CONTENT

Click on a title to go directly to the article

EU INSTITUTIONS AND POLICIES

› PUBLIC HEALTH
  CROSS-BORDER HEALTHCARE DIRECTIVE ADOPTED
  VOTE OF THE EUROPEAN PARLIAMENT ON THE DIRECTIVE ON FALSIFIED MEDICINES
  COMMISSION GUIDELINES FOR QUALITY ASSURANCE IN COLORECTAL CANCER
  RARE DISEASES EUROBAROMETER
  EUROPEAN PARLIAMENT RESOLUTION ON TUBERCULOSIS
  WORKING GROUP ON HEALTH INFORMATION
  MEDICINES FOR OLDER PEOPLE
  EUROPEAN MEDICINES AGENCY ROAD MAP

› INTERNAL MARKET
  PUBLIC HEARING ON THE RECOGNITION OF PROFESSIONAL QUALIFICATIONS
  FREE MOVEMENT OF WORKERS: COMMISSION REASONED OPINION SENT TO ITALY
  REPORT ON THE IMPLEMENTATION OF THE SERVICES DIRECTIVE
  COMMISSION GUIDE TO EU RULES ON SERVICES OF GENERAL INTEREST

› ENTERPRISE AND INDUSTRY
  EUROPEAN PARLIAMENT VOTE ON RECYCLING ELECTRONIC WASTE

› INFORMATION SOCIETY
  EMERGENCY SERVICES AND 112 DAY
  EHEALTH STRATEGIES REPORTS

EUROPEAN COURT OF JUSTICE

CASE C-490/09, EUROPEAN COMMISSION V LUXEMBOURG, 27 JANUARY 2011
SOCIAL SECURITY COORDINATION – COMMISSION VERSUS SPAIN
PROGRAMMES AND PROJECTS

RESEARCH – TELEHEALTH “RENEWING HEALTH” PROJECT
RESEARCH – DUQUE PROJECT CONSORTIUM MEETING
RESEARCH – CONSULTATION ON RESEARCH AND INNOVATION FUNDING

OTHER NEWS

LAUNCH OF GLOBAL PATIENT SAFETY ALERTS
LATVIAN MINISTER OF HEALTH AND WHO/EUROPE COLLABORATION
WHO/EUROPE COURSE ON HEALTH FINANCING
SOCIAL POLICY
WHO/EUROPE AND ITALY DISCUSS EUROPEAN HEALTH SUPPORT FOR PEOPLE AFFECTED BY THE CRISIS IN NORTH AFRICA
HIGH-LEVEL FORUM ON HEALTH EQUITY IN SLOVENIA

PUBLICATIONS

MORTALITY AMENABLE TO HEALTH CARE – OECD WORKING PAPERS

HOPE CONFERENCES AND EVENTS CO-ORGANISED BY HOPE
EU INSTITUTIONS AND POLICIES

CROSS-BORDER HEALTHCARE DIRECTIVE ADOPTED

On 28 February 2011, the EU Council of Ministers approved the European Parliament's amendments on a draft directive, which seeks to facilitate access to safe and high-quality cross-border healthcare and promote cooperation on healthcare between Member States. The Austrian, Polish, Portuguese and Romanian delegations voted against and the Slovak delegation abstained.

The European Parliament amendments reflect a second-reading-compromise reached between the Belgian Presidency and representatives of the European Parliament in an informal triilogue on 15 December 2010. In line with Article 294 of the Lisbon Treaty, the cross-border healthcare directive has now been adopted. Member States will have 30 months to transpose the directive's provision into national legislation.

The new directive contains the following provisions (see also HOPE newsletter n° 78).

- As a general rule, patients will be allowed to receive healthcare in another Member State and be reimbursed up to the level of costs that would have been assumed by the Member State of affiliation, if this healthcare had been provided there.
- Instead of reimbursing the patient, Member States of affiliation may also decide to pay the healthcare provider directly.
- For overriding reasons of general interest, a Member State of affiliation may limit the application of the rules on reimbursement for cross-border healthcare.
- Member States may introduce a system of prior authorisation to manage the possible outflow of patients: this is, however, limited to healthcare that is subject to planning requirements, such as hospital care and healthcare that involves highly specialised and cost-intensive medical infrastructure or equipment.
- Member States will have to establish national contact points that must provide patients with information about their rights and entitlements and practical aspects of receiving cross border healthcare, e.g. information about healthcare providers, quality and safety, accessibility of hospitals for persons with disabilities, to enable patients to make an informed choice.
- Co-operation between Member States in the field of healthcare has been strengthened, e.g. in the field of e-health and rare diseases. Sales of medicinal products and medical devices on the internet, long-term care services provided in residential homes and the access and allocation of organs for the purpose of transplantation fall outside the scope of the directive.

More information:
VOTE OF THE EUROPEAN PARLIAMENT ON THE DIRECTIVE ON FALSIFIED MEDICINES

On 16 February 2011, the European Parliament voted in favour of a proposed Directive on Falsified Medicines. The resolution was adopted with 569 votes in favour, 12 against and 7 abstentions.

The Directive proposes new initiatives to help safeguard the medicines supply chain and protect patients, including: the introduction of safety features like serial numbers and tamper evident seals; more stringent rules on importing active pharmaceutical ingredients; tighter scrutiny of supply chain intermediaries such as brokers and traders; greater sanctions against counterfeiters; and the development of a consistent, harmonised approach to inspections.

A major element is the decision to regulate the sale of medicines over the internet, something that was left out of the European Commission’s draft proposal of December 2008. MEPs deemed it necessary to regulate internet sales because this is a key route by which fake medicines enter the EU market, and studies have shown that over half of drugs purchased in this way are counterfeit. Not all EU Member States permit internet sales, but in those that do the legislation will bring in an official authorisation system and certification scheme - including an official logo - to help the public identify legitimate sites. The challenge now is for the European Commission, along with EU regulators, industry and other stakeholders, to translate the Directive into implementable, scalable and inter-operable systems.

Interpretation of the wording may leave some elements open to debate and further refinement by working groups, for example defining the scope of the legislation. This is likely to concern only prescription medicines in the first instance, but the Directive does not exclude the possibility of a risk-assessment approach which could mean medicines deemed to be at low risk of counterfeiting are exempted. The details of the safety feature requirements, as well as the level of traceability that might be required, also need to be fleshed out.

The vote in favour has been warmly welcomed by industry associations and healthcare bodies. The European Federation of Pharmaceutical Industries and Associations (EFPIA), called the vote "an important move in achieving greater protection for patients from counterfeit medicines". Pharmacist groups also welcomed the new Directive, but also had worries about some elements within it. The Pharmaceutical Group of the European Union (PGEU) said in a statement that "many of the details of electronic verification are left to be determined by the European Commission, including the type of unique identifier to be attached to medicines packs, the organisation of databases which will support the verification system, and even which medicines are to be covered by the verification process." The PGEU wants the verification system to be applied as broadly as possible within the prescription medicine category, on the presumption that "all prescription medicines are at risk of falsification." It also has reservations about the use of a logo to certify genuine online pharmacies, pointing to evidence that similar schemes have been compromised in the past and could lull the public into a false sense of security. The PGEU logo has itself twice been falsified, for the purpose of apparent ‘approval’ of an illegal internet pharmacy operating from Russia, it points out.

The European Generic Medicines Association (EGA) also welcomed the news, although it has long had misgivings about the possible need for generic medicines to be included in the scope of the Directive, arguing that the addition of safety features could make some products uneconomic to produce.
The next step will be for the Council of Ministers to formally approve the final text. EU Member States will have less than two years to transpose it in their legislation.

More information:  

**COMMISSION GUIDELINES FOR QUALITY ASSURANCE IN COLORECTAL CANCER**

On 3 February 2011, on the eve of World Cancer Day, the European Commission published the first edition of European guidelines for quality assurance in colorectal cancer (CCR) screening and diagnostics, with the object, as the name suggests, of improving the screening and diagnostics of this disease. At European level, this type of cancer is the second most diagnosed cancer and the second-highest cause of death by cancer, with one in every seven new cases of cancer and one in every eight fatal cases of cancer.

The new guidelines for quality assurance in colorectal cancer screening and diagnostics form the final part of a triptych, together with two others on breast cancer and cervical cancer, which aim to help the member states in the execution of their national screening and detection programmes. By following these guidelines, the European Commission considers that the member states can make their healthcare systems more effective and, in particular, improve the diagnostics and treatment of cancers identified in the screening process. National screening practised as per the procedure recommended by the European Union could cut fatal cases of CCR by 15% in people of the corresponding age group (50-74 years old), who are invited to attend a screening session.

More information:  

**RARE DISEASES EUROBAROMETER**

Rare diseases cause great suffering to many EU citizens. Up to 36 million Europeans are affected, and need proper diagnosis and treatment. A Eurobarometer survey published on 28 February 2011, on the 4th World Rare Diseases Day, reveals widespread support for action on rare diseases at EU level: 95% of those surveyed believe there should be more European cooperation in this area and that rare disease patients should have the right to access appropriate care in another member state.

European Health Commissioner John Dalli said that it was of the greatest importance that cooperation on rare diseases should be improved, as the necessary medical expertise may not be available in every Member State. The European Commission “is engaged in added value action to help citizens access the care they need across the EU”, he stated.
Among the key findings of the survey were that:

- 63% of respondents chose the correct definition of rare diseases;
- 17% of those surveyed know someone suffering from a rare disease;
- almost all (96%) agree that national health authorities should give support to those suffering from rare diseases and fully reimburse their medication, even if it is very expensive (93%);
- over 90% of respondents agree that allocating resources for research, access to treatment, communication and patient support is justified. Some well-known rare diseases are cystic fibrosis, haemophilia and Duchenne muscular dystrophy.

More information:
http://ec.europa.eu/public_opinion/archives/eb_special_379_360_en.htm#361

EUROPEAN PARLIAMENT RESOLUTION ON TUBERCULOSIS

On 3 February 2011, the European Parliament adopted a resolution which states that in order to fight tuberculosis, vaccinations are an essential tool, together with better detection tests - reliable, inexpensive and dependable - and more effective diagnosis and treatment, “implying a major overhaul of research and increased, sustainable funding”.

The resolution stresses that only a vaccination programme involving a large-scale vaccination campaign can have a positive effect in eliminating tuberculosis by 2050. It calls upon the European Commission to explore innovative means of funding, such as the creation of a financial guarantee by the Member States and/or the EU to raise funds for the TBVI initiative (for vaccination against tuberculosis), from the European Investment Bank (EIB), in order to guarantee the funding of research into neglected and unprofitable diseases in developing countries.

WORKING GROUP ON HEALTH INFORMATION

The latest meeting of the Experts Group on Health Information or Health Information Committee (HIC) has been held on 22 November 2010 in Luxembourg. The scope of the meeting was to exchange updated information about the work of the committee and to set the main priorities for 2011.

The Health Information Committee is one of the consultative structures that support the European Commission in the development of the EU Health strategy, bringing together national governments, local and regional authorities, stakeholders, national and international organisations and experts.

In particular, the Health Information Committee (HIC) works together with the Commission to agree on needs and solutions for European health information and reconcile the technical issues and resource constraints of this information with the overall EU policy and strategic needs; assists in defining and overseeing technical work needed to achieve this work; and acts as a platform for cooperation and collaboration on health information at European level.
During the meeting, the technical groups established within the Committee presented the current state of the art.

- The “European Community Health Indicators Monitoring” (ECHIM) group reported on the joint action. There is good progress on the validation of indicators; a pilot data collection questionnaire was started. A point of discussion will be the future of ECHIM and the sustainability.

- The subgroup on the “European Health Examination Survey” (EHES) reported about the joint action. The aim of this joint action is providing comparable information on major chronic disease risk factors and disease prevalence and to pilot the fieldwork, data collection, assessment and reporting. In order to prepare for a full-scale HES a pilot survey has been or is being implemented during 2010/2011 in 13 Member States (FIN, CZ, DE, EL, IT, MT, NL, NO, PT, PL, SK, ES, UK). Results of the pilot survey will be analysed in a meeting in early 2011.

- The Task Force on Health Expectancies reported on the state of the negotiation about the joint action “European Health and Life Expectancy Information System” (EHLEIS). The joint action has the objective to increase the utility of Healthy Life Years (HLY) indicators for EU public health through the consolidation of the existing information system developed by the EHLEIS project 2007-2010. The joint action is still under negotiation with the EAHC.

The project “Health in Europe: Information and Data Interface” (HEIDI) was also presented during the meeting. It is meant to be a wikipedia on health information, representing a tool for pooling, presenting and updating good quality health information throughout Europe. The main target audience is represented by policy makers, health professionals, academics, NGOs, etc... however anyone can browse HEIDI and make suggestions about the contents. The Commission underlined the intention to steer the process of HEIDI, but not to take responsibility for the individual content of the pages, which would remain the responsibility of the authors and editors. The Commission also agreed with the importance of making information available in all languages and explored the possibility of automated translation tools.

OECD presented the new publication "Health at a glance", covering all 27 EU Member States, the 3 EFTA countries and Turkey. The indicators selected are mainly from the ECHI shortlist except the data on health expenditure. It was agreed that in the future, Member States would welcome the opportunity to comment in more detail the draft text of such reports.

Finally, with regard to the work plan 2011 the main update was that, since the European Commission focus only on a few priorities, for Health Information there will be only 3 areas with funding – rare diseases, cancer and health information.

More information:  
http://ec.europa.eu/health/strategy/events/ev_20101122_en.htm
**MEDICINES FOR OLDER PEOPLE**

On 18 February 2011, the European Medicines Agency launched strategy on medicines for older people. The Agency will ensure that the needs of the ageing population in the European Union are taken into account in the development and evaluation of new medicines, according to its geriatric medicines strategy.

The strategy sets out the Agency’s vision for the development of medicines for the elderly by building on its existing activities. In particular, the Agency aims to:

- ensure that the medicines used by older people are of high quality and are studied appropriately in the older population, both before and after authorisation;
- improve the availability of information for older people on the use of medicines.

The strategy was adopted by the Committee for Medicinal Products for Human Use (CHMP) and it represents a key step forward in the Agency’s commitment towards responding to its changing environment, as set out in its “Road map to 2015”.

The European platform AGE welcomed the new strategy. “Considering the ageing of the EU population and the financial pressure on healthcare systems, the need to have better tailor-made medicines for older people and access to reliable, unbiased and independent information is crucial”, declared Anne-Sophie Parent, AGE Platform Europe’s Secretary General after the European Medicine Agency announced its new medicine strategy for the next five years.

The commitment taken by the European Medicine Agency to develop new medicines which address the specific age-related safety and efficiency issues is an important step forward. It comes very timely with the launch of the European Innovation Partnership on Active and Healthy Ageing and the forthcoming European Year 2012 on Active ageing and echoes AGE repeated call for the setting up of a geriatric medicines committee at EMA, similar to the pediatric medicines committee. The proposed EMA strategy is an important step forward and will ensure that more appropriate medicines are developed for our rapidly ageing population as well as better information on an adequate use of medicine. Today still many avoidable hospitalizations among older people result from the improper use of medicines, either overmedication, or interaction of medication. “This strategy should mobilise healthcare professionals from nurses to community pharmacists, professional and informal carers and older people themselves and should deliver both social and economic benefits for the individuals and society”, added Ms Parent.

**More information:**

http://www.ema.europa.eu/ema/index.jsp?curl=pages/special_topics/general/general_content_00249.jsp&murl=menus/special_topics/special_topics.jsp&mid=WC0b01ac058004cbb9&jsenabled=true
EUROPEAN MEDICINES AGENCY ROAD MAP

The European Medicines Agency published its final “Road map to 2015”, coinciding with the 16th anniversary of its inauguration. The “Road map to 2015” sets out the Agency’s vision in further developing its role as a European public-health agency in the field of medicines and has been drafted in consultation with the Agency’s partners and stakeholders to ensure as broad a consensus as possible on the best way forward.

The road map proposes three priority areas for future actions to strengthen the Agency’s role in protecting and promoting human and animal health in the European Union - addressing public-health needs, facilitating access to medicines and optimising the safe and rational use of medicines.

More information:

PUBLIC HEARING ON THE RECOGNITION OF PROFESSIONAL QUALIFICATIONS

A hearing on the Recognition of Professional Qualifications was held on 21 February 2011 in Brussels. The Directorate General for Internal Market and Services organised this meeting in order to discuss opinions and to find answers to some questions posed in the Consultation Paper on this issue. The Commission is still looking for responses to the Consultation Paper by DG Internal Market and Services on the Professional Qualifications Directive. The deadline for answers is 15 March 2011.

Jonathan Faull, Jürgen Tiedhe and Tjalling De Vries from the European Commission launched the consultation with a short introduction, raising the importance of economic growth and job creation. For this reason it was emphasized that the “Single Market should be seen as an opportunity and not a threat”. Furthermore, it was pointed out that the topic of mutual recognition is of high importance on the European Parliament’s agenda but it still needs further discussions.

The public hearing was concentrated around three main themes. Firstly, the issue of simplification of the Directive: many professionals found the procedure to be complex, lengthy and often expensive. Such complications could serve as a barrier to the movement of workers and it could thus hinder achieving economic growth and more job creation. Secondly, the integration of professions into the Single Market was debated. In this section of the conference, the main questions arose around temporary mobility and the subject of the professional card. The necessity of such a card and the kind of information that should be indicated on it, were both debated. The third and last theme was the issue of confidence in the system. This part was unarguably of high importance in the health care sector. It was agreed on that trust has to be strengthened especially in an era of economic crisis and ageing. The diversity of cultures and languages are of increased importance when so many workers
cross borders every year. This has led to discussions on language skills and continuing professional development. In light of these three challenges, Member States and professionals from different sectors gave their views on the Professional Qualification Directive.

More information:

FREE MOVEMENT OF WORKERS: COMMISSION REASONED OPINION SENT TO ITALY

On 16 February 2011, the European Commission requested that Italy took professional experience and seniority acquired by doctors in another Member State into account when determining their rank or working conditions (like salary, grade career development) in the Italian public sector. The Commission considers that the current rules are discriminatory since they affect primarily workers of other Member States.

More information:

REPORT ON THE IMPLEMENTATION OF THE SERVICES DIRECTIVE

The European Parliament approved during its plenary session on 14 February 2011 the report of Evelyne Gebhardt (S&D, Germany) on implementation of the directive on the liberalising of services in the EU.

The rapporteur reminded MEPs of the lively debates in 2006 that accompanied the drafting and adoption of the directive, which aims to help complete the single market in the services sector and, thus, to encourage economic activity and employment (potentially it represents an increase in EU GDP of between 0.6 and 1.5%). Four years on and the EP has been called on to assess how well the directive is being applied.

The main failings flagged up by the rapporteur and MEPs are:
- delays and unequal levels of transposition and implementation of the directive among Member States, the legislation of which is often far too complex;
- the inadequacy of one-stop-shops which are too few and are poorly equipped (language is a major handicap for SMEs) when these are the key to the success of the directive and must be easily accessible both physically and electronically;
- the lack of training and awareness-raising by national administrations;
- the lack of legal clarity over the areas where the directive applies, and in particular over those areas that are not part of the directive, resulting from the vagueness of the definition of services of general interest [SGI] and unclear distinction from services of general economic interest [SGEI].

During the debate, the largest political groups (EPP, S&D and ALDE) supported the conclusions of the report and the aims and general thrust of the directive. Opposition came from the Greens, who were critical of the costs of assessment for public administrations and of the ambiguities of the directive,

HOPE – European Hospital and Healthcare Federation
NEWSLETTER N° 79 – February 2011
Page 10 of 25
which fails to take sufficient account of public services. The GUE/NGL criticised the liberalism of a directive, which puts the free market above the right to organise, destroys public services and increases social and wage dumping. The Right and the Eurosceptics see it as an EU intrusion in national affairs and a further source of red tape.

**COMMISSION GUIDE TO EU RULES ON SERVICES OF GENERAL INTEREST**

On 28 January 2011, the European Commission published a guide to EU rules and the Lisbon Treaty on competition, the internal market and public procurement for services of general interest (SGI).

The intention is to end what the Commission considers as mistaken views by some politicians and local authorities that it is planning to force all services of general interest out to tender. The EU rules and the Lisbon Treaty do indeed apply to SGI, particularly social services, but do not apply in the same way as other services. The Commission points out that competition law does not force contracts to be put out for tender because it is possible, under certain conditions, to decide on special exceptions. The freedom to supply services and the freedom of establishment are key aspects of EU law, but the European Court of Justice allows restrictions in order to pursue social policy objectives. Likewise, the Services Directive (Directive 123/2006/EC) does not apply to all social services, and the public procurement directives (2004/18/EC and 2004/17/EC) do not make it compulsory to select the lowest bid.

An update on an early 2007 guide, the new document is based on FAQs on state aid and public procurement from the Interactive Information System (IIS) set up in 2008 to clarify application of SGI rules.


**EUROPEAN PARLIAMENT VOTE ON RECYCLING ELECTRONIC WASTE**

On 3 February 2011, the European Parliament called for high-quality disposal of electrical and electronic waste with reduced red tape for companies.

Its first reading of the revised draft directive relating to the recycling of electrical and electronic waste (the EEWD) has been awaited because agreement was reached under the Belgian Presidency on the separate directive dealing with dangerous chemicals contained in electronic and electrical waste.
By a large majority (580 to 37 with 22 abstentions), the MEPs set new waste collection, recycling and re-use targets that they hope will remedy the ineffectiveness of EU legislation to date (since introduced in 2004) because only 35% of electrical and electronic waste generated in the EU meets EU reporting and processing requirements.

Karl-Heinz Florenz (EPP, Germany), rapporteur on this issue, explained that one cannot go on like this without recycling waste and the Parliament sent a strong message to local authorities, manufactures and consumers to get them all to play their part in collecting and recycling waste. He said the Parliament had also set stricter rules to stop the illegal export of potentially lethal waste to developing countries.

The European Parliament wants Member States to collect at least 85% of electrical and electronic waste by 2016, with an interim target for 2012 of 4 kg of electronic waste per inhabitant under existing rules, or the amount of waste collected in 2010 (if higher than 4 kg). The MEPs recommend a 50% to 75% electronic waste recycling target depending on the type of waste and new target of re-using 5% of electronic waste.

They want the directive to apply to all electrical and electronic waste bar a few exceptions like big industrial plant machinery, military vehicles and equipment, and photovoltaic cells from solar panels, which have to be recycled by specially qualified staff.

To reduce red tape and cost for business, the MEPs recommend reducing the number of categories of waste and simplifying the registration and reporting requirements.

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**EMERGENCY SERVICES AND 112 DAY**

To mark the “European 112 Day” on 11 February 2011, the European Commission urged Member States to step up their efforts to increase public awareness of the existence of the 112 number, which can be used in all EU Member States to reach emergency services.

An EU-wide survey has shown that around three out of four EU citizens still do not know this life-saving number. EU telecoms rules require Member States, however, to make their citizens aware of the 112 number. To increase the protection of EU citizens, Member States are further required to improve the accuracy and reliability of caller location information under the new EU telecoms rules, which must be implemented into national law by 25 May this year.
eHEALTH STRATEGIES REPORTS

The synthesis report on Europe's progress in eHealth policies and implementations along with more than 30 country reports is now published. With the financial support of the European Commission, Empirica Communication and Technology Research coordinated the study entitled "European countries on their journey towards national eHealth infrastructures - evidence of progress and recommendations for cooperative actions".

The summary report traces European countries' progress along the goals set out in the eHealth Action Plan. It focuses on the core applications of EHR-like/patient summary and ePrescription systems. It also analyses governance, structural and legal issues as well as policy lifecycle aspects. Study results show that in virtually all European countries surveyed, political as well as stakeholder interest in eHealth policies, and the planning and implementation of national or regional infrastructures, has strengthened considerably. This concerns not so much the number of new priority objectives identified, infrastructure elements tackled or pilots run, but rather the overall level of awareness, activities and concrete undertakings. European Commission as well as Member State initiated activities and co-operations like epSOS or the eHealth Governance Initiative significantly contributed to this state of affairs.

More information: www.ehealth-strategies.eu
EUROPEAN COURT OF JUSTICE

CASE C-490/09, EUROPEAN COMMISSION V LUXEMBOURG, 27 JANUARY 2011

- Judgment of the Court
- Failure of a Member State to fulfil its obligations - Article 49 CE - Freedom to provide services

By failing to provide, in its regulations in force in 2008, for the reimbursement of costs for biomedical analyses and examinations when these services are provided in another Member State, Luxembourg restricted the freedom to provide services (art.49 EC).

This was the verdict of the Court in its ruling of 27 January 2011 in Case C-490/09, which supported the concerns of the European Commission (recourse brought on 30 November 2009).

In its reasoned opinion of October 2008, the Commission essentially laid out two objections:
- on the one hand, these medical costs are reimbursed in Luxembourg only through the system directly covering the costs (known as the “third-party payment system”), which does not apply if the patient uses a laboratory established outside the country, which would then deny the interested party the option to be reimbursed;
- additionally, costs for analyses and examinations carried out in other member states are not reimbursed if these services were not carried out in the full respect of conditions laid down by Luxembourg legislation.

For example, the Luxembourg authorities do not reimburse the costs for these analyses and examinations unless they were carried out by a separate analysis laboratory, whereas in certain member states, they are carried out by the doctors themselves. These national provisions, therefore, constitute a restriction on freedom to provide services, the Commission argued.

The Court supported these arguments, firstly indicating that the former objection relates only to healthcare services provided by service providers, which have not concluded an agreement with the Luxembourg health insurance companies, as care supplied by agreed service providers “is covered under the third-party payment system”. Although the laws of Luxembourg do not prevent holders of social insurance from consulting service providers established outside the country, they do not allow the costs for services provided by a non-accredited provider to be reimbursed, even though reimbursement is the only way of covering the cost for this care. It appears “illusory (...) to imagine that large numbers of service providers situated in the other Member States are led to conclude agreements with Luxembourg health-insurance companies”.

As a result, Luxembourg law in practice rules out de facto the possibility of covering the costs of laboratory analyses and examinations carried out by “almost all, or even all” providers of medical services established in other Member States. It “discourages, or even prevents” people affiliated to a Luxembourg social security policy from turning to these service providers, which constitute an obstacle to the freedom to provide services.

Additionally, the Court agrees with the Commission’s opinion that Luxembourg has not demonstrated that its laws could be justified by the objective of maintaining a well-balanced medical
and hospital service, which is accessible to all, or by the objective of ensuring public health protection aims.

More information:

SOCIAL SECURITY COORDINATION – COMMISSION VERSUS SPAIN

On 16 February 2011, the Commission decided to take Spain to the European Court of Justice for refusing EU pensioners access to free medication while temporarily residing in Spain.

Under EU social security legislation (Regulation 883/2004), pensioners temporarily residing in another Member State can make use of their European Health Insurance Card (EHIC) to receive necessary healthcare under the same conditions as pensioners insured under the sickness insurance scheme of the visiting Member State.

Under Spanish law, pensioners can get medication for free, which is why pensioners from other EU Member States should equally have an access to free medication when temporarily residing in Spain. The Commission explains that the Spanish authorities however, refuse free medication to EU pensioners because the EHIC does not indicate that they are pensioners. Spain requires EU pensioners to present a supplementary document issued by their national social security services certifying in the Spanish language that he or she is in receipt of a state pension. In the Commission’s view, the refusal of the Spanish authorities is contrary to the above-mentioned provisions and discriminates against EU pensioners temporarily residing in Spain. Moreover, the requirement to present such a supplementary document is contrary to the purpose of the EHIC, which aims at simplifying procedures and reducing red tape for insured persons when they need health care during a temporary stay in another Member State.

More information:
EU PROGRAMMES AND PROJECTS

RESEARCH – TELEHEALTH “RENEWING HEALTH” PROJECT

On 17 February 2011, HOPE was invited to join the User Advisory Board meeting of the project on telehealth called “RENEWING HeALTH”, REgioNs of Europe WorkINg toGether for HEALTH. The project, co-funded by the European Commission, DG Information Society and Media in the Competitiveness and Innovation Framework Programme (CIP), aims to improve health services in Europe for the increasing number of patients suffering from chronic conditions – in particular diabetes, cardiovascular disease and chronic lung problems. The overall project goal is to demonstrate that telehealth based services improve quality of life, enable patient involvement and empowerment while optimising the use of resources in health provision. The project will establish and continuously enhance a comprehensive, multidisciplinary and reusable evaluation methodology to strengthen the evidence-based use of telehealth-based services in Europe and worldwide. The project involves a consortium of 9 of the most advanced regions in the implementation of health-related ICT services, belonging to 9 different Member States or Associated Countries. The mission of the User Advisory Board is to ensure that the interest and needs of the key actors are properly recognised and taken into account throughout the project and its evaluation.

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

RESEARCH – DUQUE PROJECT CONSORTIUM MEETING

HOPE participated to the DUQuE consortium meeting that took place on 24 and 25 February 2011 in Barcelona. The meeting was hosted by FAD, the leader of the project and gathered all project partners and project experts. During the meeting, project main research objectives and its outcomes have been discussed, the conceptual model was reviewed, and the calendar of analysis was rescheduled.

The project started in November 2009 and will last until 2013 and is co-funded by the EU 7th Research Framework. The research results will be presented in Berlin at the DUQuE final conference scheduled for 17 December 2012. In order to get the research conclusions on the quality assessment, the project foresees the surveys by the mean of questionnaires at the hospital and departmental levels, surveys at the patient level, and visits.

The questionnaires are now finalized and translated into eight languages, as the survey will be undertaken with the assistance of the country coordinators in 8 countries (Czech Republic, England, France, Germany, Poland, Portugal, Spain and Turkey). The recruitment of the hospitals (agreed number of 30 hospitals per country) is in progress.

More information: www.duque.eu
RESEARCH – CONSULTATION ON RESEARCH AND INNOVATION FUNDING

Creating more growth and jobs through a radical shake-up of EU research and innovation funding is the aim of a consultation launched by the Commission on 9 February 2011.

The proposed “Common Strategic Framework”, set out in a Green Paper, will cover the current Framework Programme for Research (FP7), the Competitiveness and Innovation Framework Programme (CIP) and the European Institute of Innovation and Technology (EIT).

This should create a coherent set of instruments, along the whole “innovation chain” starting from basic research, culminating in bringing innovative products and services to market, and also supporting non-technological innovation, for example in design and marketing. The Commission’s Green Paper also provides the basis for far-reaching simplification of procedures and rules. The changes aim to maximise the contribution of EU research and innovation funding to the Innovation Union and the Europe 2020 Strategy.

The Common Strategic Framework proposed by the Commission in its Green Paper combines three key aspects. Firstly, a clear focus on three mutually reinforcing objectives: giving the EU a world-beating science base; boosting competitiveness across the board; and tackling major challenges, such as climate change, resource efficiency, energy and food security, health and an ageing population. Secondly, making EU funding more attractive and easier to access for participants, for example, through a single entry point with common IT tools or a one-stop shop for providing advice and support to participants throughout the funding process.

Furthermore, the Common Strategic Framework will allow a simpler and more streamlined set of funding instruments covering the full innovation chain, including basic research, applied research, collaboration between academia and industry and firm-level innovation. Flexibility will be promoted to encourage diversity and business involvement. Applicants should be able to apply for several different projects without repeatedly providing the same information. Thirdly and finally, there will be much simpler and more consistent accounting procedures for the use of the funds received. This may involve, for example, greater use of lump sum payments. Greater simplicity will make financial control of EU taxpayers’ money easier and more effective.

Other ideas in the Green Paper include:
- further steps to pool Member States’ national research funding;
- better links with cohesion funding; using EU funding to stimulate public procurement;
- more use of prizes;
- further strengthening the role of the European Research Council and of financial instruments such as the Risk-Sharing Finance Facility (RSFF) and the loan guarantee and venture capital investments;
- and drawing up a set of performance indicators to measure the success of EU research and innovation funding.

In the course of the coming weeks, the Commission will launch a competition to find the most inspiring name for the new common framework.

The public consultation is open until 20 May 2011.
On 10 June, the Commission will organise a major closing conference as a follow-up to the public consultation. The name for the new Strategic Framework will be announced there. Thereafter, and probably in October of this year, Research and Innovation Commissioner Máire Geoghegan-Quinn will bring forward a legislative proposal for research and innovation spending under the future EU budget post-2013.

OTHER NEWS

LAUNCH OF GLOBAL PATIENT SAFETY ALERTS

WHO Patient Safety together with the Canadian Patient Safety Institute worked on the development and the launch of Global Patient Safety Alerts, a publicly available web-based platform that gives frontline health-care providers and organizations around the world access to information on patient safety incidents, from causes to recommendations and solutions.

Sir Liam Donaldson, Chair of WHO Patient Safety, launched this initiative on the 15 February 2011.

More information:

LATVIAN MINISTER OF HEALTH AND WHO/EUROPE COLLABORATION

On 24 February 2011, Juris Barzdins, Minister of Health of Latvia, met with Zsuzsanna Jakab, WHO Regional Director for Europe to discuss the general WHO/Europe’s work and WHO/Europe’s continuing contribution to the development of the Latvian public health strategy.

Life expectancy in Latvia is 71.2 years, below the average for the Region (75.4). Key health concerns include heavy spirits consumption, high binge-drinking levels and widespread tobacco use.

WHO/Europe’s current work with the Ministry of Health of Latvia focuses on:
- strengthening health policy and the health system;
- promoting healthy lifestyles and reducing risk factors;
- preventing avoidable mortality and disability.

Moreover, in September 2010, WHO experts spoke at the Latvian parliament on the health-budget challenges facing the country due to the economic crisis. WHO’s technical assistance in the development of the public health strategy includes support for policy dialogue and stakeholder engagement, a content review and policy recommendations. Consultations began in 2011, and a technical workshop on health indicators is planned for March 2011, to be followed by a broader cross-sectoral consultation organized by WHO/Europe in early April.

Other issues discussed during the meeting include:
- the new European health policy, Health 2020;
- World Health Day 2011, which focuses in Europe on antibiotic resistance;
- European Immunization Week in April; and
- the health status of Latvia compared with the rest of the WHO European Region, including possible public health interventions to address gaps.

More information:
WHO/EUROPE COURSE ON HEALTH FINANCING

WHO/Europe’s office in Barcelona, Spain will host a new course on health financing on 2–6 May 2011. Its special theme is universal coverage.

The weeklong, intensive training programme focuses on improving health systems’ performance through better policy on health financing, and includes:

- designing a benefit package: equity, affordability and transparency;
- raising revenues: thinking outside the box;
- pooling health revenues: the costs of fragmentation;
- purchasing: getting more health for the money;
- coordinating reform: aligning policy instruments with policy objectives.

The course, that will incorporate the topic of universal coverage in each of its teaching modules, is designed for policy-makers in the health sector, government staff in charge of social policy, senior managers of service-provider organizations and experts involved in health system reform.

The course will be delivered in English. The deadline for applications is 15 March 2011.

More information:

SOCIAL POLICY

On 28 February 2011, a meeting was held on the issue of active and healthy ageing organized by the European Policy Centre. The Chief Executive of the host organization, Hans Martens, led the discussions and started the meeting with a short introduction on the importance of the topic. As the baby boom generation enters the retirement age while birth rates are decreasing, less working-age people will have to pay for a relatively larger amount of pension. The latter is only one angle to look at the issue of “ageing”. Medical improvement, innovations have also led us to reach longer life expectancy. Because of the need for longer employment in order to release the economic burden on younger people, and because of the longer life expectancy, it is of increased importance that elderly are active and healthy. This means that quality of life should be improved at the later ages to which innovations are essential.

Three main speakers gave short presentations on the topic of active and healthy ageing from different perspectives. Maria Iglesia-Gomez from DG Health and Consumers introduced the stakeholders to the project “European Innovation Partnership on Active and Healthy Ageing.” The main aim is to link stakeholders and reach a more optimal funding with better results. It was also emphasized that innovations play a crucial role in reaching these goals. However, the process leading from research to the market will need to be speeded up and guaranteed. The project is concentrated around three main areas of action: “Individuals as patients and consumers”, “Health and social care systems”, “Products, devices & services”. Paul Timmers gave an ICT perspective on the subject, on behalf of DG Information Society and Media. He stressed the importance and the potentials of
innovations and technology in health for example in integrated care or personalized medicine. Moreover, these improvements should not be resisted, but it should be realized how much help it would give to health care workers. Finally, Anne-Sophie Parent spoke on behalf of the AGE Platform Europe. She made several arguments that are all important in achieving more active and healthy ageing. Prevention stood out as one of the most important ones. Although the effects of investing in prevention are long-term, it is essential for better health at a later age. Furthermore, partnerships are needed on a multi-sectoral level when it comes to action. Not only health, but also the transport and housing sectors can do a lot to improve the quality of life of the elderly. Concerning innovations, it should not be resisted because it could help health care workers’ job as well as increase its quality significantly.

Following the panel discussion, stakeholders could join in with questions and comments targeted to the speakers. Partnership, as such, was found to be a very useful tool by all participants. It has the potential to bridge gaps, connect all separated stakeholders, funds and other resources in an optimal way.

More information: http://epc.eu

WHO/EUROPE AND ITALY DISCUSS EUROPEAN HEALTH SUPPORT FOR PEOPLE AFFECTED BY THE CRISIS IN NORTH AFRICA

On 27 February 2011, the Minister of Health for Italy, Professor Ferruccio Fazio, met the WHO Regional Director for Europe, Ms Zsuzsanna Jakab, to discuss how WHO/Europe and Italy can work together to address the public health challenges faced by people affected by, and fleeing from, the crisis in the Libyan Arab Jamahiriya.

It is necessary to ensure that health is protected both in Italy and in Europe but also to help the African populations affected by the crisis. WHO/Europe and the Italian Ministry of Health discussed a series of actions, such as support for improving local health services’ preparedness through technical advice on public health operations, enhancing epidemiological surveillance of the health status of people migrating to Italy, improve early warning and monitoring measures, and environmental health and disease control activities, in the event of the arrival of large numbers of displaced people, as well as the strengthening of the health services in the countries affected by the crisis.

It was agreed that depending on how the situation progressed, WHO/Europe and Italy would convene a meeting in Rome on 18 March 2011 of European Member States, the WHO Regional Office for the Eastern Mediterranean and other key players, to coordinate the help being provided and to discuss contingency plans if the crisis escalates.

HIGH-LEVEL FORUM ON HEALTH EQUITY IN SLOVENIA

A high-level forum on health equity was held on 1 February 2011 in Slovenia with the aim of contributing to the discussion of political and policy options, approaches and incentives that will form the basis for action on social determinants of health. Over the last two decades, Slovenia has worked with WHO/Europe, the European Union (EU) and other partners to build commitment to social determinants of health and reduction of inequalities in health within the WHO European Region and beyond. It plans to place these two issues higher on the Government’s agenda for the development of the country over the next 10 years, and this goal is in synergy with broader European and international initiatives to reduce inequalities within and between countries.

The forum on health equity, hosted by Dr Dorijan Marušič, Minister of Health of the Republic of Slovenia, brought together participants from other ministries, including the ministers of Labour, Family and Social Affairs and of Education and Sport and other high-level participants such as the Minister of Health of the Federation of Bosnia and Herzegovina, the Minister of Health and Social Welfare of Republika Srpska, Bosnia and Herzegovina and the former Minister of Health of Serbia.

Dr Marušič expressed commitment to joint action, and underlined Slovenia’s role as an active partner in developing Health 2020. He added that Slovenia advocates health equity in its capacity as neighbour and sponsor of the South-eastern Europe (SEE) Health Network, as well as its work with European organizations and countries.

At the forum, cross-government commitment and coordination, and inter-country collaboration were identified as key factors in reducing inequities and promoting health.

The new health policy for Europe will be developed through a participatory process and underpinned by evidence covering the WHO European Region. A central component of this evidence will come from a European review of the social determinants of health and the health divide, chaired by Professor Sir Michael Marmot, United Kingdom. Speaking in Slovenia, he explained that the review would investigate gaps in knowledge, identify priority policy areas and propose potentially effective interventions across the diverse countries in the Region, and produce a framework for targets and indicators. This work will cover eight key areas:
- early years, education and the family;
- employment and working conditions, including occupation, unemployment and migrant workers;
- social exclusion, disadvantage and vulnerability;
- gross domestic product, taxation, income and welfare;
- sustainability and community;
- ill health prevention and treatment;
- gender; and
- older people.

The final report is due to submitted to the WHO Regional Committee for Europe in September 2012.

PUBLICATIONS

MORTALITY AMENABLE TO HEALTH CARE – OECD WORKING PAPERS

The OECD methodological and statistical study entitled “Mortality amenable to health care in 31 OECD countries: estimates and methodological issues” has been published in January 2011. This paper aims to assess the potential of the concept of “mortality amenable to health care” in health care systems performance and presents estimates of this concept in 31 OECD countries for the period 1997-2007.

In order to provide a more precise measure of the outcomes attributed to health care interventions, researchers have developed the indicator of “mortality amenable to health care”. Generally defined as premature deaths, this notion takes into account premature deaths for a list of diseases, for which effective health interventions are deemed to exist and might prevent deaths before a certain age limit.

The main objectives of this study are:

- To provide estimates of mortality amenable to health care for a large set of OECD countries and to measure the sensitivity of this indicator to two different lists of causes and age groups;
- To compare these two lists with broader measures of life expectancies and potential years of life lost (PYLL), which do not select any particular causes of death and to assess the differences and value-added of indicators of “amenable mortality”;
- To assess the potential and limitations of the “amenable mortality” indicator in analysing improvements in the performance of health care systems.

The constitution of a consensual list of causes amenable to health care may be delivered in 2011 by the current EU-funded project AMIEHS. Indeed, this project develops a validated set of available mortality-based indicators that can be used in the future surveillance of the performance of health systems in Europe.

More information:
A two-day conference is organised in Brussels on 11 and 12 April 2011 to celebrate the 5th European Patients’ Right Day, under the leadership of the association Active Citizenship.

The reinforcement of Patients’ rights will become effective only with the co-operation and commitment of all healthcare stakeholders in every EU Member States. HOPE was very innovative by designing in 1979 the Charter of the Hospital Patient. Since then, this issue has always remained at the core of its activities.

Celebrating a European Patients’ Rights Day every year in all EU Member States is greatly contributing to its goals. It is an occasion to inform, discuss and take commitments to improve patients’ rights in Europe and put citizens at the centre of health policy.

A tender for the collection of good practices is organised on the following website:

http://www.activecitizenship.net/content/blogcategory/72/179/
In 2011, HOPE Exchange Programme will be organised for the 30th time. Thousands of people from all over Europe - participants, host organisations, national and local co-ordinators - contributed to the success of this programme during three decades.

HOPE Exchange Programme, a 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. HOPE Exchange Programme 2011 starts on 23 May and ends on 21 June 2011.

Each year, a different topic is associated to the programme, which is closed by HOPE Agora, a conference and an evaluation meeting around the topic. “Better health - A shared challenge for hospitals and primary health care” will be the subject for 2011. The Finnish HOPE member will organise the 2011 Agora concluding the Programme, in Turku on June 20-21, 2011.