# NEWSLETTER

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CONTENT

## *HEALTH PRIORITIES*

Luxembourg is holding the Presidency of the Council of the European Union for the twelfth time in the second semester of 2015 (from the 1st of July to the 31th of December).

Luxembourg Health Minister Lydia Mutsch will be leading the health agenda. First elected to Parliament in 1989, she has been since 2000 the Mayor of Esch-sur-Alzette, having previously been a member of the communal council since 1988. She has been a member of the Luxembourg Socialist Workers' Party since 1987. Following the legislative elections of 20 October 2013, Lydia Mutsch joined the Government as Minister of Health, Minister for Equal Opportunities on 4 December 2013.

Healthcare is not high on the Luxembourg presidency agenda. However, the presidency will seek to get agreement on the medical devices and in vitro diagnostic medical devices Regulations on which the Council adopted a partial negotiation position in June.

In the area of public health, the presidency will be focusing on patients and innovation. It will focus on the following issues:

- *Personalised medicine*: the presidency will initiate a reflection process on improved access to personalised medicine. Issues such as financing and innovative approaches to personalised medicine were discussed during a high-level conference hosted by the presidency on 8 July 2015. Outcomes will be used to compile Council conclusions which will adopted at the EPSCO Council meeting on 8 December 2015.
- *Dementia*: the presidency will initiate a reflection process on dementia. This dossier will be continued by the following Dutch presidency in 2016.
- *Ebola*: a conference on the lessons learned from the Ebola crisis will be organised from 12 to 14 October 2015 in coordination with the European Commission and the WHO.
- *Cross-border healthcare*: during the informal meeting of EU Health Ministers taking place on 24-25 September 2015, delegations will discuss the implementation of the cross-border healthcare Directive.

The Luxembourg presidency will also steer the discussions on the 2015 United Nations Climate Change Conference to be held in Paris from 30 November to 11 December, with a view to adopting an ambitious negotiating mandate.

***Luxembourg presidency official website: http://www.eu2015lu.eu/en/index.html***

***The programme of the presidency is available at: -http://www.eu2015lu.eu/en/la-presidence/a-propos-presidence/programme-et-priorites/PROGR_POLITIQUE_EN.pdf***

***The calendar of the presidency is available at: http://www.eu2015lu.eu/en/la-presidence/a-propos-presidence/programme-et-priorites/LU_Presidency_calendar_EN.pdf***

Public Health

## *IMPLEMENTATION OF CLINICAL TRIALS REGULATION*

On 16 and 17 June 2015, the meeting of the Heads of Medicines Agencies (HMA) and Clinical Trials Facilitation Group (CTFG) took place in Riga. The main focus was the implementation of the new Clinical Trials Regulation. This Regulation came into force in June 2014 and will apply from 28 May 2016.

Until the Regulation will become applicable, all clinical trials performed in the European Union are required to be conducted in accordance with the Clinical Trials Directive 2001/20/EU, which aimed to harmonise the requirements for clinical trials across the EU, whilst ensuring the safety of clinical trial participants, the ethical soundness of trials and the reliability and robustness of data generated. While achieving some of its aims, the Directive has also increased the administrative burden and costs of conducting clinical trials in the EU significantly, and caused considerable delays in launching new trials. That is why, in the summer of 2012, the European Commission issued a proposal for an EU Regulation on clinical trials on medicinal products for human use, to replace the existing EU Directive on Clinical Trials.

The Regulation will ensure that there will be much more publicly available information regarding clinical trials. For example, there will be an obligation for sponsors to publish results of all clinical trials even if they are not positive. Moreover, the Regulation stipulates that all clinical trials applications will be submitted through one single Portal: the European Clinical Trial Database.

During the meeting, participants (clinical trial experts from national medicines agencies in Europe and from the European Medicines Agency) discussed topics linked to the Regulation like the preparation of national normative acts in EU Member States, issues related to the assessment of clinical trials applications, operation of national ethics committees and the substance of the new single Portal.

## *mHEALTH – COMMISSION STAKEHOLDERS' MEETING*

HOPE attended on 6 July 2015 in Brussels the Commission mHealth stakeholders' meeting.

The meeting was organised by DG CONNECT as a follow-up to the Green Paper on mobile health and the public consultation with the aim to further discuss with the stakeholders possible future policy actions on quality and reliability of mobile health applications. It was attended by representatives from public authorities, industry, academia, patient and professional associations.

Peteris Zilgalvis, Head of Health and Wellbeing Unit in Directorate General CONNECT summarised in the introductory presentation the results of the public consultation and the discussion that took place at the open mHealth stakeholder meeting on 12 May 2015 in Riga, outlining the main concerns and proposed actions as regards safety and transparency aspects of lifestyle and wellbeing apps.

To address the issue of legal clarity, the Commission has started preparations to develop a pro-innovation legal framework aiming to clarify the legal status of health and wellness apps as consumer products. In order to clarify the borderline between "medical" and "lifestyle and wellbeing apps" work is ongoing to review and update the Medical Devices Vigilance System (MEDDEV) guidelines.

The Commission also announced the intention of facilitating the development of a European standard on quality criteria for the development of health and wellness apps, taking as a basis the publicly available specification PAS: 277 recently published by the British Standards Institution (BSI).

The Commission proposed for discussion a possible future collaboration between interested Member State public authorities on topics such as the development of common assessment methodologies, the facilitation of mutual recognition or the building of a common platform for certified health apps.

The Commission also introduced the idea of setting up a working group developing guidelines at the EU level for assessing validity of data for the purposes of linking apps to the electronic health records (EHR). The aim of this group would be to develop guidelines on the criteria that could be used by public authorities, health care providers, professional and patient associations, developers and other relevant bodies to assess the validity and reliability of the data collected and processed by health apps with the purpose of linking the data to electronic health records.

HOPE expressed its interest to be involved in this working group.

***More information and presentations are available at:***
***https://ec.europa.eu/digital-agenda/en/news/next-mhealth-stakeholder-meeting***

## *HEALTH WORKFORCE – REPORT ON RECRUITMENT AND RETENTION*

In April 2015, the European Commission published a report about "Recruitment and retention of the health workforce in Europe".

This study aimed to identify and to analyse effective strategies for the recruitment and retention of health professionals. It also aims to provide lessons and inspiration for the development of organisational strategies and human resource policies in Europe. It consists of eight case studies on recruitment and retention – covering 40 interventions from 21 countries - and two workshops that brought together experts and stakeholders in the area of recruitment and retention of health workers.

The high employment potential of healthcare and the need for innovative approaches and strategies to attract and equip young people with the right skills in the health sector was discussed at the EU Health Ministers meeting in July 2012.

The study identifies a number of success factors relevant for recruitment and retention in the following four areas: education, regulation, financial incentives and, professional and personal support. In general, the report recommends to create a supporting working environment; for example, by offering continuous professional development, education and research opportunities to professionals. It also proposes to implement activities to support the physical and emotional wellbeing of staff.

The report gives some recommendations to improve the recruitment and retention of health workforce in Europe. Recommendations spans from the choice to the implementation and monitoring of recruitment and retention interventions. Policy makers and managers in health and social care can optimise recruitment and retention results by using these recommendations to design interventions that meet their distinctive, context-specifics needs. Moreover, the report recommends offering interventions with enough freedom to allow different actors to select the element that suit their needs and skill set.

Finally, the report illustrates actions to be taken at European level on recruitment and retention. It stresses that European cooperation and knowledge exchange in this area is still underdeveloped and that EU investment in research and dissemination could stimulate and support innovation in health staff recruitment and retention. Member State should support active cross country learning and dissemination of recruitment and retention good practices and promote support for research and development in the funding of recruitment and retention interventions.

***The report is available at:***
***http://ec.europa.eu/health/workforce/key_documents/recruitment_retention/index_en.htm***

## *SAFETY OF MEDICAL DEVICES CONTAINING DEHP – SCENIHR OPINION*

The Scientific Committee on Emerging and Newly Identified Health Risks (SCENIHR) has published the final opinion on the safety of medical devices containing DEHP-plasticised PVC or other plasticisers on neonates and other groups possibly at risk.

SCENIHR provides opinions on emerging or newly-identified health and environmental risks and on broad, complex or multidisciplinary issues requiring a comprehensive assessment of risks to consumer safety or public health and related issues not covered by other EU risk assessment bodies.

This opinion is updating the 2008 SCENIHR opinion. The main focus is on the potential risk for patients exposed to DEHP or similar plasticising compounds leaching from medical devices.

DEHP is a is a compound used as a plasticiser in many products made of polyvinyl chloride plastic, including some medical devices. According to the Council Directive 93/42/ECC, medical devices may only be placed on the market if they meet the essential requirements laid down in the Annex 1 of the Directive. Safety concern has been expressed for high-risk patients groups, such as neonate, infant, pregnant and breast-feeding women exposed to DEHP.

In 2008, the study concluded that there was no conclusive scientist evidence that DEHP exposure via medical treatment has harmful effects in humans. However, it was underlined that further studies were required to confirm or reject the suggestion of adverse effects of DEHP in humans.

In this study, SCENIHR considers that adult patients undergoing hemodialysis and children are potentially at higher risk. Moreover, there is evidence suggesting that the DEHP causes the most severe reproductive toxicity in animal studies, when compared to other alternative plasticisers.

However, SCENIHR also points out that the survival of premature infants often depends on the availability of the same medical devices which result in a relatively high DEHP exposure due to treatment. The potential for replacement of DEHP in these products should be considered against their efficiency in the treatment, as well as the toxicological profile and leaching properties of the alternative materials.

***The final opinion is available at:***
***http://ec.europa.eu/health/scientific_committees/emerging/docs/scenihr_o_047.pdf***

## *EUROPEAN REFERENCE NETWORKS 2ND CONFERENCE – 8-9 OCTOBER 2015, LISBON*

On 8 and 9 October 2015 the European Commission DG Health and Food safety will organise the "2nd Conference on European Reference Network", in Lisbon (Portugal). The conference will be hosted by the Ministry of Health of Portugal under the Luxembourgish EU Presidency.

The first conference took place in Brussels in 2014. The Directive 2011/24/EU on the application of patient's rights in cross-border healthcare (Article 12) provides cooperation between highly specialised healthcare providers across the EU by establishing a system of European Reference Networks. This cooperation is supported by the European Commission and is based on voluntary participation from Member States.

The aim of the conference is to discuss and raise awareness on the state of the art on the organisation of highly specialised networks and centers of expertise across the EU, to present the draft assessment manual and toolbox to be used for assess the Network proposals and to help prepare healthcare providers for the call for proposals of European Reference Network that the Commission will launch.

It addresses highly specialised healthcare providers, experts, national authorities, decision-makers, patient and professional organisations and other interested stakeholders.

The conference will focus on the implementation of European Reference Networks and facilitate the exchange of information and will prepare the forthcoming call for European Reference Networks, which will be launched in2016.

***More information, the agenda and registration are available at:***
***http://ec.europa.eu/health/ern/events/ev_20151008_en.htm***

## *EXPERT PANEL ON INVESTING IN HEALTH – OPINION ON CROSS-BORDER COOPERATION*

On 29 July 2015, the Expert Panel on effective ways of investing in health adopted an opinion on cross-border cooperation in health.

The Expert Panel on Effective Ways of Investing in Health is a multi-sectorial and independent expert panel set up by the Commission to provide it with sound and timely scientific advice in order to promote modern, responsive and sustainable health systems.

The concept of cross-border cooperation in health is based on the article 168 TFUE and is facilitated by the Directive 2011/24/EU on the application of patients' rights in cross-border healthcare. Indeed, it ensures patients mobility as well as an access to safe and high quality cross-border care.

This opinion was requested by the Commission's Health and Consumers Directorate General in order to identify potential benefits and areas which could benefit from it as well as obstacles to cross-border cooperation and priority actions to overcome them.

In the opinion, the Expert Panel first identifies potential benefits of cross-border cooperation on a provider, payer and patient perspective. Potential benefits include the freedom for patients to choose to be treated wherever they want, increased mobility for health professionals, the improvement of professional and vocational education for staff members as well as treatment in nearby facilities and a quicker response in medical emergencies. It also identifies geographical areas which could benefit from greater formal cross-border cooperation.

Then, the Expert Panel focuses on obstacles to cross-border cooperation and divides them in three main categories:

1. lack of information and transparency about treatments in another Member State;
2. uncertainty about payments and related reimbursement procedures;
3. arrangements for follow-up and post treatments issues.

Finally, it suggests as priority actions at EU level the development of a system to provide data on the number of patients going to another Member State to receive care, which types of treatments they received, which problems arose and what are the possible solutions.

***The opinion is available at:***
***http://ec.europa.eu/health/expert_panel/opinions/docs/009_crossborder_cooperation_en.pdf***

## *EXPERT PANEL ON INVESTING IN HEALTH – NEW MANDATES*

The Expert Panel on Effective Ways of Investing in Health was assigned in July 2015 with two new mandates, being asked to give a scientific opinion on two different subjects related to the efficiency of the health systems in the EU.

With the first new mandate, the Expert Panel was asked to give an opinion on the added value of an EU action towards the creation of a typology of health policy reforms and framework for evaluating reform effects. The aim is to help Member States in achieving the sustainability of health systems facing an economic crisis which requests them to adapt their expenditures and also to be efficient. The proposal is to categorise different types of reforms for the sustainability of health systems based on dimensions of interest such as the time, target of reforms and financing.

The typology of health policy reforms will be complemented with a template to evaluate the health policy effects of each reform in order to guide EU Member States in their policy choices. If possible, a framework for fiscal quantification of reform effects will be added. The Expert Panel will release the opinion in two stages. In the first, the typology and template have to be completed by the end of 2015 or beginning 2016. The second should focus on technical measures concerning its implementation and be released by the end of 2016.

The second opinion of the Expert Panel will be on the creation of a guidance concerning best practices and potential pitfalls in public health sector commissioning from private providers. Indeed, contracts between public health systems and private sector providers need to be carefully designed in order to avoid inefficiencies in health systems and guarantee the quality and security of care. The guidance will allow choosing the best contract features knowing how they affect incentives and outcomes.

This second opinion of the Expert Panel is expected for the end of 2015, beginning of 2016.

***The requests for opinion are available at:***
***http://ec.europa.eu/health/expert_panel/mandates/docs/typology_health_policy_reforms_en.pdf***
***http://ec.europa.eu/health/expert_panel/mandates/docs/commissioning_private_providers_en.pdf***

## *STANDARDISATION IN HEALTHCARE – JOINT LETTER TO COMMISSION PRESIDENT*

On 3 July 2015, HOPE together with the Standing Committee of European Doctors (CPME) and the Council of European Dentists (CED) jointly addressed a letter to the Commission President Jean-Claude Juncker on the topic of standardisation in healthcare.

The three associations expressed concern about the efforts at European level on the subject of standardising medical treatments and other healthcare services, considering that this risks jeopardising good quality of care and calls on decision makers both at EU and national level to refrain from supporting any activities seeking the standardisation of healthcare services by standardisation institutes. Indeed, recent initiatives in standardisation at EU level have gone beyond the products and facilities supporting healthcare and have interfered with the services delivered by healthcare professionals in patient care.

The letter highlights that there are already specific instruments established within the healthcare sector such as evidence-based guidelines and recommendations developed by health professionals. Contrarily to a set of standards, these instruments support appropriate and high quality healthcare and exist with "a legitimate basis" built on the national competences and the EU treaties.Healthcare professionals' therapeutic freedom, which is fundamental to ensure both quality of treatment and patients' rights, is also guaranteed by such instruments which also set up monitoring and sanction mechanisms.

Standards, such as those developed with the involvement of standardisation institutes, created outside of these structures cannot rely on these mechanisms, thus creating ambiguity as to their enforcement.

On 31 July, the European Network of Medical Competent Authorities (ENMCA) also sent a letter to the European Commission and the European Committee for Standardisation (CEN) outlining similar concerns with a trend towards the standardisation of healthcare in the EU.

Justice

## *DATA PROTECTION – EUROBAROMETER*

In June 2015, the Commission published a special Eurobarometer report on data protection. The report built upon a survey covering the 28 Member States of the EU.

Since the first EU directive on data protection has been adopted in 1995, a significant technological progress has been observed. Besides, different ways in which EU Member States implemented the directive have led to an EU-wide disparity that resulted in additional administrative burden for businesses.

The proposal for a general data protection Regulation was published by the Commission in January 2012. The draft 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. It contains provisions which could have an important impact on the provision of healthcare services and research.

In this context, the aim of the Eurobarometer on data protection is to support the finalisation of the on-going data protection reform by exploring EU citizens' views on this issue.
The report highlights EU citizens' feeling of lack of control over their personal data. EU citizens generally care about the disclosure of their personal data and most of them think it is important the same rights and protection over personal information are applied regardless of the country in which the public authority or private company offering the service is based.

Concerning the collection and processing of personal data by other parties, EU citizens trust health and medical institutions more than online businesses, banks or phone companies. Around three-quarters of Europeans affirmed they trust hospitals for the management of their personal data. However, people have become more sceptical than in the past, with a 4 % drop from 2010. Compared with health and medical institutions, only one quarter of EU citizens trust online businesses, and half of respondents trust EU institutions with the management of their personal data.

The report also revealed a general lack of awareness and knowledge about privacy policies. Europeans generally fear that the online provision of their personal information may constitute a risk of being a victim of fraud. In this regard, most of them consider that ensuring the safety of personal information provided online should be a shared responsibility between online companies, public authorities and individuals themselves.

***The Eurobarometer is available at:***
***http://ec.europa.eu/public_opinion/archives/ebs/ebs_431_en.pdf***

## *MATERNITY LEAVE – PARLIAMENT RESOLUTION AND COMMISSION WITHDRAWAL*

On 20 May 2015, the European Parliament adopted during the plenary session in Strasbourg a resolution on maternity leave. The resolution was adopted with 419 votes in favour, 97 against and 161 abstentions.

A proposal for the revision of the current legislation containing provision on maternity leave was published back in October 2008. The European Commission proposed increasing compulsory maternity leave to 18 weeks, of which six would have been taken immediately after childbirth. It also recommended to Member States to pay women their full salary during this leave period. The European Parliament's Women's Right and Gender Equality Committee backed a report by Portuguese MEP Edite Estrela (S&D), to increase minimum compulsory maternity leave to 20 weeks. This draft directive was adopted by the European Parliament the 20th of October 2010. But, the text has been stuck in the Council since.

In September 2014, Frans Timmermans, First Vice-President of the EU Commission, in charge of Better Regulation, Inter-Institutional Relations, Rule of Law and the Charter of Fundamental Rights, set a six months deadline for the Parliament and the Council to find a compromise. Otherwise, the legislative proposal would have been withdrawn.

With this resolution, MEPs reiterated their willingness to end the deadlock and calls for the Commission to play its role of the "honest broker" and to engage a constructive dialogue with the co-legislators with a view of reconciling the position of both the Parliament and the Council.

Among other texts, the resolution referred to the parliament resolution of 10 March 2015 on progress on equality between women and men in the European Union in 2013, which calls for policy-changes to achieve gender equality.

The principle of equal treatment of women and men implies that there is no discrimination, also on account of motherhood, fatherhood and the fact of shouldering family responsibilities. In fact, the sharing of family and domestic responsibilities between women and men is essential in order to achieve gender equality. Whereas, women spend every week, three times as long as men, on household chores, more women than men are living in the poverty exclusion and, a quarter of Member States do not offer paternity leave.

With this resolution the Parliament also asked, in case of withdrawal of the draft legislation, for an immediate alternative to be started under the Luxembourg presidency of the Council of the European Union in order to improve health and safety of pregnant workers or workers who have recently given birth or are breastfeeding.

Finally, the European Parliament reiterated its willingness to draft a separate directive establishing a paid paternity leave of a last ten working days and encouraging measures, legislative and otherwise, enabling men, and fathers in particular, to exercise their right to achieve a work-life balance.

On 1st July 2015, the European Commission officially announced the withdrawal of the legislative proposal. At the same time, the Commission reiterated its commitment to continue the work on this topic by presenting a new broader initiative under its Work Programme for 2016.

A roadmap setting the Commission's approach for further work on this topic will be published before the withdrawal to become effective. The Commission also announced the launch of a public consultation to gather stakeholders' views.

***The European Parliament resolution is available at:***
***http://www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P8-TA-2015-0207&language=EN&ring=B8-2015-0453***

## *EUROPEAN PROFESSIONAL CARD AND ALERT MECHANISM – IMPLEMENTING REGULATION*

On 24 June 2015, the European Commission adopted the implementing Regulation on the procedure for issuance of the European Professional Card and the application of the alert mechanism pursuant to the Professional Qualifications Directive.

The European Professional Card (EPC) is an electronic procedure for the recognition of professional qualifications between countries of the European Union. In January 2016, the EPC will be available for nurses responsible for general care, pharmacists, physiotherapists, mountain guides and real estate agents. They will be able to apply for the recognition of their qualification in other EU countries through the Internal Market Information System (IMI), an IT-based information network that links up national, regional and local authorities across borders.

The purpose of the EPC will be to make it easier for professional qualifications to be recognised and for members of a regulated profession to practise elsewhere in the EU. This will be achieved by involving the relevant authorities in professionals' home countries. According to article 1 of the implementing Regulation, each Member State shall designate competent authorities responsible for EPC applications for each of the professions listed. Moreover, they shall register in the Internal Market Information System at least one competent authority for each profession.

The implementing Regulation also covers issues such as the format of the EPC, information to be submitted with EPC applications, the application documentation requirements (including translations and certified copies), payment modalities, handling of written applications, access to the IMI file, and certain other technical details.

The Directive introduced a proactive alert mechanism, supported by the IMI system, concerning professionals who have been prohibited or restricted from practice on the territory of one Member State, or who have used falsified documentation in support of their application for the recognition of their qualification. The implementing Regulation contains provisions on the authorities entitled to send and receive alerts as well as on the withdrawal and closure of alerts, and complementary measures to ensure the security of processing.

***The implementing Regulation is available at:***
***http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=OJ:JOL_2015_159_R_0003***

## *EU SOCIAL SECURITY COORDINATION – PUBLIC CONSULTATION*

The European Commission has launched a public consultation on the EU Social Security Coordination.

This initiative is part of the "Labour Mobility Package" announced in the Commission Work Programme 2015. It follows the 2012 public consultation on a revision of the EU provisions on coordination of long-term care benefits and unemployment benefits.

The so-called "EU social security coordination" provides rules to protect the rights of people moving within the EU, to ensure they do not lose their social security protection when moving to another EU country. The first EU social security coordination rules were adopted in 1958. Since then, they have been updated many times and their scope has been enlarged to include more social security benefits and more groups of mobile persons, including family members of workers and inactive persons.

The purpose of this consultation is thus to gather views on the functioning of the current coordination rules in a number of cross-border situations. The contributions will feed into a possible revision of Regulation (EC) No 883/2004 and (EC) No 987/2009 on the coordination of social security systems. Any citizen or organisation may participate to the on-line consultation.

In fact, the European Commission is considering another update to ensure that the social security coordination rules respond to social, economic and political developments in the EU countries. Two types of benefits are especially being looked at: family benefits and unemployed benefits.

**The deadline to reply to the consultation is 7 October 2015.**

***More information:***
***http://ec.europa.eu/social/main.jsp?catId=333&langId=en&consultId=16&visib=0&furtherConsult=yes***


## *PUBLIC HEALTH AND TTIP – PARLIAMENTARY QUESTIONS*

On 18 June, Commissioner for trade Cecilia Malmström, on behalf of the Commission answered to two parliamentary questions related to public health provisions in the TTIP.

The TTIP is an agreement which regulates trade between the European Union and the United States of America (USA). It is currently in the negotiation phase, which was set to finish by the end of 2014, but negotiations have dragged on and have been re-launched in 2015.

Parliamentary questions are aimed at enabling the European Parliament to scrutinise actions from EU institutions and bodies. These questions are addressed by Members of the European Parliament to other European Union Institutions and bodies, which should then provide a reply to the European Parliament.

On 31 March 2015, MEPs Martina Anderson (GUE/NGL, Ireland), Lynn Boylan (GUE/NGL, Ireland) and Liadh Ní Riada (GUE/NGL, Ireland) asked a question for written answer to the Commission on publicly funded health services in the TTIP. MEPs asked the Commission to clarify ways and means of exclusion of publicly funded health services from the TTIP. Besides, they also asked the Commission how it will ensure that these services are not included again in the agreement in the future.

In its answer, Commissioner for trade stressed that there was a "*long-standing EU policy of excluding publicly funded health services*" from its trade agreements. In this way, it notably referred to its free trade agreement with Canada as well as to its Trade in Services Agreement (TiSA), a trade agreement currently being negotiated by 24 members of the World Trade Organisation (WTO), including the EU.

Finally, she clarified that the Commission does not intend to depart from this traditional exclusion and that, in any event, inclusion of publicly funded health services in the agreement would be subject to the approval of the Council and European Parliament.

The second parliamentary question focused on public health insurance and financial services. As the German public health insurance consists of a mixture of service providers and insurance, MEP Ismail Ertug (S&D, Germany) asked the Commission if the German public health insurance "*would be treated like any profit-oriented financial service provider*" under the TTIP. Besides, he also asked which actions the EU envisages in order to prevent impairment of the functioning of the public insurance systems in Member States by the TTIP.

Commissioner for trade Cecilia Malmström answered that "*EU trade agreements maintain broad prerogatives for EU Governments with respect to public services, including the regulation of health and statutory health insurance*". In this way, she referred to her joint statement with her US counterpart Michael Froman where EU and US confirmed US and EU trade agreements do not prevent Governments, at any level, from providing or supporting services in areas such as health.

Therefore, she affirmed that "*there is no danger of TTIP triggering any impairment of the functioning of the public health insurance systems in Member States*".

***More information on TTIP:***
***http://ec.europa.eu/trade/policy/in-focus/ttip/index_en.htm***

***The parliamentary questions and answers are available at:***
***http://www.europarl.europa.eu/sides/getAllAnswers.do?reference=E-2015-005095&language=EN***
***http://www.europarl.europa.eu/sides/getAllAnswers.do?reference=E-2015-005577&language=EN***

## *TTIP – EUROPEAN PARLIAMENT ADOPTS RESOLUTION*

On 8 July 2015, the European Parliament adopted a non-binding resolution containing its recommendations to the European Commission on the negotiation for the Transatlantic Trade and Investment Partnership (TTIP).

The Transatlantic Trade Investment Partnership is a trade and investment agreement being negotiated between the United States of America and the European Union. It is currently in the negotiation phase, which was set to finish by the end of 2014, but negotiations have dragged on and have been re-launched in 2015.

With this non-binding resolution the European Parliament, in the context of ongoing negotiations on TTIP, addresses some recommendations to the European Commission on a number of areas such as market access, the regulatory cooperation and coherence pillar and non-tariff barriers to trade (NTBs), rules, transparency, civil society involvement, and the public and political outreach.

The European Parliament believes that the EU and the US are key strategic partners. The TTIP is the most recent EU-US project and should reinvigorate the transatlantic partnership as a whole.

However, the European Commission has to ensure that the TTIP's negotiations are transparent and lead to an ambitious and balanced trade and investment agreement that would promote sustainable growth with shared benefits across Member States.

Regarding market access, the European Commission has to ensure that the market access offers in the different areas are reciprocal, equally ambitious and reflect both parties' expectations. The Parliament asked the Commission to build on the joint statement reflecting the negotiators' clear commitment to exclude current and future Services of General Interest as well as Services of General Economic Interest from the scope of application of TTIP, (including but not limited to water, health, social services, social security systems and education), to ensure that national and if applicable local authorities retain the full right to introduce, adopt, maintain or repeal any measures with regards to the commissioning, organisation, funding and provision of public services as provided in the Treaties as well as in the EU's negotiating mandate. MEPs asked this exclusion to be applied irrespective of how the services are provided and funded.

Regarding the regulatory cooperation and coherence pillar and NTBs, the Commission has to ensure that the regulatory cooperation chapter promotes a transparent, effective, pro-competitive

economic environment through the identification and prevention of potential future non-tariff barriers to trade. Moreover, the Commission needs to support the establishment of a structured dialogue and cooperation between regulators in the most transparent way possible and involving stakeholders. The European Parliament also asked the Commission to recognise that, where the EU and the US have very different rules, there will be no agreement, such as on public healthcare services, GMOs, the use of hormones in the bovine sector, REACH and its implementation, and the cloning of animals for farming purposes, and therefore not to negotiate on these issues.

Regarding the rules, according to MEPs the European Commission has to combine negotiations on market access and regulatory cooperation with the establishment of ambitious rules and principles. The Commission has also to ensure that the sustainable development chapter is binding and enforceable and aims at the full and effective ratification, implementation and enforcement of the eight fundamental International Labour Organisation conventions and their contents and the core international environmental agreements.

Regarding transparency, civil society involvement and public and political outreach, the European Commission should continue ongoing efforts to increase transparency in the negotiations by making more negotiation proposals available to the general public. The Parliament recommends the Commission to encourage Member States to involve their national parliaments in line with their respective constitutional obligations, to provide all necessary support for Member States to fulfil this task and to strengthen outreach to national parliaments in order to keep them informed of progresses.

***More information on TTIP:***
***http://ec.europa.eu/trade/policy/in-focus/ttip/index_en.htm***

***The resolution is available at:***
***http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+TA+P8-TA-2015-0252+0+DOC+PDF+V0//EN***

## *WORKING TIME DIRECTIVE AND NON-CONSULTANT HOSPITAL DOCTORS IN IRELAND – JUDGMENT*

On 9 July 2015, the European Court of Justice delivered a judgement dismissing the Commission's action claiming that Ireland had failed to comply with the working time directive (Directive 2003/88) rules for non-consultant hospital doctors (NCHD).

The working time directive requires EU countries to guarantee minimum standards applicable throughout the EU with regard to workers' rights. The directive lays down minimum daily and weekly rest periods as well as a limit to weekly working hours. The directive also sets out special rules on working hours for workers in a limited number of sectors, including doctors in training.

Considering that Ireland failed to fulfil its obligations under the directive for NCHD, the Commission sent a letter of formal notice to Ireland in 2009. In 2011, the Commission issued a reasoned opinion inviting Ireland to take necessary measures to comply with the directive within 2 months. As the Commission was still not satisfied with the Irish response, it decided to bring an action before the Court.

The Commission claimed that the collective agreement signed between the Irish Medical Organisation (representing all doctors practicing in Ireland) and the Health Service Executive (HSE - representing Irish health authorities) infringed the provisions of the working time directive. Accordingly, Ireland faced the risk of having to pay lump sum and/or penalty payment in case of infringement.

By the first ground of complaint, the Commission advocated that some provisions of the collective agreement infringed the directive by not considering certain training times for NCHD as "working time" and therefore excluding them from the scope of the rules of the directive.

Referring to its settled case-law, the Court affirmed that the determining factor for the classification of working time under the meaning of the directive is that a person is required to be "*physically present at the place determined by the employer and to be available to the employer in order to provide the appropriate services immediately in case of need*".

In this regards, Ireland claimed that during the concerned training hours, NCHD are not available to pursue their professional activities and that the relationship between NCHD and their training organisation is separate from that which exists between NCHD and their employer. The training requirements for NCHD do not form an integral part of their employment. The employer does not direct the conduct of such training, does not determine the activities which NCHD must undertake under that training, nor the progression of NCHD within that training, and it does not determine the place.

In the second ground of complaint, the Commission argued that the collective agreement extension of the reference period from 6 to 12 months for NCHD whose employment contracts are 12 months or longer constituted an infringement of the directive.

Member States may establish reference periods for the application of the directive which may not exceed 6 months. However, member States have the option to derogate from this provision "*subject to compliance with the general principles relating to the protection of the safety and health of workers, of allowing, for* [...] *reasons concerning the organisation of work, collective agreements* [...] *to set reference periods in no event exceeding 12 months*."

Ireland claimed that the extension of the reference period for NCHD from 6 to 12 months for NCHD whose contracts are greater than 12 months was justified by reasons concerning the organisation of work, which necessitates an extension of the reference period. In particular, the HSE was concerned as to its ability to roster the NCHD flexibly in order to implement fully its statutory obligations.

The Court concluded that the Commission had not succeeded, in relation to Ireland, in proving the existence of practice contrary to the provisions of the working time directive as regards the organisation of the working time of NCHD.

***The judgment is available at:***
***http://curia.europa.eu/juris/document/document.jsf?text=&docid=165651&pageIndex=0&doclang=EN&mode=lst&dir=&occ=first&part=1&cid=82148***


## *QUALITY OF PUBLIC SOCIAL AND HEALTH SERVICES – EU FUNDING TO CROATIA AND SERBIA BORDER REGIONS*

On 24 August 2015, the European Commission announced the investment of €34 million in the border regions of Croatia and Serbia through the Interreg IPA CBC Croatia-Serbia programme.

IPA supports cross-border co-operation between candidate countries, potential candidate countries and EU Member States.

The Interreg IPA CBC Croatia-Serbia programme covers four border regions in Croatia (Osječko-baranjska county, Vukovarsko-srijemska county, Brodsko-posavska county and Požeško-slavonska county) and five Serbian districts (North Bačka district, West Bačka district, South Bačka district, Srem district and Mačva district). It is managed by the Agency for Regional Development of the Republic of Croatia – Directorate for Managing Cooperation Programmes and Regional Development.

Funding will be used to improve the quality of public social and health services. Supporting the increased use of sustainable resources and cross border monitoring of environmental risks will be another focus of the programme. Moreover, the programme will boost cross border tourism activity. Finally, funding will also be allocated to strengthen the links between businesses and research institutions, thus boosting regional competitiveness.

More specifically, some of the expected impacts include:

- improved quality of public health and social care services;
- better management of environmental and biodiversity protection and upgraded joint cross border management system for risk prevention;
- increased capacities for the development of sustainable energy by providing a platform for smart energy management and renewable energy use in public infrastructures, including in public buildings, and in the public housing sector;
- an improved cross border tourism offer thanks to a better coordination between stakeholders in the tourism sector and to the development of joint tourism strategies, as well as action plans and studies on the preservation of cultural and natural heritages;
- improved competitiveness through the setup of business networks.

***More information on IPA Cross-Border Cooperation Programmes:***
***http://ec.europa.eu/regional_policy/en/funding/ipa/cross-border/***

## *JOINT ACTION HEALTH WORKFORCE PLANNING AND FORECASTING – REPORTS ON THE APPLICABILITY OF THE WHO GLOBAL CODE OF PRACTICE AND ON TERMINOLOGY GAP ANALYSIS*

The Joint Action on Health Workforce Planning and Forecasting released in July 2015 a report on "The applicability of the WHO Global Code of Practice on the International recruitment of Health Personnel within a European Context".

The preparation of this document was led by the health Service Management Training Center of Semmelweis University in Budapest (Hungary). This report is a part of the "mobility activity" of work package 4 of the Joint Action, which explores and summarises the current knowledge of health workforce mobility data situation in the EU focusing on gaps in mobility terminology, data and their availability.

The WHO Global Code aims to establish and promote voluntary principles and practice for the ethical international recruitment of health personnel and to facilitate the strengthening of health systems. The Joint Action on Health Workforce Planning and Forecasting is a three year programme running from April 2013 to June 2016, bringing together partners representing countries, regions and interest groups from across Europe and international organisations. It is supported by the European Commission in the framework of the European Action Plan for the Health Workforce.

The report's scope is to describe the outcomes of two workshops aimed at gathering stakeholders' views about the applicability of the WHO Code. The main value of this activity was its contribution to knowledge sharing and offering an opportunity to discuss the WHO Code between health workforce experts from across the EU.

After a first introductory part presenting a literature review, the Joint Action and the international context, a chapter is dedicated to the illustration of Member States' experiences relating to the implementation of the WHO Code. Four country cases – Ireland, Germany, Finland and Moldova – are presented and demonstrate the efforts these countries have made with different levels of success on the path towards implementing the Code.

The third and final part of the report is related to the applicability of the WHO Code in Europe. There are considerable efforts in some Member States that are considered big recruiters to avoid recruiting from countries on the WHO list with critical shortages. Some solutions that benefit to all the actors have to be elaborated. More attention has to be given to the integration and fair treatment of foreign health personnel. Employment has to be based on ethical principles, avoiding discrimination. Finally, sharing of knowledge should be continued and data exchange on mobility should be as automatic as possible.

In July 2015, the WP4 of the Joint Action on European Health Workforce Planning and Forecasting also released its first deliverable on *Terminology gap analysis* which is focused on the evaluation of the Joint Questionnaire on non-monetary health statistics, developed by Eurostat, OECD and WHO in 2010. The scope of this joint data collection is to improve the consistency of figures reported on human resources to health. This tool addressed the need of having a clear view over the European Union situation about the topic under examination.

In principle, the Joint Questionnaire should overcome any bias created by different methodologies of data collection of EU countries. Moreover, it should enhance the possibilities of assess the extent and impact of health workforce challenges and possible policies.

Work Package 4 performed an analysis and presented this report aimed at advancing this data collection scheme. It also provides policy recommendations to improve health workforce data collection in EU Member States.

This activity contribute to the overall aim of the Joint Action to support Members States in developing a reliable health workforce planning system that enables the fulfilment of national healthcare needs.

***The report on the applicability of the WHO Global Code of Practice is available at:***
***http://euhwforce.weebly.com/uploads/2/3/0/5/23054358/150609_wp4_who_applicabilty_report.pdf***

***The report on the terminology gap analysis is available at:***
***http://euhwforce.weebly.com/uploads/2/3/0/5/23054358/150618_wp4_do41_terminology_gap_analysis_final.pdf***

## *INNOVATIVE MEDICINES INITIATIVES – CALL FOR PROPOSALS*

On 9 July 2015, the Innovative Medicines Initiative (IMI) has launched its 5th Call for proposals under the IMI 2 programme.

IMI is a partnership between the EU and the European Federation of Pharmaceutical Industries and Associations (EFPIA). It is working to improve health by speeding up the development of, and patient access to, innovative medicines, particularly in areas where there is an unmet medical or social need. It does this by facilitating the collaboration between the key players in health research.

IMI 2 Call 5 features six topics. Of these, four focuses on different aspects of Alzheimer's disease, one focuses on diabetic kidney disease, and one addresses patient input on assessments of the benefits and risks of medicines.

IMI2 Call 5 has a total budget of € 95 million. Half of the budget comes from the European Commission through the Horizon 2020 programme for research and innovation. The other half comes from EFPIA companies involved in the projects as well as other Associated Partners.

**The deadline for submitting proposals is 13 October 2015.**

*More information:* ***http://www.imi.europa.eu/content/stage-1-16***

## *EUROPEAN REFERENCE NETWORKS – CALL FOR TENDER FOR THE SELECTION OF INDEPENDENT ASSESSMENT BODIES*

The European Commission has recently published a call for tender concerning the selection of the independent assessment/evaluation bodies in charge of the assessment of the applications of European Reference Network (ERN) and membership proposals.

These networks are meant to improve access to and provision of high-quality health care to all patients who have conditions requiring a concentration of specialised resources or expertise and could also act as focal points for medical training and research, information dissemination and evaluation, especially for rare diseases.

The technical assessment of ERN proposals will be performed by contracted institutions or entities with a solid background and experience in the field of accreditation/ certification. Thus, the purpose of this call for tender is to conclude Multiple Framework Contracts with reopening of competition with Independent Assessment Bodies capable of performing the technical assessment of European Reference Networks (Networks) proposals and healthcare provider's applications under the framework of Article 12 of Directive 2011/24/EU on patients' rights in cross-border healthcare.

**The deadline to submit proposals is 22 September 2015.**

***More information:*** ***http://ec.europa.eu/chafea/health/tender-09-2015_en.html***

## *HIV/AIDS AND ASSOCIATED INFECTIONS – CALL FOR TENDER*

The European Commission has recently launched a call for tender concerning the development of a behavioural survey for HIV/AIDS and associated infections and a tailored training for healthcare professionals and community based health workers to facilitate the access and improve the quality of prevention, diagnosis of HIV/AIDS, STI and viral hepatitis and health care services for men who have sex with men (MSM).

The objective of this call for tender is to provide sound evidence about the sexual health, including new behaviour trends in life style and behaviour of men who have sex with men (MSM) in Europe. And at same time, to assess and define the knowledge, attitudes and practices that should be employed to ensure the effective implementation of targeted prevention strategies by community based health workers (CHW), when providing health services for men who have sex with men.

**The deadline to submit proposals is 22 September 2015.**

***More information:*** ***http://ec.europa.eu/chafea/health/tender-04-2015_en.html***

## *HEALTH INEQUALITIES – CALL FOR TENDER*

The European Commission has recently announced the opening of a call for tenders on a "Pilot project related to reducing health inequalities: building expertise and evaluation of actions".

The subject of this contract is to support knowledge-sharing and policy development in order to reduce health inequalities in the EU, with a focus on the lifestyle determinants of alcohol and nutrition and physical activity (particularly in Member States and regions with the greatest needs) by:

1. updating scientific evidence and reviewing policies and actions, in particular within the area of lifestyle and behavioural economics;
2. conducting case studies on policies and actions in different Member States aiming to reduce health inequalities;
3. implementing workshops and expert exchange with the objective of breaking barriers to intersectoral action on health inequalities;
4. ensuring synergies and support to the health determinants-related joint actions;
5. facilitating information exchange and collaboration between groups of experts and stakeholders.

**The deadline to submit proposals is 21 September 2015.**

***More information:***
***http://ec.europa.eu/dgs/health_food-safety/funding/call_sante_2014-c4-032_en.htm***

## *LIFE-MED PROJECT – NEW INTEGRATE SYSTEM TO REDUCE WASTE BY MEDICAL EQUIPMENT*

Life-MED, Medical Equipment Discarded – A new integrate system to reduce waste by medical equipment and medical WEEE – is a project co-funded by the EU under the LIFE programme.

The project, started in July 2014 and ending in June 2017, addresses primarily the environmental problem of sustainable waste and natural management. It supports waste prevention programmes and measures to promote the application of the waste hierarchy.

It provides a reduction in the production of waste from health care facilities and veterinary clinics through the application of an integrated system that foresees the preventive donation of biomedical equipment and devices to organisations and associations in the EU territory. At the end of the project, the disposal of 100 ton of equipment will be avoided.

The sustainability of the management of hospital waste will be addressed also through the analysis of the regulatory framework within a working table of consultation, composed of Italian institutional stakeholders in charge with these issues (consortia, control authorities, Government agencies in charge, sector trade associations).

Among the latest updates from the project there is a first sending of medical equipment previously recovered to Kaunas (Lithuania) on the 12th of May 2015, in cooperation with local authorities. Also, on the 12th of May 2015 a survey was organised to Bucharest in order to explore opportunities of cooperation and donation of Life-MED recovered equipment.

***More information: http://www.life-med-equipment.eu/sito/***

## *UNITED4HEALTH POLICY ADVISORY BOARD*

On 6 July 2015, HOPE attended the meeting of the United4Health Policy Advisory Board. The meeting aimed at discussing some provisional policy messages that can be delivered based on the project results concerning Chronic Obstructive Pulmonary Disease (COPD).

United4Health is a project co-financed by the European Commission under the ICT Policy Support Programme (ICT PSP). The project is a large scale study that aims to reach new frontiers in the evaluation and deployment of information technology and communications (ICT) services for the management of people living with chronic diseases in home settings. The programme involves patients affected by diabetes, chronic obstructive pulmonary disease (COPD), and cardiovascular disease.

The meeting started with a series of presentations of telehealth services for patients affected by COPD in Israel, South Norway, Wales, South Yorkshire, Scotland and Galicia.

The presentations highlighted some key elements for an effective deployment of telehealth services such as collaboration with doctors, GPs and nurses. Development of partnerships with health professionals indeed results in better acceptance. It was also pointed out that goals might be different for different stakeholders and this should be taken into account when implementing the service. To be successful, a telehealth service needs to be integrated into the daily routine practice and not constitute extra work for health professionals. Thus, change management plays a crucial role. Finally, involvement of patients in the design of the service and robust evaluation were recognised as fundamental.

Major difficulties encountered by the different sites implementing the services were mainly related to the lack of appropriate infrastructure in place (e.g. wireless coverage) and the recruitment of patients. According to the study protocol, COPD patients had to be recruited at the hospital. However, it was noticed that telehealth services might most benefit COPD patients at the early or mid-stage of the disease and not the sickest ones who look for care at the hospital.

In the second part of the meeting two parallel groups discussed what the deployment lessons presented mean for telehealth "doers" such as managers and health professionals.

The next Policy Advisory Board meeting will be held in September 2015 on the topic of "*Diabetes: policy messages*".

***More information on United4Health: http://united4health.eu/***

## *HEALTH LITERACY SURVEY MALTA 2014*


54.2% of the Maltese adult population has a 'sufficient' or 'excellent' level of health literacy whilst 45.8% have a 'problematic' or 'inadequate' level of health literacy. This resulted from the Health Literacy Survey Malta conducted during July 2014. The study was carried out by the Office of the Commissioner for Mental Health in partnership with the National Statistics Office in an effort to measure the health literacy level of the Maltese population and explore ways on how health literacy can be further advanced in the future.

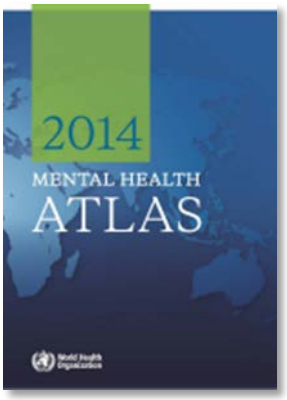
National results compare quite well with the findings of the European Health Literacy Survey (EU HLS) carried out in eight Member States with a mean European General Health Literacy Index of 33.8 as against 34.0 for Malta.

The survey was undertaken in Malta as part of the follow-up of initiatives linked to the European Year 2014 dedicated to Citizenship. It recommends that Health Literacy (HL) should be integrated in policy making and practice to ensure health equity, citizen empowerment and patient centred care.

The report presents results for Malta of the EU-HLS 16, the abridged version of the original survey questionnaire. Section 2 is a description of the sampling techniques adopted and the methodology used in the analysis. The main findings have been outlined in Section 3. Section 4 examines the correlation between health behaviours/outcomes and the level of HL. Section 5 provides details on the relevance of the social gradient for HL levels. Section 6 highlights the sub groups of the population that were found to have increased risk of low levels of HL. Section 7 examines the correlation between HL and health service use. The Maltese and English versions of the questionnaire used in this survey can be found annexed to the report.

***The report is available at:***
***https://health.gov.mt/en/CommMentalHealth/Documents/health-literacy/health-literacy-survey-malta-2014.pdf***

## *MENTAL HEALTH ATLAS 2014 – WHO PUBLICATION*




In July 2015, WHO published the Mental Health Atlas 2014 which assumes new importance as source information for the EU Member States.

Worldwide, nearly 1 out on 10 people have a mental health disorder, but only 1% of the global health workforce is working on mental health. This means, for example, that nearly half of the world population lives in a country where there is less than one psychiatrist per 100,000 people.

Furthermore, the report states that global spending on mental health is still very low. Low and middle-income countries spend less than US$ 2 per capita per year on mental health, whereas high-income countries spend more than US$ 50. The 2014 edition of the publication contains data on the availability of mental health services and resources across the world and it also includes financial allocations, human resources and specialised facilities for mental health from 171 countries.

***More information:***
***http://apps.who.int/iris/bitstream/10665/178879/1/9789241565011_eng.pdf?ua=1&ua=1***

## *OECD HEALTH STATISTICS 2015 – COUNTRY NOTES*

In July 2015, OECD published specific country notes using data from the database OECD Health Statistics 2015 which aims at providing qualitative and quantitative information about health spending in 31 OECD countries.

The document can be used as a comparative instrument to evaluate different National Health Systems on the basis of different figures. The country notes focus on data such as the growth of per-capita health spending, the share of GDP allocated to health expenditure, the average per capita spending. In this way the reader has a clear overview of these aspects in many EU Member States.

***More information:***
***http://www.oecd.org/health/oecd-health-statistics-2015-country-notes.htm***

## *TOWARDS A GUIDED AND PHASED INTRODUCTION OF HIGHRISK MEDICAL DEVICES IN BELGIUM – KCE PUBLICATION*

In July 2015, the Belgian Health Care Knowledge Center (KCE) published a report concerning the introduction of high-risk medical devices in Belgium.

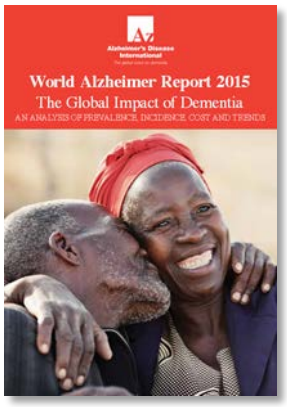
This study explores the possibilities for a guided introduction of certain high-risk medical devices in the Belgian healthcare system since, for this area of new technologies, safety and patients' health issues are particularly important. For the report, the notion of high-risk medical devices covers "Class III" medical devices, active implantable medical devices and any other implantable medical devices.

The aim of the report is to study, within the European framework, a coherent set of rules related to patient's health and safety.

***More information:*** ***http://kce.fgov.be/sites/default/files/page_documents/KCE249_High-risk%20medical%20devices_Report.pdf***

## *WORLD ALZHEIMER REPORT 2015*

The World Alzheimer Report 2015 was released in August 2015.




The report updates Alzheimer's disease International's data on dementia's global prevalence, incidence and cost, highlighting dementia's increasing impact on low and middle income countries (LMICs).

Findings show that there are currently around 46.8 million people living with dementia around the world, with numbers set to increase to 74.7 million by 2030 and 131.5 million by 2050. There are over 9.9 million new cases of dementia each year worldwide, implying one new case every 3.2 seconds.

The current annual societal and economic cost of dementia is US $818 billion, and it is expected to become a trillion dollar disease in just three years' time. The findings show that the cost of dementia has increased by 35% since the 2010 World Alzheimer Report estimate of US $604 billion. This means that if global dementia care was a country, it would be the 18th largest economy in the world, and would exceed the market values of companies such as Apple (US $742 billion) and Google (US $368 billion).

The report concludes with recommendations urging policy makers around the world to approach the issue with a broader agenda and a wider representation of countries and regions, particularly those in the G20 group of nations. A key recommendation of the report calls for a significant upscaling of research investment into care, treatment, prevention and cure.

***More information:*** ***http://www.alz.co.uk/research/WorldAlzheimerReport2015.pdf***

## *WHAT DO PATIENTS AND CARERS NEED IN HEALTH APP BUT ARE NOT GETTING? – REPORT*


The report "What do patients and carers need in health apps - but are not getting?" has recently been published. It presents the results of a study carried out by the UK-based research, publishing and consultancy group PatientView, in conjunction with Health 2.0, TICBioMed and the EU-funded GET project.

The research for this project was undertaken in two steps. In the first step, a global survey was conducted from June to October 2014. PatientView, in collaboration with Health 2.0, carried out a global study into what patients and carers want from health apps. Respondents of the survey were 1,120 from 31 countries and almost 50 therapy areas (10% with diabetes, 9.6% with cancer, 7.6% with arthritis etc.).

This survey aimed to provide information to app developers about how to work with patients and healthcare professionals to improve apps to help meet unmet patient and carers needs and, to identify specific examples of unmet needs across different therapy areas.

The survey concluded that patients and carers are using apps but largely to gather information, aspire to do a lot more with apps and, want to use technologies in conjunction with their healthcare professionals. Moreover, they need guidance on which apps are the best for them. To finish, they want understandable information on their medical symptoms and conditions.

The second step was a cross-stakeholder meeting held during the Health 2.0 Europe Conference in London, on 12 November 2014, to analyse the result of the survey. The workshop gathered 50 stakeholders who had a variety of roles, including: patients, carers, people with disabilities, app developers, clinicians, representatives of pharmaceutical, medical technology and telecoms industries, experts in medical communications and health education, and policy makers.
The participants were asked to review the unmet needs identified by the survey. Also, they were asked to rank in order of importance these unmet needs and identify potential ideas to address top ranking need for their therapy area.

***More information:***
***http://www.ehealthnews.eu/images/stories/pdf/patientview_white_paper_2015.pdf***

## *SOCIAL RETURN ON INVESTMENT METHODOLOGY TO ACCOUNT FOR VALUE FOR MONEY OF PUBLIC HEALTH INTERVENTIONS – A SYSTEMATIC REVIEW*

This article published in July 2015 provides an overview of social return on investment application in public health and explores lessons learnt from previous studies. Furthermore, it makes recommendations for future application of this tool in public health.

The social return on investment methodology has the capacity to measure broader socio-economic outcomes. It is also a tool aimed at analysing and computing views of multiple stakeholders in a singular monetary ratio.

Authors conducted a systematic review of peer-reviewed and grey literature published between January 1996 and December 2014 and used qualitative and quantitative methods to gather information on the topic. However, there is still a lack of consensus on who to include as beneficiaries, how to account for counterfactual and appropriate study-time horizon.

Social return on investment can be applied across many healthcare settings. Finally, the best practices shown in the research could improve the robustness of this instrument.

***More information:***
***http://www.biomedcentral.com/content/pdf/s12889-015-1935-7.pdf***

## *STRATEGIC PURCHASING REFORM IN ESTONIA: REDUCING INEQUALITIES IN ACCESS WHILE IMPROVING CARE CONCENTRATION AND QUALITY*

This article published in July 2015 describes the healthcare strategic purchasing reform adopted in in Estonia in 2014. The new purchasing procedures have now started to be implemented in specialist care.

The main changes of this reform include different areas of intervention. For example, access criteria are now based on population need rather than historical supply. This action aims at achieving equal access of providers and specialties. Stricter definition and use of optimal workload criteria to increase the concentration of specialist care have been introduced. Additionally, the reform acts toward a better consideration of patient movement and an increased emphasis on quality of healthcare.

The new criteria described were first used in 2014 but is too early to draw firm conclusions on the impact on care quality or on actors. Nevertheless, the process has sparked debate on the role of selective contracting and the role of public and private providers.

Lastly, the Estonian experience may hold important lessons for other countries looking to overcome inequalities in access while concentrating care and improving care quality.

***More information:***
***http://ac.els-cdn.com/S0168851015001621/1-s2.0-S0168851015001621-main.pdf?_tid=d9e832f2-2ad4-11e5-bd36-00000aacb35e&acdnat=1436953118_6d9fbf3f804c89fc438e80117fb18d57***

## *WHAT ARE THE CORE PREDICTORS OF 'HASSLES' AMONG PATIENTS WITH MULTIMORBIDITY IN PRIMARY CARE? – A CROSS SECTIONAL STUDY*

This article, published in July 2015, looks at the 'hassles' in primary care among patients with multimorbidity.

The health services are often organised to manage discrete long-term conditions. But this is done using guidelines related to one single condition. However, multimorbidity is a condition affecting many elderly patients.

Qualitative research suggests that these patients experience problems in their care, including multiple appointments, poor co-ordination, and conflicting recommendations. Though, there is limited quantitative evidence supporting managers and health professionals.

The results of this study have been gathered through a survey, which was sent to 1,460 patients with multimorbidity. They were also asked to complete a range of self-report measures including multimorbidity, their experience of multimorbidity and service delivery. Data were then analysed using regression modelling.

The 'hassles' most often reported by patients were associated to: lack of information about conditions and treatment options; poor communication among health professionals and poor access to specialist care. There was a significant relationship between numbers of conditions and reports of 'hassles'.

Therefore, patients with multimorbidity frequently report on primary care. A priority for future research should be on the development of new models of care that had better supply for these patients.

***More information:***
***http://www.biomedcentral.com/content/pdf/s12913-015-0927-8.pdf***

## *HIGH PERFORMING HOSPITALS: A QUALITATIVE SYSTEMATIC REVIEW OF ASSOCIATED FACTORS AND PRACTICAL STRATEGIES FOR IMPROVEMENT – RESEARCH*

The objective of this study which results were presented in July 2015 was to undertake a systematic review of qualitative literature in order to identify: methods used to define high performing hospitals; the factors associated with high performers and practical strategies for improvement.

High performing hospitals attain excellence across multiple measures of performance and multiple departments. Factors leading to high performance are complex and an exclusive quantitative approach may fail to identify richly descriptive or relevant contextual factors.

Eligible studies required the use of a quantitative method (to identify high performing hospitals), and qualitative methods or tools (to identify factors associated with high performing hospitals or hospital departments).

Finally, a total of 19 studies from a possible 11,428 were included in the review. A range of process, output, outcome and other indicators were used to identify high performing hospitals. Fifty-six practical strategies for achieving high performance were catalogued.

***More information:***
***http://www.biomedcentral.com/content/pdf/s12913-015-0879-z.pdf***

## *HOW EFFECTIVE ARE PATIENT SAFETY INITIATIVES? A RETROSPECTIVE PATIENT RECORD REVIEW STUDY OF CHANGES TO PATIENT SAFETY OVER TIME*

This Dutch research which results were published in July aimed at assessing whether, compared with previous years, hospital care became safer in 2011/2012.

This assessment was expressed in terms of preventable adverse event (AE) rates alongside patient safety initiatives.

In three national adverse event studies, patient records of 2004, 2008 and 2011/2012 were reviewed. This work has been conducted respectively in 21 hospitals in 2004, 20 hospitals in 2008 and 20 hospitals in 2011/2012. In each hospital, 400, 200 and 200 patient records were sampled, respectively. In total 15,997 patient admissions were included in the study.

Uncorrected crude overall adverse event rates showed no change in 2011/2012 in comparison with 2008. Instead, the preventable adverse events showed a reduction of 45%.

Finally, the study reveals some improvements in preventable AEs. These enhancements are even more evident in the areas that were considered during the comprehensive national safety programme taken into consideration.

***More information:***
***http://qualitysafety.bmj.com/content/early/2015/07/06/bmjqs-2014-003702.full.pdf+html***

## *RANKING HOSPITALS ON AVOIDABLE DEATH RATES DERIVED FROM RETROSPECTIVE CASE RECORD REVIEW: METHODOLOGICAL OBSERVATIONS AND LIMITATIONS*

This article published in July 2015 presents the results of a survey on hospital ranking methods.

Reducing the number of avoidable deaths in hospitals is the focus of many quality improvement initiatives started worldwide. Comparing indicators of avoidable mortality between different hospitals could help to target improvement efforts.

Unlike performance comparisons based on hospital standardised mortality ratio (HSMR), the UK Government announced a new policy initiative. It will rank hospitals for avoidable mortality based on case reviews of 2,000 deaths in English hospitals each year. Although this initiative aims to overcome limitations of current policies, two statistical properties of the proposed approach mean that it is unsuitable for classifying hospital performance.

The first issue relates to the ability to identify whether any one death really was avoidable on a case-by-case basis.

In line with previous studies using RCRR, these investigators asked experienced clinicians to rate whether a death was preventable (on a 6 point Likert scale).

Their study recognised that the use of a semi-continuous scale better reflects 'the probabilistic nature of reviewers' decision making, more closely than requiring a simple "yes" or "no" response'. Where there is more than a 50% chance that the death was preventable, deaths are classified as avoidable, so those below 50% are not.

***More information:***
***http://qualitysafety.bmj.com/content/early/2015/07/03/bmjqs-2015-004366.full.pdf+html***

## *THE IMPACT OF PHYSICIAN-NURSE TASK SHIFTING IN PRIMARY CARE ON THE COURSE OF DISEASE – A SYSTEMATIC REVIEW*

This systematic review which results were published in July 2015 was conducted to assess the evidence about task shifting of physician-nurse in relation to the course of disease.

Different sources where used to extract information: MEDLINE, Embase, The Cochrane Library, CINAHL and the reference list of included studies and relevant reviews.

Randomised controlled trials (RCTs) were then selected and critically appraised. Twelve RCTs comprising 22,617 randomised patients meeting the inclusion criteria were conducted mainly in Europe. Nurse-led care was delivered mainly by nurse practitioners following structured protocols and validated instruments in most studies. Twenty-five unique disease-specific measures of the course of disease were reported in the 12 RCTs.

The study concludes that trained nurses may have the ability to achieve outcome results that are at least similar to physicians' for managing the course of disease. This happens when they are following structured protocols and validated instruments. However, the evidence is limited by a series of factors: by a small number of studies reporting a broad range of disease-specific outcomes; by low reporting standards of interventions, roles and clinicians' characteristics, skills and qualifications; and the quality of studies.

***More information:***
***http://www.human-resources-health.com/content/pdf/s12960-015-0049-8.pdf***


## *EUROPEAN HEALTH FORUM GASTEIN 2015*

The 18th European Health Forum Gastein (EHFG) will be held from 30 September to 2 October 2015 in Gastein, Austria on "*Securing Health in Europe- balancing priorities, sharing responsibilities".*

The EHFG is a platform of discussion of more than 600 leading experts in the field of public health and health care. The conference gathers various participants - from politicians to representatives of interest groups, from senior-decision-makers to experts- thus allowing cross border exchange of experience, information and cooperation.

This annual health policy event supported by the European Commission and the Austrian Minister of Health is contributing to the development of European Health policies.

The EHFG 2015 will focus on different topics such as the health system performance, the pricing of medicine, health security, healthy ageing of workers, multi-morbidity, mHealth, health threat response and the European Development Aid.

Following the conference, the EHFG will produce a catalogue of recommendation and observation- *The Gastein Health Outcomes*- which will be sent to national and European institutions dealing with health policy development and implementation.

***More information: http://www.ehfg.org/home.html***

## *2ND EUROPEAN FORUM FOR PUBLIC PROCUREMENT OF HEALTHCARE INNOVATION – 9 SEPTEMBER 2015, PARIS*

Resah (http://resah.fr/), a central purchasing body of French Healthcare organisations (hospitals and nursing homes), is organising on Wednesday 9 September 2015 in Paris the "*2nd European Forum For Public Procurement of Healthcare Innovation"* in collaboration with the INSPIRE Project (http://inspirecampus.eu/), financed by the European Commission.

The procurement of innovation is an important challenge for the future and especially for the healthcare sector. The European Commission has decided to place innovation at the center of the Horizon 2020 program.

The "2nd European Forum For Public Procurement of Healthcare Innovation" will be the opportunity for all European organisations concerned by innovation in the healthcare sector to be informed about what it is doing at the moment in France, what kind of tools the European Commission proposes to facilitate the procurement of innovation and get examples from ongoing European Projects.

The first part of the event (morning) will be in French and the second part (afternoon) will be in English. A translation service will be available the whole day.

***The event is free of charge. To register or to receive more information, please contact s.bourg@resah.fr***

## *LUXEMBOURG PRESIDENCY OF THE EU – CONFERENCE ON PERSONALISED MEDICINE*

On 8 July 2015, the Luxembourg Presidency of the EU organised a conference on *"Making Access to Personalised Medicine a Reality for Patients".*

The Luxembourgish Presidency has indeed made personalised medicine one of its health policy priorities during its mandate.

Personalised medicine is often described as providing "'the right patient with the right treatment at the right dose at the right time". More broadly, personalised medicine may be thought of as the tailoring of medical treatment to the individual characteristic, needs, and preferences of patient during all stages of care, including prevention, diagnosis, treatment, and follow up.

The discussions were centered on the concept of Personalised Medicine as referring to innovative medical interventions tailored to the specific needs of individual patients, thus providing better treatment and preventing undesirable adverse reactions while fostering a more efficient and cost-effective healthcare system.

The conference's main findings will feed into Council Conclusions to be adopted by the 28 EU Health Ministers during the Council meeting of 8 December 2015.

## *ASSESSING THE IMPACT OF THE CROSS-BORDER HEALTHCARE DIRECTIVE – EPF CONFERENCE*

On 2 July 2015, the European Patients' Forum (EPF) organised a conference on *"Cross-border healthcare: is it working for patients across the EU?".* EPF is an umbrella organisation that works with patients' groups in public health and health advocacy across Europe.

In 2011, the Directive on the application of patients' rights in cross-border healthcare (Directive 2011/24/UE) was adopted. The major aim of this new legislation was to clarify the existing rules on access and reimbursement of cross-border healthcare, as well as to promote high quality care in the EU.

In 2014, EPF organised a series of regional conferences in order to raise awareness on the directive as well as to assess the impacts of the legislation two years after it came into force. EPF then published a report on conclusions and recommendations resulting from these regional conferences.

In light of the EPF report, the aim of the conference was to explore improvements and gaps in the implementation of the directive from the perspective of patients and National Contact Points (NCPs), as well as to propose recommendations for the future.

In its opening remarks, EU Commissioner for Health and Food Safety Vytenis Andriukaitis underlined that the Commission observed a lack of effective and complete transposition of the directive in the Member States, which deters patients from using their rights in cross-border healthcare.

Starting with the patients' perspective, the main identified barriers were the following:

- financial barriers: problems of equity of access due to the upfront payment;
- information gap: lack of awareness and complexity of the available information;
- quality and safety issues: continuity of care and complaint procedures.

Then, the conference focused on the role of NCPs, their current challenges and possible recommendations. In this way, it was stressed that NCPs should be more visible, easily accessible and provide information in other languages than the national language of their country.

Finally, three parallel interactive group sessions aimed at exploring specific priority topics within the directive. Participants proposed a set of recommendations including a better involvement of patients' organisations in the monitoring of the directive's implementation as well as the use of EU funds to support the payment of patients' ancillary costs in cross-border healthcare (e.g. travelling expenses).

The Commission report on the operation of the directive will be released in early September.
On 24-25 September, an informal meeting of EU Health Ministers will take place in Luxembourg to discuss the issue of the cross-border healthcare directive implementation.

***The conference report is available at:***
***http://www.eu-patient.eu/globalassets/events/2015-eu-cbhc/20150810_cbhc_report_final.pdf***

***EPF report on cross border healthcare is available at: http://www.eu-patient.eu/globalassets/policy/cross-borderhealthcare/cbhc-summary-report-final-2015.pdf***

## *HEALTH LITERACY IN EUROPE – STOA WORKSHOP*

On July 1st, a workshop took place in the European Parliament on Health Literacy in Europe *"Empowering patients- how can technology contribute to improving health literacy"*. The workshop was organised by the European Parliament Science and Technology Options Assessment Committee (STOA). STOA is an independent expert body of the European Parliament that provides assessments of the various scientific or technological options in different EU policy sectors.

Health literacy refers to people's knowledge and capacity to access, understand, and use health information in order to make sound health decisions in the context of everyday life.

While European health systems are facing important challenges such as budgetary restrictions, an increase in chronic diseases and a shortage of health professionals, there is a real need to promote health literacy and empower citizens to take care about their health. Indeed, low health literacy has an impact on the management of chronic diseases leading to a higher mortality and an increase of healthcare costs.

The aim of the workshop was to review the current situation of health literacy in Europe and to express recommendations for the future.

Kristine Sorensen from the University of Maastricht presented the results of the European Health Literacy Survey which was conducted from 2009 to 2012. The survey highlighted that one over two interrogated people experience challenges with health literacy. Besides, health literacy depends on people's social status and living environment.

60 % of the people look for health information on the internet, Terje Peesto from DG CONNECT said. Accordingly, Kaisa Immonen-Charalambous from the European Patients' Forum affirmed that patients face an overload of health information while they doubt if they can trust the quality of such information.

Roberto Bertollini from the WHO representation to the European Union presented some recommendations stemming out from the WHO Regional Office for Europe's booklet on "Health Literacy- The solid facts". In this way, he advocated the need to strengthen the evidence base for health literacy as well as to share knowledge in Europe.

It was recommended to promote health literacy monitoring by supporting the networking and cooperation of health professionals. In this respect, it was called for a well-integrated health professionals' management as well as a transformation of their training.

Concerning patients 'participation, Marc Lange from the European Health Telematics Association (EHTEL) claimed that patients should be provided with an access to their own medical data by using electronic health records. Such action would enable them to get a better knowledge of their health situation and better interact with doctors for making health decisions.

Finally it was agreed that health literacy should be put on the EU policy agenda uniting policies from different sectors (e.g. employment, education, health, etc.), researchers and practitioners in order to increase access to healthcare thereby improving citizens' quality of life.

***The WHO Regional Office for Europe booklet on "Health literacy- the solid facts" is available at:***
***http://www.euro.who.int/__data/assets/pdf_file/0008/190655/e96854.pdf***

***More information on the European Health Literacy Survey from the University of Maastricht is available at:***
***http://www.maastrichtuniversity.nl/web/Institutes/FHML/CAPHRI/DepartmentsCAPHRI/InternationalHealth/ResearchINTHEALTH/Projects/HealthLiteracyHLSEU.htm***

## *ALLERGY AND ASTHMA PATIENTS NEED CLEAR AIR IN EUROPE – EUROPEAN PARLIAMENT MEETING*

On 1st July 2015, HOPE attended a policy meeting of the European Parliament Interest Group on Allergy and Asthma, co-organised by the European Academy of Allergy and Clinical Immunology (EAACI) and the European Free Alliance (EFA).

The meeting was co-hosted by MEP Nessa Childers (S&D, Ireland) and MEP Sirpa Pietikainen (EPP, Finland). The aim was to discuss and debate the ongoing EU efforts to review clean air legislations in Europe ahead of the Environment, Health and Food Safety (ENVI) committee vote on the National Emission Ceilings (NEC) Directive.

The meeting was divided into three parts. The first part of the meeting was dedicated to the topic "Allergy, asthma and air quality in Europe- What we know, where we are going, what EU should do?" A presentation was given by Prof. Jeroen Buters, Chair of the European Academy of Allergy and Clinical Immunology (EAACI) Group on Aerobiology and Pollution. He explained that since 1960's, allergies have increased in Europe. This phenomenon can be explained both by the increasing pollution and life style factors.

The second part of the meeting focused on "Allergy and asthma in the context of the revision of clean air legislation at EU level", presented by Mr Thomas Verheye, Head of Unit C3 – Air quality at the European Commission DG Environment and Ms. Anne Stauffer, Deputy Director of Health and Environment Alliance.

For Mr Verheye, there is a serious air problem in Europe. It is one of the environmental causes of premature death (over 400 000 premature deaths in 2010, 10 times more than traffic incidents). For this reason, a revision of the Directive on the National Emission Ceilings is needed. In fact, enhanced measures would not only be of benefit for the environment but would also generate lower healthcare cost, higher productivity of workforce and less damage to building.

First, Mrs Stauffer showed a video which reveal how much Brussels is a polluted-city. Then, she talked about "The Lancet Report" which explains how climate change is a medical emergency, why climate change affects health and the potential risk for human health if things remain unchanged.

The third part was a roundtable discussion animated by Prof. Antonella Muraro (EAACI President), Ms. Christine Rolland (EFA President), Mr Dan Murphy (European Asthma Research and Innovation Partnership) and Ms. Ingrid Kossler (European Economic and Social Committee). Prof Muraro is a paediatrician and therefore her speech focused on children issues. In fact, pollution provokes severe allergic manifestations, like food allergies which will affect more and more the current and next generations. Ms. Rolland talked about the risk that by 2025 more than 50% of the European population will suffer of at least one type of allergy. To her, access to clean air is a fundamental right. Mr Murphy demonstrated that high level of pollution provokes allergy or breath diseases. This brings to take medications so it is negative for healthcare systems. Finally, Ms. Kossler said that pollution is a common enemy in Europe and that it is possible to change attitudes.

***More information:*** ***http://knowyourairforhealth.eu/***

## *THE STATE OF TRUST IN THE HEALTHCARE SECTOR*

On 1st July 2015, Edelman Brussels presented the 15th annual Edelman Trust Barometer, conducted across 27 countries. This global survey includes a part on trust in healthcare and its implications on regulation and innovation.

Among the general population, a majority believes that health is not sufficiently regulated while less than one in five considers that health is too regulated.

When comparing the EU countries to the global trust numbers, trust is consistently lower in the EU compared to the global average.

Innovations in healthcare are perceived as driven by technology and business targets, rather than improving people's lives. A key message is that innovations need to earn the trust of the population. Transparency and third party validation of innovations are considered essential.

***The 2015 Edelman Trust Barometer is available at:***
***http://www.edelman.com/2015-edelman-trust-barometer-2/trust-and-innovation-edelman-trust-barometer/global-results/***

## *OUTSIDE-IN: DIGITAL HEALTH REVOLUTION? – POLITICO EVENT*

On 1st July 2015, HOPE attended in Brussels the event *"Outside-In: Digital health revolution?".*

The event was organised by POLITICO in collaboration with Philips and the Permanent Representation of the Netherlands to the EU. POLITICO is a global politics and policy news organisation headquartered in Washington DC. In April 2015, a European edition of the publication was launched aiming at covering politics, policy and personalities of the EU.

The aim of the event was to examine the opportunities and challenges facing the widespread deployment of digital health care in Europe. It was attended by a wide range of stakeholders active in the health area, EU institutions, consultancies and industry.

The scene was set by Jeroen Tas, CEO Healthcare Informatics, Solutions & Services at Philips. He stressed how 80% of health spending is devoted to chronic diseases care. He also pointed out that today we are assisting to a shift towards accountable care, based on paying for outcomes. Finally, he also mentioned that health is about consumers and represents an important part of the market. There is currently a gap between what technology can offer today and its uptake. Like in other sectors, we need to think in terms of customer segmentation to produce products targeted to the needs of patients and thus reduce costs.

The event continued with an interview of Alexander De Croo, Deputy Prime Minister of Belgium. He underlined that by 2020 almost all jobs will require digital skills, a real challenge knowing that today in Belgium only 50% of the workforce possesses such skills. He also stated that open data are the way forward as data are community goods; databases such as the one of INAMI (National Institute for Health and Disability Insurance) should be made publicly available.

Regarding privacy, according to Mr De Croo the solution would be the empowerment of the individual who will be the responsible of his/her own data and able to opt-out from its use.

It followed a panel discussion with Seán Kelly MEP (EPP, Ireland), Nicola Bedlington (Secretary General – European Patients' Forum), Zoran Stančič (Deputy Director-Genreal – DG CNECT) and Mark Willems (Founder and CEO – Minddistrict). MEP Kelly gave an update about the status of the negotiations for the review of the General Data Protection Regulation. The first trilogue took place on 24 June; the challenge will be to find a balance between the rights of the data subjects and opportunities for companies to grow. He also mentioned that the introduction of a specific consent for research purposes will impede valuable research to be carried out in Europe.

Providing the patients' perspective, Ms. Bedlington highlighted that patients are happy to share their data thereby contributing to medical research and mentioned the importance for eHealth solutions to be available for all patients, not just the most privileged.

Mr Stančič from DG CNECT reminded that with the strategy for a Digital Single Market, the Commission aims to remove main obstacles and fragmentation still existing across the EU. Common standards enabling interoperability of digital solutions across borders are also needed. Questioned about the gap between technology today available and its uptake in Member States, he pointed out that indeed tools should be provided to Member States which help them to benefit the most from innovative solutions.

Finally, Mark Willems pointed out from a SMEs perspective that legal security and reimbursement still remain important barriers to innovation. Thus, he invited to recognise the important role played by healthcare providers and health insurances as they represent the main enablers for innovative health solutions to be adopted on a wide scale.

## *MEP INTEREST GROUP ON BRAIN, MIND AND PAIN*

On 24 June 2015, HOPE attended in Brussels the MEP Interest Group on brain, mind and pain. The group is composed of Members of the European Parliament (MEPs) who have a particular interest in improving the welfare of people living with neurological and pain conditions. The group is co-chaired by Marian Harkin (ALDE, Ireland), Jeroen Lenaers (EPP, Netherlands) and Daciana Octavia Sârbu (S&D, Romania). It is supported by the European Federation of Neurological Associations (EFNA) and Pain Alliance Europe (PAE), pan-European umbrella organisations which together represent national and European patient advocacy groups.

Every year, 1 in 3 Europeans are affected by brain disorder and 1 in 5 by chronic pain. Neurological and pain disorders have a huge societal and personal impact. New treatments are urgently needed to improve the economic output and quality of life of patients.

Opening the meeting, Ms. Audrey Craven, EFNA Past President, highlighted the important role played by patient organisations: they represent the most important source from which patients get information about their condition. Thus, such organisations must be appropriately supported and resourced.

Dr Jennifer Barnett from the University of Cambridge revealed that many neurological disorders which are deemed "unpreventable", can certainly be prevented – at least in part – through simple lifestyle modifications. She used the example of Alzheimer's disease in which approximately 50% of the risk of developing the disease is attributable to seven modifiable risk factors (i.e. depression, physical inactivity, hypertension, obesity, low education, smoking and diabetes). Contrarily to common belief, Alzheimer disease starts in the brain at the age of 20-30. A preventive attitude and healthy lifestyle must be adopted earlier in lifetime and education is key to achieve this objective.

MEP Marian Harking stressed how important is to receive feedback from patient organisations so that policymakers understand how they can input at best on legislation and policies. She mentioned that the project of putting forward a legislative proposal for a musculoskeletal Directive failed because of resistances in the Council. However, she renewed her commitment to continue the work on this area envisaging a different non-legislative instrument such as a framework.

The next meeting of the interest group will take place on 14 October and will focus on the topic of stigma.

***More information:*** ***http://www.brainmindpain.eu/***

# AGENDA

## UPCOMING CONFERENCES

### *HOSPITAL+ INNOVATION CONGRESS*

***21-22 October 2015 – Odense (Denmark)***

The Hospital+ Innovation Congress will take place on 21-22 October 2015 in Odense (Denmark).

In the next ten years, Denmark will invest more than €5.6 billion in 16 new hospitals projects. These include new greenfield projects as well as expansion of existing capacity.

The congress is an open invitation to the international health community to join the discussion and to co-create innovative solutions to current issues under this year's themes, patient involvement and increased efficiency. At the congress, you are invited to learn about Danish perspectives of building hospitals and to contribute to future healthcare solutions.

In 2013, the conference was a great success with more than 350 participants from all over the world networking and sharing knowledge with their peers in an international environment.

***More information:*** ***http://www.hospitalplusinnovation.com/***

### *STUDY VISIT*
### *ASSURING QUALITY IN THE ENGLISH NHS*

***29-30 October 2015 – Dartford (Kent - UK)***

HOPE UK member is organising on 29-30 October 2015 a study visit for senior healthcare professionals, managers and policy makers on "Assuring quality in the English NHS".

The English NHS has seen significant reforms in the past 5 years, with an increasing focus on the quality of care provided. This study tour is aimed at clinical and managerial colleagues working in senior operational, policy or strategic roles in other European health systems. The two-day programme will provide delegates with a deeper knowledge of the NHS in England, including how healthcare is purchased and regulated from both a financial, quality and safety perspective. Additionally, there will be a strong focus on the largest component of the workforce in the NHS - its nurses - and how important nurses and nurse leadership is in providing and maintaining quality.

The event will hear from national healthcare policy makers, regulators, commissioners (purchasers) and leaders. There will also be a local focus, with the opportunity for a hospital tour and to see how national policy is interpreted and implemented locally to provide high quality care. A more detailed programme will be available shortly.

The hosts for the visit are Dartford and Gravesham NHS Trust, which offers a comprehensive range of mainly acute hospital based services to more than 270,000 people in Kent, in the South East of England. The Trust's specialties include day-care surgery; general surgery; trauma; orthopaedics; cardiology; maternity and general medicine. The Trusts team of nearly 3000 professional and friendly staff provide care for patients across the full range of day-patient, in-patient and out-patient care.

Dartford can be reached by fast, and direct, trains from Central London.

**Deadline for application is 15 October 2015.**

***Provisional programme***

***For more information, or to register your interest, please contact:***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## *EUROPEAN HOSPITAL CONFERENCE*

***19 November 2015 – Düsseldorf (Germany)***

The 3rd Joint European Hospital Conference (EHC) will takes place as part of MEDICA 2015 on 19 November 2015.

The EHC will address different political, medical and economic topics from across all of Europe. Dr Vytenis Andriukaitis, Commissioner for Health and Food Safety within the EU Commission, plans to participate in this conference.

High-ranking speakers from the European Hospital and Healthcare Federation (HOPE), the European Association of Hospital Managers (EAHM) and the Association of European Hospital Physicians (AEMH) will take a detailed stance on the topics:

- patient-oriented hospital care in the future;
- patient-oriented hospital care in the practice.

All presentations will be translated simultaneously into English, French and German.

***More information:***
***http://www.medica.de/cipp/md_medica/custom/pub/content,oid,33332/lang,2/ticket,g_u_e_s_t/src,EHC2/~/EUROPEAN_HOSPITAL_CONFERENCE.html***

## *HOPE AGORA 2016*
## *INNOVATION IN HOSPITALS AND HEALTHCARE: THE WAY FORWARD*

***6-8 June 2016 – Rome (Italy)***

In 2016, HOPE celebrates its 50th anniversary. To mark this occasion, HOPE Agora will be organised in Rome (Italy), the city where HOPE was founded in 1966.

HOPE Agora will take place from 6 to 8 June included and will conclude the HOPE Exchange Programme, which in 2016 will reach its 35th edition. This 4-week training period starting on 9 May 2016 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 topic of the HOPE Exchange Programme 2016 will be "**Innovation in hospitals and healthcare: the way forward**". The topic of 2016 will be a follow up of the Programme 2015 "Hospitals 2020: hospitals of the future, healthcare of the future", which was all about innovations in management and organisation of hospitals and healthcare services. Innovations are taking place in all kinds of fields: patient care, human resources, information systems, finances, quality management, etc. Considering the enormous diversity of systems and practices in Europe, what is innovative in one place might of course be common practice in another.

**Applications for the HOPE Exchange Programme 2016 are now open. Deadline for application is 31 October 2015.**

***More information on the HOPE Exchange Programme 2016:***
***http://www.hope.be/04exchange/exchangeprogramme2016.html***

***More information on HOPE Agora: http://www.hope-agora.eu/***