



**COUNCIL OF
THE EUROPEAN UNION**



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2733rd Council Meeting

Employment, Social Policy, Health and Consumer Affairs

Luxembourg, 1-2 June 2006

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Consumer Protection

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9658/06 (Presse 148)

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Main Results of the Council

*The Council adopted a Directive on **food additives**, by qualified majority and at first reading.*

The Council reached political agreement on:

- a draft Regulation establishing a **European Institute for Gender Equality**;*
- a draft Decision on **Guidelines for the Employment Policies of the Member States for 2006**;*
- a draft Decision establishing a **Community programme for Employment and Social Solidarity**.*

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PARTICIPANTS

The Governments of the Member States and the European Commission were represented as follows:

Belgium:

Mr Peter VANVELTHOVEN
Mr Rudy DEMOTTE

Minister for Employment
Minister for Social Affairs and Public Health

Czech Republic:

Mr Čestmír SAJDA

Deputy Minister for Labour and Social Affairs,
Department of the Deputy Minister for the European
Union and International Relations

Denmark:

Mr Claus Hjort FREDERIKSEN
Ms Eva Kjer HANSEN

Minister for Employment
Minister for Social Affairs and Equal Opportunities

Germany:

Ms Gerd ANDRES

Parliamentary State Secretary to the Federal Minister for
Economic Affairs and Labour

Ms Marion CASPERS-MERK

Parliamentary State Secretary to the Federal Minister for
Health

Estonia:

Mr Jaak AAB

Minister for Social Affairs

Greece:

Mr Savvas TSITOURIDIS
Mr Georgios KONSTANTOPOULOS

Minister for Employment and Social Protection
State Secretary for Health and Social Solidarity

Spain:

Mr Jesús CALDERA SÁNCHEZ-CAPITÁN

Minister for Labour and Social Affairs

France:

Mr Gérard LARCHER

Minister with responsibility for Employment, Labour and
the Integration of Young People into Employment
Minister for Health and Solidarity

Mr Xavier BERTRAND

Ireland:

Mr Séamus BRENNAN
Mr Tony KILLEEN

Minister for Social and Family Affairs
Minister of State at the Department of Enterprise, Trade
and Employment with special responsibility for Labour
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Minister of State at the Department of Health and Children
with special responsibility for Health Promotion and other
matters

Mr Sean POWER

Italy:

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Ms Franca DONAGGIO

Minister for Labour and Social Policy
State secretary for Welfare, Ministry for Labour and
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Minister for Health

Ms Livia TURCO

Cyprus:

Mr Christos TALIADOROS
Mr Andreas GAVRIELIDES

Minister for Labour and Social Insurance
Minister for Health

Latvia:

Ms Dagnija STAĶE
Mr Gundars BĒRZIŅŠ

Minister for Welfare
Minister for Health

Lithuania:

Mr Rimantas KAIRELIS

State Secretary at the Ministry of Social Security and
Labour

Mr Žilvinas PADAIGA

Minister for Health

Luxembourg:

Ms Marie-Josée JACOBS

Mr François BILTGEN

Mr Mars DI BARTOLOMEO

Hungary:

Mr Gábor CSIZMÁR

Mr Gábor KAPOCS

Malta:

Mr Louis GALEA

Mr Louis DEGUARA

Netherlands:

Mr Aart Jan de GEUS

Mr Johannes Franciscus HOOGERVORST

Austria:

Mr Martin BARTENSTEIN

Ms Ursula HAUBNER

Ms Maria RAUCH-KALLAT

Poland:

Ms Anna KALATA

Mr Jarosław PINKAS

Portugal:

Mr José VIEIRA DA SILVA

Mr António CORREIA DE CAMPOS

Slovenia:

Mr Janez DROBNIČ

Mr Andrej BRUČAN

Slovakia:

Mr Miroslav BEBLAVÝ

Mr Rudolf ZAJAC

Finland:

Ms Tarja FILATOV

Ms Tuula HAATAINEN

Ms Liisa HYSSÄLÄ

Sweden:

Mr Hans KARLSSON

Mr Morgan JOHANSSON

United Kingdom:

Mr Alistair DARLING

Ms Anne McGUIRE

Ms Rosie WINTERTON

Minister for the Family and Integration, Minister for Equal Opportunities

Minister for Labour and Employment, Minister for Culture, Higher Education and Research, Minister for Religious Affairs

Minister for Health and Social Security

Minister for Labour and Employment

Undersecretary of State, Ministry of Health

Minister for Education, Youth and Employment

Minister for Health, the Elderly and Community Care

Minister for Social Affairs and Employment

Minister for Health, Welfare and Sport

Federal Minister for Economic Affairs and Labour

Federal Minister for Social Security, Generations and Consumer Protection

Federal Minister for Health and Women

Minister for Labour and Social Policy

Undersecretary of State, Ministry of Health

Minister for Labour and Social Solidarity

Minister for Health

Minister for Labour, the Family and Social Affairs

Minister for Health

State Secretary at the Ministry of Labour, Social Affairs and the Family

Minister for Health

Minister for Labour

Minister of Social Affairs and Health

Minister of Health and Social Services

Minister at the Ministry of Industry, Employment and Communications, with responsibility for Working Life

Minister at the Ministry of Social Affairs, with responsibility for Public Health and Social Services

Secretary of State for Trade and Industry

Parliamentary Under-Secretary of State for Disabled People

Minister of State for Health

Commission:

Mr Vladimír ŠPIDLA

Mr Markos KYPRIANOU

Member

Member

Other participants:

Mr Tom MULHERIN
Mr Maarten CAMPS

Chairman of the European Social Protection Committee
Chairman of the Employment Committee

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The Governments of the Acceding States were represented as follows:

Bulgaria:

Ms Emilia MASLAROVA
Mr Valeri TZEKOV

Minister for Labour and Social Policy
Deputy Minister of Healthcare

Romania:

Mr Gheorghe BARBU
Mr Anton Vlad ILIESCU

Minister for Labour, Social Solidarity and Family
Secretary of State, Ministry of Health

ITEMS DEBATED**EMPLOYMENT AND SOCIAL POLICY**– ***EU Sustainable Development Strategy – Social inclusion***

The Council held an extensive policy debate (*public debate*) and endorsed a joint opinion of the Social Protection and Employment Committees (9330/06) on the review of the EU Sustainable Development Strategy (SDS).

Special emphasis was given to the issue of reducing poverty (in particular for children and older people) and strengthening social cohesion. The following issues received particular attention:

- a substantial increase in employment, improving quality and productivity at work, as well as strengthening social cohesion should continue to be crucial components of the SDS;
- the social dimension of the SDS must be strengthened by ensuring close cooperation with the existing processes under the open method of coordination in social protection and social inclusion, and the revised Lisbon strategy;
- Member States should continue to pursuing the shift towards active and preventive policies, in particular in the light of the challenges raised by globalisation and demographic change;
- promoting good governance is essential. In this respect, the participation of people directly experiencing poverty is important and inspiration should be taken from the annual meetings at European level of people experiencing poverty;
- there is a need for greater prioritisation of the objectives, targets and key actions, and the mix of policy instruments proposed in the SDS review package; the role of indicators is of particular importance in this respect;
- the EPSCO Council has a role to play in delivering visible results and measurable progress in implementing the EU SDS, in particular through increased synergies across policies and processes, including the Lisbon agenda;
- an ambitious EU SDS should contribute to greater coherence between EU internal policies and its international commitments. In the social area, particular efforts should be made to promote decent work.

In summing up the debate, the President noted that delegations were of the opinion that there was no need for a new process in this area as the open method of coordination (in particular exchange of good practices and use of indicators for monitoring developments) provided an adequate framework for integrating social inclusion into the SDS as one of its essential elements.

It is recalled that, in June 2005, the European Council adopted a Declaration on Guiding Principles for Sustainable Development based on 4 objectives: *environmental protection, social equity and cohesion, economic prosperity and meeting international responsibilities*¹.

In December 2005, the European Council took note of the presentation by the Commission of its communication on a renewed sustainable development strategy for the next 5 years (15796/05) and looked forward "to adopting in June 2006 an ambitious and comprehensive strategy, comprising targets, indicators and an effective monitoring procedure, which should integrate the internal and external dimensions and be based on a positive long-term vision, bringing together the Community's sustainable development priorities and objectives in a clear, coherent strategy that can be communicated simply and effectively to citizens."².

The Presidency is currently consulting all the relevant Council configurations with a view to the adoption of the renewed EU SDS by the European Council in June 2006.

¹ 10255/05.

² Paragraph 13 of the December 2005 European Council conclusions (15914/1/05).

– *Social services of general interest*

The Council was briefed by the Commission on its Communication: *Implementing the Community Lisbon programme: social services of general interest in the EU (9038/06)*. The Chairman of the Social Protection Committee presented orally the preliminary views of the Committee on this communication.

The aim of the Communication is to identify the specific characteristics of social services of general interest and to clarify to what extent EU state aid, internal market and public procurement rules should apply to these services. It is to be seen in the context of the overall discussion on the draft "services" Directive, from the scope of which certain social services are excluded.

The Communication puts forward an open list of characteristics reflecting the specific nature of social services of general interest. In addition to the traditional criteria (universality, transparency, continuity, accessibility, etc.), these characteristics refer to the organisational conditions and modalities applying to those services.

The Communication will constitute the starting-point for consultation by the Commission of Member States, service providers and users of services.

– *Social security*

Implementing regulation

Pending the European Parliament's opinion at first reading, the Council reached a partial¹ general approach on a draft Regulation aimed at implementing Regulation (EC) No 883/2004² on the coordination of social security systems (9584/06 + ADD I).

Regulation (EC) No 883/2004 was the first step in a process aimed at modernising and simplifying EU rules on the coordination of national social security systems, which are intended to allow EU citizens to move freely within Europe, while maintaining their rights to social security benefits (health, pensions, unemployment benefits, etc.). This process must be completed with the adoption of an implementing regulation³, to replace Regulation (EEC) No 574/72 and for which a proposal is now under examination.

Legal basis proposed: Articles 42 and 308 of the Treaty – unanimity required for a Council decision; co-decision with the European Parliament applicable.

Annex XI

Pending the European Parliament's opinion at first reading, the Council reached a partial⁴ general approach on a draft Regulation amending Regulation (EC) No 883/2004 on the coordination of social security systems, and determining the content of Annex XI (9613/06).

The proposed Regulation lays down provisions regarding specific aspects of individual Member States' legislation that will form the content of Annex XI to Regulation (EC) No 883/2004⁵.

Legal basis proposed: Articles 42 and 308 of the Treaty – unanimity required for a Council decision; co-decision with the European Parliament applicable.

¹ Covering Titles I and II of the Commission proposal. Examination of the proposal will be pursued under the incoming Presidencies.

² Regulation of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems, OJ L 166, 30.4.2004, corrigendum OJ L 200, 7.6.2004.

³ See Article 89 of Regulation (EC) No 883/2004.

⁴ Covering the parts of the proposal corresponding to Titles I and II of the proposed implementing regulation. Examination of the proposal will be pursued under the incoming Presidencies.

⁵ See Article 83 of Regulation (EC) No 883/2004.

– *EU Institute for Gender Equality*

The Council reached political agreement, by unanimity¹, on a draft Regulation establishing a European Institute for Gender Equality. The Commission, however, could not support the representative Management Board adopted by the Council, preferring a Board of a limited size, as set out in its amended proposal².

The draft Regulation aims at establishing an European Institute to give technical support to the Community institutions and the Member States, in particular as regards the collection, analysis and dissemination of data and comparable statistics and the development of methodological tools for integrating gender equality policies (gender mainstreaming), as well as to increase awareness among European Union citizens.

An overall amount of EUR 52.5 million for 2007 to 2013 to cover the Institute's expenses is indicated in the Commission's financial statement.

Legal basis proposed: Articles 13(2) and 141(3) of the Treaty – co-decision procedure with the European Parliament applicable and qualified majority required for a Council decision. The European Parliament delivered its opinion on 14 March 2006 (5133/06). Many of the amendments were incorporated in the text submitted to the Council.

The text, as agreed, will be adopted as a common position at a forthcoming Council session and sent to the European Parliament with a view to the second reading.

¹ Poland abstained, as the national consultation procedure with its Parliament was still ongoing.

² 9195/06.

– *Beijing Platform for Action - Council conclusions*

The Council adopted the following conclusions on the review of implementation by Member States and EU institutions of the Beijing Platform for Action¹:

"THE COUNCIL OF THE EUROPEAN UNION

Whereas:

1. Gender equality is a fundamental principle of the European Union enshrined in the EC Treaty and one of the objectives and tasks of the Community and that mainstreaming equality between women and men in all its activities represents a specific mission for the Community.
2. Following the UN's Fourth World Conference on Women in Beijing in 1995, the Madrid European Council (15 to 16 December 1995) requested an annual review of the implementation in the Member States of the Beijing Platform for Action.
3. The follow-up process in 1996 and 1997 revealed a need for more constant and systematic EU monitoring and assessment of the implementation of the Beijing Platform for Action.
4. On 2 December 1998, the Council agreed that the annual assessment of the implementation of the Platform for Action would include a proposal on a set of quantitative and qualitative indicators and benchmarks.
5. Since 1999, sets of quantitative and qualitative indicators have been developed by subsequent Presidencies in some of the 12 critical areas of concern in the Beijing Platform for Action, namely: 1999 - Women in political decision-making; 2000 - Women in the economy (reconciliation of work and family life); 2001 - Women in the economy (on equal pay); 2002 - Violence against women; 2003 - Women and men in economic decision-making; 2004 - Sexual harassment at the workplace. Each year the Council has adopted conclusions on these indicators.
6. In the context of the 10-year review of the Beijing Platform for Action, the EU ministers responsible for gender equality, on 4 February 2005 adopted a common declaration which, inter alia, reaffirms the strong support for and commitment to the full and effective implementation of the Beijing Declaration and Platform for Action.

¹ With Germany abstaining.

7. In line with the European Council of 20-21 March 2003 the Commission prepares, in collaboration with the EU Member States, an annual report to the Spring European Council on developments towards gender equality and orientations for the gender mainstreaming of policy areas.
8. On 29 June 2000 the Council agreed on establishing the Social Protection Committee (SPC) in order to serve as a vehicle for cooperative exchange between the European Commission and the Member States of the EU about modernising and improving social protection systems. The Committee established an Indicators' Sub-Group to work on the development of indicators and statistics in support of its tasks. Part of the Committee's mandate is to work on the policy challenges "to ensure high quality and sustainable health care".
9. On 4 October 2004, the Council endorsed the SPC's Opinion on the Commission's Communication regarding the application of the Open Method of Coordination to health care and long-term care.
10. On 23 September 2002, the European Parliament and the Council adopted a "Programme of Community action in the field of Public Health (2003-2008)", the overall objectives being to improve health information and knowledge, to respond rapidly to health threats and to promote health and prevent diseases by addressing health determinants across all policies and activities.
11. In the framework of the Beijing Platform for Action, health is understood as defined by the World Health Organisation as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The Austrian Presidency of the EU has issued a report drawing up the following three indicators concerning women and health:
 - Healthy Life Years

The "Healthy Life Years" indicator is in the core set of the European Structural Indicators.
 - Access to health care (unmet demand)

In 2002, the Barcelona European Council recognised three guiding principles for the reform of health care systems, one of them being accessibility for all.

– Cardio-Vascular Diseases

Cardiovascular disease is the largest cause of death of women in the European Union.

These indicators should be disaggregated by sex.

1. RECALLS the commitment taken by Member States to secure women's rights to the enjoyment of the highest standard of physical and mental health throughout the whole life cycle in equality with men, and that the lack of a gender perspective in health represents an obstacle to achieving gender equality, as laid down in the Beijing Platform for Action.
2. RECALLS that within the “Programme of Community action in the field of Public Health (2003-2008)” the Council declares that all relevant statistics should be broken down and analysed by gender.
3. RECALLS that Member States have committed themselves to taking measures and developing proper indicators and statistics in order to further implement the Beijing Platform for Action and that in June 2005, the Council invited the Commission to include the assessment of relevant indicators, developed for the follow-up of the implementation of the Beijing Platform for Action, in its annual report to the Spring European Council.
4. STRESSES that the recognition of the gender dimension in health, as mentioned in the “Roadmap for equality between women and men, 2006-2010” (COM(2006) 92 final), is an essential part of EU health policies.
5. TAKES NOTE of the report on women's health presented by the Austrian Presidency and of the three indicators for the future follow-up of the Beijing Platform for Action regarding the critical area of women and health.
6. RECOGNISES
 - that women tend to have a lower percentage of life expectancy without disability;
 - that the EU needs to take into account a specific gender perspective while identifying the various barriers to access to, and use of, health care;
 - that for a long time the research on cardiovascular disease has been based on long-term studies of men, so the findings are not necessarily applicable to women.

7. INVITES forthcoming Presidencies, in cooperation with Member States, as well as the Commission to take the necessary measures to ensure a gender perspective in health policies and in the Open Method of Coordination on health and long term care and to focus, within the Sub-Group on Indicators, on the gender perspective of indicators on health.
8. INVITES the Member States to further improve the collection, compilation, analysis and dissemination of timely, reliable, comparable data disaggregated by sex and age, inter alia through the involvement of the National Statistical Institutes, as well as in the framework of the Community Statistical Programme so that statistics and medical information on the three indicators proposed by the Austrian Presidency, as well as statistical information on other indicators relating to the topics of the Beijing Platform, can be regularly produced and regular examinations conducted; ALSO INVITES the Member States to collect gender-specific data and further develop gender health indicators at Community level.
9. UNDERTAKES to continue its focus on the critical areas of concern mentioned in the Beijing Platform for Action and to review regularly the progress achieved and invites forthcoming Presidencies, in collaboration with Member States, to return to issues which have previously been discussed and assess progress in those areas by means of the established indicators.
10. URGES the European Commission and the Member States to take into account the issues discussed in the context of the follow-up of the Beijing Platform for Action, for which indicators have already been adopted, in other Community processes, where appropriate.
11. CALLS upon governments to:
 - determine the prerequisites for good health in both women and men, taking into account the specific aspects of women's health in order to establish an enabling environment for each sex;
 - promote research on gender equality in health.
12. INVITES the Commission and the Member States, according to their respective competencies, to integrate gender health considerations into health policies with particular emphasis on the three indicators (Healthy life years, Access to health care (unmet demand), Cardio-Vascular Diseases) proposed by the Austrian Presidency."

The Council also took note of the Presidency report presenting three indicators for the future follow-up of the Beijing Platform for Action in the critical area of "Women and Health".

– *Flexicurity*

The Council endorsed the joint contribution of the Employment Committee and of the Social Protection Committee on flexicurity (9633/06).

The Spring 2006 European Council invited Member States to pay special attention to "flexicurity" and to promote flexibility combined with employment security and reduce labour market segmentation¹.

The joint contribution identifies four elements for achieving a good balance between flexibility and security in the labour market: availability of suitable contractual arrangements, active labour market policies, credible lifelong learning systems and modern social security systems.

It recognises that further analysis is needed to take account of the particular situation of Member States, concerning, *inter alia*,

- specific examples of what works well in different countries;
- internal quantitative and functional flexibility (i.e. the organisation of work) and various aspects of labour law;
- the measurement of flexicurity;
- the costs and benefits of flexicurity for different groups on the labour market, including for people on its margins;
- the costs and benefits of flexicurity for public finance and society as a whole;
- sustainability of social and financial commitments, especially in adverse economic conditions;
- different pathways towards (more) flexicurity for Member States with different starting points.

The Committees note the intention of the Commission to publish a green paper on labour law, analyse flexicurity aspects in the context of the annual progress report and adopt a communication on a set of common principles in 2007 as well as the intention of the forthcoming Finnish Presidency to include this issue on the agenda for the Tripartite Social Summit in the autumn of 2006.

¹ See 7775/06.

– *Portability of supplementary pension rights*

Pending the opinion of the European Parliament at first reading, the Council took note of a progress report on examination of the proposal for a Directive on improving the portability of supplementary pension rights (9100/1/06).

In view of the increasing importance of supplementary pension schemes to cover the risk associated with old age in Member States, the Commission proposal aims to facilitate worker's freedom of movement across Member States and their mobility within a Member State, by eliminating any restrictive provisions linked to these supplementary pension schemes which may limit the opportunities for mobile workers to build up sufficient pension rights throughout their working lives.

Its main objectives are to:

- facilitate the acquisition of occupational pension rights;
- guarantee an adequate protection of the dormant rights of outgoing workers;
- facilitate the transfer of acquired pension rights;
- ensure that workers receive appropriate information in the event of their occupational mobility.

Legal basis proposed: Articles 42 and 94 of the Treaty – unanimity required for a Council decision and co-decision procedure with the European Parliament.

– *Programme for Employment and Social Solidarity – PROGRESS*

Now that an agreement on the financial framework for 2007-2013 has been reached, the Council reached full¹ political agreement on a draft Decision establishing a Community programme for Employment and Social Solidarity.

The aim of the programme is to support financially the implementation of the objectives of the European Union in the employment and social affairs area and thereby contribute to the achievement of the Lisbon Strategy.

It comprises five sections: employment, social protection and inclusion, working conditions, anti-discrimination and diversity, and gender equality.

By establishing a single and streamlined financial instrument, the Decision will consolidate the four specific action programmes currently in place, providing for the continuation and development of the activities launched on the basis of the following:

- Council Decision establishing a Community action programme to combat discrimination (2001 to 2006)²;
- Council Decision establishing a Programme relating to the Community framework strategy on gender equality³;
- Decision of the European Parliament and of the Council establishing a programme of Community action to encourage cooperation between Member States to combat social exclusion⁴;
- Council Decision on Community incentive measures in the field of employment⁵, and

¹ At the (EPSCO) Council of 8 and 9 December 2005, the Council reached partial political agreement on the proposal.

² Council Decision 2000/750/EC of 27 November 2000 (OJ L 303, 2.12.2000, p. 23).

³ Council Decision 2001/51/EC of 20 December 2000 (OJ L 17, 19.1.2001, p. 22).

⁴ Decision of the European Parliament and of the Council 50/2002/EC of 7 December 2001 (OJ L 10, 12.1.2002, p. 1).

⁵ Decision of the European Parliament and of the Council 1145/2002/EC of 10 June 2002 (OJ L 170, 29.6.2002, p. 1).

- Decision of the European Parliament and of the Council establishing a Community action programme to promote organisations active at European level in the field of equality between men and women¹,

as well as those activities undertaken at Community level in relation to working conditions.

The budget for the duration of the programme is EUR 658 million at 2004 prices.

Legal basis proposed: Articles 13(2), 129 and 137(2)(a) of the Treaty – qualified majority required for a Council decision; co-decision procedure with the European Parliament applicable. The European Parliament delivered its opinion on 6 September (11954/05).

The text as agreed will be adopted as a common position by a subsequent Council and sent to the European Parliament with a view to the second reading.

¹ Decision of the European Parliament and of the Council 848/2004/EC of 29 April 2004 (OJ L 157, 30.4.2004, p. 18, corrected in OJ L 195, 2.6.2004, p.7).

– *Guidelines for the Employment Policies of the Member States*

The Council reached political agreement on a draft Decision establishing the Guidelines for the Employment Policies of the Member States for 2006 (9471/06).

As proposed by the Commission, the guidelines adopted last year (10205/05) remain unchanged.

Legal basis proposed: Article 128(2) of the Treaty – qualified majority required for a Council decision; consultation of the European Parliament, the Economic and Social Committee, the Employment Committee and the Committee of the Regions required.

The text as agreed will be submitted to the European Council in June 2006 for endorsement and formally adopted at a forthcoming Council session.

– *Working time*

Following its earlier debate in December 2005, the Council again held lengthy and extensive discussions on a modified proposal for Directive of the European Parliament and of the Council aimed at amending Directive 2003/88/EC concerning certain aspects of the organisation of working time¹, on the basis of compromise texts tabled by the Presidency concerning the controversial issue of the opt-out.

All delegations and the Commission welcomed the Presidency's determination to achieve an overall agreement in view of the need for a common solution to the challenges resulting from the Simap-Jaeger judgements.

However, in spite of the progress made in identifying possible elements for an agreement, and given the differences in the labour market situations and in Member States' views on the possible need and conditions for maintaining the opt-out, it was not possible to reach overall political agreement at this stage.

The objectives of the Commission amended proposal are twofold:

First, to take into account the European Court of Justice's case law, in particular rulings in the SIMAP² and Jaeger³ cases, which held that on-call duty performed by a doctor when he is required to be physically present in the hospital must be regarded as working time.

Second, to review some of the provisions of Directive 2003/88/EC concerning the possibility of not applying the maximum weekly working time (48 hours) if the worker gives his agreement to carry out such work (the "opt-out" provision).

The key issues still to be resolved relate to the opt-out provision as well as to the question of whether the maximum weekly working time is calculated per contract or per worker.

Legal basis proposed: Article 137(2) of the Treaty – qualified majority required for a Council decision; co-decision procedure with the European Parliament applicable. The European Parliament delivered its first-reading opinion on 11 May 2005 (8725/05) and the Commission its amended proposal on 31 May 2005 (9554/05).

¹ OJ L 299, 18.11.2003, p. 9.

² Judgement of the Court of 3 October 2000 in case C-303/98, Sindicato de Médicos de Asistencia Pública (SIMAP) v. Conselleria de Sanidad y Consumo de la Generalidad Valenciana, ECR 2000, p. I-07963.

³ Judgement of the Court of 9 September 2003 in case C-151/02, reference for a preliminary ruling: Landesarbeitsgericht Schleswig-Holstein (Germany) in the proceedings pending before that court between Landeshauptstadt Kiel and Norbert Jaeger, ECR 2003, p. I-08389.

HEALTH– *Food additives*

The Council adopted, by qualified majority¹ and at first reading², a Directive amending Directive 95/2/EC on food additives other than colours and sweeteners and Directive 94/35/EC on sweeteners for use in foodstuffs (*PE-CONS 3663/05*).

Directive 95/2/EC on food additives other than colours and sweeteners sets out a list of authorised food additives, the foodstuffs in which they may be used and their conditions of use. It needs to be adapted in the light of recent technical and scientific developments.

Changes concern:

- the revision of current authorisations (nitrite and nitrate; weaning foods; food supplements and foods for special medical purposes; p-Hydroxybenzoates; gelling agents in jelly mini-cups);
- the authorisation of new food additives (e.g. erythritol; 4-Hexylresorcinol; Soybean hemicellulose; ethyl cellulose, pullulan; TBHQ);
- the authorisation for extending the use of authorised food additives (sodium hydrogen carbonate in sour milk cheese; sorbates and benzoates in crustaceans; silicon dioxide as a carrier; additives in traditional products).

Directive 94/35/EC on sweeteners for use in foodstuffs sets out a list of authorised sweeteners, the foodstuffs in which they may be used and their conditions of use. It needs to be adapted in the light of recent technical and scientific developments.

Changes concern the authorisation of a new food additive (erythritol).

Legal basis proposed: Article 95 of the Treaty – qualified majority required for a Council decision; co-decision procedure with the European Parliament applicable. The European Parliament delivered its first-reading opinion on 26 October 2005 (*13689/06*).

¹ With Belgium, Denmark and the Netherlands voting against.

² The Council accepted all the amendments suggested by the European Parliament (*13689/05*).

– *Women's health - Council conclusions*

The Council adopted the following conclusions:

"THE COUNCIL OF THE EUROPEAN UNION:

1. NOTES that the citizens of the European Union, more than half of them being women, attach great importance to the highest possible levels of human health and consider it to be an essential prerequisite to a high quality of life.
2. RECALLS THAT:
 - Article 3(2) of the EC Treaty and Article 23 of the Charter of Fundamental Rights of the European Union state that equality between women and men shall be ensured in all policy areas;
 - Article 152 of the EC Treaty states that a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities, and provides that Community action is to complement national policies and be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health;
 - On 4 December 1997, the Council adopted a Resolution concerning the report¹ on the state of women's health in the European Community²;
 - On 9 March 1997, the European Parliament adopted a Resolution on the report of the Commission on the state of women's health in the European Community³;
 - On 28 April 2005, the European Parliament adopted a Resolution on modernising social protection and developing good quality healthcare, calling on the Commission to submit a new report on the health situation of women in the European Union⁴.
3. RECALLS the report on the progress made within the European Union as regards the implementation of the Beijing Platform for Action established in January 2005 by the Luxembourg Presidency that underlined that women's health is still an area of concern and stressed the importance of the collection of relevant data.

¹ 8537/97; COM(97) 224 final.

² OJ C 394, 30.12.1997, p. 1.

³ OJ C 175, 21.6.1999, p. 68.

⁴ A6-0085/2005.

4. RECALLS the Strategic Action Plan for the Health of Women in Europe endorsed at the WHO meeting in Copenhagen, on 5-7 February 2001.
5. ACKNOWLEDGES that social and health determinants, clinical manifestations, therapeutical approaches, effectiveness and side effects of treatment of disease and disorders may differ between women and men.
6. STRESSES the importance of raising awareness amongst the general public but also health care professionals that gender is a key determinant of health.
7. RECOGNISES the importance of addressing inequalities that may exist within and between Member States, by tackling social and economic health determinants.
8. WELCOMES the Commission Communication: A Roadmap for equality between women and men (2006-2010)¹ recognising the gender dimension in health, inter alia, aiming at strengthening gender mainstreaming in health policies.
9. NOTES that the Programme of Community Action in the Field of Public Health (2003-2008)² aims to protect human health and improve public health, thereby contributing towards tackling inequalities in health.
10. WELCOMES the fact that the proposal for a Council Decision concerning the Specific Programme “Cooperation” implementing the 7th Framework Programme (2007-2013) of the European Community for research, technological development and demonstration activities³ intends to integrate gender aspects in health research.
11. ACKNOWLEDGES the need for gender-related biomedical research as well as research on socio-economic determinants.
12. RECOGNISES that although women live longer than men, they suffer a greater burden of unhealthy life years. The incidence and prevalence of certain diseases like osteoporosis are higher in women. Others such as cardiovascular disease, cancer and mental health problems affect men and women differently. Some diseases related to birth and reproductive organs like endometriosis and cervical cancer affect women exclusively.

¹ 7034/06.

² OJ L 271, 9.10.2002, p. 1.

³ 12736/05.

13. EMPHASISES that cardiovascular disease is a major cause of death and of reduced quality of life for women in the European Union, despite still being perceived as predominantly male disease in some Member States.
14. NOTES WITH CONCERN that the rise in smoking among females in some Member States is causing a substantially increased risk of lung cancer and cardiovascular diseases.
15. NOTES WITH CONCERN that depression is predicted in some Member States to be the major burden of disease for women by 2020. Mental ill health has an impact on quality of life and can therefore influence morbidity and mortality.
16. RECOGNISES the major impact of unhealthy lifestyles on a significant number of diseases and therefore the potential which the promotion of inter alia healthy diets and physical activity has for reducing cardiovascular diseases and certain forms of cancer.
17. AGREES that gender sensitive prevention measures, health promotion and treatment contribute towards reducing morbidity and mortality from major diseases among women and consequently improve their quality of life.
18. NOTES that reliable, compatible, comparable data on the status of women's health is essential to improve information to the public and develop appropriate strategies, policies and actions to ensure a high level of health protection, and that gender-specific data and reporting are essential for policy making.
19. UNDERLINES that after almost a decade a new report on the health status of women in the enlarged European Union is needed.
20. INVITES the Member States to:
 - Collect gender-specific data on health, and to break down and analyse statistics by gender;
 - Take initiatives to enhance general and health professionals' knowledge on the relationship between gender and health;

- Promote health and prevent disease taking into account where appropriate gender difference;
- Promote research into the different effects of medicines on women and men, and gender- specific health research;
- Encourage gender mainstreaming in healthcare;
- Examine and tackle health inequalities which may exist accordingly in order to reduce the health gap and ensure equality of treatment and access to care.

21. INVITES the European Commission to

- Integrate gender aspects in health research;
- Support the exchange of information and experience on good practice in gender-sensitive health promotion and prevention;
- Assist Member States in developing effective strategies to reduce health inequalities with a gender dimension;
- Promote and strengthen the comparability and compatibility of gender-specific information on health across Member States and at Community level through the development of appropriate data;
- Present a second report on the state of women's health in the European Union.

22. INVITES the European Commission to draw on the expertise of EUROSTAT and of the future European Institute for Gender Equality in order to contribute to data collection and analysis and the sharing of best practice.

23. INVITES the European Commission to continue to cooperate with the relevant international and intergovernmental organisations, in particular the WHO and OECD, to ensure effective coordination of activities."

– *Healthy lifestyles – Prevention of type 2 diabetes - Council conclusions*

The Council adopted the following conclusions:

"THE COUNCIL OF THE EUROPEAN UNION:

1. NOTES that the citizens of the European Union attach great importance to the highest possible levels of human health and consider it to be an essential prerequisite to a high quality of life;
2. NOTES further that EU action needs to address major causes of death and premature death and major causes of reduced quality of life for the citizens of the European Union.
3. RECALLS THAT:
 - Article 152 of the EC Treaty provides that Community action is to complement national policies and be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Community action in the field of public health shall respect the responsibilities of the Member States for the organisation and delivery of health services and medical care;
 - On 29 June 2000, the Council adopted a Resolution on action on health determinants¹;
 - On 14 December 2000, the Council adopted a Resolution on Health and Nutrition²;
 - On 2 December 2002, the Council adopted Conclusions on Obesity³;
 - On 2 December 2003, the Council adopted Conclusions on Healthy Lifestyles⁴.

¹ OJ C 218, 31.07.2000, p. 8.

² OJ C 20, 23.01.2001, p. 1.

³ OJ C 11, 17.01.2003, p. 3.

⁴ OJ C 22, 27.01.2004, p. 1.

4. RECALLS ALSO THAT:

- On 2 June 2004, the Council took note of information from the Irish Presidency on the potential for a European strategy for diabetes¹;
- On 15 March 2005, the European Commission launched the EU Platform on Diet, Physical Activity and Health;
- On 8 December 2005, the European Commission adopted a Green Paper on Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases, which addresses the determinants underlying the onset of Type 2 diabetes;
- On 3 April 2006, the European Parliament adopted a Written Declaration on diabetes².

5. NOTES the conclusions of the Austrian Presidency Conference "Prevention of Type 2 Diabetes" held on 15-16 February 2006 in Vienna, Austria, with the participation of experts from Member States, acceding States and candidate countries, including health professionals and representatives of diabetes associations and patient groups, that are reflected in the Annex.
6. EMPHASISES that diabetes is one of the major causes of death and premature death as well as of reduced quality of life for the citizens of the European Union.
7. STATES that health determinants have an impact on diabetes and that, apart from family history and increasing age, the main risk factors of Type 2 diabetes are excess body weight, a sedentary lifestyle, tobacco use and/or high blood pressure, which can be influenced by taking action in respect of the underlying factors. Other contributory factors include gestational diabetes (diabetes during pregnancy), impaired glucose tolerance or impaired fasting glycaemia.
8. RECOGNISES that Type 2 diabetes and its complications (cardiovascular, renal, ocular and foot-related) are frequently diagnosed too late and the complications are frequently detected only at the time of diagnosis.
9. STATES that preventive measures, early detection and diagnosis and effective management of the disease can result in reduced mortality from diabetes and increasing life expectancy and quality of life of European populations.

¹ 9808/04.

² Written declaration 1/2006.

10. IS CONCERNED by the negative consequences for health, and the incidence of diabetes in particular, of the increase in overweight and obesity among the population of all ages in the European Union, especially among children and young people. The impact of Type 2 diabetes on women in their early reproductive years is of particular concern.
11. STATES that urgent targeted action on diabetes and the underlying health determinants is needed to address the growing incidence and prevalence of disease as well as the rise in the direct and indirect costs thereof.
12. RECOGNISES that it is possible to prevent or delay the onset of Type 2 diabetes and to reduce associated complications by addressing the underlying health determinants, particularly poor diet and physical inactivity, even in early childhood.
13. RECOGNISES that preventing diabetes has a direct positive benefit on other non-communicable diseases, e.g. cardiovascular diseases, which are also major health risks for the citizens of the European Union, and on burdens for health systems and economies.
14. ACKNOWLEDGES the need for diabetes monitoring and surveillance, including the exchange of information on diabetes mortality, morbidity and risk factor data, and for a greater understanding of lifestyles, knowledge, attitudes and behaviours in populations across the EU.
15. ACKNOWLEDGES that further research in Europe on the health determinants for combating the risk factors for diabetes could make a positive contribution to addressing the disease in the future.
16. RECOGNISES that, in order to address and reduce suffering from diabetes, a long-term approach incorporating actions aimed at the healthy population as well as at individuals at high risk or living with diabetes is necessary.
17. ACKNOWLEDGES that health promotion requires an integrated approach and needs to be comprehensive, transparent, multi-sectoral, multidisciplinary, participatory and based on the best available research and evidence. In particular, disease prevention needs to target people throughout the life cycle, especially those who are most at risk of diabetes, taking account of social, cultural, gender-related and age differences. Efforts should be made to address appropriate evaluation, including monitoring and surveillance of actions and programmes.

18. WELCOMES that the Commission has set up the Platform for Action on Diet, Physical Activity and Health.
19. ACKNOWLEDGES the important role that civil society can play in preventing diabetes and its consequences.
20. INVITES the Member States to consider, within the context of the adoption or review of national public health strategies and their efforts to focus on health determinants and promotion of healthy lifestyles, and with regard to available resources:
 - Collection, registration, monitoring and reporting at national level of comprehensive diabetes epidemiological and economic data as well as data on the underlying factors;
 - Development and implementation of framework plans, as appropriate, addressing diabetes and/or its determinants, of evidence-based disease prevention, screening and management founded on best practices and comprising an evaluation system with measurable targets to track health outcomes and cost-effectiveness, taking into account Member States' organisation and delivery of their respective health services, ethical, legal, cultural and other relevant issues and available resources;
 - Development of evidence-based, sustainable and cost-effective public awareness and primary prevention measures that are accessible and affordable to meet the needs of those most at risk of developing diabetes as well as the population as a whole;
 - Development of affordable and accessible secondary prevention measures based on national evidence-based guidelines and aimed at detecting and preventing the development of diabetes complications;
 - Adoption of a holistic, multi-sectoral, multidisciplinary management approach to people with diabetes including an emphasis on prevention, involving primary, secondary and community care, social services and education services;
 - Further development of comprehensive diabetes training for healthcare professionals.

21. INVITES the European Commission to support, as appropriate, Member States in their efforts to prevent diabetes, and to promote a healthy lifestyle by:
- Identifying diabetes as a public health challenge in Europe and encouraging networking and the exchange of information between Member States with a view to promoting best practices, to enhancing the co-ordination of health promotion and prevention policies and programmes for the whole population and high-risk groups and to reducing inequalities and optimising healthcare resources;
 - Facilitating and supporting European diabetes research in basic and clinical science and ensuring the wide dissemination of the results of this research across Europe;
 - Examining and strengthening the comparability of diabetes epidemiological evidence by considering the establishment of standardised outputs for monitoring, surveillance and reporting of diabetes mortality, morbidity and risk factor data across Member States;
 - Reporting on Member States' actions in order to emphasise health determinants, promote healthy lifestyles, national diabetes plans and prevention measures, on the basis of information provided by Member States, assessing the extent to which the proposed measures are working effectively, and considering the need for further action;
 - Continuing the work on the development of a comprehensive approach to health determinants at European level, including a coherent and comprehensive nutrition and physical activity policy, and addressing the impact on public health of the promotion, marketing and presentation, in particular to children, of energy dense foods and sugar-sweetened drinks;
 - Building on the work of the EU Platform for Action on Diet, Physical Activity and Health and encouraging the development and implementation of national diabetes prevention programmes and measures;
 - Taking the health determinants and risk factors of diabetes into account across EU policies.
22. INVITES the Commission to continue to cooperate with the relevant international and inter-governmental organisations, in particular the World Health Organisation and the OECD, to ensure effective coordination of activities."

– *Common values and principles in EU-health systems - Council conclusions*

The Council adopted the following conclusions:

"THE COUNCIL OF THE EUROPEAN UNION:

1. NOTES that the European Commission in its amended proposal for a Directive of the European Parliament and of the Council on services in the internal market has decided to remove healthcare services from the scope of the Directive, thereby incorporating amendments proposed by the European Parliament.
2. NOTES that the European Commission has stated that it will develop a Community framework for safe, high quality and efficient health services, by reinforcing cooperation between Member States and providing clarity and certainty over the application of Community law to health services and healthcare.
3. RECOGNIZES that recent judgements in the European Court of Justice have highlighted the need to clarify the interaction between the EC Treaty provisions, particularly on the free movement of services and the health services provided by national health systems.
4. CONSIDERS that health systems are a central part of Europe's high levels of social protection and make a major contribution to social cohesion and social justice.
5. RECALLS the overarching values of universality, access to good quality care, equity and solidarity.
6. ENDORSES the attached Statement on common values and principles that underpin the health systems in the Member States of the European Union (Annex).
7. INVITES the European Commission to ensure that common values and principles contained in the Statement are respected when drafting specific proposals concerning health services.
8. INVITES the Institutions of the European Union to ensure that common values and principles contained in the Statement are respected in their work.

Statement on common values and principles

This is a statement by the 25 Health Ministers of the European Union, about the common values and principles that underpin Europe's health systems. We believe such a statement is important in providing clarity for our citizens, and timely, because of the recent vote of the Parliament and the revised proposal of the Commission to remove healthcare from the proposed Directive on Services in the Internal Market. We strongly believe that developments in this area should result from political consensus, and not solely from case law.

We also believe that it will be important to safeguard the common values and principles outlined below as regards the application of competition rules on the systems that implement them.

This statement builds on discussions that have taken place in the Council and with the Commission as part of the Open Method of Coordination, and the High Level Process of Reflection on Patient Mobility and healthcare development in the EU. It also takes into account the legal instruments at European or international level which have an impact in the field of health.

This statement sets out the common values and principles that are shared across the European Union about how health systems respond to the needs of the populations and patients that they serve. It also explains that the practical ways in which these values and principles become a reality in the health systems of the EU vary significantly between Member States, and will continue to do so. In particular, decisions about the basket of healthcare to which citizens are entitled and the mechanisms used to finance and deliver that healthcare, such as the extent to which it is appropriate to rely on market mechanisms and competitive pressures to manage health systems must be taken in the national context.

Common Values and Principles

The health systems of the European Union are a central part of Europe's high levels of social protection, and contribute to social cohesion and social justice as well as to sustainable development.

The overarching values of *universality, access to good quality care, equity, and solidarity* have been widely accepted in the work of the different EU institutions. Together they constitute a set of values that are shared across Europe. Universality means that no-one is barred access to health care; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay. EU health systems also aim to reduce the gap in health inequalities, which is a concern of EU Member States; closely linked to this is the work in the Member States' systems on the prevention of illness and disease by inter alia the promotion of healthy lifestyles

All health systems in the EU aim to make provision, which is patient-centred and responsive to individual need.

However, different Member States have different approaches to making a practical reality of these values: they have, for example, different approaches to questions such as whether individuals should pay a personal contribution towards the cost of elements of their health care, or whether there is a general contribution, and whether this is paid for from supplementary insurance. Member States have implemented different provisions to ensure equity: some have chosen to express it in terms of the rights of patients; others in terms of the obligations of healthcare providers. Enforcement is also carried out differently – in some Member States it is through the courts, in others through boards, ombudsmen etc.

It is an essential feature of all our systems that we aim to make them financially sustainable in a way which safeguards these values into the future.

To adopt an approach that shift focus towards preventive measures is an integral part of Member States strategy to reduce the economic burden on the national health care systems as prevention significantly contributes to cost reduction in healthcare and therefore to financial sustainability by avoiding disease and therefore follow up costs.

Beneath these overarching values, there is also a set of operating principles that are shared across the European Union, in the sense that all EU citizens would expect to find them, and structures to support them in a health system anywhere in the EU. These include:

– Quality:

All EU health systems strive to provide good quality care. This is achieved in particular through the obligation to continuous training of healthcare staff based on clearly defined national standards and ensuring that staff have access to advice about best practice in quality, stimulating innovation and spreading good practice, developing systems to ensure good clinical governance, and through monitoring quality in the health system. An important part of this agenda also relates to the principle of safety.

– Safety:

Patients can expect each EU health system to secure a systematic approach to ensuring patient safety, including the monitoring of risk factors and adequate, training for health professionals, and protection against misleading advertising of health products and treatments.

– Care that is based on evidence and ethics:

Demographic challenges and new medical technologies can give rise to difficult questions (of ethics and affordability), which all EU Member States must answer. Ensuring that care systems are evidence-based is essential, both for providing high-quality treatment, and ensuring sustainability over the long term. All systems have to deal with the challenge of prioritising health care in a way that balances the needs of individual patients with the financial resources available to treat the whole population

– Patient Involvement:

All EU health systems aim to be patient-centred. This means they aim to involve patients in their treatment, to be transparent with them, and to offer them choices where this is possible, e.g. a choice between different health care service providers. Each system aims to offer individuals information about their health status, and the right to be fully informed about the treatment being offered to them, and to consent to such treatment. All systems should also be publicly accountable and ensure good governance and transparency.

– Redress:

Patients should have a right to redress if things go wrong. This includes having a transparent and fair complaints procedure, and clear information about liabilities and specific forms of redress determined by the health system in question (e.g. compensation).

– Privacy and confidentiality:

The right of all EU citizens to confidentiality of personal information is recognised in EU and national legislation.

As Health Ministers, we note increasing interest in the question of the role of market mechanisms (including competitive pressure) in the management of health systems. There are many policy developments in this area under way in the health systems of the European Union which are aimed at encouraging plurality and choice and making most efficient use of resources. We can learn from each other's policy developments in this area, but it is for individual member states to determine their own approach with specific interventions tailored to the health system concerned.

Whilst it is not appropriate to try to standardise health systems at an EU level, there is immense value in work at a European level on health care. Member States are committed to working together to share experiences and information about approaches and good practice, for example through the Commission's High Level Group on Health Services and Medical Care, or through the ongoing Open Method of Coordination on healthcare and long-term care, in order to achieve the shared goal of promoting more efficient and accessible high-quality healthcare in Europe. We believe there is particular value in any appropriate initiative on health services ensuring clarity for European citizens about their rights and entitlements when they move from one EU Member State to another and in enshrining these values and principles in a legal framework in order to ensure legal certainty.

In conclusion, our health systems are a fundamental part of Europe's social infrastructure. We do not under-estimate the challenges that lie ahead in reconciling individual needs with the available finances, as the population of Europe ages, as expectations rise, and as medicine advances. In discussing future strategies, our shared concern should be to protect the values and principles that underpin the health systems of the EU. As Health Ministers in the 25 Member States of the European Union, we invite the European Institutions to ensure that their work will protect these values as work develops to explore the implications of the European Union on health systems as well as the integration of health aspects in all policies."

– *EU Sustainable Development Strategy*

The Council held a policy debate in the context of the review of the EU Sustainable Development Strategy (SDS).

The debate covered the following issues:

- Adequacy and sufficiency of the objectives, targets and key actions concerning public health proposed in the SDS Review package¹, to meet the challenges of Sustainable Development and to address unsustainable trends in the health sector in an efficient manner;
- Contribution of health to economic development and achievements of the Lisbon Strategy;
- Contribution of an EU SDS to coherence between EU internal policies and its international commitments and to sustainable development at both EU and global level.

Delegations unanimously welcomed the inclusion of public health as a priority area in the EU SDS Review Package. Improved health was considered vital for economic development and wealth.

Several delegations underlined that the link between sustainable development and human health should be more explicitly expressed in the reviewed SDS.

Delegations also emphasised that the scope of the impact assessment of new legislative measures should cover also the health dimension, for instance as a tool to mainstream health into all policies.

The financial sustainability of the health systems has also been raised.

The EU could play a leading role in setting the international public health agenda and in developing evidence based measures to tackle the international public health challenges.

¹ 15796/05.

In June 2005, the European Council adopted a Declaration on Guiding Principles for Sustainable Development based on 4 objectives: *environmental protection, social equity and cohesion, economic prosperity and meeting international responsibilities*¹.

In December 2005, the European Council took note of the presentation by the Commission of its communication on a renewed sustainable development strategy for the next 5 years² and looked forward "to adopting in June 2006 an ambitious and comprehensive strategy, comprising targets, indicators and an effective monitoring procedure, which should integrate the internal and external dimensions and be based on a positive long-term vision, bringing together the Community's sustainable development priorities and objectives in a clear, coherent strategy that can be communicated simply and effectively to citizens."³

The Presidency is currently consulting all the relevant Council configurations with a view to the adoption of the renewed EU SDS by the June 2006 European Council.

¹ 10255/05.

² 15796/05.

³ Paragraph 13 of the December 2005 European Council conclusions (15914/1/05).

– *Pandemic influenza preparedness and planning*

The Council held an exchange of views on pandemic influenza preparedness and planning, focusing specifically on the steps to be taken, at EU level, in order to be prepared in case of a human pandemic influenza.

Delegations expressed their views concerning the establishment of a European strategic stockpile of antivirals and the number of treatments that this stockpile should comprise, the virtual or actual nature of the stockpile, the moment when the stockpile should be established.

The exchange of views followed-up the discussion at the informal meeting of Health Ministers in Vienna, in February and April 2006.

Discussion on legal, technical and financial aspects of this issue will continue under the forthcoming Presidency.

– ***Combating HIV/AIDS***

The Council held an exchange of views on the Commission communication on *combating HIV/AIDS within the EU and in the neighbouring countries 2006-2009*.

The debate covered, in particular, the following issues:

- Areas [e.g. human rights, stigma and discrimination, promotion of prevention, early diagnosis, access to treatment, research], which should be particularly stressed to boost the combat of the global threat; strengthen of primary prevention; strategy/actions needed at European level to underpin and strengthen Member States' prevention activities;
- Assistance to neighbouring countries in their efforts to control the HIV/AIDS epidemic;
- Need for a future involvement of the European Council.

Prevention, fight against stigma and discrimination, relaunching of the information campaigns, easy and equal access to treatment, combating prostitution and trade in narcotics, investment on the research of new treatments and vaccines were identified as some of the initiatives essential to halt the spread of the epidemic.

Robust public health monitoring and epidemiological systems would help Member States to tailor their actions to the groups most at risk of the HIV. Reinforced cooperation with the authorities and NGO's as well as exchange of good practices are crucial to assist neighbouring countries.

The involvement of the Heads of State or Government covering both the EU and external dimensions was deemed desirable to joint efforts to counter the epidemic and to put HIV/AIDS as a high priority on international agenda.

It is recalled that the HIV/AIDS epidemic has been an important focus of concern and action of the EU's public health activities since the late 80's.

The EU and its neighbouring countries now face the threat of a "new epidemic". Parts of Europe have the fastest rate of new HIV/AIDS cases in the world. Figures released by UN-AIDS confirm that the number of new infections is increasing throughout the 25 Member States and in its East-European neighbours. The transmission pattern is also changing. While sexually transmitted infections remain predominant in some parts of the European continent, many of the rapid rises in infections are due to intravenous drug users.

– *Advanced therapy medicinal products*

Pending the first-reading opinion of the European Parliament, the Council took note of a progress report on a proposal for a Regulation on advanced therapy medicinal products (15023/05).

The main objective of this proposal is to create a single legal framework for three kinds of therapies (gene therapy, somatic cell therapy and tissue-engineering) where scientific and technical development is very rapid.

Developments in this field are of great importance for future treatment of illnesses, so there is a major need to create Community rules in order to facilitate innovation, development and clinical testing in an emerging market.

The Commission brought forward a proposal that deals with security and efficacy of products based on advanced therapies once the original material is there, rather than on the origin of the material, since such issues are handled in other legal instruments (e.g. the tissue Directive).

Legal basis proposed: Article 95 of the Treaty – qualified majority required for a Council decision; co-decision procedure with the European Parliament applicable.

– *Medical devices*

Pending the first-reading opinion of the European Parliament, the Council took note of a progress report (9522/06) on a proposal for a Directive as regards the review of the medical device directives (5072/06).

The proposal aims at clarifying the existing legislation (Directives 90/385/EEC¹, 93/42/EEC² and 98/79/EC³) and at creating a basis for a general review by the Commission of legislation on the medical devices area.

Legal basis proposed: Article 95 of the Treaty – qualified majority required for a Council decision; co-decision procedure with the European Parliament applicable.

¹ Council Directive 90/385/EEC of 20 June 1990 on the approximation of the laws of the Member States relating to active implantable medical devices. OJ L 189 , 20.7.1990, p. 17.

² Council Directive 93/42/EEC of 14 June 1993 concerning medical devices. OJ L 169, 12.7.1993, p. 1.

³ Directive 98/79/EC of the European Parliament and of the Council of 27 October 1998 on in vitro diagnostic medical devices. OJ L 331, 7.12.1998, p. 1.

OTHER BUSINESS

The Council was briefed by the Presidency on the following issues:

- Proposal for a Regulation establishing the European Globalisation adjustment Fund (9594/06);
- Presidency conferences:
 - "Conference on Social Services of General Interest" (Vienna, 20 April 2006) (9459/06);
 - "Fifth meeting of people experiencing poverty" (Brussels, 12 and 13 May 2006) (9682/06);
 - "Conference on cultural and political conditions of social models in Europe" (Vienna, 19 and 20 May 2006) (9849/06);
 - "Conference on closing the pay gap between men and women" (Brussels, 22 May 2006) (9841/06);
 - "Outcome of the first International Conference on Chemicals Management (ICCM 1)" (Dubai, 4 to 6 February 2006) (8930/06);
 - Conference on Harmful Traditional Practices (HTP) (5675/06).
- Co-decision files (health claims, vitamins, medicinal products for paediatric use);

The Council was briefed by the Commission on the following issues:

- Commission communication entitled "Guidance on the posting of workers in the framework of the provision of services" (9924/06);
- Commission communication entitled "Implementing the partnership for growth and jobs: Making European a pole of excellence on corporate social responsibility" (9918/06);
- Commission communication on promoting decent work for all (9921/06);

- European Year of Equal Opportunities for all, 2007 (9916/06);
- Proposal for a Decision establishing a Programme of Community action in the field of Health and Consumer protection (2007-2013) - Progress report (9512/06);
- Framework Convention on Tobacco Control (9902/06);
- Commission High Level Group on health services and medical care (9903/06);
- Mental health (9904/06);
- Post G-10 Strategy (9906/06);
- Commission Communication on Injury Prevention and Safety promotion (9907/06);
- Commission Communication on the EU Alcohol Strategy (9908/06).

The Council was briefed by the Presidency and the Commission on the following issue:

- E-Health Conference in Málaga (9783/06 ADD 1).

The Council was briefed by the Portuguese delegation on the following issue:

- Conference of Council of Europe Ministers on Family Matters: "Changes in Parenting" (9893/06).

OTHER ITEMS APPROVED

FISHERIES

Blue whiting and herring

The Council adopted a Regulation amending Council Regulation (EC) No 51/2006¹ in order to implement arrangement between the Community and the Faroe Islands of 23 February 2006 on mutual access to blue whiting and herring stocks in each other's fishing zones.

¹ OJ L 16, 20.1.2006, p. 1.