



NEWSLETTER

N° 121 – December 2014

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12-13 March 2015 – Brussels (Belgium)

***PASQ JOINT ACTION (European Union Network for Patient Safety and Quality of Care)
FINAL CONFERENCE***

1-2 June 2015 – Warsaw (Poland)

***HOPE AGORA 2015
HOSPITALS 2020: HOSPITALS OF THE FUTURE, HEALTHCARE OF THE FUTURE***

10-12 June 2015 – Oslo (Norway)

***HPH CONFERENCE 2015
PERSON-ORIENTED HEALTH PROMOTION IN A RAPIDLY CHANGING WORLD: CO-
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HEALTH PRIORITIES

Taking over from Italy, the Latvian Presidency of the Council of the EU starts on 1 January 2015 and will last until the end of June.

The Presidency's priorities in the area of health will be:

- encouraging healthy lifestyle and physical activity;
- highlighting the importance of fighting multidrug resistant tuberculosis;
- facilitating discussions on the future of alcohol policy;
- emphasising the importance of patient-centred healthcare.

On the legislative side, the Presidency will continue negotiations in the Council with a view to reach an agreement with the Parliament on the Regulations on medical devices and in vitro diagnostic medical devices. It will also work to secure an early second agreement on the Regulation on psychoactive substances.

The Working Party on Public Health at senior level, which will meet on 17 February, will focus on the topics of cost effective use of medicines, the engagement of the EU in the international health forum and update on activities and development of the EU Health Strategy.

The following events will also take place throughout the six months:

- High level conference on healthy lifestyle: nutrition and physical activity for children and youngsters, Riga, 23-24 February;
- Ministerial conference on tuberculosis, Riga, 31 March;
- eHealth Week, Riga, 11-13 May.

More information:

<http://www.es2015.lv/en/>

EU INSTITUTIONS AND POLICIES



EUROPEAN COMMISSION WORK PROGRAMME 2015

In December, the European Commission published its work programme for 2015, which sets out the actions that the Commission intends to take over during the next 12 months.

The work programme sets out 23 new initiatives in 10 priority policy areas which the Commission is committed to deliver in 2015. Some of these initiatives might have an impact on the organisation and operation of hospital and healthcare services. These are:

- *Labour mobility package*, which aims at supporting labour mobility and tackling abuse by means of better coordination of social security systems, the targeted review of the Posting of Workers Directive and enhanced EURES (European Employment Services), a cooperation network designed to facilitate the free movement of workers within the European Economic Area;
- *European Agenda on Migration*, which aims at developing a new approach on legal migration to make the EU an attractive destination for talents and skills and improve the management of migration by intensifying cooperation with third countries. The agenda includes the revision of the Blue Card Directive, the EU-wide work permit for highly skilled workers.

A list of dossiers which will be subject to withdrawal or revision in 2015 has also been included in the programme. Those of interest for the hospital and healthcare sector are:

- the proposal for a Directive relating to the transparency of measures regulating the prices of medicinal products for human use and their inclusion in the scope of public health insurance systems. Because of opposition of several Member States in the Council, an agreement seems difficult to be achieved. Therefore, the Commission plans to withdraw this legislative initiative;
- the proposal for a Directive amending the Council Directive 95/85/EEC on the introduction of measures to encourage improvements in the safety and health at work of pregnant workers and workers who have recently given birth or are breastfeeding. If not agreed within six months, this legislative initiative will be withdrawn and replaced by a new one.

The Commission also published a document containing REFIT actions. These actions build on the Regulatory Fitness Programme (REFIT), which seeks to cut red tape and remove regulatory burdens. Relevant actions to be mentioned include two evaluations to be initiated in 2015:

- evaluation of the relevance of standardisation activities and the EU standardisation system as laid down in the Regulation 1025/2012 on European standardisation;
- evaluation of the Directive 2011/7/EU on combating late payments in commercial transactions.

The Commission's 2015 work programme is available at:
http://ec.europa.eu/atwork/key-documents/index_en.htm



REORGANISATION OF DG SANCO – LETTER FROM STAKEHOLDERS

In December 2014, HOPE co-signed with other health stakeholders a letter addressed to the European Commission's President Jean-Claude Juncker. The letter expresses concern over the decision to assign the health technology portfolio, which encompasses medical devices, to DG Enterprise and Industry (ENTR).

When on 22 October the Commission's President announced his decision to leave the medicinal products portfolio to the Commissioner for Health and Food Safety Health, health organisations believed also health technology would have been returned to DG SANCO. But during his speech at the European Parliament, the President indeed did not mention both portfolios. As a matter of fact, the decision issued on 1 November 2014 on the organisation of responsibilities of the Members of the Commission ([C\(2014\) 9000](#)), shows that Unit SANCO B2 (Health Technology and Cosmetics) will be moved to DG ENTR.

As for medicinal products, stakeholders believe that the Health Directorate-General is best placed to ensure health technologies are regulated in the interest of patients' safety and public health. Pharmaceuticals and health technologies are of equal importance in the provision of care and should not be treated differently.

For this reason, the joint letter reiterates the plea to keep the portfolio of health technologies in the Directorate-General for Health and calls on the Commission to put the health of European citizens before economic interests.

The joint letter is available at:

http://cpme.dyndns.org:591/adopted/2014/140_Commission_Division_Compences_DGSante_DGEntr_December2014FINAL.pdf

eHEALTH – EUROBAROMETER ON EUROPEAN CITIZENS' DIGITAL HEALTH LITERACY

The European Commission has recently published the results of a Eurobarometer survey on European citizens' digital health literacy. The survey aimed to explore whether and how Europeans use the Internet and online resources to obtain health-related information.

The results show that a large part of European citizens consider Internet an important resource when looking for information about health and healthy lifestyle. In particular:

- over 75% think the Internet is a good way of finding out more about health;
- six out of ten Europeans go online when looking for health information;
- 90% of those said that the Internet helped them to improve their knowledge about health-related topics.

However, Internet is not the unique source used to obtain health-related information. Most people who did not use the Internet said they usually rely on their doctor.

The report also points out some inequalities in digital health literacy. For example, it highlights the connection existing between Europeans' digital health literacy and their general level of education. As a matter of fact, 71% of respondents who finished their education aged 20 or above reported having used the Internet to search for health-related information, against only 23% of people who left school aged 15 or under. Access to Internet is another important factor: a third of the respondents who did not use the Internet to search for health information said it is because they do not have Internet access.

This survey's results will help the Commission to design policies on eHealth that are focused on people's needs and requirements.

The report is available at:

http://ec.europa.eu/public_opinion/flash/fl_404_en.pdf

eHEALTH – LEGAL STUDY ON ELECTRONIC HEALTH RECORDS

The European Commission has recently published the report "Overview of the national laws on electronic health records in the EU Member States and their interaction with the provision of cross-border eHealth services".

This study was commissioned with the objective to provide an overview of the current national laws on electronic health records in the EU Member States and their interaction with the provision of cross-border eHealth services mentioned in the Directive 2011/24/EU on patients' rights in cross-border healthcare.

To this end, the study first identified and examined the national laws of the 28 Member States and Norway and identified legal barriers for cross-border transfer data from electronic health records and for the provision of cross-border eHealth services. It then secondly formulated recommendations addressed to the eHealth Network (i.e. the network of national responsible authorities on eHealth) on how the national laws and the European framework must evolve to support cross-border eHealth services.

The recommendations cover the topics examined by the study: content and interoperability of the electronic health records; security aspects; patient consent; creation, access and update of electronic health records; liability; secondary use; archiving duration; links between ePrescriptions and electronic health records.

The report is available at:

http://ec.europa.eu/health/ehealth/docs/laws_report_recommendations_en.pdf

PATIENT SAFETY AND QUALITY OF CARE – EXPERT GROUP MEETING

On 18 December 2014, the Patient Safety and Quality of Care Expert Group met for the first time after the election of the new European Commission. The Expert Group (formerly Working Group) brings together representatives from all 28 EU countries, EFTA countries, international organisations and stakeholders, including HOPE. The group assists in developing the EU patient safety and quality agenda.

The meeting started with a presentation from the European Commission on the Commission's second report on the implementation of the 2009 Council Recommendation on patient safety, which was published in June 2014. The 2009 Council Recommendation set up a strategy based on four areas of action: policies and programmes on patient safety, empowering patients, reporting adverse events and education and training of healthcare workers. This report tries to underline the progress made, especially in terms of: development of policies and programmes (26 countries developed patient safety strategies or programmes), reporting systems on adverse events (existing in 27 countries) and patient empowerment. However, the report also highlights the need for further efforts at EU level and proposes a list of actions including the development of guidelines and a common definition of quality of care.

After this presentation, the Italian Presidency of the Council described the content of the recently adopted Council conclusions on patient safety and quality of care including the prevention and control of healthcare associated infections and antimicrobial resistance, and actions proposed to the Commission and the Member States such as the collection of information on adverse events and the promotion of research. During the day, the opinion of the Expert Panel on Effective Ways of Investing in Health on the future EU agenda on patient safety and quality of care as well as the EMPATHiE study (Empowering patients in the management of chronic diseases) were also presented.

All this background information provided to the group was aimed at facilitating discussions and share of ideas on the future directions of the EU agenda on patient safety and quality of care, the role to be played by the Expert Group and what should be the content of the work programme for 2015. Some of the suggestions emerged during the discussion pointed out: the importance to continue the work "on the field" such as the one initiated by the PaSQ Joint Action through the implementation of selected safe clinical practices; the need of further work in the areas of patient involvement and patient empowerment and to enhance efforts to promote education in patient safety.

A discussion paper will be prepared by the European Commission with a view to define the priorities which will guide the work of the Expert Group in 2015, common objectives to be achieved and the actions needed. All Expert Group members will have the opportunity to provide feedback and comments to the document during the next meeting of the Expert Group, which will take place on 11 February 2015.

More information:

http://ec.europa.eu/health/patient_safety/policy/index_en.htm

PATIENT SAFETY AND QUALITY OF CARE – COUNCIL CONCLUSIONS

On 1 December 2014, the Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) adopted Conclusions on patient safety and quality of care including the prevention and control of healthcare associated infections and antimicrobial resistance.

The conclusions call on Member States and the Commission to put in place a number of activities to improve patient safety and quality of care in the EU. In particular, the conclusions welcome the work done by the European Network for Patient Safety and Quality of Care (Joint Action PaSQ) as regards the exchange and implementation of good practices in Member States and invite Member States and the Commission to take into account the results from PaSQ Joint Action when developing further work on the dimensions of quality in healthcare and in the finalisation by December 2016 of a framework for a sustainable EU collaboration on patient safety and quality of care.

Since its beginning in 2012, HOPE has been deeply involved in the activities of PaSQ Joint Action and is responsible for the organisation of the final conference which will take place in Brussels on 12-13 March 2015, where main results achieved will be presented.

More information:

http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lisa/145976.pdf

INNOVATION FOR THE BENEFIT OF PATIENTS – COUNCIL CONCLUSIONS

On 1 December 2014, the Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) adopted Conclusions on innovation for the benefit of patients. These conclusions mainly deal with the topic of access to innovative medicinal products and health technologies and call on the Member States and the Commission to further develop activities on a certain number of issues.

These activities include the increase of information-sharing on prices and expenditure on medicinal products, further enhance the work on Health Technology Assessment (HTA) and continue dialogue between stakeholders and competent authorities.

More information:

http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lisa/145978.pdf

CROSS-BORDER CARE – REPORT ON IMPACT OF INFORMATION ON PATIENT'S CHOICE

A study on the impact of information on patients' choice in the context of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare has recently been published. The study has been commissioned by the Executive Agency for Consumers, Health and Food (CHAFEA), acting on behalf of the European Commission (DG SANCO).

The study was divided into two phases: Phase I was based on a controlled online experiment and a survey undertaken in eight Member States, which investigated the impact of information on respondents' choice to seek healthcare cross-border in the EU. This first phase also included a survey

of payers. In a second phase, a shortened version of the Phase I experiment was implemented along with a survey that asked respondents questions about their experience as regards the National Contact Points' (NCPs) websites.

As a result, the survey identified key drivers of travelling to another Member State for a medical treatment. The main drivers identified are:

- cost of the treatment;
- waiting time;
- trust in the country's healthcare system.

Consequently, authors recommended that information about prices and waiting time are easily accessible on NCPs' websites.

When it comes to payers, they highlighted that the Directive facilitates cooperation among payers in different Member States, but they also pointed out some critical elements. In their opinion, the information provided to patients are too complex to understand and not sufficient to enable patients to make an informed choice about going abroad to receive treatment.

Finally, the findings showed that the main reason for patients to visit NCPs' website was to find information about healthcare in a Member State other than their home country. However, the majority of users reported the information was not easy to find, and that in some cases not all information were provided or more details were needed.

More information:

http://ec.europa.eu/health/cross_border_care/docs/cbhc_information_patientschoice_en.pdf



DATA PROTECTION – JHA COUNCIL

On 4 December 2014, during the meeting of the Justice and Home Affairs (JHA) Council, Ministers reached a partial general approach on specific aspects of the draft data protection regulation. The new legislation aims to strengthen current EU data protection rules and to ensure a more harmonised approach to data protection and privacy across the European Union. The draft proposal contains provisions which could have an important impact on the provision of healthcare services and research.

The partial general approach concerns articles which are crucial to the question of the public sector (Article 1, Article 6, paragraphs (2) and (3), Article 21, and related recitals). The amendments proposed by the Council recognise the necessity expressed by Member States to dispose of a sufficient level of flexibility in determining the data protection requirements applicable to the public sector.

The partial general approach covers also some specific processing situations set out in chapter IX and the related recitals. This includes article 83 on the processing for historical, statistical and scientific research purposes. Article 81 (processing of personal data concerning health) has been incorporated by the Council into article 9, which regards the processing of special categories of personal data. However, this text was not part of the partial general approach and will be subject to further scrutiny at technical level.

This partial agreement was reached with the understanding that no final agreement is attained until an agreement is reached on the entire text of the proposal, which means these provisions are susceptible to changes in the future.

The incoming Latvian presidency of the Council aims to adopt a general approach on this dossier by end of March 2015.



WORKING TIME – PUBLIC CONSULTATION

On 1 December 2014, the European Commission launched a public consultation on the review of the Working Time Directive (Directive 2003/88/EC). The working time Directive requires EU countries to guarantee minimum standards applicable throughout the EU with regard to workers' rights. The Directive also sets out special rules on working hours for workers in a limited number of sectors, including doctors in training.

Working time is a long-standing issue at EU level. In September 2004, the European Commission published a proposal for the revision of the working time Directive. The need for a new directive was caused by a number of European Court of Justice Rulings. This proposal was not adopted, since the European Parliament and the Council could not reach agreement on it during the last meeting of the Conciliation Committee, which took place in April 2009.

Divergent views mainly concerned the issues of on call time (i.e. periods when the worker is required to be available to the employer at the workplace in order to provide his or her services in case of need), the opt-out clause relative to the 48 hours per week limit and multiple contracts.

The main purpose of this consultation is to gather insights and contributions from the public in the context of the ongoing European Commission's review and impact assessment process concerning the Working Time Directive and possible changes to the Directive. Contributions can be received from citizens, organisations and public authorities.

The deadline to submit contributions is 15 March 2015.

More information:

<http://ec.europa.eu/social/main.jsp?catId=333&consultId=14&visib=0&furtherConsult=yes&langId=en>



NETWORK ON QUALITY AND COST-EFFECTIVENESS IN LONG-TERM CARE AND DEPENDENCY PREVENTION – CALL FOR PROPOSALS

The European Commission has recently launched a call for proposals on establishing a network on quality and cost-effectiveness in long-term care and dependency prevention.

The purpose of this call is to bring together institutions that can develop solid evidence on the cost-effectiveness of investments in a wide range of measures to reduce the gap between the need for, and supply of, long-term care, including prevention, rehabilitation, assistive technologies and age-friendly environments as well as a more efficient organisation of care systems (notably through better coordination of the different actors involved in providing care).

By establishing a network of institutions that have already collected relevant evidence, or are capable of doing so, it is expected that a common body of evidence can be generated and made available to policy makers across the EU, helping them to use public money in the most effective way in order to ensure access to high-quality care in a sustainable manner.

The deadline for the submission of proposals is 31 March 2015.

More information:

<http://ec.europa.eu/social/main.jsp?catId=629&langId=en&callId=425&furtherCalls=yes>

EUROPEAN REFERENCE NETWORKS – NEWS ON TENDERS

Under the Directive on the application of patients' rights in cross-border healthcare, the development of European Reference Networks (ERNs) was seen as a primordial area for cross-border cooperation among Member-States. ERNs aim to unite the best specialists from across Europe to tackle complex or rare medical conditions that require highly specialised healthcare and a concentration of knowledge and resources.

A tender concerning the development of a manual and toolbox for the assessment of ERNs was launched last July and has been awarded to a consortium led by the European Organisation for Rare Diseases (EURORDIS) and where HOPE is involved as a partner. The assessment manual and toolbox produced will address all the steps of the process from the call for Networks and providers to the approval of the Networks including the materials and methods to be used and the expected end products, thus being essential for the objective assessment of ERN proposals to be presented in December 2015.

As regards ERNs, the Consumer, Health and Food Executive Agency (CHAFAEA) has also recently launched another tender for the development of a study on the services to be provided by the European Reference Networks and its Members. The purpose of this contract is to provide a conceptual framework, catalogue and analysis on the typology, characteristics and cost of services to be provided by the European Reference Networks and its Members.

The deadline for the submission of proposals is 30 January 2015.

More information on the call for tender for a study on the services to be provided by the European Reference Networks and its Members:

http://ec.europa.eu/chafea/health/tender-25-2014_en.html

More information on European Reference Networks:

http://ec.europa.eu/health/ern/policy/index_en.htm

GREEN@HOSPITAL – FINAL WORKSHOP ON 20 FEBRUARY, ANCONA, ITALY

The project Green@Hospital is organising a final workshop on 20 February in Ancona (Italy) entitled “Re-energising healthcare, a sustainable challenge?”. The workshop will take place within the Green@Hospital Week, an entire week of events focused on healthcare innovation, efficiency and sustainability.

The GREEN@Hospital project, co-funded by the European Commission under the ICT Policy Support Programme, aims at integrating the latest ICT solutions in order to obtain significant energy savings in existing hospital buildings, through a better management of energy resources and losses reduction.

Hospitals are known to be large energy consumers and in most European countries the high proportion of ageing building stocks makes hospitals amongst the least energy efficient public buildings. Nowadays there is a growing urgency to achieve real energy savings from existing building stocks and to build more sustainable new hospitals.

Within the project a Web-based Energy Management and Control System (Web-EMCS) has been developed. It integrates monitors and controls multiple buildings systems at the component level. In order to demonstrate the validity of this solution under real operating conditions, four hospitals across Europe took part in a pilot. Each hospital made available specific areas selected considering the presence of: 1) renewable energy sources, 2) already available building management systems to be easily integrated in the Web-EMCS, 3) refurbishing plans aiming at energy efficiency improvement.

The hospitals involved in the pilot are: Hospital de Mollet, Mollet del Vallès (Spain); University Hospital Virgen de las Nieves of the Servicio Andaluz de Salud in Granada (Spain); Azienda Ospedaliero Universitaria – Ospedali Riuniti di Ancona (Italy); Hospital of Chania (Greece).

More information on the project and the final workshop:

<http://www.greenhospital-project.eu/>

PATIENT SAFETY – CHAFEA CONFERENCE

On 2 and 3 December 2014, HOPE was invited in Rome to the conference “Promoting patient safety and quality of care: the EU contribution to national actions” organised by the Consumer, Health and Food Executive Agency (CHAFEA).

The event aimed at providing a platform of discussion for journalists, experts and policymakers from the Directorate-General for Health and Consumers (DG SANCO), representatives from the Consumer, Health and Food Executive Agency (CHAFEA) and project coordinators working on projects co-funded by the EU Health Programmes.

HOPE Chief Executive, Pascal Garel, was invited to present the work carried out on medication reconciliation within the European Union Network for Patient Safety (EUNetPaS project) and its successor PaSQ Joint Action. HOPE played a key role within both initiatives. In EUNetPaS, HOPE was the leader of a work package, whose main objective was to identify good practices in reducing medication errors and implementation of some of them in hospitals. A total of 75 practices were implemented in 66 hospitals from 11 countries.

Within PaSQ, HOPE was involved in the recruitment of health care organisations participating in the implementation of the medication reconciliation good practice. A total of 124 health care organisations from 11 countries were involved in this implementation process, which took place from September 2013 to September 2014.

During the conference, other projects in the area of patient safety and quality of care were presented, some of them in which HOPE has been involved as a partner, such as DUQuE (Deepening our understanding of quality improvement in Europe) and EURHOBOP (European Hospital Benchmarking by Outcomes in Acute Coronary Syndrome Processes).

The event ended with a panel discussion on the current policy agenda and challenges and opportunities for future EU collaboration.

More information and presentations are available at:

<http://ec.europa.eu/chafea/news/news355.html>

MOMENTUM – BLUEPRINT ON TELEMEDICINE DEPLOYMENT

In December 2014, the Momentum project released the *European telemedicine deployment blueprint* to assist “telemedicine doers” introduce healthcare services at distance through information technology. The blueprint for doers describes 18 critical success factors for telemedicine deployment with detail, context, indicators, and descriptions, including an attachment with case studies.

The *Momentum blueprint* builds on an earlier and shorter version of the 18 critical success factors that was released in May 2014. Since then, healthcare stakeholders from across the EU Member States joined dozens of conference presentations, moderated workshops and online fora to provide feedback on the critical success factors and to contribute to a more detailed and refined document.

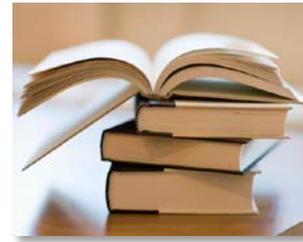
HOPE was also deeply involved in this review process, especially regarding the critical success factors contributing to a deployment strategy and for managing organisational change.

Momentum is a project co-financed by the European Commission under the ICT Policy Support Programme (ICT PSP). Started in February 2012 and ending in January 2015, it aimed to create a platform across which the key players shared their knowledge and experience in deploying telemedicine services into routine care. The Blueprint represents the main outcome of the project.

The telemedicine deployment blueprint is available at: http://telemedicine-momentum.eu/wp-content/uploads/2014/12/D3.2_v13_Momentum_ConsolidatedBlueprint.pdf

More information on Momentum: <http://telemedicine-momentum.eu/>

REPORTS AND PUBLICATIONS



HEALTH AT A GLANCE: EUROPE 2014 – OECD/EC REPORT



The latest edition of “*Health at a Glance: Europe*” has recently been published. This publication, which is the result of a collaboration between the OECD and the European Commission in the field of health information, presents a set of key indicators related to health status, determinants of health, health care resources and activities, quality of care, access to care, and health expenditure and financing in 35 European countries, including the 28 European Union Member States, four candidate countries and three EFTA countries.

The selection of indicators is based largely on the European Core Health Indicators (ECHI) shortlist, a set of indicators that has been developed to guide the reporting of health statistics in the European Union. This is complemented by additional indicators on quality of care, access to care and health expenditure, building on the OECD expertise in these areas.

Compared with the previous edition, this edition includes a greater number of ECHI indicators, reflecting progress in the availability of comparable data in the areas of non-medical determinants of health and access to care. It also includes a new chapter dedicated to access to care, including selected indicators on financial access, geographic access and timely access.

The report highlights that large inequalities in health remain across and within countries. These are largely due to disparities in access to and quality of care, as well as individual lifestyles and behaviours. This makes it all the more important that all European countries put in place effective public health strategies to prevent diseases and contribute to the reduction in health inequalities.

More information:

http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/health-at-a-glance-europe-2014_health_glance_eur-2014-en#page1

MENTAL HEALTH AND WORK IN THE NETHERLANDS – OECD REPORT



This OECD Report shows that one in three people on unemployment, social assistance or disability benefits, experience psychological problems such as distress, depression or anxiety. The OECD estimates that mental health issues cost European economy in lost productivity, health care and social spending.

Therefore, tackling mental ill-health of the working-age population is becoming a key issue for labor market and social policies in OECD countries, whose governments increasingly recognise that policy has a major role to play in keeping people with mental ill-health in employment or bringing those outside of the labor market back to it, and in preventing mental illness. Nevertheless, public support for unemployment and social assistance beneficiaries temporarily too sick to work due to mental ill-health is insufficient. General practitioners and mental health care providers are neither required nor encouraged to focus on work in the treatment process.

Case management support in collaboration with mental health specialists should be offered by the public employment service and the municipalities as soon as possible after job loss. This can prevent a worsening of mental health problems and reduce the risk of long-term inactivity. Early action is also needed in the education system. Preventive programs in schools are needed, as well as better support for youth in the school-to-work transition.

This report on the Netherlands is the seventh in a series of reports looking at how the broader education, health, social and labor market policy challenges are being tackled in a number of OECD countries by quoting many important policy changes in the past two decades in the Netherlands.

More information:

http://www.keepeek.com/Digital-Asset-Management/oecd/employment/mental-health-and-work-netherlands_9789264223301-en#page1

ACCESS TO HEALTHCARE IN TIMES OF CRISIS – EUROFOUND REPORT



In the wake of the economic and financial crisis, many European governments have cut spending on healthcare services. At the same time, unemployment, financial strain and reduced prevention have increased the need for certain healthcare services, while falling disposable income has made access to healthcare more difficult for many EU households.

This report published by the European Foundation for the Improvement of Living and Working Conditions (EUROFUND) identifies the groups most likely to face barriers to healthcare as a consequence of the crisis, including a number of new groups that have been generally overlooked by policymakers. It suggests a range of policy pointers, including the need to consider mitigating measures in tandem with policy reform, and suggests

policymakers and service providers might consider reviewing crisis responses once financial pressures on EU Member States begin to ease.

More information:

http://eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef1442en.pdf

USE OF PERSONAL PROTECTIVE EQUIPMENT FOR SAFE FIRST ASSESSMENT OF POSSIBLE EVD CASES – ECDC TUTORIAL REPORT



The European Centre for Disease Prevention and Control's (ECDC) mission is to identify, assess and communicate current and emerging threats to human health posed by infectious diseases.

In the context of the current Ebola virus outbreak, ECDC issues risk assessments and regular updates on the epidemiological situation. The ongoing Ebola epidemic demonstrates that the risk of transmission to healthcare workers is not limited to the worst affected West African countries. It also underscores the relevance of staff safety and protection.

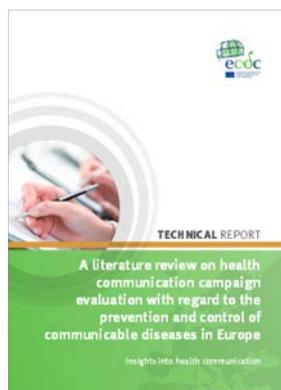
After having released a first tutorial (see November newsletter) which provided practical information on the proper use of personal protective equipment (PPE) at the point of care, including technical requirements and procurement aspects, the ECDC has recently released this second tutorial, which complements the previous one and aims to improve the protection of staff dealing with Ebola Virus Disease (EVD) in non-specialised centres.

It focuses on the use of various PPE components appropriate in the first assessment of possible EVD cases, particularly in healthcare facilities with a European standard of care but not designated for treatment of EVD patients. The main target audience are healthcare professionals working in non-specialised settings in the EU/EEA, in particular those responsible for first assessment in non-specialised healthcare settings.

More information:

<http://www.ecdc.europa.eu/en/publications/Publications/Use-of-PPE-for-safe-first-assessment.pdf>

PREVENTION AND CONTROL OF COMMUNICABLE DISEASES – ECDC LITERATURE REVIEW ON HEALTH COMMUNICATION CAMPAIGN EVALUATION



The European Centre for Disease Prevention and Control (ECDC) has recently published a report which collates and summarises the literature on communication campaign evaluation with relevance to the prevention and control of communicable diseases. The aim of this review is to contribute to the evidence base on health communication evaluation research in order to aid public health professionals and researchers in the development of future evaluation strategies.

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The review is divided into two sections. In the first section the focus is on reviewing evaluations of campaigns undertaken in the EU and European Economic Area (EEA) countries, however, examples from the wider European region are also included. The second section, addressing challenges posed by campaign evaluation, draws on broader international literature pertaining to the identification of health communication campaign evaluation tools, frameworks and models.

It would appear that there has been very few high quality European evaluation studies carried out in the last decade in relation to communicable disease prevention campaigns. Nevertheless, it is evident in reviewing the literature that there are valuable existing frameworks and guidelines that can help guide and inform evaluation research development.

More information:

<http://www.ecdc.europa.eu/en/publications/Publications/Campaign-evaluation.pdf>

IMMUNO-ONCOLOGY – ACTION FRAMEWORK REPORT AND PATIENT GUIDE

The European Cancer Patient Coalition (ECPC) has recently launched an *Immuno-Oncology Action Framework Report* and a *Patient Guide to Immuno-Oncology*. These documents were launched during an event at the European Parliament co-hosted by MEPs Philippe de Backer (ALDE, Belgium) and Cristian Silviu Buşoi (EPP, Romania). Both MEPs are members of the Expert Group on Immuno-Oncology, which was established earlier this year as an independent network of patients, oncology healthcare professionals, scientists, researchers, and politicians. The Expert Group aims to help improve understanding of immuno-oncology therapies, and develop concrete recommendations of how European and national policymakers can encourage rapid and appropriate patient access to immuno-oncology therapies across Europe.

Immuno-oncology therapies are a new cancer treatment modality that uses the immune system to fight cancer. They have been recognised as a true breakthrough in cancer therapy, offering the hope of long-term, quality survival for the very first time to many patients for whom prognosis was previously very poor.

The Immuno-Oncology Action Framework Report contains recommendations to EU-level policymakers and national politicians, to encourage them to create more flexibility in regulatory and valuation frameworks, secure funding for innovative cancer therapies, and integrate the most effective therapies into national cancer plans.

The Patient Guide to Immuno-Oncology aims to help patients understand what these new therapies are, how they differ from existing treatments, and what role they will play in years to come.

The Immuno-Oncology Action Framework Report is available at:

<http://www.ecpc.org/Documents/Policy&Advocacy/Immuno-Oncology/Event%2019th%20Nov%202014/IO%20action%20framework%20FINAL%20Dec14%20lores.pdf>

The Patient Guide to Immuno-Oncology is available at:

<http://www.ecpc.org/Documents/Policy&Advocacy/Immuno-Oncology/Event%2019th%20Nov%202014/IO%20patients%20leaflet.pdf>

FRANCO-BELGIAN CROSS-BORDER HEALTHCARE COOPERATION – CONFERENCE REPORT

The OpenDays, the European Week of Regions and Cities is an annual four-day event during which cities and regions showcase their capacity to create growth and jobs, implement European Union cohesion policy, and prove the importance of the local and regional level for good European governance.

In the context of the OpenDays, a seminar was held on 7 October 2014 in Brussels on the topic of “Cross-border healthcare cooperation on the Franco-Belgian border: strategic challenges and prospects”. Around one hundred participants attended the event, including medical specialists and the representatives of hospitals, health insurance funds, regional health agencies, health observatories and patient associations.

This report illustrates the main outcomes of the conference, as well as some key dates marking the Franco-Belgian cross-border health cooperation and a list of Interreg IV projects linked to the topic of cross-border healthcare cooperation.

More information:

<http://www.interreg-fwvl.eu/admin/upload/page/file/1470.pdf>

WILLINGNESS TO PAY FOR INFORMAL CARE IN FRANCE – REVIEW ARTICLE

Recently appeared on Health Economics Review 2014, this article tries to assess the relationship between the monetary value of informal care -approximated with caregiver's willingness to pay to reduce caregiving time- and caregiver's need of three types of support services: care training, respite care and support group. Developing such services may be the only way to provide sustainable informal care in the future, along with efficient allocation.

The research this article is based upon uses data derived from two representative national surveys conducted by the French National Institute of Statistics and Economic Studies and the French Head Office of Research, Studies, Evaluation and Statistics of the Social Affairs Ministry in 2008. The contingent valuation method was used to approximate the monetary value of informal care. The model was run on 223 informal caregivers of people with Alzheimer's Disease. On average, one hour of informal care was estimated at €12.1. Monetary value of informal care was influenced by the caregiver's need of care training. No similar association was found for respite care or support group. Since informal caring value increases with caregivers' need of care training, improving caring skills and capabilities through training support is likely to improve its benefits.

More information:

<http://www.healtheconomicsreview.com/content/4/1/34>

MEASURING AND COMPARING HEALTH CARE WAITING TIMES IN OECD COUNTRIES – REVIEW ARTICLE

Waiting times for elective treatments are a main health-policy concern in several OECD countries. This study describes common measures of waiting times from administrative data across OECD countries. It gives an emphasis on common elective procedures, such as hip and knee replacement, and cataract surgery, where waiting times are notoriously long. It provides comparative data on waiting times across 12 OECD countries and presents trends in waiting times over the last decade.

Waiting times appear to be low in the Netherlands and Denmark. In the last decade the United Kingdom (in particular England), Finland and the Netherlands have witnessed large reductions in waiting times which can be attributed to a range of policy initiatives, including higher spending, waiting-times target schemes and incentive mechanisms, which reward higher levels of activity. The negative trend in these countries has, however, halted or reversed in recent years. The analysis also emphasises systematic differences across different waiting-time measures, in particular between the distribution of waiting times of patients treated versus that of patients on the list.

More information:

http://ac.els-cdn.com/S0168851014002267/1-s2.0-S0168851014002267-main.pdf?_tid=61aadf56-89do-11e4-b089-00000aabof6c&acdnat=1419249061_bde91f58foa17758f9adc8a33c92f8b6

FORGONE CARE AND FINANCIAL BURDEN DUE TO OUT-OF-POCKET PAYMENTS WITHIN THE GERMAN HEALTH CARE SYSTEM – RESEARCH

This paper focuses on the analysis of determinants of the total amount of out-of-pocket (OOP) payments, the financial burden caused by OOP payments and the relinquishment of health care services due to OOP payments.

The amount of OOP payments within the German health care system has risen steadily within the last years. OOP payments aim to strengthen patients' cost awareness and try to restrict the demand on medical necessary treatments. However, besides the intended decline of non-induced health care services, there's a risk that people also forgot necessary treatments because the utilisation of health care services depends not only on need-factors but also on the ability to pay for it.

The empirical analysis is based on cross-sectional data of the German subsample (n = 2851) of the Survey of Health, Ageing and Retirement in Europe (SHARE). SHARE is a representative panel study among private households with persons above the age of 50 years and covers a wide range of topics, e.g. health behavior, health status and information about the socio-economic status. Individuals with low income as well as people suffering from chronic illnesses face a higher financial burden and forgot health care services more frequently at the same time. Especially for the group of people with chronic illnesses and low-income earners it cannot be ruled out that they also forgot necessary medical treatments due to the relatively high financial burden they face. Hence, it is required to facilitate the access to necessary care for these groups.

More information: <http://www.healtheconomicsreview.com/content/pdf/s13561-014-0036-0.pdf>

SOCIOECONOMIC DIFFERENCES IN THE USE OF ILL-DEFINED CAUSES OF DEATH IN 16 EUROPEAN COUNTRIES – RESEARCH ARTICLE

This research investigates educational differences in the use of ill-defined causes of death in official mortality statistics. Cause-of-death data linked to information on socioeconomic position form one of the most important sources of information about health inequalities in many countries. Hence the proportion of deaths from ill-defined conditions is one of the indicators of the quality of cause-of-death data.

The researchers have calculated the proportion of all deaths in each educational group that were classified as due to "Symptoms, signs and ill-defined conditions" by using age-standardised mortality rates from 16 European countries. Then they tested if this proportion differed across educational groups. The proportion of ill-defined causes of death was lower than 6.5% among men and 4.5% among women in all European countries, without any clear geographical pattern. This proportion statistically significantly differed by educational groups in several countries with in most cases a higher proportion among less than secondary educated people compared with tertiary educated people.

So this study shows evidence for educational differences in the distribution of ill-defined causes of death. However, the differences between educational groups were small suggesting that socioeconomic inequalities in cause-specific mortality in Europe are not likely to be biased.

More information: <http://www.biomedcentral.com/content/pdf/1471-2458-14-1295.pdf>

CONTINUITY OF GP CARE AND USE OF COMPLEMENTARY AND ALTERNATIVE MEDICAL PROVIDERS – POPULATION-BASED CROSS-SECTIONAL SURVEY

The aim of this study is to test the association between continuity of general practitioner (GP) care and the use of complementary and alternative medical (CAM) providers. Continuity of GP care is associated with reduced use of emergency departments, hospitalisation and outpatient specialist services. Evidence about the relationship between continuity and use of CAM providers has so far been lacking.

So the researchers used questionnaire data from the sixth Tromsø Study, conducted in 2007–8. Using descriptive statistical methods, they estimated the proportion using a CAM provider among adults (30–87 years) who had visited a GP during the last 12 months. They studied the association between the duration of the GP-patient relationship and the use of CAM providers. Of 9,743 eligible GP users, 85.1% had seen the same GP for more than two years, 83.7% among women and 86.9% among men. The probability of visiting a CAM provider was lower among those with a GP relationship of more than 2 years compared to those with a shorter GP relationship. Other factors associated with CAM use were female gender, poor health, low age and high income. There was no association with education. Continuity of GP care as measured by the duration of the GP-patient relationship was associated with lower use of CAM providers. In line with previous studies, this suggests that continuity of GP care may contribute to health care delivery from fewer providers.

More information: <http://www.biomedcentral.com/content/pdf/s12913-014-0629-7.pdf>

PATIENTS' EXPECTATIONS OF VARIATION IN QUALITY OF HOSPITAL CARE – RESEARCH ARTICLE

In this article the authors want to assess the role of patients' expectations regarding variation in the quality of hospital care in determining whether they search for comparative performance information (CPI). Choice of hospital based on CPI was introduced for Dutch healthcare consumers at least 5 years ago, but CPI use has not yet become commonplace.

A questionnaire (for a cross-sectional survey) was distributed to 475 orthopedic patients in a consecutive sample, who underwent primary hip or knee replacement in a university, teaching, or community hospital between September 2009 and July 2010. Of the 302 patients (63%) who responded, 13% reported searching for CPI to help them choose a hospital. People who expected quality differences between hospitals (67%) were more likely to search for CPI than those who did not. Quality differences were most often expected in hospital reputation, distance, and accessibility. Patients who did not search for CPI stated that they felt no need for this type of information. Patients' expectations regarding variation in quality of care are positively related to their reported search for CPI. To increase the relevance of CPI for patients, future studies should explore the underlying reasoning of patients about meaningful quality-of-care variation between hospitals.

More information: <http://www.biomedcentral.com/content/pdf/s12913-014-0617-y.pdf>

COMPARING THE IMPLEMENTATION OF TEAM APPROACHES FOR IMPROVING DIABETES CARE IN COMMUNITY HEALTH CENTERS – RESEARCH ARTICLE

As patient panel management and community-based care management may be viable strategies for community health centers to improve the quality of diabetes care for vulnerable patient populations, this study aims to clarify implementation processes and experiences of integrating office-based medical assistant (MA) panel management and community health worker (CHW) community-based management into routine care for diabetic patients.

The study involves interviews and surveys of clinicians and staff to assess differences in practice culture among intervention and control groups. So implementation processes and experiences varied considerably among the practices implementing CHW and MA team-based approaches, resulting in differences in the organisation of health coaching and self-management support activities.

Importantly, CHW and MA responsibilities converged over time to focus on health coaching of diabetic patients. MA health coaches experienced difficulty in allocating dedicated time due to other MA responsibilities that often crowded out time for diabetic patient health coaching. Time constraints also limited the personal introduction of patients to health coaches by clinicians. Participants highlighted the importance of a supportive team climate and proactive leadership as important enablers for MAs and CHWs to implement their health coaching responsibilities and also promoted professional growth. Implementation of team-based strategies to improve diabetes care for vulnerable populations was diverse, however all practices converged in their foci on health coaching roles of CHWs and MAs.

The study suggests that a flexible approach to implementing health coaching is more important than fidelity to rigid models that do not allow for variable allocation of responsibilities across team members. Clinicians play an instrumental role in supporting health coaches to grow into their new patient care responsibilities.

More information: <http://www.biomedcentral.com/content/pdf/s12913-014-0608-z.pdf>

IMPLEMENTATION OF THE 2011 THERAPEUTIC ACTIVITY ACT – WILL COMMERCIALISATION IMPROVE THE FINANCIAL PERFORMANCE OF POLISH HOSPITALS?

The Therapeutic Activity Act that came into force on 1 July 2011 was aimed at achieving a large-scale transformation of public hospitals into Commercial Code companies. The change of the legal form, from a public entity to a for-profit company, was expected to improve the poor economic efficiency of the public hospital sector. However, the mere change of the legal form does not guarantee a better financial performance of hospitals and thus the success of the Act.

In many cases, deep internal changes are needed to achieve improvements in the financial performance of particular hospitals. In addition, a set of other measures at the national and regional levels, such as the mapping of health needs of the population, have to accompany the legal transformations in order to improve the efficiency of the hospital sector. The recent slowdown in the rate of the transformations is another factor that renders the success of the Act uncertain.

More information:

<http://www.healthpolicyjrn.com/article/So168-8510%2814%2900263-2/fulltext>

HEALTHCARE FINANCING REFORM IN LATVIA – SWITCHING FROM SOCIAL HEALTH INSURANCE TO NHS AND BACK?

In the 1990s, Latvia aimed at introducing Social Health Insurance (SHI) but later changed to a National Health Service (NHS) type system. The NHS is financed from general taxation, provides coverage to the entire population, and pays for a basic service package purchased from independent public and private providers.

In November 2013, the Cabinet of Ministers passed a draft Healthcare Financing Law, aiming at increasing public expenditures on health by introducing Compulsory Health Insurance (CHI) and linking entitlement to health services to the payment of income tax. Opponents of the reform argue that linking entitlement to health services to the payment of income tax does not have the potential to increase public expenditures on health but that it can contribute to compromising universal coverage and access to health services of certain population groups. In view of strong opposition, it is unlikely that the law will be adopted before parliamentary elections in October 2014.

Nevertheless, the discussion around the law is interesting because of three main reasons: (1) it can illustrate why the concept of SHI remains attractive – not only for Latvia but also for other countries, (2) it shows that a change from NHS to SHI does not imply major institutional reforms, and (3) it

demonstrates the potential problems of introducing SHI, i.e. of linking entitlement to health services to the payment of contributions.

More information: <http://www.healthpolicyjrn.com/article/So168-8510%2814%2900259-0/pdf>

UNREGULATED ACCESS TO HEALTH-CARE SERVICES IS ASSOCIATED WITH OVERUTILISATION – LESSONS FROM AUSTRIA

The Austrian health-care system is characterised by free provider choice and uncontrolled access to all levels of care. Using primary data, the ECOHCARE study shows that hospitalisation rates for the secondary and tertiary care levels in Austria are both 4.4 times higher than those reported from the USA using a similar methodology.

At the same time, essential functions of the primary care sector are weak. Authors propose that regulating access to secondary and tertiary care and restricting free provider choice to the primary care level would both reverse over utilisation and strengthen the primary care sector.

More information:

<http://eurpub.oxfordjournals.org/content/eurpub/early/2014/11/22/eurpub.cku189.full.pdf>



CDI – CONFERENCE AT THE EUROPEAN PARLIAMENT

On 2 December 2014, HOPE co-hosted with MEP Karin Kadenbach (S&D, Austria) and CDI Europe, a conference at the European Parliament on *Clostridium difficile* infection (CDI) and Healthcare-associated infections (HAIs). CDI Europe is an expert-led initiative that aims to promote a better standard of care for patients with CDI in Europe.

The event followed on from the launch of the "CDI in Europe" report in April 2013, which was supported by multiple European stakeholders and quoted in the European Parliament Resolution on Patient Safety and HAIs, adopted in October 2013. The main objective of the conference was to highlight the urgent actions needed to address current issues as regards the management of HAIs and CDI, a prominent infection in Europe. Experts from across Europe came together with members of the European Parliament to discuss ways to improve current gaps in diagnosis, treatment, control and surveillance.

During the event, MEP Karin Kadenbach led discussions on the burden of CDI within the policy context of European action on HAIs. Joined by a number of pan-European scientific societies and clinical experts, the group discussed their respective roles in addressing HAIs and explored ways to collaborate to improve the quality of care for patients.

HOPE provided a presentation on the role of the hospital management in addressing CDI and other HAIs while representatives from the European Commission and the European Patient's Forum respectively highlighted the work carried out in the area of HAIs and the role to be played by patients and the importance of their involvement.

THE CROSS-BORDER CARE DIRECTIVE ONE YEAR INTO PRACTICE – WORKSHOP

The workshop "The Cross-border care Directive (2011/24/EU) one year into practice" took place in Venice on 23 and 24 October 2014 as part of the Italian Presidency of the EU Council and with the support of the "Mattone Internazionale" project. One year after the transposition of the Directive (Directive 2011/24/EU) concerning the application of patients' rights in cross-border health care, the workshop aimed to discuss its implementation in the Member States.

After welcome greetings from Veneto Region, Josep Figueras, Director of the European Observatory on Health Systems and Health Policy, presented the main issues and problems related to cross-border healthcare debate and what impact it can have on health systems as a whole.

Martin Seychell, Vice-Director of DG SANCO, gave an overview on the state of implementation of Directive 2011/24/EU in the Member States. He stressed that it is the first time the Member States adopt a directive in such a large majority, with particular focus on the needs of patients who must

have the instruments to make a choice. Karsten Vrangbæk, from the University of Copenhagen, pointed out how the availability of resources (financial, administrative, etc.) has had a key role in the implementation of the Directive across borders. A theoretical model was shown to explain the variables that influence the process of implementation of the Directive in the Member States: institutional context, available material resources, domestic political context, available time and agreement or not with the implemented national policies.

Chiara Marinacci, of the Ministry of Health, presented the role of the National Contact Point in Italy. Article number 6 of the Directive specifies that each Member State must designate one or more National Contact Points (NCPs). The National Contact Points provide information to both affiliated and non-affiliated citizens. The NCPs have disclosure obligations with respect to the following issues: standards of safety and quality of the providers of health treatments, accessibility for disabled people, rights and procedures for access to treatments at home country and other EU Member States and reimbursement.

Fredrik Lindén presented EPSOS Project (Smart Open Services for European Patients Project) whose he is the coordinator. It is a project of interoperability in the field of eHealth co-financed by the European Union under the ICT PSP programme, which involves 25 European countries represented by at least 50 public administrations (Ministries of Health at national and regional levels), national competence centres and companies with the aim of creating an electronic sharing of health data in Europe, in compliance with the regulatory framework and existing information systems in the countries participating in the initiative.

At the end of the first working day, several Member States (Italy, Austria, Germany, France, Slovenia and England) debated on patients' rights in the context of cross-border health care.

Giovanni Nicoletti, of the Italian Ministry of Health, opened the second working day by explaining that the directive is not only a legislative and administrative instrument. There is opportunity to change the vision of the health system at a European level although some resistance persists nationally.

Martin Seychell spoke about the future prospects for an easier access to better and safer health care. He showed that the Commission is focusing more on practical issues and is working to help Member States to meet the needs of their citizens in the next five years.

A first parallel session was entitled "Collaboration between Hospitals across borders in Europe - aspirations and reality." Irene Glinos, of the European Observatory on Health Systems and Health Policy presented the "Hospitals and Borders, a handbook that examines the reasons for hospitals to work together. Sara Pupato, President of HOPE talked about freedom of movement and cross-border cooperation in Europe. John Martin, of the European Critical Care Foundation, presented the results of a European survey on treatment of heart attacks across borders. Paolo Benetollo, of the AOUI of Verona, presented HoNCAB, a project which aims to enable the exchange of experiences, to facilitate reimbursement procedures among Member States and to develop a system for the sharing of information among Member States, a network of hospitals, a comparison among DRGs and a data system on concrete experiences to be compared. Rita Baeten, of the European Observatory on Health Systems and Health Policy, who presented a case of cross-border cooperation on the flow of patients between France and Belgium. Nikolay Vasev, University of

Copenhagen, presented the transposition of the Directive 2011/24/EU in Austrian and Bulgarian health systems.

In the second session, "Quality and standard of health care in the Member States", Paolo Di Loreto, Coordinator of International Mobility Table of the Health Committee and Scientific Coordinator of TELL ME project explained that the Directive does not provide information only on administrative issues and reimbursement but also on effectiveness and quality of care, on the autonomy of the Member States, on the responsibility of the Member States and on the monitoring of compliance with quality standards. Helena Legido-Quigley, of the London School of Hygiene and Tropical Medicine, stressed the importance of quality of care and of the widely accepted clinical guidelines. Vanda Raho, of Agenas explained the role of support for development strategies in health among the Ministry and the Italian regions of Agenas. Dr. Martin Seychell that in his last speech spoke about European reference networks and explained their context, legal basis, timetable and challenges. Linda Richieri, Umbria Region, who presented the position paper produced as part of PMI on the issues related to quality and accreditation. Then, during a panel discussion, Helena Legido-Quigley, Bjorn Broge and Eva M. Kernstock presented models of quality and accreditation of health care systems as used in Germany and Austria.

The two working days represented an important opportunity for discussion and analysis of the role of different levels of government, outlining the best practices developed in the context of cross-border collaboration.

More information and presentations are available at:

http://www.progettomattoneinternazionale.it/servizi/eventi/cerca_faseo3.aspx?ID=2458

AGENDA



UPCOMING CONFERENCES

PASQ JOINT ACTION FINAL CONFERENCE



12-13 March 2015 – Brussels (Belgium)

The final conference of the European Union Network for Patient Safety and Quality of Care (PaSQ Joint Action) will take place in Brussels on 12-13 March 2015 at the Thon Hotel EU.

The Joint Action, which started in April 2012, aimed to improve Patient Safety and Quality of Care through sharing of information, experience, and the implementation of good practices.

During the final conference, the results of the Joint Action will be showcased and there will be an opportunity for participants coming from all over Europe to share experiences and good practices on patient safety. The conference will also represent an opportunity to discuss about future work on patient safety at EU level.

More information will soon be available at: www.pasq.eu

HOPE AGORA 2015



HOSPITALS 2020:

*HOSPITALS OF THE FUTURE,
HEALTHCARE OF THE FUTURE*

1-2 June 2015 – Warsaw (Poland)

In 2015, HOPE organises its exchange programme for the 34th time. This 4-week training period is targeting hospital and healthcare professionals with managerial responsibilities. They are working in hospitals and healthcare facilities, adequately experienced in their profession with a minimum of three years of experience and have proficiency in the language that is accepted by the host country.

During their stay, HOPE Exchange Programme participants are discovering a different healthcare institution, a different healthcare system as well as other ways of working.

The HOPE Exchange Programme 2015 starts on 4 May and ends on 31 May, followed by the closing conference "HOPE Agora" in Warsaw (Poland) on 1 and 2 June 2015. The closing conference is considered as part of the training and all professionals should attend it.

Each year a different topic is associated to the programme. "**Hospitals 2020: hospitals of the future, healthcare of the future**" will be the topic for 2015.

More information on the HOPE Exchange Programme:

<http://www.hope.be/04exchange/exchangefirstpage.html>



HPH CONFERENCE 2015

PERSON-ORIENTED HEALTH PROMOTION IN A RAPIDLY CHANGING WORLD: CO-PRODUCTION – CONTINUITY – NEW MEDIA & TECHNOLOGIES

10-12 June 2015 – Oslo (Norway)

The Health Promoting Hospitals (HPH) conference of 2015 will be held in Oslo, Norway, from June 10-12, 2015 with the title **"Person-oriented health promotion in a rapidly changing world: Co-production – continuity – new media & technologies"**. With this general theme, the conference will pay special attention to the comprehensive somato-psycho-social health needs of patients and their families, but also those of healthcare staff and community members.

The deadline for abstract submission is extended until 16 January 2015. The topics applicable for abstract submission are related to the following main themes of the conference:

- the somato-psycho-social health needs of people;
- co-producing health – techniques and examples;
- health promotion in continuous and integrated care;
- new media & technologies to address health and health promotion.

Other topics related to the themes of HPH working groups and task forces and other topics of relevance to HPH are also applicable for abstract submission. These are "Health promoting healthcare organisations as supportive settings for ...":

- child, adolescent and maternal health;
- older patients and age-friendly care;
- refugees, migrants and minorities;
- psychiatric patients;
- mental health of somatic patients;
- alcohol prevention;
- tobacco cessation;
- physical activity promotion;
- healthy nutrition;
- pain-free healthcare;
- environment-friendly healthcare;
- workplace health promotion;
- community health promotion and public health;
- self-help friendly hospitals;
- HPH standards and guidelines;
- health-literate healthcare;
- equity in healthcare.

More information: <http://www.hphconferences.org/oslo2015.html>