



NEWSLETTER

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DANISH PRESIDENCY – HEALTH PRIORITIES

From January 2012 to mid 2012, Denmark will hold the Presidency of the European Council for the seventh time, with the task of guiding the work among the Member States. During the Danish Presidency of the Council of the EU, several dossiers will lead the work of the Council in the Health area.

Antimicrobial resistance

The rising level of resistance due to the increased use of antibiotics in both humans and animals is a challenge for most European countries. Previous Presidencies have already addressed the issue of increased antimicrobial resistance. Denmark will keep this issue high on the agenda and will focus on promoting a more rational use of antibiotics and on strengthening and improving the surveillance of the use of and resistance to antibiotics.

Action Programme in the field of Health

The key purpose of the EU Action Programme in the Field of Health (2008-2013) is to help achieve a high level of protection for the health and safety of European citizens. The programme has three objectives: improve citizens' health security; promote health, including the reduction of health inequalities; generate and disseminate health information and knowledge. Along with the programme, funds have been allocated in the EU's budget for the financing of projects and joint initiatives that can contribute to achieving these objectives.

Amendment of the Directive on Tobacco

Currently, the Commission is preparing an amendment of the present directive on tobacco from 2001, which provides a number of requirements that tobacco products on the European market have to fulfill, such as: the determination of threshold values for tar, nicotine and carbon monoxide, provisions on warning labels, bans on the use of terms such as "light", "mild" and the like, as well as requirements on filing which additives are used in tobacco products.

Amendment of the Transparency Directive

In May 2011, the Commission completed a broad public consultation on the need for an amendment of the Transparency Directive, which aims to ensure transparency in the measures that Member States establish for the purpose of controlling prices of and limit public reimbursement for medical products.

The Health Threats Package

The opening negotiations of the Commission's proposal for a Health Threats Package will take place during the Danish Presidency of the Council of the EU. The proposal aims to achieve a cross-sectorial approach to health threats in order to link initiatives in the health sector to already existing EU policies in other areas. The proposal focuses on ensuring better coordination of crisis responses and crisis handling of major cross-border health threats.

More information on the website of the Presidency: <http://eu2012.dk/en>



CROSS-BORDER HEALTH THREATS – COMMISSION MEASURES TO PROTECT CITIZENS

On 8 December 2011, building on lessons learned with recent crises such as the H1N1 pandemic in 2009, the volcanic ash cloud in 2010 and the outbreak of E. coli in 2011, the European Commission adopted a legislative proposal on the means to address serious cross-border health threats.

The key measures of the proposal are:

1. to extend the existing co-ordination mechanism for communicable diseases to all health threats caused by biological, chemical or environmental causes;
2. to reinforce the mandate of the Health Security Committee;
3. to strengthen preparedness for crises (by enabling joint purchasing of vaccines for example);
4. to provide the means to recognise a European "health emergency situation" for the purpose of making medicines available faster;
5. to agree on European wide emergency cross border measures when a crisis results in large scale mortality and national measures fail to stop the disease from spreading.

The European Commission has developed capacities to response to serious cross-border health threats and set up specific policies, instruments and mechanisms to address these threats. However, until now, the response has depended on the nature of the threat and serious cross-border health threats have not been treated in a consistent manner at EU level.

This proposal has been submitted to the European Parliament and the Council.

More information:

http://ec.europa.eu/health/preparedness_response/policy/index_en.htm

EUROPEAN COUNCIL MEETING CONCLUSIONS

At the European Council on Employment, Social Policy, Health and Consumers affairs of 1 and 2 December 2011, the Ministers adopted three main conclusions in the field of health.

The first set of conclusions focuses on chronic respiratory diseases in children. Entitled "Prevention, early diagnosis and treatment of chronic respiratory diseases in children", it calls on Member States to "give appropriate consideration to the prevention, early diagnosis and treatment of chronic respiratory diseases in children in their health programmes" and urges them to increase awareness of these diseases. In addition, the conclusions invite the European Commission to support Member States by developing and implementing effective policies on the prevention of chronic and

respiratory diseases in children, by improving networking between different institutions in charge of implementation, and by strengthening collaboration between national centres and international research networks. The conclusions are built on the outcomes of the expert conference on *"Prevention and control of childhood asthma and allergy in EU from public health point of view: urgent need to fill the gaps"*, held on 21-22 September 2011 in Warsaw. It put emphasis on the necessity for action on the prevention, early detection and treatment of chronic respiratory diseases in children at local, regional, national and EU level.

The second set of conclusions is entitled "Early detection and treatment of communication disorders in children, including the use of e-Health tools and innovative solutions". It encourages Member States to prioritize early detection in the field of communication disorders in children, by screening and follow-up for hearing, vision and speech disorders in children. The conclusions call on Member States and the European Commission to consider the field of communication disorders in children in the process of the work to be carried out on European Reference Networks in line with the cross-border health directive. In addition, it strongly advises the European Commission and Member States to give appropriate consideration to this topic in the frame of the EU's current e-Health initiatives, including the e-Health network. Finally, the European Council conclusions urge the European Commission to adopt the criteria and conditions for European reference networks by the end of 2013.

The last set of conclusions address the issue of closing the health gaps by promoting healthy lifestyles behaviours. According to the European Commission, there are major differences in health between Member States, and in today's Europe, six of the seven biggest factors for premature death relate to what we drink, eat and how we move. Entitled "Closing health gaps within the EU through concerted action to promote healthy lifestyle behaviours", the set of conclusions calls on Member States to develop policies and actions promoting healthy lifestyle behaviours and addressing social determinants in order to contribute to closing health gaps. It also strongly advises Member States and the European Commission to maintain and strengthen actions and policies that have proved to be effective in reducing health gaps, to support the implementation of a "Health in all Policies approach", to intensify cooperation and to "make better use of existing networks". In addition, the conclusions encourage the promotion of a healthy lifestyle through tobacco control, reduction of fat, salt, sugar and energy in food and through the implementation of the World Health Organisation's set recommendations for the marketing of food and non-alcoholic beverages.

The Council Meeting was also the occasion for Ministers to discuss the Commission's "Health for Growth Programme", which was welcomed by a large majority.

More information:

http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/fr/lsa/126581.pdf



PROFESSIONAL QUALIFICATIONS DIRECTIVE – COMMISSION PROPOSAL

On 19 December 2011, the European Commission adopted a legislative proposal for modernising the Professional Qualifications Directive (2005/36/EC). The proposal was developed in the context of the ageing of the European workforce and the expected rise in labour shortages for highly skilled professionals between now and 2020. Its aim is to simplify the rules for the mobility of professionals. In addition, the proposal strongly encourages Member States to review the scope of their regulated professions and to address public worries about language skills and the lack of effective alert systems about professional malpractice, especially in the health sector.

Main elements of the proposal

- The introduction of a European Professional card, which would enable interested professionals to have the possibility of benefiting from easier and faster recognition of their qualifications, which is expected to facilitate their mobility. The card would allow the professional to provide services or become established in another Member State. It would take the form of an electronic certificate and would be made available according to the needs expressed by the professions.
- Better access to information on the recognition of professional qualifications: Points of Single Contact, set under the Services Directive, would enable professionals to obtain information in one place about the documents required to have their qualifications recognized and offer the possibility of completing online recognition procedures.
- Updating minimum training requirements for doctors, dentists, pharmacists, nurses, midwives, veterinary surgeons and architects. For example, the entry level for nursing and midwifery training would pass from 10 years to 12 years of general education.
- Introducing an alert mechanism for health professionals benefiting from an automatic recognition: competent authorities of a Member State would be obliged to alert competent authorities of all other Member States about a health professional who has been prohibited from exercising his professional activity by a public authority or a court.
- Introducing common training frameworks and common training tests. Automatic recognition would be given on the basis of a common set of knowledge, skills and competences or a common test assessing.
- Mutual evaluation exercise on regulated professions: the proposed Directive establishes a mechanism to ensure greater transparency and justification of regulated professions.

More information:

http://ec.europa.eu/internal_market/qualifications/policy_developments/index_en.htm

COMMISSION REVISION OF THE PUBLIC PROCUREMENT DIRECTIVE

On 20 December 2011, the European Commission announced the revision of the public procurement Directives. This revision is part of an overall programme to modernise public tendering in the European Union, which also includes a Directive on concessions.

The proposed reform focuses on modernizing existing tools and instruments and target five goals. Simplifying the rules and procedures for public procurement and make them more flexible is proposed by the Commission by strengthening the possibility of increased recourse to negotiation; extending and, in the longer term, generalizing electronic communication in public procurement; drastically cutting the administrative burden through a significant reduction of documents required from economic operators.

The Commission would like to encouraging access to public procurement for SMEs through measures aiming at cutting the administrative burden and trough strong incentives to divide tenders into lots and limit the financial capacity requirements for the submission of a tender. Facilitating a qualitative improvement in the use of public procurement is proposed by ensuring greater consideration for social and environmental criteria such as life-cycle costs or the integration of vulnerable and disadvantaged persons, thereby helping to achieve the objectives of the Europe 2020 Strategy.

A fourth element is to improve the existing guarantees in terms of combating conflicts of interest, favouritism and corruption in order to better ensure the integrity of procedures, given the financial implications.

Finally, the Commission proposes to appoint a single national authority responsible for monitoring, performing and checking public contracts by Member States, in order to ensure that the rules are properly applied in practice.

The reform of legislation on public procurement is one of the twelve priority actions set out in the Single Market Act adopted in April 2011. Along with the recent and current budgetary constraints, public tendering has become a priority for all Member States.

The Programme of modernisation of public tendering in the European Union also includes a Directive on concessions, which until now have been only partially regulated at European level. This Directive covers the partnership agreements between a body, which is generally public, and a business, which is often private and assures operative risks linked with maintenance and development of infrastructures or supplies services of general interest. It aims to complete the European public procurement regime by including service concessions, the only concession not yet governed by secondary legislation. The proposed rules aim to guarantee effective access to the concessions market for all European businesses, including SMEs

The Commission's proposals will be transmitted to the Council of Ministers and the European Parliament with a view to launching the legislative procedure for their adoption, expected to take place before the end of 2012.

More information: http://ec.europa.eu/internal_market/publicprocurement/index_en.htm



COMMISSION ADOPTS NEW RULES ON SERVICES OF GENERAL INTEREST (SGEI)

On 20 December 2011, after months of debate and stakeholder consultations, the European Commission adopted a revised package of EU aid rules for the assessment of public compensation for services of general economic interest (SGEI).

The new rules replace the “Monti-Kroes” Package, which entered into force in 2005 and aim at facilitating the application of the rules for public funding of SGEIs. The new package’s overall objective is to bring clarification to key state aid rules and introduce simpler rules for SGEIs that are small, have a local scope or pursue social objectives. It also seeks to take better account of competition consideration for larger SGEIs.

The new package consists of four instruments that will apply to all authorities (national, regional, local) that grant compensation for the provision of SGEI:

- a new Communication, clarifying basic concepts of State aid, which are relevant for SGEIs;
- a revised Decision that exempts Member States from notification to the European Commission for specific SGEI-categories;
- a revised Framework for assessing large compensation amounts allocated to operators outside the social services field. Those cases have to be notified to the Commission and may be declared compatible if they meet certain criteria. The new rules introduce, in particular, a more precise methodology to determine the amount of compensation;
- a new proposal for a *de minimis* Regulation, providing that compensation below a certain threshold does not fall under state aid scrutiny, is expected to be adopted in the spring of 2012, after a final round of consultation.

Although Member States are free to define which services are of general interest, the Commission’s role is to ensure that public funding allocated for the provision of these services does not distort competition in the European Internal market.

One of the major changes brought by the new Package is that all social services are henceforth exempt from the obligation of notification to the Commission, regardless of the amount of the received compensation. The services concerned must meet "*social needs as regards health and long term care, childcare, access to and reintegration in the labour market, social housing and the care and social inclusion of vulnerable groups*". Until now, only hospitals and social housing were exempted from notification. Other SGEIs are exempted from notification to the Commission of the public funding they receive amounts to less than €15 million a year.

Another key element put forth by the new Package, is the setting up of *de minimis* amounts (€500.000 over three years) for services below which the measure is deemed free of aid. This is expected to reduce red tape for small SGEIs. A final decision will be taken in the spring.

In addition to these changes, the Commission's new Package seeks to put under greater scrutiny SGEIs involving compensation amounts of more than €15 million a year and where the potential for distortions of competition within the single market is higher. Up to now, the threshold for notification amounted to €30 million a year.

Moreover, according to the new rules, whenever possible, the SGEI should be entrusted through an open and transparent public tender to ensure the best quality at the cheapest cost for taxpayers who pay for the services.

More information: http://ec.europa.eu/competition/state_aid/legislation/sgei.html



ACCESS TO MEDICINES – MEETING OF STEERING GROUP

On 14 December 2011, HOPE attended the Meeting of the Steering Group on Access to Medicines in Europe, in Warsaw, Poland.

After a short introduction reminding the audience of the key areas that have been at the heart of the Polish Presidency's agenda in terms of health, the European Commission gave a brief update on the legislative proposal of the Transparency Directive.

The Commission first gave an overview of the context and the rationale behind the review, stating that while Member State competency was fully recognized in the field of medicines insuring, pricing and reimbursement, the revision of the directive aimed at making improvements in terms of transparency. In the past year, an impact assessment study and a public consultation were launched by the European Commission in preparation of the legislative text, which should be officially presented in January 2012.

One of the key elements of the revision proposed by the Commission is to reduce time limits for the pricing and reimbursement for generic medicine. This point led to considerable debate. A majority of the participants welcomed the shortening of these time limits; however, several participants expressed the worry that the shortening of these time limits would have a negative impact on the quality of the Health Technology Assessments of new drugs. The Commission assured that this was being taken into consideration when defining the new time limits for pricing and reimbursement.

The European Commission also did a short presentation of the renewed Strategy on Corporate Social Responsibility (CSR) and of the setting up of the Platform on Ethics and Transparency. The European Commission's will to actively support and promote a more responsible uptake of responsible practices by European enterprises was re-affirmed. On 25 October 2011, the Commission published a new Communication on CSR, strongly encouraging an alignment of European and global approaches on CSR. The Commission also emphasized the importance of involving all stakeholders, including

patients and health professionals in the process, a fact welcomed by many participants. Discussion then focused on the proposal of the Commission to develop a high-level European CSR code.

The meeting of the Steering Group on Access to Medicines was also an occasion to exchange views on the Platform on Access to Medicines in Africa and on the major data gap issues in Africa.

Finally, representatives of the five Working Groups of the Group on Access to Medicines presented a brief update of their work and current and future activities.

ACCESS TO MEDICINES

WORKING GROUP ON FACILITATING SUPPLY IN SMALL MARKETS

On 14 December 2011, HOPE attended the second meeting of the Working Group on Facilitating Supply in Small Markets also took place in Warsaw, right after the meeting of the Steering Group on Access to Medicines.

The first item on the agenda was the finalisation of the draft template and the questionnaires developed by Eminent and addressed at the competent authorities and economic operators of countries experiencing medicine supply issues related to the small size of their markets. A few comments were made on the wording used in the documents.

Then, Latvia and Malta gave short presentations of the situation in their respective country. Finally, the European Association of Pharmaceutical Full-line Wholesalers (GIRP) said a few words on the contribution of full-time wholesalers to the issue of supply shortages and suggested a few solutions for countries to become more attractive to pharmaceutical full-line wholesalers. The two main suggestions put forward by GIRP were for countries: to facilitate the registration of medicines; to establish emergency provisions.

EUROPEAN PROGRAMMES AND PROJECTS

PUBLIC HEALTH – 2012 COMMISSION WORK PLAN

On 1 December 2011, the European Commission adopted the work plan for 2012 for the second programme of Community action in the field of health, setting out the activities to be co-financed in 2012.

The mission of the programme of Community action in the field of health is “to complement, support and add value to the policies of the Member States”. It aims at contributing to solidarity and prosperity in the EU by protecting and promoting human health and safety and by improving public health.

The €51.130.200 budget for the 2012 public health work programme represents a slight increase from last year’s budget, which amounted to €47.060.000. With regards to grants, the 2012 work plan presents significant changes in comparison to the budgets set for 2011. Whereas they had benefited of an extremely important increase of funding between 2010 and 2011, joint actions are the clear losers this year, with a grant amounting to €8.950.000, a great reduction in comparison to 2011’s €17.040.000 grant. Consequently, the grant for projects has more than doubled in comparison to last year, amounting to €13.171.820. Operating grants have been allocated a budget of €4.400.000 and procurement has suffered a slight decrease in funding in comparison to 2011 with a dedicated budget of €14.463.980. Conference grants still amount to €800.000, €200.000 for Presidency and €600.000 for other conferences. Direct grants are estimated at €2.633.000 in 2012 and can only be awarded to the following international organisations: Council of Europe, International Agency for Research on Cancer (IARC), International Organisation for Migration and Organisation for Economic Cooperation and development (OECD). Finally, the EU contribution to the World Health Organisation (WHO) Framework on Tobacco Control will amount to €200.000 in 2012.

Actions under this work plan are mainly directed at supporting the delivery of the priorities set by the Europe 2020 Strategy, in particular the Smart Growth and Inclusive Growth set by the strategy. The objectives of the Europe 2020 Strategy matches those of the EU Health Strategy, which maintains that investigating in health can boost innovation, create new skills and jobs and reduce inequalities in health.

In 2012, the Health Programme will contribute to the objectives of the following flagships under the Europe 2020 Strategy:

- the pilot Innovation Partnership on Active and Healthy Ageing under the flagship Initiative Innovation Europe. The partnership’s aim is to enable European citizens to lead active, healthy and independent lives as long as possible;
- the European Platform against Poverty and Social Exclusion of the Europe 2020 Strategy. The actions of the platform aim to improve access of vulnerable populations to health care, support their social inclusion, and fight the discrimination they suffer from;
- the agenda for new skills and jobs, which provides the framework for work on the health workforce.

As keeping people healthy and active for longer has a positive impact on productivity and competitiveness, complementary action is also planned on the main risk factors for health such as nutrition, alcohol abuse and smoking, as well as in the areas of major, chronic and rare diseases.

In addition, the work plan has envisaged several activities to collect data, produce scientific evidence and effectively process information to citizens, stakeholders and policy-makers.

The work plan still pursues the three main objectives of the second programme of Community action in the field of health:

1. improving citizen's health security;
2. promoting health, including the reduction of health inequalities;
3. and generating and disseminating health information and knowledge.

To achieve the **first objective** of the second programme of Community action in the field of health, the work plan will focus on:

- developing risk management capacity and procedures, improve preparedness and planning for health emergencies;
- develop strategies and mechanisms for preventing, exchanging information on and responding to health threats from communicable and non-communicable diseases and health threats from physical, chemical or biological sources, including deliberate release acts;
- improving citizen's safety through scientific advice;
- improving citizen's safety in regards to the safety and quality of organs and substances of human origin, blood and blood derivatives.

One of the actions to achieve this goal will be the launch of a €1.150.000 Joint Action aiming at supporting Member States in organising an optimal allocation and use/transplantation of donated organs through multilateral and bilateral agreements and through transplantation in other Member States. In addition, a direct grant will be allocated to an action aiming at helping effectively disseminate best practices in the donation and transplantation of organs.

To achieve the **second objective** of the Programme, the work plan will seek to:

- Increase life years and promoting healthy ageing. A €4.021.820 project grant will be allocated to support the implementation of the European Innovation Partnership on Active and Healthy Ageing.
- Identify the causes of and address and reduce health inequalities within and between Member States; support collaboration on issues of cross-border care and patient and health professional mobility. Amongst other things, a study will be conducted on patient empowerment in relation to the Cross-border Healthcare Directive and a €3.000.000 Joint Action will be led on the topic of forecasting health workforce needs for effective planning in the EU.
- Address health determinants to promote and improve physical and mental health and take action on key factors such as nutrition and physical activity. On of the tools to achieve this objective will be launch of a €1.500.000 Joint Action on mental health and well-being, aiming at establishing a process for structured work on mental health involving Member States, stakeholders in the health and other relevant sectors, and international organisations.
- Take action on the prevention of major and rare diseases.

Finally, in order to meet the **third objective** of the second programme of Community action in the field of health:

- The Commission will set up a European Health Information System, through actions and initiatives such as: collecting and disseminating health information via cooperation with the Organisation for Economic Cooperation and Development or incorporating the European Observatory on Health Care Systems and Policies.
- Health information will be disseminated, analysed and applied. Information will be provided to citizens, stakeholders, and policy-makers. A €1.000.000 action focusing on obtaining an expert facility to provide advice on the efficiency and effectiveness of health systems, at the request of Member States or the Commission, will be launched.

More information: http://ec.europa.eu/health/programme/docs/wp2012_en.pdf

CROSS-BORDER – EUREGIO II – RESULTS

The three-year project EUREGIO II “Solutions for improving cooperation in border regions” ran from December 2008 to November 2011. The EUREGIO II project aimed to support health and health service related cross-border activities in border regions.

It was following the project "Evaluation of cross border activities in the European Union" (EUREGIO, 2004-2007) and was complementary to the project "Health investments in Structural Funds 2000-2006: learning lessons to inform regions in the 2007-2013 period" (EUREGIO III). These projects have received funding under the Public Health Programme of the European Union.

The EUREGIO II project produced three deliverables:

- a Handbook on the effective use of INTERREG funding in cross-border healthcare, developed within work package 4, led by Gesundheitsmanagement OG, Vienna, Austria;
- a Guideline for the use of Health Technology Assessment (HTA) in border settings, developed within work package 5, led by THE European Hospital and Healthcare Federation (HOPE), Brussels, Belgium;
- a Legal Report concerning liability and data protection issues in cross border cooperation developed within work package 6, managed by Ingeborg van der Molen, Maastricht University, Maastricht, the Netherlands.

The Handbook on the effective use of INTERREG funding in cross-border healthcare provides relevant practical information for different stakeholders responsible for healthcare cooperation in border regions. It is intended to be used as a support tool in the decision making process as well as in providing practical guidance on devising, implementing and evaluating cross-border health projects. The handbook summarises all the relevant information on cross-border cooperation in border regions, Structural Funds (especially INTERREG), and the relevance of EU funding. It analyses several models of good practice to stimulate knowledge regarding opportunities and challenges and to identify barriers to accessing EU funding programmes. Fact sheets have been developed to provide effective recommendations about the conditions required when planning and implementing cross border healthcare activities.

The Guideline for the use of Health Technology Assessment (HTA) in cross border regions has been designed to inform decisions about the introduction of a new technology – often a new instrument or equipment, an organizational procedure, or a new treatment – in local cross border settings. The Guideline aims to empower all decision-makers in border regions to effectively develop and implement new technologies. It also supports the work of healthcare professionals who have no specific expertise in the field of HTA. The Guideline addresses the needs of both cooperating and not-cooperating hospitals situated in border regions. It offers practical indications and examples about how to answer the questions and where to find the information. The Guideline has been tested in two experimental case studies – developed in the University hospitals of Maastricht and Aachen and coordinated by Dr. Saskia Knies of the Maastricht University – which have been included in the document. These case studies represent until now the first and unique examples of HTAs in small-sized, local cross border settings.

The Legal Report gives insight into how border regions actually tackle legal challenges, it underlines what is of legal importance and where loopholes still exist, and shows that combined efforts can lead to best practice projects within cross-border health care. Experiences from some European regions have been gathered to investigate which kinds of problems still exist, how they have been tackled and if a real need for a (European) regulation exist. The report discusses the future of data protection and gives recommendations such as the creation of a sustainable and transparent legal basis when cooperating across the border, and if possible the use of a legal toolkit within cross-border health care service projects.

The Euregio II project materials are online and a portal has been developed to allow visitors giving feedbacks

<http://www.euregio2-conference.eu/app/webroot/info/>.

Comments will be received through the website until mid-January and they will be incorporated into the materials.

More information at: http://www.euregio2-conference.eu/info/#project_info

CROSS-BORDER – EUREGIO II – FINAL CONFERENCE

The conference “Effective cross-border care: Next Generation” held on 16 November 2011 in Maastricht examined how the growth of cross-border care in Europe’s border regions intersects with the evolution of the European Union in coming decades. This conference was an initiative of the European project EUREGIO II “Solutions for improving health care cooperation in border regions”. The conference focused on the three main topics investigated in the European Commission co-funded project EUREGIO II: technology and health, inequalities and health, law, politics and health. During the conference, these three topics were presented and discussed with participants in three consecutive sessions. Issues and opportunities were presented at two levels: regional development and European vision to 2050.

During the introductory session, Dr. Matt Commers (Maastricht University) examined the role and importance of cross-border regional health plans as instruments to tackle inequities in health status

and in access to service, and as means to compete successfully. He also introduced the EUREGIO II project and the aims of the conference. Dr. Jeffrey Stacey (U.S. State Department, Washington DC) discussed the EU and US way of tackling healthcare issues and offered a cross-cutting perspective of the future of the EU.

The first session “technology and health”, was opened by Dr. Saskia Knies (Maastricht University) who illustrated the Guideline for the use of Health Technology Assessment (HTA) in border settings, developed in the project EUREGIO II. This tool makes it possible to apply a HTA methodology in local cross border settings keeping into account the main differences in health care systems, in particular reimbursement and costs/prices, practice patterns, epidemiology & demography, and legal aspects. Prof. Dr. Maarten IJzerman (University of Twente) addressed the future and evolution of medical technology in Europe, exploring how early HTA can enable sustainable healthcare and economic development. Dr. Govert Derix discussed the difficulties, advantages and paradoxes of euregional settings, he explained that healthcare is a vehicle to overcome obstacles, because it often has already an inter-regional perspective, and presented the model of Euregio Meuse-Rheine as an example of integration and cooperation, to be followed across Europe.

The second session “Inequality and health”, was opened by Dr. Chibuzo Opara (Maastricht University) who illustrated the contents of the Handbook for the use of structural funds in cross-border regions, developed in the project EUREGIO II. The book aims to be a practical tool for actors involved in decision making in cross-border health care cooperation, offering a summary of information about structural funds and providing practical examples from some regions. Prof. dr. John Wilkinson (Durham University) produced a comprehensive overview of the inequalities in health in the regions of Europe and identified the future trends, their hindering factors and opportunities. Prof. Jonathan Watson (Health ClusterNET & University of Nottingham) illustrated the other EU funded projects in the area of cross border cooperation EUREGIO III and HEALTHEQUITY-2020, in order to sustain further cross border cooperation in the future he underlined the need of considering health and equity in all policies, use tools that employ existing data to show health gains and assess the capacity and capability of regions to use these tools/processes and use evidence generated to inform regional planning and investment decisions.

The third session “Law, politics and health” was opened by Drs. Ingeborg van der Molen who discussed the findings of the report “Legal challenges in cross-border cooperation”, developed in the project EUREGIO II. She presented the recommendations arising from this work, which include the creation of a sustainable and transparent legal basis when cooperating across borders, if possible with the use of a legal toolkit within cross-border health care service projects. Mr. Karsten Uno Petersen (EU Committee of Regions) discussed the ways to balance the new healthcare needs of EU citizens and the diminishing resources, underlining the need of creating updated pension schemes, valuing the experience of elderly people, boosting EU policies and programmes for innovative actions on ehealth, welfare tech, active ageing, etc. and fostering cooperation with regional and local authorities responsible for delivering health services to their citizens. Prof. dr. Helmut Brand finally discussed the possible scenarios of evolution for a EU in health systems.

All sessions were followed by a plenary discussion where the hundred participants could exchange visions, strategy and tactics relating to the cutting edge of cross-border care in Europe.

More information and presentations at: <http://www.euregio2-conference.eu/info/>

HORIZON 2020: €80 BILLION INVESTMENT IN RESEARCH AND INNOVATION

On 30 November 2011, European Commissioner for Research, Innovation and Science, Máire Geoghegan-Quinn, presented the proposal of a €80 Billion Horizon 2020 Programme for research and innovation. The programme would aim at boosting research, innovation and competitiveness in Europe and is set to replace the 7th Framework Programme that expires at the end of 2012.

Commissioner for Education, Culture, Multilingualism and Youth, Mrs. Androulla Vassiliou, laid out a Strategic Innovation Agenda for the European Institute of Innovation and Technology (EIT), which would receive, if agreed, €2.8 billion of funding under Horizon 2020. In parallel, Vice-President of the European Commission, Mr. Antonio Tajani, put forward a complementary new programme to boost competitiveness and innovation in Small and Medium Enterprises (SMEs), with an additional budget of €2.5 billion.

It is the first time that all EU research and innovation funding would be brought under a single programme.

Horizon 2020 concentrates on turning scientific breakthroughs into innovative products and services that provide business opportunities and change people's lives. Moreover, it aims at drastically cutting administrative burden, by simplifying the rules and procedures in order to attract top level researchers as well as a wider diversity of innovative businesses.

The Programme aims at achieving three major objectives.

- Support the EU to maintain its leading position as world leader in science, allocating €24.6 billion to this purpose, including a 77% increase of funding to the European Research Council (ERC).
- It will also help the EU secure its leading position in industrial innovation, with a budget of €17.9 billion.
- Finally, it will allocate €31.7 billion to address six major areas of concerns for Europeans:
 - health, demographic change and well-being;
 - food security, sustainable agriculture, marine and maritime research and the bio-economy;
 - secure, clean and efficient energy;
 - smart, green and integrated transport;
 - climate action, resource efficiency and raw materials;
 - inclusive, innovative and secure societies.

The European Research Ministers unanimously welcomed the Commission's new Research and Innovation Programme at the Ministers meeting on 6 December 2011 in Brussels. Although very little concerns were expressed overall, some of the countries who had had little benefit from the current framework programme voiced their worry that their participation would remain marginal in Horizon 2020. This highlighted the need to reduce the existing gaps in the field of research and innovation within the EU.

Following the meeting, European Commissioner for Research, Innovation and Science, Máire Geoghegan-Quinn recalled the Commission's hope to use European structural fund resources to

bring infrastructure and equipment to standard in all the potential centres of excellence in low-result regions across the EU. Other countries, mainly Belgium and Germany, expressed their fear that including in one the funding for research and innovation programmes and for human and social sciences will lead to the temptation to “make money” out of the latter field, despite the fact that it does not have that vocation.

More information: http://ec.europa.eu/research/horizon2020/index_en.cfm?pg=home

FIVE JOINT PROGRAMMING INITIATIVES LAUNCHED BY COUNCIL

On 6 December 2011, the EU Council adopted conclusions that kick-start five joint programming initiatives aiming at strengthening competitiveness on research and innovation: “Healthy and Productive Seas and Oceans”, “Urban Europe - Global Challenges, Local Solutions and Water”, “Connecting Climate Knowledge for Europe”, “Water Challenges for a Changing World”. Deals with the need to recognise water as a “growing societal challenge and an innovation priority”.

The fifth one, “The Microbial Challenge - an emerging threat to human health” puts the emphasis on the necessity to deal with the human health threat caused by the rise of antimicrobial resistance. It recognises the healthcare costs and indirect costs caused by resistant bacteria, and addresses the issue of the misuse and overuse of antibiotics. Finally, this initiative brings forth the need for a comprehensive solution to be taken on this issue by many sectors of society: healthcare, policy-makers, education, industry, environmental agencies etc.

More information:

http://www.consilium.europa.eu//uedocs/cms_data/docs/pressdata/en/intm/126583.pdf

REPORTS AND PUBLICATIONS

EUROHEALTH – WHO PUBLICATION

The edition number 4, volume 17 of EuroHealth has just been published by the WHO European Observatory on Health Systems and Policy. The three sections of the publication focus on the effects of the Professional Qualifications Directive (2005/36/EC); on healthcare fraud and corruption in Europe; and on out-of-pocket spending and performance management in healthcare.

The Recognition of Professional Qualifications Directive (2005/36/EC) guarantees the free movement of doctors in the European Economic Area. It requires regulators, such as the General Medical Council, to automatically recognise other European qualifications. The three articles in the publication provide evidence of the regulator, physicians and nurses' perspective, focusing on the UK. The first article outlines some of the regulatory gaps with the Directive. The second article focuses on the recent Professional Qualifications Directive (2005/36 EC) Green Paper, which proposes significant changes to the Directive. Health professional bodies in the UK welcome the changes but remain concerned about the assessment of continuing professional development across the EU and the language skills of doctors crossing borders. The third article underlines how this Directive has impacted not only on the free movement of professionals and patient safety, but also on women's education and professional life in an expanding Europe.

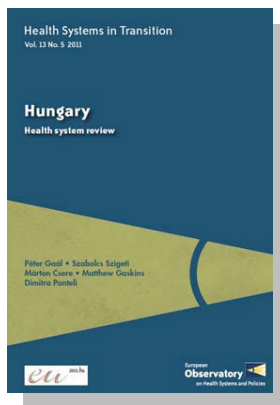
The second section of the publication focuses on healthcare fraud and corruption in Europe, at first defining healthcare fraud and corruption and identifying how health care systems may be affected. The case studies drive the attention on key issues, which could be of national relevance. The first article discusses the issue surrounding patients who travel from Belgium to the Netherlands to purchase pharmaceuticals at cheaper prices using the European Health Insurance Card (EHIC). The second article describes the Scottish National Health Service's clear strategy centred on the '4Ds': deterring, detecting, disabling and dealing with fraud, through its Counter Fraud Services (CFS) Agency. The third article provides an example of how provider fraud has been detected through annual monitoring by the Norwegian Health Economics Administration and demonstrates how a defined corporate control strategy and professional anti-fraud competencies can efficiently detect subtle methods of unjustified claims by a provider.

In the third section, data collection methods for determining out-of-pocket spending are identified in twelve countries of the Former Soviet Union and advantages and disadvantages of demand-side, supply-side and amalgamated approaches are discussed. In addition, the theoretical arguments and conflicting motivations and incentives to consider when looking at conflicting motivations and incentives to consider when looking at performance management in health care are discussed.

Available at:

http://www.euro.who.int/_data/assets/pdf_file/0004/154516/Eurohealth_Vol-17_No-4_web.pdf

HIT HUNGARY – WHO PUBLICATION



The WHO European Observatory on Health Systems and Policies has published the new profile of the Hungarian health system, part of the series “Health Systems in Transition” (HiTs).

The Health Systems in Transition (HiT) profiles are reports that provide a detailed description of a health system, reforms and policy initiatives under development in a specific country, providing relevant information to support policy-makers and analysts in the development of health systems in Europe and facilitating the exchange of experiences of reform strategies in different countries. They are based on a periodically revised template in order to facilitate comparisons between countries.

The new HiT on Hungary provides key information on all aspects of the health care system, including the unitary health insurance system, out-of-pocket payments, healthcare delivery by both public and private providers and attempted reforms.

Despite significant improvements in recent years, many health outcomes remain poor when compared with European Union averages. Lifestyle factors – especially the traditionally unhealthy Hungarian diet, alcohol consumption and smoking – play a very important role in shaping the overall health of the population.

The Hungarian constitution assigns overall responsibility for social welfare and health care provision to the central government, but other actors also take part in decisions related to the organization and functioning of the health system. Local governments own most hospitals and other health care facilities and are responsible for the capital cost of health services and for ensuring the provision of care. Private entrepreneurs play a central role in primary and pharmaceutical care and an increasing one in specialist care. The use of private capital in the provision of inpatient care is still controversial.

Participation in the health insurance scheme is compulsory for not all citizens living in Hungary, and opting out is permitted. The benefits package is comprehensive but not exhaustive. Both a positive and a negative list are currently in place. Voluntary health insurance does not play a significant role. The share of total health expenditure attributable to private sources has been increasing over the years, most of it accounted for Out of Pocket (OOP) expenses. A considerable share of OOP expenses is attributable to informal payments. Other sources of finance are EU capital grants, which are invested mostly in human resource and health care infrastructure development.

The provider payment system has become output-based. Family doctors services are paid through capitation, outpatient specialist care through a fee-for-service point system, acute inpatient services through a payment system based on diagnosis-related groups (DRGs) and chronic care through per diem rates. Physicians are either salaried employees or private entrepreneurs contracted by the National Health Insurance Fund Administration (NHIFA), other health professionals are mostly paid by salary. Physicians are unevenly distributed, both in terms of geography and specialties. Their number has dropped substantially since 2003, and increased professional mobility may lead to a further decline in this ratio in the near future.

In 2009, local governments owned 78% of all hospital beds, almost 20% were in Budapest. In general, health care investments have been poorly coordinated and guided by local economic interests rather than by the health needs of the population. Municipalities are responsible for primary health care, including family doctor services, dental care, out-of-hours surgery services etc; family doctors have a gate-keeping role, but this is neither exclusive nor successful. The provision of secondary and tertiary care is shared among municipalities, counties, central government and private providers. Local governments are responsible for providing social care. Long-term care is provided by both the health and the social sectors. Mental health care is integrated into the main health and social care system, both organizationally and in terms of financing. Medical rehabilitation is underfunded and short-staffed, and access to services is subject to substantial regional disparities.

Avoiding unnecessary hospitalization has been recognized as a means of improving efficiency, and over the past 15 years day care has been fostered through a number of regulations. Nevertheless, large variations exist in service delivery, both geographically and by specialization, and equity needs still to be realized. Attempts to improve the efficiency of the health system have centered mostly on payment reforms. The introduction of output-based payment methods led to substantial improvements in the technical efficiency of the system, however, allocative efficiency in the health care system is still problematic. Remaining issues with efficiency include overtreatment, DRG-creep and point inflation induced by the current system, use of ineffective or obsolete technologies, parallel service provision and medicalisation of social problems. Initiatives to tackle these issues, such as the Care Coordination System (CCS), have been implemented with varying degrees of success.

Transparency and accountability in the health care system are unevenly developed. A comprehensive system for monitoring performance has not been established, with the exception of that related to expenditure. Although a range of initiatives have been developed to measure and track the quality of care using quality indicators, these have yet to be implemented in a systematic fashion.

Having achieved a successful transition from an overly centralised, integrated Semashko-style health care system to a purchaser-provider split model with new payment methods, challenges with sustainable health care financing remain. A further challenge is the need to tackle informal payments, which are a deeply rooted characteristic of the Hungarian health system.

Since 2004, reforms aimed at reshaping the stewardship and organisation of the health care system have been attempted with varying success. Cost-containment has remained the dominant health policy objective, and public expenditure on health has declined substantially in recent years. This, in turn, has had a direct impact on the growing human resource crisis in the health system. On the other hand, Hungary is a target country for cross-border health care, mainly for dental care but also for rehabilitative services, such as medical spa treatment. The health industry can thus be a potential strategic area for economic development and growth.

Available at:

<http://www.euro.who.int/en/who-we-are/partners/observatory/news/news/2012/12/new-hit-on-hungary>

GOVERNING PUBLIC HOSPITALS – WHO PUBLICATION



The new book “Governing Public Hospitals”, just published by the WHO Europe, analyses the key issues that have emerged from developments in public-sector hospital governance models and summarises the general findings and looks in detail at hospital governance in eight countries.

The governance of public hospitals in Europe is changing. Individual hospitals have been given varying degrees of semi-autonomy within the public sector and empowered to make key strategic, financial and clinical decisions. The challenge for hospital-level governance is to integrate national health policy and objectives and operational hospital management into a coherent and effective institutional-level strategy.

This study explores the major developments and their implications for national and European health policy, focusing on hospital-level decision-making and draws together both theoretical and practical evidence. It includes an in-depth assessment of eight different country models of semi-autonomy, in the Czech Republic, England, Estonia, Israel, the Netherlands, Norway, Portugal and Spain.

Available at:

<http://www.euro.who.int/en/what-we-publish/abstracts/governing-public-hospitals.-reform-strategies-and-the-movement-towards-institutional-autonomy>

OTHER NEWS – EUROPE

ENSURING TOMORROW'S HEALTH: WORKFORCE PLANNING AND MOBILITY

Between 7 and 9 December 2011, a variety of health stakeholders gathered at the International Conference “Ensuring tomorrow’s Health: workforce planning and mobility”, which took place in Brussels, Belgium.

The conference was divided in four panels:

- workforce planning and forecasting;
- workforce strategies and practices at national level;
- data and monitoring: standardization and harmonization of data collection;
- international framework and mechanisms.

Breakout sessions were also organised after each panel to allow participants to discuss the panel topic in smaller groups and exchange views on the issues at stake.

The first day of the conference was dedicated to the presentation of the four panels and of the issues at stake in regards to health professional workforce planning, to a quick overview of the three EU projects that focused on that topic (RN4CAST, MoHProf and Prometheus), and to the first panel on workforce planning and forecasting.

Interventions on the expected shortages in the health professional workforce of several countries were made. Miklós Szócska, the Minister of State for Health and the Ministry of National Resources of Hungary, pointed to the emerging human resources crisis and the need for an increased EU and international collaboration. An overview of the situation on health professional migration and the issues surrounding this migration in the Philippines was also given by Secretary Imelda Nicolas, Chair of the Commission on Philipinos Overseas.

The general question and topic that was addressed during the first panel on planning and forecasting was the recognised need for countries to develop health workforce policies, mobilize stakeholders, assess future health workforce needs and commit to adjusting the national workforce to these needs.

The second day of the conference was dedicated to the three remaining panels.

The panel on national strategies and practices focused on the presentation of different national experiences and perspectives on the issue of health workforce planning and migration. Different speakers from various countries (E.g. USA/Canada, Poland/Lithuania, and Slovenia) addressed the challenges of developing and sustaining an adequate health workforce at the national level. A series of factors were put forward by the speakers to explain the emigration or immigration of health professionals such as: wages, working conditions, over-regulation and bureaucracy, professional opportunities, training opportunities, loan programmes, registration rules of medical or nursing schools etc.

During the third panel, which related to data and monitoring, focus was put on what was currently under way to improve the data situation in Europe and what could be further achieved, notably to harmonize and standardize data collection. Gaëtan Lafortune, from the Organisation for Economic Co-operation and Development (OECD), highlighted the fact that it was often not a question of collecting more data, but rather a question of harmonising and standardising existing data. He added that the question of “which data?”, “for what purpose?” was also not frequently enough asked. Mr. Lafortune also mentioned the fact that the OECD, the World Health Organisation (WHO) and Eurostat had decided to harmonize their data collection.

The fourth panel, which focused on multi-country, regional and international frameworks and mechanisms, addressed the importance for national practises to balance between local needs and capacities and the international recruitment policies. It also brought forth the question of whether “ethical” and “responsible” solutions existed to respond to the issue of health professional migration. Galina Perfilieva, from the WHO Regional Office for Europe, highlighted the crisis that was emerging in some African countries due to the immigration of health professionals, which led to extreme shortages in the number of nurses and doctors.

Suggestions on how “receiving” countries could act to prevent “sending” countries from suffering from dangerous health professional shortages were put forward, such as bilateral agreements, circular migration, or the application of a code of ethical recruitment of health professionals.

The last day of the conference was dedicated to general conclusions and closing remarks.

More information:

http://hrh2011.belgium.iom.int/index.php?option=com_content&view=article&id=53&Itemid=60

<http://www.fp7-prometheus.eu/>

<http://www.rn4cast.eu/>

<http://www.mohprof.eu/LIVE/>

SUSTAINING AND IMPLEMENTING UNIVERSAL HEALTH COVERAGE 4 PERSPECTIVES FOR 5 CONTINENTS

The International Conference on Sustaining and Implementing Universal Health Coverage will take place on 10th February 2012 at the Bocconi University, Milan and will be hosted by SDA Bocconi School of Management and Master MIHMEP (Master in International Healthcare Management, Economics and Policy).

The Conference addresses the most challenging topics of universal health, including Global Health & Development; Health Care Management; Health Systems Planning and Governance; Pharmaceutical & Medical Technology. These four different perspectives will be exposed and discussed during the Plenary and the Round Table sessions by high level, worldwide Academics and prominent figures from all areas of Health Care, Policy, Management, Economics, Global and Public Health.

Esteemed guest speakers will take part in the event, such as representatives of Harvard School of Public Health, London School of Hygiene and Tropical Medicine (LSHTM), OECD, European Commission, World Bank and World Health organization (WHO).

The event is open to all who have a keen interest in this global theme, which concerns all countries from the most industrialized to emerging markets and developing countries.

More information at:

http://www.sdabocconi.it/en/universal_health_coverage/

HOPE CONFERENCES AND EVENTS CO-ORGANISED BY HOPE

INNOVATION IN HEALTHCARE WITHOUT BORDERS

16-17 April 2012 – Brussels (BE)

The European Commission is organizing in collaboration with several European stakeholders a conference on innovation that aims to bring together the key stakeholders involved in the innovation process of the healthcare sector in view of Europe 2020 and the Innovation Union Plan.

The main objective of the conference is to act as an innovation in healthcare policy forum involving the key actors and policy-makers in order to:

- identify major challenges and build consensus to address them;
- develop initiatives and opportunities for Healthcare Innovation;
- provide continuity with previous events.

2012 Conference sessions will develop two tracks:

"Removing borders in the health supply chain"

assessing priorities achieved to date and areas where additional efforts are needed

"Inequality and solidarity"

exploring new challenges within EU and beyond.

Building on the events of May 2010 and March 2011, the 2012 conference is organized by the services of the European Commission (DG Research and Innovation, DG Enterprise and Industry, DG Health and Consumers, DG for Regional Policy), in consultation with other relevant DGs, major health associations and stakeholders.

Commissioner for Research and Innovation Máire Geoghegan-Quinn, Commissioner Antonio Tajani, responsible for Industry and Entrepreneurship, Commissioner for Health and Consumers John Dalli and Regional Policy Commissioner Johannes Hahn are invited to be among the speakers.

The programme of plenary and parallel sessions will allow a large space for debate and networking. It will be complemented by a small "fair" where associations and support structures will provide information to participants.

Information on the 2010 and 2011 conferences, including outcome reports, is available:

http://ec.europa.eu/research/health/innovation-in-healthcare-2011_en.html

Further information, including the draft programme and registration guidance, will be available by begin January 2012 at:

http://ec.europa.eu/research/health/policy-issues-eu-policy_en.html

**AGEING HEALTH WORKFORCE – AGEING PATIENTS:
MULTIPLE CHALLENGES FOR HOSPITALS AND HEALTHCARE IN EUROPE**

11-13 June 2012 – Berlin (DE)

In 2012, HOPE Exchange Programme will be organized for the 31st time. This 4-week training period is targeting hospital and healthcare professionals with managerial responsibilities. They are working in hospitals and healthcare facilities, adequately experienced in their profession with a minimum of three years of experience and have proficiency in the language that is accepted by the host country. During their stay, HOPE Exchange Programme participants are discovering a different healthcare institution, a different healthcare system as well as other ways of working.

Each year a different topic is associated to the programme, which is closed by HOPE Agora, an evaluation meeting and conference. “Ageing health workforce – ageing patients: multiple challenges for hospitals and healthcare in Europe” is the subject for 2012. HOPE German Member will organize the 31st edition of HOPE Agora in Berlin on June 11-13, 2012.

More information on HOPE Exchange Programme:

<http://www.hope.be/04exchange/exchangefirstpage.html>

More information about the conference HOSPAGE

www.hospage.eu

SAVE THE DATE