III. Assessment – research – training

- The institution of techniques of evaluation of dependency is of fundamental importance.
- Member states must promote research in chronic diseases and the causes of disability in elderly persons, in particular in the senile dementias.
- The care of an elderly person at home or in an institution, calls for a specific training in geriatics, both basic and continuing, for general practitioners, as well as for specialists.

IV. Organisation of medical care

- In all member states, the policy trends are towards maintaining elderly people at home where the family doctor in his role, as the personal confidential advisor of his patients, is the co-ordinator of medical care.
- With a view to an improved response to the needs of elderly persons, co-ordination of social and health care is an absolute necessity.
- To this end, there must be co-ordination between the doctor and:
  - The family and neighbours (as a priority).
  - The nursing and other health professions.
  - Social workers.
- Other organisations and services for the elderly.
- Maintaining the elderly person at home appears to be the most economic approach for society and the most humane for the individual. It calls for an adequate training of the general practitioner in evaluation techniques, palliative care of elderly persons, and terminal care. It requires involvement in and development of new techniques for care of the elderly at home by specialists.
- When there is a need for special accommodation of the elderly person due to psychological, physical, family or social factors, this calls for a type of accommodation which is a real substitute for the home, geared to human needs, with a stimulating style of life, leisure and occupational activities.
- Day hospitals and hospitalisation for the night or the week-end must avoid the psychological trauma of hospitalisation in an elderly person.
- Temporary accommodation is a valuable alternative to hospitalisation and gives a chance for families to have a rest.
- The hospitalisation of an elderly person should only be used as a last resort.

Aware of the importance of the demographic trends in aging and its effects on the future of Europe, the Standing Committee of Doctors of the EEC, on the basis of these recommendations, proposes to the European institutions and to competent authorities in every member state that they should willingly engage in a policy of support for the elderly population.

10.2 Declaration on the Green Paper on the structure of social policy in Europe

Curia, 1994 (CP 94/54)

The Standing Committee of Doctors in Europe (CP) meeting in Curia, Portugal, on 16 April 1994,

- carefully examined the Green Paper on European Social Policy,
- reasserts its interest in the different Project Actions concerning Public Health envisaged by European bodies and is surprised that the Green Paper on Social Policy is being set aside from the content of existing actions;
- requests to be an ex-officio member of the committees which shall prepare and develop this policy;
- shall contribute, on the basis of previous policy statements, in particular the "Hennigan report", as a partner of the Commission and as the representative of Doctors in Europe which shall be in the frontline of implementing these projects;

Concerning the Social Policy as it is outlined in the Green Paper, as a preliminary stage to the White Paper, the doctors of the European Union wish to reassert the need to respect the diversity of national health systems as well as the way in which they are funded, whether based on taxation or on social contributions.

The European Union does not have a mandate to pursue general harmonisation. The present diversity is actually based on historic, cultural and social traditions, to which the people of Europe as well as doctors are attached. Furthermore, the various systems also include provisions enabling doctors to take part in their management. This must be respected.

10.3 Resolution on "Hazardous Waste"

(CP 94/52)

According to the directive 91/689/EEC the Commission of the European Communities is preparing a catalogue on "hazardous waste".

The above mentioned directive and the draft catalogue state that all waste from health care institutions will be classifed as "hazardous waste".

The Standing Committee of Doctors in Europe (CP) met in Curia, Portugal, on April 16, 1994.

The Heads of delegations are strongly opposed to this classification for the following reasons:

1. Scientific studies have proven that only a very small fraction of waste from health care institutions (e.g. hospitals) is "infectious" or otherwise dangerous.
2. The current concept of disposing of health care waste as "hazardous waste" risks preventing any recycling initiatives.
3. The classification of all waste from health care institutions as "hazardous waste" will impose an excessive financial burden for many hospitals,

clinics, practices and medical institutes, creating budgetary constraint and a detrimental effect for patients.

The Standing Committee of Doctors in Europe demands that the Council of Ministers and the EC Commission develop and apply a reasonable and scientific definition on "hazardous waste". The CP is willing to provide the necessary expert support for this task.

10.4 Resolution on the Agency for Safety and Health

Curia, 1994 (CP 94/53)

Resolution

The Standing Committee of Doctors in Europe (CP) met in Curia, Portugal, on the 16th of April 1994:

- noting the existence of an Agency for Safety and Health
- noting its working programme 1994-2000.
- asks the Agency to direct attention to the implementation of the existing legislation before considering new initiatives and wants to be involved in achieving the Agency's objectives.

10.5 Standing Committee of European Doctors (CP) Proposals for Inclusion in second EU public Health Framework Programme

(CP 97/1010 Rev 1)

The Standing Committee of European Doctors (CP) is an umbrella organisation representing all branches of the medical profession in Europe. Founded in 1959, it now has medical organisations from 17 European Economic Area (EEA) countries as full members, and others from European countries outside the EEA as observers. One of its principal aims is to promote the highest standard of medical training, medical practice and health care within the European Union, in order to achieve the highest possible standard of public health. It works closely with many organisations representing different sectors of the medical profession at European level.

The CP welcomes the opportunity to contribute to the shaping of future public health policy in the EU and expresses its support for the Commission in drawing up the second public health framework programme. Its members are willing to cooperate in any way which would be helpful. We acknowledge that defining "public health" is not easy, given the diversity of approaches across the EU, but wish to use the broadest possible interpretation, to enable the European Union to act as necessary to protect and improve the health of its citizens.

We set out below some areas which we consider to be particularly important. These do not constitute a finite list, and we are happy to advise on any other areas which the Commission identifies as important. While we understand the many different pressures facing policy makers, we wish to see an integrated approach to health, i.e. an approach where policy in all areas is scrutinised to ensure that it has a positive impact on health. We have tried to focus on quality of life, i.e. ways of adding life to years as well as years to life. Thus, as well as concentrating on the promotion of healthy lifestyles, we have also singled out chronic conditions which, even if not immediately life-threatening, undermine the quality of life over long periodes for large numbers of people and have a significant impact on professional activity and health care spending.

1. Common Agricultural Policy (CAP)

We realise that this is an area where there are many conflicting interests, but we believe that it is time to re-examine the CAP. Doing so would be entirely consistent with the Commission's work in other areas, as the current policy has an impact on nutrition, smoking, alcohol consumption, and the environment, which in turn have an impact on many medical conditions. There is also increasing concern about the use of anti-microbial drugs on farm animals, and the potential link with the development of drug-resistant organisms.

We should like to see a commitment to the provision of healthier crops at accessible prices, produced with minimal environmental damage – ending, for example, the anomaly whereby large quantities of surplus fruit and vegetable crops are destroyed while many EU citizens are unable to afford those which reach the shops. We wish this adjustment – which is particularly important if the EU is to enlarge further to include the countries of Central and Eastern Europe – to be made in a manner which safeguards the livelihoods of farmere and agricultural workers.

By taking an approach such as this, we believe that it should be possible to harmonise the objectives of the CAP as set out in Article 39 of the Treaty with the Maastricht requirement to assess the health impact of all policy areas.

1.1 Nutrition

This overlaps to a large extent with our proposal to review the CAP. We note that the Commission has already identified nutrition as a priority for its 1997 health promotion programme and welcome the fact that it has done so.

Diet is an important subject both for education and research for a number of reasons. It has an influence on a range of conditions, such as cardiovascular and metabolic diseases; its influence on some cancers needs further exploration, and for this reason we should also like to see it linked to the Europe Against