



# NEWSLETTER

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***HOPE AGORA 2015***

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***NHS CONFEDERATION ANNUAL CONFERENCE & EXHIBITION 2015***

***10-12 June 2015 – Oslo (Norway)***

***HPH CONFERENCE 2015***

***PERSON-ORIENTED HEALTH PROMOTION IN A RAPIDLY CHANGING WORLD:***

***CO-PRODUCTION – CONTINUITY – NEW MEDIA & TECHNOLOGIES***

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

***EUROPEAN HOSPITAL CONFERENCE***



### ***HUMAN TISSUES AND CELLS – NEW DIRECTIVES ADOPTED***

On 8 April 2015, the Commission adopted two Directives providing new rules on human tissues and cells for higher quality, safety and standards.

The first Directive adopted (2015/565) modifies the existing European legislation on the use of human tissues and cells (Directive 2006/86/EC) as regards certain technical requirements for the coding of human tissues and cells. This Directive aims at facilitating the tracing of human tissues and cells between the donor and the recipient.

A Single European Code shall be applied to human tissues and cells and the Commission shall host an IT-platform for a uniform labelling of all tissues and cells distributed in the EU. In case of an adverse event which may affect safety and quality of the cells or tissues, this label will facilitate the traceability and the treatment of the recipients.

The second Directive 2015/566 sets up procedural rules for verifying the equivalent standards of quality and safety of imported tissues and cells. This legislation aims at ensuring that human cells and tissues imported from third countries meet the same safety and quality requirements than the ones procured, processed and distributed in the EU.

Member States should transpose these Directives into national legislation by 29 October 2016. They shall then apply those provisions from 29 April 2017.

*The Directive on technical requirements for the coding of human tissues and cells available at:*  
<http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=OJ:L:2015:093:FULL&from=EN%20-%20page=45>

*The Directive on procedures for verifying the equivalent standards of quality and safety of imported tissues and cells is available at:*  
[http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=OJ:JOL\\_2015\\_093\\_R\\_0007&from=EN](http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=OJ:JOL_2015_093_R_0007&from=EN)

## ***AVAILABILITY OF BLOOD, BLOOD COMPONENTS AND PLASMA DERIVATIVES – CREATIVE CEUTICAL REPORT***

On 8 April 2015, the Commission published a report on an EU-wide overview of the market of blood, blood components and plasma derivatives focusing on their availability for patients.

Funded by the EU Health Programme 2008-2013, this report was drafted by Creativ Ceutical in the frame of a specific contract with the Consumer, Health, Agriculture and Food Executive Agency (CHAFAEA) acting under the mandate of the Commission.

The Creativ-Ceutical report was then revised by the Commission to include stakeholders' comments. Creativ-Ceutical is an international consulting firm dedicated to supporting the life science industry and health authorities in strategic decision-making.

Maintaining an adequate blood and plasma supply for patients requiring transfusion or plasma derived products, while ensuring appropriate use and warranting safety of products for transfusion, together with the prevention of transmission of infectious diseases, are major concerns of national health authorities, as well as of the European Commission.

In this context, the report provides detailed information on the availability of blood components and plasma derived medicinal products to patients within the EU. In addition, many stakeholders from the blood and plasma sectors were consulted to discuss topics such as voluntary unpaid donations, product shortages, imports and exports of these products within and outside Europe, achievement of self-sufficiency as well as potential difficulties in the regulatory environment that may hinder access to patients.

*The report is available at:*

[http://ec.europa.eu/health/blood\\_tissues\\_organs/docs/20150408\\_cc\\_report\\_en.pdf](http://ec.europa.eu/health/blood_tissues_organs/docs/20150408_cc_report_en.pdf)

## ***MEDICATION ERRORS – CONSULTATION ON EMA GOOD PRACTICE GUIDANCE***

On 14 April 2015, the European Medicines Agency (EMA) launched a consultation on the draft version of a good practice guidance on medication errors. The purpose of this guidance is to support industry and regulators in the implementation of changes introduced with the EU pharmacovigilance legislation in relation to medication errors which affect the operation of pharmacovigilance systems in EU Member States.

As a member of the Working Group on Patient Safety and Quality of Care, HOPE was consulted among other stakeholders in the draft of the guidance.

The good practice guidance is composed of the two following guides:

- good practice guide on recording, coding, reporting and assessment of medication errors and on risk minimisation and prevention of medical errors;
- good practice guide on risk minimisation and prevention of medication errors and an addendum on a strategy to minimise the potential risk of medication errors associated with the introduction of high strength insulins and fixed combination insulin products.

The first guide clarifies specific aspects related to recording, coding, reporting and assessment of medication errors in the context of EU pharmacovigilance activities. The objective is to improve the reporting and learning from medication errors for the benefit of public health.

The second guide focuses on key principles of risk management planning in relation to medication errors arising from the medicinal product. It describes the main sources and categories of medication errors and how the risk of such errors can be minimised throughout the product life cycle. The addendum to this guide provides a strategy to minimise the potential risk of medication errors associated with the introduction of high strength insulins (i.e. higher than the EU-wide standard of 100 units/ml concentration) and fixed combinations of insulin with another non-insulin injectable blood glucose lowering agent.

With this public consultation EMA is also seeking stakeholder feedback on specific questions in relation to medication errors which are provided in the cover pages of the consultation documents.

**Comments from the stakeholders should be submitted by 14 June.**

*The consultation document on the draft guide on recording, coding, reporting and assessment of medication errors is available at:*

[http://www.ema.europa.eu/docs/en\\_GB/document\\_library/Regulatory\\_and\\_procedural\\_guideline/2015/04/WC500185536.pdf](http://www.ema.europa.eu/docs/en_GB/document_library/Regulatory_and_procedural_guideline/2015/04/WC500185536.pdf)

*The consultation document on the draft guide on risk minimisation and prevention of medical error is available at:*

[http://www.ema.europa.eu/docs/en\\_GB/document\\_library/Regulatory\\_and\\_procedural\\_guideline/2015/04/WC500185538.pdf](http://www.ema.europa.eu/docs/en_GB/document_library/Regulatory_and_procedural_guideline/2015/04/WC500185538.pdf)

*The consultation document on the draft addendum to the guide on risk minimisation and prevention of medical error is available at:*

[http://www.ema.europa.eu/docs/en\\_GB/document\\_library/Regulatory\\_and\\_procedural\\_guideline/2015/04/WC500185537.pdf](http://www.ema.europa.eu/docs/en_GB/document_library/Regulatory_and_procedural_guideline/2015/04/WC500185537.pdf)

## **PATIENT SAFETY AND USE OF ANTIMICROBIALS – ADOPTION OF REPORT BY ENVI COMMITTEE**

On 14 April 2015, members of the European Parliament Environment, Health and Food Safety (ENVI) Committee unanimously adopted an own-initiative report setting up recommendations for improving patient safety, including a more prudent use of antimicrobials.

Every year, 25,000 people die across the EU of infections caused by resistant bacteria. This phenomenon can partly be explained by the misuse of antimicrobials, as well as by the stagnation in the development of new antimicrobials.

The report on “Safer healthcare in Europe: improving patient safety and fighting antimicrobial resistance” was drafted by the parliamentary Rapporteur Piernicola Pedicini (EFD, Italy), and proposes solutions for tackling growing resistance to antibiotics in humans and animals.

To start with, MEPs suggest prohibiting the use of human antibiotics without prescription. In this regard, they also recommend implementing marketing practices which would prevent conflicts of interest between producers and prescribers. Besides, the committee advocated better information to the patients and increased monitoring and infection control. In addition, the proposed report urges pharmaceutical companies to invest in the research and development of new antimicrobials.

The report also focuses on the use of antimicrobials in the veterinary sector, where MEPs advocate for a more responsible use of animal antimicrobials, notably by allowing their use only for therapeutic purposes after veterinary diagnosis.

Finally, considering the economic crisis pressure on national health budgets, MEPs called on Member States to ensure that austerity measures would not affect their healthcare systems, with a consequent negative impact on patient safety. The parliamentary Rapporteur was pleased to affirm that these recommendations are a "very important result which will provide a quantum leap in European healthcare and help preventing a major death toll".

The report needs now to be adopted in the European Parliament plenary session scheduled for May.

### ***PATIENT SAFETY – TRANSLATIONS OF REPORTS ON REPORTING AND LEARNING SYSTEMS AND EDUCATION AND TRAINING***

As part of the "Patient Safety Package" released in June 2014, the European Commission published in April 2015 two reports on Reporting and learning systems for patient safety incidents across Europe and on Education and training in patient safety across Europe produced by the Commission's Patient Safety and Quality of Care Working Group, of which HOPE is member.

Both reports gather existing knowledge and illustrate examples and experiences from EU countries in the areas of education and training and reporting and learning systems. In particular, in the report on reporting and learning systems for patient safety incidents across Europe, HOPE Exchange Programme was mentioned by the Latvian member of the working group as being the rationale for the establishment in Latvia of such a system at the hospital level. This proves the benefits and the impact of the HOPE Exchange Programme, which enables experiences and good practices to be shared among European health professionals.

The Commission has recently made available translated versions of these reports in all the official languages of the EU so that dissemination of the knowledge gathered can be fostered at national level.

*The translated versions of the reports are available at:*

[http://ec.europa.eu/health/patient\\_safety/policy/package\\_en.htm](http://ec.europa.eu/health/patient_safety/policy/package_en.htm)

## ***MULTISTAKEHOLDERS WORKSHOP ON PHARMACEUTICAL INDUSTRY***

On 15 April 2015, HOPE attended the Multistakeholders Workshop on Pharmaceutical Industry in Riga, Latvia.

The workshop, organised by the Latvian Presidency of the Council, brought together competent authorities responsible for pricing and reimbursement of pharmaceuticals and other relevant public and private stakeholders. It had the purpose of informing stakeholders about several activities carried out by the Commission and the European Medicines Agency (EMA) in the area of pharmaceuticals.

During the meeting, the European Commission gave an update about the proposal for the revision of the Directive relating to the transparency of measures regulating the prices of medicinal products for human use and their inclusion in the scope of public health insurance systems. In its Annual Work Programme for 2015, the Commission announced its plan to withdraw this legislative initiative due to a lack of foreseeable agreement in the Council. This decision was finalised in March 2015. However, the Commission announced its commitment to ensure that the current Directive (89/105/EEC) is correctly enforced. Thus, the Commission will intensify vigilance about implementation and interpretation by the EU Court of Justice. It will also welcome and seek inputs from all stakeholders about issues faced and information that can be relevant for the enforcement of the Directive.

The meeting represented also an opportunity for the Commission to provide an update on the Expert Group on Safe and Timely Access to Medicines for Patients (STAMP) created at the beginning of 2015. STAMP aims to provide advice and expertise to the Commission services in relation to the implementation of the EU Pharmaceutical legislation, as well as programmes and policies in this field. It will look at national experiences with regard to the implementation of the current regulatory framework and will look at more efficient ways to use the already existing tools.

Members of STAMP are the Member States, EEA countries and EMA. The Commission services may invite experts with specific competence in a subject on the agenda to make a presentation or take part in the work of the group on an ad hoc basis. There are 4 total meetings of STAMP scheduled for 2015. The next meeting will take place the 6<sup>th</sup> of May.

The Commission also announced the intention to continue the work on the assessment of market penetration and uptake of biosimilars initiated within the Platform on access to medicines in Europe. The Commission proposed to develop a first set of indicators on the market uptake and penetration of biosimilars with a view to publish an annual report, which will allow for a common understanding and interpretation of available data.

The set of indicators will be presented during the next multistakeholders workshop which will take place in Brussels on 6 October.



## ***EMERGING AND NEWLY IDENTIFIED HEALTH RISKS – SCENIHR POSITION STATEMENT***

On 9 April 2015, the Scientific Committee on Emerging and Newly-Identified Health Risks (SCENIHR) published a position statement on emerging and newly identified health risks to be drawn to the attention of the European Commission.

The SCENIHR provides the Commission with scientific advices for preparing its policy and legislative proposals in the field of consumer safety, public health and environment. It particularly deals with issues of emerging or newly identified health and environmental risks.

The aim of this report is to draw the Commission's attention on emerging issues that the SCENIHR has identified as potentially harmful for human health and environment.

For each emerging issue, the report specifies the exposure category, the suggested hazard category as well as the preliminary impact estimation. The report notably deals with issues such as cyanotoxins risk (haemodialysis), the use of nanomaterials for medical imaging, drug delivery and electromagnetic fields.

This report will be used by SCENIHR secretariat as basis for discussion of potential new mandates with relevant Commission departments.

*The position statement is available at:*

[http://ec.europa.eu/health/scientific\\_committees/emerging/docs/scenihr\\_s\\_002.pdf](http://ec.europa.eu/health/scientific_committees/emerging/docs/scenihr_s_002.pdf)

## ***LETTER FROM THE COMMISSIONER FOR HEALTH AND FOOD SAFETY TO EU HEALTH MINISTERS***

On 7 April 2015, Vytenis Andriukaitis, European Commissioner for Health and Food Safety, wrote a letter to EU Health Ministers to express his view on EU health policy priorities.

The Commissioner stressed the importance of the health sector for the European economy, and advocated the need for a "cross policy approach" in health.

In the letter, he clearly affirmed that his priorities for EU health policy are:

- prevention;
- promotion
- protection.

Starting with prevention, Dr. Andriukaitis emphasised the need to focus on health determinants, early screening and chronic disease prevention.

Then, as far as promotion is concerned, the Commissioner stated that healthy choices should be made "*available and affordable*". Besides, he advocated for an integrated approach in primary and secondary care, and called for more efforts to promote health technologies and innovation.

Finally, with regards to protection, Dr. Andriukaitis stressed the need to improve preparedness to address cross-border health threats, as well as to reinforce efforts to tackle communicable diseases.

The Commissioner called for a dialogue and an exchange of views with EU Health Ministers on EU health policy at the Informal meeting of Health Ministers which took place in Riga on 20-21 April. On the occasion of this meeting, the Health Ministers and Heads of Delegation discussed the need for a new policy framework for reducing alcohol-related harm, and the EU's role in harmonisation of national policies in this area. Due to the recent tragic event concerning refugees in the Mediterranean, the problem of migration was also raised. The Ministers agreed that a common solution for this issue needs to be found by addressing its causes and also taking into account its health aspects.

*The letter of the Commissioner to EU Health Ministers is available at:*

[http://ec.europa.eu/commission/2014-2019/andriukaitis/announcements/letter-eu-ministers-health\\_en](http://ec.europa.eu/commission/2014-2019/andriukaitis/announcements/letter-eu-ministers-health_en)



## ***SOCIAL ECONOMY INTERGROUP PUBLIC HEARING – INTEGRATING SOCIAL ECONOMY INTO EU POLICY PROGRAMME***

On 22 April 2015, HOPE attended the conference “Integrating Social Economy into the EU policy programme”, organised by the Social Economy Intergroup.

The core themes were the role of this alternative economy in the economic sphere, its impact from a socio-economical point of view, and the role of governmental and non-governmental institutions.

Since the aim of the Social Economy Intergroup is to create a dialogue between MEPs, social economy actors and European institutions, two roundtables with different speakers were set.

The first part of the conference was an opportunity to hear from the EU Institutions. Although the Social Economy Intergroup complained about the scarce priority given by the new Commission to the discussed theme, a positive message was sent by the Commission’s representative. The European Commission, through the new DG Growth is currently working on fostering social economy through many specific programs and competitions for social entrepreneurship.

The second part of the conference gave the floor to members of the civil society, social partners and organisations promoting social economy. The second panel underlined the necessity of sustaining the social economy since for example in the Mediterranean area (Italy, Portugal, Spain and Greece) 900.000 social enterprises and 9 millions of people are part of this sector.

Moreover, the role of research centers in this field is very important to capture the differences between social economy and traditional economy. Several projects, including by the International Research Network, started at the international level. One of them involves approximately 200 researchers, and has the aim of understanding the features, the aim and the social impact of social economy on our society and economy.

Finally, the UK Council is launching a programme, especially for students and young people, to interface with social economy and entrepreneurship. This program is also supported by partnership across the world with different countries, such as Canada.



### **TRANSPARENCY OF PRICING OF MEDICINAL PRODUCTS – JUDGMENT**

On 26 February 2015, the European Court of Justice delivered a judgment on the interpretation of Directive 89/105/EEC on the transparency of measures regulating the pricing of medicinal products for human use and their inclusion in the scope of national health insurance systems.

Directive 89/105/EEC aims at ensuring more transparency in the setting of the pricing of medicinal products as well as reimbursement by national health insurance systems. In this regard, article 6(2) of the Directive put some obligations on competent authorities when they take a decision on the inclusion or the exclusion of medicinal products on the list of medicinal products covered by the national health insurance system. To comply with the Directive, when refusing to include a medicinal product on the list of reimbursable products, the competent authorities have to provide a “*statement of reasons based upon objective and verifiable criteria*”

Servier, a French laboratory, sells a medicinal product (Protelos) for osteoporosis treatment. In September 2011, the competent authority decided to include this medicinal product in the list of reimbursable medicinal products. However, the reimbursement of the product was limited to patients who cannot be treated by bisphosphonate-based medicinal products or who do not present any risk factor for a venous thromboembolic event.

As the French laboratory was not satisfied with the reimbursement limitation set for its product, it decided to bring an action against this decision to the Council of State.

The question asked to the Court was to know whether the Directive requires that the obligation to state reasons is also applicable in case of decisions which reinstates a product in the list of medicinal products covered by the health insurance system, but which limits the reimbursement of that product to a specific category of patients.

The Court interpreted the Directive in the light of its objective of transparency of pricing, and decided that “*Article 6(2) of Directive 89/105 must be interpreted as meaning that the obligation to state reasons [...] is applicable to a decision which reinstates a product in the list of medicinal products covered by the health insurance system, but which limits the reimbursement of that product to a specific category of patients*”.

***The judgment is available at:***

***<http://curia.europa.eu/juris/celex.jsf?celex=62013CJ0691&lang1=en&type=TXT&ancre=>***



### ***EUROPEAN FUND FOR STRATEGIC INVESTMENTS – VOTE BY PARLIAMENTARY COMMITTEES***

In November 2014, the European Commission presented a plan to boost investment in the European Union, announcing the creation of a new European Fund for Strategic Investments (EFSI). This was followed in January 2015 by the tabling of a legislative proposal for the EFSI, which will be established in close partnership with the European Investment Bank.

The Commission proposal aims to mobilise funding for projects of at least €315 billion to help promote growth and employment.

On 20 April, the Budgets and Economic and Monetary Affairs parliamentary committees adopted the report drafted by MEPs José Manuel Fernandes (EPP, Portugal) for the Budgets Committee and Udo Bullmann (S&D, Germany) for the Economic and Monetary Affairs Committee. The report was approved with 69 votes in favour, 13 against and with 6 abstentions.

The Commission proposal creates an initial EU guarantee fund of €16 billion, which has to be filled by reallocating existing funds from the EU research and transport budgets. This provision created concern among the scientific community. MEPs opposed to this by stating that the Commission should find alternative resources to finance the guarantee fund. The fund should be gradually filled via the annual budgetary procedure until it reaches €8 billion by 2022. The guarantee itself should be “irrevocable and unconditional”, so as to reassure investors.

Furthermore, MEPs pronounced themselves over the governance of the EFSI by stating that the fund’s investment committee should be composed of eight members to ensure geographical balance and provide the widest possible range of expertise. The Parliament should approve both this panel and the proposed managing director, whom is entitled to hear along with the chair of the steering board. The steering board should be composed of four members.

The committees have also approved a mandate to start negotiations with the Council. Negotiations started on 23 April 2015, with the aim of establishing a compromise to be voted by the Parliament during the June plenary session, so as to have the fund up and running by mid-2015, in line with the Commission’s plan.

## **COMMISSION CODE OF CONDUCT ON MOBILE HEALTH APPS – CALL FOR TENDER**

On 21 April 2015, the Commission published an ex-ante advertisement of a call for tender entitled “Development Leader - Project Editor for EC code of conduct on mobile health apps”.

Article 29 of Directive 95/46/EC on data protection set up a Working Party on the Protection of Individuals with regard to the Processing of Personal Data, the so-called “Article 29 Working Party”. This call for tender follows the decision of the Article 29 Working Party subgroup on mobile health (mHealth) data protection to set up an ad hoc working group to start working on the drafting of a code of conduct on mobile health apps, taking into account the current revision of data protection rules.

Applications developers are sometimes not aware of data protection rules. In addition, only few of them have a privacy policy. The EU code of conduct on mHealth applications would provide mobile application developers with more guidance and clarity on the existing data protection rules.

The purpose of the call for tender is to find a development leader and project editor for the Commission code of conduct on mobile health applications. The latter will manage stakeholder development efforts, be in charge of editing the code of conduct and will prepare the necessary additional material to support the work of the subgroup of the Article 29 Working Party. The final version of the code of conduct should be delivered on the second quarter of 2016 at the latest.

Interested economic operators can express their interest to participate in the call for tender “Development Leader - Project Editor for EC code of conduct on mobile health apps” **until 6 May 2015**.

The invitation to tender will be sent to all economic operators who expressed interest, if any, as well as to any other economic operator that the contracting authority wishes to invite. Only the candidates invited by the contracting authority to participate in this procurement procedure will be admissible. Tenders submitted by groupings of economic operators other than the ones declared in response to the ex-ante advertisement and invited to participate in this procurement procedure will be rejected.

*More information on the call for tender is available at:*

<http://ec.europa.eu/digital-agenda/en/news/ex-ante-publicity-low-value-contracts-between-eur-15000-and-eur-60000-development-leader>

## **BETTER USE OF ANTIBIOTICS – €1 MILLION HORIZON PRIZE**

In March 2015, the Horizon prize for better use of antibiotics was launched.

It is a €1 million prize funded under Horizon 2020, the EU's research and innovation programme, that will be awarded to a person or team who can most effectively develop rapid point-of-care test that will reduce the use of antibiotics in a safe way in patients with upper respiratory tract infections such as pharyngitis, sinusitis, otitis or bronchitis.

The objectives of this prize are to reduce the unnecessary use of antibiotics in case of viral upper respiratory tract infections as well as the costs and side effects linked to the use of antibiotics.

The prize also aims at delaying the emergence of antibiotic resistant organisms and enabling health-care providers to take early decisions in the management of upper respiratory tract infections.

Finally, this prize should facilitate health care providers' decision not to prescribe antibiotics in case of viral infections and to ease patients' acceptance of not taking antibiotics for viral infections.

The test should fulfil at best the following criteria:

- potential to reduce the use of antibiotics;
- accuracy and safety;
- minimal or non-invasive;
- low cost and affordable;
- rapid:
- easy to use.

**The participants can submit their application until the deadline of 17 August 2016.**

*More information:*

<http://ec.europa.eu/research/participants/portal/desktop/en/opportunities/h2020/topics/14060-hoa-01-2015.html?#tab2>

## **UNITED<sub>4</sub>HEALTH POLICY ADVISORY BOARD**

On 9 April 2015, HOPE attended the meeting of the United<sub>4</sub>Health Policy Advisory Board. The meeting aimed at discussing some provisional policy messages that can be delivered based on the project results in the area of cardiac conditions.

United<sub>4</sub>Health is a project co-financed by the European Commission under the ICT Policy Support Programme (ICT PSP). The project is a large scale study that aims to reach new frontiers in the evaluation and deployment of information technology and communications (ICT) services for the management of people living with chronic diseases in home settings.

To reach this goal, the project is utilising the results and good practices from previous projects and trials, including the Renewing Health project (in which HOPE was also involved as an advisor),

providing scaled up solutions. The programme involves patients affected by Diabetes, Chronic Obstructive Pulmonary Disease (COPD), and Cardiovascular disease.

In the first part of the meeting, a number of initiatives were presented such as the telemonitoring of chronic heart failure in Veneto Region (Italy) and participants got an insight on the first results from the United4Health project. Preliminary findings demonstrate that several barriers to the deployment of telehealth might come from lack of available connectivity and issues with the lengthy process required for the procurement of equipment. Some of the lessons learned show the importance of taking into account local problems and local benefits for the successful deployment of services. The data collection within United4Health will continue until September 2015. Results relevant from an economic and organisational perspective will be available by the end of 2015.

The second part of the meeting was dedicated to a common exercise, with all the participants exploring how the Business Model Canvas can help in the development of effective business models in the field of telemonitoring of cardiac conditions. Participants used ITHACA (a telemedicine service for chronic hypertensive patients) as a case study to fill in the Business Model Canvas.

Finally, based on the presentations during the day, inputs on aspects that are considered as important from the point of view of EU stakeholders representing patients, healthcare professionals, healthcare providers and payers were gathered and will be compiled in a discussion paper.

The United4Health Policy Advisory Board will meet again in summer 2015 to continue discussions about relevant policy messages that can be delivered by the end of the project in December 2015.

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

## ***JOINT ACTION HEALTH WORKFORCE PLANNING AND FORECASTING – WP6 WORKSHOP***

On 23 April 2015, HOPE participated to a workshop organised by the joint action workforce planning and forecasting Work Package 6 team in London. The aim of the event was to present to participants the first draft of the deliverable Do62 – Report on Future Skills and Competencies. The document represents a series of policy briefs aimed at supporting the Member States in estimating the future skills and competencies required in the future health workforce as well as their distribution. The professional categories taken into consideration are: doctors, nurses, midwives, pharmacists and dentists. To consider the future skills and competencies of the health workforce, horizon scanning methods have been used to gather information and to state the potential implication of health workforce planning.

During the day, participants were asked to give their contribution in two sessions. In the first one, the topics discussed were about the impact of some aspect of health services and population on skills and competencies. The second one was focused on the relevance of challenges on health workforce (e.g. resource-constraint, regulation and education) on skills and competencies. The feedbacks collected will be used to update the second version of the deliverable.

*More information on the Joint Action on Health Workforce Planning and Forecasting:: <http://www.euhwforce.eu/>*



## ***A BEGINNER GUIDE TO EU FUNDING – EU FUNDING OPPORTUNITIES IN 2014-20***



The European commission recently published a beginner guide to EU funding. The guide provides a general overview of the available EU funding opportunities. The publication explains the main steps of the application procedure, and gives some information about accountability and control in EU funding management.

The guide distinguishes seven main categories of potential applicants; SMEs, NGOs, young people, researchers, farmers, public bodies and others. For each category, the guide enumerates the various existing funding opportunities available under the 2014-2020 financial period while providing information about current EU programmes.

Finally, the publication provides an insight of the available amounts of some of the 2014-2020 programmes.

*The guide is available at: [http://ec.europa.eu/budget/funding/index\\_en](http://ec.europa.eu/budget/funding/index_en)*

## REPORTS AND PUBLICATIONS

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### ***THE IMPACT OF AUSTERITY MEASURES ON THE RIGHT TO HEALTHCARE – EUROPEAN PARLIAMENT STUDY***

In March 2015, the European Parliament's Committee on Civil Liberties, Justice and Home Affairs (LIBE) published a study on "The impact of the crisis on fundamental rights across Member States of the EU". This comparative analysis focuses on the overall impact of the crisis in the different Member States, and in various sectors of life such as healthcare, jobs and education.

The right to healthcare refers to the right to have access to health services. This right is protected by many international instruments. Article 35 of the Charter of Fundamental Rights of the European Union provides for a right of access to preventive healthcare and to benefit from medical treatment under the conditions established by national laws and practices.

As a result of the economic and financial crisis, all Member States introduced measures affecting access to healthcare. These measures were directed toward the reorganisation of hospital and healthcare providers, reducing salaries as well as the number of staff, administrative reforms, etc. The study from the Parliament reveals that austerity measures had an important impact on access to healthcare in all Member States.

First, the crisis increased the financial burden on citizens for accessing healthcare. In southern countries, new participation fees were introduced for many healthcare services from primary care to emergency visits. Concerning the cost of drugs, budget constraints led to an increase in patients' contribution for medicines and pharmaceutical material.

Then, the reorganisation of hospitals and other healthcare providers led to a decrease in the number of hospital beds, rationalisation of costs, and a reduction in the number of medical staff.

Consequently, waiting times increased in many southern countries. In addition, cuts in healthcare expenditure intensified inequalities. In this regard, many vulnerable groups of population such as unemployed or poor people, undocumented migrants, inhabitants of isolated regions, disabled people, etc. were disproportionately affected by the measures imposed.

*More information:*

[http://www.europarl.europa.eu/RegData/etudes/STUD/2015/510021/IPOL\\_STU\(2015\)510021\\_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2015/510021/IPOL_STU(2015)510021_EN.pdf)

## **PSYCHOTHERAPY FOR MENTAL ILLNESSES IN EUROPE – JRC REPORT**



The Joint Research Centre (JRC) recently published a science and policy report on psychotherapy and mental illnesses in Europe. The JRC is the in-house science service from the European Commission, which provides independent scientific advice and support to EU policy making.

Mental health is increasingly being recognised as fundamental to EU health policy. As opposed to psychiatric care, which is firmly regulated in European Member States, psychotherapy lacks of a general regulatory framework. In addition, there is no current comprehensive mental health report focusing on psychotherapy. Accordingly, this recently published JCR's report focuses on mental health from the angle of psychotherapy treatments in Europe, aiming at summarising the evidence base

supporting psychotherapeutic treatments for mental illnesses, and exploring its role in the treatment for mental illnesses.

The report first draws the reader's attention on the evidence of the benefits of this method for treating mental illnesses such as anxiety and depression. Indeed, psychotherapy treatments produce solid and long lasting effects, while they also prove to be cost efficient.

Then, the report emphasises the need for more regulation of professional titles and of the activity of psychotherapy as such. Indeed, studies used for drafting the report showed that there is a large heterogeneity in various central aspects of psychotherapy provision across the different European countries, such as training of professionals and provision of psychotherapy by the public health system.

The diversity between European countries in terms of degree and nature of the regulation of psychotherapy constitutes a threat for the legal protection of titles such as "psychotherapists", and may enable any unqualified person to exercise this activity, with a consequent impact on the quality of the interventions delivered. Thus, the report argues that there might be scope for a systematic comparison of national concepts of psychotherapy across Europe.

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

<http://publications.jrc.ec.europa.eu/repository/bitstream/JRC94870/psychotherapy%20for%20mental%20illness%20in%20europe.pdf>

## **ACCESS TO NEW MEDICINES IN EUROPE – WHO PUBLICATION**

The WHO recently published "Access to new medicines in Europe: technical review of policy initiatives and opportunities for collaboration and research". This report, with a focus on sustainable access to new medicines, reviews policies that affect medicines throughout their lifecycle (from research and development to disinvestment), examining the current evidence base across Europe.

While many European countries have not traditionally required active priority-setting for access to medicines, appraising new medicines using pharmacoeconomics is increasingly seen as critical in order to improve efficiency in spending while maintaining an appropriate balance between access and cost-effectiveness.

The study features findings from 27 countries and explores different ways in which health authorities in European countries are dealing with high spending on new medicines, including methods such as restrictive treatment guidelines, target levels for use of generics, and limitations on the use of particularly expensive drugs. It also outlines possible policy directions and choices that may help governments to reduce high prices when introducing new drugs.

**More information:** [http://www.euro.who.int/data/assets/pdf\\_file/0003/273819/WHO-Medicines-Report-FINAL2015.pdf?ua=1](http://www.euro.who.int/data/assets/pdf_file/0003/273819/WHO-Medicines-Report-FINAL2015.pdf?ua=1)

## **INTERNATIONAL HEALTH REGULATIONS.– WHO PUBLICATION**



The WHO recently published “International Health Regulations. A guide for public health emergency contingency planning at designated points of entry”.

This guide was designed to assist WHO Member States, both large and small, to bridge the gap between the legal requirements of the International Health Regulations (IHR) and the pragmatic readiness and response capacity for public health emergencies at designated points of entry (POE).

Under IHR (2005), Member States must comply with the legal requirements set out for designated POE. Furthermore, each country should ensure that the core capacities for designated POE are in place by June 2012, in principle. Many countries have prioritised their designation of several international airports, ports or ground crossings, while some small countries have chosen to designate only one airport and/or port to handle incoming and departing travellers during public health emergency situations. IHR (2005) requires that a public health emergency contingency plan (PHECP) is developed and maintained in designated POE for responding to events that may constitute a public health emergency of international concern (PHEIC).

This guide provides a recommended approach, structure and logical set of considerations for the National Points of Entry Health Authority (NaPHA) to guide local points of entry health officers (PHOs) and emergency planners responsible for POE to develop a PHECP at a designated POE.

This guide is primarily targeted at NaPHA since it is responsible for driving IHR compliance related to POE, as well as mentoring, guiding and advocating for the development of a robust PHECP at designated POE. Other relevant authorities can also use the guide as a reference document.

IHR is a revision of the International Health Regulations (1969). It represents a “paradigm shift” involving a number of major changes in focus, including: from fixed diseases to all public health threats; from control of borders to also containment at source; and from pre-set measures to adapted responses.

**More information:**

[http://www.wpro.who.int/emerging\\_diseases/documents/PHECP\\_Guide\\_web.pdf?ua=1](http://www.wpro.who.int/emerging_diseases/documents/PHECP_Guide_web.pdf?ua=1)

## THE RELATIONSHIP BETWEEN PSYCHOSOCIAL RISK FACTORS AND HEALTH OUTCOMES OF CHRONIC DISEASES – WHO REPORT



The WHO recently published a report named “*The relationship between psychosocial risk factors and health outcomes of chronic diseases. A review of the evidence for cancer and cardiovascular diseases*”.

This report summarises the best available evidence for a link between psychosocial factors and morbidity and mortality from cardiovascular diseases and cancer in the WHO European Region. The authors searched a total of 1822 Medline and PubMed articles published in English since January 2000, and identified 37 systematic reviews and meta-analyses. The psychosocial factors repeatedly identified as related to chronic diseases, in and outside work, included: high job demand, low autonomy, low control or high effort–reward imbalance, interpersonal conflicts, and

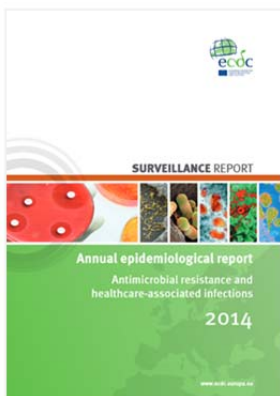
low social support or low trust.

The evidence suggests that multiple adverse psychosocial factors are independently associated with a range of chronic diseases throughout adulthood. In addition, the social gradient in health observed throughout adulthood may partly operate through psychosocial factors on the pathway between socioeconomic characteristics and health. Psychosocial factors might therefore become part of complex total risk-reducing interventions focusing on multiple risk factors.

**More information:** [http://www.euro.who.int/\\_data/assets/pdf\\_file/0011/273737/OMS-EURO-HEN-PsychologicalFactorsReport-A5-20150320-v5-FINAL.pdf?ua=1](http://www.euro.who.int/_data/assets/pdf_file/0011/273737/OMS-EURO-HEN-PsychologicalFactorsReport-A5-20150320-v5-FINAL.pdf?ua=1)

## ANTIMICROBIAL RESISTANCE AND HEALTHCARE-ASSOCIATED INFECTIONS – ECDC REPORT

In April 2015, the European Centre for Disease Prevention and Control (ECDC) published its annual epidemiological report 2014 on “Antimicrobial resistance and healthcare-associated infections”.



The ECDC is an EU agency aimed at protecting at best Europe from infectious diseases. Its main missions are to identify, assess and communicate current and emerging threats to human health caused by infectious diseases.

ECDC annual epidemiological reports aim at providing a better understanding of communicable diseases in Europe, but it should also assist policymakers and health leaders in their actions against diseases.

The present report focuses on antimicrobial resistance, antimicrobial consumption and healthcare-associated infections. In this regards, it provides an overview of the epidemiology of communicable diseases of public health significance in Europe.

This report covers the years 2008–2012 and aims to be consistent with previously published ECDC surveillance reports for 2012 relating to specific diseases and disease groups. This document was the

result of an active screening of various sources, such as national epidemiological bulletins and international networks, and various additional formal and informal sources.

To start with, the report provides surveillance data on different types of antimicrobial resistance, both at European and national level. In this regard, ECDC stresses the need for more international cooperation in this field.

Then, concerning antimicrobials consumption, the report concentrates on the consumption of antibiotics for systemic use in the community. In this respect, ECDC called the European Antimicrobial Resistance Surveillance Network to improve surveillance of antimicrobial consumption at the level of each individual hospital in EU/EEA countries.

Finally, with regards to healthcare associated infections, the report focuses both on a survey of healthcare-associated infections and antimicrobial use in European long-term care facilities, as well as on targeted surveillance of surgical site infections and of infections acquired in intensive care units. As a conclusion, ECDC advocates that further emphasis should be put on harmonisation of surveillance methods in Europe.

*More information:* <http://ecdc.europa.eu/en/publications/Publications/antimicrobial-resistance-annual-epidemiological-report.pdf>

## **ADAPTING EU HEALTH POLICY TO AN EVOLVING EUROPE – FRIENDS OF EUROPE REPORT**

Friends of Europe has recently published a report on “*What the EU should ‘Start’, ‘Stop’ or ‘Do Differently’*” concerning EU health policy.

Friends of Europe is a think-tank focusing on global and European issues. Europe is currently facing major key societal challenges for health such as ageing population, health inequalities, shortages of skilled health workers as well as an increased burden of chronic diseases. Considering the urgent need for reforming Europe’s health systems, Friends of Europe convened a Health Working Group aiming at proposing recommendations for a better EU health policy.

The Health Working Group brings together a wide range of stakeholders representing policymakers at EU and national level, international organisations, academia, health-related industries and non-governmental organisations.

Recognising the need for a change, the Working Group proposed a set of 21 recommendations that can be divided into four main categories:

- improve information for decision-making;
- foster and support greater innovation;
- improve health governance and governance;
- reduce the political risk for implementing change.

*More information:* <http://www.friendsofeurope.org/media/uploads/2015/02/Health-Report-2015-FINAL.pdf>

## ***RECOMMENDATIONS FOR A MORE CARING EU – FRIENDS OF EUROPE REPORT***

*Friends of Europe* has recently published its final report proposing recommendations for a more caring Europe. Friends of Europe is a leading think-tank specialised in global and European issues, dealing mainly with political, economic, social and environmental challenges.

In a context of economic, social and political crisis, there is a growing mistrust in the European project. EU Member States are facing increasing social inequalities and imbalances, and cross border mobility seems more and more difficult to reconcile with social protection.

In spring 2014, Friends of Europe decided to bring together a High-Level Group on Social policy in order to work on policy proposals addressing major European social challenges. The High Level Group gathers key social stakeholders such as trade union leaders, former ministers and EU commissioners and academics.

The Group's recommendations can be summarised as follows:

- promote a mainstreaming social policy involving the economic, education, employment and budgetary policies;
- promote social and civic dialogue as key components of the European Social Model;
- improve social investment and support intergenerational solidarity and education;
- reconcile mobility and social protection;
- facilitate social inclusion.

*More information:* <http://www.friendsofeurope.org/media/uploads/2015/02/Social-Report-2015-WEB.pdf>

## ***INCREASING BURDEN AND COMPLEXITY OF MULTIMORBIDITY – STUDY***

On 23 April 2015, a research named "Increasing burden and complexity of multimorbidity" was published.

Multimorbidity, the co-occurrence of two or more chronic conditions, is common among older adults and is known to be associated with high costs and gaps in quality of care. Population-based estimates of multimorbidity are not readily available, which makes future planning a challenge. The authors aimed to estimate the population-based prevalence and trends of multimorbidity in Ontario, Canada and to examine patterns in the co-occurrence of chronic conditions.

With regard to the methodology used, the cohort study includes all Ontarians (aged 0 to 105 years) with at least one of 16 common chronic conditions. Descriptive statistics were used to examine and compare the prevalence of multimorbidity by age and number of conditions in 2003 and 2009. The co-occurrence of chronic conditions among individuals with multimorbidity was also explored.

The prevalence of multimorbidity among Ontarians rose from 17.4% in 2003 to 24.3% in 2009, a 40% increase. This increase over time was evident across all age groups. Within individual chronic conditions, multimorbidity rates ranged from 44% to 99%. Remarkably, there were no dominant patterns of co-occurring conditions.

The high prevalence of multimorbidity and numerous combinations of conditions suggests that single, disease-oriented management programs may be less effective or efficient tools for high quality care compared to person-centered approaches.

*More information:* <http://www.biomedcentral.com/content/pdf/s12889-015-1733-2.pdf>

### ***OUTCOMES MEASURED BY MORTALITY RATES, QUALITY OF LIFE AND DEGREE OF AUTONOMY IN THE FIRST YEAR IN STROKE UNITS IN SPAIN – STUDY***

On 17 March 2015, a research belonging to the field of quality of life and health was published.

The primary objective of this sub analysis of the CONOCES study was to examine outcomes in terms of mortality rates, quality of life and degree of autonomy over the first year in patients admitted to stroke units in Spain. The secondary objective was to identify the factors determining good prognosis.

A sample of patients who had suffered a confirmed stroke and been admitted to a Stroke Unit in the Spanish healthcare system, were studied. Socio-demographic, clinical variables and variables related to the level of severity (NIHSS), the level of autonomy (Barthel, modified Rankin) and quality of life (EQ-5D) were recorded at the time of admission. The same was done three months and one year after the event. Factors determining prognosis were analysed using logistic regression and ROC curves.

A total of 321 patients were recruited, 33% of whom received thrombolytic treatment, which was associated with better results on the Barthel and the modified Rankin scales and in terms of the risk of death. Mean quality of life measured through EQ-5D improved from 0.57 at discharge to 0.65 one year later. Full autonomy level measured by Barthel index increased from 30.1% at discharge to 52.8% at one year and by the modified Rankin scale from 51% to 71%. The rates for in-hospital and 1-year mortality were 5.9% and 17.4% respectively. Low NIHSS scores were associated with a good prognosis with all the outcome variables. The three instruments applied (NIHSS, Barthel and modified Rankin scales) on admission showed good discriminative ability for patient prognosis in the ROC curves.

The study shows that there has been a change in the prognosis for stroke in Spain in recent years. Moreover, survival and functional outcome have also improved following the introduction of a new model of care. These results clearly promote extension of the model based on stroke units and reinforced rehabilitation to the majority of the more than 100,000 strokes that occur annually in Spain.

*More information:* <http://www.hqlo.com/content/pdf/s12955-015-0230-8.pdf>



## ***BARRIERS AND OPPORTUNITIES FOR ENHANCING PATIENT RECRUITMENT AND RETENTION IN CLINICAL RESEARCH – FINDINGS FROM AN INTERVIEW STUDY***

On 12 March 2015, a research was published about barriers and opportunities for enhancing patient recruitment and retention in clinical research in the UK.

The aim of this study is to identify and examine staff views of the key organisational barriers and facilitators to patient recruitment work in one clinical research group located in an NHS Academic Health Science Centre.

The methodology concerned the submission of a qualitative study utilising in-depth, one-to-one semi-structured interviews. These were done with 11 purposively selected staff, with particular responsibilities related to recruiting and retaining patients, and also on clinical research subjects. The findings highlight four key factors that staff perceived to be most significant for the successful recruitment and retention of patients. Moreover the output identifies how staff located these factors within patients, studies, the research center, the trust, and beyond the trust. These factors are: the competition for research participants at an organisational and national level, the tension between clinical and clinical research; inequity between personal patient burden and benefit; the structure and relationships within clinical research teams, in particular the low tacit status of recruitment skills.

The results of this case-study highlight current systematic challenges to patient recruitment and retention in clinical studies more generally as seen from the perspective of staff at the 'sharp end' of recruiting. Staff experience is that, beyond individual clinical research design and protocol factors, wider organisational and extra-organisational norms, structures, and processes operate as significant facilitators or hindrances in the recruitment of patients as research subjects.

*More information:* <http://www.health-policy-systems.com/content/pdf/1478-4505-13-8.pdf>

## ***DOES CLINICAL GOVERNANCE INFLUENCE THE APPROPRIATENESS OF HOSPITAL STAY? – STUDY***

A cross-sectional study was conducted in 2012 in an Italian Teaching Hospital. The OPTIGOV© (Optimizing Health Care Governance) methodology was used to quantify the level of implementation of Clinical Governance globally and in its main dimensions.

Organisational appropriateness was measured retrospectively using the Italian version of the Appropriateness Evaluation Protocol to analyse a random sample of medical records for each clinical unit. Pearson-correlation and multiple linear regression were used to test the relationship between the percentage of inappropriate days of hospital stay and the Clinical Governance implementation levels

For this study 47 units were assessed. Adjusted multiple regression analysis resulted in a significant association between the percentage of inappropriate days and the overall Clinical Governance score ( $\beta = -0.28$ ;  $p < 0.001$ ; R-squared = 0.8). EBM and Clinical Audit represented the Clinical Governance dimensions which had the strongest association with organisational appropriateness.

This study suggests that the evaluation of both Clinical Governance and organisational appropriateness through standardised and repeatable tools is a key strategy for healthcare quality. The relationship between the two underlines the central role of Clinical Governance, and especially of EBM and Clinical Audit, in determining a rational improvement of appropriateness levels.

*More information:* <http://www.biomedcentral.com/content/pdf/s12913-015-0795-2.pdf>

### ***COST-UTILITY ANALYSIS OF A PREVENTIVE HOME VISIT PROGRAMME FOR OLDER ADULTS IN GERMANY***

On 3 April 2015, a research titled "Cost-utility analysis of a preventive home visit program for older adults in Germany" was published. The purpose of this study was to analyse the cost-effectiveness of preventive home visits from a societal perspective in Germany.

This study is part of a multi-centre, non-blinded, randomised controlled trial aiming at the reduction of nursing home admissions. Participants were older than 80 years and living at home. Up to three home visits were conducted to identify self-care deficits and risk factors, to present recommendations and to implement solutions. The control group received usual care. A cost-utility analysis using quality-adjusted life years (QALY) based on the EQ-5D was performed. Resource utilisation was assessed by means of the interview version of a patient questionnaire. A cost-effectiveness acceptability curve controlled for prognostic variables was constructed and a sensitivity analysis to control for the influence of the mode of QALY calculation was performed.

For this study, 278 individuals (intervention group: 133; control group: 145) were included in the analysis. During 18 months, follow-up mean adjusted total cost, and number of QALY were higher in the intervention group (but differences were not significant). For preventive home visits the probability of an incremental cost-effectiveness ratio <50,000 EUR per QALY was only 15%. The results were robust with respect to the mode of QALY calculation.

Finally, the research shows that evaluated preventive home visits programme is unlikely to be cost-effective.

*More information:* <http://www.biomedcentral.com/content/pdf/s12913-015-0817-0.pdf>

### ***ACCOUNTING FOR QUALITY: ON THE RELATIONSHIP BETWEEN ACCOUNTING AND QUALITY IMPROVEMENT IN HEALTHCARE – ARTICLE***

Accounting -that is, standardised measurement, public reporting, performance evaluation and managerial control- is commonly seen to provide the core infrastructure for quality improvement in healthcare.

Yet, accounting successfully for quality has been a problematic endeavor, often producing dysfunctional effects. This has raised questions about the appropriate role for accounting in achieving quality improvement. This paper contributes to this debate by contrasting the specific way in which accounting is understood and operationalised for quality improvement in the UK National Health Service (NHS) with findings from the broadly defined 'social studies of accounting' literature and illustrative examples.

This paper highlights three significant differences between the way that accounting is understood to operate in the dominant health policy discourse and recent healthcare reforms, and in the social studies of accounting literature. It shows that accounting does not just find things out, but makes them up. It shows that accounting is not simply a matter of substance, but of style. And it shows that accounting does not just facilitate, but displaces, control.

A recently published paper concludes that accounting is not necessarily incompatible with the ambition of quality improvement, but that it would need to be understood and operationalised in new ways in order to contribute to this end. Proposals for this new way of advancing accounting are discussed.

*More information:* <http://www.biomedcentral.com/content/pdf/s12913-015-0769-4.pdf>

### ***A ROADMAP FOR COMPARING READMISSION POLICIES WITH APPLICATION TO DENMARK, ENGLAND, GERMANY AND THE UNITED STATES***

Hospital readmissions receive increasing interest from policy makers because reducing unnecessary readmissions has the potential to simultaneously improve quality and save costs.

A recently published paper reviews readmission policies in Denmark, England, Germany and the United States (Medicare system). The suggested roadmap enables researchers and policy makers to systematically compare and analyse readmission policies. Considerable differences are found across countries.

In Germany, the readmission policy aims to avoid unintended consequences of the introduction of DRG-based payment; it focuses on readmissions of individual patients and hospitals receive only one DRG-based payment for both the initial and the re-admission. In Denmark, England and the US readmission policies aim at quality improvement and focus on readmission rates. In Denmark, readmission rates are publicly reported but payments are not adjusted in relation to readmissions. In England and the US, financial incentives penalise hospitals with readmission rates above a certain benchmark. In England, this benchmark is defined through local clinical review, while it is based on the risk-adjusted national average in the US. At present, not enough evidence exists to give recommendations on the optimal design of readmission policies.

The roadmap can be a tool for systematically assessing how elements of other countries' readmission policies can potentially be adopted to improve national policies.

*More information:*

[http://ac.els-cdn.com/S0168851014003431/1-s2.0-S0168851014003431-main.pdf?\\_tid=dbe7660c-ecce-11e4-85cc-00000aacb35f&acdnat=1430133572\\_5b63b916641574b1cf0494a4519fb126](http://ac.els-cdn.com/S0168851014003431/1-s2.0-S0168851014003431-main.pdf?_tid=dbe7660c-ecce-11e4-85cc-00000aacb35f&acdnat=1430133572_5b63b916641574b1cf0494a4519fb126)

## ***THE SHORT-RUN CAUSAL EFFECT OF TUMOR DETECTION AND TREATMENT ON PSYCHOSOCIAL WELL-BEING, WORK, AND INCOME***

The aim of this paper, published on 5 April 2015, is to estimate the short-run causal effect of tumor detection and treatment on psychosocial well-being, work and income.

Tumor detection was considered as a random event, in order to compare individuals' average outcomes in the year of diagnosis with the year before.

Authors argued for using panel data estimation techniques that could have enabled them to control for observed and unobserved information intrinsic to the individual and time constants. The research authors used data of a national representative panel in the Netherlands that includes health survey information and data on work, education, and income between 2007 and 2012.

Findings show differences in the psychosocial dysfunction of men and women in response to tumor detection and treatment. Women, not men, are decreasingly likely to participate in the labor force as a result of malignant tumor detection, while no significant effects are found on her personal or household income. Authors demonstrated that fixed effects panel data models are superior to matching techniques.

***More information:***

<http://goo.gl/rpaMzA>

## ***SIX PRINCIPLES TO ENHANCE HEALTH WORKFORCE FLEXIBILITY – ARTICLE***

On 7 April 2015, an article concerning the breaking of boundaries that block the health workforce flexibility and responsiveness to the population needs was published.

It must be said that health services require sufficient numbers and types of skilled workers to meet population needs. Shortages of personnel may impact negatively on workforce flexibility. However, there are several reasons that can explain why the health workforce cannot or does not meet population needs.

Several new models of care are being developed to enhance workforce flexibility by enabling existing staff to work to their full scope of practice, extend their roles or by introducing new workers. This theoretical paper proposes six principles that have the potential to enhance health workforce flexibility, specifically:

1. measure health system performance from the perspective of the patient;
2. minimise training times;
3. regulate tasks (competencies), not professions;
4. match rewards and indemnity to the levels of skill and risk required to perform a particular task, not professional title;
5. ensure that practitioners have all the skills they need to perform the tasks required to work in the environment in which they work;
6. enable practitioners to work to their full scope of practice delegate tasks where required.

These proposed principles will challenge some of the existing social norms around health-care delivery; however, many of these principles are already being applied, albeit on a small scale. This paper discusses the implications of these potential reforms.

*More information:* <http://www.human-resources-health.com/content/pdf/1478-4491-13-9.pdf>

## ***HEALTH LITERACY IN EUROPE – COMPARATIVE RESULTS OF THE EUROPEAN HEALTH LITERACY SURVEY***

A recently published article presents selected findings from the first European comparative survey on health literacy in populations.

Closely linked to empowerment, it can be defined as the ability of citizens to make sound decisions concerning health in daily life -at home, at work, in health care, at the market place and in the political arena. In spite of the growing attention for the concept among European health policymakers, researchers and practitioners, information about the status of health literacy in Europe remains scarce.

To address this shortcoming, a consortium of nine organisations from eight EU Member States (Austria, Bulgaria, Germany, Greece, Ireland, the Netherlands, Poland and Spain) launched the European Health Literacy Project (HLS-EU) to conduct the first comparative European health literacy survey.

This article presents selected findings from the first European comparative survey using the HLS-EU-Q conducted in 2011. More in-depth descriptions of methods and results are available in the research report of the HLS-EU project.

The paper specifically considers how health literacy is distributed in the population of the countries involved, what proportions of the population show limited health literacy, which vulnerable groups have an above-average proportion of limited health literacy and whether there is a social gradient for health literacy.

*More information:*

<http://eurpub.oxfordjournals.org/content/eurpub/early/2015/04/04/eurpub.ckvo43.full.pdf>

## OTHER NEWS – EUROPE

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### ***EUROPEAN HEALTH AWARD 2015 – EUROPEAN HEALTH FORUM GASTEIN***

The European Health Awards (EHA) 2015 was launched at the beginning of this year, as part of the European Health Forum Gastein.

The European Health Forum Gastein is a policy platform for discussion gathering various decision makers in the field of public health and healthcare. This annual event is composed of a three-day programme enabling information exchange about current health challenges.

The EHA was set up in 2007 to promote cross border cooperation, as well as the exchange of good practices addressing current challenges such as disparities in health status, access to services and the provision of treatment within Europe. This award is aimed at honouring initiatives for improving public health and healthcare in Europe.

In October, the winner will be given a 10 000 € prize at the European Health Forum in Gastein (Austria).

The selection criteria are the following:

- a health initiative being in its implementation phase in at least two European countries;
- a provision of some preliminary results of the initiative;
- the initiative focuses on public health or healthcare delivery, from the angle of access to healthcare, quality of care, cost-efficiency or health prevention;
- an innovative initiative being sustainable and transferable to other countries.

Last year, the rewarded initiative was the EpiSouth Plus Project. The objective of this project was to increase health security in the Mediterranean Area and Balkans by enhancing preparedness to threats and to bio-security risks at national and regional levels in the framework of the International Health Regulations implementation.

**Applications should be submitted by 29 May 2015.**

***More information on the European Health Award 2015 is available at:***  
***<http://www.ehfg.org/award.html>***

## ***CHES POLICY DIALOGUE – END OF LIFE CARE: COMBINING ETHICS WITH ECONOMICS***

On 14 April 2015, HOPE took part to the conference “*End of life care: Combining Ethics with Economics*”, organised by the European Policy Centre.

The aim of the conference was to define how to reach a balance between economics and ethic for end-of-life care. The discussion focused on the ageing society and ethical questions about how to meet the needs of patients, especially the elderly, in the last stages of their lives. The speakers have tried to define how to look at these issues and how to intervene in order to ensure that patients’ right would be respected. Furthermore, the discussion has concerned the role of palliative care as a substitutive of end-of-life treatments.

At the beginning of the conference, insights about the end-of-life expenditure were given by the OECD Health Economist, David Morgan. For instance the costs of end-of-life care account for the 11% of the total health expenditure in The Netherlands. This expenditure is mostly related to treatments offered to people aged 65 years or more. The top three diseases to which the end-of-life care expenditure is related are: muscular sclerosis, cancer and cardiovascular diseases. Moreover, these costs recur more in hospital care than in home care.

Polypharmacy (mostly related to elderly) represents one of the highest costs related to end-of-life care, costs that concentrate in the last days, months, years of patients’ life. Since 1990 the life expectancy of the population has been growing of 3 months per year. The population ageing phenomena just postponed both patients’ death and end-of-life costs. Palliative care plays a fundamental role as “substitutive” of end-of-life care, when treatments cannot avoid the patient death. As stressed during the conference, patients’ rights and their empowerment must be central, especially when expenditure rationing is put in place. For this reason, it is important to define who should decide who gets treated or not as well as the length and the type of treatments.

From the point of view of the DG Health and Food Safety, the problem is not having a population that lives longer but ensuring good health. This means a continuous increase of end-of-life expenditure by time. Again, the role of palliative care should be revised and applied more often, not only in the oncology area, as it happened in the past. Providing treatments which is known that would not have positive effects on the patient is not acceptable.

## ***TOWARD SUSTAINABLE KIDNEY CARE – EUROPEAN KIDNEY CARE FORUM***

On 30 March 2015, HOPE attended the European Kidney Forum on sustainable kidney care. This forum gathered representatives of stakeholders such as patients, donors, healthcare professionals, EU institutions, economists and academics.

The event was organised by the European Kidney Health Alliance (EKHA), an alliance of non-profit organisations representing key European stakeholders in the kidney care sector. The forum was hosted by the MEP Group for Kidney Health, which is an informal group of MEPs committed to helping improve the policy response to the growing burden of kidney disease in Europe.

In Europe, 1 in 10 adults have some degree of kidney disease, and the prevalence of kidney disease is rising exponentially. However, there is an important lack of awareness and of recognition of the burden of kidney disease. EKHA and the MEP Group for Kidney Health organised this forum in order to raise awareness around kidney disease, and to advocate for improved access to care and patient choice.

Throughout the event, kidney disease was described as a seriously invalidating disease which affects a substantial part of the population. Nevertheless, there is still a lack of streamline approach to tackle this issue in Europe. In this regard, the speakers proposed some recommendations for a more sustainable kidney care in Europe.

First, all the speakers stressed the importance of promoting early prevention and care awareness. In addition, Hans Bart and Wim Altena, kidney donors and transplant recipients from the Dutch Kidney Patient's Association, insisted on the necessity to enable informed patients' choice, an area where there is still a lot of progress to be made.

Then, Professor Rainer Oberbauer, from the Medical University of Vienna, advocated the promotion of home dialysis instead of clinic dialysis. Indeed, clinic dialysis is more expensive and provides less quality of care for the patient.

Finally, the speakers called for more policy incentives for transplantation, which is the most cost efficient and successful treatment in kidney diseases. In this regard, the economist Dr. Arne Björnberg called for a presumed donor legislation. This legislation would provide that individuals are presumed to consent to donate their organs and would be classified as potential donors unless they expressed their opposition to donation before death.

Besides, EKHA's Chairman Prof. Em. Raymond Vanholder advocated EU financial incentives to increase and improve national transplantation programmes.

*More information on the European Kidney Health Alliance is available at: <http://www.ekha.eu/>*

## ***PRICING OF MEDICINES – COOPERATION BETWEEN NETHERLANDS AND BELGIUM***

On 21 April, Belgian Health Minister Maggie De Block announced that Belgium and the Netherlands would jointly negotiate with pharmaceutical groups for the purchase of remedies for rare diseases.

In Europe, the authorisation procedure for many human and veterinary medicines is centralised at the EU level. However, the responsibility of medicines' pricing remains entirely national. Accordingly, negotiations usually take part exclusively between pharmaceutical companies and individual countries.

Member States increasingly have to face drugs high prices such as hepatitis C treatment which price reached around 80.000€ in 2014. Consequently, last year, France and Italy tried to convince EU Member States to create joint purchasing agreements. But this attempt failed because of the resistance of other Member States.



In December 2014, Belgium and the Netherlands initiated talks as they were both concerned with a limited number of patients with rare disease in their country, before signing an agreement in Riga in April.

In the beginning of 2016, Netherlands will hold the presidency of the Council of the European Union. Dutch Health Minister Edith Schippers said The Netherlands plans to focus on European cooperation on drug prices and on enabling innovative medicines to be available faster on the European market and at affordable prices.

## AGENDA

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## UPCOMING CONFERENCES

### *HOPE AGORA 2015*

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

*1-2 June 2015 – Warsaw (Poland)*

The closing conference of the 34<sup>th</sup> 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: [www.hope-agera.eu](http://www.hope-agera.eu)*



## **NHS CONFEDERATION ANNUAL CONFERENCE & EXHIBITION 2015**

***3-5 June 2015 – Liverpool (United Kingdom)***

The NHS Confederation conference is the largest and most influential annual meeting point for the NHS and UK health and care sector.

This year it will bring together 2700+ senior health and care leaders, decision-makers, partners and stakeholders at a critical juncture for health and care in the UK, just three weeks after the general election.

Over three days of learning, discussion and debate, delegates will address the big strategic issues facing the sector including funding and finance; innovation and new models of care; quality and outcomes; and public health.

The issues, challenges and opportunities will be common to healthcare systems across Europe and the conference offers a valuable opportunity to share ideas, knowledge, innovations and solutions with peers in the UK.

If you are interested in attending and want to find out more then please contact Michael Wood ([Michael.Wood@nhsconfed.org](mailto:Michael.Wood@nhsconfed.org)) at the NHS Confederation European Office for all the details.



***Information about the event including the programme can be found on the conference website:***  
***[www.nhsconfed.org/2015](http://www.nhsconfed.org/2015)***

## ***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>***

## ***EUROPEAN HOSPITAL CONFERENCE***

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

The 3rd Joint European Hospital Conference (EHC) will take place as part of MEDICA 2015 on 19 November 2015. The EHC will address different political, medical and economic topics from across all of Europe. Dr. Vytenis Andriukaitis, Commissioner for Health and Food Safety within the EU Commission, plans to participate in this conference.

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

**Patient-oriented hospital care in the future**  
**Patient-oriented hospital care in the practice**

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

***More information:***

***[http://www.medica.de/cipp/md\\_medica/custom/pub/content.oid,33332/lang,2/ticket,gu es t/sr c,EHC2/~EUROPEAN HOSPITAL CONFERENCE.html](http://www.medica.de/cipp/md_medica/custom/pub/content.oid,33332/lang,2/ticket,gu es t/sr c,EHC2/~EUROPEAN HOSPITAL CONFERENCE.html)***