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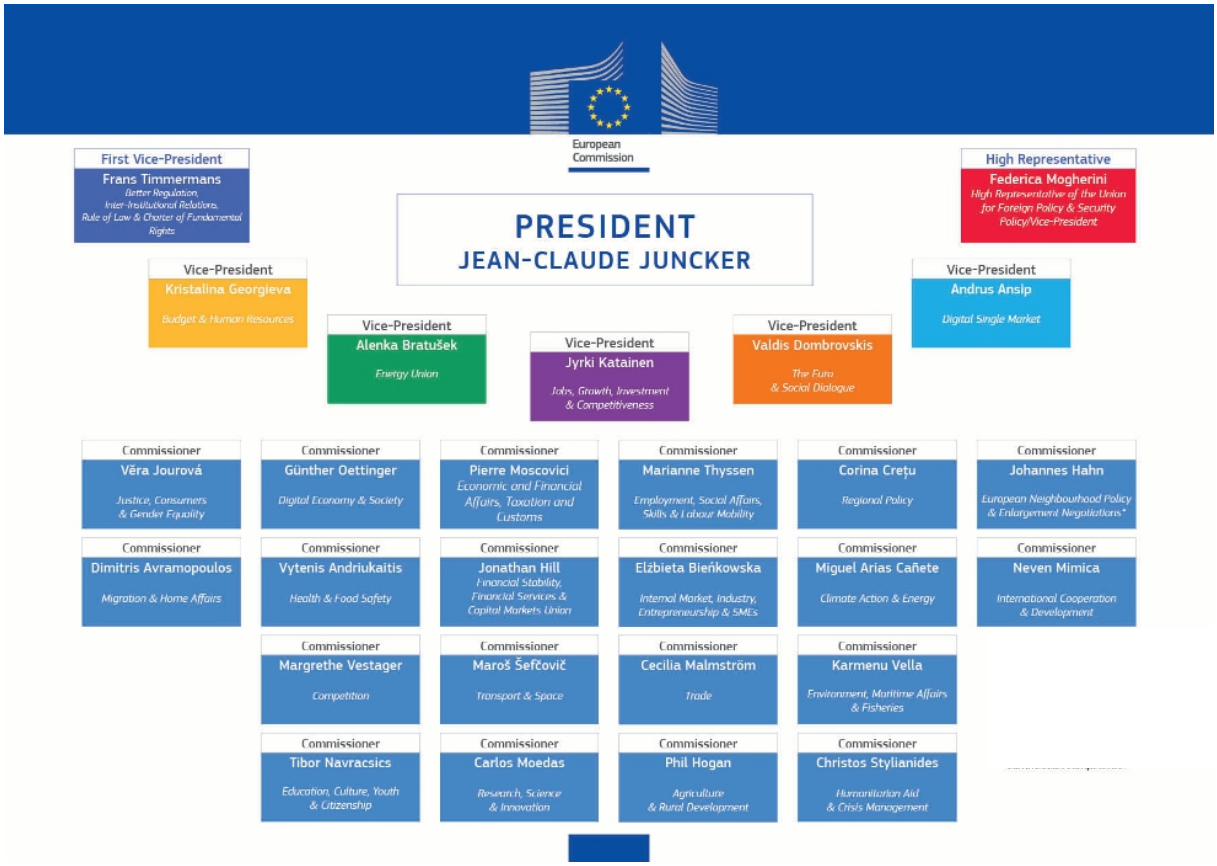
NEW EUROPEAN COMMISSION APPROVED BY PARLIAMENT



On 22 October 2014, the European Parliament approved the new European Commission with 423 votes in favour, 209 against and 67 abstentions.

Mr Vytenis Andriukaitis from Lithuania will be the new Commissioner for Health and Food Safety. Graduated in medicine and history, since December 2012 he held the position of Minister of Health in Lithuania. During the hearing with the European Parliament back in September, Mr Andriukaitis indicated the priorities during his mandate, which are:

- the pooling of Member States' efforts to invest in health;
- the implementation of the cross-border healthcare and tobacco legislations;
- a new procedure to deal with GMOs.

Now that the European Parliament has given its consent, the European Council will formally appoint the European Commission, which will start its term of office on 1 November 2014.

MEDICINAL PRODUCTS AND HEALTH TECHNOLOGIES BACK TO HEALTH DIRECTORATE GENERAL

When on 10 September the names of the new Commissioners and respective portfolios have been unveiled, one of the most striking changes in the Health and Food Safety Directorate General was the move of the medicinal products and health technologies portfolios as well as the European Medicines Agency from the Commissioner for Health and Food Safety to the Commissioner for Internal Market, Industry, Entrepreneurship and SMEs.

In response to such a change, HOPE together with other 35 EU health stakeholders, signed a joint open letter to the new Commission's President Jean-Claude Juncker expressing their concern (see the article in the September Newsletter). Concern was also expressed by Members of the European Parliament and Health Ministers from several Member States.

On 22 October the Commission's President announced his decision to leave the medicinal products and health technologies portfolios to the Commissioner for Health and Food Safety. Stakeholders welcomed this decision, hoping this represents a change in the Commission's priorities and a clear sign that the main driver of EU policies concerning pharmaceuticals and health technologies should be promoting and protecting health and patient safety rather than market considerations and the foster of competitiveness.

PATIENT SAFETY – COMMISSION'S EXPERT PANEL OPINION

The Expert Panel on Effective Ways of Investing in Health is a panel of scientists set up to provide the European Commission with sound and timely scientific advice on effective ways of investing in health.

The Expert Panel has recently released its final opinion on future EU agenda on quality of healthcare with a special emphasis on patient safety. The final opinion took into account the results of a public consultation which ran from August to September 2014 and where 174 contributions were received.

In its opinion, the Expert Panel identified a subset of commonly accepted core dimensions of quality and safety applicable to all health services and for which goals, standards and indicators should be developed in order to guarantee high quality health care services in the Member States and at EU level.

The core dimensions identified are:

- effectiveness (improve health outcome);
- safety (prevent avoidable harm related with care);
- appropriateness (comply with current professional knowledge, meet standards);
- patient-centred (consider patients/people as key partners in the process of care);
- efficiency and equity (optimal use of available resources without differences, variations and disparities in the health achievements of individuals and groups).

In the final part of the opinion, the Expert Panel suggests some actions that can be taken at EU level to improve the identified core dimensions of quality of care. In particular, it stresses the crucial role that can be played by the European Commission for the improvement of the quality of healthcare and the safety of patients.

The actions proposed cover:

- the use of a comprehensive conceptual framework in relation to quality and safety;
- the development of guidelines and inter-professional sharing of good practices;
- funding research on quality and safety;
- economic issues related to the defined quality dimensions;
- education and training for the new roles of both patients and health professionals;
- information technology and information systems significant for health quality and safety;
- quality and safety aspects of the burden of chronic diseases and inequalities in health;
- the HTA network and increasing attention to Health System Impact Assessment.

The final opinion is available at:
http://ec.europa.eu/health/expert_panel/opinions/docs/oo6_safety_quality_of_care_en.pdf

EUROPEAN CODE AGAINST CANCER – FOURTH EDITION

On 14 October 2014, the fourth edition of the European Code against Cancer was launched. This fourth edition has been prepared in 2012–2013 by cancer specialists, scientists, and other experts from across the European Union in a project coordinated by the International Agency for Research on Cancer, with financial support from the EU Health Programme.

The code, which was created in 1987, aims to raise citizens' awareness about risk factors and the importance played by the adoption of healthy lifestyles and prevention through screening. It therefore lists 12 recommendations on actions that individual citizens can take to help prevent cancer. The recommendations are based on the latest scientific evidence. The code will soon be translated in 23 languages.

More information: ***http://cancer-code-europe.iarc.fr/index.php/en/***

EUROPEAN INITIATIVE ON BREAST CANCER – CALL FOR EXPRESSIONS OF INTEREST

In the framework of the European Initiative on Breast Cancer, the European Commission has recently launched a call for expressions of interest, inviting individual experts to join two working groups respectively dedicated to "Guidelines Development" and "Quality Assurance Scheme Development".

The Guidelines Development Group will define the scope, evaluate the evidence, and develop the draft recommendations for the new version of the European Guidelines for Breast Cancer Screening and Diagnosis. The members of the Guidelines Development Group will include:

- professionals: people actively working in breast cancer screening and diagnosis;
- individual citizens or patients: users of breast cancer screening and diagnosis services (such as patients diagnosed of breast cancer), their family members and their carers;
- methodologists in fields relevant to guideline development.

The Quality Assurance Scheme Development Group will agree on the general quality requirements and make use of the evidence provided by the guidelines for the quality requirements specific for breast-cancer care. This group will include:

- professionals: people actively working in breast cancer screening and diagnosis;
- individual citizens or patients: users of breast cancer screening and diagnosis services (such as patients diagnosed of breast cancer), their family members and their carers.

The deadline for the submission of applications is 1 December 2014.

More information:
http://ec.europa.eu/health/major_chronic_diseases/diseases/cancer/call_ecibc_en.htm

EBOLA – HEALTH IMPLICATIONS FOR THE EU

The current Ebola outbreak affecting the West Africa region is the worst such outbreak on record. The World Health Organization (WHO) declared it a Public Health Emergency of International Concern, calling for a coordinated international response. As of 10 October, there have been more than 8399 reported cases, including 4033 deaths from the disease (WHO). To date, 10 patients have been repatriated to the EU/EEA with confirmed or suspected Ebola and the first secondary case of Ebola in Europe has been confirmed on 6 October.

Ebola poses the greatest risk to the European citizens who are currently present in the affected countries, most notably to the health staff and volunteers helping to stop the spread of Ebola. Accordingly, the Commission started work to develop a European mechanism for medical evacuations. The European Commission's Emergency Response Coordination Centre (ERCC) facilitates the transport of relief items to West Africa and will, if necessary, fund and coordinate the evacuation of international staff from Liberia, Guinea and Sierra Leone.

The Commission has been working on preparedness and coordination of risk management together with Member States and with the support of the European Centre for Disease Prevention and Control (ECDC) and the WHO since the outbreak began. The EU Health Security Committee (HSC), established under the Decision of the European Parliament and of the Council on serious cross border threats to health is coordinating the exchange of information and coordination of preparedness, in response to Ebola in the EU.

So far, during the outbreak, the HSC has:

- activated networks for secure hospital facilities;
- activated networks for high security laboratories to ensure all Member States can access such laboratories to diagnose Ebola;
- endorsed information for travellers which is published in all EU languages;
- approved key media messages, which have been translated into all EU languages;
- undertaken work on procedures for airports and health authorities on handling possible cases of Ebola identified during a flight and on preparedness of health systems for treating Ebola cases;
- endorsed a case definition allowing for identification of Ebola cases in the EU.

According to the analysis by ECDC of the information provided by national authorities, most Member States seem to be well prepared. The most challenging issues concern the evacuation from affected countries and treatment in the affected countries. There are potentially further challenges for some Member States in access to treatment facilities, transport of patients, availability of laboratories, expertise and resources. In the spirit of solidarity, the HSC is coordinating the sharing of certain key resources which Member States have offered to put at the disposal of other countries if required. These include offers of support on medical evacuation, treatment and diagnostic facilities.

There is currently no authorised or proven treatment for Ebola. On the research front, the Commission intends to quickly mobilise funds from Horizon 2020 via an emergency procedure to support clinical trials on candidate vaccines and therapies. The details are under discussion with the WHO and the European Medicines Agency in order to define the most appropriate research actions that could add value.

PARLIAMENTARY WORKING GROUP ON INNOVATION, ACCESS TO MEDICINES AND POVERTY-RELATED DISEASES – NEW TERM STARTS

On 7 October 2014, the European Parliament Working Group on Innovation, Access to Medicines and Poverty-Related Diseases hosted its inauguration reception for the 2014-2019 parliamentary term. MEPs, EU and WHO officials participated in the reception. During the meeting important topics were discussed, which included: funding research for poverty-related and neglected diseases, immunisation of children in developing countries and multi-drug resistant Tuberculosis in Europe, prices of hepatitis C treatment, neglect of pharmaceutical companies concerning Ebola research.

The MEP Glenis Willmott (S&D, UK) is the successor of previous chair MEP David Martin (S&D, UK). MEP Willmott has experience in working on health issues at the EU level as she was and still is a

member of the Environment, Public Health and Food Safety (ENVI) Parliamentary Committee. The vice-chair position went to MEP Judith Sargentini (Greens/EFA, Netherlands), which areas of interest cover vaccines and better access to health in developing countries. The Working Group on Innovation, Access to Medicines and Poverty-Related Diseases operates as a Bureau of MEPs with a Secretariat formed by Médecins Sans Frontières' Campaign for Access to Essential Medicines and Global Health Advocates.

The Working Group works to improve the availability of medicines in some of the poorest countries in the EU and across the world, where preventable diseases kill millions each year. It is a mediator of dialogue between Members of the European Parliament, the European Commission, and civil society to ensure that European policies deliver a coherent, comprehensive and pro-active response to address the need for innovation, access to medicines and quality health care.

With respect to previous achievements, the Working Group will continue working on ensuring improved access to medicines, tackling antimicrobial resistance and the inclusion of an ambitious, outcome-oriented and rights-based health goal in the post 2015 framework.

CLINICAL DATA – NEW EMA POLICY

On 2 October 2014, the European Medicines Agency (EMA) published a new policy on publication of clinical data submitted under the centralised marketing authorisation procedure.

The new policy aims to increase transparency, allowing the access to clinical reports through a technical tool. Access to clinical reports will be possible once the marketing authorisation procedure has been finalised and a decision has therefore been taken. Thanks to the new policy, the scientific community will be able to verify original analysis and conclusions or carrying out further analysis and generate new knowledge. Medicines development will ultimately benefit from this increased transparency and will gain in efficiency as all developers will have the possibility to learn from past successes and failures.

The policy will enter into force 1 January2015.

The new policy on publication of clinical data is available at:
http://www.ema.europa.eu/docs/en_GB/document_library/Other/2014/10/WC500174796.pdf

TRANSPARENCY DIRECTIVE – DOSSIER ON HOLD

In March 2012, the European Commission published a proposal for the revision of the Directive on the transparency of measures regulating the prices of medicinal products for human use and their inclusion in the scope of public health insurance systems. This revised directive faced the opposition of several Member States in the Council, which led the European Commission to publish a new revised proposal in March 2013.

The draft proposal aim to strengthen the implementation of the provisions set out by the Directive, in particular in regard to compliance with time limits for pricing and reimbursement procedures, the non-respect of which may cause delays in patient access to treatments.

Although the Italian Presidency of the Council planned to make this dossier one of its priorities, discussions have not started yet, the Presidency having decided to concentrate its efforts on the draft proposals on medical devices.

DATA PROTECTION – JHA COUNCIL

On 10 October 2014, during the meeting of the Justice and Home Affairs (JHA) Council, Ministers reached a partial agreement on specific aspects of the draft general data protection regulation. The new legislation aims to strengthen current EU data protection rules, to ensure a more harmonised approach to data protection and privacy across the European Union. The draft proposal contains provisions which could have an important impact on the provision of healthcare services and research.

The partial agreement reached includes chapter IV and the related recitals, which define the obligations for data controllers and processors. The obligations include the need for an objective assessment of the risk, to determine whether the data processing operations bring about a high risk. High risk means a specific risk of infringing the rights and freedoms of individuals.

However, this partial agreement was reached with the understanding that no final agreement is attained until an agreement is reached on the entire text of the proposal, which means this chapter is still susceptible to changes in the future.

Ministers also held a discussion about the "right to be forgotten" principle, including its connection with freedom of expression. This was a political debate not linked to the legal text of the draft regulation. The debate followed the judgment of the EU Court of Justice in case C-131/12 where the Court argued that on the basis of the existing directive, data subjects may exercise their right to erasure of data and their right to object to personal data processing against online controllers such as search engines.

The Council acknowledged the importance of the right to erasure and the right to oppose data processing, in particular in a digital environment. At the same time, the Member States set great store by freedom of expression. Balancing the fundamental right to data protection with freedom of expression will have to be done on a case-by-case basis.

After the meeting, the Italian Presidency of the Council declared to be confident about the fact that a general agreement on the draft regulation could be reached before the end of the year.

TTIP – SEVENTH ROUND OF NEGOTIATIONS

The seventh round of negotiations on the Transatlantic Trade Investment Partnership (TTIP) between EU and the US took place from 29 September to 3 October in Chevy Chase (Maryland).

A large part of the discussions focused on the regulatory part of the TTIP. As regards the horizontal disciplines (i.e. cross-cutting issues applying to all sectors such as regulatory coherence, technical barriers to trade, etc.), the parties are now engaged in discussions based on textual proposals.

As regards the key specific sectors (pharmaceuticals, automobiles, chemicals, textiles, cosmetics, medical devices, engineering, pesticides etc.) the work is being guided by the regulators and it is focusing on the identification of unnecessary duplications while preserving the mandate of each regulator.

The EU's Chief TTIP Negotiator, Ignacio Garcia Bercero, stated that nothing will be done which could lower or endanger the protection of the environment, health, safety, consumers or any other public policy goals pursued by the EU. It also explained that, with regards to negotiations on services, these exclude any commitments on public services. Governments will remain free to decide at any time that certain services should be provided by the public sector.

More informationn: http://ec.europa.eu/trade/policy/in-focus/ttip/

REIMBURSEMENT OF CROSS-BORDER CARE – JUDGMENT

Social security — Article 22(2), second subparagraph, of Regulation (EEC) No 1408/71 — Health insurance — Hospital treatment provided in another Member State — Prior authorisation refused — Lack of medication and basic medical supplies and infrastructure

In case C-268/13 Elena Petru, a Romanian citizen, claimed to be reimbursed for an open-heart surgical treatment she had in Germany as she argued that the Romanian hospital where she was supposed to be treated lacked of the necessary medicines and medical equipment. Ms Petru's application for prior authorisation to have her surgery performed in Germany and reimbursed by her health insurer in Romania was refused. However, Ms. Petru still went to Germany for the surgery and sued the Romania's health insurer.

Based on the Judgment of the European Court of Justice of 9 October 2014 it was ruled that: the second subparagraph of Article 22(2) of Council Regulation No 1408/71 of 14 June 1971 must be interpreted as meaning that the authorisation necessary under this mentioned article cannot be refused where it is because of a lack of medication and basic medical supplies and infrastructure such that the hospital care concerned cannot be provided in good time in the insured person's Member State of residence. The question whether that is impossible must be determined by reference to all the hospital establishments in that Member State that are capable of providing the treatment in question and by reference to the period within which the treatment could be obtained in good time.

The European Court of Justice ruling brings clarification that Elena Petru might be entitled to reimbursement only if the treatment was unavailable within the reasonable time in any of the Romanian hospitals and if the insurer covers the procedure at home.

More information:
http://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1414147756301&uri=CELEX:62013CJ0268

MOMENTUM – FINAL CONSORTIUM MEETING

On 30 September 2014, HOPE attended in Brussels the final consortium meeting of the thematic network Momentum. Momentum is a project co-financed by the European Commission under the ICT Policy Support Programme (ICT PSP). It is about creating a platform across which the key players can share their knowledge and experience in deploying telemedicine services into routine care. One of the outcomes of the project is the development of a Blueprint for telemedicine deployment.

The purpose of this meeting was to review and validate the "Consolidated Blueprint" for telemedicine deployment and to advance planning of the final few months of the project, including testing and finalisation of the Blueprint. A workshop was organised so that each part of the Blueprint has been commented with fresh eyes by external participants with a view to identify what needs to be clarified and how to make the future Blueprint more robust and internally consistent.

The consolidated version of the Blueprint will be published at the beginning of November and presented during the final Momentum workshop, which will be held in Brussels on 26 November.

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

TAKING STOCK OF ACHIEVEMENTS IN 2010-2014 – COMMISSION REPORT

The European Commission has recently published the report "Taking stock of EU public health, food safety, animal and plant health policy achievement in 2010-2014".

The report begins with an introduction of current and future challenges with regard to the mentioned policies. After this introduction, it highlights achievements for the period 2010-2014 in terms of objectives reached to address the described challenges.

In the health area, the following achievements are illustrated:

- channelling EU policies and health funds to improve health and health systems;
- tackling health determinants and lifestyle issues linked to tobacco and alcohol consumption, fighting obesity and reducing health inequalities;
- strengthening coordination on communicable diseases and health threats, by improving preparedness and response to health emergencies;
- continuing the work within the European Innovation Partnership on Active and Healthy Ageing;
- work on the transposition of the cross-border healthcare directive;
- support to Member States in addressing chronic and rare diseases;
- work on key issues related to pharmaceuticals such as falsifies medicines, pharmacovigilance and clinical trials.

More information:
http://ec.europa.eu/health/docs/2010_2014_policy_achievements_en.pdf

EUROPEAN INITIATIVE ON ALZHEIMER'S DISEASE AND OTHER DEMENTIAS – COMMISSION IMPLEMENTATION REPORT

The European Commission has recently published a report on the implementation of the European Initiative on Alzheimer's disease and other dementias. The report presents the key activities that have taken place since 2009 and summarises main achievements in the area of "actions providing support to Member States in ensuring effective and efficient recognition, prevention, diagnosis, treatment, care, and research for Alzheimer's disease and other dementias in Europe".

A wide range of activities have been implemented as part of the strategy, in the context of EU-health policy and of other EU-policy areas. The activities presented in this report include, among others, the Joint Action Alzheimer Cooperative Valuation in Europe (ALCOVE), the European Innovation Partnership on Active and Healthy Ageing, EU-level activities in the fields of research (including the Joint Programming Initiative on Neurodegenerative Diseases [JPND]), eHealth, long-term care, and health statistics.

In order to give evidence about the extent to which the strategy has supported developments at national level, the report summarises the findings from a survey among the Member States. The report also refers to the initiative of the G8-Group to start up a "Global action against Dementia", in which the Commission has been involved through its participation in the Summit of Ministers of Health launching the process in December 2013 and the following series of high-level forums. In its final section, the report provides an outlook on a number of forthcoming Commission's activities on dementia.

More information:
http://ec.europa.eu/health/major_chronic_diseases/docs/2014_implreport_alzheimer_dementias_en.pdf

FIRST CONFERENCE ON EUROPEAN REFERENCE NETWORKS – REPORT

Establishing European Reference Networks (ERNs) of highly specialised healthcare providers represents a clear added value for the EU and will help to provide affordable, high-quality and cost-effective healthcare to patients with conditions requiring a particular concentration of resources or expertise, and to improve these patients' access to the best possible expertise and care available in the EU for their condition.

The legal framework, as foreseen in the Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, was adopted on 10th of March 2014 by the Commission, after an exhaustive consultation process with national authorities, experts, and stakeholders, providing for the criteria and conditions that Networks and its Members shall fulfil and for the establishment and evaluation of future Networks.

DG SANCO organised a conference on European Reference Network on 23rd of June 2014 in Brussels which brought together highly specialised healthcare providers, experts, national

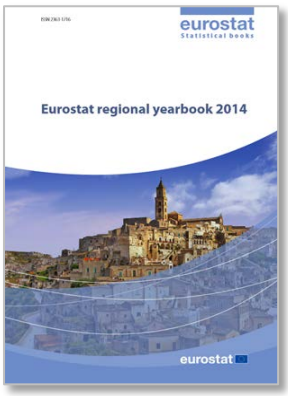
authorities, decision–makers, and independent bodies with experience in the assessment and evaluation of healthcare providers. The aim of the conference was to discuss the state of play on the organisation of highly specialised networks and their members across the EU and to look into the next steps of the deployment process, in preparation for the forthcoming call for European Reference Networks in 2015.

The main future challenges will be the implementation or establishment procedure (ensuring the compatibility with the criteria laid down in the delegated decision and evaluating providers that want to build up a network) and the sustainability of ERNs and Centres of Expertise (CoE). The latter will be the responsibility of Member States but a solution is still needed to ensure the sustainability of ERNs.

In terms of milestones and steps forward, the ERN legal acts entered into force in May 2014. The call for the assessment manual took place in July 2014, the call for selection of independent bodies will be made in the fourth quarter of 2014, the call for networks in the fourth quarter of 2015, and the establishment of networks in the second quarter of 2015.

More information: ***http://ec.europa.eu/health/ern/docs/ev_20140623_mi_en.pdf***

EUROSTAT REGIONAL YEARBOOK 2014



The Eurostat regional yearbook 2014 gives a detailed picture relating to a broad range of statistical topics across the regions of the Member States of the European Union, as well as the regions of the European Free Trade Association (EFTA) and candidate countries.

Each chapter presents statistical information in maps, figures and tables, accompanied by a description of the policy context, main findings and data sources. These regional indicators are presented for the following 11 subjects: population, health, education, the labour market, the economy, structural business statistics, research and innovation, the information society, tourism, transport, and agriculture.

In addition, four special focus chapters are included in this edition: these look at the environment, land cover and land use, European cities, and regional competitiveness.

More information:
http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-HA-14-001/EN/KS-HA-14-001-EN.PDF

TRENDS IN HEALTH SYSTEMS IN THE FORMER SOVIET COUNTRIES – EUROPEAN OBSERVATORY PUBLICATION

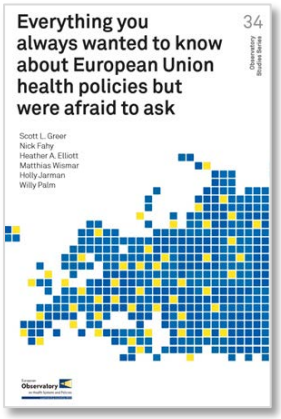
After the break-up of the Soviet Union in 1991, the countries that emerged from it faced myriad challenges, including the need to reorganise the organisation, financing and provision of health services. Over two decades later, this book analyses the progress that twelve of these countries (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan) have made in reforming their health systems.

Building on the health system reviews of the European Observatory on Health Systems and Policies (the HiT series), it illustrates the benefits of international comparisons of health systems, describing the often markedly different paths taken and evaluating the consequences of these choices.

This book will be an important resource for those with an interest in health systems and policies in the post-Soviet countries, but also for those interested in health systems in general. It will be of particular use to governments in central and eastern Europe and the former Soviet countries (and those advising them), to international and non-governmental organisations active in the region, and to researchers of health systems and policies.

More information:
http://www.euro.who.int/__data/assets/pdf_file/0019/261271/Trends-in-health-systems-in-the-former-Soviet-countries.pdf?ua=1

EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT EUROPEAN UNION HEALTH POLICIES BUT WERE AFRAID TO ASK – EUROPEAN OBSERVATORY PUBLICATION



The EU's health mandate allows for a comprehensive set of public health actions. And there are other EU policies, though not health related, which have important consequences for governing, financing, staffing and delivering health services. In other words: EU actions affect the health of Europe's population and the performance of health systems.

Given how important health systems are, we need an informed debate on the role of the EU and its contribution. But this is not easy because EU health policy is difficult to comprehend. There is no single strategy with a neat body of legislation implementing it; rather, there are many different objectives and instruments, some of which appear in unlikely places.

Understanding the EU role in health is especially important now, when health systems have to deal with a plethora of challenges, the European social model is confronted by the threat posed by the financial crisis, and the EU is facing increasing euro-scepticism in politics.

This book makes EU health policy in its entirety (and complexity) accessible to political and technical debate. To this end the volume focuses on four aspects of EU health policy:

- the EU institutions, processes and powers related to health;
- the EU action taken on the basis of this health mandate;
- the non-health action affecting health and health systems;
- and, because of its growing importance, financial governance and what it means for European health systems.

This book is aimed at policymakers and students of public health and health systems in the EU who want to understand how the EU can add value in their quest improving population health and the performance of health systems in Member States.

More information:
http://www.euro.who.int/__data/assets/pdf_file/0008/259955/Everything-you-always-wanted-to-know-about-European-Union-health-policies-but-were-afraid-to-ask.pdf?ua=1

HEALTH SYSTEM RESPONSES TO FINANCIAL PRESSURES IN IRELAND – EUROPEAN OBSERVATORY PUBLICATION

Ireland's recent financial and economic crisis - one of the most severe in the European Union - led to unprecedented reductions in levels of public spending. Public spending on the health sector fell particularly sharply. How did the Irish health system respond to the financial pressure created by the crisis? What were the options available to health policy-makers as they sought to adapt to a lower level of public financing? How did the policy changes introduced affect the health system's performance? These are some of the questions this book addresses.

Originally commissioned by the Department of Health in Ireland, the book draws on international experience to assess and reflect on the challenges the health system has faced as a result of the crisis, to review underlying structural issues in the health sector and to identify priority areas for improving efficiency, quality and equitable access to health care. The book will be of interest to policy-makers and researchers in Ireland and other countries who want to understand the short- and longer term implications of sharp reductions in public spending on health.

More information:
http://www.euro.who.int/__data/assets/pdf_file/0006/260088/Health-system-responses-to-financial-pressures-in-Ireland.pdf?ua=1

SURVEILLANCE OF ANTIMICROBIAL CONSUMPTION IN EUROPE – ECDC REPORT 2012

The third annual report of the European Surveillance of Antimicrobial Consumption Network (ESAC-Net) was published by the European Centre for Disease Prevention and Control (ECDC). The report is based on antimicrobial consumption data from the community (primary care sector) and the hospital sector reported to ECDC for the year 2012 by 28 EU Member States and two EEA non-EU countries (Iceland and Norway).

In the community, consumption of antibacterials for systemic use in 2012 varied between the 30 countries by a factor of 2.8 between the highest consumption (31.9 defined daily doses, DDD, per 1 000 inhabitants and per day in Greece) and the lowest (11.3 DDD per 1 000 inhabitants and per day in the Netherlands). The population-weighted EU/EEA mean consumption was 21.5 DDD per 1 000 inhabitants and per day and no significant trends in the mean consumption are apparent for the last 5 years. The largest increase in consumption of antibacterials for systemic use in the community was seen in the United Kingdom, whereas Greece and Poland reported a 9% decrease in the consumption.

In 2012, 25 countries reported data on consumption of antimycotics and antifungals for systemic use in the community. Consumption varied by a factor of 7.2 between the highest consumption (3.3DDD per 1 000 inhabitants and per day in Belgium) and the lowest (0.46 DDD per 1 000 inhabitants and per day in Malta).

In the hospital sector, consumption of antibacterials for systemic use data varied from 1.0 DDD per 1 000 inhabitants and per day in the Netherlands, to 2.8 in Finland. The population-weighted EU/EEA mean consumption was 2.0 DDD per 1 000 inhabitants and per day and no significant trends in the mean consumption are apparent for the last five years.

In 2012, data on total antiviral consumption, jointly presented for both the community and the hospital sector, were available from 24 countries. Consumption varied by a factor of 11 between the highest (4.4 DDD per 1 000 inhabitants and per day in Portugal) and the lowest consumption (0.1 DDD per 1 000 inhabitants and per day in Malta).

Inter-country comparisons using the results presented in this report should be made with caution. ESAC-Net aims to obtain hospital sector data from all network participants though this is currently not the case as a number of countries cannot provide separate hospital consumption data as defined in the reporting protocol.

More information:
http://www.ecdc.europa.eu/en/publications/Publications/antimicrobial-consumption-europe-esac-net-2012.pdf

THE AUSTRIAN HEALTH REFORM 2013 – PAPER

The Austrian health system is much more complex and fragmented than in other OECD countries. In 2013 legislation was adopted to enhance efficiency through better balancing care provision across providers by promoting new primary care models and better coordination of care. Reform objectives should be achieved by cooperative and unified decision making across key stakeholders and by adherence to a budget cap that prescribes fiscal containment on the order of 3.4 billion Euros until 2016. This is priced into the envisaged savings of the current consolidation program.

Efforts have been made to bridge the accountability divide by establishing agreements and administrative layers to govern the health system by objectives. Yet, more could have been achieved. For example, cross-stakeholder pooling of funds for better contracting governance and effective purchasing across care settings could have been introduced. This would have required addressing overcapacity and fragmentation within social security. At the same time, legal provisions for cooperative governance between Sickness Funds and the governments on the regional level should have been stipulated. The Austrian 2013 reform is interesting to other countries as it aims to ensure better-balanced care at a sustainable path by employing a public management approach to governance relations across key payers of care.

More information:
http://www.healthpolicyjrnl.com/article/S0168-8510%2814%2900231-0/fulltext

INTERACTIONS BETWEEN LEAN MANAGEMENT AND THE PSYCHOSOCIAL WORK ENVIRONMENT IN A HOSPITAL SETTING – MULTI-METHOD STUDY

As health care struggles to meet increasing demands with limited resources, Lean has become a popular management approach. It has mainly been studied in relation to health care performance.

This study aimed to explore the interaction between Lean and the psychosocial work environment. The psychosocial work environment was measured twice with the Copenhagen Psychosocial Questionnaire (COPSOQ) employee survey during Lean implementations on May-June 2010 (T1) and November-December 2011 (T2) at three units - an Emergency Department (ED), Ward-I and Ward-II. Information based on qualitative data analysis of the Lean implementations and context from a previous paper was subsequently compared with COPSOQ-data. Between T1 and T2, qualitative information showed a well-organised and steady Lean implementation on Ward-I with active employee participation, a partial Lean implementation on Ward-II with employees not seeing a clear need for such an intervention, and deterioration in already implemented Lean activities at ED, due to the declining interest of top management. Quantitative data analysis showed a significant relation between the expected and actual results regarding changes in the psychosocial work environment. Ward-I showed major improvements especially related to job control and social support, ED showed a major decline with some exceptions while Ward-II also showed improvements similar to Ward-I.

The results suggest that Lean may have a positive impact on the psychosocial work environment given that it is properly implemented. Also, the psychosocial work environment may even deteriorate if Lean work deteriorates after implementation. Employee managers and researchers

should note the importance of employee involvement in the change process. Employee involvement may minimise the intervention's harmful effects on psychosocial work factors.

More information:
http://www.biomedcentral.com/content/pdf/1472-6963-14-480.pdf

NATIONAL INDICATORS OF HEALTH LITERACY – POPULATION-BASED SURVEY AMONG DANISH ADULTS

Health literacy is a multidimensional concept covering a range of cognitive and social skills necessary for participation in health care. Knowledge of health literacy levels in general populations and how health literacy levels impacts on social health inequity is lacking. The primary aim of this study was to perform a population-based assessment of dimensions of health literacy related to understanding health information and to engaging with healthcare providers. Secondly, the aim was to examine associations between socio-economic characteristics with these dimensions of health literacy.

A population-based survey was conducted between January and April 2013 in the Central Denmark Region. Postal invitations were sent to a random sample of 46,354 individuals >25 years of age. A total of 29,473 (63.6%) responded to the survey. Response options ranged from 1 (very difficult) to 4 (very easy). Between 8.8% and 20.2% of the general population perceived the health literacy tasks as difficult or very difficult at the individual item level. On the scale level, the mean rating for i) understanding health information was 3.10 and 3.07 for ii) engagement with health care providers. Low levels of the two dimensions were associated with low income, low education level, living alone, and to non-Danish ethnicity. A substantial proportion of the Danish population perceives difficulties related to understanding health information and engaging with healthcare providers.

The study supports previous findings of a socio-economic gradient in health literacy. New insight is provided on the feasibility of measuring health literacy which is of importance for optimising health systems.

More information:
http://www.biomedcentral.com/content/pdf/1471-2458-14-1095.pdf

EXPLORING HOW 'QUALITY' IS CONCEPTUALISED IN EUROPEAN HOSPITALS AND HEALTHCARE SYSTEMS – STUDY

It is important to understand how quality is conceptualised as a means to successfully implement improvement efforts and bridge potential disconnect in language about quality between system levels, professions, and clinical services. The aim was therefore to explore and compare conceptualisation of quality among national bodies (macro level), senior hospital managers (meso level), and professional groups within clinical micro systems (micro level) in a cross-national study.

This cross-national multi-level case study combined analysis of national policy documents and regulations at the macro level with semi-structured interviews (383) and non-participant observation (803 hours) of key meetings and shadowing of staff at the meso and micro levels in ten purposively sampled European hospitals (England, the Netherlands, Portugal, Sweden, and Norway). Fieldwork at the meso and micro levels was undertaken over a 12-month period (2011–2012) and different types of micro systems were included (maternity, oncology, orthopaedics, elderly care, intensive care, and geriatrics).

The three quality dimensions clinical effectiveness, patient safety, and patient experience were incorporated in macro level policies in all countries. Senior hospital managers adopted a similar conceptualisation, but also included efficiency and costs in their conceptualisation of quality. 'Quality' in the forms of measuring indicators and performance management were dominant among senior hospital managers (with clinical and non-clinical background). The quality conceptualisation differed across system levels (macro-meso-micro), among professional groups (nurses, doctors, managers), and between the studied micro systems in ten sampled European hospitals. The differential emphasis on the three quality dimensions was strongly linked to professional roles, personal ideas, and beliefs at the micro level. Clinical effectiveness was dominant among physicians (evidence-based approach), while patient experience was dominant among nurses (patient-centred care, enough time to talk with patients). Conceptualisation varied between micro systems depending on the type of services provided.

More information: ***http://www.biomedcentral.com/1472-6963/14/478***

EXPLORING THE RELATIONSHIP BETWEEN GOVERNANCE MECHANISMS IN HEALTHCARE AND HEALTH WORKFORCE OUTCOMES – SYSTEMATIC REVIEW

The objective of this systematic review of diverse evidence was to examine the relationship between health system governance and workforce outcomes. Particular attention was paid to how governance mechanisms facilitate change in the workforce to ensure the effective use of all health providers.

In accordance with standard systematic review procedures, the research team independently screened over 4300 abstracts found in database searches, website searches, and bibliographies. Searches were limited to 2001–2012, included only publications from Canada, the United Kingdom, the Netherlands, New Zealand, Australia, and the United States. 113 articles that discussed both workforce and governance were retained and extracted into narrative summary tables for synthesis.

Six types of governance mechanisms emerged from the analysis. *Shared governance*, *Magnet accreditation*, and *professional development initiatives* were all associated with improved outcomes for the health workforce (e.g., decreased turnover, increased job satisfaction, increased empowerment, etc.). Implementation of *quality-focused initiatives* was associated with apprehension among providers, but opportunities for provider training on these initiatives increased quality and improved work attitudes. Research on *reorganisation of healthcare delivery* suggests that changing to team-based care is accompanied by stress and concerns about role clarity, that outcomes vary for providers in private versus public organisations, and that co-operative clinics are

beneficial for physicians. *Funding schemes* required a supplementary search to achieve adequate depth and coverage.

The results of the review show that while there are governance mechanisms that consider workforce impacts, it is not to the extent one might expect given the importance of the workforce for improving patient outcomes. To successfully implement governance mechanisms in this domain, there are key strategies recommended to support change and achieve desired outcomes. The most important of these are: to build trust by clearly articulating the organisation's goal; considering the workforce through planning, implementation, and evaluation phases; and providing strong leadership.

More information: ***http://www.biomedcentral.com/1472-6963/14/479***

MANAGING DAILY SURGERY SCHEDULES IN A TEACHING HOSPITAL – MIXED-INTEGER OPTIMISATION APPROACH

This study examined the daily surgical scheduling problem in a teaching hospital. This problem relates to the use of multiple operating rooms and different types of surgeons in a typical surgical day with deterministic operation durations.

Teaching hospitals play a key role in the health-care system; however, existing models assume that the duration of surgery is independent of the surgeon's skills. The case of a Spanish public hospital was analysed, in which continuous pressures and budgeting reductions entail the more efficient use of resources. To obtain an optimal solution for this problem, a mixed-integer programming model and user-friendly interface that facilitate the scheduling of planned operations was developed. The research team implemented a simulation model to assist the evaluation of different dispatching policies for surgeries and surgeons. The typical aspects the authors taken into account were the type of surgeon, potential overtime, idling time of surgeons, and the use of operating rooms. It is necessary to consider the expertise of a given surgeon when formulating a schedule: such skill can decrease the probability of delays that could affect subsequent surgeries or cause cancellation of the final surgery. Optimal solutions for a set of given instances were obtained through surgical information related to acceptable times collected from a Spanish public hospital.

The research team developed a computer-aided framework with a user-friendly interface for use by a surgical manager that presents a 3-D simulation of the problem. Additionally, they obtained an efficient formulation for this complex problem. However, the spread of this kind of operation research in Spanish public health hospitals will take a long time since there is a lack of knowledge of the beneficial techniques and possibilities that operational research can offer for the health-care system.

More information: ***http://www.biomedcentral.com/1472-6963/14/464***

INFLUENCE OF LIFESTYLE FACTORS ON LONG-TERM SICKNESS ABSENCE AMONG FEMALE HEALTHCARE WORKERS – PROSPECTIVE COHORT STUDY

In female healthcare workers, an unhealthy lifestyle is associated with higher risk of LTSA. The cohort study examined the association between lifestyle factors (smoking, leisure-time physical activity and body mass index) and the occurrence of long-term sickness absence (LTSA; more than three consecutive weeks of registered sickness absence) within a cohort of female health care workers.

A total of 7401 employees filled out a questionnaire about their health behaviour and work environment. Subsequently, they were followed for 12 months in a national register on social transfer payments (DREAM register. Significant associations between all three lifestyle factors and risk of LTSA were found. The strongest lifestyle factor was current smoking, which increased the risk of LTSA by 35% compared to non- smokers. For body mass index, the risk of LTSA increased with the distance away from 18.5 kg/m2 in either direction. In other words, the more underweight or overweight the women were, the higher the risk of LTSA. A dose response relationship was found between LTSA and leisure-time physical activity, so that increasing physical activity results in decreasing risk of LTSA.

More information: ***http://www.biomedcentral.com/content/pdf/1471-2458-14-1084.pdf***

EVALUATION OF A WEB BASED TOOL TO IMPROVE HEALTH BEHAVIOURS IN HEALTHCARE STAFF – STUDY

A web-based tool was developed and piloted by being made available to healthcare staff in Wales from September 2012 to March 2013. This evaluation included two primary outcome measures: general health and mental well-being, and six secondary outcome measures: sickness absence, alcohol use, healthy eating, smoking, physical activity and maintaining a healthy BMI. The aim was to assess the feasibility of a web-based tool to improve health behaviours in healthcare staff.

Healthcare staff joined via a website, chose two of five challenges, and recorded their health behaviours using an online tool on a regular basis. Evaluation was undertaken by comparing baseline and follow up questionnaires. 1708 individuals explored the programme's website, of whom 1320 selected two lifestyle challenges to address. Of these 346 individuals (26.2%; 346/1320) completed the end of project evaluation questions for the main outcome and provided the basis of the evaluation.

Comparing pre-post data among respondents who engaged with the programme as a whole, self-reported general health status improved in 35.3%; mental health status improved in 33%; alcohol consumption score fell in 27.2%; reported fruit and vegetable consumption (7 day recall) increased; average time spent on vigorous exercise increased from 40.6 minutes a week to 67.6 minutes a week; and 41 individuals noted a positive change to their BMI classification category. Combining interactive web-based tools as part of a multi-media programme is feasible, increases health behaviours and generates interest among a proportion of the healthcare workforce. Further work is required to improve maintenance of engagement over time.

More information: ***http://www.intarchmed.com/content/7/1/44***

EUROPEAN HEALTH FORUM GASTEIN – HUMAN RESOURCES MOBILITY

On 2 October 2014, HOPE was invited to speak at the workshop "Human resources mobility: on the lookout for new approaches between planning, managing and free choice".

The aim of the workshop was to identify policy options for dealing with health professional mobility. Health mobility is affecting the size and composition of the health workforce in countries and with it the performance of health systems. To find suitable options countries need to understand the mobility trends, the costs and benefits of health professional mobility in sending and receiving countries and the ethics involved. The other speakers were from the OECD, the WHO collaborating centre for health workforce and planning and from the Swiss Federal Office of Public Health, sponsor of the session and co-organiser with the European Observatory for Health Systems and Policies.

OPEN DAYS 2014 – STRUCTURAL FUNDS

On 7 October 2014, HOPE organised with the Association of European Regions and COCIR (European Association representing the medical imaging and healthcare IT industry) a workshop on the importance of using the European Structural and Investments Funds (ESIF) to drive sustainable healthcare systems. This was part of the Open Days 2014, a series of events organised every year in Brussels to gather regional decision makers.

Good health is recognised as an important asset for regional development and competitiveness. Yet health inequalities are increasing across Europe's regions, as shown by the WHO. The three partners were offering a debate demonstrating the critical role European Structural and Investment Funds (ESIF) can play in achieving sustainable healthcare models, with better access for and inclusion of patients.

Under the new EU Structural and Investment Funds rules, these can still support Member States and their regions in transforming and modernising their healthcare systems. The debate will discuss how investment in health infrastructure and eHealth, in innovative care delivery models and in qualitative training of health professionals represent an effective use of EU Structural and Investment Funds.

Sylvain Giraud, Head of Unit D1 "Strategy and International", DG SANCO, European Commission, presented the role of DG SANCO in raising awareness on the eligibility of health investments under the ESIF 2014-2020. The Commission has published a guidance document setting priority areas of investment in health, which is cross-linked with the ESIF thematic objectives. It shows how ESIF can contribute to health and in return how health investments can contribute to ESIF's overall objectives. The Guide identifies four key areas of investment: capacity building; demographic change (Active and Healthy Ageing); health inequalities / access to health; reform of health systems.

George Zervos, Head of Special Service Health & Social Solidarity, Greek Ministry of Health, presented a policy paper on health adopted in May 2013, which principles are reflected in the Greek Partnership Agreement. Greece faces a lack of finance while in need of a health reform to address structural issues. The objectives of the health investments under the new ESIF programming period are to ensure healthcare sustainability, reduce health inequalities and upgrade human capital. Greece is also promoting a digital modernisation of the healthcare system through IT technology and health e-services.

Antoni Zwiefka, Senior Specialist, Lower Silesia Region, presented historical perspectives on the use of funds. During the period 2007-2013, Lower Silesia Region benefited from low financing for the health sector from the Structural Funds. However, the Region was still able to develop better health infrastructure and high-speed access to Internet. In 2014, Lower Silesia Region joined the European project Carewell, which will enable the delivery of integrated healthcare to frail elderly patients with complex needs. Under the ESIF 2014-2020, Lower Silesia Region has planned projects to integrate healthcare with telecare and to create platforms, which will support patients.

Karsten Uno Petersen, Vice-President of the Regional Council of Syddanmark & President of AER Committee "Social Policy and Public Health", showed the Smart Specialisation Strategy designed around three areas including Health and Social Innovation. The objectives of the Region in the field of health are to optimise and streamline hospitals, create growth and jobs and provide a quality and better experienced system. Syddanmark Region has been working with the entire value chain, in close cooperation between the public and the private sector, which has led to the creation of the Health Innovation Centre. An evaluation of the impact of the Structural Funds 2007-2013 shows a creation of 800 jobs in the Region.

Susana Fernandez Nocelo, Coordinator of European Projects, Galician Health Authority, presented the Health Innovation Platform, the main tool of the Galician public health system, co-funded at 80% by the Structural Funds 2007-2013. The Health Innovation Platform is geared towards improving quality, efficiency and sustainability of the Galician healthcare system. It is open to collaborative projects with all stakeholders including universities, companies, patients, etc. New innovation health projects are in the pipeline under the ERDF programme Hospital 2050 - Innova Saúde.

PACT FOR PATIENT SAFETY – LAUNCH IN THE EUROPEAN PARLIAMENT

On 15 October 2014 in the European Parliament a new fraternity of civil society and citizens for safer healthcare - Pact for Patient Safety - was launched by the Irish Patients Association. The aim was to showcase how engagement in the Pact and its signatories across Europe can support the call for greater accountability, access and patient safety in healthcare systems.

In the introduction the director of the Irish Patients Association related to patient safety in the context of current Ebola situation – how it is not just the problem of Africa, but a global problem regarding also European countries and calling for action. MEP Anneliese Dodds (S&D, UK), congratulated on the initiative of the Pact, appreciating the inclusion of patients and underlined many barriers on the way to create a safe healthcare. She encouraged to focus on collecting data, and what's more important now, on publishing, disseminating and understanding it. A representative from the European Commission (DG SANCO) mentioned the importance of European nature of the Pact and highlighted the importance of patient safety in the EU agenda.

To contrast the need of launching the Pact for Patient Safety, some failures in healthcare systems were indicated: high rate of healthcare acquired infections (HAI) and HAI-related high costs for hospitals, medication errors at prescription level, lack of comparable and reliable data of adverse effects and quality. All that calls for the creation of patient safety strategy programmes at national level and introduction of infection control staff across all EU countries. Further, it was suggested that in order to gain patient's trust, citizens should be included in the dialogue about safety of care and transparent information about drugs before they are launched on the market should be provided to patients.

A representative from the European Centre for Disease Prevention and Control (ECDC) presented activities and current undertakings of ECDC: HAI-net with standardised methodology, provision of feedback and reports on HAI and antimicrobial resistance to Member States, interactive database and many others. He also mentioned that in most cases, data is already collected at local and national level and the problem is to transfer and standardise this data at EU-wide level.

More information will soon be available at the newly launched website:
http://www.pact4safety.com/

LEADERSHIP AND MANAGEMENT – EVENT

On 16 October 2014, HOPE took part to the second event for employees holding executive positions organised by "Espace Cadre" at the *Centre Hospitalier Régional Universitaire* (CHRU) of Lille (France).

HOPE presentation was aimed at illustrating the role and the responsibilities of managers working in the healthcare sector in Europe as well as evidences emerging from the study HOPE conducted with the former National Institute for Innovation and Improvement.

The study "An Overview of the Role of Nurses and Midwives in Leadership and Management in Europe" compared the function of these two professional categories in Europe. This was followed by concrete examples from professionals of other European countries, showing the influence of

different social and health care systems in Europe on managerial roles in each national context. Participants expressed a strong interest for the HOPE Exchange Programme.

ACCESS BARRIERS TO HEALTH CARE FOR PEOPLE WITH CHRONIC DISEASES IN EUROPE – EULAR CONFERENCE

On 16 October 2014, HOPE attended in Brussels the conference organised by the European League against Rheumatism (EULAR) on the topic "Analysing how to reduce the Access Barriers to Health Care for People with Chronic Diseases in Europe".

During the morning session, experts from the World Health Organization (WHO), the European Commission (DG SANCO), and a wide range of stakeholder organisations presented political recommendations to all levels of health policy making: European, national and regional.

The lack of medical specialists and of early referral to them, too long waiting times for patients in many Member States, information gaps both on the side of patients and of general practitioners, as well as financial constraints impacting for instance reimbursement of medication were among the key access barriers to health care identified. In many countries, rather than improving, the situation seems to be deteriorating, as a result of the financial crisis and related austerity measures.

In the afternoon session, four workshops took place on the following topics: health systems response to financial constraints; patient empowerment, health literacy and information to patients; health professionals: availability/composition, roles, training, mobility, accreditation; access to treatments and medicines: availability, pricing and reimbursement. The workshops were co-chaired by EU stakeholders, with HOPE participating as co-chair in the fourth workshop dedicated to access to treatments and medicines.

Finally, the event concluded with a panel discussion about the role of the EU in tackling access barriers. Various issues around this topic were debated and panellist highlighted the need for better indicators in order to obtain information on access to care comparable at EU level.

THE CASE FOR CROSS-BORDER COLLABORATION – WORKSHOP

On 29 October 2014, the European Critical Care Foundation (ECCF) organised in Trieste (Italy) a workshop entitled "The case for cross-border collaboration: a pilot project to improve access to primary angioplasty to treat acute heart attack patients across borders between Italy, Slovenia and Croatia". The workshop was organised with the support and cooperation of the Mattone Internazionale Project.

In the treatment of acute heart attacks, timely, effective intervention is essential for better outcomes for both patients and healthcare providers. Action to overcome barriers in access to recommended best therapies requires mobilising multiple partners: health service providers, hospital staff, emergency transport services, patient organisations, policy makers and the general public. The various geographic, economic and organisational barriers that impede access become even more challenging to resolve in a cross-border context.

With the implementation of the Cross-border Healthcare Directive now fully underway, this workshop provided a timely opportunity to take stock of existing efforts to improve collaboration across borders in the region, in the management of patients with acute coronary syndromes.

During the workshop, the HoNCAB project (Support creation of pilot network of hospitals related to payment of care for cross border patients –www.honcab.eu) in which HOPE is involved as a partner was presented. The presentation focused on the part of the project dedicated to the investigation of the topic of tourism and cross-border care.

eHEALTH – COCIR SUMMIT – 18-19 NOVEMBRE 2014, BRUSSELS

The 1st Annual COCIR eHealth Summit will be organised in Brussels on 18 and 19 November 2014.

In the upcoming era of integrated care hospitals and other care providers will collaborate and share patient data, knowledge and insights form day-to-day operations. They will focus on continuous care, disease prevention and disease management.

This journey of transformation is however just at the beginning. Enabled by innovative technologies coupled with electronic information and communication systems, connected and coordinated healthcare organisations provide numerous opportunities to deliver care for patients while offering greater transparency, flexibility and choice, and increasing access to the services available.

Main topics at the eHealth Summit will include:

- integrated care and chronic disease;
- hospital IT investments and EPR deployment;
- regional & national longitudinal Electronic Health Record deployment;
- big data;
- mHealth.

***HOPE members can get a rebate by using the code* CeHS14HOPE**

More information :
http://www.cocirehealthsummit2014.org

AGENDA

UPCOMING CONFERENCES

APDH 5TH INTERNATIONAL HOSPITAL CONGRESS

THE NATIONAL HEALTH SERVICE - (RE)COGNISE THE CHANGES

20- 22 November 2014 – Lisbon (Portugal)

The Portuguese Association for Hospital Development (APDH) is preparing its "5th International Hospital Congress", this year under the theme "**The National Health Service - (Re)Cognise the Changes**" taking place on 20, 21 and 22 November 2014 in Lisbon.

On 20 November, the 8th edition of the Best Practices for Health Award will take place. At the same time, participants will be invited to participate to roundtables and workshops.

On 21 November, the conference will be opened by eminent speakers, representatives of Portuguese Institutions and European Organisations. One of them will be Mrs. Dr. Sara Pupato Ferrari, HOPE President. The topics presented during the day will be: reforms of the National Health System: different perspectives; 40 years history of the public hospitals in Portugal and the evaluation of the Patient Safety culture in the health organisations.

On 22 November, the discussion will be on the role of hospital in the society and the acknowledgement of changes in the NHS. At the end of the conference the winner for the Best Practices for Health and the Scientific Poster of the 5th International Congress of Hospital will be nominated.

More information and registration: http://5cih.url.ph/?lang=en

PASQ JOINT ACTION FINAL CONFERENCE

12-13 March 2015 – Brussels (Belgium)

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

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

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

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

HOPE AGORA 2015

HOSPITALS 2020:

HOSPITALS OF THE FUTURE,
HEALTHCARE OF THE FUTURE

31 May-2 June 2015 – Warsaw (Poland)

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

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

The HOPE Exchange Programme 2015 starts on 4 May and ends on 30 May, followed by the closing conference "HOPE Agora" in Warsaw (Poland) from 31 May to 2 June 2015. The closing conference is considered as part of the training and all professionals should attend it.

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

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

hope Agora 2015

Warsaw, 31 May - 2 June

www.hope-agora.eu

HPH CONFERENCE 2015

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

10-12 June 2015 – Oslo (Norway)

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

The deadline for abstract submission is 20 December 2014. The topics applicable for abstract submission are related to the following main themes of the conference:

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

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

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

More information: ***http://www.hphconferences.org/oslo2015.html***