



# NEWSLETTER

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## **UPCOMING CONFERENCES**

***12-13 March 2015 – Brussels (Belgium)***

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

***1-2 June 2015 – Warsaw (Poland)***

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

***10-12 June 2015 – Oslo (Norway)***

***HPH CONFERENCE 2015  
PERSON-ORIENTED HEALTH PROMOTION IN A RAPIDLY CHANGING WORLD:  
CO-PRODUCTION – CONTINUITY – NEW MEDIA & TECHNOLOGIES***

## HOPE ACTIVITIES

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### ***STUDY TOUR – QUALITY ASSURANCE IN GERMAN HOSPITAL CARE***

HOPE encourages its members to contribute to cross-border exchange of good practices. It has become a tradition, that members invite each other to share evidence and experience on topics of special relevance for the provision of a high level of quality in healthcare.

On behalf of this tradition, the German Hospital Federation (DKG – Deutsche Krankenhausgesellschaft) organised a study tour on the topic “Quality assurance in German hospital care”. For two days on 30 and 31 October, 25 participants coming from 12 EU Member States and Serbia were joining the workshop. Amongst them were representatives from Ministries, from hospital organisations as well from hospitals, all being in charge of quality in health and hospital care within their organisations.

The first day started with a series of presentations. Mr Marc Schreiner (Director EU-policies/international affairs at DKG) welcomed the participants in the premises of DKG’s headquarter, introduced the organisation as umbrella association of all German hospitals and provided an insight into the current political debate on the issue of quality.

Following presentations focused on DKG’s activities to promote quality in hospital care with a focus also on patient safety: an overview of all major national initiatives since 2003 and a description of actors, aims and outcomes was provided. Examples on DKG’s activities on quality assurance were also illustrated in two areas of special expertise like organ donation and premature births.

A representative from the Federal Joint Committee, where binding quality indicators for hospital care are set up by service providers’ and health insurances’ organisations, extensively described the composition, working methods and some of the activities of the committee. The first day concluded with a presentation of the AQUA-institute, the executive body for the external quality assurance model, and a presentation of the division “hospitals” of the Federal Association of Statutory Health Insurance Funds (SHI funds).

The second day started with a presentation from KTQ (“Cooperation for transparency and quality”) and a description of the accreditation process of hospitals. This was followed by a presentation of the company “qualitätskliniken.de”, together with its “five dimensions of quality”, being the basis for the transparency register with its almost 300 participating hospitals all over Germany and across all kinds of ownership.

After these presentations, the participants were carried to the military hospital and welcomed by Colonel MD Dr Christian Zechel as the deputy hospital director and head of quality management. After an introduction to the history, mandate and current state of the hospital he showed different examples of quality assurance in the local organisation of this hospital, e.g. an integrated IT-system enabling access to patient files across the different departments and showing compliance with quality management requirements. He ended his presentation by giving some examples of certifications and accreditations of different departments. Participants afterwards were shown around to decorated wards, e.g. the “wound centre” which received a certificate “wound centre,

dermatology, vascular surgery and trauma surgery” in September 2014 only, being the third hospital in Germany awarded. The visit ended at the rescue services centre of the hospital which also is certified and running the most modern models of rescue cars.



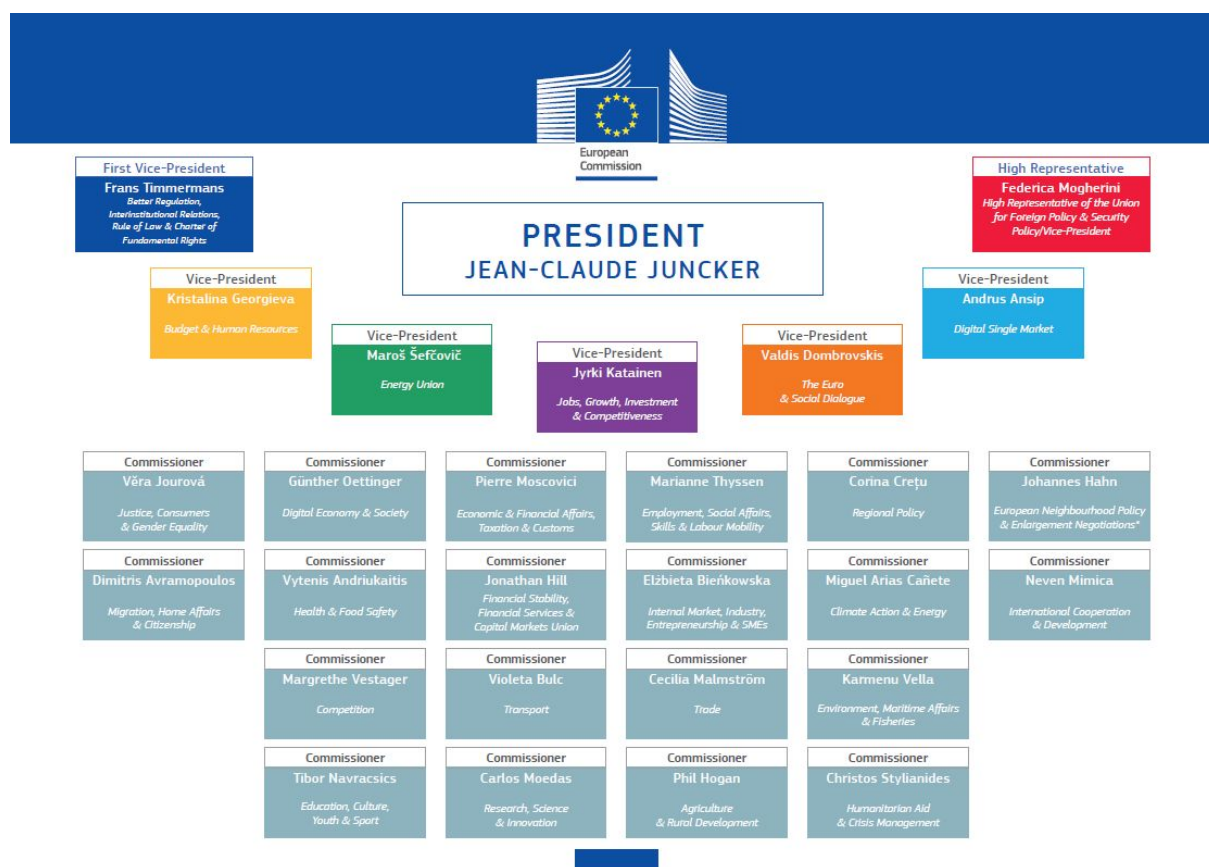
*More information and presentations are available at:*

<http://www.hope.be/04exchange/study tours/study tours first page.html.html>

## EU INSTITUTIONS AND POLICIES



### NEW EUROPEAN COMMISSION AT WORK



The new European Commission officially assumed office on 1 November, after the formal appointment received by the European Council. The new Commission, headed by Jean-Claude Juncker, is committed to restore citizens' confidence by demonstrating that the EU can deliver for them on the big challenges facing European economies and societies.

Mr Vytenis Andriukaitis from Lithuania is 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.

But the mission letter of the President of the European Commission of 1 November 2014 asks the Commissioner to focus on five topics including working together with the Commissioner for Internal Market, Industry, Entrepreneurship and SMEs to jointly develop EU policies as regards medicines and pharmaceuticals products while taking fully into account that medicines are not good like any other. The focus should also be on developing expertise on performance assessments of health systems, drawing lessons from recent experience, and from EU-funded research projects to build up country-specific and cross-country knowledge, which can inform policies at national and European level. To the extent that it relates to the quality and productivity of the EU workforce, to the modernisation of social protection systems and to the quality and effectiveness of public expenditure, this expertise can also usefully inform the work of the European semester of economic policy coordination.

The preparation of the 2015 Commission Work Programme started on 12 November. This process will be foreseen by First Vice-President Frans Timmermans, in charge of Better Regulation, Interinstitutional Relations, the Rule of Law and the Charter of Fundamental Rights. He will lead discussions on orientations within the College of Commissioners and with the European Parliament and the Member States in the General Affairs Council.

The 2015 Work Programme is expected to be adopted in mid-December.





### ***REORGANISATION OF DG SANCO – UPDATE***

Contrarily to the thought of many health organisations, the Commission's President Jean-Claude Juncker finally decided to definitively assign the health technology and cosmetics dossiers to DG Enterprise and Industry (ENTR). Only the medicinal products portfolio will remain responsibility of the Commissioner for Health and Food Safety.

Health organisations believed both portfolios would have been returned to DG SANCO when on 22 October the Commission's President announced his decision to leave the medicinal products portfolio to the Commissioner for Health and Food Safety. But during his speech at the European Parliament, he indeed did not refer to health technology and cosmetics.

Back in September, when the reorganisation of the two Commission's Directorate Generals was firstly announced, HOPE, together with other 35 EU health stakeholders express concern about this decision in a [joint letter](#). Concern was also expressed by Members of the European Parliament and Health Ministers from several Member States.

### ***MEDICAL DEVICES – UPDATE***

In September 2012, the European Commission published two proposals for Regulations on medical devices and in vitro diagnostic medical devices.

The aim of both proposals is to address inconsistencies in interpretation by the Member States of the current rules, increase patient safety, remove obstacles to the internal market, improve transparency with regards to information to patients, and strengthen the rules on traceability. The necessity of revision of the current EU rules particularly emerged following the scandal of defective breast implants produced by the French PIP company.

The European Parliament adopted its position in first reading in April 2014. After the European elections, in September 2014 the dossier on medical devices was assigned to Rapporteur Glenis Willmott (S&D, UK), who replaces the outgoing MEP Dagmar Roth-Behrendt. MEP Peter Liese (EPP, Germany) remains the Rapporteur for the Regulation on in vitro diagnostic medical devices.

In the Council, little progress has been achieved by the Italian Presidency. Some issues still divide Member States such as the reprocessing of single-use medical devices. Some Member States would like the issue to be regulated at EU level while others believe this is a national competence. Another issue is the surveillance of medical devices where not all agree on the balance between controls before and after placing devices on the market. Finally, a common position has not been found yet regarding the inclusion or not of aesthetic devices in the Regulation.

The Italian Presidency presented a progress report on this dossier during the next meeting of the Employment, Social Policy, Health and Consumer Affairs (EPSCO) Council taking place on 1 December.



## ***EBOLA OUTBREAK – MEETING WITH THE COMMISSION***

The Commission invited European health and other professionals likely to enter into contact with Ebola patients to a meeting in Luxembourg on 13 November 2014.

The aim was to identify gaps and challenges for organisations and their members in the context of Ebola, and to identify areas for EU support and discuss possible joint activities.

Invitees include European groups of medical specialists such as doctors, nurses and hospital pharmacists, patients' groups such as the European Patients' Forum, and border organisations such as Airports Council International and the European Sea Ports Association. Unfortunately only HOPE, the European federation of nurses, doctors (generalists and specialists) and the European Federation of Funeral services attended the meeting.

The meeting provided a forum to exchange information on Ebola. The Commission informed participants about activities to tackle Ebola at EU level, and learned how organisations of health professionals inform their target groups about Ebola.

The European Commission and EU Member States are closely collaborating within the Health Security Committee to manage the latest developments and to coordinate approaches on prevention and preparedness for Ebola. The European Centre for Disease Prevention and Control (ECDC) and the World Health Organisation (WHO) are producing risk assessments, epidemiological updates, advice to travellers and other information about the emergency.

After a review of the situation by the European Centre for Disease Control, the Commission services presented activities at EU level. Several Directorates Generals are involved but coordination is managed by the ECHO (European Commission's Humanitarian aid and Civil Protection department) with its emergency respond unit. DG Research is funding research on Ebola with projects in FP7 (Antigone, Predemics, Prepare including a questionnaire to hospitals on preparedness, Tell me) and an exceptional procedure was launched in Horizon 2020 for a budget of 24 million for 5 projects (including Reaction with coordinator INSERM and IF-Ebola with coordinator IRD), other actions in innovative medicines initiative with 280 million euros for a large scale clinical trials of new vaccines and Europe Developing Countries clinical trials partnership.

WHO-Europe was also represented and emphasised that the real fight is not in Europe. On the basis of what a strong health care system means, WHO considers Europe being low risk and that entry screening is not recommended but that exist screening is; the most important being to provide good information. ECDC presented the resource available for health professionals and the design of a virtual network of physicians.

EFN expressed a strong concern that European healthcare systems would face major challenges with Ebola patients. HOPE presented the information gathered through its network and its recent work on communicating in health crisis situations.

### ***More information:***

[http://ecdc.europa.eu/en/healthtopics/ebola\\_marburg\\_fever/Pages/index.aspx](http://ecdc.europa.eu/en/healthtopics/ebola_marburg_fever/Pages/index.aspx)

[http://ec.europa.eu/health/preparedness\\_response/risk\\_management/hsc/index\\_en.htm](http://ec.europa.eu/health/preparedness_response/risk_management/hsc/index_en.htm)

[http://ec.europa.eu/health/ebola/index\\_en.htm](http://ec.europa.eu/health/ebola/index_en.htm)

## ***ePRESCRIPTIONS – eHEALTH NETWORK ADOPTS GUIDELINES***

On 18 November 2014, the eHealth Network adopted guidelines on ePrescriptions during its 6<sup>th</sup> meeting. The eHealth Network is the network of national responsible authorities on eHealth. Its establishment was provided by the Directive 2011/24/EU on patients' rights in cross-border healthcare.

Being a partner of the eHealth Governance Initiative (eHGI), the preparatory body of the eHealth Network, HOPE and other EU stakeholders contributed to the process of revision of the guidelines. The guidelines on ePrescription aim to support Member States in developing interoperability of ePrescriptions. In a context where national health systems are moving towards electronic systems for medical prescriptions, it is important to ensure ePrescriptions can be used safely in another Member State.

The guidelines lay out the type of data needed to share prescriptions across borders. They also describe how the data should be transferred, provided the patient gives his or her consent to use the ePrescription service. The guidelines can be used by Member States on a voluntary basis.

*The Guidelines are available at:*

[http://ec.europa.eu/health/ehealth/docs/eprescription\\_guidelines\\_en.pdf](http://ec.europa.eu/health/ehealth/docs/eprescription_guidelines_en.pdf)

## ***RARE DISEASES – RECOMMENDATION ON WAYS TO IMPROVE CODIFICATION IN HEALTH INFORMATION SYSTEMS***

The Commission Expert Group on Rare Diseases has recently adopted Recommendation on ways to improve codification in health information systems.

Currently, only a small fraction of rare diseases have codes in international nomenclatures, making it a challenge to trace patients with rare diseases in health information systems on a national and international level. Having codes for each rare disease would help European and national health authorities obtain a better knowledge of healthcare pathways and of their impact on specialised health care services (e.g. centres of expertise) as well as on a country's budget planning for health and social service. It would also help in providing data for clinical research.

*The Recommendation is available at:*

[http://ec.europa.eu/health/rare\\_diseases/docs/recommendation\\_coding\\_cegrd\\_en.pdf](http://ec.europa.eu/health/rare_diseases/docs/recommendation_coding_cegrd_en.pdf)

## ***PHARMACEUTICAL INDUSTRY – COMMISSION MULTISTAKEHOLDER WORKSHOP***

On 22 October, the European Commission organised a multistakeholder workshop in Rome. This meeting was the first after the finalisation of the activities under the "Process on Corporate Responsibility in the Field of Pharmaceuticals". Within this process, HOPE was involved as a stakeholder in the Steering Group, and had the role to generate momentum and to ensure an effective development of the projects undertaken within the process.

The workshop brought together competent authorities responsible for pricing and reimbursement of pharmaceuticals and other relevant public and private stakeholders. It was the first opportunity to share views after the adoption last summer of the Commission Staff Working Document (SWD) entitled "[Pharmaceutical Industry: a strategic sector for the European economy](#)".

Several topics related to previous or ongoing activities were discussed during the meeting such as pricing and reimbursement issues. It was highlighted the need to better understand how prices are determined and explore flexible and innovative solutions which will allow Member States to ensure access to valuable medicines while rewarding innovation and promoting a cost-effective and rational use of pharmaceuticals. It was also stressed that such solutions and progress can happen through collaboration rather than legislation.

The topic of Managed Entry Agreements (MEAs) was also discussed and a proposal was put forward to create a Network on MEAs to assess the impact of MEAs on cost containment and patients' access and integrate MEAs in the HTA process.

In the course of the workshop, other topics were identified by some of the participants as potential topics for further exploration, the main of which are:

- the importance of maintaining the multistakeholders dialogue without repeating work/discussions which have already taken place but developing them further and operationally;
- the inclusion of representatives of regulatory agencies in EU level discussions on topics related to pricing and reimbursement;
- an increased focus on patients and payers' needs;
- aspects concerning SMEs, i.e. access to finance and reduction of regulatory burden;
- support to the sustainability of innovative industry in order to enable them to come up with new medicines by keeping patients in the centre of attention;
- unintended consequences of the application of external reference pricing – to be followed up by a pilot;
- rational use of medicines;
- demographic changes;
- recognition of medicines shortages, not necessarily of new and expensive medicines;
- implications in non-European markets of policy decisions taken in the EU;
- long-term commitment of the industry.

Based on other inputs received until the end of November, the Commission will prepare a short paper as a basis for the organisation of future meetings.

## EUROPEAN ANTIBIOTIC AWARENESS DAY



The European Antibiotic Awareness Day 2014 took place on 18 November to raise awareness about the threat of antibiotic resistance and the prudent antibiotic use. Latest data confirms that resistance to antimicrobials is increasing in Europe, creating a concern for public health. Raising awareness on prudent use of antibiotics is key in order to stop resistant bacteria to develop.

Ahead of the European Antibiotic Awareness Day, the European Centre for Disease Prevention and Control (ECDC) published the [Antimicrobial resistance surveillance report](#) and a [report on Surveillance of antimicrobial consumption](#). The reports collect data from 30 countries on antimicrobial resistance and antimicrobial consumption from the community (primary care sector) and the hospital sector. Countries submitted data to two Networks both part of the ECDC: the European Antimicrobial Resistance Surveillance Network (EARS-Net) and the European Surveillance of Antimicrobial Consumption Network (ESAC-Net).

This year European Antibiotic Awareness Day campaign focused on the theme of self-medication with antibiotics. Many Europeans still wrongly believe that antibiotics are effective against colds or flu. The latest Europe-wide survey (Eurobarometer, 2013) pointed out that many Europeans use left-over antibiotics from previous prescriptions or try to buy antibiotics without a medical prescription.

The ECDC prepared a [toolkit](#) which contains template materials and some suggested key messages focusing on self-medication with antibiotics.

*More information:*

<http://ecdc.europa.eu/en/eaad/Pages/Home.aspx>



### ***TTIP – NEW TRANSPARENCY RULES APPROVED***

On 25 November, the European Commission published a communication outlining how more transparency will be injected into the negotiations on a Transatlantic Trade and Investment Partnership (TTIP).

The main transparency initiatives will include:

- provision of more extensive access to TTIP documents notably by making public more EU negotiating texts that the Commission already shares with Member States and Parliament. However, this excludes US documents or common documents without the agreement of the US and EU market opening offers on tariffs, services, investment and procurement as they are the essence of the confidential part of the negotiations,;
- provision of a broad access to TTIP texts to all MEPs, subject to appropriate modalities to ensure the confidentiality of the information provided;
- publication of additional on-line materials and more extensive reporting on the outcomes of negotiation rounds.

Many concerns have been expressed by the civil society on the impact TTIP will have on health services. HOPE will work with its members to ensure health systems will not be negatively affected by TTIP.

*More information on TTIP:*

<http://ec.europa.eu/trade/policy/in-focus/ttip/>

*The Communication on transparency in TTIP negotiations is available at:*

[http://ec.europa.eu/news/2014/docs/c\\_2014\\_9052\\_en.pdf](http://ec.europa.eu/news/2014/docs/c_2014_9052_en.pdf)



### ***EUNETHTA JA2 – TRAINING COURSE FOR EUNETHTA STAKEHOLDERS***

On 29 October 2014, HOPE was part of a training course for EUnetHTA Stakeholders aimed at providing to the attendants the main information on HTA and its tools. In particular, during the meeting, WP leaders of the Joint Action 2 clarified the mission and the tasks of EUnetHTA as well as its key principles and core model.

The scope of these sessions was to be familiar with EUnetHTA, understanding the mission and tasks and getting an overview of the main tools. Then, the outcome to reach was to be able for the participants to explain what is meant by HTA and be aware of the key principles of how to conduct an HTA. Finally, attendants were involved in a session whose purpose was to learn where to find rapid core HTA information in a EUnetHTA pilot and how to use it in a decision making process.

***More information on EUnetHTA:***

***<http://www.eunethta.eu/>***

### ***JOINT ACTION CANCER CONTROL – WORK PACKAGE 2 MEETING***

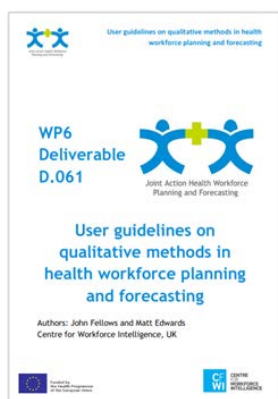
On 18 November 2014, HOPE participated to a meeting aiming at clarifying the dissemination and communication strategy to be developed by WP2 of Join Action on Cancer Control (Cancon). The participants invited at the event, mainly stakeholders active at the national as well as the European level, were asked to explain to the audience their expectations but also the contribution to the success of the project.

In the afternoon session, the leaders of the six core work packages gave a short presentation on the work packages content which was followed by an in-depth explanation on the actions to put in place to develop web pages, newsletter and social media strategy.

***More information on Cancon:***

***<http://www.cancercontrol.eu/index.php>***

## **JOINT ACTION HEALTH WORKFORCE PLANNING AND FORECASTING – USER GUIDELINES ON QUALITATIVE METHODS IN HEALTH WORKFORCE PLANNING AND FORECASTING**



These user guidelines have been produced by the Centre for Workforce Intelligence (CfWI) with support of a broad network of international representatives, as part of the Joint Action on European Health Workforce Planning and Forecasting.

They are aimed broadly at health workforce planners and forecasters in Member States and stakeholder organisations in the European Union who would like to apply qualitative methods to improve their health workforce planning and forecasting in their specific national contexts. The document describes the qualitative methods used by partners in Work Package 6 in the Joint Action on Health Workforce Planning and Forecasting. Qualitative methods are those which are used to gather and process information on the key factors affecting the supply and demand of health workforces (through techniques such as interviews) and includes methods to describe and quantify potential futures.

*The Guidelines are available at:*

[http://euhwforce.weebly.com/uploads/2/3/0/5/23054358/jahwf\\_do61\\_user\\_guidelines\\_on\\_qualitative\\_methods\\_approved.pdf](http://euhwforce.weebly.com/uploads/2/3/0/5/23054358/jahwf_do61_user_guidelines_on_qualitative_methods_approved.pdf)

*More information on Joint Action on Health Workforce Planning and Forecasting:*

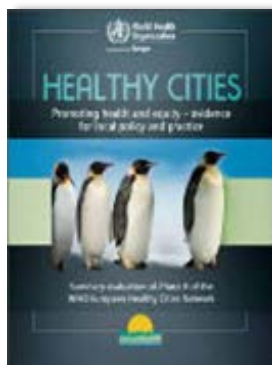
<http://www.euhwforce.eu/>



## REPORTS AND PUBLICATIONS



### **HEALTHY CITIES. EVIDENCE FOR LOCAL POLICY AND PRACTICE – WHO PUBLICATION**



This publication summarises the evaluation of Phase V (2009–2013) of the WHO European Healthy Cities Network. The evaluation process was designed in collaboration with city representatives, academic institutions and public health experts. It adopted a realist synthesis approach, being responsive to the unique social, cultural, political, health and epidemiological circumstances in the 99 cities in the WHO European Healthy Cities Network and 20 accredited national networks.

The evaluation findings are rooted in the enduring values such as equity, governance, partnership, participation and sustainability. Also considering the core Phase V themes, this publication focuses on policy and governance, healthy urban environments and design, caring and supportive environments, health and active living, national networks' performance and effects on health and equity. The evaluation finds good progress among cities and networks that differs in scale and quality. The healthy cities movement adds value and allows local governments to invest in health and well-being and address inequities through novel approaches to developing health.

**More information:**

[http://www.euro.who.int/\\_data/assets/pdf\\_file/0007/262492/Healthy-Cities-promoting-health-and-equity.pdf](http://www.euro.who.int/_data/assets/pdf_file/0007/262492/Healthy-Cities-promoting-health-and-equity.pdf)

### **HIT ITALY – EUROPEAN OBSERVATORY PUBLICATION**



The European Observatory on Health Systems and Policies has recently published a health system review on Italy as part of the series "Health Systems in Transition" (HiTs). The publication of this report coincides with the Italian Presidency of the European Union's Council of Ministers.

The Health Systems in Transition (HiT) profiles are reports that provide a detailed description of a health system, reforms and policy initiatives under development in a specific country. Main chapters focus on organisation and governance of the health system, financing, physical and human resources, provision of services, principal health care reforms and assessment of the health system.

Faced with rising regional deficits and austerity budgets focused on reduced public spending, the Italian National Health Service has been grappling with a dual challenge: containing or even reducing health expenditure while at the same time dealing with greater demand for its services. To date, these efforts have managed to be successful - regional deficits are now largely under control and the benefit package continues to be delivered effectively, albeit with much more tightly stretched resources and increased cost-sharing for some services. Italy's belt-tightening responses to its fiscal crisis have also exacerbated the existing inequity across regions, where gaps in service provision and health system performance persist.

Government policies have focused on setting caps on pharmaceutical spending, reducing the number of hospital beds and shifting care away from acute stays, increasing co-payments and instituting new purchasing contracts for medical goods. A major policy tool has been the adoption of "financial recovery plans" by high-deficit regional health systems, targeting the structural determinants of costs, as well as national "health pacts" binding regions to budgetary discipline. However, the overt focus on financial retrenchment should not overshadow the need for longer term strategies for better health system performance, such as efforts to promote greater group practice among health professionals working in primary care, bolstering the quality of professionals managing public facilities, and ensuring that the concentration of organisational control by regions of health care providers does not stifle innovation.

*More information:*

[http://www.euro.who.int/\\_data/assets/pdf\\_file/0003/263253/HiT-Italy.pdf?ua=1](http://www.euro.who.int/_data/assets/pdf_file/0003/263253/HiT-Italy.pdf?ua=1)

## ***HOW CAN PUBLIC REPORTING OF QUALITY INFORMATION DRIVE THE PUBLIC TO CHOOSE CARE PROVIDERS? – EUROPEAN OBSERVATORY POLICY SUMMARY***

Promoting and enabling choice in publicly-funded health and long-term care services has gained popularity in many countries over recent decades, as it can empower individuals and bring about improved care and outcomes as providers compete for business. But for choice (and competition) of care provider to live up to its potential, people need good comparative information about care providers to make informed decisions.

In the policy summary authors review the literature on the measurement and reporting of quality information, provide insights to support future investment in public reporting systems, and summarise strategies aiming to increase the use of reporting by patients and users.

It shows that widespread use of quality information has been slow to materialise across health and long-term care, despite the extensive investment in reporting systems by governments and private sector organisations. There is, however, some evidence that reporting encourages providers to address quality issues to improve their reputation in the sector.

The policy summary is targeted at policy-makers, care providers and information developers. The evidence will be helpful for them in creating reports more likely to be used and valued by patients and users when choosing health or care providers. This summary was published as part of a European Commission project, the European Union Cross-Border Care Collaboration (EUCBCC).

*More information:* <http://goo.gl/N7doUw>

## **CROSS-BORDER HEALTH CARE IN EUROPE – EUROPEAN OBSERVATORY POLICY SUMMARY**

Patient mobility is high on the political agenda in the EU, with increasing numbers of people crossing European borders. Issues relating to health professional mobility have received less attention, yet this is an important policy issue for the EU considering the scale of and reliance on professional mobility between countries, and existing variations in educational and professional standards.

This new policy summary explores how European health systems are responding to increasing patient and professional mobility across the European Union. Recent legislative changes which clarify patient entitlements to cross-border care are likely to have important impacts on national and EU-wide policies. However, measures to optimise implementation of clinical guidelines, discharge summaries, use of technologies and regulation of professional standards are all likely to be beneficial for patients receiving care in their home country as well as for those who travel abroad. It combines a literature search with evidence gathered by the Evaluating Care Across Borders (European Union Cross Border Care Collaboration) Project to provide an update on the 2005 "Policy Brief on Cross-Border Health Care in the European Union".

**More information:**

[http://www.euro.who.int/\\_data/assets/pdf\\_file/0009/263538/Cross-border-health-care-in-Europe-Eng.pdf?ua=1](http://www.euro.who.int/_data/assets/pdf_file/0009/263538/Cross-border-health-care-in-Europe-Eng.pdf?ua=1)

## **ANTIMICROBIAL RESISTANCE SURVEILLANCE IN EUROPE – ECDC REPORT 2013**



Antibiotic resistance is a serious threat to public health in Europe, leading to increased healthcare costs, prolonged hospital stays, treatment failures and sometimes death. Prudent antibiotic use and comprehensive infection control strategies targeting all healthcare sectors (acute care hospitals, long-term care facilities and ambulatory care) are the cornerstones of effective interventions to prevent selection and transmission of antibiotic-resistant bacteria.

The European Centre for Disease Prevention and Control (ECDC) has recently published its Antimicrobial resistance surveillance report. It presents antimicrobial resistance data for seven microorganisms of major public health importance: *Escherichia coli*, *Klebsiella pneumoniae*,

*Pseudomonas aeruginosa*, *Acinetobacter* species, *Streptococcus pneumoniae*, *Staphylococcus aureus*, and *Enterococci*.

For 2013, data were reported by 30 countries and the report also presents trend analyses for the period 2010–2013.

**More information:**

<http://www.ecdc.europa.eu/en/publications/Publications/antimicrobial-resistance-surveillance-europe-2013.pdf>

## **TRANSFERABILITY OF HEALTH PROMOTION AND HEALTH EDUCATION APPROACHES BETWEEN NON-COMMUNICABLE AND COMMUNICABLE DISEASES – ECDC REPORT**



The European Centre for Disease Prevention and Control (ECDC) has recently published a report on the transferability of health promotion and health education approaches between non-communicable and communicable diseases.

This review examines approaches to the prevention of chronic (non-communicable) diseases that have been developed and used in health education and health promotion and considers how these approaches have been applied to the prevention of communicable diseases.

The study assumes that many of the causal factors considered for the prevention of diseases and the efforts required to change them apply to both non-communicable diseases and communicable diseases. Details are presented on applicable health education and health promotion models for prevention and possible modification of these models is considered for use in the sphere of infectious diseases.

**More information:**

<http://www.ecdc.europa.eu/en/publications/Publications/transferability-of-health-promotion-2014.pdf>

## **CRITICAL ASPECTS OF THE SAFE USE OF PERSONAL PROTECTIVE EQUIPMENT – ECDC TUTORIAL REPORT**



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

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

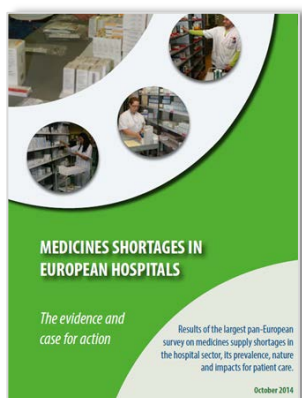
For this reason, the ECDC released this tutorial, which presents the fundamental concepts of personal protective equipment (PPE) and barrier nursing to support preparedness in hospitals across Europe. It provides practical information on the proper use of PPE at the point of care, including technical requirements and procurement aspects.

Furthermore, it aims to strengthen preparedness and capacities for the safe use of PPE in hospitals in Europe and other countries with equivalent standards in health care.

**More information:**

<http://www.ecdc.europa.eu/en/publications/Publications/safe-use-of-ppe.pdf>

## **MEDICINES SHORTAGES – 2014 EAHP REPORT**



On 17 November 2014, the European Association of Hospital Pharmacists (EAHP) published a very debatable report on medicines shortages in European hospitals.

The report presented result of a survey of only 600 hospital pharmacists in over 30 countries, and with an over representation of some of them (in particular those affected by the crisis) and under-representation of others.

The headline findings are then not relevant as European figures even if they may for some individual Member States.

**More information:**

[www.eahp.eu/sites/default/files/shortages\\_reporto5online.pdf](http://www.eahp.eu/sites/default/files/shortages_reporto5online.pdf)

## **ORGANISATIONAL READINESS FOR KNOWLEDGE TRANSLATION IN CHRONIC CARE – DELPHI STUDY**

Healthcare organisations need to be ready prior to implement evidence-based interventions. In this study, authors sought to achieve consensus on a framework to assess the readiness of healthcare organisations to implement evidence-based interventions in the context of chronic care.

They conducted a web-based modified Delphi study between March and May 2013 and contacted 76 potentially eligible international experts working in the fields of organisational readiness (OR), knowledge translation (KT), and chronic care to comment upon the 76 elements resulting from a proposed conceptual map. This conceptual map was based on a systematic review of the existing frameworks of Organizational Readiness for Change (ORC) in healthcare. In total, 14 participants completed the first round and 10 completed the two rounds. Panel members reached consensus on the applicability and importance of 6 out of 17 dimensions and 28 out of 59 sub-dimensions to assess OR for KT in the context of chronic care. This study results provided the most important and applicable dimensions and sub-dimensions for assessing OR-KT in the context of chronic care.

**More information:**

<http://www.biomedcentral.com/content/pdf/s12913-014-0534-0.pdf>

## **TRANSFERABILITY OF HEALTH COST EVALUATION ACROSS LOCATIONS IN ONCOLOGY – ANALYSIS**

The transferability of economic evaluation in health care is of increasing interest in today's globalised environment. Here, authors propose a methodology for assessing the variability of data elements in cost evaluations in oncology. This method was tested in the context of the European Network of Excellence "Connective Tissues Cancers Network".

Using a database that was previously aimed at exploring sarcoma management practices in Rhône-Alpes (France) and Veneto (Italy), they developed a model to assess the transferability of health cost evaluation across different locations. A nested data structure with 60 final factors of variability (e.g., unit cost of chest radiograph) within 16 variability areas (e.g., unit cost of imaging) within 12 objects (e.g., diagnoses) was produced in Italy and France, separately. Distances between objects were measured by Euclidean distance, Mahalanobis distance, and city-block metric. A hierarchical structure using cluster analysis (CA) was constructed. The objects were also represented by their projections and area of variability through correlation studies using principal component analysis (PCA).

Finally, a hierarchical clustering based on principal components was performed. CA and PCA were found to be useful for assessing the variability of cost evaluations across countries. In future studies, regression methods could be applied after these methods to elucidate the determinants of the differences found in these analyses.

*More information:*

<http://www.biomedcentral.com/content/pdf/s12913-014-0537-x.pdf>

## **HUMAN RESOURCE MANAGEMENT IN POST-CONFLICT HEALTH SYSTEMS – REVIEW**

In post-conflict settings, severe disruption to health systems invariably leaves populations at high risk of disease and in greater need of health provision than more stable resource-poor countries. The health workforce is often a direct victim of conflict. Effective human resource management (HRM) strategies and policies are critical to addressing the systemic effects of conflict on the health workforce such as flight of human capital, mismatches between skills and service needs, breakdown of pre-service training, and lack of human resource data.

This paper reviews published literatures across three functional areas of HRM in post-conflict settings: workforce supply, workforce distribution, and workforce performance. Authors searched published literatures for articles published in English between 2003 and 2013. The search used context-specific keywords (e.g. post-conflict, reconstruction) in combination with topic-related keywords based on an analytical framework containing the three functional areas of HRM (supply, distribution, and performance) and several corresponding HRM topic areas under these. In addition, the framework includes a number of cross-cutting topics such as leadership and governance, finance, and gender.

The literature is growing but still limited. Many publications have focused on health workforce supply issues, including pre-service education and training, pay, and recruitment. Less is known about workforce distribution, especially governance and administrative systems for deployment and incentive policies to redress geographical workforce imbalances. Apart from in-service training, workforce performance is particularly under-researched in the areas of performance-based incentives, management and supervision, work organisation and job design, and performance appraisal. Research is largely on HRM in the early post-conflict period and has relied on secondary data. More primary research is needed across the areas of workforce supply, workforce distribution, and workforce performance. However, this should apply a longer-term focus throughout the



different post-conflict phases, while paying attention to key cross-cutting themes such as leadership and governance, gender equity, and task shifting.

The research gaps identified should enable future studies to examine how HRM could be used to meet both short and long term objectives for rebuilding health workforces and thereby contribute to achieving more equitable and sustainable health systems outcomes after conflict.

*More information:*

<http://www.conflictandhealth.com/content/pdf/1752-1505-8-18.pdf>

## **CROSS-BORDER PATIENT MOBILITY IN THE EUROPEAN UNION – ARTICLE**

In this article the author, Rita Beaten, describes briefly the scenario on European NHSs after the introduction of the EU Directive on patients' rights in cross-border healthcare. The number of patients within the European Union (EU) deliberately travelling to another EU Member State to receive planned health care is relatively small. Patients do, however, prefer to be treated abroad when they are more familiar with the language, culture or health care system across the border or when the appropriate services abroad are nearer than similar services in their country of residence.

This is typically the case of citizens living in sparsely populated border regions. The Directive may increase legal certainty and transparency on benefit packages, tariffs and reimbursement levels and may push authorities to address weaknesses in the domestic systems, particularly regarding waiting times. It may, however, also require the benefit package to be revised or adapting the payment system.

*More information:*

<http://hsr.sagepub.com/content/19/4/195.full.pdf+html>

## **GENERATING HEALTH TECHNOLOGY ASSESSMENT EVIDENCE FOR RARE DISEASES – STUDY**

Rare diseases are often heterogeneous in their progression and response to treatment, with only a small population for study. This provides challenges for evidence generation to support HTA, so novel research methods are required.

Discussion with an expert panel was augmented with references and case studies to explore robust approaches for HTA evidence generation for rare disease treatments. Traditional RCTs can be modified using sequential, three-stage or adaptive designs to gain more power from a small patient population or to focus trial design. However, such designs need to maintain important design aspects such as randomisation and blinding and be analysed to take account of the multiple analyses performed. N-of-1 trials use within-patient randomisation to test repeat periods of treatment and control until a response is clear. Such trials could be particularly valuable for rare diseases and when prospectively planned across several patients and analysed using Bayesian techniques, a population effect can be estimated that might be of value to HTA.



When the optimal outcome is unclear in a rare disease, disease specific patient reported outcomes can elucidate impacts on patients' functioning and wellbeing. Likewise, qualitative research can be used to elicit patients' perspectives, with just a small number of patients. International consensus is needed on ways to improve evidence collection and assessment of technologies for rare diseases, which recognise the value of novel study designs and analyses in a setting where the outcomes and effects of importance are yet to be agreed.

*More information:*

<http://journals.cambridge.org/download.php?file=%2FTHC%2FSo266462314000464a.pdf&code=7f5b6c4592a999503395fd739ff44a29>

### **MEASURING PERFORMANCE IN OFF-PATENT DRUG MARKETS – A METHODOLOGICAL FRAMEWORK AND EMPIRICAL EVIDENCE FROM TWELVE EU MEMBER STATES**

This paper develops a methodological framework to help evaluate the performance of generic pharmaceutical policies post-patent expiry or after loss of exclusivity in non-tendering settings, comprising five indicators (generic availability, time delay to and speed of generic entry, number of generic competitors, price developments, and generic volume share evolution) and proposes a series of metrics to evaluate performance.

The paper subsequently tests this framework across twelve EU Member States (MS) by using IMS data on 101 patent expired molecules over the 1998–2010 period. Results indicate that significant variation exists in generic market entry, price competition and generic penetration across the study countries. Size of a geographical market is not a predictor of generic market entry intensity or price decline. Regardless of geographic or product market size, many off patent molecules lack generic competitors two years after loss of exclusivity. The ranges in each of the five proposed indicators suggest, first, that there are numerous factors – including institutional ones – contributing to the success of generic entry, price decline and market penetration and, second, MS should seek a combination of supply and demand-side policies in order to maximise cost-savings from generics. Overall, there seems to be considerable potential for faster generic entry, uptake and greater generic competition, particularly for molecules at the lower end of the market.

*More information:*

<http://www.healthpolicyjrnal.com/article/So168-8510%2814%2900206-1/fulltext>



### ***DUTCH HOSPITALS PROVIDE RELIABLE "ONE CLICK" PATIENT INFORMATION USING THE QUALITY WINDOW***

In 2013, the Dutch healthcare system was once again ranked number one in the European Health Consumer Index (EHCI). The newly launched Quality Window continues the country's work to maintain reliable and quality healthcare.

Dutch hospitals are overwhelmed with requests for data and statistics on the quality of their care and treatments. Social media and the internet are the vehicles for this growing public demand. Although it is impossible to provide all of the information patients request, Dutch general hospitals have taken a big step by launching the so-called Quality Window earlier this year. Developed partly by patients, the Quality Window intends to meet the patient demand for information. All Dutch general hospitals already participate on a voluntary basis, and university hospitals promise to follow soon. So far, the new system appears to be a success.

In the Netherlands, hospitals provide data to authoritative bodies such as the Dutch Care Institute (a government-initiated program), including data on the quality of care. However, it is difficult for patients and other groups to obtain, use, and process this data. Patient groups seek such information so as to provide details to the public about care options. Health insurance companies want this data to assess whether a hospital meets safety standards and volume criteria – and if not, to open discussions with the hospital board. The Dutch Health Care Inspectorate, which is a government-run organisation to supervise hospitals, would also benefit from such information. Last but not least, the Dutch media, which frequently focuses on healthcare issues, could use this hospital data to underpin its reporting.

#### **TRANSPARENCY**

For some time now, both the public and the government have called for transparency in the quality of care. Hospitals too would like to gain more control. Therefore, general hospitals in the Netherlands have established transparency as a strategic theme for the coming years. The healthcare sector wants to be proactive in this transparency, publishing information itself instead of waiting for media rankings, as such rankings are often inaccurate and thus of little relevance to the average patient.

#### **WHAT IS THE QUALITY WINDOW?**

The Dutch Association of Hospitals (Nederlandse Vereniging van Ziekenhuizen - NVZ) was inspired by the development of a tool for Dutch school accountability, which provides information such as children's results, their rating of the school, their parents' opinions of the school, etc. The NVZ wanted to develop a similar "window" for patients that would give them an impression of a hospital's

qualities. This led to the development of the Quality Window, an online platform for patients that reports on general aspects of the quality of care at hospitals around the country. The Quality Window provides hospital scores and data in 10 indicators, presented in a recognizable and easy-to-understand format on hospital homepages. Scores include patient experience ratings, the number of well-founded complaints made against the hospital, and the frequency of verification of medication upon admission and discharge.

### **USING THE QUALITY WINDOW**

In many cases, a hospital's results can be compared to the previous year, the national average, or to measures like the mortality rate. In addition, the Quality Window provides general explanations of what the indicators mean and the extent to which an indicator mirrors a hospital's actual quality level. Many hospitals also take the opportunity to expand on how indicators materialise in practice and actions they are taking towards improvement. In this way, the data is made not only accessible to patients, but also comprehensible and useable. Both hospitals and the NVZ view this as an important added value of the Quality Window. The goal now is to expand the tool beyond the current structural and process indicators into also providing scores on actual outcomes.

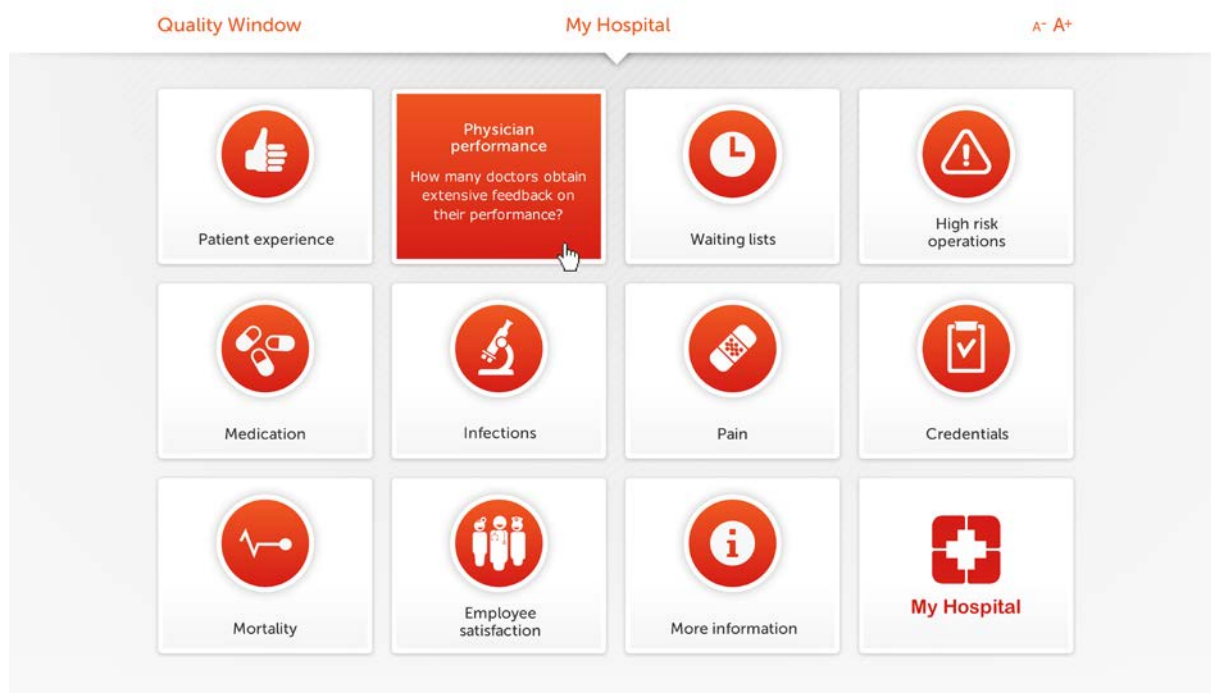
### **IMPORTANT CHOICES**

Since the NVZ wanted to create a clear and comprehensible tool for patients, it had to make choices. The 10 indicators were chosen by hospital board members, quality consultants, experts, and patients, in collaboration with the Dutch Federation of Patients and Consumer Organisations, the NPCF. The NVZ also set out conditions for the indicators. First, that they are relevant to the patient. Second, that they have already existed for several years. And third, that they are distinctive (for this reason, issues such as pressure ulcers were not included). One of the goals of the Quality Window, too, was that it did not increase the administrative burden on hospitals.

### **PUBLIC PARTICIPATION ROUNDS**

After the 10 indicators were chosen, they were further developed and tested in a pilot at six hospitals. The Quality Window was then designed, developed, and updated through feedback meetings with boards, patients, and the NVZ, and through various tests with several groups of patients and quality and communication consultants.

## THE 10 INDICATORS



### 1. Patient experience

The first indicator in the Quality Window addresses the patient experience. How does a patient experience the hospital? This indicator is measured by a general rating in patient satisfaction. The number of legitimate complaints is also shown, and a link to the hospital's complaints policy is provided. Results are compared with previous years. The patient experience indicator is also presented alongside data about the hospital's size.

### 2. Physician performance

The main question addressed by this indicator is: how many doctors obtain extensive feedback on their performance? This is an indicator from the Dutch Health Care Inspectorate. It concerns the percentage of extended feedback interviews once every two years with colleagues and sometimes with patients, on the performance of the doctor according to the Individually Functioning Medical Specialists methodology – the so-called IFMS calls. This result is compared with the national average and with a previous year.

### 3. Waiting lists

This indicator is measured by the speed with which a patient can be treated at a hospital, in other words, by the length of a hospital's waiting lists. This indicator includes the average waiting times for outpatient and inpatient treatment in a single year.

### 4. High risk operations

How often does a hospital perform risky operations, and do these operations meet the volume requirements? This indicator is provided by the Dutch Health Care Inspectorate, the Ministry of Health, and the Dutch Institute for Clinical Auditing (DICA). It presents data on the actual number of operations and the corresponding requirements for the number of operations performed (i.e.

volume). The closer operation numbers are to the minimum recommended amount, as determined by professional associations of doctors, the more likely it is that operations are conducted according to current standards.

#### **5. Medication**

This indicator, from the hospital's safety management system, is measured as the percentage of patients whose medication use is checked upon admission and discharge. Results are compared to the previous year.

#### **6. Infections**

How often do infections occur after surgery? This is also an indicator from the safety management system. It includes the number of cases of central line associated sepsis and the percentage of infections after knee and hip operations. The results are compared to the previous year.

#### **7. Pain**

How much pain do patients experience in this hospital? The Dutch Health Care Inspectorate provides the percentage of patients who indicated a pain score of 7 or below, on a scale of 1 to 10, at some point during the first 72 hours after surgery. The theme includes a link to the hospital's pain policy. Results are compared to the national average and to the previous year.

#### **8. Credentials**

This indicator addresses the general quality of the hospital, and includes licenses, certifications, and accreditations given by e.g. patient organisations or health insurance companies. Patients can also find a link to the annual quality monitor reports of the Dutch Health Care Inspectorate.

#### **9. Mortality**

An indicator that often gains attention in the media is a hospital's mortality rate. The Dutch Ministry of Health has mandated that the Hospital Standardized Mortality Ratio (HSMR) be accessible to patients. Although this indicator is much in dispute because of its complex nature, it does point to the potentially avoidable deaths. The indicator is measured as the ratio of the actual number of acute in-hospital deaths to the expected number of in-hospital deaths (based on the patient's characteristics upon admission). This section of the Quality Window links to the SMRs of specific diagnoses.

#### **10. Employee satisfaction**

How does staff rate the hospital? This information is taken from employee satisfaction surveys. It is an indication for the motivation levels of staff, and as such aims to contribute to better care. Results are compared to previous surveys.

### **CONCLUSION**

The Quality Window was launched in May 2014 and received positive media attention around the country. But that was only the beginning.

The Quality Window is under continuous development. The NVZ is monitoring the indicators and, if necessary, will replace them with new, more relevant ones. Hospitals themselves can update their Quality Window at any time, and each year the NVZ will send a reminder to them to review and update their data.

There are also plans to develop diagnosis-specific Quality Windows. These windows will give patients insight into the quality of care particular to their condition or disease. The emphasis here will be more on treatment results by means of outcome indicators. Such indicators, however, will have to be introduced cautiously, but they will shed new light on hospitals and their performance. Ultimately, the NVZ aims to use the Quality Window to bring Dutch hospital care to new levels, ensuring safer, more transparent, and better medical results nationwide.

*More information (in Dutch):*

<https://www.nvz-kwaliteitsvenster.nl/>



### ***MIGRATION OF HEALTHCARE WORKERS – ILO PROJECT FINAL CONFERENCE***

The final conference of the Decent Work Across Borders project was organised on 7 November 2014 in Brussels.

The International Labour Organization (ILO) is the United Nations' international organisation responsible for drawing up and overseeing international labour standards. It is the only 'tripartite' United Nations agency that brings together representatives of governments, employers and workers to jointly shape policies and programs promoting Decent Work for All.

In 2006, the [ILO Multilateral Framework on Labour Migration](#) was adopted by the ILO constituents. These non-binding principles and guidelines are a response to widespread demands for practical guidance and action with a view to maximising the benefits of labour migration for all parties.

Whereas the demand for Filipino nurses and other health professionals to work overseas and migrate has encouraged thousands to pursue nursing, India and, to a lesser degree Vietnam are now also looking into this strategy measuring the challenges and opportunities it offers. These countries are actively pursuing cooperative agreements on hiring of health care professionals to various destination countries, and in particular, European Member States. Balancing the right to health, decent work and the right to freedom of movement is a constant preoccupation.

While migrant health care workers from developing countries are contributing to the health care sector of developed countries, the migration of professionals and skilled workers from developing countries is perceived to negatively affect the development potentials of the countries of origin. This phenomenon has been referred to as the "brain drain". The international migration of health care professionals directly impacts the achievement of health-related Millennium Development Goals (MDGs), which relies upon strong and sufficiently staffed national health care systems. As a consequence, sending and receiving countries have shown interest in developing voluntary policies to facilitate the return of healthcare professionals to their source country with the aim to support their resuming active participation in the health workforce of their home country.

In this context, the ILO [Decent Work Across Borders](#) project has commissioned over the past months a series of research papers to better document the various dimensions of the mobility of health care professionals in the aim to bring policy makers and stakeholders together to discuss the best options to ensure that the migration of health professionals benefits all concerned.

In 2011, the European Union has awarded the ILO funds to work on the issue of circular migration. The ILO *Decent Work Across Borders project: A Pilot project for Migrant Health Professionals and Skilled Workers* seeks to better understand schemes in line with circular migration of health professionals. This is done by engaging governments, trade unions, and employers organisations around three main objectives: to strengthen mechanisms of policy dialogue among stakeholders; to



strengthen employment services for healthcare professionals and skilled workers; to enhance labour market information system with regards to the migration of healthcare professionals and skilled workers.

Through this project, the ILO seeks to facilitate an approach to migration that benefits the migrant workers, the source and destination countries within a rights-based framework for labour migration management. The project focuses its activities on three Asian countries with significant outflows of health professionals and skilled workers for foreign employment, namely: the Philippines, India, and, in a more modest way Vietnam.

The objective of the conference was to provide a venue for sharing some of the emerging/potential good practices and lessons learned stemming from the ILO *Decent Work Across Borders* project achievements and implementing partners in addressing the mobility of health professionals between source and destination countries.

Specifically, the conference was devoted to the restitution of the project's achievements on the following topics: assessing the nursing skills comparability between the Philippines and selected countries in Europe; avenues to mobility: lessons from bilateral labour arrangements on the mobility of health professionals and option for circular migration; promoting ethical recruitment for the mobility of health professionals – public and private options; the role of trade union in promoting international ethical recruitment.

Approximately 20 organisations, including HOPE, based in Brussels were invited to participate in the meeting.

### ***EUROPEAN SOCIETY OF RADIOLOGY – BRUSSELS, 4 NOVEMBER 2014***

The European Society of Radiology (ESR) invited HOPE to speak at their European Parliament event.

The ESR appealed to the newly installed European Commission and the recently elected European Parliament to back stricter measures for medical imaging procedures as a part of a wider effort to improve patient care and safety.

"More targeted and more efficient use of medical imaging techniques will reduce unnecessary exposure to radiation, and also improve health outcomes through better diagnosis and more effective treatment," ESR President (Dr. Lorenzo Bonomo) told event attendees. "Common indicators and parameters should be developed at the European level."

Elisabeth Morin-Chartier, a French Member of the European Parliament (MEP) said she would use her influence to support the proposals and speed any legislative measures through the EU system. She stood alongside fellow French MEP Natalie Griesbeck from the liberal Alliance for Liberals and Democrats for Europe (ALDE) group and Italian Patrizia Toia from the left of center Socialists & Democrats (S&D) group.

The ESR event took place the day after the European Commission commenced office for a new, five-year term. Andrzej Rys, the Commission's director for Health Systems and Products, backed the

principles of the ESR's appeal, but also refused to be drawn into saying what might reasonably be expected in terms of new legislation.

Former ESR President Dr. Guy Frija warned there were wide gaps across European countries in the radiology sector, from the number of radiologists per person and annual income of trainee radiologists, to CT scanners per 1,000 inhabitants and exams per person.

Dr. Hans-Ulrich Kauczor, who is Chair of the ESR Research Committee and head of the radiology and diagnostic department at the University Hospital in Heidelberg, Germany, appealed for education and training for radiologists, saying there needs to be harmonisation of basic standards across Europe. He called on the EU institutions to back the ESR's European Training Curriculum for Radiology and the European Diploma in Radiology, and said there should be mandatory continuous medical education and professional development throughout the EU. "The principle of free movement of professionals in the EU has to be balanced with qualifications," Kauczor said.

Kauczor also called for European biobanks to be set up: a structured repository for imaging data to simplify access to personalised medicine, clinical trials, and drug development, as well as generic imaging biomarkers.

ESR First Vice President Dr. Luis Donoso noted a more systematised use of radiology would reduce the 10% to 30% of unneeded radiology procedures that are performed every year.

"More targeted and more efficient use of medical imaging techniques will not only reduce unnecessary exposure to radiation, and thereby help prevent harmful effects, but will also improve health outcomes through better diagnosis and more effective treatment," said Donoso, who is also the director of the diagnostic imaging department at Barcelona University Hospital.

This was an opportunity for HOPE as a conclusion to remind the European context of major diversity, to link the ESR initiative to the quality and patient safety agenda as well as to personalised medicine.

## ***eHEALTH – CONFERENCE AT THE EUROPEAN PARLIAMENT***

On 19 November 2014, HOPE attended the conference organised by MEP Cristian-Silviu Buşoi (EPP, Romania) at the European Parliament.

The conference, entitled "Promoting eHealth: efficiency, transparency and equal access to health services for patients", had the objective to illustrate developments in the area of eHealth, concrete initiatives at Member States and EU levels and discuss about challenges identified when implementing these concrete initiatives.

In the introductory speech, MEP Peter Liese (EPP, Germany) expressed the opinion that a common regulatory framework is needed at EU level in the area of eHealth. He also underlined the importance of data protection, given the high level of sensitivity of health data.

A first panel composed by the European Commission and COCIR, the European Coordination Committee of the Radiological, Electromedical and Healthcare IT Industry was invited to start the

debate on this issue. COCIR's secretary general, Mrs. Nicole Denjoy, provided the point of view of the industry in this area and highlighted several challenges which currently hamper the full deployment of eHealth solutions, such as lack of harmonisation, different HTA and reimbursement systems in the EU and the unavailability of adequate research funding.

This intervention was followed by two presentations from the European Commission, Directorate Generals for Health and Consumers and Communication Networks, Content and Technology. Both highlighted the work done by the Commission in the area of eHealth and next steps. Among the future actions it was mentioned the willingness to create a EU infrastructure for health data exchange through Connecting Europe Facility funding, and the need to work more on areas such as big data and electronic health records. The Commission will also publish in December a summary report from the consultation on mobile health (mHealth) launched in April 2014 and which received 211 responses. Further policy actions on mHealth will also be announced in 2015.

In the second part of the conference another panel was invited to illustrate experiences from two Member States: France and Romania. Both presentations introduced the regulatory framework in the respective countries and some example of eHealth solutions such as telemedicine services or electronic health records implemented.

In his concluding remarks, MEP Cristian-Silviu Buşoi reiterated the importance of eHealth and its willingness and commitment to collaborate with stakeholders during the course of his mandate.

## AGENDA

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## UPCOMING CONFERENCES



### *PASQ JOINT ACTION FINAL CONFERENCE*

*12-13 March 2015 – Brussels (Belgium)*



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

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

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

*More information will soon be available at: [www.pasq.eu](http://www.pasq.eu)*

## HOPE AGORA 2015



*HOSPITALS 2020:*

*HOSPITALS OF THE FUTURE,  
HEALTHCARE OF THE FUTURE*

*1-2 June 2015 – Warsaw (Poland)*

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

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

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

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

*More information on the HOPE Exchange Programme:*  
<http://www.hope.be/o4exchange/exchangefirstpage.html>



## **HPH CONFERENCE 2015**

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

**10-12 June 2015 – Oslo (Norway)**

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

**The deadline for abstract submission is 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>