EUROPEAN PARLIAMENT 2009 - 2014

Plenary sitting

A7-0221/2013

18.6.2013

REPORT

Impact of the crisis on access to care for vulnerable groups
(2013/2044(INI))

Committee on Employment and Social Affairs

Rapporteur: Jean Lambert

PR_INI

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MOTION FOR A EUROPEAN PARLIAMENT RESOLUTION

on the impact of the crisis on access to care for vulnerable groups

(2013/2044(INI))

The European Parliament,

– having regard to the Treaty on European Union, in particular Article 3(3) thereof, and the Treaty on the Functioning of the European Union, in particular Articles 9, 151, 153 and 168 thereof,

– having regard to the Charter of Fundamental Rights of the European Union, in particular Articles 1, 21, 23, 24, 25, 34 and 35 thereof,

– having regard to the revised European Social Charter, in particular its Articles 30 (on the right to protection against poverty and social exclusion) and 16 (on the right of the family to social, legal and economic protection),

– having regard to the European Convention on Human Rights,

– having regard to the United Nations Convention on the Rights of Persons with Disabilities,

– having regard to the United Nations Convention on the Rights of the Child,

– having regard to Council Directive 2000/43/EC of 29th June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin[1],

– having regard to Regulation (EC) No 1081/2006 of the European Parliament and of the Council of 5 July 2006 on the European Social Fund and repealing Regulation (EC) No 1784/1999[2],

– having regard to the Commission proposal of 6 October 2011 for a regulation on the European Social Fund and repealing Regulation No 1081/2006 (COM(2011)0607),

– having regard to the Commission communication entitled 'Solidarity in health: reducing health inequalities in the EU' (COM(2009)0567),

– having regard to the Commission communication entitled 'Europe 2020: A strategy for smart, sustainable and inclusive growth' (COM(2010)2020),

– having regard to the Commission communication entitled 'European Disability Strategy 2010-2020: A Renewed Commitment to a Barrier-Free Europe' (COM(2010)0636),

– having regard to the Commission communication entitled 'The European Platform against Poverty and Social Exclusion: A European framework for social and territorial cohesion'

[1] OJ L 180, 19.7.2000, p. 22.
[2] OJ L 210, 31.7.2006, p. 12.

(COM(2010)0758),

– having regard to the Commission communication entitled 'An EU Framework for National Roma Integration Strategies up to 2020' (COM(2011)0173),

– having regard to the Commission communication entitled 'Taking forward the Strategic Implementation Plan of the European Innovation Partnership on Active and Healthy Ageing' (COM (2012)0083),

– having regard to the Commission report entitled 'Employment and Social Developments in Europe 2012',

– having regard to its resolution of 9 October 2008 on promoting social inclusion and combating poverty, including child poverty, in the EU[1],

– having regard to its resolution of 6 May 2009 on the active inclusion of people excluded from the labour market[2],

– having regard to its resolution of 19 February 2009 on Social Economy[3],

– having regard to its resolution of 16 June 2010 on EU 2020[4],

– having regard to its resolution of 17 June 2010 on gender aspects of the economic downturn and financial crisis[5],

– having regard to its resolution of 6 July 2010 on promoting youth access to the labour market, strengthening trainee, internship and apprenticeship status[6],

– having regard to its resolution of 20 October 2010 on the financial, economic and social crisis: recommendations concerning measures and initiatives to be taken (mid-term report)[7],

– having regard to its resolution of 7 July 2011 on the Scheme for food distribution to the most deprived persons in the Union[8],

– having regard to its resolution of 9 March 2011 on the EU strategy on Roma inclusion[9],

– having regard to its resolution of 8 March 2011 on reducing health inequalities in the EU[10],

[1] OJ C 9 E, 15.1.2010, p. 11.
[2] OJ C 212 E, 5.8.2010, p. 23.
[3] OJ C 76 E, 25.3.2013, p. 16.
[4] OJ C 236 E, 12.8.2011, p. 57.
[5] OJ C236 E, 12.8.2011, p. 79.
[6] OJ C 351 E, 2.12.2011, p. 29.
[7] OJ C70 E, 8.3.2012, p. 19.
[8] OJ C33 E, 5.2.2013, p.188.
[9] OJ C199 E, 7.7.2012, p.112.
[10] OJ C199 E, 7.7.2012, p. 25.

– having regard to its resolution of 14 September 2011 on an EU Homelessness Strategy[1],

– having regard to its resolution of 25 October 2011 on mobility and inclusion of people with disabilities and the European Disability Strategy 2010-2020[2],

– having regard to its resolution of 7 February 2013 on the European Semester for economic policy coordination: employment and social aspects in the Annual Growth Survey 2013[3],

– having regard to its declarations of 22 April 2008 on ending street homelessness and of 16 December 2010 on an EU homelessness strategy,

– having regard to the reports of 2011 of the European Union Fundamental Rights Agency, 'Migrants in an irregular situation: access to healthcare in 10 European Union Member States[4]' and 'Fundamental rights of migrants in an irregular situation in the European Union',

– having regard to the third report of the Social Protection Committee of March 2012 entitled 'The social impact of the economic crisis and ongoing fiscal consolidation',

– having regard to the report of Doctors of the World entitled 'Access to health care for vulnerable groups in the European Union in 2012',

– having regard to the Eurofound report 'Third European Quality of Life Survey - Quality of life in Europe: Impacts of the crisis'[5],

– having regard to the Eurofound report 'Household debt advisory services in the European Union'[6],

– having regard to the Eurofound report 'Living conditions of the Roma: Substandard housing and health'[7],

– having regard to the Eurofound report 'Active inclusion of young people with disabilities

[1] OJ C51 E, 22.02.2013, p.101.
[2] OJ C131 E, 8.05.2013, p. 9.
[3] Texts adopted P7_TA (2013)0053.
[4] FRA: 'Migrants in an irregular situation: access to healthcare in 10 European Union Member States', October 2011 - http://fra.europa.eu/en/publication/2012/migrants-irregular-situation-access-healthcare-10-european-union-member-states
[5] Eurofound (2012), Third European Quality of Life Survey - Quality of life in Europe: Impacts of the crisis, Publications Office of the European Union, Luxembourg - http://www.eurofound.europa.eu/publications/htmlfiles/ef1264.htm
[6] Eurofound (2012), Household debt advisory services in the European Union, Publications Office of the European Union, Luxembourg - http://www.eurofound.europa.eu/publications/htmlfiles/ef1189.htm
[7] Eurofound (2012), Living conditions of the Roma: Substandard housing and health, Publications Office of the European Union, Luxembourg - http://www.eurofound.europa.eu/pubdocs/2012/02/en/1/EF1202EN.pdf

or health problems'[1],

– having regard to the OECD report entitled 'Health at a glance - Europe 2012',

– having regard to the ILO publication 'Social security for all – Addressing inequities in access to health care for vulnerable groups in countries of Europe and Central Asia',

– having regard to Rule 48 of its Rules of Procedure,

– having regard to the report of the Committee on Employment and Social Affairs and the opinion of the Committee on Women's Rights and Gender Equality (A7-0221/2013),

A. whereas all human beings are born free, with equal dignity and rights, and it is the responsibility of the Member States to promote and guarantee these rights through their constitutions and public health systems; whereas gender inequalities in access to health care and in health outcomes exist throughout the EU;

B. whereas the fundamental values of the EU should be respected even in a crisis situation and access to care**,** healthcare and social assistance should be seen as a basic right for all in the EU; whereas on the contrary, health, care and social services have been cut in the majority of Member States as a consequence of the implementation of austerity policies, thus undermining universal access and the quality of services;

C. whereas healthcare systems across the EU face significant challenges, including persisting eurozone sovereign debt crises resulting in pressure on public finances, an ageing population, the changing nature of health services and rising health costs, all of which clearly indicates the urgent need for reform;

D. whereas the EU has the world's most advanced social protection system, with the highest contributions for social benefits for citizens; stresses that maintaining and further developing the European social model must be a political priority;

E. whereas the World Health Organisation has stated in the Tallinn Charter that health is a key factor contributing to economic development and wealth;

F. whereas the inequality gap is growing in a number of Member States as the poorest and most deprived in those states become even poorer; whereas in 2011 some 24.2 % of the EU's population were at risk of poverty or exclusion; whereas, furthermore, self-reported health among low-income earners has worsened, with an increasingly large health gap as compared to the 25 % of the population with the highest income;

G. whereas long-term unemployment rates are rising, leaving many citizens without insurance cover and thereby restricting their access to health services;

H. whereas the most vulnerable groups are being hit disproportionately in the current crisis as they suffer the double impact of income loss and reduced care services;

[1] Eurofound (2012), Active inclusion of young people with disabilities or health problems, Publications Office of the European Union, Luxembourg - http://www.eurofound.europa.eu/areas/socialcohesion/illnessdisabilityyoung.htm

I. whereas the ‘chronic poor’, often long-term unemployed or employed on low salaries, single people living alone with children who are not in employment or who are working few hours, and older people in central and eastern Europe are consistently identified as among the most vulnerable groups;

J. whereas the most recent studies confirm the emergence of a new group of vulnerable people, who were previously relatively well-off, but are now in need because of levels of personal debt: people in ‘new to need’ group may not be able to make ends meet, and start to default on bills and payments related to debts or are no longer able to pay for necessary care services, and fear having to leave their accommodation;

K. whereas an important role is played by public services – publicly owned and managed, with democratic involvement of their users – in areas essential to welfare, including health, education, justice, water, housing, transport, and care of children and the elderly;

L. whereas the fragmentation of healthcare systems may lead to the situation where many patients do not receive medically necessary care while others receive care that may be unnecessary or even harmful;

M. whereas the crisis has increased the risk of long-term exclusion from the labour market, particularly for young people, who are the most vulnerable to its consequences regarding future labour participation and earnings;

N. whereas more and more people in the EU are working beyond the statutory retirement age, partly because of financial need, with other sources of post-retirement household income having come under pressure;

O. whereas the costs of services to service users are rising in some Member States, which means that many people are no longer able to afford an adequate level of service to meet their defined needs, resulting in a loss of independence, additional stress in their domestic or employment circumstances, or potentially damaging effects on their health leading to their social exclusion;

P. whereas healthcare systems may (unintentionally) create barriers in access to healthcare or provide healthcare of different quality to people who share more than one protected trait, such as sex, age or membership of a minority group;

Q. whereas some social security systems being altered in order to remove or limit access to healthcare for certain groups and to reimbursements for certain treatments and medications[1], creating additional risks for personal and public health, as well as for the long-term sustainability of those systems;

R. whereas it is estimated that most care in the EU is currently being provided by informal, unpaid carers; whereas this enormous resource is under threat, owing to a number of demographic developments and the increasing care burden;

[1] See, for example, Article 5 of Spanish Royal Decree No 16/2012 of 20 April 2012, which entered into force on 28 December 2012. Available at: http://noticias.juridicas.com/base_datos/Admin/rdl16-2012.html#a5.

S. whereas the right to a range of in-home, residential and other community support services, including personal assistance, is enshrined in Articles 19 and 26 of the UN Convention on the Rights of Persons with Disabilities;

T. whereas the reasons for placing children in alternative care arrangements are complex and multidimensional, but often appear as directly or indirectly related to poverty and social exclusion;

U. whereas a lack of accurate and accessible information can contribute to vulnerable groups being unable to access the necessary care to which they are entitled;

V. whereas reports point to increasing difficulties being encountered by some EU nationals and others with legal entitlement in accessing their right to care in a crossborder situation;

W. whereas problems of medical demography (low levels of care provision in certain geographical areas) in a number of Member States make it harder for vulnerable groups to access care;

X. whereas reports of growing social division and aggression resulting in verbal and physical attacks against minorities and vulnerable people are increasing; whereas such incidents should be reported in detail;

Y. whereas in some Member States regression in policy with regard to people with disabilities, learning difficulties or psychiatric illness is leading to a move away from an inclusion rights-based approach aiming at full inclusion in the community towards the more institutional and segregating approach of the past;

Z. stresses the high employment potential of the health and social care sector across the EU;

AA. whereas many jobs in the healthcare and care sector in some Member States are still poorly paid, often not offering formal contracts and other basic labour rights and have low attractiveness because of the high risk of physical and emotional stress, the threat of burnout, and a lack of career development opportunities; whereas the sector offers little training and, moreover, its employees are predominantly ageing people, women and migrant workers; whereas care in the EU is often provided by informal unpaid carers, who themselves can be considered a vulnerable group due to increasing pressures to provide more sophisticated and technical levels of care; whereas a number of Member States lack a quality care service that is available to all regardless of income;

AB. whereas the transition from institutional to community-based forms of care requires increased housing-related support to enable vulnerable people to live independently;

AC. whereas young people leaving care settings for an independent life are particularly exposed to poverty and social exclusion;

AD. whereas growing numbers of elderly people must be classed as vulnerable;

AE. whereas poor EU citizens who are nationals of other Member States and third-country nationals covered by the social security system of another Member State can also

experience major difficulties in accessing care;

AF. whereas all people are entitled to a standard of living enabling them and their families to enjoy health and wellbeing;

AG. whereas it is important to stress the significance of civil society and its organisations, which play a vital role in reaching out to excluded groups;

AH. whereas health protection has important effects on the quality, length and dignity of human life;

AI. whereas approximately 10 % of births in a given year in the EU are premature (gestational age under 37 weeks), and whereas mothers of pre-term babies often lack access to health services of the requisite standard, a fact which makes itself felt even more strongly in terms of work-life balance;

AJ. whereas poverty, inadequate education and a lower level of social integration result in poor health outcomes; whereas the main barriers to healthcare for vulnerable groups are lack of knowledge and understanding of the health system, administrative problems, lack of knowledge regarding disease prevention, and lack of physical access to services;

1. Calls on the Commission to require Member States to provide information on the austerity measures being implemented and to carry out social impact assessments of austerity measures and include recommendations tackling the medium-term and long-term social and economic impact of such measures in their country-specific recommendations; calls on the Commission to produce regular summary reports of such assessments and forward them to Parliament; requests that the European Semester process should not only focus on the financial sustainability of social security systems but also take into account possible impacts on the accessibility and quality dimension of care services;

2. Calls on the Commission and the Member States to encourage and promote social investment in social services such as the health, care and social sectors, sectors which are essential in view of demographic changes and of the social consequences of the crisis, and have great potential for job creation;

3. Is convinced that the necessary reforms should address the quality and efficiency of healthcare, should improve access to the right care at the right time in the right setting, and should keep people healthy and ensure that the common and avoidable complications of illnesses are prevented to the greatest extent possible;

4. Recalls that the Member States have agreed to adopt an approach marking a shift away from ‘curative’ measures addressing the symptoms of exclusion and ill health and towards ‘preventive’ measures, ‘as a strategy to improve quality of life and reduce the burden of chronic diseases, frailty and disability’[1]; stresses, in this respect, the long-term costs of non-action;

5. Considers that leaving vulnerable individuals without access to healthcare or care services

[1] Council Conclusions on healthy and dignified ageing, 2980th Employment, Social Policy, Health and Consumer Affairs Council meeting, November 2009.

is a false economy as this may have a long-term negative impact on both healthcare costs and individual and public health;

6. Considers that many of the short-term cost-reduction measures currently being implemented, such as the introduction of up-front access to healthcare fees, higher out-of-pocket expenditure or exclusion from access to care of vulnerable groups such as irregular migrants, have not been fully assessed for their wider social and economic consequences or potentially discriminatory effects and long-term implications, including dangers to public health and possible consequences for life expectancy; underlines the fact that such measures have disproportionate negative impacts on vulnerable groups;

7. Considers it regrettable that the social stigma attached to certain medical conditions deters individuals from seeking necessary care, which may also leave communicable diseases**,** for example, untreated, with a subsequent risk to public health;

8. Regrets the disproportionate impact that countries' apprehension practices and reporting obligations linked to immigration law enforcement have on undocumented migrants' ability to receive medical attention[1];

9. Recognises that there are close relationships between a range of vulnerabilities, experience of institutional care, lack of access to quality community-based care and resulting homelessness; recalls that health and care services can play an important role in preventing and tackling poverty and social exclusion, including extreme forms such as homelessness; stresses that groups presenting several vulnerability factors, such as Roma, persons without a valid residence permit or homeless people, are at an even higher risk of being left out of risk prevention campaigns, screening and treatment;

10. Points to the long-term negative effects of cuts to preventive care measures in times of crisis; considers that preventive measures, if they need to be reduced, should at least be raised back to the previous level, so as to preserve continuity and not destroy infrastructure; emphasises that the economic and financial crisis and the so-called austerity policies imposed on some Member States should not be cause for disinvestment in national health services but that, given their importance and essential nature, efforts should, on the contrary, be made to consolidate these services to meet the needs of society, particularly its most vulnerable groups;

11. Considers that austerity measures should not under any circumstances deprive citizens of their access to basic social and health services or innovation and quality in social service provision and should not reverse positive trends in policy development;

12. Calls on the Member States to promote recruitment in social care services and to work on increasing the attractiveness of the sector as a viable career option for young people;

13. Stresses that the number of EU citizens living in another EU country than their own and having no health insurance, for reasons such as unemployment or no longer having a

[1] The FRA guidelines' Apprehension of migrants in an irregular situation – fundamental rights considerations' propose key principles to Member States on detection and reporting practices in and near medical facilities: http://fra.europa.eu/sites/default/files/document-on-apprehensions_1.pdf

residence permit, is on the rise; underlines the fact that EU citizens covered by health insurance in another EU country often have difficulty in accessing care as they have to pay beforehand;

14. Is concerned that persons with disabilities across the EU are being disproportionately affected by cuts in public spending, as a result of which they are losing the support services which allow them to live independently in the community;

15. Considers that this is leading to an increase in the number of people living in long-term institutional care and the further social exclusion of persons with disabilities in the EU, which is in direct violation of the EU's commitments under the UN Convention on the Rights of Persons with Disabilities and the European Disability Strategy 2010-2020;

16. Stresses that the care to be received by people with disabilities should be provided in an accessible way, in terms not only of infrastructure but also of communication, which is especially important in the case of persons with intellectual disabilities (learning difficulties); stresses the need to encourage the training of care providers and general practitioners to deliver care in an accessible way;

17. Considers that any cuts to care and support services for young people or other vulnerable groups are liable to undermine existing EU policies on active inclusion; stresses that high youth unemployment rates put additional pressure on all kinds of social services and that targeted action could help;

18. Notes that, because of rising unemployment and long-term unemployment due to the crisis, a large proportion of our fellow citizens – the long-term unemployed and their dependents – are being denied access to the public health system, social security and healthcare; calls on the Member States, and especially those with the highest unemployment rates, effectively and rapidly to address this major issue through the adoption of the necessary measures;

19. Welcomes the Commission recommendation of 20 February 2013 on 'Investing in Children: breaking the cycle of disadvantage'; recognises the importance and cost-effectiveness of early-years investment in children, in terms of developing their full potential; recognises that investing in high-quality social services is essential for the development of appropriate and effective child protection services and for the establishment of comprehensive prevention strategies; recalls the importance of adopting a life-course perspective and of health promotion, prevention and early diagnosis; stresses that the recent measles pandemic has shown how important free vaccinations for children are for public health;

20. Recognises the huge social and economic contribution made by family members acting as carers and volunteers (informal care), and the increasing responsibilities placed upon them by reductions in service provision or the rising costs thereof; considers that austerity measures should not lead to overburdening informal carers even further; stresses the importance of recognising the expertise of carers and guaranteeing high-quality work; calls for appropriate support and assistance for family members acting as carers in terms of combining care and career, and considers that time spent as a carer must be calculated into pension eligibility; stresses that most care provision in the EU is provided on an

informal basis, i.e. by family members and volunteers, and calls on the Commission, the Member States and the social partners to enhance the appreciation of and financial rewards for this contribution;

21. Recognises that more and more women are involved in paid work (although earning 18 % less than men), while at the same time women are still relatively often carers (78 % of all caregivers are women), and that this challenges the goal of a satisfactory work-life balance; believes that, in general, flexible work options are important in helping people to combine work and care; is concerned at the negative impact of reductions in service provision or the rising costs thereof on employment levels amongst women, work-life balance, gender equality and healthy ageing;

22. Recalls that the care sector has been identified by the EU as an area of potential growth in employment, and that Parliament has identified the need for better pay and training in order to make this an attractive career choice and improve the quality of service; points to the noticeable lack of workers in parts of the health and care provision sector, and calls on the Member States to promote care training among young people, as well as training measures which can help caregivers and providers better understand the needs of care recipients;

23. Stresses the increasing importance of mobile service provision in order to bring services to those who require them, in urban as well as in rural areas;

24. Underlines the valuable contribution of the volunteer sector to the care of elderly people in need of care and, where necessary, of isolated individuals living on their own;

25. Appreciates the fact that the European Innovation Partnership on Active and Healthy Ageing (EIP) has been chosen to meet the challenges resulting from demographic ageing; this includes the objective of increasing the healthy lifespan of EU citizens by two years by 2020; it also pursues a triple-win situation for Europe by:

    i) enhancing the health and quality of life of older people,

    ii) improving the sustainability and efficiency of care systems, and

    iii) creating growth and market opportunities for businesses;

26. Recognises the work done by third-sector and voluntary organisations, but considers that this should not be a substitute for the state's responsibility to provide high-quality, effective, reliable and affordable services that are accessible to all as a public good, with financial support from public resources;

27. Highlights the European Quality Framework for Long-Term Care, which provides principles and guidelines for the dignity and wellbeing of elderly people in need of care and was published as part of the Commission's WeDO project[1];

[1] WeDO, a project supported by the European Commission (2010-2012), was run by a steering group comprising 18 partner organisations in 12 Member States. The common interest of all the partner organisations was and remains to improve the quality of life of elderly people in need of care.

28. Calls on the Member States to improve health literacy and provide suitable information on available services to vulnerable groups who often have difficulty accessing the services they need; of equal importance is the involvement of care recipients and carers in the decision-making processes which affect them;

Recommendations

29. Calls on the Commission to obtain comparable and current data in the form of a fundamental analysis relating to access to care;

30. Calls on the Commission and the Member States, in cooperation with all relevant stakeholders, to monitor and address in the national reform plans which national policies run counter to the 2020 poverty reduction target; calls on the Member States to place a special focus on the most vulnerable groups, to remove access barriers, improve and strengthen take-up and preventive measures at an early stage in order to return to a rights-based approach, and prevent to long-term damage and costs stemming from non-action;

31. Calls on the Commission, the social partners and the Member States to act on the findings of an analysis of the strengths and weaknesses of the 2012 European Year for Active Ageing and Solidarity between Generations;

32. Recalls that austerity policies, with their cuts to social services and welfare and their deflationary impact on the economy, are incompatible with the achievement of the 2020 poverty reduction target, as well as with other EU social inclusion, equality, anti-poverty and territorial cohesion targets;

33. Urges the Member States to cooperate in seeking to implement a maximum number of programmes to improve health standards among the most vulnerable groups, in particular children and young people, in the context of mobility, this being recognised as a fundamental right within the EU;

34. Calls on the Commission to examine the tensions that may arise between social security rights under Regulation 883/2004[1] and the operation of Directive 2004/38/EC[2], with a view to recommending any changes that may be required to close gaps in coverage;

35. Urges the Commission and all Member States to set priorities, to close gaps between men and women, and to ensure effective access for women to health services and family planning, as well as paying special attention to other vulnerable and disadvantaged groups needing social health protection;

36. Calls on the Commission to include social safeguards protecting care and social services and social protection systems in agreements with countries in receipt of financial assistance; calls on the Commission and the Member States to develop the use of new technologies such as telemedicine in order to facilitate access to care;

37. Calls on the Commission to promote equal access to early childhood education and care,

[1] OJ L 166, 30.4.2004, p. 1.
[2] OJ L 158, 30.4.2004, p. 77.

and provide adequate financial support for these services;

38. Urges the Member States to provide community-based services to children with disabilities;

39. Calls on the Member States to identify and eliminate obstacles and barriers regarding disabled people's access to public transport, services and information;

40. Calls on the Commission and the Member States to set up priorities to close gaps and provide effective access to health services for vulnerable groups including poor women, migrants and Roma in the area of social health protection, by ensuring the affordability, availability and quality of healthcare, as well as efficient and effective organisation and adequate financing in all geographical areas;

41. Urges the Member States to adopt policies that promote health and the prevention of disease by guaranteeing free, universal and quality healthcare for the most disadvantaged groups, with particular attention to guaranteeing primary healthcare, preventive medicine, and access to diagnosis, treatment and rehabilitation; calls for provision of the means required to combat the main public health problems facing women and guarantee the right to sexual and reproductive health, health services for women who are victims of violence, and healthcare for infants;

42. Calls on the Member States, in cooperation with the Commission, to consider more fully the link between physical and mental health on the one hand and unemployment and job insecurity on the other – which have been revealed by the crisis as major phenomena – in order to have proper planning in place to prevent and address harmful consequences of this kind;

43. Strongly recommends that Member States reinforce their health services regarding prevention and primary care, focusing on improving women's health and access to care, particularly for women living in areas remote from urban centres, as well as on measures for the most disadvantaged groups – children and young people, the elderly, persons with disabilities, the unemployed and the homeless – that guarantee the right to regular medical monitoring for all;

44. Urges the Commission and the Member States to treat maternity and neonatal care, especially in cases of premature birth, as a public health priority and to incorporate it in European and national public health strategies;

45. Calls on the Commission and the Member States to organise the necessary education and continuing training courses for all health professionals working in pre-conception, maternity and neonatal care units, with the aim of preventing premature births and reducing the incidence of chronic diseases affecting those born pre-term;

46. Urges the Member States to ensure appropriate assistance to women during and after pregnancy and lactation, by offering free caring/consultation services when needed and adequate nutrition, especially to those running the risk of poverty and social exclusion because of the recent economic crisis;

47. Urges Member States to develop suitable structures for offering people medico-social appointments so as to take greater account of the living conditions of the poorest;

48. Calls on Member States to provide accessible and clear information on the rights of migrants in all relevant languages, including Romani;

49. Urges the Member States to take action against hate crime and to promote anti-discrimination policies, if necessary by strengthening their national anti-discrimination bodies and promoting training within public authorities;

50. Urges the Member States to implement Article 19 TFEU and adopt the directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation in order to prohibit discrimination based on religion or belief, disability, age or sexual orientation[1] and to put into effect the principle of equal treatment in the areas of social protection, including social security and healthcare, education, and access to and supply of goods and services which are commercially available to the public, including housing;

51. Calls on the Member States to carry out impact assessments to ensure that measures taken that might impact the most vulnerable are in compliance with the principles laid down in the EU Charter for Fundamental Rights and in conformity with Directive 2000/43/EC implementing the principle of equal treatment between persons irrespective of racial or ethnic origin[2];

52. Urges the Member States to prevent homelessness, to provide the necessary care for homeless people, and not to criminalise homelessness in their national legislation;

53. Urges the Commission and the Member States to ensure that any policy or funding programmes designed to support social innovation and/or care-related services target those services that best meet social needs and improve people's quality of life, and that they are developed in close cooperation and consultation with the organisations that defend and represent vulnerable groups;

54. Points to the scope of Parliament's Social Business Initiative and stresses the importance of the social economy, which can, together with social businesses, effectively reinforce the fast-growing area of health and social care;

55. Urges the Commission and the Council to work with Parliament to reinforce funding to programmes that target vulnerable groups; urges the Commission to take all the measures available to it to ensure full take-up and maximum disbursement under the European Social Fund, the Fund for European Aid to the Most Deprived and other relevant instruments which address the needs of people who are vulnerable or at risk of exclusion, and to support Member States' efforts to meet the Europe 2020 poverty target and to promote innovation and quality in the health and care sectors; stresses the importance of related funding instruments such as the EU Programme for Social Change and Innovation and the European Social Entrepreneurship Fund;

[1] COM(2008)0426.
[2] OJ L 180, 19.7.2000, p.22.

56. Calls on the Commission to develop a package of objective and subjective indicators with a view to measuring and regularly publishing on the material and non-material components of wellbeing, including social indicators, in order to complement European and national GDP and unemployment indicators and thus measure societal progress and not just economic development;

57. Calls on the Commission and the Member States to explicitly recognise the invaluable contribution made by informal carers; urges the Member States to put in place and maintain targeted support measures for carers and the voluntary sector, in the interests of providing more personal, quality and cost-effective measures, e.g. measures enabling reconciliation of work and family life, facilitating better cooperation and coordination between informal and formal care providers, and ensuring appropriate social security policies and training for carers; calls on the Commission and the Member States to develop a coherent framework for all types of care leave; calls on the Commission to propose a directive on carers' leave, in line with the subsidiarity principle as set out in the Treaties;

58. Calls on the Member States to provide accurate and easily understandable information in the relevant languages and formats on entitlement to care, and to make it widely accessible;

59. Calls on the Commission, the Member States and the social partners to draw up clear definitions of professional profiles in the care sector which enable rights and obligations to be precisely delimited;

60. Calls on the Member States to integrate all potential actors at local, regional and national level, including the social partners, into initiatives concerning prevention, health and social services;

61. Urges Member States to promote the training programmes required by the care and support sectors, and to offer grants to those undertaking relevant studies;

62. Urges the Commission to promote a campaign with the aim of recruiting young people and improving the public image of the care sector as employer;

63. Calls for the employment rights of those working in the care sector to be respected, including the right to a decent income and decent conditions and the right to join and form trade unions with collective bargaining rights;

64. Urges the Member States to support national, regional and local authorities in setting up sustainable funding schemes for care services and in developing training and retraining schemes for the workforce with the help of ESF funding;

65. Urges the social partners to develop a formal social dialogue relating to the care sector;

66. Instructs its President to forward this resolution to the Council, the Commission and the governments of the Member States.

EXPLANATORY STATEMENT

The Employment and Social Affairs Committee (EMPL) has been concerned for some time as to the effect of so-called austerity measures on society in general and vulnerable groups in particular. This has been expressed via various actions such as: our reports on the Annual Growth Survey[1], where we have expressed the view that the social dimension must be included as an integral part of the EU's crisis response; the report on Youth and the Crisis[2]; our opinion on Women and the Crisis[3] and the forthcoming report on Homelessness[4]. We also have a number of reports dealing with the EU2020 Strategy, especially in relation to the Inclusive Growth and Anti-Poverty Platform, where we have made clear our view that we should aim to prevent poverty as it offends human dignity, but also as a focus on prevention generally proves more cost-effective in the long-term. EMPL has argued for 20% of ESF funding to be dedicated to tackling poverty and is currently developing its position on the proposed Fund for the Materially Deprived[5] where the Committee has already reported on certain issues in depth, your Rapporteur has sought not to duplicate that work.

In this initiative report, your Rapporteur aims to identify a number of issues arising for those groups known to be vulnerable, some groups where needs are becoming more evident and new, and potentially vulnerable groups developing as a result of current changing conditions, such as personal indebtedness. The Committee is very grateful to the various organisations which have provided us with up-to-date information. The need for accurate, comparable data which is as recent as possible has been clearly identified as a priority.

It is clear that the care sector for older people, those with physical or learning disabilities and those providing support for children or young people, or others with specific needs is under increasing stress as spending is reduced yet demand increases. Healthcare provision faces similar challenges. These cuts, whether in services or social benefits, affect both those who need care and those who provide it. Public sector budgets are being cut. Third-sector providers report diminishing income from public sector contracts, grant-funding and public donations: a number fear for their future: even voluntary effort requires an infrastructure. We could see short-terms cuts giving rise to long-term problems.

There is growing evidence that social inequality is continuing to develop within parts of the EU due to a deteriorating situation for already vulnerable groups, where many of the poorest are becoming poorer.[6] This has major repercussions for the poverty reduction targets and inclusive growth dimension of the EU2020 Strategy. Some social security systems, especially those which assume a certain family-based structure, or where entitlements may be conditional on certain work patterns, also appear less able to cope with the increased pressures of the crisis, not least in respect to child-poverty.[7]

[1] Cornelissen report 2012 and Lope Fontagné report 2013 on the Annual Growth Survey (2011/2320(INI) (2012/2257(INI))
[2] Turunen report on promoting youth access to the labour market (2009/2221(INI))
[3] Zimmer report on the impact of the economic crisis on gender (2012/2301(INI))
[4] 'Delli' report on social housing
[5] Proposal for a Regulation on the Fund for European Aid to the Most Deprived
[6] Employment and Social Developments in Europe 2012 and 3rd European Quality of Life Survey, Eurofound 2012
[7] Social Protection Committee Advisory report to the European Commission on Tackling and preventing Child Poverty and promoting child well-being June 27, 2012 –

One clear issue of social responsibility in this crisis is the role of access to healthcare. While public health itself is the concern of another Committee, barriers are created in a number of Member States by social security rules. For example, health insurance terminating after a period of unemployment or systems barring certain groups, such as undocumented migrants, from primary or non-urgent care, or which are based on full-time work which disadvantage part-time or casual workers. Women in general, but especially women of ethnic minority background such as Roma and migrant workers, are particularly disadvantaged[1]. A number of Member States are modifying or reforming social security systems: such changes should be assessed to ensure that people are not excluded from coverage. The number of people who are homeless or in short-term accommodation is rising in a number of Member States, this is resulting in many having no continuity of care: some children are not receiving basic immunisations and it is clear that certain communicable diseases are re-appearing amongst those who are poorly housed and lack access to services. It would appear that some EU nationals are unable to access care in another Member State, despite the provision of Regulation 883/2004[2], due to the way in which Directive 2004/38/EC[3]is implemented: this should be explored and coverage gaps closed.

Rising costs of co-financing or prescriptions, when compared to the incomes of those in need, are deterring people from seeking care at an early stage and thus requiring more expensive and urgent care later. This may also result in an inability to continuing treatment programmes which may result in absence from work or, tragically, negative medical outcomes. The shame or stigma of seeking care for certain conditions, such as HIV/AIDS, STDs or even cancer in some societies is also reported to be a barrier. Rates in some Member States are rising. Some countries are aiming to reduce the cost of pharmaceuticals themselves by greater co-operation between purchasing bodies concerning procurement. Healthcare staffing has significantly reduced in a number of countries which has also affected the provision of services, including in rural areas where provision was already weaker. Staff have suffered pay cuts in some countries with one result being staff leaving to work in another job or another country: both have implications for the long-term sustainability of healthcare delivery.

The Committee was also told of a developing concern relating to those on short-term or casual contracts who are likely to lose out on workplace health benefits in addition to problems caused by irregular income.

It should also be remembered that in some Member States**,** complex access procedures to social security and welfare provision may also deter some people from claiming or receiving their due entitlement, which has implications for their ability to cope. This is also an issue for some in a cross-border situation. Staff reductions, inadequate training or high staff- turnover may also mean that the quality or accuracy of information may be compromised and thus render people more vulnerable.

Low, uncertain or lack of disposable income, coupled with rising utility costs may also mean people being cut off from essential services in some Member States and thus having no access to heating or cooling with consequent health outcomes, especially in extreme weather

[1] Paper 8 Social Security for All, Scheil-Adlung and Kuhl, ILO 2011
[2] Regulation (EC) No 883/2004 on the coordination of social security systems
[3] Directive 2004/38/EC on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States

conditions. Care in a home setting becomes virtually impossible in such a situation. Access to basic utilities should be assured.

Reductions in benefits and/ or services are reported as having a direct, negative effect on people with disabilities and their quality of life. The Committee was told that, in a worst-case scenario, care was being reduced to "cleaning and feeding" and no longer promoting independent living and the social model of disability in line with the EU's commitments under the UN Convention on the rights of persons with disabilities. Some Member States are no longer moving away from institutionalised care and more innovative, empowering approaches to care are being set aside, even when they are more cost-effective. There is also increased experience of "hate-speech", bullying and assault against people with disabilities, those with mental health problems and other vulnerable groups such as (undocumented) migrants and Roma: people who are viewed as "costing too much to care for". This attitude is fanned by certain political movements and media and some political rhetoric. Discriminatory behaviour should not go unchecked, both for the safety and dignity of the individuals attacked and those working with them.

Care for older people with particular needs is also under stress in many countries. Long-term care benefits do not exist in all Member States and, even where they do, may still be accompanied by costs for additional services. Care is often informal, provided by family members who may also be employed or have other care responsibilities, and services which help them are under pressure. They may find themselves providing relatively demanding medical attention with little or no training or support. Costs of support services such as home-helps may be rising or help withdrawn. Child-carers may also be supporting adults with challenging or addictive behaviours and effectively raising their own siblings. This informal care effectively saves national governments an enormous amount of money and it would be a false economy to undermine support for those who do it. There is also the question of the longer-term sustainability of informal care in light of the changing composition of households.

As regards professional care, this is a sector renowned for low pay, poor working conditions and often rapid staff turnover, and it is no surprise there are staff shortages. In some Member States care may be provided by private individuals at home, with little or no effective regulation: Parliament has declared the importance of the ILO Convention on Domestic Workers in this regard. Industrial relations are often weak, so a social partner sector approach could help to raise standards.

With regard to child development, we know the importance of high-quality early years experience. Evidence shows that social factors are particularly critical in the early years of life, which have a strong impact on a child's future health, educational development and life-chances. It is worth highlighting that the highest rate of return to human capital investment is found in early childhood years[1], while public expenditure is typically lowest for this age group [2] Almost 1 million children are estimated to be living in alternative care in the EU: the disadvantages they face are well known as is the need for high-quality social service

[1] The case for investing in disadvantaged young children, James J. Heckman University of Chicago and University College Dublin, European Experts Networks on Economics in Education, January 2012
[2] "The Benefits of Early Child Development Program: An Economic Analysis", Van der Gaag, J. and Tan, J.P.,

intervention to either prevent their going in to care, or having a more community-based, supported experience while there, and during their transition to independence.

The potentially serious consequences for society of increasing insecurity and an inability to deliver effective care have been stressed to our Committee. The involvement of the "troika" in national budgets means that the EU is seen as having a direct effect on areas which are primarily Member State responsibilities, so the EU should also be seen as promoting solutions. At the very least, comprehensive social impact assessments of changes in social security systems and provision of care services are essential in order to avoid making a bad situation worse, creating long-term problems and undermining other policy goals: that is a task for the EU in the "troika" and in the assessment of National Reform Plans.

29.5.2013

OPINION OF THE COMMITTEE ON WOMEN'S RIGHTS AND GENDER EQUALITY

for the Committee on Employment and Social Affairs

on the impact of the crisis on access to care for vulnerable groups
(2013/2044(INI))

Rapporteur: Inês Cristina Zuber

SUGGESTIONS

The Committee on Women's Rights and Gender Equality calls on the Committee on Employment and Social Affairs, as the committee responsible, to incorporate the following suggestions in its motion for a resolution:

A. whereas all human beings are born free, with equal dignity and rights, and it is the responsibility of the Member States to promote and guarantee these rights through their constitutions and public health systems; whereas gender inequalities in access to health care and in health outcomes exist throughout the EU;

B. whereas certain groups, for example women with a disability, are obliged to spend more on healthcare than the rest of the population;

C. whereas all people are entitled to a standard of living enabling them and their families to enjoy health and wellbeing;

D. whereas all people, irrespective of their gender, ethnic background, religious or cultural beliefs or disabilities, have the right to health protection, independently of their economic and social condition and their nationality; whereas this right should be realised through both preventive and curative medical care and rehabilitation, and responsibility should lie first and foremost with the Member States through their public health systems;

E. whereas it is important to stress the significance of civil society and its organisations, which play a vital role in reaching out to excluded groups;

F. whereas the current economic crisis and the adoption of policies to combat public deficits have led in some Member States to a reduction in national health budgets; whereas this has resulted in a risk of reduced access to healthcare for the most disadvantaged groups – children, the elderly, people with disabilities, migrants and ethnic minorities;

G. whereas women are more likely to withdraw from the labour market, for various reasons (pregnancy, family responsibilities or caring for dependants), and this affects their health insurance status and their access to healthcare;

H. whereas in 2011, 24.2 % of the population of the EU (119.6 million people) was considered at risk of poverty and/or social exclusion, with 25 million of these being children; whereas women encounter greater obstacles when entering the labour market, making it more difficult for them to lead ordered and independent lives;

I. whereas health protection has important effects on the quality, length and dignity of human life;

J. whereas approximately 10 % of births a year in the EU are premature (gestational age under 37 weeks) and whereas mothers of pre-term babies often lack access to health services of the requisite standard, a fact which makes itself felt even more strongly in terms of work-life balance;

K. whereas poverty, inadequate education and a lower level of social integration result in poor health outcomes; whereas the main barriers to healthcare for vulnerable groups are lack of knowledge and understanding of the health system, administrative problems, lack of knowledge regarding disease prevention, and lack of physical access to services;

L. whereas the ageing population is one of the most fundamental challenges facing Europe;

1. Strongly recommends that adjustments to public health budgets should not affect those who are particularly vulnerable and that such groups should, rather, constitute a priority; therefore recommends a thoroughgoing reform in support of the health and care services sectors, which should be complemented by increased and more effective public investment in those services in order to meet citizens' needs, and, in particular, to tackle gender inequalities in health and ensure equal access to healthcare for the most disadvantaged groups;

2. Calls on the Member States not to intensify women's burden of caring by returning them to their traditional family role;

3. Recommends strongly that drastic measures be taken to combat unemployment in the context of the economic and financial crisis and to provide adequate funding for the provision of suitable and adequate health and welfare services in order to help meet the needs of an ageing population;

4. Urges the Member States to adopt policies that promote health and the prevention of disease by guaranteeing free, universal and quality healthcare for the most disadvantaged groups, with particular attention to guaranteeing primary healthcare, preventive medicine, and access to diagnosis, treatment and rehabilitation; calls for provision of the means required to combat the main public health problems facing women and guarantee the right to sexual and reproductive health, health services for women who are victims of violence, and healthcare for infants;

5. Strongly recommends that Member States reinforce their health services regarding

prevention and primary care, focusing on improving women's health and access to care, particularly for women living in areas remote from urban centres, as well as on measures for the most disadvantaged groups – children and young people, the elderly, persons with disabilities, the unemployed and the homeless – that guarantee the right to regular medical monitoring for all;

6. Urges the Commission and the Member States to treat maternity and neonatal care, especially in cases of premature birth, as a public health priority and to incorporate it in European and national public health strategies;

7. Calls on the Commission and the Member States to organise the necessary education and continuing training courses for all health professionals working in pre-conception, maternity, and neonatal care units, with the aim of preventing premature births and reducing the incidence of chronic diseases affecting those born pre-term;

8. Urges the Member States to ensure appropriate assistance to women during and after pregnancy and lactation, by offering free caring/consultation services when needed and adequate nutrition, especially to those running the risk of poverty and social exclusion because of the recent economic crisis;

9. Urges the Member States to cooperate in seeking to implement a maximum number of programmes to improve health standards among the most vulnerable groups, in particular children and young people, in the context of mobility, this being recognised as a fundamental right within the EU;

10. Urges the Commission and all Member States to set priorities, to close gaps between men and women, and to ensure effective access for women to health services and family planning, as well as paying special attention to other vulnerable and disadvantaged groups needing social health protection;

11. Calls on the Commission to publish a report on the impact of the economic and financial crisis on the most vulnerable, particularly in terms of access to preventive healthcare and medical treatment.

RESULT OF FINAL VOTE IN COMMITTEE

Date adopted	29.5.2013
Result of final vote	+: 26 –: 1 0: 1
Members present for the final vote	Regina Bastos, Edit Bauer, Andrea Češková, Marije Cornelissen, Edite Estrela, Iratxe García Pérez, Mikael Gustafsson, Mary Honeyball, Lívia Járóka, Teresa Jiménez-Becerril Barrio, Constance Le Grip, Astrid Lulling, Barbara Matera, Elisabeth Morin-Chartier, Krisztina Morvai, Norica Nicolai, Siiri Oviir, Antonyia Parvanova, Joanna Senyszyn, Joanna Katarzyna Skrzydlewska, Marc Tarabella, Anna Záborská
Substitute(s) present for the final vote	Roberta Angelilli, Rosa Estaràs Ferragut, Nicole Kiil-Nielsen, Katarína Neveďalová, Chrysoula Paliadeli, Antigoni Papadopoulou, Angelika Werthmann
Substitute(s) under Rule 187(2) present for the final vote	Martina Anderson

RESULT OF FINAL VOTE IN COMMITTEE

Date adopted	30.5.2013
Result of final vote	+: 36 –: 1 0: 2
Members present for the final vote	Edit Bauer, Heinz K. Becker, Jean-Luc Bennahmias, Phil Bennion, Pervenche Berès, Vilija Blinkevičiūtė, Milan Cabrnoch, Alejandro Cercas, Ole Christensen, Derek Roland Clark, Minodora Cliveti, Marije Cornelissen, Frédéric Daerden, Sari Essayah, Richard Falbr, Marian Harkin, Nadja Hirsch, Stephen Hughes, Danuta Jazłowiecka, Martin Kastler, Ádám Kósa, Jean Lambert, Patrick Le Hyaric, Verónica Lope Fontagné, Olle Ludvigsson, Thomas Mann, Csaba Őry, Sylvana Rapti, Licia Ronzulli, Nicole Sinclaire, Joanna Katarzyna Skrzydlewska, Jutta Steinruck, Traian Ungureanu, Inês Cristina Zuber
Substitute(s) present for the final vote	Malika Benarab-Attou, Iliana Malinova Iotova, Svetoslav Hristov Malinov, Ria Oomen-Ruijten, Antigoni Papadopoulou