



NEWSLETTER

N° 96 – September 2012

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25-26 October 2012 – Bled (Slovenia)

4TH INTERNATIONAL CONGRESS OF HOSPITALS –
"AGEING AND HEALTH: CHALLENGES IN TIMES OF CHANGE"
7-9 November 2012 – Lisbon (Portugal)

EUROPEAN ANTIBIOTIC AWARENESS DAY
16 November 2012 – Brussels (Belgium)

DUQUE FINAL CONFERENCE
"DEEPENING OUR UNDERSTANDING OF QUALITY IMPROVEMENT IN EUROPE"
17 December 2012 – Berlin (Germany)

EAHP ANNUAL CONGRESS
IMPROVING PATIENT OUTCOMES- A SHARED RESPONSIBILITY
13-15 March 2013 – Paris (France)

HPH CONFERENCE 2013
TOWARDS A MORE HEALTH-ORIENTED HEALTH SERVICE
22-24 May 2013 – Gothenburg (Sweden)

HOPE AGORA 2013
PATIENT SAFETY IN PRACTICE – HOW TO MANAGE RISKS TO PATIENT SAFETY AND QUALITY
IN EUROPEAN HEALTHCARE
10-12 June 2013 – The Hague (The Netherlands)

IRELAND'S PRESIDENCY OF THE COUNCIL OF THE EUROPEAN UNION

FIRST INFORMATION ON PRIORITIES



Ireland's Presidency of the Council of the European Union begins on the 1st January 2013 and runs for the first half of the year. The Irish Presidency is working on its priorities for the EU.

The priorities for the Irish Presidency will be centered around three broad areas: Employment and Growth, Health & Well being, Innovation.

Their legislative priorities will be the revision of the medical devices directives, the revision of the clinical trials directive and the Health for Growth Programme (2014-2020).

The Irish Presidency is planning the Health Council Meeting for EU Health Ministers for March 2013. The focus of this Health Council meeting will be on innovation.



MEDICAL DEVICES – COMMISSION PROPOSES TWO REGULATIONS

On 26 September 2012, the European Commission published two new Regulation proposals, one on medical devices and one on in vitro diagnostic devices. Aiming at ensuring safer, more effective and innovative medical devices for patients, consumers and healthcare professionals, the proposals were designed to be more transparent and better adapted to scientific and technological progress.

According to the Commission, the key elements of the proposal are the following.

- ▶ Wider and clearer scope of EU legislation, extended to include, for example, implants for aesthetic purposes, and clarified for instance, as regards medical software
- ▶ Stronger supervision of independent assessment bodies by national authorities
- ▶ More powers and obligations for assessment bodies, to ensure thorough testing and regular checks on manufacturers, including unannounced factory inspections and sample testing
- ▶ Clearer rights and responsibilities for manufacturers, importers and distributors, applying also to diagnostic services and internet sales
- ▶ Extended database on medical devices, providing comprehensive and public information on products available on the EU market with access to the key data by patients, healthcare professionals and the public at large
- ▶ Better traceability of devices throughout the supply chain, enabling a swift and effective response to safety concerns (a Unique Device Identification system will be introduced to enhance post-market safety of medical devices, to help to reduce medical errors and to fight against counterfeiting)
- ▶ Stricter requirements for clinical evidence, to ensure patient and consumer safety
- ▶ Adaptation of the rules to technological and scientific progress, for example the adaptation of the safety and performance requirements applicable to new health technologies, such as software or nanomaterials used in healthcare

- ▶ Better coordination between national surveillance authorities, to ensure that only safe devices are available on the European market
- ▶ Alignment to international guidelines, to facilitate international trade

More information:

http://ec.europa.eu/health/medical-devices/index_en.htm

INFORMATION TO PATIENTS – CYPRUS PRESIDENCY INTERRUPTS COUNCIL DISCUSSIONS

Member States supported the Cyprus Presidency's decision of not addressing the issue of information to patients for prescription-only medicines this semester.

In October 2011, the European Commission had amended its initial Directive and Regulation proposals on information to patients for prescription-only medicines, setting out a framework whereby companies with marketing authorisation for a product could – and to some extent had to – provide good quality and objective information on their prescription-only medicines to the general public.

According to the Commission, the proposals aimed at empowering patients and enabling them to achieve a more rational use of medicines, whilst, at the same time, maintaining the ban on advertising prescription-only medicines. It also sought to further strengthen the current system for monitoring the safety of medicines, known as *pharmacovigilance*.

Member States not only unanimously agreed to interrupt Council discussions on this issue but also said to be waiting for the European Commission to withdraw its proposal.

More information:

http://ec.europa.eu/health/human-use/information-to-patient/legislative-developments_en.htm

PHARMACOVIGILANCE – NEW RULES ADOPTED

On 11 September 2011, the European Parliament and EU Ministers adopted a report by Linda McAvan (S&D, UK) in the field of pharmacovigilance, aiming at tightening up the European system for picking up and evaluating potential problems with medicinal products in any EU Member States.

The existing legislative framework for pharmacovigilance was revised in 2010 and entered into force in July 2012. However, following the Mediator scandal in 2011, the European Commission subjected the framework to a stress test that revealed a number of weaknesses that needed to be addressed.

The new rules will introduce an automatic emergency procedure, including an EU safety evaluation and possible EU-wide withdrawal if, for example, a Member State were to withdraw a medicinal

product from the market. This procedure would also be triggered if a company decided not to renew a marketing authorization for safety reasons.

In addition, the changes in legislation will also force companies to be more transparent: if a company withdraws a medicinal product from the market, it will have to state explicitly whether it has done so for safety reasons. The aim is to determine whether the "commercial reasons" sometimes given by companies for withdrawing a product in fact mask safety concerns.

Finally, the European Medicines Agency will also have to set up a system to ensure that all new medicines and any medicines for which regulators have on-going safety concerns are labeled with a black symbol, to enable patients and healthcare professionals to identify them.

More information:

http://ec.europa.eu/health/human-use/pharmacovigilance/index_en.htm



WORKING-TIME DIRECTIVE – EU SOCIAL PARTNERS' NEGOTIATION PERIOD PROLONGED

The European Commission has followed-up with the European Social Partners' common proposal to prolong the negotiation period for the revision of the Working-Time Directive to 31st December 2012.

In December 2011, the European Union (EU) social partners began negotiations with the aim of updating the EU Working Time Directive (2003/88/EC).

The social partners originally intended to reach an agreement on appropriate reform of the Directive by September 2012, but the European Commission (EC) has now given them until 31 December 2012 to do so.

According to article 154 of the Treaty on the Functioning of the EU (TFEU), the European Commission is required to consult with the EU social partners before it can propose any changes to EU social legislation.

More information:

<http://ec.europa.eu/social/main.jsp?catId=706&langId=en&intPagelId=205>



ENERGY DIRECTIVE ADOPTED

On Tuesday 11 September 2012, the European parliament meeting In Strasbourg adopted the energy efficiency directive by 632 votes in favour, 25 against and 19 abstentions.

The directive should allow the EU to achieve its indicative objective of 20% energy savings by the end of the decade and possibly save the EU €50 billion per year through binding measures on energy savings, such as the renovation of public buildings, energy-saving programmes for public services, and energy audits for large companies.

The directive compels Member States to develop three year plans (2014, 2017 and 2020) for energy efficiency, in order to reach the 20% target. In 2014, the Commission will take stock on progress made and might propose other measures, including binding national objectives, if the EU comes off track.

In the context of those plans, Member States would have to establish long term roadmaps for the renovation of buildings.

Member States would have to renovate 3% of the total floor area of "heated and/or cooled buildings owned and occupied by their central government" (administrative departments whose responsibilities cover the entire territory of a Member State). This will apply to buildings with a "total useful floor area" of more than 500 m², and as from July 2015, of more than 250 m². However, Member States will also be able to use alternative means to achieve equivalent energy savings.

In the short term, the 3% rate of annual renovation of public buildings is strictly limited to the buildings of the central national authorities. Public authorities should also set an example with regard to public procurement by buying greener goods and services, with the article of the text on this being reviewed in 2015.

More information:

http://ec.europa.eu/energy/efficiency/eed/eed_en.htm



MOMENTUM – QUESTIONNAIRE ON DEPLOYMENT OF TELEMEDICINE

MOMENTUM, a European project funded by the CIP ICT Policy Support Programme, is building a network of telemedicine practitioners to help develop European capacities for deploying telemedicine services in daily practice. Its principal outcome will be a blueprint for European deployment of telemedicine services, which will be developed, validated and tested over two years.

Currently working on its initial research and data collection process, MOMENTUM has developed a questionnaire to gather information about telemedicine services in a structured way.

The MOMENTUM questionnaire is gathering knowledge on the key factors that have led to successful or unsuccessful results in relation to deployment of telemedicine services. Based on all the knowledge and information collected in the questionnaire, MOMENTUM will provide the European community with a blueprint for deployment of telemedicine services.

Consequently MOMENTUM focuses only on telemedicine services which are either running as part of mainstream service delivery (routine care) or which have been discontinued, i.e. they are no longer running. That means telemedicine services, which are currently under development and/or testing and which are running under special conditions like project funding and support, are not eligible for this questionnaire. For MOMENTUM, telemedicine services exclude services that are considered “wellness” services.

MOMENTUM calls for all relevant initiatives to contribute to the survey by completing the online questionnaire. Any institution or organisation – public or private – that runs or is responsible for a telemedicine service that fits the questionnaire's inclusion criteria is welcome to contribute. Respondents can therefore include private providers if they themselves are responsible for providing and running the telemedicine service (however, not if the business is a provider to a third party). In the latter case, third parties are welcome to contribute to the survey.

This questionnaire is available on-line only. To receive your invitation to complete the questionnaire, please send an email to questionnaire@telemedicine-momentum.eu

The questionnaire must be completed before 1st November 2012. Answers received before 15th October would however be more than welcomed, as they would enable the Consortium to proceed with the data aggregation and analysis as early on as possible.

More information on the project is available at
www.telemedicine-momentum.eu

EUROPLAN II PROJECT – IMPLEMENTATION OF NATIONAL PLANS FOR RARE DISEASES

Actions to support the implementation of national plans or strategies for Rare Diseases are back on the agenda with EUROPLAN II – the continuation of a European Commission-funded project to provide national health authorities with tools for the development of national strategies following the European Council Recommendation on an Action in the field of Rare Diseases.

EURORDIS Rare Diseases Europe worked with 15 National Alliances in EUROPLAN I (2008-2011) and is collaborating with 24 Alliances or national patient groups in EUROPLAN II, in order to facilitate the organisation of national conferences aimed at promoting key measures and fostering the dialogue amongst relevant stakeholders.

As part of EUROPLAN II, 23 conferences will take place in 19 EU countries and 4 non-EU countries: Belgium, Croatia, Cyprus, Denmark, Finland, France, Greece, Hungary, Ireland, Italy, Luxembourg, Netherlands, Poland, Portugal, Romania, Slovakia, Spain, Sweden, United Kingdom, Georgia, Russia, Serbia and Ukraine.

The conferences are the cornerstone of this project as they aim to promote the implementation of a national policy for rare diseases, adapted to each country's specific needs while integrating European policies in their national system. In order to fulfil this objective, EURORDIS relies on 10 patient representatives, who will act as Advisors to the National Alliances in charge of organising the conferences. The Advisors will ensure that a common methodology is used and that all conferences follow the same format and touch on all the relevant topics. The conferences, which are patient led, must ensure the participation of all the stakeholders needed to implement the right policies.

A EUROPLAN II inception workshop was organised on 10-11 September in Rome by Prof. Taruscio, of the Italian Institute for Health, leader of EUROPLAN II. It was attended by health authorities from EU Member States as well as from Armenia, Georgia and Norway (altogether 27 countries). The meeting aimed to develop common suggestions for specific activities in support of national planning.

More information:

***<http://www.eurordis.org/europlan-support>
www.europlanproject.eu***

GLOBAL COMPARATORS – HOSPITAL BENCHMARKING AND NETWORKING TOOL

The Dr Foster Global Comparators is a benchmarking and improvement network that aims at helping the world's leading hospitals, by providing them with the opportunity to develop international standards of leading clinical practice through collaborative working, sharing of data and international networking.

According to the Global Comparators Group, the challenges facing healthcare systems transcend national boundaries. Healthcare leaders globally face the often competing pressures of increasing the quality of care whilst being more cost-effective.

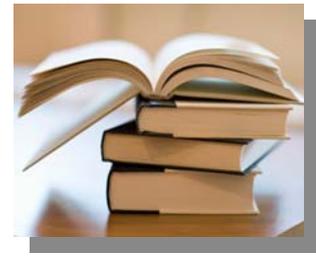
To meet these multiple, interrelated challenges, hospitals are increasingly looking for ways to differentiate themselves. This is leading many of the world's elite medical institutions to compare themselves with and learn from other leading hospitals around the world.

The Global Comparators project is comprised of three key elements, with a strong focus on international collaboration and structured networking running throughout: Data Comparison through the Global Comparators toolkit, Global Outcomes Accelerated Learning, Research.

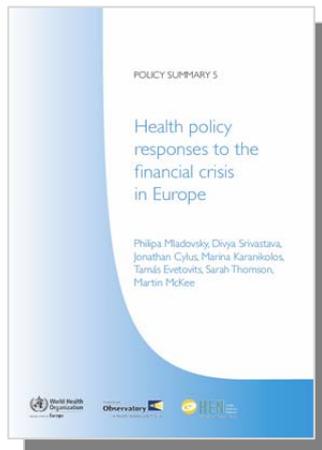
More information:

globalcomparators.com

REPORTS AND PUBLICATIONS



HOW EUROPE RESPONDS TO THE CRISIS – WHO REPORT



HEN, the Health Evidence Network of the World Health Organization (WHO), has just published a report describing how policymakers throughout Europe are responding to the financial crisis.

According to the report, countries respond in different ways. While some introduced many new measures, others did not introduce any new piece of policy. The authors point to the fact that some health systems were better prepared than others due to fiscal measures they had taken before the crisis, such as accumulating financial reserves. In several instances, policies planned before 2008 were implemented with greater intensity or speed as they became more urgent or politically feasible in face of the crisis. There were cases where planned reforms were slowed down or abandoned in response to the crisis.

In its report, HEN also shows that European Region countries employed a mix of policy tools in response to the financial crisis. According to them, some of the policy responses were positive, suggesting that some countries have used the crisis to increase efficiency. In addition, the report produces a list of policy tools likely to promote health system goals, which includes the following tools:

- risk pooling;
- strategic purchasing;
- HTA - health technology assessment;
- controlled investment;
- public health measures;
- price reductions for pharmaceuticals combined with rational prescribing and dispensing;
- shifting from inpatient to day-care or ambulatory care;
- integration and coordination of primary care and secondary care, and of health and social care;
- reducing administrative costs while maintaining capacity to manage the health system;
- fiscal policies to expand the public revenue base;
- counter-cyclical measures, including subsidies, to protect access and financial protection, especially among poorer people and regular users of healthcare.

It also gives a list of policy tools that risk undermining health system, such as:

- reducing the scope of essential services covered;
- reducing population coverage;
- increases in waiting times for essential services;
- user charges for essential services;
- attrition of health workers caused by reductions in salaries.

According to the authors, where the short-term situation compels governments to cut public spending on health, the policy emphasis should be on cutting wisely to minimize adverse effects on health system performance, enhancing value and facilitating efficiency-enhancing reforms in the longer run. The authors also strongly believe that arbitrary cuts to essential services may further destabilize the health system if they erode financial protection, equitable access to care and the quality of care provided, increasing costs in the longer term. Finally, the authors conclude that in addition to introducing new inefficiencies, cuts across the board are unlikely to address existing inefficiencies, potentially exacerbating the fiscal constraint.

More information:

http://www.euro.who.int/data/assets/pdf_file/0009/170865/e96643.pdf

INTERSECTORAL GOVERNANCE FOR HEALTH IN ALL POLICIES – WHO PUBLICATION



The WHO European Observatory on Health Systems and Policies has published, with the collaboration of the International Union for Health Promotion and Education (IUHPE), "Intersectoral Governance for Health in All Policies. Structures, actions and experiences". Based on the idea that most of the decisions that affect health are due to policies outside the sector, this publication shows how intersectoral policies operate and gives 20 examples from different parts of the world to encourage Governments to address health in all policies (HiAP).

HiAP is a policy principle to improve population health, addressing factors that reside outside the health system and in policy sectors other than health. Two critical aspects of current thinking inform the rationale for HiAP: the ideas that sociocultural factors define the prerequisites for health and limit peoples' choices in changing to so-called healthier behaviours, and that diseases are exacerbated and differentially distributed in direct relationship to inequities in society. Three key elements are integrated throughout the discussion: governance, the social determinants of health (SDoH) and HiAP. Governance provides the mechanism for action, through HiAP, on the SDoH.

Governance, by definition, involves multiple actors at multiple levels of government. Ministerial linkages are generally seen as a prerequisite for intersectoral governance action on HiAP. The term frequently refers to working together at the cabinet level, through a variety of structures and processes. Among other initiatives, the publication shows how different joined-up governments

might work in relation to HiAP like Cabinet Committees in Ireland, Scotland, Wales, New Zealand and Australia; Cabinet secretariats and parliamentary committees in the United Kingdom; or a mega-ministry in Hungary, which could be seen as an opportunity to improve the ability to mobilize internal resources for health.

The publication also gives different approaches to joint budgeting, which becomes an attractive proposition within the context of engaging action for health in departments, which do not have a dedicated budget for cross-cutting health issues. Whereas joint budgeting is an example of intersectoral funding, delegated financing is an example of financing beyond government. The book shows how it can facilitate HiAP by co-financing arrangements for health and providing funds for intersectoral programmes and projects.

The conceptual framework of public engagement and how it may relate to action on HiAP is described and analysed through two examples from Canada and the United States as well as the stakeholder engagement through the example of health conferences in the German state of North Rhine–Westphalia. Industry engagement, in the form of public-private partnerships (PPPs), can also merge issues of governance action on HiAP with the governance challenges for PPPs themselves as it is shown in the EU Platform for Action on Diet, Physical Activity and Health.

The concept of HiAP has been raised up by major international health policy developments. On the one hand, the Millennium Development Goals (MDGs) have been in the background of much of the global efforts on health. Secondly, the Finnish European Union (EU) Council Presidency in 2006, the Rome Declaration on HiAP in 2007, followed by the Adelaide Statement on HiAP (2010), with its emphasis on “moving towards a shared governance for health and well-being”. Thirdly, the work of the World Health Organization (WHO) Commission on Social Determinants of Health (CSDH) and the release of the final report, “Closing the gap in a generation: health equity through action on the social determinants of health” finally put the focus in the living conditions.

More information at:

<http://www.euro.who.int/en/what-we-publish/abstracts/intersectoral-governance-for-health-in-all-policies.-structures.-actions-and-experiences>

HIT BULGARIA – WHO PUBLICATION



The WHO European Observatory on Health Systems and Policies has published the new profile of the Bulgarian health system, part of the series "Health Systems in Transition" (HiTs).

The Health Systems in Transition (HiT) profiles are reports that provide a detailed description of a health system, reforms and policy initiatives under development in a specific country. They are based on a periodically revised template in order to facilitate comparisons between countries.

Bulgaria is characterized by some weak indicators, especially about mortality and morbidity. The major risk factor is smoking, and in 2008 the average standardized death rate (SDR) for smoking was twice as high as the EU15 average.

The Bulgarian health system was reformed in 1998 with the endorsement of the Health Insurance Act, which introduced a social health insurance (SHI) system with compulsory and voluntary insurances. The insurance system, through the National Health Insurance Fund (NHIF), covers diagnostic, treatment and rehabilitation services as well as medications for insured individuals. The Ministry of Health is responsible for providing and funding public health services, emergency care, transplantations, transfusion haematology, tuberculosis treatment and inpatient mental health care. Beyond the package covered by the NHIF all citizens are free to purchase different insurance packages. However, in 2010 less than 3% of the population purchased some form of voluntary health insurance.

Health care is financed from compulsory health insurance contributions, taxes, out-of-pocket (OOP) payments, voluntary health insurance premiums, corporate payments, donations, and external funding. The rate of public health expenditure as a share of total expenditure is still higher than the rate of private expenditure (respectively 57.8% and 42.2% in 2008). The share of formal OOP payments (user fees and direct payments) accounted for more than 86% of all private health expenditures in 2008, however, informal payments in the health sector represent a substantial part of total OOP payments (47.1% in 2006).

Social health insurance contributions are calculated at 8% of monthly income, paid by the insured individuals, their employers, or the state. The NHIF is the main purchaser of health services, while user fees exist for visits to physicians, dentists, laboratories and hospitals and apply to all patients with few exceptions. Investment for state and municipal health establishments is financed from the state or municipal share in the establishment's capital. For local hospitals, municipality funding for new investment and maintenance costs has shown a downward trend. The Ministry of Health runs various programmes for investment in medical infrastructure that health care establishments can apply to.

Relations between the NHIF and health care providers are based on the contract model. The Fund and the professional associations of physicians and dentists sign the National Framework Contract (NFC), which regulates the format and operational procedures of the compulsory health insurance system. Based on the NFC, providers sign individual contracts with the regional branches of the Fund. Providers are mainly paid prospectively for the services they will provide to the population on a fee-for-service and per capita basis.

Organisational relations between purchasers and providers in the field of voluntary health insurance are based on integrated and reimbursement models.

General practitioners are the central figure in primary care and act as a gatekeeper for specialized ambulatory and hospital care. Ambulatory care is provided by specialized autonomous outpatient facilities, most of them with a contractual relationship with the National Health Insurance Fund. All primary, and the majority of specialized, outpatient facilities are privately owned. Inpatient care is delivered mainly through a network of public and private hospitals, divided into multi-profile and specialized hospitals. There are also other inpatient health care establishments such as comprehensive cancer centres, centres for dermato–venereal diseases and hospices.

Imperfections in the organisation of primary health care, the underutilization of ambulatory care, a regionally uneven distribution of general practitioners, the lack of incentives for primary and specialized medical practices services and the lack of integration and coordination of different levels of care have led to increased utilization of specialized care and increased hospitalization rates.

In general, whilst the Bulgarian health system possesses the characteristics of a democratic, liberalized, and market-oriented health system, it suffers from substantial weaknesses, which result in an unsatisfactory population health status. Health inequalities between the urban and rural populations, as well as inequalities in access to the health system, continued to grow throughout the process of reforming the system. The improvement rate of population health status, as reflected in some health indicators, has been insufficient to achieve the reform goals, which means that the need for further reform seems even greater than in the early 1990s.

More information:

http://www.euro.who.int/_data/assets/pdf_file/0006/169314/E96624.pdf

2012 REPORT ON THE STATE OF THE ART OF RARE DISEASE ACTIVITIES IN EUROPE



The 2012 report on the state of the art of rare disease activities in Europe of the European Union committee of experts on rare diseases has just been published.

The report has been produced by the Scientific Secretariat of the European Union Committee of Experts on Rare Diseases (EUCERD, formerly the European Commission's Rare Diseases Task Force) through the EUCERD Joint Action: Working for Rare Diseases (N° 2011 22 01), which covers a three year period (March 2012 – February 2015).

The report aims to provide an informative and descriptive overview of rare disease activities at European Union (EU) and Member State (MS) level in the field of rare diseases and orphan medicinal products up to the end of 2011. A range of stakeholders in each Member State/country have been consulted during the elaboration of the report, which has been validated as an accurate representation of activities at national level, to the best of their knowledge, by the Member State/country representatives of the European Union Committee of Experts on Rare Diseases.

The report is split into five parts.

- ▶ Part I: Overview of rare disease activities in Europe
- ▶ Part II: Key developments in the field of rare diseases in 2011
- ▶ Part III: European Commission activities in the field of rare diseases
- ▶ Part IV: European Medicines Agency activities and other European activities in the field of rare diseases
- ▶ Part V: Activities in EU Member States and other European countries in the field of rare diseases

Each part contains the description of the methodology, sources and validation process of the entire report, and concludes with a selected bibliography and list of persons having contributed to the report.

More information:

http://ec.europa.eu/health/rare_diseases/publications/index_en.htm

HEALTH IN THE EU - WHAT IS IN THERE FOR YOU? EUROPEAN COMMISSION BROCHURE

A new brochure about recent achievements of the Commission in the field of health has just been published.

It showcases what the EU has done to improve people's health status.



The themes listed in the brochure are:

- cross-border healthcare;
- cross-border health threats;
- E. coli outbreak;
- resistant bacteria;
- safety and quality of medicines;
- blood, tissues and cell donation;
- 3rd Multi-Annual EU Health Programme (2014-2020);
- the risk factors of chronic diseases;
- active and healthy ageing;
- global health;
- scientific committees;
- communicating health.

More information:

http://ec.europa.eu/health/strategy/docs/recent_achievements_2012_en.pdf

PUBLIC SERVICE REVIEW: HEALTH AND SOCIAL CARE

The "Public Service Review: Health and Social Care" presents an opportunity to read how UK and its European neighbours are combating the same health challenges. It also provides a vital forum for discussing and debating new ideas and practices. Comprehensive and up-to-date, it aims to be the one essential read for all those involved in the provision of health and social care.

More information:

http://www.publicservice.co.uk/pub_selectissue.asp?publication=Health%20and%20Social%20Care



SHARP INJURIES - 3RD EUROPEAN BIOSAFETY SUMMIT

The 3rd Annual European Biosafety Summit took place in London, on 1st June 2012. The Summit gathered several keynote speakers, including representatives of the European Commission, EU-OSHA, the Health and Safety Executive, and the Social Partners - EPSU and HOSPEEM, as well as a victim of needlestick injury.

It focused on analyzing the state of implementation of the Directive on Sharps Injuries (2010/32/EU) in the EU Member States and on raising awareness of the serious health risks caused by sharps injuries.

In addition, the participants were informed on the practical steps that employers and workers could take in order to prepare the implementation of the Directive by 11 May 2013.

Mike Ashton, a victim of needlestick injury, shared his testimony, insisting on the need to “*get rid of ignorance, arrogance and complacency to move forward*”, and warned that community nurses were at greater risk of sharp injuries.

The European Biosafety Network was established following the adoption of the new European Directive on Sharps Injuries with a commitment to improve the safety of patients and healthcare and non-healthcare workers. The founding partners of the Network are the Spanish General Council of Nursing and the British public services union UNISON.

The Network is an inclusive organisation made up of national and European professional institutions, representative associations, unions and other interested parties committed to the prevention and elimination of sharps injuries throughout the European Union. The Network's focus is on promoting and encouraging the early legislative implementation of the Directive in Member States by raising awareness, providing guidance, the dissemination of information and effective reporting and monitoring.

More information:

<http://www.europeanbiosafetynetwork.eu/>

HIGH LEVEL "HEALTHY AGEING" CONFERENCE

On 5 and 6 September 2012, the high-level conference on "Healthy Ageing" organised by the Ministry of Health in the framework of the Cyprus Presidency of the Council of the EU took place in Nicosia, Cyprus.

The conference strongly highlighted the fact that healthy ageing could be achieved by the implementation of preventive, early diagnosis and health promotion programmes from the early stages of life and throughout the lifecycle.

During the Conference, leading experts in the area of health from the European Commission, other involved EU organisations, the World Health Organization and academic institutions, presented and discussed issues pertaining to the direct relationship between health promotion and protection of health from early childhood throughout the lifecycle and to elderly years.

Special emphasis was given to discussions on the implementation of programmes leading to healthy ageing. There was an extensive discussion on the new trends in the area of healthcare provision, through multidisciplinary approaches which encompass patient and community involvement and which focus on actions of prevention, early diagnosis including screening programmes, treatment and eventually active ageing and independent living.

The Conference's conclusions will set the basis for respective Council Conclusions that Member States will be called to adopt, which will approach the issue of Healthy Ageing as a continuous process across the lifecycle, formulated through multidisciplinary healthcare approaches.

More information:

<http://www.cy2012.eu/index.php/en/political-calendar/areas/employment-social-policy-health-consumer-affairs/healthy-ageing-across-the-lifecycle>

INFORMATION AND COMMUNICATION TECHNOLOGIES (ICT) AND ACTIVE AGEING

On 11 September 2012, the European Economic and Social Committee organised the "Information and Communication Technologies (ICT) and Active Ageing" hearing in Brussels.

This is the 5th of a series of hearings focusing on active ageing organised by this Committee. Mr. Xavier Verboven, Co-president of the Co-ordination Group of the European Year 2012, chaired this meeting, which was conducted around three main pillars: keeping a paid or unpaid activity; ICT and autonomy; and ICT and services to people, opportunities for companies and stakeholders.

Ms. Laure Batut, Rapporteur of the opinions "Enhancing digital literacy, e-skills and e-inclusion" and "The digital market as a driver for growth", and co-chair of the session asked the audience the following questions: Could ICT help us get older better? Could they offer us better living conditions when reaching a certain age?

FIRST PILLAR: ICT AND KEEPING A PAID OR UNPAID ACTIVITY

Mr. Bruno Costantini, Secretary General of FERPA – the European Federation of Retired and Older People-, began the session stating that ICT were a key aspect in citizens' lives. In his opinion, interoperable communications can be useful to improve all aspects of our lives (transport, health, environment, access to culture, e-government, etc.), and to keep older populations active. To do so, we need to clarify the role the elder play in society (for example, as a source of knowledge) and re-organise working places according to their capacities, he said. Constantini highlighted the importance of intergenerational learning as well as cooperation among Member States.

Ms. Greet Vermeulen, from Eurofound, centred her presentation on "Ageing, ICT and working conditions". She presented a survey that is conducted every four years in Europe on different aspects of working conditions and how ICT are used. The report, which will be available in December, shows that the use of ICT is increasing in the workplace, most of all in high skilled jobs and in sectors like finances, education, public administration and defence. According to Ms. Vermeulen, certain working conditions are more threatening to older workers and ICT can represent a solution, by facilitating, for example, teleworking. Nevertheless, she believes there are many additional aspects that need to be studied: does working from home liberate us or does it lead to working all day? Are ICT good supports at work or do they isolates us?

SECOND PILLAR: ICT AND AUTONOMY

Mr. Koji Ouchi, First Secretary of the Mission of Japan to the EU, opened the second pillar with a presentation on "The ICT contribution to a more energetic, sustainable and diversified ageing society and a more dynamic economy". In 2050, Japanese society will have more than 40% of its population over 65 years old, with no generational replacement. In Japan, Mr. Ouchi said, it is believed that ICT will help control the social costs of this situation. The First Secretary of the Mission of Japan to the EU also presented a series of projects related to ICT and social services, such as the Electronic Health Record to collect information; the Telemedecine Project for cardiologists to assist population living in rural or isolated areas; or the Smart Television project, which helps getting older people engaged in social activities.

Next, Ms. Karina Marcus, Director of the Joint Programme AAL (Ambient Assisted Living), described the possibilities offered by the Programme, which started in 2008 to enhance - through the use of ICT- the quality of life of older people in terms of housing, community and work. Financed by the Member States and the EU, AAL has engaged SMEs, universities, research organisations and large enterprises for several projects related to the 5 calls already funded: chronic conditions; social interactions; self-serve society; mobility and home care. The 6th call, which is now opened, consists in organising a conference related to these issues.

Mr. Michael Mulquin, from the Project "Go-myLife", presented the "Go-myLife" mobile social networking platform, which is a sort of Facebook for older people. "Older people are just like everyone else, they want to enjoy life the same as the rest but they are in another stage of life", Mulquin said. Go-myLife, tested in the UK and Poland, has tighter privacy controls and is an easier tool to use than Facebook, Mulquin said.

THIRD PILLAR: ICT AND SERVICES TO THE PERSON: OPPORTUNITIES FOR COMPANIES AND STAKEHOLDERS

Mr. Pierre Bauby, an expert from the European Economic and Social Committee, highlighted the role of SGI (Services of General Interests) in relation to ageing. According to him, one can look at SGI from two angles: the needs of older people (health, education, transport, accessibility to ICT, social inclusion) and the needs of society (reject any discrimination, use the potential of their experience and to transmit these values). Mr. Bauby pointed out that they were no SGI adapted to ageing as well as no SGI of universal access to ICT. In his opinion, EU funds should contribute to innovation in form and content in order to answer to the needs of the elderly: adapting technologies (accessibility), fighting against rejection and ensuring human contact.

The last presentation of the hearing was "ICT and people: The need for training and professionalization of careers" by Ms. Fanny Cools, from the Think Tank "Pour la Solidarité". She said ICT should be used to include people that have become dependent, making neighbourhood services more professional and technological. According to the research "Pour la Solidarité" conducted, these neighbourhood services are failing in regards with the quality of services, the time factor and creating networks. Ms. Cools shared examples of ICT projects carried out in some countries in Europe that have indeed improved these three aspects and pointed out the need for training public workers as a pre-requisite for the use of ICT.

METHODS, RESEARCH AND POLICIES TO REDUCE COLORECTAL CANCER PREVALENCE

On 18 September 2012 and under the auspices of the Cyprus Presidency of the European Union Council, a meeting was organised in the European Parliament on "Methods, research and policies to reduce colorectal cancer prevalence in Europe", hosted by MEP Pavel Poc.

Myrto Azina-Chronides, from the Cyprus Presidency of the EU Council, pointed out the need for prevention in colorectal cancer, disease which affects 400,000 new patients every year in the European Union. For her, the actions to be taken are the following: to raise priority to colorectal cancer; personalized and integrated care based in guidelines; research; cancer registers; to promote partnerships; and better rehabilitation and palliative care services.

Representing the European Commission, John F. Ryan said that among the European Commission's priorities is the need to foster prevention as only 3% of the budget of health in member countries is dedicated to prevention. Colorectal cancer screening was one of the recommendations of the European Commission but only 16% of the countries are doing it. He explained the opportunities that Horizon 2020 could bring to CRC research.

Prof. Colm O'Morain for the United European Gastroenterology (UEG) said colorectal cancer screening in all Member States was stated in the Written Declaration 68/2010 to fight colorectal cancer in the European Union. For him, this needs to be done within the European Union guidelines, in a patient friendly and cost-effective way. O'Morain said more research and education is also needed.

Prof. Herman Brenner (UEG) said that, after making a comprehensive literature research of 55 publications from 32 studies, consistent findings in all studies show that colorectal cancer screening

by any method is more affordable than the lack of screening. He gave the example of screening colonoscopy in Germany which had a cost of 274€ per participant but lead to savings of 490 € per participant.

Prof. Ladislav Dusek, from Masaryk University, shared the Czech experience in the harmonization of registers. He says that a good information system helps optimize resources, fosters collaboration and gives practical support in the implementation and evaluation of actions.

Mr. Peter Hulscher shared his personal experience as a patient of colorectal cancer late diagnosed. Dr. Luc Colemont (Sint Vincentius Hospital and personal physician of Mr. Peter Hulscher) spoke about the positive aspects of colorectal cancer which has a high incidence but the early diagnosis has a very good prognostic. He called the attention to the importance of education, screening and prevention. To foster that he has created the Foundation STOP "Strong Against Colon Cancer".

Prof. Niek De Wit (UEG) presented colorectal screening introduced in the Dutch health programme where medical interventions for primary prevention like polypectomy reduced colorectal cancer incidence up to 60-75%. For him, there is an urgent need of prevention. Dr. Ida Korfage (UEG), from the Erasmus University Medical Centre in Rotterdam, said that screening is associated to people with high education and with health insurance. 33% of the people that were screened in her hospital had some kind of colorectal cancer.

Dr. Frank Niggemeier (German Permanent Representation) said health competencies are responsibility of Member States but that the EU can complement national policies with information, cooperation as well as with other methods. Mr Niggemeier said that Germany is now implementing a National Cancer Plan, with a law changed to take on account protocols. A personal letter will be sent to everyone over 55 years old to invite them to be screened. They will also work on the clinical cancer registers with usual epidemiology data but also information of treatments. They will also promote healthier lifestyles.

MEP Paul Rübzig (EPP) said that the strategy for colorectal cancer has to take on account opinions of patients, doctors, researches, politicians and teachers. For him, among the possibilities to fight against CRC is to integrate the European Research Council in Horizon 2020.

RESEARCH SYMPOSIUM ON DIGESTIVE AND LIVER DISEASES

On 20 September 2012, the Research Symposium on Digestive and Liver Diseases was organised in the European Parliament, in collaboration with the United European Gastroenterology (UEG). The meeting was chaired by MEP Paul Rübig, from the Science and Technology Options Assessment of the European Parliament and Prof. Michael Manns, from the UEG.

The meeting gathered representatives from the three European Institutions as well as members from the UEG and the Liver Patients' Association to analyse the current situation of these diseases and to identify the priorities for action and the steps to address the main challenges.

Maria José Vidal-Ragout, from the European Commission, pointed out the rapid expansion of digestive and liver diseases, the raising of costs of the treatments and the shortening of the life of technologies. In her opinion, personalised medicine can be a cost-savings solution. She reminded that the budget allocated for Horizon 2020 has a "simplified architecture" in comparison to the Framework Programme 7 and takes into account the demographic changes and the ageing of the population.

Dr. Myrto Azina-Chronides, from the Cyprus Presidency of the EU Council, said the digestive system and the liver can be affected by a wide range of factors: viral infections, drugs, nutrition, immune system, etc. Colorectal mortality rate is 200.000 and the pancreas cancer 60.000. Mrs. Azina-Chronides believes there has to be a comprehensive approach and a holistic control of these diseases, from primary and secondary prevention to research. She also pointed out some achievements like molecular signalling pathways, stem cell research, the development of 2 rotavirus vaccines as well as the endoscope imaging techniques. In her opinion, there is still a lot more to be done as research in the US is 3.5 times the European, leading to a brain drain. She claims for an International Partnership on research and said the Cyprus presidency will "Work towards a better health for all".

Prof. Colm O'Morain, President of the UEG, presented research priorities for digestive and liver diseases. He said the challenges are in finding new methods and tools of diagnosis, reducing the high incidence, identifying the causes of the illnesses as well as reducing the cost of medicines which should be more patients' friendly. He gave some examples of different diseases like the Helicobacter Pylori, Cirrhosis or Inflammatory Bowel Diseases explaining their impact on health, the incidence rates and the most relevant needs for reach.

Prof. Eric Van Han Custen (UEG) explained that all cancers are different. He presented the challenges of colorectal cancer such as the high incidence (due to the ageing of the population), the late diagnosis, the lack of information about the causes, the study of molecular markers, etc. Prof. Van Han Custen also identified unmet needs like screening programmes, understanding the taxonomy of colon cancer and developing new drugs and models for clinical trials and research. He pointed out that the US spends twice as much on cancer as any other country but has the same survival rates.

One of the main problems of pancreatic cancer according to Prof. Matthias Löhr (UEG) is the late diagnosis. Only a few drugs work and they have high side effects. Only 20% of the patients are operable and the medium period of survival is 24 months. Despite all this, the money allocated for

research is much less than in other types of cancer. Prof. Löhr called for action in transnational research combining genomic and proteomic studies.

Mr. Achim Kautz, from the European Liver Patients' Association (ELPA), said there were health inequalities among Member States in liver cancer. He made a quick review on different illnesses related to liver diseases – Viral Hepatitis, Autoimmune diseases, metabolic diseases and late stage of liver diseases – and identified the challenges, most of them related to more effective drugs with less interactions. Mr. Kautz said the ELPA welcomes all research activities in fields where the pharmaceutical industries has concerns (non-profitable) or no interests. He also called for more action and cooperation among institutions in order to promote healthier diet and the practice of sports as obesity is a risk factor for many cancers, Luhan said.

Prof. Reinhold Stockbrügger (UEG) spoke about the importance of prevention in colorectal cancer. Most countries do not have screening programmes. Prof. Stockbrügger said risk factors in colorectal cancer are common to many cancers and diseases, putting the accent in smoking, physical activity, alcohol intake, waist circumference and the diet. The professor said we should switch the idea of screening cancer in an isolated manner to work on an integrated cancer screening and prevention, calling the attention to the role of the general practitioner.

Prof. Niel De Wit (UEG) presented gastrointestinal diseases and the high impact in the quality of life as well as the societal impact and the high medical costs. There is a high demand on endoscopy services, which, in the opinion of Prof. De Wit, should be used just for high risk patients. He believes patient education and a high fibre diet are fundamental. For De Wit, an optimal management requires an EU perspective and the use of guidelines.

Prof. Luigi Ricciardiello (UEG) shared the experience of UEG on the European funding schemes with the project on the “beneficial effects of bioactive compounds in humans”, which focuses on the role and mechanisms of action of three bioactives to determine how they affect physiologically-relevant primary and secondary endpoints for Metabolic Syndrome (which is related to colon cancer risk). Among the positive aspects of the EU funding there is, for Prof. Ricciardiello, the more global impact of the results and, among the cons, the different level of commitment from all parties and the high bureaucracy.

Mrs. Beatrice De Vos (Promethera Biosciences) shared the benefits of cell therapy for the treatment of liver diseases.

Mr. Michael Manns (UEG) said the EU Council and Health Research should accelerate excellent biomedical research in the EU, promote the collaboration of disciplines, involve all the stakeholders taking in account the issue of age and obesity. To achieve that, a Strategic Framework is needed according to Mr Manns.

More information:

<http://www.europarl.europa.eu/stoa/cms/cache/offonce/home/events/workshops/liver;jsessionid=ADo809086A1AFFB52CD7CC6C979C54FA>

ENGAGEMENT OF DOCTORS IN MANAGEMENT – BRUSSELS, 6 DECEMBER 2012

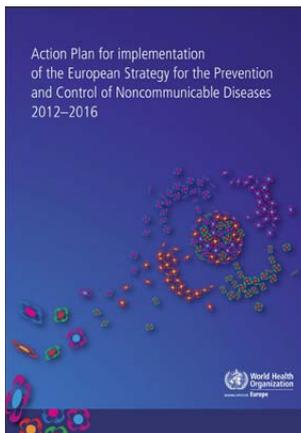
The seminar “Enhancing the engagement of doctors in the management of European health systems” will be organised on 6th December 2012, in the Cost Office, in Brussels.

COST Action IS0903 is examining the role of doctors in management and the impact this is having on organisation, innovation and the incorporation of user voice within health systems. We invite you to join us at this one day summit, where we will share findings and outputs from the Action and explore the implications for policy and practice.

For More Information/Booking please contact: Kathy Hartley, Centre for Innovation in Health Management, Leeds University Business School, Leeds, LS2 9JT, UK
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WHO ACTION PLAN FOR THE IMPLEMENTATION OF THE EUROPEAN STRATEGY FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES FOR 2012-2016



The World Health Organization (WHO) published its Action Plan for the Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases for 2012-2016. According to WHO, investing in prevention and improved control of noncommunicable diseases (NCD) will reduce premature death and preventable morbidity and disability, and improve the quality of life and well-being of people and societies.

No less than 86% of deaths and 77% of the disease burden in the WHO European Region are caused by this broad group of disorders, which show an epidemiological distribution with great inequalities reflecting a social gradient, while they are linked by common risk factors, underlying determinants and opportunities for intervention.

WHO's Action Plan takes account of Members States' existing commitments and focuses on priority action areas and interventions for the next five years (2012–2016) within a comprehensive and integrated framework.

It was developed through a consultative process, guided by the Standing Committee of the Regional Committee, and including meetings of NCD focal points and of the European Health Policy Forum for High- Level Government Officials. Its formulation has taken place against a backdrop of development of the new European health policy (Health 2020) and the Public Health Framework for Action, as well as the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, April 2011) and the United Nations high-level Meeting on Noncommunicable Diseases (New York, September 2011) and takes account of these processes.

More information:

http://www.euro.who.int/_data/assets/pdf_file/0019/170155/e96638.pdf

WHO LAUNCHES QUALITYRIGHTS TOOL KIT

On 28 June 2012 the World Health Organization (WHO) launched its QualityRights Tool Kit, a landmark document of the WHO's QualityRights Project setting the key quality and human rights standards that need to be met in all mental health and social care facilities.

The toolkit provides guidance on how to conduct a comprehensive assessment, report findings and make recommendations to end violations and improve quality and human rights in facilities.

The event outlined WHO's global campaign to improve care and halt human rights violations against people with mental health conditions. Speakers with a wide range of experiences – from the world of Hollywood to the urban slums of India – provided their personal insight and perspectives on the difficult situation faced by millions of people with mental health conditions around the world, and on how WHO QualityRights will break new ground in the drive to raise human rights and quality standards in mental health and social care.

More information:

http://www.who.int/mental_health/policy/quality_rights/qrs_tool_kit_launch/en/index.html

To download the WHO QualityRights tool Kit:

http://www.who.int/mental_health/publications/QualityRights_toolkit/en/index.html

AGENDA



UPCOMING CONFERENCES ORGANISED AND CO-ORGANISED BY HOPE

CROSS-BORDER HEALTHCARE IN EUROPE

25-26 October 2012 – Bled (Slovenia)

Considering that the enforcement of the new European Directive will be an important landmark for the European healthcare system, the University Medical Centre of Ljubljana is organising a conference on cross-border health care in Europe.

It will take place on 25 and 26 October 2012 in Bled (Slovenia).

The goals of the conference will be:

- providing the most relevant and up-to-date information about the Directive 2011/24/EU on Patients' Rights in cross-border health care;
- enabling health care institution managers, health funds management, patients, health systems regulators, health care providers and experts to thoroughly prepare their health care institutions and employees;
- providing the participants with all relevant information and facts regarding the changes that will take place with the enforcement of the new European Directive;
- guiding the participants through the changes and providing various perspectives on the upcoming Directive by competent international lecturers and experts in various fields of the health care system.

More information:

www.crossborderhealthcare-conference.eu

4TH INTERNATIONAL CONGRESS OF HOSPITALS –

"AGEING AND HEALTH: CHALLENGES IN TIMES OF CHANGE"

7-9 November 2012 – Lisbon (Portugal)

Following the last 10 years, APDH is organising the 4th International Congress of Hospitals, that will take place the 7, 8 and 9 November in Lisbon, at the Auditorium in the Edifício Tomé Dias, at the INFARMED - Instituto Nacional da Farmácia e do Medicamento. This year's theme will be "Ageing and Health: Challenges in times of Change".

The present economic and financial crisis has exposed many countries to serious internal disturbances, revealing national vulnerabilities at structural and systemic levels and an emerging need of international support. Like the other two countries before, this support was consummate in April 2011, with a request for an intervention to the European Commission (EC), the European Central Bank (ECB) and the International Monetary Fund (IMF). This resulted in the negotiation of an Economic Adjustment Program (Memorandum of Understanding) which covered all the existing sectors, including the health sector.

This situation prompted a strong rationalization of services and a strict control of the expenditure, strongly impacting in the health sector organisations, particularly the hospitals, due to the mandatory presentation of an operational cost reduction plan, by at least 200 million Euros; achieved by cutting on the management personnel and by concentrating on and by rationalizing the hospitals and health centres and by imposing yearly limits to the PPP contracting.

The strictness of these austerity measures impose some reflection regarding its impact, both at systemic and structural levels, and also because the economic and financial crisis cannot be isolated from other facts that must also be analysed, such as the demographic changes, the difficulties in accessing the health care, the weakening of the social security systems and the inevitable need for more sustainable policies. Therefore, it is crucial to find answers capable of reversing the economic crisis, but that will simultaneously keep unwavering health and support systems.

Some particularities of the health sector in the last years, which are also important to approach, are the existing global level predisposition, to the shortage of resources to face the needs of the populations and the phenomenon of the migration of health professionals, which is still poorly regulated.

The relevance of these situations placed them on top of the national and international agendas such as that of the World Health Organization, the European Hospital and Healthcare Federation (HOPE), the European Union and many others.

More information: www.apdh.pt

EUROPEAN ANTIBIOTIC AWARENESS DAY

16 November 2012 – Brussels (Belgium)

The European Centre for Disease Control organises with HOPE the European Antibiotic Awareness Day on 16 November 2012 in Brussels.

In November 2001, the European Union (EU) Health Ministers adopted a Council Recommendation on the prudent use of antimicrobial agents in human medicine which stated that EU Member States should inform the general public of the importance of prudent use of antimicrobial agents by, in particular, raising awareness of the problem of antimicrobial resistance and encouraging realistic public expectations for the prescription of antimicrobial agents.

As a result, for example, in Belgium and France, national awareness campaigns to educate the public and primary care prescribers about appropriate outpatient antibiotic use have successfully resulted in a decrease in antibiotic prescriptions

The success of these campaigns stimulated a European initiative coordinated by the European Centre for Disease Prevention and Control (ECDC), and named "European Antibiotic Awareness Day" (EAAD), to take place each year around the 18 November.

At the beginning of 2008, ECDC set up a Technical Advisory Committee for the EAAD, including representatives from Belgium, France, Greece, Poland, Spain, Sweden and the UK, as well as HOPE, the CPME representing doctors, the European Society of Clinical Microbiology and Infectious Diseases (ESCMID), DG SANCO and DG RTD and WHO/Europe. The TAC's terms of reference are to discuss in detail the strategy for EAAD, including campaign objectives, target audience, key messages and evaluation methodology.

Preparation of EAAD was achieved through collaboration amongst ECDC, the Technical Advisory Committee and the Network of National Antimicrobial Resistance (AMR) Focal Points. A good working partnership among all these institutions and Member State representatives was achieved through regular meetings, as well as exchange of information and ideas, in preparation of EAAD. Gaining political support for the campaign was identified early on as an important success factor. Therefore, a lunch seminar for MEPS was held in the European Parliament, Brussels, in October 2007, where the concept of an EAAD was publicly launched.

In the development of the campaign, ECDC and its partners decided to apply a social marketing approach. Health professionals have a key role to play in hospitals, by ensuring the correct prescribing, dosage, duration and selection of antibiotics.

The campaign objectives are to support national activities aimed at raising awareness of prudent antibiotic use among the general public as well as particular target audiences such as primary care prescribers and hospital prescribers. It is also to support national activities aiming at maintaining the efficacy of antibiotics and slowing down the emergence and spread of resistant bacteria.

More information:

<http://antibiotic.ecdc.europa.eu>

DUQUE FINAL CONFERENCE

"DEEPENING OUR UNDERSTANDING OF QUALITY IMPROVEMENT IN EUROPE"

17 December 2012 – Berlin (Germany)

In light of great advances in the assessment and improvement of quality of care, policymakers, healthcare providers and researchers are keen to evaluate the effectiveness of various quality improvement governance approaches, particularly at the hospital level.

The DUQuE project, led by a consortium of prestigious research centres and universities in the field of health care quality in Europe, provides promising theoretical insights and evidence-based toolkits related to improving the effectiveness of quality improvement systems in hospitals.

Using data from 188 hospitals from seven European countries (Czech Republic, France, Germany, Poland, Portugal, Spain and Turkey), the four year multi-method project assessed the relationship of various quality improvement governance approaches with quality indicators of hospital care (specifically clinical effectiveness, patient safety and patient reported outcomes).

The conference will enable the presentation of DUQuE's main findings, and provide a friendly, open forum for the discussion of the results. Evidence-based guidance documents, practical toolkits and appraisal schemes for hospital managers, purchasing agencies and governments interested in the development and assessment of hospital quality improvement systems will also be presented. The conference attendance will be free.

More information: <http://www.duque.eu/>

To register, send your request to duque@uk-koeln.de

EAHP ANNUAL CONGRESS

IMPROVING PATIENT OUTCOMES- A SHARED RESPONSIBILITY

13-15 March 2013 – Paris (France)

The European Association of Hospital Pharmacists (EAHP) is accredited by the Accreditation Council of Pharmacy Education as a provider of continuing pharmacy education.

The EAHP represents more than 21.000 hospital pharmacists in 31 European countries and is an association of national organisations representing hospital pharmacists at the European and international levels.

The congress will address various topics such as the ethics and risks in antibiotic prophylaxis, European-wide pharmacy standards, the prevention of critical incidents, nutrition, medicines across the interface or inter-professional learning.

More information:

http://www.eahp.eu/sites/default/files/files/EAHP%20announcement_p1.pdf

HPH CONFERENCE 2013

TOWARDS A MORE HEALTH-ORIENTED HEALTH SERVICE

22-24 May 2013 – Gothenburg (Sweden)

The 21st International Conference of the Health Promoting Hospitals Network (HPH) will be held from May 22-24, 2013, in Gothenburg, Sweden.

The programme will highlight innovative themes with a high potential for HPH. Under the working title "Towards a more health-oriented health service", the conference will focus on:

- WHO Euro's health 2020 strategy
- Patient-reported health outcomes as promising tools
- Findings from neuropsychimmunology and consequences for health promotion
- Health impacts of environment and design
- Patient empowerment
- Health system support for health promotion

The Call for Papers will be open from 1 October to 20 December 2012.

More information: <http://www.hphconferences.org/gothenburg2013>

HOPE AGORA 2013

PATIENT SAFETY IN PRACTICE – HOW TO MANAGE RISKS TO PATIENT SAFETY AND QUALITY IN EUROPEAN HEALTHCARE

10-12 June 2013 – The Hague (The Netherlands)

In 2013, HOPE organises its exchange programme for the 32nd time. The HOPE Exchange Programme starts on 13 May and ends on 12 June 2013.

Each year a different topic is associated to the programme, which is closed HOPE Agora, a conference and evaluation meeting. The 2013 HOPE Agora will be held in Den Haag (The Hague, The Netherlands) from 10 to 12 June 2013 around the topic "Patient Safety in Practice - How to manage risks to patient safety and quality in European healthcare".

More information on the HOPE Exchange Programme:
<http://www.hope.be/04exchange/exchangefirstpage.html>