NEWSLETTER

N° 123 – February 2015

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www.hope-agora.eu

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Public Health

CLINICAL TRIALS – EMA PROPOSAL RISKS TO JEOPARDISE TRANSPARENCY

The Association Internationale de la Mutualité (AIM), Health Action International (HAI) Europe, the International Society of Drug Bulletins (ISDB), the Medicines in Europe Forum (MiEF) consider that the European Medicines Agency (EMA) proposals for the application of the transparency rules of the European clinical trials Regulation waters down transparency provisions.

The revised clinical trials Regulation (EU No 536/2014) was adopted in April 2014. The new Regulation aims at boosting clinical research in Europe by simplifying the rules for conducting clinical trials, while maintaining high standards of patient safety.

A majority of hospitals are involved in research studies which often take the form of clinical trials. The newly adopted Regulation represents for HOPE a significant improvement to the previous Directive and a clear attempt to streamline the authorisation of new clinical trials and improve transparency.

The European Medicines Agency (EMA) launched the last 21 January 2015 a public consultation on how the transparency rules of the European clinical trials Regulation will be applied in the new clinical trial database. The database will be used for submission and maintenance of clinical trial applications and authorisations within the EU. It will serve as the source of public information on the clinical trial applications assessed, and all clinical trials conducted in the EU. According to the Regulation, EMA is responsible for the development and maintenance of the database, while the authorisation and oversight of clinical trials will remain with the EU Member States.

The document under consultation until 18 February sets out proposals for the application of the transparency rules of the European clinical trials Regulation. The proposals aim to balance the right of patients and the public to access extensive and timely information on clinical trials, and developers' and researchers' need to benefit from investments.

In a joint response, the Association Internationale de la Mutualité (AIM), Health Action International (HAI) Europe, The International Society of Drug Bulletins (ISDB), The Medicines in Europe Forum (MiEF) pointed out that the EMA's proposal misinterprets the clinical trials Regulation and waters down transparency provisions.

In particular, it is underlined that EMA proposes a very broad definition of "commercially confidential information". Thus, the implementation of this definition would allow clinical trial

sponsors to circumvent the publication of whole documents (including trial protocols, subject information sheets, investigator brochures, the investigational medicinal product dossier, etc.) on the grounds that their economic interests might be potentially undermined.

Furthermore, the EMA also proposes to defer the trial information (e.g., trial protocols, investigational medicinal product dossier (IMPD) safety and efficacy sections) up to 10 years after the end of a trial by establishing a complex classification system that ranks clinical trial documents into different categories. This will allow clinical trial sponsors to postpone or even avoid the publication of clinical data on the grounds of commercial confidentiality.

Finally, the proposal also states that "the EU database will not contain any individual patient listings from clinical trials" even though such listings are part of clinical study reports. In the joint response, it is highlighted that such data is fundamental to allow secondary research and analysis. It is therefore important to ensure that all clinical trial data information made available is in a legible, easily usable, downloadable and searchable format.

The full joint response is available at:
http://english.prescrire.org/Docu/DOCSEUROPE/20150218_EMAaddendumTransparency.pdf

ACCESS TO MEDICINES – DEBATE AT THE EUROPEAN PARLIAMENT

On 11 February 2015, during the plenary session in Strasbourg, MEPs hold a debate on the topic of access to medicines in the EU.

MEPs highlighted the need for more transparency on pharmaceutical pricing, particularly in view of the budgetary pressures on national health systems.

The session was attended by the Latvian Secretary of State for European Affairs, Zanda Kalnina-Lukasevica, and the Commissioner for Humanitarian Aid and Crisis Management, Christos Stylianides on behalf of Vice-President Jyrki Katainen.

Ms Kalnina-Lukasevica stressed that in December 2014, the Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) adopted conclusions on innovation for the benefit of patients, which invited Member States and the Commission to deepen work in several areas, namely to explore opportunities for exchange of information between competent bodies in relation to the "life cycle approach" for innovative medicinal products.

The Council invited them as well to implement the Health Technology Assessment (HTA) Strategy adopted recently by the HTA Network and to increase effective sharing of information on prices and expenditures on medicinal products – such a measure should contribute to greater transparency, while respecting the competence of Member States for financing their health systems, including reimbursement of medicinal products. It was also requested to increase transparency from all relevant actors – including industry – that could contribute to increased availability and accessibility of innovative products. At the end of her intervention, Ms. Kalnina-Lukasevica pointed out that the Latvian Presidency will work on the implementation of the Council conclusions in the coming months.

Commissioner Stylianides also mentioned the Council conclusions on innovation for the benefit of patients and informed about the 1st meeting held on 27 January 2015 by the newly established Commission's Expert Group on Safe and Timely Access to Medicine for Patients (STAMP). This expert group will examine ways to use existing regulatory tools under EU pharmaceutical legislation more effectively with the aim of fostering innovation and further facilitating safe and timely access, in order to end the unavailability of innovative medicines for patients with unmet medical needs.

Many MEPs took the floor during the debate, stressing the need to improve access to medicines for patients in Europe, which is in certain cases hampered by pricing and reimbursement issues.

EUROPEAN REFERENCE NETWORKS – UPDATE

Since the last European Reference Networks (ERNs) news in the December HOPE newsletter, progress has been made in several areas, namely:

- On 19 January 2015, the ERN Board of Member States approved the rules of procedure for the functioning of the Board. The main tasks of the Board are: approval of Networks proposals and healthcare provider's membership applications included in a Network proposal; approval of healthcare providers wishing to join an existing Network; termination of a Network (evaluation); loss of membership.
- The development of the assessment manual and toolbox for the ERNs has started. The tender regarding this task has been awarded to the PACE-ERN consortium led by the European Organisation for Rare Diseases (EURORDIS) and where HOPE is involved as a partner. The assessment manual and toolbox produced will address all the steps of the process from the call for Networks and providers to the approval of the Networks including the materials and methods to be used and the expected end products, thus being essential for the objective assessment of ERN proposals to be presented in December 2015.
- Websites of the pilot Networks on Rare Paediatric Cancer (ExporNet) and neurologic complex conditions (E-pilepsy) funded by the Public Health Programme have been launched.

The Commission foresees to launch its call for ERNs in December 2015.

More information: http://ec.europa.eu/health/ern/policy/index_en.htm

CEN PUBLISHES STANDARD ON AESTHETIC SURGERY SERVICES

On 20 January 2015, the European Committee for Standardization (CEN) announced the publication of a new European Standard in relation to aesthetic surgery services (EN 16372).

Some EU Member States have specific regulations on aesthetic surgery, but most countries do not have them. CEN considers that this gap can now be closed by the voluntary European Standard on aesthetic surgery services. It is expected that this standard will help to improve the quality of these services, enhance the safety and satisfaction of patients, and reduce the risk of complications.

This new voluntary European Standard provides requirements and recommendations in relation to services provided by aesthetic surgery practitioners. These recommendations concern various aspects such as: ethics and marketing, information provided to patients, competencies of the surgeons, the consultation procedure, requirements for clinical facilities and post-operative follow-up.

The new European Standard was developed by CEN's Project Committee on "Aesthetic Surgery and Aesthetic Non-surgical Medical services", which was set up in 2010. This Committee includes practitioners nominated by CEN Members as well as other stakeholders including the European consumer voice in standardisation (ANEC), which represents consumer interests in standardisation.

The new European Standard was formally approved by CEN in October 2014 and the final version of the standard was made available to all CEN Members (National Standardization Bodies) on 17 December. Before the end of June 2015, this standard will be published at national level by CEN Members in 33 European countries.

PATIENT SAFETY AND QUALITY OF CARE – EXPERT GROUP MEETING

On 11 February 2015, HOPE attended the meeting of the Patient Safety and Quality of Care Expert Group.

The Expert Group brings together representatives from all 28 EU countries, EFTA countries, international organisations and stakeholders, including HOPE. The group assists in developing the EU patient safety and quality agenda.

Following up from the last meeting on 18 December, the group met again with the main purpose of reviewing and discussing the work programme for 2015 presented by the European Commission. This Commission's first proposal was based on the input received at the previous meeting.

The Commission explained the vision standing behind the proposal presented, which is to:

- streamline and simplify current work;
- create synergies and avoid duplication;
- increase visibility.

A new possible future structure was also presented. The structure proposed is based on three layers:

1. Set up of Work streams composed by 20-25 experts. Experts will be selected through a call for interest. There will be three Work streams at the beginning, each of them working on a very specific topic. The three initial topics proposed are: 1) exchange of good practices (mainly building on the work done by the PaSQ Joint Action); 2) information to patients on patient safety and quality of care; 3) self-care.
2. An Executive Board composed of Member States will monitor the work of the Work streams as well as membership and will nominate the leader of each Work stream. The Commission stressed the importance to exploit the potential and the new opportunities offered by IT tools. Thus, several teleconferences can be foreseen to present/follow up the work done within the Work streams.

3. As one of the objectives is to increase visibility, the third layer should aim at engaging a wide range of stakeholders (MEPs, healthcare providers, healthcare professionals, academia, etc.). Conferences will then be organised to present good practices and to promote further involvement.

The Commission also proposed the establishment of a prize that can be awarded once/twice per year to good initiatives.

The details of the proposal will be articulated in a concept note that will be circulated by the Commission among the participants of the Expert Group. The concept note and the proposal will be open to comments. The objective is to adopt this document and the work plan in the next meeting of the Expert Group, which will take place on 8 June.

The meeting was also an opportunity to hear about other initiatives in the area of patient safety and quality of care. The PaSQ Joint Action (European Union Network for Patient Safety and Quality of Care) was reviewed, with a special focus on the sustainability activities. The project final results will be presented during a meeting co-organised by HOPE in Brussels on 12-13 March.

The WHO presented the progress with the work on the Minimal Information Model (MIM) for Patient Safety Reporting, a project started in 2013. The MIM intends to be a core set of elements of a reporting system, which provides minimal information. Its purpose is to facilitate a common tool that could be used for aggregation, communication, and learning across different reporting systems. The project entered into its final phase: a consultation was launched in May 2014 to review the project findings, and facilitate a wider expert discussion about the relevance, pertinence, and conditions of use of a MIM for patient safety reporting and learning systems. Based on the results, recommendations will be formulated at the end of the project.

Other initiatives presented were the EU regulatory Network's draft guidance on medication errors produced by the European Medicines Agency (EMA), the results and recommendations from the project European Musculoskeletal Conditions Surveillance and Information Network (eumusc.net), which aimed to developing and operationalising a relevant health surveillance and information system, leading to improved musculoskeletal health for all. Finally, a recently published study to map and review Continuous Professional Development (CPD) and lifelong learning of health professionals in the EU/EFTA was also illustrated.

More information:
http://ec.europa.eu/health/patient_safety/policy/index_en.htm

Presentations are available at:
http://ec.europa.eu/health/patient_safety/events/ev_20150211_en.htm

EXPERT PANEL ON INVESTING IN HEALTH – NEW REQUESTED OPINIONS

The Expert Panel on Effective Ways of Investing in Health is a panel of independent scientists set up to provide the European Commission with "sound and timely scientific advice on effective ways of investing in health". The opinions formulated by the Expert Panel are not binding.

On 25 February 2015, the European Commission requested three opinions on the following topics.

- *Access to healthcare*. Four main areas need to be investigated by the panel:
  1) the impact of poor access to healthcare on EU health systems and the broader economy;
  2) provide a taxonomy of the groups most excluded, the role played by stakeholders in the identification of main problems as well as a list of monitoring tools already available or that can be developed;
  3) definition of the limits of acceptable variations in access to healthcare and healthcare provision among Member States;
  4) identification of policy actions that can be taken to improve access to healthcare and the role of the EU.

- *Cross-border cooperation*. The Expert Panel has been asked to identify existing as well as potential areas of cross-border cooperation in healthcare provision. It will also have to investigate the main barriers as well as actions that can be taken at EU level to overcome these obstacles.

- *Disruptive innovation in healthcare: considerations for the future*. The Expert Panel will have to develop a simple taxonomy of disruptive innovation by identifying key types and categories of services and technologies. Experts will also have to identify knowledge gaps and suggest areas where further research is needed. Finally, experts have also been asked to look into drivers and barriers and to investigate the implications of disruptive innovation in training and education of clinicians, healthcare staff and other stakeholder.

All opinions should be finalised by June 2015.

More information on the Expert Panel on Effective Ways of Investing in Health:
http://ec.europa.eu/health/expert_panel/index_en.htm

COMPETITION AMONG HEALTHCARE PROVIDERS IN THE EU – CONSULTATION ON EXPERT PANEL ON INVESTING IN HEALTH PRELIMINARY OPINION

On 24 February 2015, the European Commission launched a public consultation on the preliminary opinion on the "Competition among Health Care Providers in the European Union: Investigating Policy Options".

The Expert Panel on Effective Ways of Investing in Health is a panel of independent scientists set up to provide the European Commission with "sound and timely scientific advice on effective ways of investing in health." The opinions formulated by the Expert Panel are not binding.

With this public consultation the Expert Panel is seeking feedback from the scientific community and stakeholders. The contributions received will be used by the Experts for the consolidation of the opinion.

The opinion addresses the role of competition among healthcare providers as an instrument to improve efficiency in the use of health system resources. The conditions for competition to be a useful instrument vary across countries, healthcare subsectors and time. According to the opinion,

introducing, increasing or changing competition in health services is a delicate policy exercise. The need for an appropriate regulatory framework should be analysed, and relevant institutions and mechanisms be put in place.

Accreditation of providers and the detailed design of payment systems are of specific importance, states the report. Sound policy evaluation studies are also needed to assess and judge the impact of competition, because policy design and policy outcomes are likely to vary from one context to another. Key elements to consider when introducing, changing or increasing competition are ensuring market transparency, with availability of information on quality and prices, careful monitoring of access and equity effects, promoting health literacy, and enforcement of competition rules to prevent the creation, strengthening and abuse of dominant positions.

The deadline for the submission of contributions is 8 April 2015.

More information on the Expert Panel on Effective Ways of Investing in Health:
http://ec.europa.eu/health/expert_panel/index_en.htm

More information on the consultation:
http://ec.europa.eu/health/expert_panel/consultations/competition_healthcare_providers_en.htm

ANTIMICROBIAL RESISTANCE – COMMISSION PUBLISHES PROGRESS REPORT

On 26 February 2015, the European Commission published a progress report on the Action Plan against the raising threats from Antimicrobial Resistance.

Antimicrobial Resistance (AMR) is a serious, worldwide, public health concern for both humans and animals. According to data from 2009, 25000 patients in the EU die annually as a result of infections caused by resistant bacteria. The costs incurred by AMR amount to an estimated 1.5 billion Euros annually, due to loss of productivity and an increase in healthcare expenditure costs.

The European Commission launched in November 2011 a five year Action Plan against Antimicrobial Resistance. The Plan is based on a holistic approach involving all sectors and aspects of antimicrobial resistance (public health, animal health, food safety, consumer safety, research, non-therapeutic use of antimicrobials, etc.). It aims at strengthening the prevention and control of antimicrobial resistance across the sectors and at securing the availability of effective antimicrobial agents. The Action Plan covers seven areas and sets out 12 concrete actions both in the human and veterinary field.

With the progress report, the services of the Commission are further informing the European Parliament, Member States and other stakeholders about the progress made so far on the implementation of the Action Plan.

For example, to promote the appropriate use of antibiotics in human medicine, the EU is financing ARNA, a study to identify the drivers behind the attainment of antibiotics without a prescription; and the ARPEC project aiming to improve the quality of antibiotic prescribing for children. To strengthen the prudent use of antimicrobials, the Commission adopted in September 2014 new legislative proposals on veterinary medicines and on medicated feed that will address the threat of

AMR in both areas. Amongst the report's conclusions is that AMR will remain a priority in the EU beyond 2016.

The European Commission also announced the institution of a prize of 1 million Euros, which will be awarded to the person or team that develops a rapid test to tell whether a patient needs to be treated with antibiotics or not.

The progress report on the Action Plan against the raising threats from Antimicrobial Resistance is available at:
http://ec.europa.eu/health/antimicrobial_resistance/docs/2015_amr_progress_report_en.pdf

More information on the Commission's prize on better use of antibiotics:
http://ec.europa.eu/research/horizonprize/index.cfm?prize=better-use-antibiotics

SOCIAL ECONOMY INTERGROUP – RE-LAUNCH

The Social Economy Intergroup (SEIG) was officially re-launched by its members on 27 January 2015 during the constitutive meeting held at the European Parliament, in Brussels.

Social Economy represents 2 million enterprises and employs over 14 million paid employees in the European Union. The promotion of Social Economy can contribute to job creation, growth, and further social cohesion in the European Union.

The new bureau is formed by 5 co-chairs and 2 vice-chairs, who were elected by the members: Mr. Jens Nilsson (S&D, Sweden), Mr. Ramón Luis Valcárcel (EPP, Spain), Ms. Beatriz Becerra (ALDE, Spain), Ms. Marie-Christine Vergiat (GUE/NGL, France) and Mr. Sven Giegold (GREENS/EFA, Germany) and the two vice-chairs, Ms. Sofía Ribeiro (EPP, Portugal) and Ms. Elena Gentile (S&D, Italy). The bureau will decide the activities and political priorities of the SEIG for the next 4 and half years. However, the main guidelines from the SEIG were already agreed by its members.

The bureau plans to organise two public hearings on spring 2015 on the inclusion of the social economy among the political priorities of the European Commission for this new mandate. In order to ensure the development and visibility of social economy, the SEIG aims to formulate concrete proposals to the European Commission.

TTIP – DOCUMENT LEAKED

The EU's draft position on TTIP and specifically the part that refers to EU and Member States commitments and reservations on specific issues regarding goods and services was leaked on 26 February to the BBC.

TTIP is currently one of the most popular acronyms in the international policy making scene. It stands for Transatlantic Trade and Investment Partnership (TTIP). In practice, the TTIP is an agreement which regulates trade between the European Union comprised of 28 member countries, and the United States of America (USA). The TTIP is currently in the negotiation phase , which was set to finish by the end of 2014, but negotiations have dragged on and have been re-launched in 2015.

The 103 age document, entitled "Trade in services and investment schedule commitments and reservations" is available here.

More information: http://news.bbc.co.uk/2/shared/bsp/hi/pdfs/26_02_2015_ttip.pdf

EMERGENCY AMBULANCE SERVICES AND COSTS CONTROL

The Court of Justice of the EU ruled on 11 December 2014 (case C-113/13) that in order to ensure the social purpose of emergency ambulance services and for reasons of budgetary efficiency, Member States may entrust these services on a preferential basis, and award them directly to voluntary associations.

In 2010, the Italian region Liguria concluded a framework agreement with various national public aid associations representing local voluntary associations in order to regulate the relations between the health and hospital authorities and those associations. Under that framework agreement, the Local Health Authority N.5 concluded agreements for urgent and emergency ambulance services with the associations affiliated to the national public aid associations with which the framework agreement was concluded, without issuing a call for tenders. The cooperatives San Lorenzo and Croce Verde Cogema then sought to have those agreements annulled.

Hearing an appeal in that case, the Italian Council of State asked the Court of Justice whether the rules of EU law on public procurement and competition allow national legislation which enables the local authorities to entrust the provision of ambulance services on a preferential basis and by direct award, without any form of advertising, to the voluntary associations covered by the agreements which receive only reimbursement for the costs actually incurred and a fraction of their overall costs.

The Court concludes that the EU Treaty allows national legislation which provides that the provision of ambulance services must be entrusted on a preferential basis and awarded directly, without any advertising, to the voluntary associations covered by the agreements, in so far as the legal and contractual framework actually contributes to the social purpose and the pursuit of the objectives of the good of the community and budgetary efficiency.

More information:
http://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1425031560375&uri=CELEX:62013CJ0113

CHRODIS – STAKEHOLDER FORUM

On 19 February, HOPE attended the 2nd Stakeholder Forum held by the Joint Action on Chronic Diseases and Promoting Healthy Ageing Across the Life Cycle (JA-CHRODIS).

In addition to the participation of JA-CHRODIS consortium members, relevant stakeholders (e.g. health professionals, policy makers, patient organisations, etc.) are being invited to contribute to the process of identifying good practices in European countries and regions in the field of chronic disease prevention and care, focusing on cardiovascular diseases, stroke and type 2 diabetes. The aim of JA-CHRODIS is to set up a Platform for Knowledge Exchange.

JA-CHRODIS is co-funded by the Health Programme of the European Union.

More information: http://www.chrodis.eu/

JOINT ACTION FOR MENTAL HEALTH AND WELL-BEING – STAKEHOLDERS' MEETING

HOPE was invited to the Joint Action for Mental Health and Well-being stakeholders' meeting that took place in Brussels on 25 February 2015.

Significant efforts have been made by EU and Member States (MS) to improve mental health of the populations. Yet, despite all these efforts, a lot remains to be done. In European countries, at least 30% of people with severe mental disorders do not have access to mental healthcare, and the majority of the population do not benefit from the interventions that have proved to be effective in prevention and promotion.

It was in this context that the European Pact for Mental Health and Well-being, launched in June 2008, agreed that "there is a need for a decisive political step to make mental health and well-being a key priority" and that "the mental health and well-being of citizens and groups, including all age groups, different genders, ethnic origins and socio-economic groups, needs to be promoted based on targeted interventions that take into account and are sensitive to the diversity of the European population".

To attain these objectives, a series of thematic conferences were organised, from 2009 to 2011, to facilitate the sharing of experiences and to strengthen collaboration between stakeholders. Finally, giving sequence to all these events, in 2011, the Council invited Member States and the Commission to set up a Joint Action on mental health and well-being under the health program.

The Joint Action for Mental Health and Well-being (JA MH-WB), launched in 2013, aims at building a framework for action in mental health policy at the European level and builds on previous work developed under the European Pact for Mental Health and Well-being. It involves 51 partners representing 28 EU Member States and 11 European organisations, and is coordinated by the Nova Medical School/Faculdade de Ciências Médicas, Nova University of Lisbon, Portugal.

The Joint Action addresses issues related to five areas:

- promotion of mental health at the workplaces;
- promotion of mental health in schools;
- promoting action against depression and suicide and implementation of e-health approaches;
- developing community-based and socially inclusive mental healthcare for people with severe mental disorders;
- promoting the integration of mental health in all policies.

In each of the five areas of work of the Joint Action, a similar methodology was adopted, which includes a situation analysis in participating countries, the development of recommendations for action, and the support to the endorsement of a framework for action by EU and Member States.
Concerning "developing community-based and socially inclusive mental healthcare for people with severe mental disorders" the Joint Action found out that from 2005 to 2011, 1/3 of 28 Member States maintained or even increased beds. Community based services only been partially developed in most countries but there have been substantial development of short-stay in general hospitals.

Coordinators of the five areas of work of the Joint Action at the national level are using the meetings of the national networks to build consensus and promote their engagement. The same objective will be attained through meetings and other activities at the European level that will contribute to strengthen/create networks.

To support the endorsement of the recommendations by Member States and the EU, and promote their commitment for follow-up actions, a final Joint Action conference will be organised in the beginning of 2016.

Finally, to build the sustainability of mental health policy initiatives in Europe, a close collaboration was established with other European mental health initiatives, in the research, clinical and policy areas, and a specific strategy will be developed to create the mechanisms that are required to support a permanent, structured and coherent cooperation in mental health policy in Europe in the future.

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

EU: MORE EQUALITY IN HEALTHCARE – EUNETHTA PROJECT

On 26 February 2015, HOPE was invited to the joint action EUnetHTA stakeholders meeting. In 2012 a EU initiative, a collaboration between Health Technology Assessment (HTA) agencies (EUnetHTA), was set up in order to achieve the European Commission goal of creating more equitable, cost-effective and available healthcare throughout its Member States. HOPE is since then involved in this initiative as stakeholder.

Today, across EU governments there are differences in HTA processes, with two major models used. One, used in countries such as France, is based on determination of added clinical benefit, which then leads to price negotiation and a final decision. In other countries, such as the UK, a health economics analysis using the price is proposed by a company and the decision is based on the calculation of the estimated cost/QALY. This is then compared to the threshold acceptable for the country's policy makers. The licensing of drugs is already carried out at a pan-European level by the European Medicines Agency (EMA).

Within this framework, the EU initiative proposes a centralised approach to HTA. The EUnetHTA Joint Action 2 Grant Agreement has been in place since 1 October 2012, and is scheduled to run for three years. 37 partners in 26 EU Member States are involved. Two types of collaborative action have been attempted. The first is to cooperate on HTA production for avoiding duplication of work and increasing consistency and transparency. To achieve that, joint assessment reports of core HTA information have been created in order to have templates for companies to submit data and methodological guidelines for HTA bodies to follow.

The second type of collaboration is a project to improve the quality of data produced in primary research. Early dialogues meetings, disease specific guidelines and a definition of common core protocols for the collection of additional data have been set up. In early dialogues, the company presents its development plan and asks questions to HTA bodies to check whether the choices made are appropriate.

More information on EUnetHTA: www.eunethta.eu/

DEVELOPMENT OF EVIDENCE BASED STRATEGIES TO IMPROVE THE HEALTH OF ISOLATED AND VULNERABLE PERSONS – CALL FOR TENDER

The European Commission has recently launched a call for tender for the organisation of a pilot project related to the development of evidence-based strategies to improve the health of people living in isolated and vulnerable situations.

The pilot project aims to facilitate the development and implementation of actions to improve the health and access to health services of people in vulnerable and isolated situations at national and regional levels through raising awareness of their specific health and service needs. Developing and disseminating knowledge on best practices for effective action as well as supporting the involvement of Member States, regional authorities and other stakeholders are also important aspects of this project.

More specifically, the objectives of the contract are to gather and assess information on the particular health needs and risk factors faced by people living in isolated and vulnerable situations; review existing approaches and identify best practices to promote health and prevent health problems; support the development and implementation of actions through establishing a group of experts for information exchange; facilitate capacity building and training, and disseminate project results in Member States.

Capacity building and training activities for the development and implementation of actions must enable a wide participation of competent authorities and non-governmental bodies of EU Member States, representing different geographic, socio-economic and cultural settings. Representativeness in terms of sector and expert area should also be ensured when establishing an expert group.

The deadline for the submission of proposals is 13 March 2015.

More information:
http://ec.europa.eu/dgs/health_food-safety/funding/call_sante_2014-c4-034_en.htm

INNOVATION PROCUREMENT – HORIZON 2020 CALLS FOR PROPOSAL

Horizon 2020 provides EU funding to start innovation procurements. This funding is targeted at potential buyers of innovative solutions: groups of public procurers, possibly together with other types of procurers that are providing services of public interest and have similar procurement needs (e.g. private, NGO procurers).

Horizon 2020 provides different types of support for procurers:

- Coordination and Support Actions (CSA) support coordination and networking activities for groups of procurers to investigate the feasibility and/or prepare the ground for concrete future innovation procurements. CSA grants do not provide EU co-financing for an actual procurement.
- PCP or PPI Cofund actions co-finance both the procurement cost for groups of procurers to buy together the research, development and validation (PCP) or deployment (PPI) of innovative solutions as well as coordination and networking costs to prepare, manage and follow up such procurements. More in specific:
  - *Public Procurement of Innovative solutions (PPI)* can be used by procurers when challenges of public interest can be addressed by innovative solutions that are nearly or already in small quantity on the market. PPI can thus be used when there is no need for procurement of new R&D to bring solutions to the market, but a clear signal from a sizeable amount of early adopters/launch customers that they are willing to purchase/deploy the innovative solutions if those can be delivered with the desired quality and price by a specific moment in time. A PPI may still involve conformance testing before deployment.
  - *Pre-Commercial Procurement (PCP)* can be used by procurers when there are no near-to-the-market solutions yet that meet all the procurers' requirements and new R&D is needed to get new solutions developed and tested to address the procurement need. PCP can then compare the pros and cons of alternative solutions approaches and de-risk the promising innovations step-by-step via solution design, prototyping, development and first product testing. PCP is a public procurement of R&D services that does not include the deployment of commercial volumes of end-products.

Several call for proposals in this domain are currently open. Depending on the call, deadlines are set for 14 April or 21 April 2015.

More information on the calls for proposal:
http://ec.europa.eu/research/participants/portal/desktop/en/opportunities/h2020/ftags/innov_proc.html#c,topics=flags/s/InnovationProcurement/1/1&+callStatus/asc

More information on Horizon 2020:
http://ec.europa.eu/programmes/horizon2020/

MOMENTUM – FINAL VERSION OF BLUEPRINT FOR TELEMEDICINE DEPLOYMENT

On 5 February 2015, the Momentum project released the final validated and tested version of the *Blueprint for telemedicine deployment*, which offers critical success factors and performance indicators that help decision makers to scale up healthcare services from a distance through information technology.

The Blueprint also delivers a self-assessment toolkit that helps an organisation determine whether it is "ready" for telemedicine deployment.

The final Momentum Blueprint builds on two earlier versions which were released in May 2014 and December 2014. This final version was substantially edited and abridged; the explanations and the order of the critical success factors were improved; and the self-assessment toolkit was added. The toolkit is a combination of the Telemedicine Readiness Self-Assessment Tool (TREAT) and Momentum's critical success factors. Used under the right circumstances, the toolkit helps to measure the level of readiness of an organisation by way of a comprehensive questionnaire and a consultative workshop involving all stakeholders. It can ensure that the people in the organisation share the vision of scaling-up and are committed to its success.

Momentum was a project co-financed by the European Commission under the ICT Policy Support Programme (ICT PSP). Started in February 2012 and ended in January 2015, it aimed to create a platform across which the key players shared their knowledge and experience in deploying telemedicine services into routine care. The Blueprint represents the main outcome of the project.

HOPE was involved as an editor of the Blueprint throughout the entire length of the project. This consisted in reviewing the draft sections of the document which describe the critical success factors in the areas of deployment strategy and of managing organisational change.

The final validated and tested version of the Blueprint for telemedicine deployment is available at:
http://telemedicine-momentum.eu/wp-content/uploads/2015/02/D3-4_v1-0_ValidatedBlueprint.pdf

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

IPPOCA – FINAL MEETING

On 15 and 16 January 2015, HOPE participated in Florence to the final meeting of IPPOCA Project during which the final results were presented and discussed as well as the possible future developments.

IPPOCA began in June 2013 and ran until January 2015. Its aim consisted in improving knowledge and practices implemented by paediatric hospital partners' health staff in case of a suspected child victim of abuse or maltreatment. Objectives were attained by the production of a manual based on the replies of a questionnaire set up in order to get a comprehensive picture of procedures already implemented by the three partner hospitals. Subsequently the evaluation of results was done in order to select a range of best practices already in use. This information is listed in an annex attached to the manual. The content of the manual is focused on issues regarding the abuse suspect: if a specific protocol to apply exists, who detects the suspect, who has to report it, how it is treated, if and how other professionals are involved. To reach a constructive comparison it was first necessary to understand the social and economic context as well as the law framework each partner is working in, after that it was possible to explore the diverse methodologies applied by the partner hospital health staff to recognise if a child could be a victim of an abuse or maltreatment.

Hospitals are often the place where a child is submitted to a medical examination and, for this reason, they can constitute the first site where violence can be detected, recognising either physical or psychological findings. A prompt discover of the problem would lead to a higher protection of the victim. Unfortunately detection and treatment procedures on abused children are in general settled by the single reality because there is not a national defined process. In addition, most medical professionals are inadequately trained although the diagnosis to detect an abuse requires a high level of skills and experience as well as procedures to be followed especially in complicated cases. It is probably due to this complexity of actions as well as the differences about social contexts, laws and health systems from one country to another that there is a lack of international and transnational protocols, guidelines or manuals applied at the hospital level.

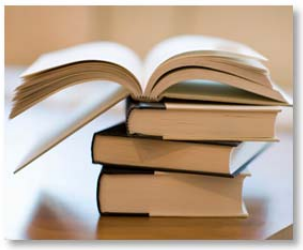
During the first day of the final meeting, partners shared and analysed the results of the Teaching Programme activities carried out within their institutions. They focused on a brief presentation of the results of the lectures as well as on the achievements accomplished. Partners acknowledged that the Teaching Programmes reached the objectives expected; the risk of a low number of participants identified in the SWOT analysis at the beginning of the project was efficiently avoided. Discussion on future possible similar initiatives after the end of the project started: partners reached a consensus on the fact that after the end of the project every institution will evaluate the possibility of repeating teaching programmes on the topic every year. Then, the dissemination activity was introduced. HOPE, in charge of coordinating the construction of the website, clarified its structure and contents as well as its possible maintenance after the end of the project.

During the second day of the meeting, all participants shared ideas on its consequences in terms of hospital services improvement and of awareness raised among relevant stakeholders at a national and European level. Each institution briefly presented the main objectives fulfilled thanks to the project in general and to the manual in particular. Then, every partner presented during a public event the results obtained according to its task. The audience was composed by relevant stakeholders, institutions and organisations.

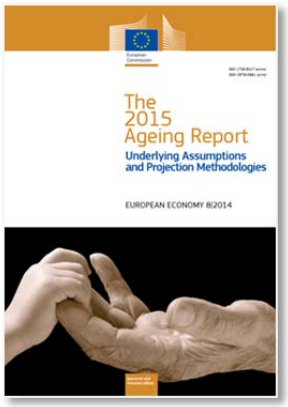
HOPE played an active role in the project, especially in the dissemination activity. It coordinated, with the collaboration of all the partners, the construction of the website and the organisation of its contents. The website was launched at the end of January 2015. Furthermore, HOPE was in charge of looking for other channels through which spreading information on the project at the European level. One of this is EPIC – European Platform for Investing in Children – which provides information about all policies that can help strengthen the capacities of children and their families to face challenges that exist in the current economic climate in Europe.

More information on IPPOCA: http://www.ippoca.eu/

IPPOCA page on EPIC platform:
http://europa.eu/epic/news/2014/20141107-daphne-iii-ippoca-project._en.htm



2015 EUROPEAN COMMISSION REPORT ON AGEING



The European Commission has recently published the "2015 Ageing Report - Underlying Assumptions and Projection Methodologies".

In 2012, the Economic and Financial Affairs (Ecofin) Council asked the Economic Policy Committee (EPC) -which provide advice and contribute to the work of the Ecofin Council and the Commission- to update its age-related expenditure projections by the autumn of 2014, to take into account new population projections by Eurostat.

The projections show in which countries, when, and to what extent ageing pressures will accelerate as the baby-boom generation retires and average life spans in the EU increase. Hence, the updated projections of age-related expenditure and the associated sustainability assessments will provide insight on both the economic impact of ageing and the risks to the long-term sustainability of Member States' public finances.

The report is structured in two parts. The first one describes the population projection, the labour force projection and the other macroeconomic assumptions as well as the sensitivity tests. The second report draws on this analysis to calculate the age-related expenditures associated with pensions, healthcare, long-term care, education and unemployment transfers.

The projections feed into a variety of policy debates at EU level, including the overarching Europe 2020 strategy for smart, sustainable and inclusive growth. In particular, they are used in the context of the European Semester so as to identify policy challenges, in the annual assessment of the sustainability of public finances carried out as part of the Stability and Growth Pact and in the analysis on the impact of ageing populations on the labour market and potential economic growth.

The chapter dedicated to healthcare presents the methodology to project public expenditure on healthcare in the 28 Member States of the EU and Norway up to 2060. Healthcare services represent a high and growing share of government spending and of total age-related expenditure. The ageing of the EU population may entail additional government expenditure. This puts public spending on healthcare at the centre of the debates on the long-term sustainability of public finances.

More information:
http://ec.europa.eu/economy_finance/publications/european_economy/2014/pdf/ee8_en.pdf

FISCAL SUSTAINABILITY CHALLENGES IN THE AREAS OF PENSION, HEALTH CARE AND LONG-TERM CARE POLICIES – COMMISSION REPORT

The report "Identifying fiscal sustainability challenges in the areas of pension, healthcare and long-term care policies" presents a horizontal assessment framework used by the Commission services to identify structural-fiscal reforms that are deemed necessary to address fiscal sustainability challenges in the Member States.

It describes the steps to ascertain the extent to which there is a policy challenge in ensuring progress towards fiscal sustainability and which policy dimensions merits closer scrutiny, taking into account the country-specific circumstances in the fields of pension policy, healthcare policy and long-term care policy.

The areas under scrutiny concern the design of national policies in the above-mentioned policy fields and are under the direct control of the Member States' governments. These areas are explicitly mentioned, in relevant cases, in the policy coordination process at EU level, the European Semester.

The deterioration in fiscal positions and increases in government debt since 2008, together with the budgetary pressures posed by population ageing, compound each other and make fiscal sustainability an acute policy challenge. Analysing prospective government debt developments and risks to fiscal sustainability is therefore crucial at the current juncture for euro-area countries and for the EU as a whole to be able to formulate appropriate policy responses and restore credibility and confidence. Developments in the recent past, in particular the sovereign debt crisis leading to conditions under which some Member States faced difficulties in accessing the market, have confirmed that fiscal sustainability challenges are not only of longer-term nature.

The strengthening of the EU fiscal sustainability assessment framework as regards the short- and medium-term dimensions, as presented in the 2012 Fiscal Sustainability Report is, therefore, all the more relevant in the context of the financial and economic crisis.

More information:
http://ec.europa.eu/economy_finance/publications/occasional_paper/2014/pdf/ocp201_en.pdf

COMPARATIVE EFFICIENCY OF HEALTH SYSTEMS, CORRECTED FOR SELECTED LIFESTYLE FACTORS – MACELI REPORT

The MACELI (Macro Cost Effectiveness corrected for Lifestyle) project studied the cost-effectiveness of European health systems, and the impact of differences in lifestyle, specifically smoking, overweight and alcohol consumption. The study covered the EU-28 Member States, Iceland, and Norway.

The project aimed to compare the cost-effectiveness of all European health systems while taking into account the variation in lifestyle behaviour between countries. First, three lifestyle factors had to be studied: smoking, overweight and alcohol use. Second, a life-table approach was required, using public health modelling to correct for the effects of lifestyle factors. Third, a list of scenarios

was included in the analyses. Fourth, a literature review concerning the cost-effectiveness of lifestyle interventions was also performed.

The combining of all these elements provided a better understanding of the impact of lifestyle on health outcomes and health spending at country level and how these healthier lifestyles might be achieved. Baseline analyses without standardising for lifestyle showed on average more health spending was associated with better health. This effect was clearest for countries with lower levels of spending. Standardisation towards a better lifestyle meant an upward shift of the health production function, but did not much alter the comparative efficiency of countries.

Lifestyle directly affected health spending, which can be explained by the fact that people with unhealthier lifestyles use more care. There was also an indirect effect in the reverse direction: improved lifestyle behavior generated a higher life expectancy, and longer lives implied greater age-related healthcare use. The scenarios ignored the costs and difficulties of achieving an improved lifestyle and this precludes any definitive statement of policy implications.

The results support the view that substantial health gains can be achieved from a healthier lifestyle. As a result, the "health production function" moves upward in hypothetical scenarios when all countries have a healthier lifestyle.
Results were put into further perspective by additional qualitative research and through several sensitivity analyses, including an indirect disease-based approach. Several shortcuts were taken to allow consistent estimates across a large number of countries, which imply that the results should be interpreted with care.

More information:
http://ec.europa.eu/health/systems_performance_assessment/docs/2015_maceli_report_en.pdf

DEMENTIA RESEARCH AND CARE: CAN BIG DATA HELP? – OECD REPORT

This report, published by OECD on 3 February 2015, represents the proceeding of the joint OECD, Ontario Brain Institute (OBI) and Institute of Health Policy, Management and Evaluation (IHPME) international workshop in Toronto, on 14-15 September 2014.

OECD countries are developing strategies to improve the quality of life of those affected by dementia, and to support long-term efforts for a disease-modifying therapy or care.

The workshop brought together leading researchers and academics, industry and non-government experts, with the aim of advancing international discussion about opportunities and challenges, as well as successful strategies, in making broad and deep data a reality. Sharing and linking the massive amounts of population-based health data (broad data) with detailed clinical and biological data (deep data) is a key issue. Government leadership and public-private partnership will be needed to provide an international resource for research, planning, policy development and performance improvement. Different measures have to be implemented: financing for data infrastructure and

incentives for data sharing, new analytics, protecting privacy and engaging with stakeholders and the public.

Next steps to design national infrastructures supporting broad and deep data are proposed. They include: launching a global centre for standards for data content and sharing; developing worldwide benchmarks to compare the performance of health systems; planning an international pilot project to demonstrate the benefits of linking broad and deep data to dementia research and care.

More information:
http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/dementia-research-and-care_9789264228429-en#page1

PREVENTING AND ADDRESSING INTIMATE PARTNER VIOLENCE AGAINST MIGRANT AND ETHNIC MINORITY WOMEN: THE ROLE OF THE HEALTH SECTOR – WHO POLICY BRIEF

Violence against women is an extreme manifestation of gender inequality in society and a serious violation of fundamental human rights. Intimate partner violence (IPV) is the most common type of such violence and takes place within couples. IPV can lead to death, physical injury, functional impairment, mental health problems, negative health behaviour, chronic conditions and reproductive health problems. Institutional discrimination, lack of access to or knowledge of services, and cultural differences can prevent women who are not only experiencing IPV but also migrants or members of ethnic minorities from seeking help.

This policy brief aims to provide input into the role of the health sector in preventing and addressing IPV among migrant women and those of ethnic minorities. It describes the scope of the problem, presenting key evidence, and makes recommendations for health policy and health systems, health facilities and health service providers.

More information:
http://www.euro.who.int/__data/assets/pdf_file/0018/270180/21256-WHO-Intimate-Partner-Violence_low_V7.pdf?ua=1

FACETS OF PUBLIC HEALTH IN EUROPE – EUROPEAN OBSERVATORY PUBLICATION

In the last two centuries, public health has reduced the impact and prevalence of infectious diseases, but much remains to be done to reduce non-communicable diseases, such as heart disease and cancer, which comprise the bulk of the disease burden on the WHO European Region.

This book takes a broad but detailed approach to public health in Europe and offers the most comprehensive analysis of the Region available. It considers a huge range of key topics in public health and includes chapters on:

- screening
- health promotion
- tackling of the social determinants of health
- health impact assessment
- the public health workforce
- public health research.

In addition, the authors consider the existing public health structures, capacities and services in a range of European countries, identifying what needs to be done to strengthen action and improve outcomes for public health. Reflecting the broad geographical scope of the entire WHO European Region, this book uses examples from a diverse range of countries to illustrate different approaches to public health.

More information:
http://www.euro.who.int/__data/assets/pdf_file/0003/271074/Facets-of-Public-Health-in-Europe.pdf?ua=1

ASSESSING CHRONIC DISEASE MANAGEMENT IN EUROPEAN HEALTH SYSTEMS – EUROPEAN OBSERVATORY PUBLICATION

Within the growing burden of chronic illness, the rapid increase in the number of people with multiple health problems represents a challenge to health systems at global level. Consequently, policy makers and practitioners face various key concerns, such as associated premature mortality and reduced physical functioning, along with higher use of health services and related costs.

Redesigning delivery systems is essential in order to better meet the needs created by chronic conditions, moving from the traditional, acute and episodic model of care, to one that better coordinates professionals and institutions and actively engages service users and their carers. Many countries have begun this process but it has been difficult to reach conclusions about the best approach to take. Care models are highly context dependent, and scientifically rigorous evaluations have been lacking.

This publication explores some of the key issues, from interpreting the evidence base to assessing the policy context for, and approaches to, chronic disease management across Europe. Drawing on twelve country reports, it provides insights into the range of care models and the people involved in delivering these; payment mechanisms and service user access; and challenges faced by countries in the implementation and evaluation of these novel approaches.

This book builds on the findings of the DISMEVAL project (Developing and validating Disease Management Evaluation methods for European healthcare systems), led by RAND Europe and funded under the European Union (EU) Seventh Framework Programme (FP7) (Agreement n° 223277).

More information:
http://www.euro.who.int/__data/assets/pdf_file/0009/270729/Assessing-chronic-disease-management-in-European-health-systems.pdf?ua=1

BRIDGING THE WORLDS OF RESEARCH AND POLICY IN EUROPEAN HEALTH SYSTEMS – EUROPEAN OBSERVATORY PUBLICATION

Policy makers need to access up-to-date and high-quality health system information for their activities. Stakeholders may try to influence health policy as well as make decisions within their own area of work. Knowledge brokers (including researchers) want to know how to best communicate to decision makers.

This publication is intended to give health system policy makers, stakeholders and researchers a clear understanding of knowledge brokering and its implications for the organisation and management of health information systems.

It consists of two different sections. The first part looks at knowledge brokering from different vantage points. The second one describes knowledge brokering in action.

The book results from a study on knowledge brokering practices in Europe that was undertaken between 2009 and 2011, called BRIDGE (Scoping study of approaches to Brokering knowledge and Research Information to support the Development and Governance of health systems in Europe).

More information:
http://www.euro.who.int/__data/assets/pdf_file/0011/270794/Bridge-Prelims-revised-8.1.15.pdf?ua=1

STRENGTHS AND WEAKNESS OF DIFFERENT POLICY MECHANISMS TO INFLUENCE HEALTH BEHAVIOUR IN THE POPULATION – EUROPEAN OBSERVATORY POLICY SUMMARY

The European Observatory recently published a Policy summary on strengths and weakness of different policy mechanisms to influence health behaviour in the population.

Governments have different tools at their disposal to influence population health and to change individual behaviours, directed upstream at some of the underlying causes of poor health, as well as at downstream challenges when poor health behaviours are already manifest. Indeed many health problems are potentially avoidable. This policy summary maps out what is known about some of these different potential mechanisms. It includes some innovative approaches that are arising from disciplines such as behavioural economics and psychology. It discusses about their effectiveness too.

The increasing pressure on healthcare systems makes the development of a well-defined and effective public health strategy important. Combinations of taxation, legislation and health information remain the core components of any strategy to influence behavioural change.

Behavioural economics seeks to explain why individuals may make decisions that do not conform to rational economic theories related, for instance, to risk and price. Policy interventions informed by behavioural economics can be softer than other forms of policy, but they should be perceived as tools to complement regulation, by moving society incrementally in a direction that might benefit all, and only as a substitute for regulation when additional enforced measures are perceived by the public as an expression of government overstepping the mark.

However, this report finds that, to date, the evidence base for actions that derive from behavioural economics and psychology is weak. Many unanswered questions remain on how best to design new innovative interventions that can complement, and in some instances augment, these well-established mechanisms.

More information:
http://www.euro.who.int/__data/assets/pdf_file/0003/270138/PS15-web.pdf?ua=1

FORECASTING FUTURE NEEDS AND OPTIMAL ALLOCATION OF MEDICAL RESIDENCY POSITIONS – THE EMILIA-ROMAGNA REGION CASE STUDY

A study on forecasting needs and optimal allocation of medical residency positions was recently released as a component of the joint action Health Workforce Planning.

This study provides regional decision makers with a requirement model to forecast the future demand of specialists at regional level. The authors developed a system dynamics (SD) model that projects the evolution of the supply of medical specialists and three demand scenarios across the planning horizon (2030). Demand scenarios account for different drivers: demography, service utilisation rates (ambulatory care and hospital discharges) and hospital beds. Based on the SD outputs (occupational and training gaps), a mixed integer programming (MIP) model computes potentially effective assignments of medical specialisation grants for each year of the projection.

The researchers compared how regional and national grants can be managed in order to reduce future gaps with respect to current training patterns. The allocation of 25 supplementary grants per year does not appear so effective in reducing expected occupational gaps as the re-modulation of all regional training vacancies. Population demographic trends will place higher stress on specialisations related to the elderly. The authors showed that an ageing population will not affect all medical specialist demand equally.

Because of complexity of medical labour market, no simulation-optimisation outputs can be considered as exact forecasts: this study is no exception. It suggests that main barriers to quantitative human resources for health (HRH) modelling are data mining efforts and the choice of appropriate demand drivers. However, despite its limitations, this study is the first quantitative attempt to define a methodology for strategic planning of HRH in the Italian context.

More information:
http://www.human-resources-health.com/content/pdf/1478-4491-13-7.pdf

MEASURING ORGANISATIONAL READINESS FOR PATIENT ENGAGEMENT (MORE) – STUDY

A study has been designed to develop a measure of organisational readiness for patient engagement, designed to monitor and facilitate healthcare organisations' willingness and ability to effectively implement patient engagement in healthcare.

Widespread implementation of patient engagement by organisations and clinical teams is not a reality yet. The development of the MORE (Measuring Organisational Readiness for Patient Engagement) scale was guided by Weiner's theory of organisational readiness for change. Weiner postulates that organisations' readiness is determined by both the willingness and ability to implement the change (i.e. in this context: patient engagement). A first version of the scale was developed basing on a literature search and evaluation of pre-existing tools. The researchers invited multidisciplinary stakeholders to participate in a two round online Delphi survey. Respondents were asked to rate the importance of each proposed item, and to comment on the proposed domains and items. Second round participants received feedback from the first round, and were asked to rerate the importance of the revised, new and unchanged items, and to provide comments.

The first version of the scale contained 51 items divided into three domains: respondents' characteristics; organisations' willingness to implement patient engagement; and organisations' ability to implement patient engagement. The final version totalled 38 items; 5 on stakeholders, 13 on organisations' willingness, and 20 on organisations' ability. So, the Delphi technique was successfully used to refine the scale's instructions, domains and items, using input from a broad range of international stakeholders, hoping that MORE can be applied in a variety of healthcare contexts worldwide. Further assessment is needed to determine the psychometric properties of the scale.

More information: ***http://www.biomedcentral.com/content/pdf/s12913-015-0717-3.pdf***

IMPACT OF PROFESSIONAL AND ORGANIZATIONAL IDENTIFICATION ON THE RELATIONSHIP BETWEEN HOSPITAL-PHYSICIAN EXCHANGE AND CUSTOMER-ORIENTED BEHAVIOUR OF PHYSICIANS – STUDY

Today hospitals face increasingly competitive market conditions. They have to struggle to build high quality hospital-physician relationships. In literature, two types of managerial strategies for optimising relationships have been identified. The first focuses on optimising the economic relationship; the second focuses on the non-economic dimension and emphasises the cooperative structure and collaborative nature of the hospital-physician relationship. The authors investigated potential spill over effects between physicians' perceptions about organisational exchange and their customer-oriented behaviours.

A cross-sectional study was conducted on 130 self-employed physicians practicing at six Belgian hospitals. Economic exchange was measured using the concept of distributive justice; non-economic exchange was measured through the concept of perceived organisational support. The outcomes of the study consist of three types of customer-oriented behaviours: internal influence, external representation, and service delivery.

The results demonstrate that both perceptions of economic and non-economic exchange are important to self-employed physicians' customer-oriented behaviours. Thus fostering organisational identification could enhance this reciprocity dynamic.

More information: ***http://www.human-resources-health.com/content/pdf/1478-4491-13-8.pdf***

ESTIMATION OF LUNG CANCER DIAGNOSIS AND TREATMENT COSTS BASED ON A PATIENT-LEVEL ANALYSIS IN CATALONIA (SPAIN) – STUDY

The aim of this paper is to determine the hospital cost associated with lung cancer diagnosis and treatment by histology, type of cost and stage at diagnosis, in the Spanish National Health Service.

Evaluation of the costs of treating disease is necessary to demonstrate cost-effectiveness. However, there are few comprehensive studies on resource use and costs associated with lung cancer patients in clinical practice, in Spain or internationally.

The authors performed a retrospective, descriptive analysis on resource use and a direct medical cost analysis. Resource utilisation data were collected by means of patient files from nine teaching hospitals. The aggregate and mean costs per patient were calculated over the first three years following diagnosis or up to death.

A total of 232 cases of lung cancer were analysed, of which 74.1% corresponded to non-small cell lung cancer (NSCLC) and 11.2% to small cell lung cancer (SCLC); 14.7% had no cytohistologic confirmation. The mean cost per patient in NSCLC ranged from 13,218 Euros in Stage III to 16,120 Euros in Stage II. The main cost components were chemotherapy (29.5%) and surgery (22.8%). Advanced disease stages were associated with a decrease in the relative weight of surgical and inpatient care costs and an increase in chemotherapy costs. In SCLC patients, the mean cost per patient was 15,418 Euros for limited disease and 12,482 Euros for extensive disease. The main cost components were chemotherapy (36.1%) and other inpatient costs (28.7%).

The study provides the costs of lung cancer treatment based on patient file reviews, with chemotherapy and surgery accounting for the major components of expenses. This analysis is a baseline study for future studies on cost-effectiveness.

More information: http://www.biomedcentral.com/content/pdf/s12913-015-0725-3.pdf

INFONET – ONLINE EUROPEAN NEWSLETTER PROMOTING ADULT EDUCATION INFORMATION

Infonet is an online European Newsletter promoting Adult Education (AE) Information. It studies, discusses and deals with versatile topics on AE including Health Promotion AE.

On Infonet are available two "interview" articles with Dr. Charmaine, Director Health Promotion and Disease Prevention Directorate at the Ministry for Energy and Health (MEH) in Malta:

- The first article entitled "Involving the target group in health promotion" speak about the importance of involving key persons from the target group when planning how best to reach and educate the group.

  http://www.infonet-ae.eu/articles-national-affairs/1317-involving-the-target

- The second article entitled "Educating parents to prevent childhood obesity" is on how to inform parents on how to prevent child obesity.

  http://www.infonet-ae.eu/articles-national-affairs/2171-educating-parents-to

Anyone interested to be interviewed on any Health Promotion AE topic can contact Infonet or write directly to the author of these articles at gaucimary@yahoo.com.

More information on Infonet: ***www.infonet-ae.eu***

EUROPEAN PARLIAMENT INTEREST GROUP ON CARERS – MEETING

On 4 February 2015, HOPE attended in Brussels a meeting of the interest group on carers coordinated by Eurocarers, the European Association Working for Carers which seeks to represent and act on behalf of informal carers in Europe.

The event was hosted by MEP Marian Harkin (ALDE, Ireland), Sirpa Pietikäinen (EPP, Finland), Jean Lambert (Greens/EFA, United Kingdom), Heinz K. Becker (EPP, Austria). It was attended by NGOs' representatives, policy makers, carers' representatives associations and representatives from the European Commission Directorate General for Employment, Social Affairs and Inclusion (DG EMPL).

Caring is the most common type of service in Europe. Family members and friends are the largest providers of health and social care support. In 23 EU Member States there is any type of support for informal carers. As a consequence of caring, people often have to give up their jobs or change them; this has an impact on carers' physical and mental health.

The meeting addressed the need and potential for EU actions and policies in the field of poverty and social exclusion, to address carers and the challenges they face. A direct correlation indeed exists between the role of informal carer, unemployment, social exclusion and poverty. The fact is that those paying for care, and family carers who have to give up or cut back paid employment (and particularly women) as a result of their caring responsibilities, risk falling into poverty. This, in turn, can have a negative impact on labour supply and the economy.

As explained by Ralf Jacob and Sven Matzke (Head of Unit and Team Leader at the Social Protection and Activation Systems Unit, DG EMPL), the Commission does not currently have a specific focus or initiative on caring. However, several initiatives are relevant such as the 2013 Staff Working Document on long term care and the 2014 Social Protection Committee/EC report on "Adequate social protection for long term care needs in an ageing society". Other EU initiatives also relate to carers, such as the Europe 2020 strategy, as the impact of caring responsibilities are relevant for achieving the employment and poverty targets.

The Commission also referred to EU reconciliation policies, and the possibility of a future Directive on carers' leave. In its "Strategy for equality between women and men 2010-2015" the Commission had already announced its intention to assess remaining gaps in entitlement to family-related leave, including carers' leave, and the options for addressing them. It remains to be seen if the new Commission will take an initiative in this respect on which social partners would need to be consulted.

The Commission also works towards sound data gathering on carers and their situation and has a number of tools at its disposal. Clearly, there are serious knowledge gaps with respect to the breadth and depth of social protection coverage across the EU. The Commission is trying to improve

the evidence base in this respect through the Labour force survey (improve questions on impact of caring on employment), the EU-SILC survey (adding questions accessibility of long term care services), the MISSOC data base, and importantly, a joint Project with OECD on "Measuring adequacy of social protection for long-term care needs". As benefits to carers are part of social protection, it is planned to add this dimension in the second phase of the project (2016-2017).

In their closing remarks, MEPs underlined that prevention is one of the keys to addressing the long term care gap. The three trends – increasing care demand, decreasing care supply and limited budget – provide the context in which solutions will have to be found. Concrete actions in this area can also be taken by the European Parliament. For instance, it was proposed that the Interest Group co-chairs could push for an own initiative report on long term care as this touches on so many aspects: employment, pensions, health training, gender equality and many others.

E-HEALTH: TAILOR-MADE HEALTHCARE? – MEETING

On 4 February 2015, HOPE took part in the event "e-Health: Tailor-made healthcare?" at the representation office in Brussels of the State of North Rhine-Westphalia.

This was jointly organised by five national insurance federations: Verband der privaten Krankenversicherung e.V. (PKV); Fédération Française des Sociétés d'Assurances (FFSA); Versicherungsverband Österreich (VVO); Polska Izba Ubezpieczeń (PIU)-Polish Insurance Association; Beroepsvereniging van de Verzekeringsondernemingen (Assuralia).

During the round table, representatives of these organisations discussed the impact of technology on private health insurance, within the overall insurance market and health sector.

New opportunities may arise for the healthcare sector from technological progress, especially the empowerment of patients. The result could be the designing of a customised health system in Europe. Social security agencies, as well as private insurers offering health and additional protections are working to understand how to face the increasing digitisation of health systems.

In the meanwhile, the European Commission is engaged in developing an appropriate framework to address this situation by promoting cost efficiency and enhancing quality. Indeed, e-Health can play a central role with reference to sustainability of healthcare systems

During the session, e-Health potential to challenge decreasing resources trend against a growing health demand, was recognised through the collection of experiences carried out in countries represented by speakers. It emerged a state of the art characterised by a great variance. While Austria and Germany move fast towards digitalised health systems, Poland is at a starting point. Therefore, the need of a standardised approach to technical progress in the health sector was addressed by all participants. The idea is promoting the definition of a harmonised legal framework for e-Health which could allow the subsequent opening of a single e-Health services market, including both healthcare providers and patients.

Moreover, speakers claimed for a further effort by the European institutions in order to empower patients. A European telecommunication market standard was declared as necessary to increase

digital patients' data safety. Indeed, today resistance is encountered on data protection topic, when pioneer digital changes are introduced in healthcare systems.

Physicians and elderly patients may experience difficulties when using digital devices. This problem can be solved through teaching and behavioural changing measures at European and national level. However, speakers recognised that current generations call for a health digitisation.

As a concluding remark, participants focused on the necessity for all healthcare systems components to cooperate. In this way, the on-going digital evolution can create patient centred healthcare systems.

BALANCING PERSONAL DATA PROTECTION AND RESEARCH PROGRESS: THE CASE OF CHILDHOOD CANCER – EUROPEAN PARLIAMENT

On 3 February 2015, HOPE attended the event "Balancing Personal Data Protection and Research Progress: the Case of Childhood Cancer" organised by SIOP EUROPE, the European Society for Paediatric Oncology, at the European Parliament in Brussels.

The event was devoted to discuss the impact on childhood cancer research and treatment of the European Union Regulation on data protection, which is currently under review.

During the first part of the conference, the speakers defined the state of the art of both patients' data protection and cancer research, according to clinical, social and legal perspectives. European cancer research relies on quality and scope of cancer registries. These are assembled by using anonymised, and protected personal data, thanks to the willingness of patients and their families (when patients are minor), to contribute to research progress. The result to obtain consists in the possibility of serving public interest by sharing knowledge and, therefore, enhancing care for cancer patients.

The European Union has in 2012 started reviewing data confidentiality rules to set up a homogenous compulsory legal standard for data collection, protection and processing. The speakers declared that the draft could negatively affect the retrospective clinical research, the bio banking and the existing population-based cancer registries.

In the second part, the participants were involved in a round table for debating these effects on the specific topic of paediatric oncological studies.

The draft EU Regulation precludes research without consent. Thus, it requires for researchers to ask for patient's explicit consent every time a researching need emerges, even on already existent data. This jeopardises the concept of broad consent. Indeed, an explicit consent can't cover all possible inquisitive aims, which continue to arise during time, with the consequence of not allowing all feasible researches. Taking an additional consent is time and resource expensive. Then, according to this measure, consent would be required also for the recording of data in population based disease registries, which are necessarily all-inclusive. On the other side, the broad consent is favoured by patients and parents, for biomedical research in paediatric cancer.

Ambiguity about definitions of anonymised and pseudonymised data in the EU Regulation has emerged during the discussion. If pseudonymisation can be a useful tool for researchers, as no personal reference is usually needed to analyse data, anonymisation is stricter and constrictive.

Moreover, technological developments in collecting and processing personal data have not been included into the Commission's draft proposal. This could challenge translational and transnational paediatric cancer research.

Finally, Ms Glenis Willmott, member of the European Parliament chairing the event, concluded by addressing the necessity for the European political community to develop a harmonised and transparent legislative framework for data protection. The objective is to increase the cure rate and the quality of cure for children and adolescents with cancer. Preference of patients, their parents and scientists for a one-time broad consent and pseudonymised data has been suggested as a point to be noted.

AGENDA

UPCOMING CONFERENCES

PASQ JOINT ACTION
(European Union Network for Patient Safety and Quality Of Care)

5TH COORDINATION MEETING

12-13 March 2015 – Brussels (Belgium)

The 5th Coordination meeting 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 meeting, 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 and agenda are available at:
http://www.pasq.eu/Events/EventsChronologically/Events2015.aspx

HOPE AGORA 2015

HOSPITALS 2020:
HOSPITALS OF THE FUTURE, HEALTHCARE OF THE FUTURE

1-2 June 2015 – Warsaw (Poland)

The closing conference of the 34th HOPE Exchange Programme will be held in Warsaw on 1-2 June 2015 around the topic **HOSPITALS 2020: hospitals of the future, healthcare of the future**.

The topic for the HOPE Exchange Programme 2015 is all about innovations in management and organisation of hospitals and healthcare services. Innovations are taking place in all kinds of fields: patient care, human resources, information systems, finances, quality management, etc. Considering the enormous diversity of systems and practices in Europe, what is innovative in one place might of course be common practice in another. The year 2020 is getting very close but has been taken as a target in several documents such as the WHO strategy "Health 2020" and the more general "Europe 2020" strategy.

More information and registration: www.hope-agora.eu

THE REGISTRATIONS FOR HOPE AGORA 2015 WILL BE OPEN FROM 4 MARCH UNTIL 20 APRIL

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, on 10-12 June 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.

There will be four sub-themes:

- addressing people's comprehensive health needs;
- co-producing health – healthcare for people by people;
- continuity of care for people by strengthening individuals and improving cooperation between healthcare services and other institutions;
- using new media & technologies to address people's health needs.

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