NEWSLETTER

N° 94 – JUNE 2012

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From 11 to 13 June 2012, the German Hospital Federation welcomed in Berlin the HOPE Agora 2012 around "Ageing health workforce - ageing patients: multiple challenges for hospitals in Europe".

The three days were devolved first to internal meetings (Governors, Liaison Officers and National Coordinators), then to the conference HOSPAGE and finally to the evaluation event of the 31st HOPE Exchange Programme.

BOARD OF GOVERNORS

HOPE Board of Governors was the starting point of three days of work. In the context of the financial and economic crisis, and to improve equity between members, Governors took the important decision of bringing a new criterion, GDP per capita, in the fee mechanism.

The crisis and its impact on health were also at the core of the debates and priority setting for the coming year. Earlier this year HOPE published an updated review of country-by-country crisis impact.

It was also devoted to the major healthcare related issues on the EU agenda: the transposition of the cross-border directive, the revision of the professional qualifications directive and the public procurement directive.

From the left to the right: Dr. György HARMAT (Hungary), Mr. Marc SCHREINER (Germany), Mr. Simon VRHUNEC (Slovenia), Mr. Francisco Antonio MATOSO (Portugal), Mrs. Eva M. WEINREICH-JENSEN (Denmark), Dr. John M. CACHIA (HOPE Past-President – Malta), Mrs. Dr. Ulrike SCHERMANN-RICHTER (Austria), Dr. Jaroslaw FEDOROWSKI (Poland), Mr. Georg BAUM (HOPE President – Germany), Ing. Joe CARUANA (Malta), Mrs. Dr. Sara C. PUPATO FERRARI (HOPE Vice-President – Spain), Mrs. Miek PEETERS (Belgium), Mrs.Dr. Vesna DJURIC (Serbia), Mr. Pascal GAREL (HOPE Chief Executive), Mrs. Pascale FLAMANT (France), Mr. Urmas SULE (Estonia), Mr. Yves-Jean DUPUIS (France), Mr. Marc HASTERT (Luxembourg), Mrs. Elisabetta ZANON (United Kingdom), Mr. Robbert SMET (Netherlands)
Present but missing on the photograph: Mrs. Dr. Aino-Liisa OUKKA (Finland), Mr. Erik SVANFELDT (Sweden)

HOSPAGE — AGEING HEALTH WORKFORCE - AGEING PATIENTS

In the last years, this issue has raised among European healthcare systems. The WHO European Observatory on health systems and policies has published a number of studies on the topic and more important the European Commission released in April 2012 an Action Plan in order to tackle the challenges linked to this trend around the European Innovative Partnership on Active and Healthy Ageing. The event gathered several hundred of participants.

Georg Baum, President of HOPE and Chief Executive of the German Hospital Federation, welcomed Mr. Daniel Bahr, the German Minister of Health, followed by a video message of Mr. John Dalli, European Commissioner for health. Recognising the importance of the event and relevance of the topic, speakers highlighted the need of learning from each other, foster innovation, improve prevention and workforce planning.

Conference keynotes were delivered by Mrs. Rita Süssmuth, former President of the German Parliament, and by Mr. Josep Figueras, director of the WHO European Observatory on health systems and policies.

Prof. Süssmuth provided the audience with an interesting view about the need of anticipating the future both for professionals and for patients, seeing the latter as citizens first, and being able of thinking out-of-the-box. Social networks of policy actors and active population need to include both young and older ones, and need to be committed in finding a new way to cooperate, being pioneers of change, fostering research in human science and not only in system research, trying to look for the potential of people and fostering continue long-life learning and re-learning.

Josep Figueras provided an overview of societal trends, exploring causes, effects and possible solutions, still leaving many opened questions: is ageing population a fiscal failure? Do we live longer to suffer even longer or have we found an equilibrium that allows us to better cope with chronic, even multiple diseases? Do, in the end, hospital pay the financial and societal cost of broader failures in the health systems? Are we delaying the change of hospital care patterns, still running hospitals as if we have normal elective, predictable patterns of diseases?

In the panel discussion that followed, Mr. Georg Baum, Mrs. Maria Iglesia Gomez from the European Commission, Mr. Evert Jan van Lente representing the European Social Insurance Platform (ESIP) and Mr. Anders Olauson, President of the European Patients' Forum (EPF), exchanged views on these future trends, how to face changes and on the European Partnership on Active and Healthy Ageing that the latter had promoted.

Parallel session 1 — Ageing health workforce

The first parallel session of the conference on the topic of "Ageing health workforce" was opened by Prof. Juhani Ilmarinen with an overview of the change of work ability across life years. He highlighted some elements – such as work arrangement, continue training, flexibility, promotion of alternative lifestyles, fair treatment – that improve work ability and satisfaction in older professionals reducing absence rates and work disability and increasing productivity.

Mrs. Eva Weinreich-Jensen (Danish Regions) gave the perspective of Regional Authorities. Focusing on skills, not on age, considering age and experience a resource, not a weakness, and then evaluating options to adjust the job when relevant are the answers to changing needs of patients and to professional patterns more adapted to the changing needs of the workforce.

Prof. Walter Sermeus (coordinator of EU-funded project RN4cast) illustrated some findings of the project RN4cast aimed at forecasting the future needs of nursing staff in Europe and in the United States. Despite the large variability across hospitals and health systems, the project results show that perceptions of nurses and patients about hospitals are related. There does exist a high consistent relationship between working environment and indicators of job satisfaction (burnout, intention to leave) and nurse staffing has a significant impact on patient outcomes (mortality) in 9 European countries.

Finally, Mrs. Caroline Hager (European Commission) illustrated the Action Plan for the EU health workforce. Pursuing the aims of improving workforce planning, anticipate skills needs, increase recruitment and retention, foster international ethical recruitment the action plan foresees better cooperation between Commission, Member States, stakeholders and social partners, better coordination across policies and an increasing use of European funds across these actions.

Parallel session 2 — Ageing patients

The second panel discussion on the topic of "Ageing patients" was opened by Dr. John Cachia, Past-President of HOPE. He illustrated the Maltese agenda on active ageing. In 2011, Malta established the Office of the Commissioner for Older Persons with the role of promoting awareness, protect, uphold and safeguard the matters relating to the rights and interests of older persons. Malta strategy for ageing well includes an active contribution in all areas of community life, flexible responses to needs and preferences and a more friendly physical and social environment.

Dr. Božidar Voljč (AGE Platform Europe) from the Anton Trstenjak Institute of Gerontology and Intergenerational Relations, Slovenia put the accent on the role of different elements influencing patients' behaviour, needs and expectations in different areas such as the use of primary care, hospital stay, consultations, drug consumption and palliative care.

Finally Prof. Elisabeth Steinhagen-Thiessen from the Charité University hospital of Berlin discussed factors affecting ageing and their interdisciplinary relationships, and the patterns of multidimensional diagnostics and integrated care adopted in Germany.

A further presentation about the reconciliation of work and elder care was given by Mrs. Anine Linder, project manager of "Network Success Factor Family", Germany. The network, that currently has 4000 members (employers), was established in 2007 as an initiative of the Association of the German Chambers of Industry and Commerce and the German Federal Government. It provides information and services about the reconciliation of work and family life, shows companies' commitment to family friendly HR strategy being based on the idea that companies learn from each other and turn family friendliness into a trademark.

A wrap up session reporting on the results of the two parallel sessions concluded the conference.

EVALUATION CONFERENCE

The 121 participants of the 31st edition of the HOPE Exchange Programme were asked to focus during their stay abroad on the consequences of ageing both of patients and healthcare professionals.

They were bringing back to Berlin the results of their 4-week stay abroad with 20 presentations by country of destination.

Like pervious years, a prize has been awarded to the three best country presentations, chosen by the HOPE National Coordinators.

Latvia won the first prize for the best presentation.

Denmark won the second prize.

The third one was awarded to the health professionals who stayed in Belgium.

All presentations and photographs will soon be available on HOPE Agora website:
www.hope-agora.eu

More information and presentations on HOSPAGE:
www.hospage.eu

CYPRUS STARTS PRESIDENCY OF THE COUNCIL OF THE EUROPEAN UNION

On 1 July 2012, Cyprus started its mandate holding the Presidency of the Council of the European Union for the next six months, following the Polish and Danish Presidencies and being the last Member State of the current Trio Presidency.

The Cyprus Presidency has declared its commitment to work towards the creation of a more effective Europe, which would have solidarity as an underlying principle, contribute to growth and job creation, promote social cohesion and provide hope to its citizens. Cyprus also stated its wish to concentrate its efforts on creating a better Europe for younger generations, as well as strengthening Europe's role in the international scene.

The six months programme of the Cypriot Presidency will focus on four priority areas:

- Europe, more efficient and sustainable
- Europe, with a better performing and growth economy
- Europe, more relevant to its citizens, with solidarity and social cohesion
- Europe in the world, closer to its neighbours

In the field of health, the Presidency will prioritize the following areas.

HEALTHY AGEING ACROSS THE LIFECYCLE

Being one of the main objectives of the European Health Strategy 2008-2013, this issue has also been addressed by previous Presidencies, which have emphasized the importance of prevention and health promotion from early years of life to achieve healthy ageing.

Taking into consideration the current economic crisis and the ageing of population, the Cyprus Presidency will aim at underlining the need to review the structure of health care services and redirect investments for cost reduction in the healthcare sector. In addition, it will also work on collecting evidence and highlighting best practices, which prove that Healthy Ageing is a matter of continuous process.

LEGISLATIVE PROPOSAL ON SERIOUS CROSS-BORDER THREATS TO HEALTH

In December 2011, the European Commission adopted a legislative proposal on serious cross-border threats to health, aiming at protecting European citizens from a wide range of health threats such as chemical, biological or environmental in nature and the provision of fully co-ordinated response in the event of a crisis. The Cyprus Presidency, taking into account the Commission's initiative, as well

as the fact that collaboration should not only be limited to EU level but extended to other neighbouring non-EU countries and international organisations, will further develop activities towards this direction.

ORGAN DONATION AND TRANSPLANTATION

Recognizing the shortage in human organs intended for transplantation throughout Europe, the Cyprus Presidency aims to highlight the need for coordinated actions in the field at community level. The Presidency plans to adopt Council Conclusions, which will further invite the Member States, the European Commission and the other EU institutions for concrete actions in ensuring public awareness on the importance of organ donation and transplantation and securing EU funds for the development of respective programmes in this field.

PHARMACOVIGILANCE

The legal framework of pharmacovigilance is defined by the EC Regulation 726/2004 on medicinal products, centrally approved by the Directive 2001/83/EC for products approved on national level. In September 2010, the European Parliament approved the amendment of the Directive 2001/83/EC and the Regulation (EC) 726/2004 on pharmacovigilance, with the objective of achieving greater patient safety and promoting improvements in public health. The new legislation will come into force as from July 2012.

CLINICAL TRIALS

On 10 December 2010, the Commission published a Communication for "*Safe, Innovative and Accessible Medicinal Products: a new vision for the pharmaceutical sector*", which announced the forthcoming evaluation of the implementation of the Directive on clinical trials. In February 2010, a public consultation was launched, based on a discussion paper on the revision of the Directive 2001/20/EC and a proposal for a revised legislation that regulates the clinical trials is expected to be dealt with by the Working Party on Pharmaceuticals and Medical Devices during the Cyprus Presidency.

TRANSPARENCY OF MEASURES REGULATING THE PRICING OF MEDICINAL PRODUCTS FOR HUMAN USE AND THEIR INCLUSION IN THE SCOPE OF NATIONAL HEALTH INSURANCE SYSTEMS

In March 2012, the Commission adopted a proposal for a Directive on the transparency of measures that regulate the pricing of medicinal products for human use, as well as their inclusion in the public insurance health systems and the cancellation of Directive 89/105/EEC. The proposed Directive aims to simplify the procedures and to replace the Directive 89/105/EEC, which no longer reflects the complexity of pricing and reimbursement procedures within the member states. The discussion of the proposal at the Working Group on Medicinal Products and Medical Devices has been initiated by the Danish Presidency and it will be continued by the Cyprus Presidency.

MEDICAL DEVICES

The results of a public consultation launched in May 2008 in the possible recasting of the medical devices directives led to the need for a fundamental revision of the existing directives in order to simplify and strengthen the current EU legal framework for medical devices to meet the growing expectations of European citizens. Additionally, the recent incidents with breast implants and large Metal-on-Metal hip replacements, revealed the need for increased coordination between the Member States in order to guarantee patient safety. The Cyprus Presidency will initiate the discussions of the new legislative proposals at the Council.

More information:
http://www.cy2012.eu/en/page/health

Public Health

COUNCIL MEETING: EMPLOYMENT, HEALTH, SOCIAL POLICY AND CONSUMER AFFAIRS

On 21 and 22 June 2012, the Danish Ministers for Employment (Ms. Mette Frederiksen), Social Affairs and Integration (Ms. Karen Hækkerup) and Health and Prevention (Ms. Astrid Krag Kristensen) met in Luxembourg for the 3177th Employment, Health, Social Policy and Consumer Affairs Council meeting.

In regards to the third multi-annual EU programme in the field of health for the period 2014-2020, the Ministers agreed on a partial general approach. The general approach is partial because the budget to be made available for the next EU public health programme will depend on the outcome of the negotiations on the next multiannual framework. The Commission proposed to support the new programme with an amount of EUR 446 million (in current prices).

Ministers also held an orientation debate on a draft decision on serious cross-border threats to health. Member States emphasized the importance of preparedness against serious cross-border threats to health, and said they believed that it could be achieved through coordination and the exchange of information between Member States within the health security committee (HSC), rather than an obligation for prior consultations or recommendations by the Commission. This was regarded important in order to respect national competencies in the field of health and to be in line with article 168 of the Treaty on the Functioning of the EU.

Ministers supported the Commission proposal to provide a legal mandate to the health security committee. Regarding the composition of this committee, most ministers argued for a standing committee of high representatives nominated by public health authorities with the possibility of inviting experts on a case-by-case basis.

Member States confirmed their wish to delete article 12 of the Commission proposal, which envisages the possibility of binding common temporary public health measures at EU level. Instead, they shared the view that Member States should deal with urgent cases of cross-border health threats through the HSC.

In addition, the Council adopted conclusions on the impact of antimicrobial resistance (AMR) in the human health sector and in the veterinary sector (10347/12), calling upon Member States to develop and implement national strategies or action plans for countering AMR.

The conclusions also strongly encouraged Member States and the Commission to examine the conditions of prescription and sale of antimicrobials in order to assess whether practices in human and animals healthcare may lead to over-prescription, overuse or misuse of antimicrobials.

TISSUES AND CELLS – EUROPEAN PARLIAMENT PUBLIC HEALTH COMMITTEE RESOLUTION

In a resolution adopted by the public health Committee 54 votes to 4 on 21 June 2012, MEPs called on to Member States to ban financial incentives for donation of tissues and cells and to clearly define the conditions under which financial compensation may be granted.

Currently, a minority of EU countries have guiding principles on compensation or incentives.

"Too few mothers are donating umbilical cord blood which leads to needless deaths. I hope that my report will increase the sharing of best practice in the European Union so that other Member States can build on the success of cord blood collection schemes in the United Kingdom run by NHS Blood and Transplant (NHSBT) and the Anthony Nolan Trust", Rapporteur Marina Yannakoudakis (ECR, UK) said.

While acknowledging that healthcare remains mainly a national responsibility, MEPs recommend that EU countries should cooperate better on cross-border donations. Their resolution says that patients could benefit further if EU countries worked more closely with Eurocet, the European registry of tissues and cells.

The committee points to the potential benefits to medicine of using stem cells. It says public and private cord blood/stem cell banks should cooperate better and Member States should provide a regulatory framework to ensure the banks operate in a highly transparent and safe way.

MEDICAL DEVICES – EUROPEAN PARLIAMENT'S RESOLUTION ON PIP

On 14 June 2012, the European Parliament (EP) adopted in final vote the PIP resolution. The Parliament fully endorsed the wording that was originally proposed by the Environment and Health Committee (ENVI) on 26 April 2012.

The adopted resolution calls on the Commission for measures to increase patient safety and improve the current regulatory system including:

- the strengthening of the designation and control of Notified Bodies in the EU, also with respect to their skills and resources;

- better vigilance reporting and coordination of Member States on incident assessments;
- increased and unexpected controls of manufacturers by notified bodies based on experience from the post-market phase;
- establishing tools to ensure the traceability of devices, in particular implants;
- establishing registers for implants and having the registers interconnected.

The European Parliament also called for - although with a thin majority - a Pre-Market Authorisation (PMA) system for medical devices, as is already the case for pharmaceuticals. The industry representatives complain that adopting a pharma-like system for devices would not address the different nature and innovation cycles of medical technologies. According to them, it may cause years of delay in the availability of medical technology solutions to European citizens and a loss of European innovation competitiveness compared with other regions.

In his address to the Parliament Commissioner's Dalli announced that the proposal by the European Commission would include a pre-market scrutiny mechanism for the quality of Notified Body assessments for high-risk devices.

ACCESS TO MEDICINES IN EUROPE – FACILITATING SUPPLY IN SMALL MARKETS

The Project group on facilitating supply in small markets was meeting on 22 May 2012 in Ljubljana, Slovenia.

This was the third face-to-face meeting of the project group on facilitating supply in small markets launched by the Commission in the framework of the Platform on access to medicines in Europe of the process of corporate responsibility in the field of pharmaceuticals.

Further to previous meetings and teleconferences, the group had agreed to launch a mapping exercise and two questionnaires, one for competent authorities and one for economic operators the results of which would be analysed with the scientific support of EMINET.

The group continued to discuss experiences of Member States and stakeholders in the area.

Iceland showed in its presentation that the problems associated with being a small market could be overcome by being in a bigger market and that the financial crisis, their size and geographical position are decisive factors and reasons for shortages. They want access to market instead of access to medicines. Especially in the generics segment, the extent of entry is below their expectations. Language in Iceland is a barrier for the market, for example for the orphans. They import specific medicines on a name patient basis but it costs too much. They propose to print leaflets in pharmacies as a possible solution to their problem. Generic substitution is mandatory; doctors are allowed to prescribe on an INN basis. Given the historic links with Denmark, their

familiarity with Danish language and the fact they used to be part of the Danish pharmaceutical market, revitalising this bond is deemed as an option and Iceland is actively exploring it. They added that this approach may be considered by other countries as well.

In Lithuania, the old cheap products disappeared from their market and they do not apply for renewal of market approval. They have to import on a name patient basis. The small size of the market makes it unattractive for companies. They propose to try to introduce innovative solutions in smaller markets. There is a lack of generics in their market and they do not have enough money to reimburse new medicines.

The UK Pharmaceutical Services Negotiating Committee was invited to make a presentation, not as a stakeholder from a small market, but as a stakeholder with experience in mapping of deficiencies in cooperation with other interested parties. The shortages are recorded in an open publicly database and the group was interested to know whether that helps to tackle the problem. They represent 11000 pharmacies and are funded by them, at the same time recognised by the Ministry of Health. Main point of their presentation was the contingency supply routes in place: if a pharmacy cannot find a product through normal route they can go directly to manufacturers. The list of deficiencies represents the end of the supply chain. They have special criteria on when to include a product on the list and it is reviewed every month. This list has been effective but has not solved the problem of shortages of branded medicines. Their list works also at the request of manufacturers to report problems, for example manufacturing problems and advice how to obtain them. They have measures in places for driving prices down; when prices are tight, they have generic shortages. Their list was formally recognised by a Ministerial Summit in 2010, it was decided that it should be maintained and according to feedback from manufacturers there has been in some cases change in buying behaviour. Still, branded medicines are of primary concern. There is a legal framework to control the continuity of supply of medicines to patients.

The literature review performed by EMINET spotted three examples of international experiences: Eastern Caribbean States Pharmaceutical Procurement Service Pan American, Pan-American Health Organisation Revolving Fund for vaccine procurement and, Gulf Cooperating Council. The examples seem to be difficult to match in a European diverse setting.

EMINET presented then the preliminary results of the mapping exercise based on the input received by the group members. These preliminary results unfortunately showed divert deficiencies reported between countries, which made the analysis of results rather problematic. A possible cause for this was that the Member States had send only some examples of their products with shortages, and the questions had not predicted some of the diversities finally received. Exception was Slovenia who had sent the full list of approximately 100 products on their list of urgently needed unauthorised products. Different ideas were discussed on how to best validate the results or plan new questions. This was a challenging issue as it was estimated that it was not the best idea to reach any conclusions based on information provided for a limited list of products.

STANDARDISATION

On 31 May, the Danish EU Presidency announced that an agreement had been reached on the proposed regulation on European Standardisation.

The Presidency stated "the agreement will improve conditions for participation of business and stakeholders in the development of standards, ensure that standards reach the market faster, which will shorten the time span from idea to production, and boost the development of European standards for services." Danish Minister of Business and Growth further confirmed "the regulation creates the foundation for the development of more European standards for services" which "can contribute to innovation and growth, which is much sought after in Europe."

The regulation is expected to enter into force on 1 January 2013, following a vote in the European Parliament plenary sitting scheduled for 10 September and a formal approval by the Council.

While the regulation as agreed reportedly restricts the right of the Commission to request the development of European standards in the delivery and organisation of services in several sectors, including healthcare, this restriction will likely not affect further development of market-driven standards.

The European Committee for Standardisation (CEN) has already initiated or completed work on a number of standards in healthcare services, including on aesthetic surgery services, chiropractor services, quality management system of health services, hearing aid technicians services, osteopath services, and quality criteria health checks.

The text of the regulation now clearly refers to the subsidiarity principle, in particular in the field of health.

"The application of the legal framework allowing the Commission to request one or several European standardisation bodies to draft a European standard or European standardisation deliverable for services is exercised while fully respecting the distribution of competences between the European Union and the Member States as laid down in the TFEU. This concerns in particular Articles 14, 151, 152, 153, 165, 166 and 168 TFEU and Protocol No 26 on Services of General Interest from which it remains exclusively with the Member States to define the fundamental principles of their social security, vocational training and health systems and to shape the framework conditions for the management, financing, organisation and delivery of the services supplied within those systems, including - without prejudice to Article 168 (4) and to Directive 2005/36/EC - the definition of requirements, quality and safety standards applicable to them. The Commission shall not, by means of such a request, affect the right to negotiate, conclude and enforce collective agreements and to take industrial action in accordance with national law and practices, which respect Union law."

While it seems that this would not prohibit CEN own-initiative action on healthcare services, the compromise wording would at least appear more restrictive as to the Commission's competences to commission the development of a standard on healthcare service, than the European Parliament report's wording would have been.

DIRECTORATE-GENERAL TAXATION AND CUSTOMS UNION – VAT

On 15 May, the Economic and Financial Affairs Council adopted conclusions on Value Added Tax.

The conclusions invite Member States to review their tax systems with the aim of making them more effective and efficient, and removing unjustified exemptions. The Commission's position is to favour a restricted use of reduced rates of VAT. In this context the Commission will launch this year an assessment of the current VAT rates structure

In its conclusions, the Council of the European Union concurs with the need to examine in further detail the present EU rules on the application of VAT to the public sector, as far as there is competition between the public and private sectors. The Council also acknowledges the desire to clarify the rules concerning non-profit-making organisations.

MEPS AND COUNCIL NEGOTIATORS AGREE ON ENERGY EFFICIENCY DIRECTIVE

On 14 June 2012, after months of negotiations, MEPs and Council negotiators agreed on a provisional deal on the proposed energy efficiency directive.

Claude Turmes (Greens/EFA, Luxembourg), who led the negotiations, said: "This deal will give a boost to Europe's economy and help achieve our energy security and climate goals. The new energy efficiency legislation sets out binding measures, which will go a significant way towards bridging the current gap the EU faces in meeting its pledge to reduce energy consumption 20% by 2020. The legislation includes a number of crucial measures that will deliver concrete energy savings".

In regards to the Renovating of buildings, if adopted, the directive would require Member States to renovate 3% of the total floor area of "heated and/or cooled buildings owned and occupied **by their central government**". This means that only buildings owned by central governments (administrative departments whose responsibilities cover the entire territory of a Member State) will be under this obligation.

This would apply to buildings with a "total useful floor area" of more than 500 m², and as from July 2015, of more than 250 m². However, Member States would also be able to use alternative means to achieve equivalent energy savings, e.g. thorough renovation.

The text that was provisionally agreed on will be put to an Energy Committee vote in July 2012, which will be followed by a plenary vote in September 2012 (provisional agenda).

CARDIO-VASCULAR BENCHMARKING – EURHOBOP

EURHOBOP was holding its final meeting on 18 and 19 June 2012 in Barcelona.

EURHOBOP provides European hospitals with a validated set of statistical functions - including determinants of in-hospital case fatality outcome indicator - to benchmark themselves about the quality of the management of myocardial infarction or unstable angina patients and in the use of the treatments aimed at removing the coronary artery occlusion. Benchmarking hospital performance is a key instrument to improve the quality of care.

EURHOBOP was a project co-funded by the European Commission, under the Second Programme of Community Action in the Field of Public Health (2008-2013) and completed in summer 2012. It contributed to pursue the objective of "generating and disseminating health information and knowledge" and was based on the preliminary results obtained in the EUPHORIC (www.euphoric-project.eu) cardiovascular pilot study (DG SANCO project 2004-08).

The project was led by IMIM, the Municipal Institute of Health Assistance - Municipal Institute of Medical Research with the participation of organisations in seven countries, including the European Hospital and Healthcare Federation (HOPE).

In EUPHORIC (www.euphoric-project.eu) a set of functions predictive of EU Hospital performance in terms of management of coronary heart disease patients and some procedures used in their admission were successfully wound up. Under EURHOBOP, the functions were validated on real life data by enrolling a large number of hospitals.

EURHOBOP considered as outcome the "in-hospital case-fatality after the procedure", a hard, standardized end-point that can be easily retrieved from medical records and administrative discharge records. Hospitals were requested to provide data of 200 consecutive patients with discharge diagnosis of MI or UA retrospectively recruited. Hospital enrolment was carried out in two phases:

- through the already established network of the associated beneficiaries (10 hospitals in each of the seven country, enrolled as Associated collaborating partners: Greece, Germany, Spain, Italy, France, Portugal, and Finland);
- opening the invitation to all the European hospitals (enrolled as Affiliated collaborating partners).

Affiliated collaborating partners are hospitals that participated in the project by uploading a data base of at least 200 consecutive individual patient data. These data contributed to the validation process of the benchmarking mathematical functions developed within the EUPHORIC project. Affiliated Collaborating Partners are now included in the list of EURHOBOP partners and therefore

appear both in the EURHOBOP website (under the section "Partner description") and in all the produced documents (reports, scientific papers, etc.) as acknowledgment and credit for their contribution.

In-hospital case-fatality was considered as the outcome indicator in patients admitted for an acute coronary syndrome (ACS) who receive a discharge diagnosis of MI or unstable angina (UA) and undergo coronary angiography, thrombolysis, or percutaneous revascularisation (angioplasty with or without stenting) for general MI and UA patient management. Several risk functions (GLM multilevel models) were validated with different levels of adjustment, developed in EUPHORIC and new ones were developed.

The results consists in a set of validated hospital mathematical functions suitable to benchmarking European Hospitals by cardiovascular disease management performance and for European citizens to determine their risk of in-hospital death when submitted to these procedure. EUPHORIC indicators were obtained from European population-based MI-UA patient registry databases of more than 27,000 cases (Euro Heart Surveys ACS-I & II, ACSIS 2003 & 2005 and MASCARA 2005). This information permitted to fit several functions to benchmark hospitals according to their actual in-hospital case-fatality as compared to their expected outcome rates, i.e., those adjusted for country, hospital and average patient characteristics in the index hospital assessed.

Another specific objective was to explore the feasibility of including other indicators of performance in the benchmarking models. We will explore the feasibility of including other simple indicators of performance for the same procedures and condition management, such as admission duration, one-year readmission rates, or TIMI risk score to further adjust the benchmarking system European hospitals.

The results also show that the outcomes in these procedures and general MI and UA management do not differ by sex. There are no outcome inequalities between men and women in the use of these procedures and in disease management in European hospitals.

Once the final versions of the benchmarking functions are validated, they will be posted on the project web site with appropriate disclaimer and user contract specifications and a large sample of European hospitals invited to register and use them to benchmark themselves. The possibility will also be offered to allow public presentation of their results in the EURHOBOP project web site summarised in a downloadable report.

More information available on:
www.eurhobop.eu

HEALTHY AGEING – PROJECTS SUBMITTED

End of June 2012, the European Innovation Partnership for active and Healthy ageing has received a total of 261 projects submitted by groups of stakeholders from both the public and private sector.In addition to those 261 projects, 54 regions and municipalities proposed themselves as "reference sites", with the aim of exchanging good practices and sharing knowledge and experience on past successes in this field.

The Partnership gathers over 50 regions, ICT companies and health providers, with the objectives to solve issues and deliver solutions for:

- better adherence to medical treatment,
- prevention of falls,
- prevention of functional decline and frailty,
- integrated care models,
- independent living and active ageing,
- age-friendly buildings, cities and environments.

The Commitments were submitted by a wide range of stakeholders, with an especially high participation of universities and research groups (37%), public authorities (17%) and health providers (17%).

Six meetings were held in June 2012, enabling stakeholders to define action groups and agree on the implementation details of each specific action. Actions plans are due to be presented by each group at the conference of partners, which will be held on 6 November 2012. The first report of the Partnership's working groups' work will be published in 2013.

More information:
http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing

MENTAL HEALTH – LEONARDO PROJECT

The project "European Practices and Procedures for the Restriction of Liberty of Patients in Psychiatric Structures Benchmarking across European Countries - Case Studies and Staff Experiences" was holding its final meeting on 24 and 25 May 2012.

Four hospitals in 2009 introduced a Leonardo Mobility file to their respective National Agencies. The aim of „Psychiatry and Mental Health" was to share experiences and practices in the psychiatric and mental disorders fields. A significant conference was organised in Jury (France) and more than 100 participants from four countries were present at 60 lectures and workshops.

In 2010, 15 partners submitted a Leonardo Partnership file regarding liberty and psychiatry. The procedures in order to restraint the freedom of hospitalized patients in psychiatry are at the centre of numerous medical and judicial discussions. The objectives of this innovative project were to produce a comparative analysis between European countries, to publish recommendations in this field and to discover alternative ways or innovative experiences. In the follow-up of the 2009

Leonardo Mobility Programme there are currently 20 partners to carry out this project. Working groups investigated themes such as the procedures for deprivation of personal freedom, isolation rooms' equipment, the involvement of patients in the procedures, alternative options, etc.

Practices in psychiatric hospitals, in units specialized for difficult patients and in prisons were studied as far as the national laws as well as the Human Rights are concerned. The key steps were assessed individually.

The general goals of all these projects are quite simple but ambitious:
- to raise confidence between European mental health bodies;
- to enhance the quality of life of users in psychiatric structures as in the community;
- to enhance the level of qualification of the staff by sharing experiences and practices;
- to develop new validated approaches;
- to disseminate innovative experiences and best practices regarding mental healthcare;
- to reach these goals, visits, conferences and lectures are organised in several European countries.

More information:
http://www.mentalnet.eu/index.php/partnership-2010-2012/final-event-may-24-25-2012

EVALUATING CARE ACROSS BORDERS – ECAB PROJECT

The EU-funded research project ECAB, evaluating care across borders, was holding a meeting in Berlin on 24 and 25 May 2012.

The "Evaluating care across borders" project is looking into various issues relating to cross-border care in Europe:
- healthcare professionals;
- treatment pathways;
- medical records;
- prescriptions and medicines;
- patient choice and public reporting;
- long-term care;
- hospital collaborations;
- telemedicine and eHealth;
- fentistry;
- media reporting of quality of care.

This project brings together major academic researchers from several European universities (e.g. London School of Hygiene &Tropical Medicine, Semmelweis University, Universidad Barcelona, London School of Economics). HOPE is invited to serve as an observer within the "Users' Advisory Board" of the project.

This fourth meeting of project's partners essentially aims at giving an overview of the progress of the ECAB project and discuss management, milestones and deliverables; to review substantive progress on individual work packages; and to prepare policy recommendations.

On Hospital collaboration in border regions, seven case studies were examined: Finland-Norway, Germany-Denmark, the Netherlands-Germany, Belgium-France, Spain-France, Austria-Germany and Romania-Bulgaria. Interviews were conducted by each team responsible of a case study. Harmonised definition of hospital collaboration was established in order to allow comparison. The first findings identified many commonalities between all case studies but variety exists concerning:

- the format of collaboration, ranging from: recruiting, contracting, leasing, cross-border branch, multi-site, merger, building new hospital (to be opened) with two forms: either purchase abroad or joint capacities;
- composition of agreements: range from to involvement of authorities;
- length and stage of collaboration.

Pending questions mainly involved the need for collaboration. This was said to originate mainly from the need for new infrastructure but also because the healthcare sector was an important economic driver in the regions studied. Still areas to be explored encompassed the coherence of incentives and opportunity considerations.

PATIENT SAFETY AND QUALITY OF CARE – KICK-OFF OF THE JOINT ACTION

The Joint Action on Patient Safety and Quality of Care (PaSQ) was officially launched on 24 and 25 May 2012 in Roskilde, Denmark.

The Danish Minister for Health, Astrid Krag was present at the kick-off of PaSQ, whose prior objective is to support the implementation of the 2009 Council Recommendations on Patient Safety.

Coordinated by the French Haute Autorité de Santé (HAS), the Joint Action aims to achieve this by strengthening cooperation between EU Member States, international organisations and EU stakeholders on issues related to the quality of health care, including patient safety and patient involvement.

The Joint Action also plans to facilitate the exchange of information and establish common principles at the EU level through the integration of knowledge, experiences and expertise gathered from Member States and EU stakeholders.

In addition it will work on facilitating the development of Patient Safety programmes in Member States, provide support to those countries less advanced in the field and promote the involvement of stakeholders through national platforms organised around one PaSQ national contact point in every EU Member State.

More specifically, four core Work Packages (WP) will aim at achieving these objectives.

WP4 key objective will identify a series of transferable good patient safety practices and share these practices through exchange mechanisms in the form of meetings, study tours, placements, workshops, twinning or technical assistance and through an interactive web tool. WP4 will centre on

Patient Safety at the clinical level, within the healthcare institution, targeting health care professionals with a key position or decision-making role.

WP5 will centre on the implementation of selected good clinical practices in patient safety in healthcare organisations of the participating Member States. It will also select healthcare organisations for implementation, establish an implementation toolbox, monitor the implementation process and assess the implementation process.

WP6 will aim at strengthening cooperation between EU Member States and stakeholders on issues related to Quality Management Systems in healthcare, including patient safety and patient involvement/empowerment. WP6 will help support and catalyse sustained collaboration and establishing learning mechanisms among Member States and stakeholders.

Finally, WP7 will examine the drivers and barriers for sustained collaboration in the field of Patient Safety and Quality of Care (PaSQ) and secure further collaboration after the Joint Action. It will also work on identifying and contacting the main stakeholders in Member States, national public institutions, authorities, agencies and target groups.

TELEMEDICINE – MOMENTUM WORKSHOP

The MOMENTUM project had its first workshop in Luleå, Sweden on 20 and 21 June 2012.

MOMENTUM, which stands for the European Momentum for Mainstreaming Telemedicine Deployment in Daily Practice, is a platform where key players in telemedicine share their knowledge and experience in deploying telemedicine services into routine care.

The key objective of the project is to draft, test and finalise a Blueprint for telemedicine deployment that offers guidance for anybody who seeks to move telemedicine from an idea or a pilot to daily practice.

HOPE, who is a partner of MOMENTUM, was present at this first workshop, during which along a brief overview of the project, case studies from Norway, Italy and Spain were presented.

More information:
www.telemedicine-Momentum.eu

PATIENT INVOLVEMENT – EUROBAROMETER SURVEY

On 18 May, the Commission published a Eurobarometer Qualitative Study on Patient Involvement in healthcare.

The study revealed that the term "patient involvement" is not understood by patients or practitioners in the same way. The main risks of patient involvement, mentioned by both patients and practitioners, are increased demands on practitioners' time, and the possibility of patients disagreeing with doctors' opinions. The internet has helped patients to have greater access to information about their symptoms and healthcare as well as about healthcare options. Patients in Eastern European countries were identified as most likely to be dissatisfied with their current level of involvement in healthcare and wanting to be more involved.

While practitioners and patients alike see the benefits of patients being more engaged and taking more responsibility for their health, the more concrete benefits of involvement in healthcare process are not clearly focussed for either healthcare professionals or patients. For example, the perception of improved cooperation between the healthcare professional and the patient being effective to achieve better health outcomes, was only mentioned by a few respondents.

Communication was central to the idea of patient involvement for many. For patients, this meant practitioners explaining to them the diagnosis and treatment. For practitioners, it meant patients describing symptoms and keeping them updated on the progress of treatment. The main barrier to effective communication was the time available for doctors to spend with patients. Both patients and practitioners described how doctors had insufficient time to explain treatment options.

Many patients described a "traditional doctor-patient relationship", where the doctor was seen as beyond questioning and patients felt uncomfortable giving feedback. Where the relationship was seen to be on a more level arrangement, patients found it easier to provide feedback. For this reason, nurses were seen as easier for some patients to communicate effectively with compared with doctors, especially those in hospitals.

While healthcare professionals tended to be satisfied with the current relationship they have with patients, patients wanted a more balanced relationship and this was often described in terms of information. While patients did not want to be responsible for decision-making, being able to ask questions and understanding how decisions were made was important.

Choice was also a key aspect of patient involvement for some patients. Choice encompassed a range of issues including: being able to change doctors and being aware of alternate treatments. Choice

was seen as more problematic for practitioners as some felt patients would be confused if given alternatives or would have less faith in the treatment proposed.

Although related more to the concept of health literacy than patient involvement per se, the internet was generally felt to be the area where there has been the most significant development with almost all patients now having greater access to information about their symptoms and healthcare (as well as healthcare options). This was seen as positive by patients but was seen more ambivalently by some practitioners. More regulated information was considered as a useful safeguard against the risk of "internet misdiagnosis" by patients.

Practitioners saw the benefits of 'patient involvement" as having more motivated and engaged patients, with increased understanding. Patients saw the benefits as having more information and options with regard to treatment, and a more open dialogue with practitioners where communication was improved and questions could be asked.

The two key risks of "patient involvement" were perceived to be the resourcing requirements needed (for example, additional time and staffing) and the negative impact it might have on the patient/doctor relationship. More explanation of healthcare and discussion of options means an increased demand on doctors' time. More input from the patient – potentially based on inaccurate information gleaned from the internet – could mean patients disagreeing with the healthcare expert and refusing the best treatment.

In addition, there were some general differences that emerged between different types of respondent. Chronically ill patients tended to have more experience in self-monitoring and other aspects and often had a more tangible understanding of patient involvement.

Finally, while there were often similar themes across all of the countries included in the study, there were differences between certain countries (which for simplicity the report refers to as "east" and "west"). In general in Eastern countries (the Czech Republic, Hungary, Latvia, Poland, Romania, Slovakia and to a lesser extent Greece) the current state of the healthcare infrastructure was often described as less inadequately funded and there tended to be a less balanced relationship between doctors and patients. In these countries, patients tended to have less understanding of what patient involvement might involve and there was more reluctance to have a more interactive relationship with their healthcare.

More information:
http://ec.europa.eu/health/healthcare/docs/eurobaro_patient_involvement_2012_en.pdf

SIMULATION OF EU CROSS-BORDER CARE DIRECTIVE – REPORT RELEASED

The report by European Social Observatory (OSE) on the simulation of the EU Cross-Border Care Directive was released at the beginning of June 2012.

The Directive on the application of Patients' Rights in Cross-Border Healthcare was one of the most controversial pieces of European healthcare legislation in recent years, and many questions remained on its possible impact.

In November 2011, stakeholder groups from Belgium, France, Germany, The Netherlands, Luxembourg and Spain participated in a stimulation aiming at forecasting the key issues raised by the Directive, discussing how they would respond in reality to these situations and addressing potential bottlenecks.

The stimulation suggests that some of the provisions strongly argued for as the Directive made its way through the legislative process may be less important in practice. It also suggests that the Directive may have unexpected impact on a number of areas, particularly on domestic health policy.

According to the report, there was a consensus in some areas, which suggests that the Directive will bring substantial legal certainty. This includes areas where tensions in implementation had been predicted such as on the articulation between the Directive and Regulation 883/04, but where, in practice, pragmatic solutions have been found.

In regards to other issues, although there was a large consensus within stakeholder groups in some areas, stakeholder groups had divergent approaches in other areas. For example, whereas purchasers and public authorities made clear that for the care to be reimbursed it should comply with the conditions as defined by the patients' Member State, the providers were equally insistent that they would not adapt procedures or processes to the conditions of the foreign health insurer or payer of the cross border patient.

Another observation revealed by the report is that some areas that were subject to heavy political wrangling were not seen to have much relevance at the practical level. This includes the provisions allowing Member States under certain conditions to prevent high inflows of patients.

However, the report suggests that in other areas the implementation of the Directive may have an important and largely unpredicted impact on domestic health policy, driving towards greater clarity on the definition of the benefit package for citizens and on the provision of information to patients.
Yet, the most striking set of conclusions from the simulation relates to the potential burden for patients travelling under the Directive. Patients will be responsible for many of the elements involved in accessing planned treatment across borders: the responsibility to find information on potential treatments, the burden of proof in demonstrating to insurers that the treatment has been carried out and the responsibility to submit the correct documentation clearly was seen to lie with patients.

One of the key themes to come through the stimulation was the need for independent information for the Directive to function well, information that is currently often not available even domestically: on reimbursement, treatment, quality and safety and the national contact points.

The stimulation also showed that the implementation of the Directive has important implications for managing health systems, even though the volumes of cross-border care under the Directive are expected to be relatively small in most countries and regions. In particular, the simulation looked at how the Directive and Regulation will work together, questions on access to care and patient inflows and rare diseases.

Finally, the report mentioned issues such as prior authorization, medical records, language and quality and safety, which were also raised by the stimulation.

More information:
http://www.ose.be/EN/index.htm

QUALITY – EUROPEAN VOICE LUNCHTIME BRIEFING

On 4 June 2012, at the Press Club Brussels Europe, , European Voice held a lunchtime briefing about how developments in evaluation techniques and tools can lead to better decision-making in healthcare.

One of the world's leading experts in this field, Professor Niek Klazinga, head of the healthcare quality indicators project at the OECD, gave the main presentation. A medical doctor, he has been co-ordinating the OECD's work on healthcare quality indicators since 2007. He holds a professorship at the University of Amsterdam and is chairman of the advisory committee on transparency in healthcare at the Dutch Ministry of Health.

His presentation was followed by comments by two expert stakeholders: Pascal Garel, Chief Executive of HOPE, and Jean Hermesse, Secretary-General of Belgium's Mutualités Chrétiennes, also chair of AIM's health systems reform working group

More information:
www.europeanvoice.com/healthcare_evaluation

CROSS-BORDER CARE – EURORDIS RELEASES Q&AS

EURORDIS, the rare diseases association, recently released Q&A to help patients advocate for their right to cross border healthcare.

EURORDIS has prepared a Questions & Answers document to help understand the EU legislation on cross border healthcare and to ensure its transposition into national law is favourable to rare disease patients.

The document, presents in 21 points, the main aspects to look out for when seeking to apply patient's rights to cross-border healthcare. For example, issues such as level of reimbursement, need for upfront payment, need for prior authorisation and reasons for refusal. It answers frequently asked questions such as: "Can I seek healthcare abroad if the treatment is not available in my country?" "Where can we find information on care provided in other Member States?" or "Can we ask for travel and accommodation expenses to be also reimbursed?"

The Directive on Patients' Rights for Cross-Border Care was officially adopted in March 2011. It aims to help patients exercise their right to reimbursement for healthcare received in another EU country; provide assurance about safety and quality of cross-border healthcare and establish formal cooperation between health systems. This is especially important for rare disease patients who cannot find the right care locally or need to access a centre of expertise in another country.

Member States have until October 2013 to transpose the Directive into national law and adopt appropriate measures. During this process, patients and their organisations have an opportunity to assert the right of every EU citizen to healthcare in another Member State and to make their voices heard when implementing this legislation.

At EURORDIS Membership Meeting in May, Nathalie Chaze from the European Commission's Directorate for Health presented an overview of the Directive. Also, patient advocates discussed why and how a patient organisation should influence the process taking the case of cross border healthcare between Belgium and the Netherlands and the case of Luxembourg.

More information:
http://www.eurordis.org/
http://www.eurordis.org/en/content/eurordis-general-assembly-2012

RESTRUCTURING HEALTH SYSTEMS – HOW TO PROMOTE HEALTH IN TIMES OF AUSTERITY?

On 6 June 2012, the European Public Health Alliance organised its 2012 Annual Conference, hosted by the European Economic and Social Committee: "Restructuring Health Systems: How to promote health in times of austerity?"

HOPE was invited to speak and a briefing paper "The economic crisis & EPHA fact & figures on the impact of the financial crisis on health" was including several elements produced by HOPE in its report.

What is the cost of the crisis on populations and their health? Are the austerity measures viable or do they put health systems into a long-term crisis? How can the EU and national authorities create a new way of thinking to tackle the consequences of the crisis and yet secure sustainable healthcare systems?

Commissioner Dalli, Zsuzsanna Jakab, Director for the WHO Europe, Sanjeev Gupta, International Monetary Fund and Pervenche Beres, chair of the Employment and Social Committee in the European Parliament took part in the debate and discussed with civil society organisations the impact of the crisis and the way forward.

More information:
http://www.epha.org/IMG/pdf/Briefing_notes-_The_economic_crisis_EPHA_facts_and_figures_on_the_impact_of_the_financial_crisis_on_health_-_June_2012.pdf

ALEC 2012 – ARCTIC LIGHT e-HEALTH CONFERENCE

The ALEC 2012- Arctic Light e-Health Conference took place in Luleå, Sweden, on 19 and 20 June 2012.

HOPE was one of the many stakeholders who attended the event, which gathered local, regional and national politicans, representatives from the business industry, public sector officials and healthcare providers.

The event focused on the deployment of e-Health services and on identifying the obstacles to a good implementation of eHealth services, evaluating the current situation and providing examples of successes and failures of eHealth deployment.

Amongst the main topics that were approached by participants were the obstacles faced by eHealth in its deployment, the role of interregional cooperation, the need to address legislation issues and identify success factors, and the role of patient involvement.

Participants also discussed policy recommendations for a wider implementation of Telemedecine, as well as the creation and use of good practice guidelines for market facilitation.

More information:
http://www.nll.se/sv/Utveckling-och-tillvaxt/Verksamhetsutveckling/e-halsa/Arctic-Light-e-Helth-Conference/Speakers-presentations/

MENTAL HEALTH – WHO CALLS ON THE RIGHTS AND DIGNITY

On 15 June 2012, the World Health Organization (WHO) launched a new tool enabling countries to ensure that quality of care and human rights standards are put in place in mental health and social care facilities around the world.

WHO urged countries to protect the rights and dignity of people with mental health conditions and developed this toolkit with major inputs from people from civil society organisations which specialize in mental and psychosocial disabilities, as well as other mental health and human rights experts.

The tool, *WHO QualityRights Tool Kit – Assessing and improving quality and human rights in mental health and social care*, establishes key standards that, according to WHO, need to be met in all facilities.

These include the need for:

- living conditions to be safe and hygienic and the social environment to be conducive to recovery;
- the provision of evidence-based care for their mental and physical health condition, on the basis of free and informed consent;
- gearing services towards enhancing people's autonomy enabling them to engage in their own recovery plans;
- reporting and halting all inhuman treatment;
- linking health services with employment, education, social and housing services in order to promote independent living in the community for mental health service users.

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

AGENDA

UPCOMING CONFERENCES

EUROPEAN HEALTH FORUM GASTEIN
CRISIS AND OPPORTUNITY – HEALTH IN AN AGE OF AUSTERITY

3-6 October 2012- Gastein, Austria

The 15th European Health Forum Gastein, entitled "*Crisis and Opportunity - Health in an Age of Austerity*", will be held between the 3rd and 6th October 2012 in Gastein, Austria.

The Forum's key objective is to facilitate the establishment of a framework for advising and developing European health policy while recognizing the importance of national and regional authorities and decision-making bodies.

In times of austerity and an increasing demand for healthcare due to demographic change, innovation and steadily improved technology, the question arises how health policy and healthcare systems are going to be shaped in the upcoming decades.

The 15th edition of the Forum will focus on:
- global governance;
- health communication;
- non-communicable diseases;
- personalized medicines;
- sustainable health systems;
- the public health challenges of 2050.

As the leading health policy conference in Europe, the Forum, acting as platform for discussion for the various stakeholders in the field of public health and health care, will gather EU, national and regional Representatives; business and industry; health care funders and service providers; civil society; as well as experts and researchers in health care and public health.

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