental functions and perception, spiritual-existential dimension, quality of life, social and societal participation and daily functioning. To apply it, individuals are invited to complete a questionnaire which will provide them with a score on each of the dimensions⁸. The idea is not to grasp how physically or mentally fit people are (e.g.) but rather to measure how well they cope with their limitations and empower them to make a change if they deem necessary. Beyond disease, the focus is rather on individuals, their resilience and what gives meaning to their lives.

The model allows to put the individual at the centre by empowering them to live healthier and happier lives. It allows to emphasise people's abilities above their limitations, an approach which would contribute to the proper integration of older people in our societies. It also paves the way towards the much-needed shift away from merely curative healthcare which is at the centre of debates in the field but does not seem to materialise.

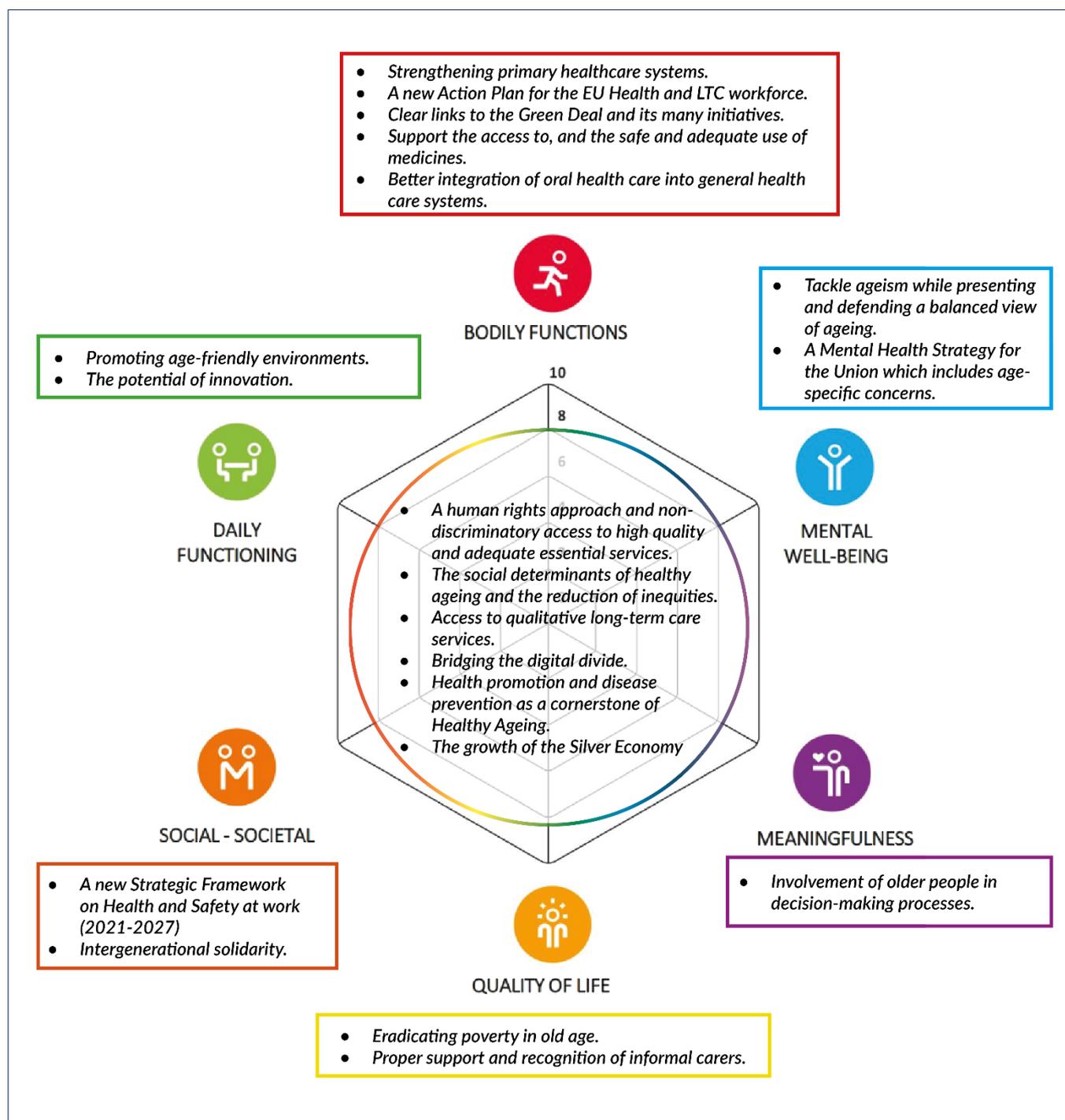
For all the above-mentioned reasons, we have decided to structure our paper according to the positive health model, highlighting the role that the EU could play in contributing to older people's fulfilment in each of the six dimensions which compose it. It is worth noting that those dimensions are closely linked to each other and some recommendations lay astride them.

⁶ By Machteld Huber. See : <https://iph.nl/positieve-gezondheid/wat-is-het/>

⁷ [Idenm](#)

⁸ The model is also called spider web model, as the scores of the questionnaire then appear on a spider web map, in which each of the axes represents one dimension.

OUR RECOMMENDATIONS



[Picture: AIM recommendations organised according to the positive health model by Machteld Huber⁹]

⁹ Picture of the « spider-web » from [Machteld Huber](#)

Overarching requests

A human rights approach and non-discriminatory access to high quality and adequate essential services.

The Green Paper should follow a human rights approach and aim at ensuring non-discriminatory access to high quality and adequate essential services.

According to WHO, ensuring older people's rights to enjoyment of the highest attainable standards of physical and mental health; an adequate standard of living; education; freedom from exploitation, violence and abuse; living in the community; and participation in public, political and cultural life¹⁰ are key in achieving healthy ageing. As such, those aspects should also be at the centre of the Green Paper.

Therefore, in AIM's view, the Green Paper should also promote equal access to quality and adequate essential services, amongst which healthcare and long-term care (LTC). AIM encourages the European Commission to establish a clear link between the Green Paper and the Strategy on the Implementation of the Charter of Fundamental Rights and the Implementation of the European Pillar of Social Rights. Prevention, health promotion, curative, rehabilitative, palliative and end-of life care should be available to older people without discrimination, regardless of individual financial means. This includes access to effective, good-quality essential medicines and vaccines; dental care, integrated and personalised qualitative care, and health and assistive technologies.

The question of access depends on many factors. First of all, it requires strong social protection systems based on solidarity to make sure services are affordable to all. The model of mutuals based on the principles of solidarity, democracy and not-for-profit, is an asset for social protection systems (health, long-term care, pensions, etc.). As such, they should be promoted and properly supported at EU level. Second, it requires high quality services to be developed, which, for healthcare and LTC includes aspects such as geographical availability, quality assurance or staff shortages concerns. Finally, for access to be ensured, people need to be empowered to properly use services.

The social determinants of healthy ageing and the reduction of inequities.

The Green Paper should take the social determinants of healthy ageing into account and aim to reduce inequities.

As WHO recognises, "(...) there is great inequity in longevity according to social and economic grouping".¹¹ Social and economic resources influence people's behaviours and choices throughout their lives and therefore have an impact on the way they age. Healthy ageing is thus closely linked to social and economic inequity. Health inequities, education, employment and income are factors which influence each other and have a tremendous impact on an individual's health and well-being. Preventing older people from falling into poverty is critical (see below). It requires flexible retirement policies, tax-funded minimum pensions, social security and access to health and long-term care services. Tackling socio-economic aspects will indeed require a cross-sectorial approach, an approach which we also follow in this paper and which the European Commission calls for in its report on demographic change.¹²

¹⁰ [WHO Decade on Healthy Ageing](#)

¹¹ *idem*

¹² [European Commission, Report on the Impact of Demographic Change.](#)

Access to qualitative long-term care services.

The Green Paper should promote access to qualitative long-term care services.

As the OECD states¹³, demand for long-term care (LTC) is expected to rise, thanks in part to ageing populations and increasing prevalence of long-term conditions such as dementia. LTC should therefore be given the attention it deserves. More precisely, we invite the European Commission to¹⁴:

- ***Ensure that data on LTC gathered across Member States is comparable:***

The first step in solving a problem is understanding its breadth. An initial measure in achieving comparable data is the establishment of EU indicators for LTC. AIM therefore welcomes the work of the European Commission in the field and encourages further efforts, on which AIM will be pleased to collaborate.

- ***Establish common needs assessment and eligibility criteria:***

AIM would welcome EU guidelines on needs assessment and eligibility criteria for LTC. They could support Member States in the establishment of national standards. Such an initiative is key, in our view, to fight inequities between and within Member States.

- ***Set minimum quality requirements for providers and develop European outcome indicators for the assessment of LTC:***

Minimum quality requirements for providers (carers, nursing homes, etc.) should be set at European level to contribute to guarantee high quality levels of care. Developing outcome indicators at European level could encourage objective and standardised assessment of LTC, which in turn would allow the collection of comparable data across MS. Those indicators would also allow to better integrate the monitoring of LTC systems within the European Semester process.

- ***Establish a Steering Group on LTC:***

There is no one-size-fits-all solution when it comes to the organisation and financing of LTC systems. However, Member States are often facing similar challenges. There is a clear added value in discussing possible solutions at European level. The European Commission could establish a Steering Group on LTC, similar to the existing one on health promotion and disease prevention. It would facilitate the exchange and the implementation of best practices.

- ***Ensure better integrated care and look into new care roles:***

AIM calls on the European Commission to encourage the exchange of best practices between Member States regarding innovative care roles or LTC governance systems. Such an exchange could take place in the above-mentioned Steering Group. The needs of LTC beneficiaries often go far beyond care need and include topics such as housing and income needs. A proper integration of health and social care delivery around patients would benefit not only individuals but also welfare systems, as it would help control costs and improve care quality.

Bridging the digital divide.

The Green Paper should establish clear links with the announced Skills Agenda for Europe and Digital Education Action Plan with the aim to achieve high levels of digital and health literacy and foster inclusion.

High levels of health literacy strengthen the impact of health promotion and disease prevention actions on elderly. It empowers people to make the right choices for their health and well-being, to use healthcare services adequately while adopting healthier behaviours. In a world where many services

¹³ <https://www.oecd.org/health/long-term-care.htm>

¹⁴ See our position paper: https://www.aim-mutual.org/wp-content/uploads/2020/03/AIMLTCpaper_FINAL.pdf

turn digital (eGovernment and agencies, counters of many essential service providers like electricity or water, eBanking, etc), high levels of digital literacy are necessary to enable societal barrier-free participation and inclusion of older generations. No matter the services which are made available, people do need the necessary skills to use them adequately and in a timely manner. Technology should also be designed so as to into account the needs and skills of older people. “Healthy ageing requires life-long learning, enabling older people to do what they value, retain the ability to make decisions and preserve their purpose, identity and independence.”¹⁵ Bridging the digital divide is a sine-qua-non condition in the achievement of those goals. It is also a key challenge raised by the European Commission in its Report on the Impact of Demographic Change.

Health promotion and disease prevention as a cornerstone of Healthy Ageing.

European citizens are living longer but not necessarily in better health. Older people who experience healthier lives are able to continue to participate and be an integral part of families and communities hence strengthening societies; however, if the added years are dominated by poor health, social isolation or dependency on care, the implications for older people and for society are much more negative.¹⁶ Adding life to years is therefore the overarching priority of the WHO decade on healthy ageing and should be the overarching goal of the Green Paper on Healthy Ageing. A first step in achieving it, is preventing or slowing down physical decline, which is only possible with a proper emphasis on health promotion and disease prevention throughout the life course.

As mentioned before, healthy ageing requires a health in all policies approach, involving a wide variety of actors – like national, regional and local governments, service providers, civil society, the private sector, organizations for older people, academia and older people, their families and friends – from a wide range of sectors - including health, finance, long-term care, social protection, education, labour, housing, transport, information and communication. Actions to improve healthy ageing are necessary at multiple levels and in multiple sectors to prevent disease, promote health, maintain intrinsic capacity and enable functional ability. Those actions should take place throughout the life cycle of a person and start from a very early stage, especially when it comes to primary prevention. Secondary and tertiary prevention strategies should be properly targeted and are very much dependent on primary care. The Farm to Fork Strategy and the EU’s Beating Cancer Plan are key instruments in this regard.

The growth of the Silver Economy

The European Commission should bet for an active inclusion of older people in the Silver Economy, rather than considering them as mere consumers.

The Silver Economy encompasses a wide range of sectors. According to a report commissioned by the European Commission¹⁷, housing, utilities and health accounted for a bit more than a quarter of the private consumption expenditure in the European Silver economy in 2015. Though these figures might change with the rapid development of connected health, robotics or assistive technologies, AIM is convinced that the Silver Economy can only flourish through healthy ageing. Older people should be considered as the main contributors and as active participants to that economy and not only as

¹⁵ WHO Decade on Healthy Ageing, p.7.

¹⁶ WHO Decade on Healthy Ageing, p. 2.

¹⁷ [European Commission, The Silver Economy, 2018, p.15.](#)

consumers. It is vital to ensure that the development of the Silver Economy happens in line with the other objectives cited in our paper. Healthy ageing is a sine-qua-non condition to that growth.

It is important to identify and take into account the health-related specifics for all economic sectors and groups. For self-employed people, such as agricultural entrepreneurs, this means that the health relevance of business transfers should be recognised and taken advantage of. In general, there is a hardly perceived need for action in the transitions from active working life to so-called retirement. Here, multiple potentials arise both for the maintenance of health (giving meaning to future activities) and for a sustainable silver economy.

*Dimension 1: Bodily Functions*¹⁸

Strengthening primary healthcare systems.

The Green paper should seek to support Member States to strengthen their primary health care systems by improving their assessment through the European Semester process and fostering the exchange of best practices while focussing on the social dimension of health care rather than a pure economic approach. Primary health care is the main entry point for (older) people into healthcare systems. The efficiency of health promotion and disease prevention strategies will very much depend on its strength. It has the potential of enhancing physical and mental capacity and well-being. For care to be efficient, it must be accessible, affordable, equitable, safe and community-based. Most healthcare systems are used to address acute health conditions. As the OECD underlines, healthcare spending is still focussed on curative care, with only an average 3% of the health budget spent on prevention.¹⁹ According to us there is room for improvement when it comes to preventive care or the management of old age conditions. Those systems need to adapt in order to deliver person-centred care integrated among providers and settings. They should be linked to the sustainable provision of integrated long-term care and primary health services responsive to older people. Across the EU, examples of best practices on a better integration of care around individuals exists, the EU should allow Member States to exchange on those best practices and reshape their systems in that direction.²⁰ The European Semester health indicators should also be reviewed in order to include the above-mentioned concerns in the measurement of process and outcome indicators.²¹

A new Action Plan for the EU Health and LTC workforce.

A strong primary healthcare also depends on a competent and sufficient health care workers.

The development of integrated health workforce planning and forecasting as well as the adaptation of health and long-term care workforce skills is in our view key in improving both the access and quality of those services. The European Commission published in 2012 an Action Plan for the EU Health Workforce. AIM calls for a proposal of new action plan, which would cover both health and long-term

¹⁸ This dimension covers medical facts and observations, complaints and pain, physical functioning, and energy.

¹⁹ OECD, [How much do OECD countries spend on Prevention?](#), p.7.

²⁰ One key aspect of strengthening primary care is the design of motivating financing models and avoiding reverse incentives.

²¹ More about our recommendations on indicators for LTC: https://www.aim-mutual.org/wp-content/uploads/2020/03/LTC_qualitycomparison_outcomemeasurement_AIMreflexionpaper.pdf

care workforce and would adapt the ambitions of the previous plans to the updated European Commission programme and to the new realities which sustain it. The Action Plan should:

- *Ensure a proper integration and funding of workforce-related issues in the new EU4Health Programme and in other funding instruments (e.g. Horizon Europe)*

The EU4Health Programme announces as main objectives to improve the EU's preparedness for future healthcare crisis and to strengthen healthcare systems and their health workforce. The COVID-19 pandemic has highlighted the importance of workforce planning also in times of crisis and has stressed the lack of human resources not only in healthcare settings but also in LTC facilities. AIM wishes to see both healthcare and LTC workforce challenges taken on board in the new programme.

- *Call for the establishment of an EU Joint Action (JA) on forecasting health and LTC workforce needs for effective planning.*²²

The Joint Action could ensure better data collection across the EU and develop methodologies for better forecasting of workforce and skills needs. It could also allow the exchange of best practices on recruitment and retention measures.

Aligning the healthcare workforce with health system goals is fundamental; just as sustaining the changes that are needed for improving the organization and the delivery of healthcare. Demographic changes increase the demand for health services. At the same time, they reduce the pool of workers available to provide those services. Strong patterns of professional migration (with increasing movement from the countries of central and Eastern Europe) pose a direct challenge to the maintenance of an equitable workforce across the EU. Proper resource planning is vital for a proper distribution of the workforce across Europe. Proper also means "up-to-date". Today's demands require more sophisticated and integrated models of planning which could in turn call for jobs redesign, and for the skills and roles of some professional groups to be transformed. Analysing the labour market and conducting needs-based planning to optimize current and future workforces to meet the needs of ageing populations seems key in the development of a sustainable, appropriately trained, deployed and managed health workforce with competence in ageing, including for comprehensive person-centred assessments and the integrated management of chronic or complex health conditions. Such an analysis should be coordinated at European Level and could take place within the JA.

In order to motivate health workers and managing a more effective workforce, working conditions are an unneglectable aspect. Supportive working environments and a proper work-life balance are only some of the prerequisites which will allow to retain healthcare workers. Incentive systems might also be an option, which will at the same time enable to influence performance and contribute to reach health goals such as, for example, a greater focus on prevention and primary care above curative care. Sharing good practices in the frame of the JA could support Member States in implementing successful strategies.

- *The Action Plan should have a clear link to the Updated Skills Agenda and establish an EU-wide collaboration on updating skills of both the health and LTC workforce.*

Human resource management must be adapted in view of ageing populations and the specific needs that such a development entails. The healthcare workforce must be properly trained in order to acquire skills which might not be traditionally offered in their current curriculum (e.g. geriatric, ICT, etc.). Interdisciplinary education, which puts different specialisations into contact from the very beginning, as well as innovative curriculum design offer a golden opportunity. It will become vital for future

²² The [previous JA](#) covered only health workforce and ended in 2015.

professionals to be able to work in interdisciplinary teams, to master technological advances and to endorse new emerging roles like for instance, “promoters” of healthy lifestyles.

Clear links to the Green Deal and its many initiatives.

Older people’s health is deeply impacted by exposure to indoor and outdoor air pollution, noise, hazardous chemicals and climate change. The Lancet Countdown underlines the particular “(...) vulnerable situation of Europe to heat exposure due to its ageing population, high rates of urbanisation, and high prevalence of cardiovascular and respiratory diseases, and diabetes”.²³ There are therefore clear links to be established between the Green Deal and the Green Paper on Ageing as many of its initiatives (e.g. Climate Law, EU Strategy on Adaptation to Climate Change, etc.) will have an impact on the way European populations will age. Older age concerns should therefore be taken into account when implementing the many actions listed in the Deal.

Support the access to, and the safe and adequate use of medicines.

Medicines is a common good and their access should therefore be ensured for all those who need them. Our model for fair pricing is a proposal on how affordability could be better guaranteed.²⁴

Medications often help maintain health and wellbeing and yet many older adults end up suffering from problems related to medication. WHO recognises that due to the traditional focus of both medical research and health care delivery models on single-disease interventions, there has been a notable lack of evidence-based solutions. Polypharmacy does not necessarily imply an overuse of medicines. Actually, the concurrent use of several medicines is sometimes necessary and beneficial. Therefore, it is vital to ensure the appropriateness of polypharmacy while limiting the use of unnecessary or inappropriate medication. The implementation of interventions such as medication reviews, in collaboration with all actors in the care path (physicians, nurses, pharmacists, patients and families) are key, just as good communication and the sharing of comprehensive and comprehensible information with patients.²⁵ These aspects are of course linked to previous highlighted challenges such as health literacy or the strengthening of primary care. Technologies can also play a vital role in ensuring proper use of medication and evaluating drug interaction. Patient-held medication records but also more practical innovations such as the connected pill dispenser have a big potential.

Better integration of oral health care into general health care systems.

Oral health is a key indicator of overall health in older age. And yet, literature review shows that the oral health status of the geriatric population is generally deficient.²⁶ The negative impact of poor oral conditions on the quality of life of older adults is thus an important public health issue.

Oral health programmes should therefore be strengthened. The World Health Organization recommends that countries adopt certain strategies for improving the oral health of the elderly. National health authorities should develop policies and measurable goals and targets for oral health.

²³ [AGE Europe, Environment matters to everyone, including older persons](#) (web)

²⁴ [AIM Fair Pricing Proposal](#)

²⁵ WHO, [Medication Safety in Polypharmacy](#)

²⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4334280/>

National public health programmes should incorporate oral health promotion and disease prevention based on the common risk factors approach. Control of oral disease and illness in older adults should be strengthened through organization of affordable oral health services, which meet their needs.²⁷ While those aspects are mostly national competences, the European Commission Green Paper has a role to play in raising awareness on the importance of oral health in old age and on its relevance to healthy ageing and encouraging Member States to take action. Moreover, specific attention should be paid to digitisation so as to ensure that its development does not have a negative impact on oral health care.

Dimension 2: Mental Well-Being²⁸

The recommendations mentioned above will also have an impact on the mental health dimension. On top of those, we underline the following aspects.

Tackle ageism while presenting and defending a balanced view of ageing.

The Green Paper should contribute to fighting stigma and negative attitudes related to ageing. Such an aim can be achieved through some of the proposals made above (e.g. health literacy amongst others) and others made below (e.g. health and safety at work framework). It should also ensure that all Union policies adopt a positive attitude and wording towards older people. Combatting ageism should also be a priority of the Mental Health Strategy for the Union described in the next paragraph.

Attitudes to age start to form in early childhood. With time they can become internalised and have a negative impact on individuals' health behaviour, physical and cognitive performance and lifespan. It can cause isolation, inappropriate care and medication or abuse. Ageism also imposes barriers in policies and programmes in sectors such as education, labour, health and social care and pensions, as it influences the way problems are framed, the questions asked and the solutions offered. Ageism therefore marginalizes older people within their communities, reducing their access to services. To put it short, ageism has harmful effects on both the physical and mental health and well-being of older people. Changing the view of population on ageing is therefore a societal challenge but also an opportunity.²⁹

A Mental Health Strategy for the Union which includes age-specific concerns.

As put forward by the Council Conclusions on the Economy of Well-being³⁰, the European Commission should “propose a Mental Health Strategy for the Union, taking into account the cross-sectoral impacts of different policies on mental health”. This strategy should follow a life-cycle approach, and include older age needs and concerns.

It should also aim at improving mental health surveillance and data collection. The current lack of availability of pertinent data makes both the understanding of the European mental health landscape and its improvement difficult. Comparable information on outcomes and evidence-based knowledge on

²⁷ https://www.who.int/oral_health/publications/orh_cdoe05_vol33.pdf

²⁸ The dimension covers cognitive functioning, emotional state, esteem/self-respect, experiencing to be in charge, manageability, self-management, resilience and sense of coherence.

²⁹ [WHO Decade of Healthy Ageing](#), p. 6.

³⁰ [Council Conclusions on the Economy of Well-being, 2019.](#)

risk and protective factors to mental health is essential to make real progress, and assess strategies and treatment.³¹

The EU Strategy should also provide guidance and recommendations for the promotion of good mental health, the improvement of early diagnosis and treatment, the strengthening of primary care, the focus on rehabilitation strategies, and the de-stigmatisation of mental health disorders at national and local level. It should contribute to “(...) non-discriminatory working environments, better working conditions, and thus to a stronger economy”.³²

Dimension 3: Social/Societal Participation³³

A new Strategic Framework on Health and Safety at work (2021-2027)

A New Strategic Framework on Health and Safety at work, like the one put forward by the Council in its Conclusions³⁴, and which puts the challenges of an ageing workforce at the centre of its concerns should be part of the Ageing Paper.

The working age population will include an increased number of older people. Many people are fit and willing to work longer. However, an important precondition is the setting of sound occupational health and safety rules throughout the career and the adaptation of workplaces. Moreover, stereotypical views of older people foster a climate of ageism in workplaces. Employers should value older people’s experience and contribution to productivity.

In order to make the most of older people’s participation to the labour market, the EU should propose a New Strategic Framework on Health and Safety at work, which puts old age-related concerns at its core. As put forward by the Council Conclusions on a New Strategic Framework on Health and Safety at work, the new framework should seek to maintain and enhance work ability through national occupational safety and health (OSH) strategies and measures in order to achieve a working life that is inclusive for workers of all ages. It should support measures enabling those with failing health or disabilities to participate and contribute, encourage employers to offer flexible working practices in order to help workers to remain in employment for longer and strengthen the knowledge of employers in supporting work ability and return to work after sick leave.³⁵

Intergenerational solidarity.

Intergenerational solidarity and a discussion on the development of a fair and sustainable social model based on the concept should be the basis for the Green Paper.

The decline of traditional family models was an unavoidable outcome of the modern economy. Small nuclear families were better suited than large intergenerational ones in a 20th century focussed on opportunity and achievement.³⁶ The COVID-19 pandemic has put intergenerational solidarity in the spotlight and underlined its value. It also revealed the deep societal impact that the lack of it can cause.

³¹ https://www.aim-mutual.org/wp-content/uploads/2017/04/Mental-Health-Joint-Position-paper-AIM_AEIP.pdf

³² [Council Conclusions on the Economy of Well-Being, p.8.](#)

³³ The dimension covers social contacts, experiencing to be accepted, meaningful relationships, community involvement, meaningful work, social and communicative skills, interest in society and making fun together.

³⁴ [Council Conclusions on a New Strategic Framework on Health and Safety at Work.](#)

³⁵ *Idem.*

³⁶ http://www.reassess.no/asset/4372/1/4372_1.pdf

Beyond the family sphere, it is at the level of society that intergenerational solidarity should be mainstreamed. A new approach to solidarity between generations is needed in order to avoid a 'generational split', prevent further causes of inequality and fight loneliness in old age. At the same time, role models in which care for the elderly is seen as women's responsibility should be avoided. From an economic point of view, it will be key to ensure that a smaller workforce does not have a lasting effect on the European economy and that the cost of caring for the elderly does not destabilise it.³⁷

We often think of intergenerational solidarity as the youth having to economically contribute in order to support the old. However, older people can also bring valuable contributions to societies through volunteer work, part-time coaching and mentoring of companies or entrepreneurs, caring for their grandchildren or family members in need of long-term care and many other community initiatives. Those contributions are as valuable as any traditional "jobs".

Fostering intergenerational solidarity requires a new approach to labour law and reform of social protection systems which look at the impact of such reforms on all generations. Those are changes which would deeply affect Member States' social security systems. And yet, they are necessary given the changing demographic and labour realities which the EU is undergoing.³⁸

Dimension 4: Daily Functioning

Promoting age-friendly environments.

The Green Paper should promote the concept of age-friendly environments. It should become a priority of EU funding programmes.

Age-friendly environments are places in which older people, regardless of their potential limitations, can age safely according to their choices. Environments where they are protected and can continue to develop professionally if they wish to do so. They allow also for personal development enabling people to participate and contribute to their communities. Urban planning, the creation of collective spaces to encourage meetings and forge social relationships, encouraging healthy mobility... Those actions contribute to break solitude, boost intergenerational solidarity (see below) and "demedicalise" social problems by focussing on the key role environments play. Health, well-being, autonomy, and dignity should be cornerstones of such environments. Age-friendly cities and communities empower all people to make the most of their abilities across the life-course. Their creation requires the involvement of multiple sectors (health, social protection, transport, housing, labour) and stakeholders (civil society, both young and older people and their organizations).³⁹ It requires "(...) understanding older people's needs, setting priorities accordingly, planning strategies and implementing them with the available human, financial and material resources and by leveraging technology".⁴⁰

³⁷ [Think Tank européen Pour la Solidarité, Active Ageing and Intergenerational Solidarity: findings, issues and perspectives, p. 101.](#)

³⁸ https://www.age-platform.eu/sites/default/files/IntergenerationalSolidarity_TheWayForward_2010-EN.pdf

³⁹ See also: WHO, [Global Age-Friendly Cities: A Guide](#), 2007

⁴⁰ [WHO Decade on Healthy Ageing, p. 10.](#)

The potential of innovation.

The European Commission needs to explore the potential of innovations while fostering healthy ageing through research and to establish effective safeguards against their harmful use.

Technology and innovations, if put at the service of people, have a clear potential in supporting healthy ageing by improving prevention, supporting rehabilitation, allowing individuals to live better longer lives at home should they wish and supporting both formal and informal carers in their tasks. Access to safe, effective, affordable essential medicines, vaccines, diagnostics and assistive technologies can optimize older people's intrinsic capacity and functional ability.

The Green Paper on Healthy Ageing should recognise that potential while underlining the key challenges and the threats that such developments could entail. Patient safety, non-discrimination, patient-centeredness, data protection, privacy and dignity are some of the key aspects which should remain at the centre of discussions in this field. The main objective of technologies should be to increase access to good-quality health and social services and to improve individuals' health and quality of life.

Dimension 5: Quality of Life

As already mentioned, all dimensions of the positive health model are interconnected. It is evident that the above-mentioned recommendations would also have a profound impact on individuals' quality of life. On top of those, another key aspect in ensuring older people's quality of life is the fight against poverty in old age.

Eradicating poverty in old age.

The Green Paper should aim at eradicating poverty in old age, notably by promoting the adequacy of pensions and of minimum income schemes.

Poverty does not solely depend on financial resources and income. It is a multidimensional phenomenon which includes the notion of precariousness, lack of opportunities, denial of rights, vulnerability. It is dependent on many factors such as culture, heating, housing, employment, social participation but also access to education, to healthcare, long-term care or medicines, etc. Many of the recommendations listed above will undoubtedly have an impact on poverty, if effectively implemented.

Principle 15 of the European Pillar of Social rights states: "everyone in old age has the right to resources that ensure living in dignity."⁴¹ While the financial aspect is not the only aspect to take into account, the adequacy of pensions plays a key role in alleviating poverty among the elderly, just as adequate minimum income schemes for those unable to work, temporarily or permanently - often because of care responsibilities towards children or elderly family members (mostly women).⁴²

When it comes to pensions, their adequacy could be assessed more systematically in the European Semester. As AGE-Platform Europe underlines, inequalities in pension systems as well as the effects of pension erosion over time should be evaluated as well, which requires to analyse the situation of the oldest pensioners as well as on a gender basis.⁴³

⁴¹ [European Commission, European Pillar of Social Rights, p. 20.](#)

⁴² https://www.age-platform.eu/sites/default/files/IntergenerationalSolidarity_TheWayForward_2010-EN.pdf

⁴³ [AGE Europe, Poverty Watch 2018, p.10.](#)

Minimum income schemes can be strong potential social protection instruments to reduce poverty and social exclusion, decrease inequalities and increase labour market participation. They can constitute social protection safety nets of the last resort, particularly relevant in the period of economic crisis due to COVID-19. Reflections on minimum income should include aspects such as minimum wage in order to tackle the growing number of “working poor” and make work a viable prospect for those distant from the labour market. Such schemes could be considered as social investments that produce more advantages than disadvantages, both for Europe and for its nations, even at the economic level.

Proper support and recognition of informal carers.

The Green Paper should call for the inclusion of carers as central partners in the EU JA mentioned above, so as to pave the way towards their recognition and the improvement of their working conditions. It should promote the use of European funds to improve the quality of life of informal carers. Innovative tools can also play a key role in alleviating the burden on informal carers (online training, counselling and guidance for relatives acting as carers, telehealth, etc.). Research in the area should therefore also be fostered at EU level.

80 percent of long-term care (LTC) is estimated to be provided by families and other “informal” carers.⁴⁴ Informal care provides the backbone of LTC in many countries. Yet, in most cases, informal carers often do not receive proper training. On the one hand, it is important to offer training to those needing it in order to guarantee qualitative care and ease the psychological and physical burden care responsibilities can represent. Indeed, while caring for a beloved person can bring personal fulfilment, carers often lack preparation and take over the task on top of other family or employment obligations. Such a situation can generate stress but also personal costs. As Eurocarers underlines, “being a carer is often associated with poverty, physical and mental health problems, isolation, employment-related issues and financial worries”.⁴⁵ On the other hand, it is key to guarantee that workers enjoy proper working conditions and a better work-life balance. This would benefit both carers’ and LTC beneficiaries’ health, which will in turn be beneficial to healthcare systems as a whole. The work life balance directive is a first initiative in the right direction.

Dimension 6: Meaningfulness⁴⁶

The effective inclusion of older people in the labour market, the promotion of health-friendly environments and of intergenerational solidarity, and many of the other recommendations we have described previously will of course have a positive effect on older people’s feeling of meaningfulness. In all actions and policies, it is also vital to ensure that their voice is heard by actively involving them.

Involvement of older people in decision-making processes.

AIM believes that older people should be involved in any decision-making processes which direct- or indirectly have an impact on their lives.

The personal development of individuals should remain an important goal of the Green Paper, just as the establishment of perspectives for the future. People’s feeling of attachment, of joy of life and of control over their lives are to be encouraged. Older people should have opportunities to contribute to

⁴⁴ [European Commission, Adequate social protection for long-term care needs in an ageing society](#), p.146

⁴⁵ [Eurocarers, What do informal carers need?](#), p. 2.

⁴⁶ The dimension is the spiritual one. It covers joy of life, striving for aims/ideals, trust, acceptance, gratitude and keep learning.

society and the labour market if they wish to. They should also be empowered to continue old hobbies and to participate in new ones including social, cultural, civic or religious activities if she/he wants to, outside or inside his/her home. They should remain in control of their own life and care as long as possible. Once properly informed, they should be respected in their choices, even when those potentially put them at risk. Health and social care services should be person-centred and timely address the changing needs of individuals. Their main objective should be to improve users' quality of life while respecting their wishes and putting them at the centre of service planning and care management. Services should take into account physical, intellectual, cultural and social perspectives of older people, but also of their families or other relatives. They should be driven by the needs of both patients and carers. To achieve proper integration and involvement, there is a clear need for a change of mind-set from all sectors in society, which should consider the many strengths of older generations rather than their weaknesses and limitations.

Conclusions

Ageing populations call for profound changes. From a societal point of view, mostly individualistic societies will have to reinforce intergenerational relationships and fight stigma against older people. Solidarity-based social protection systems will have to be further strengthened too in order to ensure their sustainability while guaranteeing that no one is left behind. Social and healthcare models will also have to be redesigned in order to allow a greater focus on prevention, to address staff shortages and improve access to qualitative person-centred care. Preserving older people's dignity and considering them as an equal interlocutor will be key in that process. The Green Paper can make a considerable contribution to the achievement of the Sustainable Development Goals. Healthy ageing should be an overarching aim of all EU initiatives and be at the centre of a sustainable recovery plan. It should also be an integral part of the European growth strategy. AIM looks forward to the Paper and to collaborating with EU Institutions to make Healthy Ageing a reality.

ANNEX 2

AIM Statement on Medical Deserts

Our recommendations :

Towards the establishment of more integrated and collaborative care models

- AIM calls on the European Commission to encourage the establishment of more integrated and collaborative care models through its European Semester process and through the below mentioned Action Plan for the EU healthcare and long-term care workforce.

Healthcare concerns, data privacy, ethics and literacy at the centre of innovative developments which are truly at the service of healthcare

- AIM invites the European Commission to take healthcare concerns, data privacy and ethics into account in its discussions around the use of AI in healthcare and the exchange of healthcare data. We also call on the EC to encourage the development of innovative tools for care delivery and to involve healthcare payers and patients in the process.
- AIM encourages the European Commission and Member States to ensure that both the general population (especially older generations) and healthcare professionals acquire the necessary skills to properly use innovative tools and make the most of innovation is key. In the same vein, rising the levels of health literacy of individuals in order to achieve higher levels of empowerment is essential.

A new Action Plan for the EU Health and LTC workforce

- AIM calls on the European Commission to adopt a new Action Plan for the EU Health and LTC workforce which includes special attention to tackle shortages in rural areas.

A strong European Health Union and greater cross-border collaboration

- AIM calls on the European Commission and on neighbouring Member States to improve cross-border collaboration so as to ensure citizens' access to timely and qualitative healthcare and long-term care services and to involve both local and national authorities in the implementation of any solution. AIM also underlines the need to properly inform citizens on their rights.
- AIM encourages the European Commission to put its Funding Instruments, its EU4Health programme but also its Rural Development Programme at the service of the improvement of accessibility to healthcare and long-term care services in rural areas and to the development and implementation of concrete solutions.

The mutual model, the key to guaranteeing equitable access

- AIM calls on the European Commission to recognise mutuals as an essential partner in the fight against health inequities and more particularly against medical deserts.

Medical Deserts: the growing care demand in rural areas unmet by a shrinking offer

As highlighted by the European Commission in its “Report on the Impact of Demographic Change”, rural areas and their populations may differ greatly across the European Union and within Member States themselves. The socio-economic status of their inhabitants vary depending on their proximity to urban areas. However, despite those many differences, rural areas are often characterised by low income and rapidly declining populations. While those populations are rapidly ageing and facing the general increase in chronic diseases, shortages of general practitioners⁴⁷ but also of specialised and emergency care persist and become a growing issue, leading to the emergence of “Medical Deserts”.

In many regions, younger generations moved away and are no longer available to take care of dependant people. Healthcare professionals prefer to settle in urban areas for financial reasons but also looking for better working conditions (see below). Consequently, the demand for both long-term care and healthcare is expected to steeply rise and become more and more challenging to answer. Big geographical distances combined to the fact that elderly people are less mobile and that few public transport is available further reinforce the problem of access. Access to healthcare services then involves a higher degree in organisation and personal cost (e.g. taking time off work, bus fares or gas prices), which makes people more likely to ignore symptoms or skip screening programmes or health checks unless there is an urgency, which in turn has an impact on their overall health.

People in rural areas should have equal access to health and long-term care

Health is a fundamental right and ensuring access to quality and affordable care an obligation of all Member States. Access to health and long-term care are also principles of the European Pillar of Social Rights and are key elements in the implementation of the Sustainable Development Goals. People who live in rural areas sometimes pay the same amount of money for their healthcare or long-term care as do people in urban areas, yet, the benefits they gain from that, are significantly fewer. By allowing medical deserts to exist in our countries we allow people, who live in affected areas, to be treated as less equal. In order to guarantee those rights in urban areas, AIM highlights the following challenges.

Towards the establishment of more integrated and collaborative care models

Better coordination between healthcare professionals is part of the solution to medical deserts. In countries like France or Germany, multi-professional medical centres aim to improve access to care in under-medicalised territories, develop outpatient telemedicine, and facilitate the coordination of health professionals in the management of chronic pathologies. In France for example, in peri-urban areas, areas with medical centres attract young doctors and allow a rebalancing of the care offer. In the rural areas far from the cities, they have a positive attractiveness mitigating the decrease of supply.⁴⁸ Medical centres thus allow for better coordinated care around patients on the one hand and for maintaining the supply of care in territories with less access to care on the other.

The transfer of competences between professionals has also constituted a solution in some cases. Still in France for example, higher rates of flu vaccination coverage in rural areas were achieved by allowing pharmacists to vaccinate. Cooperation protocols also allowed orthoptists of the country to participate in the care of patients followed by ophthalmologists.

⁴⁷ [European Commission Report on the Impact of Demographic Change](#), p. 18

⁴⁸ FNMF, [Accès territorial aux Soins](#), p. 7.

We call on the European Commission to encourage the establishment of more integrated and collaborative care models through its European Semester process and through the below mentioned Action Plan for the EU healthcare and long-term care workforce.

The answer to problems of access to health and long-term care services relies on that greater collaboration and sharing of competences and tasks between professionals combined to a greater and better use of innovation.

Healthcare concerns, data privacy, ethics and literacy at the centre of innovative developments which are truly at the service of healthcare

eHealth and telemedicine can be part of the solution. They can contribute to bring care to remote areas, allow for care to happen at home if wished, improve efficiency and to support carers in their tasks. However, to be able to rely on innovation, problems of infrastructure need to be solved and the digital divide must be bridged.

Most rural areas lack a stable and fast internet connection. As the European Commission highlights in its report, the next generation broadband access can help bridge the urban-rural divide in the digital area. Yet, its development should not happen at the expense of the health and wellbeing of inhabitants. Healthcare concerns but also data privacy and ethics must remain at the centre in the development of those infrastructures and of innovative tools and technologies.

We invite the European Commission to take them into account in its discussions around the use of AI in healthcare and the exchange of healthcare data. We also call on the EC to encourage the development of innovative tools for care delivery and to involve healthcare payers and patients in the process.

Another aspect which should be paid attention to is the digital divide. *We encourage the European Commission and Member States to ensure that both the general population (especially older generations) and healthcare professionals acquire the necessary skills to properly use innovative tools and make the most of innovation is key. In the same vein, rising the levels of health literacy of individuals in order to achieve higher levels of empowerment is essential.*

Presenting multiple advantages (easier access to specialized advice, improvement of the follow-up of chronic pathologies ...), technologies also have their limits and they will not allow for the treatment of all pathologies. They therefore need to be combined to the other key elements we highlight in our paper.

Such changes in the way healthcare professionals work and collaborate with each other but also the enhanced use of innovative tools to carry their tasks require both their skills and competences to be adapted as well as a rethinking of workforce planning.

A new Action Plan for the EU Health and LTC workforce

AIM calls on the European Commission to adopt a new Action Plan for the EU Health and LTC workforce which includes special attention to tackle shortages in rural areas.

Healthcare staff's expectations of a poorer work-life balance, lack of privacy, lower profitability, higher costs of establishment... the reasons why healthcare professionals prefer to establish in urban areas are varied. All those aspects need to be taken into account in the development of any strategy or plan to tackle the issue of staff shortages in medical deserts.

Guaranteeing access to health and long-term care services in rural areas depends on the development of integrated health workforce planning and forecasting, which takes into consideration the above-mentioned aspects, but also the adaptation of workforce skills to ageing populations. In order to motivate health workers and manage a more effective workforce, working conditions are an unneglectable aspect. Supportive working environments and a proper work-life balance are only some of the prerequisites which will allow to attract workforce. Incentive systems might also be an option.

A new EU Action Plan should contribute to discuss and tackle the many issues in which shortages find their roots. It should also ensure a proper integration and funding of workforce-related issues in the new EU4Health Programme and in other funding instruments (e.g. Horizon Europe). It should include the call for the establishment of an “EU Joint Action (JA) on forecasting health and LTC workforce needs for effective planning”. The Joint Action could ensure better data collection across the EU and develop methodologies for better forecasting of workforce and skills needs. It could also allow the exchange of best practices on recruitment and retention measures in rural and remote areas.

A strong European Health Union and greater cross-border collaboration

If collaboration between healthcare professionals is key, collaboration across the European Union and between countries should also be fostered. On the one hand, rural areas sometimes lay in border areas and coordination in the delivery of care is then beneficial. It is also essential in order to guarantee access.

On the other hand, collaboration between healthcare professionals in the same spirit of the European Reference Networks can only be an added value. The dynamic of collaboration within these ERN’s and lessons learned up to now, should allow the Commission to investigate whether this tool could be used on exchange on cancer or non-communicable diseases. With the proper technological support, experts are able to collaborate across Member states, contributing to tackle the issue of shortage of expertise in some regions and improving the quality of care. The ERN’s should be re-examined in light of the fast expansion of telemedicine in Europe and the Commission should address challenges on reimbursement of healthcare professionals and the judicial framework in which the provision of services via this framework are conducted.

Rare diseases are -given the rarity of prevalence- a topic on which European cooperation is of clear added value, The EMRaDi project⁴⁹ conducted an innovative qualitative analysis on the needs of rare disease patients and formulated recommendations to further the professional cooperation on rare diseases in cross-border regions and at European level.⁵⁰

Such cross-border collaboration should not limit itself to rare diseases. During the pandemic, some good examples of cross-border cooperation in healthcare demonstrated how cooperation and solidarity are of key importance in addressing a health pandemic.

AIM calls on the European Commission and on neighbouring Member States to improve cross-border collaboration so as to ensure citizens’ access to timely and qualitative healthcare and long-term care services and to involve both local and national authorities in the implementation of any solution. AIM also underlines the need to properly inform citizens on their rights.

⁴⁹ A European cross- border project on rare diseases to which Belgian health insurance mutuals participated.

⁵⁰ [EMRaDi project](#) - Euregio Meuse-Rhine Rare Diseases; via the INTERREG V-A Euregio Maas-Rijn-programma was conducted from 2016 until march 2020. It concluded amongst others a [final report](#) with recommendations, a factsheet [How to get EU actions on rare diseases \(RD\) closer to rd patients and their relatives?](#) and a [qualitative field analysis based on 104 interviews with patients, relatives and healthcare professionals on the existing patient pathways in the EMR](#).

AIM encourages the European Commission to put its Funding Instruments, its EU4Health programme but also its Rural Development Programme at the service of the improvement of accessibility to healthcare and long-term care services in rural areas and to the development and implementation of concrete solutions. The Rural Development Programme is key in making rural areas more attractive to younger generations and to contribute to their economic development. Ensuring access to essential services should be another of its core objectives.

The mutual model, the key to guaranteeing equitable access

The answer to tackling problems of access to essential services in rural areas mostly relies on solidarity. AIM agrees with the European Commission when it states that “the need for solidarity between generations is one of the driving forces of Europe’s recovery.”⁵¹ Solidarity between generations, between urban and rural areas, between Member States, between all citizens.

Profit should never be the driving force of healthcare or long-term care delivery. In Germany, one of the reasons for the lack of doctors in rural areas is the distribution of privately insured citizens. These are more lucrative patients for doctors. Private insurance is reserved to the wealthiest. The European Union cannot tolerate for anyone to be left behind and treated as second class citizen.

The model of healthcare mutuals, based on solidarity and limited profitability is and will be key to a sustainable and inclusive recovery. It should be recognized as a best practice model for the provision of healthcare and long-term care coverage. Mutuals make no risk selection. They reinvert any benefit for the improvement of services and at the service of their members. They do not exclude anyone from coverage and enable all their members to access the same services.

AIM calls on the European Commission to recognise mutuals as an essential partner in the fight against health inequities and more particularly against medical deserts.

⁵¹ [European Commission Report on the Impact of Demographic Change](#), p.4

ANNEX 3

AIM RECOMMENDATIONS FOR THE FUTURE OF LTC

AIM issues the following set of recommendations to decision-makers as a contribution to the ongoing debate on the future adequacy and sustainability of Long-Term Care systems. Demographic changes and rising rates of chronic diseases are putting European Long-Term Care (LTC) systems under pressure. That burden is expected to rise, as demand increases and contributions to social security systems decrease. As non-profit healthcare payers, the members of the leading international organisation of healthcare mutuals and funds, AIM, are deeply concerned about the health and well-being of citizens, and about the sustainability of both healthcare and LTC systems.

1. Ensure that data on LTC gathered across Member States is comparable:

The first step in solving a problem is understanding its breadth. An initial measure in achieving comparable data is the establishment of EU indicators for LTC. AIM therefore welcomes the work of the European Commission in the field and encourages further efforts, on which AIM will be pleased to collaborate.

2. Establish common needs assessment and eligibility criteria:

AIM would welcome EU guidelines on needs assessment and eligibility criteria for LTC. They could support Member States in the establishment of national standards. Such an initiative is key, in our view, to fight inequities between and within Member States.

3. Set minimum quality requirements for providers and develop European outcome indicators for the assessment of LTC:

Minimum quality requirements for providers (carers, nursing homes, etc.) should be set at European level to contribute to guarantee high quality levels of care. Developing outcome indicators at European level could encourage objective and standardised assessment of LTC, which in turn would allow the collection of comparable data across MS.

4. Watch out for the dangers of marketization:

AIM warns against marketization of LTC systems and the impact of for-profit provision, which would reinforce inequities and hinder access. We ask the European Commission to look into the potential effects of such a trend on accessibility and quality of LTC.

5. AIM calls for the establishment of a Steering Group on LTC:

There is no one-size-fits-all solution when it comes to the organisation and financing of LTC systems. However, Member States are often facing similar challenges. There is a clear added value in discussing possible solutions at European level. The European Commission could establish a Steering Group on LTC, similar to the existing one on health promotion and disease prevention. It would facilitate the exchange and the implementation of best practices.

6. Involve payers and patients in the development of innovative eSolutions:

Information and technology services can contribute to strengthen prevention interventions, reach more efficient LTC delivery, improve the coordination of care, and provide support to LTC users and their carers and families. To be a real added value, those solutions should be developed in collaboration with their users but also with payers organisations, especially if they are responsible for making solutions accessible to patients/citizens.

7. Develop and encourage policies which promote healthy and active ageing:

The costs of healthcare and LTC related to ageing can be controlled through policies which promote healthy and active ageing. Interventions which encourage behavioural changes, support activity and prevent or slow down diseases and care dependency are key.¹

8. Ensure better integrated care and look into new care roles:

AIM calls on the European Commission to encourage the exchange of best practices between Member States regarding innovative care roles or LTC governance systems. Such an exchange could take place in the above mentioned Steering Group. The needs of LTC beneficiaries often go far beyond care need and include topics such as housing and income needs. A proper integration of health and social care delivery would benefit not only individuals but also welfare systems, as it would help control costs and improve care quality.

9. Avoid 'abrupt' deinstitutionalisation and make a progressive shift towards community-based care:

Deinstitutionalisation should not happen at all costs. It should be a progressive process which follows a socially inclusive approach holding human dignity and human rights at its heart. Given the variety of needs, high-quality services should be made available within communities while continuing to provide mainstream services. AIM calls on the European Commission and Member States to take that point into account when discussing further developments regarding the organisation and provision of LTC.

10. Ensure a clear working status and proper working conditions for informal carers:

It is key to guarantee that carers enjoy proper working conditions and a better work-life balance. This would benefit both carers' and LTC beneficiaries' health, which in turn will be beneficial to healthcare and LTC systems as a whole. The work life balance directive is a first initiative in the right direction. AIM hopes that the new European Commission will put forward bold proposals which will pave the way towards the recognition of informal carers' status.

1. See Annex 3 p.34– AIM Reflexion Paper on LTC

Annex – AIM Reflexion Paper on LTC

Demographic developments and their impact on welfare systems are (one of) the greatest challenge(s) of the years to come. In the Euro Area, OECD figures show that the elderly population ratio has grown from 14.76% in 1993 to 19.13% in 2013.⁵² That proportion is further increasing, raising challenges for the sustainability of our social protection systems and for healthcare coverage and delivery. Increased LTC needs will call for innovative solutions in the way services are organised, financed and delivered.

This paper aims at highlighting, from an AIM's point of view, the aspects to which particular attention should be paid in the development of national or European policies in the field of long term care.

While healthcare and long-term care services should remain a Member State's competence, best practices can be highlighted so as to set implementable examples. Guidance can be provided and standards developed at European level, so as to contribute to ensuring the quality and availability of LTC services across the EU.

AIM calls for a clear and objective definition of eligibility criteria for LTC and based guidelines to fight inequities.

For health care insurance funds - which play an important role in both health care and LTC in countries like for example Germany and the Netherlands- geographically bound LTC entitlements pose different problems of planning and coordination. Payers are indeed often only responsible for their affiliates, who are not necessarily from the same geographic area. Moreover, even when risk equalisation schemes are put in place, geographically bound LTC coverage leads to disparities in benefits. Those geographical determinants of LTC entitlements are therefore an obstacle to universal access to LTC services, which AIM defends and strives for.

LTC is currently far from universal. Out-of-pocket expenditure remains very high and institutional care, which is often a safety net for those having no means to purchase other types of care, is for some the only option available. Furthermore, the lack of availability often means a greater dependence of the system on informal care (e.g. relatives) which in turn means higher expenditure for households, a negative impact on the health and well-being of relatives, and further exacerbated inequities. AIM believes that a clear and objective definition of the eligibility criteria and an assessment of needs based on established guidelines is key to overcome those inequities. Nowadays, social service officers are often responsible for deciding on the need of care, sometimes without clear and objective criteria (e.g. Sweden). European guidelines should be decided upon so as to help MS establish national standards.

AIM calls for the establishment of financing and organisational systems so as to ensure that every citizen in the EU has sustainable access to high quality LTC.

Recently, the development of market-based approaches to LTC delivery combined to the will to further empower users have led to the development of a strong consumerism focus. Private for-profit providers are increasingly contracted to deliver public services, replacing a more trust-based system. Experts detect a clear trend towards privatisation and a market-driven approach to LTC in Europe. Such a trend could exacerbate inequities, leaving the most vulnerable groups with unmet needs due to a lack of affordability and the potential implementation of systems which rely on risk selection.

⁵² OECD (2019), Elderly population (indicator). doi: 10.1787/8d805ea1-en (Accessed on 04 November 2019)

In Sweden, an act meant to forbid 'for-profit' in LTC was to be presented at the end of 2017. It was postponed and is on the agenda for the next political mandate. This clearly indicates the growing public scepticism towards the profit orientation of LTC services and policy makers in Europa should take account of it. However, should it be adopted, its impact on the quality and accessibility of LTC services would still have to be assessed so as to be able to identify it (or not) as an example to follow.

AIM calls for a more horizontal coordination between social and healthcare and the development of new care roles.

The needs of LTC beneficiaries often go far beyond care need and include issues such as housing and income needs. A proper integration of health and social care delivery would benefit not only individuals but also welfare systems, as it would help control costs and improve care quality. Currently, governance of LTC is characterised by multiple stakeholders, a division of responsibilities in the regulation, delivery and funding of care and multiple governance mechanisms. It is decentralized and fragmented with regional or local levels of government playing a much greater role in financing or regulating the sector. Collaboration between health care professionals with LTC and social care professionals is often difficult because of non-compatible funding, quality systems and different eligibility criteria. A more horizontal coordination between social and healthcare is necessary and new care roles should be developed.

Integrated care often implies care at local level. When talking about elderly dependence, the issue of isolation and solitude are highlighted as key challenges to tackle. Such issues are only aggravated by the individualistic penchant of our societies. A way of overcoming them is thus to reorganise our societies so as to make the most of interpersonal relationships.

AIM warns against the dangers of 'abrupt' deinstitutionalisation and calls for a progressive shift towards community-based care.

Figures clearly reflect a shift away from institutional care in most EU Member States, with home care being favoured and encouraged. Deinstitutionalisation should however not happen at all costs and should be a progressive process which follows a socially inclusive approach holding human dignity and human rights at its heart. Given the variety of needs, high-quality services should be made available within communities while continuing to provide mainstream services.

In Lithuania, people living in remote areas and with limited means prefer moving to the hospital in the cold months rather than investing in heating their homes. Deinstitutionalisation should only happen if solutions are put in place for all to access quality LTC and when a better integration of health and social services like housing is achieved.

AIM calls for filling the financing gap and ensuring the accessibility of LTC services for all.

One of the biggest challenges for LTC is its financing. Systems heavily relying on payroll contributions could find themselves lacking revenues, should a large proportion of old people simultaneously retire. The decline in the share of the population active in paid employment will most probably slow down the revenue generation growth. Systems will thus need to be redesigned so as to 'fill the financing gap' while ensuring the accessibility of LTC services.

Some countries have shifted to mandatory LTC insurance arrangements. Individuals contribute through payroll or pension contribution depending on their income and coverage is expanded to all irrespective of income. Still, this does not necessarily fill the gap. In Germany for example, there are rising out-of-pocket payments (no comprehensive cover) and a rising insurance rate. Filling the gap would mean far higher rates and increased inequities. There is of course no one size-fits-all solution. However, there is a clear added value in discussing possible solutions at European level, as Member States are all facing similar issues.

AIM calls for European policies to help ensure a clear working status and proper working conditions for informal carers and to set minimum requirements to guarantee high quality care.

As far as formal care is concerned, nearly 30% of workers are nurses (according to the OECD average), while the other 70% are personal care workers, who may have different titles in different countries. In many Member States, most care workers lack a LTC-related qualification. Indeed, while nurses generally have at least three years of training, there are often no standard or minimum requirements for personal carers, especially if they work in home care.⁵³ Minimum requirements should be set at European level to contribute to guarantee high quality levels of care.

Though universal access to quality formal services should remain the main objective, informal care is such a growing trend that it cannot be overlooked. Indeed, apart from the above mentioned formal workers, LTC systems currently highly rely on informal LTC. 80 percent of LTC is estimated to be provided by families and other “informal” carers. Informal care provides the backbone of LTC in many countries. Yet, in most cases, informal carers do not receive proper training and no minimum requirements exists which would guarantee high quality of care. On the one hand, it is important to set minimum requirements and to offer training to those needing it. Innovative tools, such as online training as well as counselling and guidance for relatives acting as carers could be helpful. On the other hand, it is key to guarantee that workers enjoy proper working conditions and a better work-life balance. This would benefit both carers’ and LTC beneficiaries’ health, which in turn will be beneficial to healthcare systems as a whole.

AIM calls for the further development of innovative eSolutions in collaboration with users and payers.

Innovative solutions can help ensure sustainable LTC by improving prevention, rehabilitation allowing individuals to live healthier and longer lives at home should they wish while supporting both formal and informal carers in their tasks. Information and technology services can contribute to strengthen prevention interventions, reach more efficient LTC delivery, improve the coordination of care, and provide support to LTC users and their carers and families (notably to navigate the LTC system, a maze in which it is often complicated to find one’s way). Yet, to be a real added value to people’s lives, those solutions are to be developed together with users so as to cover concrete needs. Payers are also to be included in the process. Not only will they bear the costs but they are also aware of the needs of their affiliates. They can help set priorities which would contribute to guaranteeing the sustainability and accessibility of services.

⁵³ European Commission, *Adequate social protection for long-term care needs in an ageing society*, Luxembourg: 2014, 19.

AIM calls for the development of European outcome indicators for the assessment of LTC.

Data on, and proper monitoring of LTC needs, service provision and quality of care are essential for ensuring that policies are effective and efficient. Developing outcome indicators at European level would be a good way to encourage objective and standardised assessment of LTC, which in turn would allow the collection of comparable data across MS. Such data would be highly valuable and could highlight needs and priorities and guide European action in the field.

In Sweden, an act meant to forbid 'for-profit' in LTC was to be presented at the end of 2017. It was postponed and is on the agenda for the next political mandate. This clearly indicates the growing public scepticism towards the profit orientation of LTC services and policy makers in Europe should take account of it. However, should it be adopted, its impact on the quality and accessibility of LTC services would still have to be assessed so as to be able to identify it (or not) as an example to follow.

Policies which promote healthy and active ageing should be further developed and encouraged.

While it is unquestionable that LTC demand will grow in the decades to come, population ageing might not have the 'devastating' impact on healthcare expenditure which is often depicted. According to a report published by the European Observatory on Health Systems and Policies, the metrics used for forecasts are in many cases misleading as they assume that people become dependent of society from a certain age, which is not always the case. Healthy and active older people are less costly to care for and contribute to the economy in ways which are often not properly measured. Many older people have recourse to private resources, including income for their own continued work or from accumulated assets. They continue providing paid or unpaid work sometimes beyond official retirement age and make a positive societal and economic contributions. Moreover, they still contribute to increase tax revenues, 30 to 50% of which are non-labour related (in OECD countries).⁵⁴ The costs of healthcare and LTC related to ageing can therefore be controlled through policies which promote healthy and active ageing. Interventions which encourage behavioural changes, support activity and prevent or slow down diseases and care dependency are key.

⁵⁴ European Observatory on Health Systems and Policies, *Will population ageing spell the end of the welfare state? A review of evidence and policy options.*, Copenhagen, 2018