Hospital

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WEATHERING THE RECESSION

> CULTURAL INTEGRATION

Plus

> Ambulatory Care
> Patient Admissions Prediction Tool
> Focus: Italy

OFFICIAL JOURNAL OF THE EUROPEAN ASSOCIATION OF HOSPITAL MANAGERS

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Paul Castel

OUR HOSPITALS **AND THE CRISIS**

The future of health establishments is one of the overriding preoccupations on the minds of all European citizens. This issue transcends the differences in models of care organisation throughout Europe. For many it is astonishing to realise that this question was almost completely ignored in the recent debates preceding the European Parliamentary elections even though there is no shortage of topics for discussion. If it is true that the hospital sector is still an area that the European authorities show little interest in, so numerous are the common problems that deserve attention and solutions, a communal European analysis is at least a starting point as these issues go beyond national frameworks.

There is also the question of the effects of the crisis on our hospitals. The period we are currently experiencing raises the question of which methods to adopt within our respective establishments to overcome this crisis, or rather, these crises. Actually, the word crisis takes on several meanings which are all challenges facing our hospitals:

▸ First of all the crisis of the hospital model itself, which echoes throughout Europe during passionate debates on the most effective and efficient way to organise care. Although health systems differ considerably throughout Europe, the questions are the same concerning the suitability of choices made in the past as are the concerns about the capacity of the systems in place to overcome these difficulties.

▸ Next, the economic and social crisis. No country in the European Union has been spared from the fundamental question of the economic stability of their model. Everywhere social deficits are widening, raising with intensity the question of the durability of organisations and of social welfare.

▸ Likewise the financial crisis, which, far from being solely limited to the economic sector, has hit our establishments head on. The huge slowing down of activity that we have been experiencing for almost one year presents serious dangers to the financial health of hospitals: A marked increase in public deficit, difficulty in obtaining loans, reticence to invest in structuring projects, insufficient liquid assets... The list could be considerably longer and most issues are common across Europe proving that a European level discussion would be beneficial.

▸ Finally, health crises, which our hospitals have already faced numerous times during their rich history, now take on a new dimension due to globalisation. Therefore the flu pandemic, which should hit the continent this autumn, will again put health institutions on the front line. Across Europe, these institutions are actively preparing to accommodate and take care of the population; offer them the best adapted care and therefore constitute an essential link in state organisation and national solidarity.

Crisis, a single word with several realities but at each time the same result, the extraordinary capacity of our hospitals to adapt and the force of values they embody: Solidarity, protecting those who are the weakest and the constant commitment to persevere despite the difficulties.

At a time when Europe seems to be searching for meaning, we can wager that these values will inspire them and allow them to give European citizens a common vision of their future.

Paul Castel,
President EAHM

The editorials in *(E)Hospital* are written by leading members of the EAHM. However, the contributions published here only reflect the opinion of the author and do not, in any way, represent the official position of the European Association of Hospital Managers.

Weathering the Recession

The recession has touched every European country and every sector. Contrary to the common opinion that healthcare is recession-proof, the hospital sector is no exception. This issue we bring you comments on how the recession is affecting healthcare, strategies to weather the recession and other initiatives to improve cost-effectiveness.

Richard L. Gundling from the Healthcare Financial Management Association (HFMA) takes a positive stance on the situation illustrating how many managers are unbowed in the face of this financial turmoil and gives us nine key strategies on how to weather the recession. This is followed by an insight into the situation in Ireland, commonly regarded as one of the countries hardest hit by the recession; how the healthcare system, workforce and public is coping. Silvia Ondategui-Parra explains the merits of cost-effectiveness analysis telling us what every manager needs to know on the subject and we also learn of a new initiative from the UK- a guide to teach hospital doctors about finance.

Cultural Integration

As the European Union encourages both the free movement of patients and healthcare professionals, Europe's hospitals are becoming more and more multicultural. Our dossier on cultural integration focusses on integrating foreign patients and healthcare workers. Geri-Ann Galanti and Aziz Sheikh guide us on how to provide "culturally competent healthcare" by increasing our understanding of different cultures and how their outlook on medical care can differ considerably to our own. We then hear from Dr. Jolanta Lapczynska, a Polish radiologist working in the UK. She talks of her personal experience, the pros and cons of working abroad and what obstacles she faced when trying to integrate.

Focus: Italy

The Italian National Health Service (INHS) was established in 1978 to grant universal access to a uniform level of care throughout Italy, financed by general taxation. But the Italian healthcare system is changing. Like most other European countries, the system is suffering from a lack of resources. Italy is also experiencing the regionalisation of healthcare management, focus is shifting from inpatient towards primary care and cost rationalisation is fast becoming a new trend. Our country focus introduces the healthcare system, discusses these current changes and also introduces a new association- ANMDO.

TOWARDS A BALANCED COOPERATION **OF PUBLIC AND PRIVATE ACTORS**

The European Association of Hospital Managers (EAHM) invites you to attend their latest seminar, which takes place in Düsseldorf, Germany on November 20th 2009.

The Context and Purpose of the Seminar

Most countries in Europe have evolved to a mixed system with 2 or 3 types of hospitals: Public, private not-for profit and private for profit hospitals.

Hospital managers in the different countries throughout Europe each have their own experiences with public and private activities. Private hospitals are often obliged to take part in the public service while public hospitals are trying to develop private activities to remain within their budget.

Hospital managers also come under different pressures, from financial constraints to external accountability. That being said, benchmarking could prove extremely useful for hospital managers. It would be interesting for hospital managers to benchmark the different possibilities for organising the current and future delivery of care in their hospitals.

What are the differences (and impact) on the level of quality, equity, budget etc? What is the best solution for the patient? Is outsourcing of specific activities in public hospitals a good solution? What is the best evolution for organising healthcare given the financial crisis? What is the impact of the financial crisis on the working conditions for private and public hospitals?

The purpose of the seminar is to create understanding by introducing and explaining these different models. The seminar also aims to help the participants in their search for the options that are best suited for their particular situation and system. Learning from the different systems by analysing the different options, EAHM hopes the participants will be better prepared for future decisions.

Overview of Programme

The seminar will begin with an overview of the current situation of public and private actors around Europe, indicating the factors needed to be taken into consideration when analysing the organisation of healthcare. This is followed by the viewpoints from a proponent of the public hospital model and a proponent of the private hospital model, declaring their contribution and advantages in delivering healthcare.

In the afternoon, three speakers in this field, from different countries will take the stage. They will objectively inform the participants of their experiences with public and private actors in healthcare as well as the cooperation between them.

Finally, a round table debate will be held featuring the speakers, giving participants the opportunity to ask any questions they may have.

The seminar will be held in conjunction with the EAHM General Assembly 2009 and German Hospital Day, both of which are taking place during the world's largest medical trade fair, MEDICA.

The seminar will be held in German and English. Participation is free but registration is required. Seminar details and registration form can be found on the EAHM-website:

www.eahm.eu.org

Towards a balanced cooperation of public and private actors
EAHM-Seminar, November 20th 2009, Düsseldorf

10:00 - 10:10	**Welcome –** Heinz Kölking, Vice-President of EAHM
Overview	
10:10 - 11:00	**European (over)view** - Prof. Hans Maarse, University of Maastricht
11:00 - 11:30	**View from the Public hospitals** - Paul Castel, Director General of Hospices Civils de Lyon, President of EAHM
11:30 - 12:00	**View from the Private hospitals** - Dr. Paul Garassus, European Union of Private Hospitals
12:00 - 12:15	Questions
Lunch	
Experiences from hospital directors around Europe	
14:30 – 15:00	**Experiences from Portugal** - Artur Vaz, Hospital Director, Hospital Fernando Fonseca, Portugal
15:00 – 15:30	**Experiences from Ireland** - Michael Costelloe, Managing Director, University of Pittsburgh Medical Center (UPMC) U.K. and Ireland
15:30 – 16:00	**Experiences from Germany –** Ralf-Michael Schmitz, Managing Director, Klinikum Stuttgart
16:00 – 16:45	**Round table –** Moderator: Prof. Jacques Scheres
	Conclusion

AGENDA for the 39th Ordinary General Assembly

The meeting will be held on Friday, 20 November 2009 from 17.00 – 18.30,
at Messe Düsseldorf, CCD-Ost, Düsseldorf (Germany)

1.	Approval of the agenda
2.	Approval of the minutes of the 38th Ordinary General Assembly, held on Thursday, 25 September 2008 in Graz, Austria
3.	President activity report 2008-2009
4.	Tendering of accounts for 2008
4.1.	Presentation by the Secretary General
4.2.	Auditors' report
4.3	Approval of accounts for 2008 and discharge of the Board and the Secretary General
5.	Economic plan for 2010
5.1.	Approval of the proposed membership subscription fees of full members and associate members (2.4.c of statutes)
5.2.	Approval of the economic plan for 2010
6.	Election of auditors for the year 2009
7.	Admission and exclusion of members
8.	EAHM Congress 2010, Davos
9.	Next Ordinary General Assembly 2010

IT @ NETWORKING

The IT @ Networking Awards 2009 will select outstanding European healthcare IT solutions in hospitals and healthcare facilities and bring them to the pan-European stage.

WHERE AND WHEN

Brussels, the centre of European decision-making, will be the location for the IT @ Networking Awards 2009 *(IT @ 2009)*. It will be held 29 - 30 October 2009 during the European Summit at Square, Brussels' hottest new meeting centre ensuring international attention.

WHO

The event will be organised by the *European Association of Healthcare IT Managers* (HITM) and the *European Association of Hospital Managers* (EAHM), the largest interest representations of their kind in Europe.

Attendees will include the most ambitious and forward thinking hospital CEOs, CIOs, CMIOs, hospital and healthcare IT managers and other professionals with an interest in healthcare IT.

ROLLOUT: FROM MINDBYTE TO WORKBENCH

WHAT WILL BE PRESENTED

IT @ 2009 introduces successful IT implementations in departments, hospitals and in healthcare networks.
All presentations will demonstrate:

- Minimised administration costs;
- Enhanced quality and security, or
- That the implementation has eased workflow.

FIRST DAY: MINDBYTE

The following outstanding projects will be presented during our first round MINDBYTE sessions on 29 October 2009:

MINDBYTE Session 1: 10:30 - 12:30

- An interoperability platform for telemedicine services in the Veneto Region;
- Integral healthcare information system of Montenegro;
- The health information system of the Rhône-Alpes region (SISRA) and the shared and distributed patient record (DPPR);
- The national PACS programme in England - building on the successful roll-out of PACS in England and moving forward with image sharing between hospital trusts;
- Premier health - medical imaging and the French medical electronic record (DMP);
- Digitisation of the nationwide breast cancer screening programme in The Netherlands;
- From free text to standardised language - the national development project of nursing documentation in Finland;
- Health-e-Child – an e-health platform for European paediatrics.

ORGANISERS:

European Association of HEALTHCARE IT MANAGERS

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G AWARDS 2009

MINDBYTE Session 2: 14:00 - 16:00
- Asklepios Future Hospital Programme - OneIT - standardising IT infrastructure;
- Enabling the best lifecare;
- Hospital information system SPP - a short introduction;
- JEMYS - Hospital Information Management System;
- PACSMail Clinical Networking;
- Paper free patient care;
- PAPT - Patient Admission Prediction Tool;
- Shared web-based electronic patient record for the hospital, general practitioner and patient.

MINDBYTE Session 3: 16:30 - 18:30
- A simulator for head and neck surgeons;
- CitoScreen - data management system for organised cervical cancer screening programmes;
- Computerised surveillance and alerting of nosocomial infections, antimicrobial resistance and antibiotic consumption in the Intensive Care Unit;
- Orthopaedic web-based fracture healing telediagnostic decision support system;
- The BioSig project - getting a grip on biosignals.

Submissions exceeded 70 projects, 21 are currently under review, only 9 will make it into the MINDBYTE session.

SECOND DAY: WORKBENCH

The five finalists of the *IT @ 2009* will be given 45 minutes to provide an in-depth presentation, followed by a 1/4 hour Q & A session with the specialist audience.

THE IT @ Networking Awards 2009 CEREMONY

Out of the finalists, the 3 top rated IT solutions will be awarded a prize.
The winning project will receive the IT @ Networking Awards 2009 trophy, have a detailed presentation of their solution in Europe's leading healthcare management media, and be awarded a cash prize of Euro 5,000.

SPECIAL REGISTRATION FEE FOR MEMBERS OF EAHM AND HITM

- Full Members of EAHM - please register as Invited Association Guest (IAG)	Euro 150,-
- Other CEOs, CMIOs, CIOs, hospital and healthcare IT Managers	Euro 400,-
- Other industry professionals not employed by a healthcare facility	Euro 1000,-

REGISTRATION PROCESS

For registration please visit **www.conftool.com/itawards2009/** and include the following code HO4-09-4351 to qualify for the special price of Euro 150. *For further information on the IT @ Networking Awards 2009 please visit our website **www.hitm.eu**, contact the organisers via email **awards@hitm.eu** or call **+32 / 2 / 286 8501**.*

CARDIOLOGY MANAGEMENT
IMAGING Management
ICU MANAGEMENT
KRANKENHAUS-IT Journal
CyberTherapy & Rehabilitation

Luxembourg
Association News

The Entente des Hôpitaux Luxembourgeois has moved to new offices. The new address is 5, rue des Mérovingiens au Z.A. Bourmicht à L- 8070 Bertrange.

During their General Assembly on June 30th 2009 Mr. Paul Junck has been elected as new President and Dr. Raymond Lies as Vice-President, succeeding respectively Mr. Ernest Frieden and Mr. Henri Hinterscheid.

UK
Online Scorecards for Hospitals

A new online service that allows patients to rate and compare hospitals on issues such as car parking and waiting times has been launched by Health Secretary Andy Burnham.

As patients now have the right to choose when and where they receive hospital treatment, a new web-based scorecard is now available on the NHS Choices website to give people all the information they need to make the right choice of hospital for them.

The scorecard works in a similar way to internet comparison websites and allows patients to read reviews on mortality rates, infection rates, including MRSA and Clostridium difficile, cleanliness, staff performance and quality of food.

Every hospital in England is also being asked to encourage patients to leave feedback on the NHS website, as well as responding to comments, to drive up standards. Later this year, a similar service is being launched to allow patients to rate and compare GP Practices.

Fears For Patient Safety Due to Poor NHS Records

The UK Audit Commission has found that a large percentage of patient records contained unreliable, or no, information.

The commission's checks were performed as part of its annual audit of the quality of the coding that lies beneath the bills that trusts send commissioners. The checks showed that on average eight percent of the 2008-09 bills audited were for the wrong treatment. Weak standards of documentation like this can lead to wider clinical and patient safety risks.

In a report of the audit, the commission stated, "The level of UTAs [unsafe to audit] demonstrates weaknesses in the standard of documentation, which may present wider clinical and patient safety risks." In the worst trust, 16 percent of records were unreliable.

The Netherlands
Dutch Publish a European "Robo Roadmap"

Dutch innovation agency, TNO, has published a 'robo roadmap' on the future of robotics in the medical and health sector for the next fifteen years. The roadmap is part of an EU funded study to equip the European Commission with policy recommendations for the application of robotics in healthcare. The study found 21 main innovation areas showing commercial potential, which were cut down to six key areas "ripe for investigation and road mapping."

Important areas identified include smart medical capsules that can travel through the body administering drugs or gathering information and performing surgical procedures, intelligent prosthetics, home patient monitoring systems, robot assisted mental cognitive and social therapies and surgical robots. The results of the study have been presented at the Dutch Robotics Conference and the International Conference in Rehabilitation Robotics.

Spain
Patients and the Internet

A survey of 660 doctors who work in the Spanish healthcare system- 330 in primary health care and 330 in hospitals - in the provinces of Alicante, Madrid, Zaragoza and Huesca has revealed that patients looking up details of their condition online can complicate patient-doctor relationships and even undermine doctors' authority.

The study examines how health information on the Internet is changing the relationship between doctors and patients. It reveals that hospital doctors are more likely to devote more of their time to the Internet, cooperating with specific websites and recommending websites to their patients for complimentary information. The study also showed that 96% of the doctors surveyed have been questioned by their patients about information they have read on the Internet.

Germany
Medical Technology Plan

BVMed has published a ten-point plan for the care of patients with advanced medical technology as a basis for health policy discussions due to take place in the coming months along with the German Bundestag election campaign.

The ten points are:
1. The quality rating of medical devices must be demonstrated by means of the CE quality mark;
2. Access to medical-technical innovations should be designed to be unbureaucratic and flexible;
3. It must be possible to introduce medical-technical innovations into hospitals without restrictions;
4. We advocate an innovation pool to accelerate the introduction of medical-technological innovations into the SHI;
5. We campaign for a tax-advantaged innovation savings scheme (Steuer-begünstigtes InnovationsSparen, SIS);
6. We consider health services research a useful and necessary joint task for all players in the healthcare system;
7. Cooperation between medical institutions and industry is desired and essential for the improvement of patient care;
8. Emphasis must again be on the quality of medical devices (e.g. regarding aids and appliances). Patients must be able to freely choose their service provider and their products;
9. Homecare should become regular part of SHI, and
10. Telemedicine should become part of regular care.

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Commission Steps up Action on Neurodegenerative Conditions

The Commission has recently adopted concrete proposals to deal with Alzheimer's disease, dementias and other neurodegenerative conditions. There are currently over seven million people with Alzheimer's disease and related disorders in Europe and it is predicted that this number will double in the next 20 years. Europe must plan, invest and cooperate to control the social costs of these diseases while providing patients with the best care available.

The Commission proposes four main areas of action. The objective of this European initiative is to tackle the main problems posed by Alzheimer's disease and dementias in four key areas:

- Acting early to diagnose dementia and to reduce the risk of dementia in the first place;
- Improving research coordination between EU countries;
- Sharing of best practice, and
- Providing a forum to reflect on rights, autonomy and dignity of patients.

Alzheimer's disease and related disorders have been identified by the EU countries as an area where the first Joint Programming of research activities should be launched. Joint Programming addresses EU countries willing to engage in the development of a common Strategic Research Agenda which will allow their participation on a variable geometry basis. 20 countries in Europe have already shown their willingness to pool resources and to conduct research in an area where a common initiative would offer major added value compared with the current, fragmented research efforts in Europe.

This pilot Joint Programming initiative should pave the way for other Joint Programming initiatives in the future.

For more information, please visit:
http://ec.europa.eu/health/ph_information/dissemination/diseases/alzheimer_en.htm

A H1N1: Commission Announces Target and Priority Groups for Vaccination

The European Union Health Security Committee and the Early Warning and Response authorities (HSC/EWRS) have adopted a policy statement proposed by the European Commission which outlines a shared European approach towards identifying target and priority groups for A H1N1 vaccination.

On the basis of current scientific evidence and taking into account guidance by the European Centre for Disease Control and the World Health Organisation, the HSC/EWRS statement recommends the following groups as constituting the first priority groups for A H1N1 vaccination:

- All persons from 6 months old with underlying chronic conditions (e.g. Chronic respiratory diseases; chronic cardiovascular diseases and persons with congenital or acquired immunodeficiency) starting with those with most severe symptoms;
- Pregnant women, and
- Healthcare workers.

Once these first priority groups have been vaccinated, the vaccination proceeds until the national targets have been met.

The statement stresses that it is the responsibility and mandate of each Member State to develop a vaccination strategy for Influenza A H1N1. Each country identifies national target groups that are defined as all those population groups where A H1N1 vaccination is recommended. In some cases, this may be the entire population and in other cases only specific groups. However, it is unlikely that the vaccine will be immediately available for all target groups at the same time and therefore, it is necessary to define priority groups.

For more information, please visit:
http://ec.europa.eu/health/ph_threats/com/Influenza/novelflu_en.htm

610 million euro to Support 106 New Health Research Projects

Funding comes under the Seventh Framework Programme for Research (FP7) These projects cover issues such as diagnostics, new therapies and vaccines. They have been selected through the third call for proposals of the Health Programme of FP7. A total of 679 proposals were submitted. Evaluation was performed with the help of international experts in the health research field. The 106 successful projects will now enter into final negotiation phase.

The projects selected cover a wide range of research areas such as suitability, safety and efficacy of therapies, innovative therapies, brain and brain-related diseases, infectious diseases (HIV/AIDS, tuberculosis, malaria, emerging epidemics), major diseases (diabetes, obesity, cardiovascular diseases), rare diseases, and patient safety.

The main research areas to be funded are biotechnology, generic tools and medical technologies for human health (a budget of 142 million euro is expected for a total of 19 projects), translating research for human health (a total funding of 328 million euro is to be awarded to 43 consortia), optimising the delivery of healthcare to European citizens (a budget of 64 million euro will be distributed to 22 projects) and other actions such as specific international cooperation actions (76 million euro is to be awarded to 22 consortia).

The geographical distribution of the partner countries for proposals retained is very diverse. In addition to EU Member States, another 53 countries are represented, including Croatia, Iceland, Israel, Norway, Serbia, Switzerland, FYROM, Turkey, USA, Russia, Tanzania, Uganda, India, South Africa, Brazil, Rep. of Korea, Argentina, Australia, Cameroon, Ghana, Niger, Benin, China, Gabon, Kenya, Nicaragua, Nigeria and Togo.

NEEDLES

By Rory Watson

A ground breaking agreement between healthcare employers and employees will give medical staff greater protection against injuries from needle sticks and other sharp objects when at work. With over one million such injuries every year in Europe, these are one of the most common health and safety threats staff, particularly in hospitals, face. They can cause infections, trauma and serious illnesses such as viral hepatitis and AIDs.

The eight-page agreement was signed in mid-July by the European Hospital and Healthcare Employers' Association (HOSPEEM) and the European Public Services Union (EPSU) after five months of negotiations.

Welcoming the decision to give a higher priority to tackling the phenomenon, Godfrey Perera, HOSPEEM's general secretary, said that the deal was in the interest of hospital and healthcare employers since they had a moral obligation to protect the health and safety of their staff.

"It also benefits both employers and employees because a proper risk assessment carried out reduces risks and improves employee health and safety, thereby decreasing the number of days lost by these highly trained staff, thus reducing costs," he added. Karen Jennings, the president of EPSU's health committee echoed the benefits the agreement would bring, saying "it makes a clear and positive contribution to the working lives of Europe's healthcare workers".

The agreement sets out to ensure the safest possible working environment for employees in the healthcare sector; to prevent injuries caused by all types of sharp medical objects; and to establish an integrated approach towards assessing and preventing risks. It also includes better training and information for workers.

A clause confirms that "all workers in the hospital and healthcare sector" and anyone under the managerial authority and supervision of the employers are covered by the provisions. It also notes that "employers should deploy efforts to ensure that subcontractors follow the provisions laid down in this agreement".

Special emphasis is given to thorough risk assessments. These will include an exposure determination, understanding of the importance of a well resourced and organised working environment and cover all situations "where there is injury, blood or other potentially infectious material".

The agreement spells out in detail the measures that hospital and healthcare managers must take if the assessments reveal potential sources of injury. They must specify, implement and regularly review safe procedures for using and disposing of sharp medical instruments and contaminated waste.

In addition, they should eliminate the unnecessary use of sharp implements by changing practices and introducing "safety-engineered protection mechanisms". The new code of conduct insists that the practice "of recapping shall be banned with immediate effect".

To further reduce the risk of possible dangers, the guidelines emphasise the need for effective disposal procedures and clearly marked and technically safe containers close to the areas where sharp and injection equipment are regularly used. They point to the importance of adequate training of personnel and regular health surveillance procedures.

Although students undertaking clinical training as part of their education are not formally considered as workers under the agreement, they will be covered by its prevention and protection measures and any liabilities will be regulated according to national legislation and practice.

The agreement sets out to ensure the safest possible working environment for employees in the healthcare sector

The agreement, which was hammered out in detail over five months earlier this year by the two employer and employee organisations that represent a sector with some 3.5 million jobs will soon be given stronger legal status. The European Commission, at the request of the two signatories, is preparing to table a draft proposal to enshrine the text in European law. This is unlikely to face major hurdles as it passes through the formal EU legislative process.

The agreement is the result of careful preparation. The initial impetus came from the European Parliament. In July 2006, it passed a resolution on the need to protect healthcare employees in Europe from blood-borne infections caused by needle stick injuries and called on the European Commission to draft the necessary legislation.

This led to close contacts between HOSPEEM and EPSU on the issue. These included a technical seminar in February 2008 involving all those confronted by the problem. This highlighted the many causes of injuries in hospitals and healthcare services. The negotiations began in January 2009 and were completed in June.

During the whole process, European MEPs have kept up pressure to ensure the issue remains on policy makers' agenda. As recently as April during a parliamentary debate on patient safety, the British Labour MEP Linda McAvan reminded her colleagues that an estimated one million employees in Europe's health services were affected by needle stick injuries. "This could be avoided if the needles they were using were replaced with a safer kind," she said.

STRATEGIES TO WEATHER THE RECESSION

By Richard L. Gundling

The economic recession that began in December 2007 has challenged U.S. hospitals on nearly every level. Revenue has dropped as patients forgo elective procedures and those with high insurance deductibles struggle to pay their portion of the bill. Access to capital has diminished while investment losses have depressed balance sheets and further reduced liquidity. As the amount of charity care hospitals provide has increased along with unemployment rates, state economies in financial jeopardy have cut Medicaid payments for hospital care of low-income patients. Yet many hospital financial leaders are unbowed in the face of this financial turmoil, recognising that the steps they take today to cut costs, maximise revenue, and preserve cash will make them stronger, more efficient institutions poised to respond quickly to tomorrow's economic hardships.

As part of its Healthcare Financial Pulse project, the Healthcare Financial Management Association (HFMA) surveys healthcare financial executives on a quarterly basis to assess how the economic fallout is affecting hospitals and health systems—as well as how providers are responding in the current climate. The most recent survey results were published in July 2009 and were based on 263 responses to an email survey conducted in March. Survey findings reveal that hospital finance leaders have adopted a wide array of strategies to keep their institutions financially viable and maintain their ability to serve their patients and communities through the recession. These initiatives can easily be adopted in Europe. Here are several strategies that have already paid dividends.

Keep the Focus on Value

It's not enough for hospitals to reduce their costs, they must also increase their quality—thereby proving their value to patients and payers. Other industries have long accepted and acted upon the mandate to continually demonstrate their value to stay in business. "As the hospital industry shifts to a more retail environment, providers need to learn lessons from other industries as to how they compete for the purchaser's dollar," said one hospital financial leader responding to the HFMA survey. Hospitals are approaching this issue strategically, focusing attention first on processes that are high-cost, high-volume, or prone to problems.

Patient throughput, for example, is often inefficient and fraught with problems that adversely affect hospital revenue and patient satisfaction. Overcrowded emergency departments (EDs) can result in patients seeking care elsewhere, treatment delays can lead to errors, and hiccups in admissions and discharges can waste resources. Asking staff to identify where patient throughputs break down and soliciting their advice on how to make processes more efficient allows them to create a better work environment as they enhance revenue for the hospital. Some approaches hospitals have taken to make patient throughput more efficient: Adding observation units to EDs to free up more inpatient beds, designating staff to monitor discharges and admissions, and improving space utilisation.

Renegotiate Supply Chain Design and Costs

Standardising the supply chain is among the quickest and easiest ways to reduce costs and errors. Management teams are doing their homework to secure price data for targeted products, especially for high-cost physician preference items. Finance leaders are also working closely with physicians and nurse leaders to communicate the alternatives, costs, and benefits to the organisation and secure their support.

Competition among physicians may be motivation enough for change. "No physician wants to be the most costly and least productive in their department," says Mark David Iannettoni, Chairman of Cardiovascular Surgery at the University of Iowa Hospitals and Clinics in Iowa City. As an incentive to continue improving supply chain management, a portion of the savings can be allocated to departmental budgets for use in hiring staff or purchasing equipment.

During a recession, supply manufacturers and distributors, worried about cash flow, are often inclined to accept contract terms they would have dismissed in better times. Hospitals should seek to negotiate contracts with longer payment terms and reduced acquisition prices and fast payment discounts to balance the tradeoff between the discount and improved cash flow. Because some suppliers may be curtailing production or even going out of business, hospitals need to negotiate safety stock guarantees and more favorable shortage allocation rules for guaranteed purchase volumes. They should also increase self-managed inventories and distribution, and

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develop a structured, efficient product substitution and expediting process.

Standardising products isn't the only approach to cutting supply chain costs. When one health system's seven joint surgeons realised they were using implants from nearly as many vendors, the surgeons told the vendors they would switch products if they didn't meet a capped price for the implant. All the vendors agreed, and the hospital saved 850,000 dollars the first year.

> As the hospital industry shifts to a more retail environment, providers need to learn lessons from other industries as to how they compete for the purchaser's dollar

Be Candid with Employees and Ask for Their Help

Paul F. Levy, president and CEO of Beth Israel Deaconess Medical Center in Boston, shared with 6,000 employees the sobering news that the medical centre would likely suffer an operating loss of 20 million dollars in 2009. In email messages and a town hall style meeting, he asked for their suggestions on cost-cutting measures the institution could take to offset the predicted loss. Levy announced that he would take a 10- percent salary cut and would forgo his bonus, as would senior executives, who agreed to a five percent pay cut. Employees came through with cost-cutting ideas—and overwhelmingly agreed to a salary freeze—resulting in savings of more than 16 million dollars.

Share budget data with employees and be sincere about considering their suggestions when you ask for their participation in cutting costs, advises Levy. And be open to listening to employees enumerate problems, even though it may be uncomfortable. "You can't improve if you don't know what's wrong," Levy says.

Staff According to Patient Census

To hold down labour costs, hospitals are replacing clinical positions only if volumes justify a new hire and are holding managers accountable for staffing correctly. Lee Memorial Health System in Fort Myers, Florida, controlled its labour expense by getting smarter about matching staff nurses with patient volumes. Instead of laying off staff or instituting hiring freezes—at the risk of jeopardising quality—the hospital started using a more accurate forecasting model for predicting staffing needs. The health system saved more than 11 million dollars in one year by avoiding the use of agency nurses, and staff nurses were more satisfied with the more predictable schedules, which reduced nurse vacancies. The new model has also helped the hospital refine its bed management approach at five acute hospitals, which has led to a 20 percent daily increase in the number of beds filled across the system.

Pursue Innovations in Revenue Management to Preserve Cash

In hard times, hospitals have had to rethink their patient billing practices, knowing that some patients may have lost their jobs and their health insurance. Many hospitals are providing cost estimates to patients before elective procedures so they can negotiate and commit to a payment schedule with the hospital or apply for financial assistance if they don't have the ability to pay. St. Elizabeth Medical Center in Edgewood, Ky., recovered 375,000 dollars in revenue when its automated preservice financial clearance process found that 3 percent of its self-pay patients had valid health insurance.

Automating charge capture and coding compliance in an ED is another way to add significant revenue to a hospital's balance sheet. One consultant estimates that ED bills short-change hospitals by 14 to 260 dollars per patient visit—or 184,545 to 3.2 million dollars for a hospital that has 50,000 ED visits annually.

Establish Close Working Relationships with Physicians

Hospitals are considering ways to integrate physicians into their organisations in order to cope with growing shortages of certain physician specialties, to ensure call coverage by trauma and surgical specialists, and to prepare for outcomes-based and bundled payment. Just under half of HFMA survey respondents says that it is highly or extremely likely that "nearly all hospitals will employ a majority of their physicians" in the next 10 years. In fact, the most important near-term action identified by HFMA survey participants is to develop a business plan for physician integration.

But concerns about what healthcare reform will bring has hospitals holding off on employment contracts with physicians now. Many are emphasising physician alignment strategies that focus on their referring physicians rather than jumping into direct physician employment or ownership of physician practices. They want to be sure to avoid the mistakes of the 1990s, when the last big wave

of physician integration efforts resulted in revenue and productivity losses. Employment strategies must carefully consider how physician compensation will be linked to productivity or quality improvements.

Develop Contingency Budget Plans

Given the many uncertainties facing the industry today, healthcare leaders are modeling the impact of different economic and financial scenarios. They use those models to develop budget plans that spell out temporary or permanent expense reductions that will be made if margins/revenues decline to a certain level or if other financial triggers are hit. A common trigger is decline in patient revenue or volume by a specified percentage, typically in the range of 5 percent to 20 percent. Other triggers include a shortfall below operating margin targets, consecutive months of undesirable performance, or failure to meet debt covenants.

Amend Capital Plans

With access to capital markets remaining tight, and credit ratings more important than ever, hospitals are developing financial metrics and modeling to benchmark their organisation against credit rating agency medians. They are also implementing formal processes to determine or reevaluate their organisational risk tolerance and are considering alternative forms of capital financing as market conditions change.

While they wait for credit markets to open up again fully, some hospitals are using internal cash flow to spend on projects, reevaluating whether to continue offering service lines that don't contribute to cash flow, and focusing on top-line revenue opportunities. Hospitals that can prove they have consistent and predictable financial performance and have a history of being accountable for their institutions' financial results will be in the best position to access capital when the credit crunch abates.

Be Resilient

Although this recession has been particularly challenging, hospitals have faced periods of financial adversity before and emerged with renewed strength. Many financial leaders are drawing on those experiences to gain perspective on their current economic difficulties. "Few sectors of the economy have faced and weathered, as much continuous financial tension as the hospital sector, which must regularly adjust to payment and regulatory changes," said Richard L. Clarke, DHA, FHFMA, President and CEO of HFMA. "Hospital financial leaders must, once again, marshal all of their assets to face current realities and use their considerable expertise to provide what is best for their communities."

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IRISH HEALTHCARE **AND THE RECESSION**

A Chicken and Egg Situation

By Lee Campbell

Ireland has been commonly regarded as one of the countries hardest hit by the recession. Is the situation really as bleak as everyone is making out? *(E)Hospital* spoke to someone from the Irish healthcare workforce who preferred to remain anonymous in order to give as frank an account as possible- surely this is an indication of testing times for Irish healthcare... On asking just how bleak the situation in Ireland really is the response was straight to the point: "Serious. Things are very serious." This we already guessed, but how did things get so bad and what is the general reaction to the recession? This article is a summary of our conversation describing the situation in Ireland and contains some very interesting insights.

Watching the Pennies

Financially there have been considerable cuts this year in Ireland; organisations are working off smaller budget allocations and some are carrying deficits from 2008 which makes a difficult situation even harder. Most people have been cutting back personally, watching their pennies and the hospital sector is no different. In the corridors members of staff are asking why the heating is on when it is hot enough already? Why aren't we recycling more? Could we refurbish rather than replace? Indeed, spontaneous suggestions like this from staff are becoming commonplace in Irish healthcare.

Every single process and product is being scrutinised. The HSE (National Health Service) have put their foot down and declared there will be no increases in costs from external contractors. This equates to all service providers- consumable providers, equipment providers etc, which must, in turn, be challenging for their businesses. At a minimum, zero cost increase has been achieved and in many cases a reduction has also occurred. Every single interaction around cost is a negotiation.

In many ways this situation can be regarded as positive: Negotiation has a much more predominant role than before and moreover everyone in the hospital knows that there is no "hidden pot of money". Previously, in the Irish healthcare system if you overspent you could count on getting a bailout at the end of the year. This safety net has gone and not only does management in the hospital and community sectors recognise this, but every single clinician knows it, and this is a major change. They know there is no extra money, no financial controller giving handouts.

Conversations with clinicians are different, while they may still fight to get their request on top of the pile there is a newfound understanding that if they get something, someone else gets less. Stringency in the way business is done in the healthcare sector has become very important and everyone is contributing. This can be seen at every level- for example a frontline member of nursing staff may remark that there is a lot of wastage associated with a certain product and suggest a better and more cost-effective alternative.

Organisations Walking on Tightropes

The outlook for next year is unknown. This year has been very difficult but it is very clear that things will become even more challenging. The challenge is getting the balance of providing both a safe service and a comprehensive range of services. The real challenge is how to maintain quality and safety with less money; decisions must be made on which services stay and which should go. We cannot keep spreading and thereby dropping the standards.

Savings have been made this year across the health sector but more savings will have to be found. However, all the "low-lying fruit" has pretty much gone. To see just how drastic the required cost saving measures will be we must wait for the announcement of the budget in December. Double digit reductions are anticipated.

Government Response: Moratorium on Recruitment

A moratorium on recruitment has been put in place by the government not just in the healthcare sector but on the entire public sector. Only a few professions such as medical consultants, physiotherapists, psychologists, occupational therapists and paramedics are exempt from this. The moratorium means that the authority to recruit for posts and to extend temporary contracts has been rescinded from the health service. Moreover, this authority now lies not with the Minister for Health but the Minister for Finance.

With a health workforce of over 109,000 employees there will be changes, retirements, resignations, maternity leave all of which need replacement. With such a centralised control, the moratorium makes it incredibly difficult to manage the risks facing the delivery of a safe service. Health is a people delivered service, without the people, there are service implications.

Another challenge facing the healthcare service is the HSE's plan to drop the number of administrative staff by 3%. This is sending out the perception that administrative staff are dispensable which is wholly untrue- they are part and parcel of the service provided. Jobs coming under the title of administrative staff include medical secretaries, reception staff, those dealing with medical records, HR, finance and those who provide support to clinical staff to release them from administrative duties. This seems to be moving backwards from the considerable amount of work that was done to provide extra support for clinicians during the "Celtic Tiger" period of prosperity.

Possible Solutions: IT and Care in the Community

In light of budget and staff cuts, leveraging IT could be a successful way of releasing staff through the roll out of programmes such as voice recognition technologies, PACs etc. But new investments like this must be approved by the department of finance. Successful IT implementation has the potential to reduce staff numbers whilst still continuing to ensure quality and safety of care.

It is here we hit a bump in the road: Ireland has a very poor IT infrastructure, a base of good systems is lacking and electronic patient records are not available yet. IT systems are also expensive meaning during the financial crisis the chances of investment in them, excepting a couple of national programmes like PACs, are slim. In this way it is a chicken and egg situation: To reduce the requirement for some staff, we need the IT but the chances are that IT will not be funded.

There is still a very strong drive to move care from the hospital setting into the community, however the primary care team development is still in its early stages – Significant investment in people and buildings is still required. Again the question is whether this can be delivered in such difficult financial circumstances meaning hospitals are as yet unable to release their responsibilities.

The Irish situation is truly that of the chicken and the egg. On a positive note everyone is looking at systems, becoming much more businesslike and coming up with innovative solutions. Developing the frameworks for those things is one thing, but having the funding to address the implementation is going to be a bigger challenge.

On a Personal Level

People are worried, health is, and always has been a huge issue for the public. Access to services is of particular importance as once admitted into the hospital, most patients are satisfied with their experience. In particular A€E waiting times are a cause for concern.

As in other sectors, staff are very appreciative of a permanent, pensionable position. Although you may hear people talking about how their workloads have "gone mad" this is often followed by "at least I have a job". There are an awful lot of spouses, family members who have lost their jobs creating personal pressures on individuals. Many members of staff have personal circumstances that are getting very tight.

Healthcare staff also faced a pension levy (this applies to all public servants) equating to a cut of 6-8 percent in personal income. Individuals are financially struggling at the end of each month. Between the pension levy and the 2% income levy on the entire population, most health workers are facing at least a 10 percent cut. It is likely that further focus on non core pay earnings (eg., on call, out of hours) will occur. This has begun with the scrutiny of on call earnings of non-consultant hospital doctors (NCHDs).

Conclusion: All Doom and Gloom?

The pressure and uncertainty caused by the recession can be seen on both an organisational and personal level; it is affecting everything and everyone. This interview demonstrates the severity of the situation and indicates that there may still be worse to come. But not all of the comments have been negative; lessons have been learned that will be useful in years to come. The transition to a more businesslike mentality of analysing systems and negotiating and listening to and taking on board the suggestions from every level of staff will set the Irish healthcare system in good stead for the future. Other European countries can certainly learn from the Irish experience.

COST-EFFECTIVENESS **ANALYSIS:**

What Every Manager Needs to Know

By Silvia Ondategui-Parra

The fundamental principle of economic analysis is that choices have to be made between alternative uses of resources, as there is a finite pool of resources with which to provide all medical care possible to each individual. This principle is not debated. By providing estimates of outcomes and costs, these analyses illustrate the tradeoffs involved in choosing among a variety of clinical interventions to provide the best healthcare. Never before has it been more apparent than in our current healthcare environment that these tradeoffs are inevitable.

The application of economics to clinical practice in healthcare does not necessarily mean that less money should be spent, but rather that the use of resources might be more efficient. Broadly speaking, the tools of clinical economics can be applied to the analysis of medical practice to improve decisions on how to allocate resources for clinical interventions.

Here, we will define each type of economic evaluation, highlight the basic similarities and differences, and then focus on the principle components of conducting and reporting a cost-effectiveness analysis, one of the most commonly used economic evaluations used in clinical medicine.

Cost-Identification or Cost-Minimisation Analysis

Cost-identification analysis is used to describe and quantify the cost of a particular type of medical care or the economic burden of a disease. This type of analysis, also referred to as "cost-minimisation analysis," asks the question, "What is the cost?". An implied assumption is that the health outcomes of different preventive, diagnostic or therapeutic strategies are considered equivalent. For example, an analysis that assumes the effectiveness of abdominal hysterectomy and laparoscopic-assisted vaginal hysterectomy are equivalent, and that women's preferences for each are equivalent, might simply report the costs associated with each. Although these types of analyses may identify the least costly way of obtaining an appropriate outcome, they cannot specifically predict what the relationship of cost to health outcome will be.

Cost-Effectiveness Analysis (CEA)

Cost-effectiveness analysis incorporates information about both costs and health outcomes to describe the value of a particular healthcare programme. CEA evaluates an intervention through the use of a cost-effectiveness ratio. In the ratio, all health outcomes (compared with a clearly stated alternative intervention) are included in the denominator, and all costs or changes in resource use (compared to a clearly stated alternative intervention) are included in the numerator.

This type of analysis can be used to compare more intensive forms of an intervention with less intensive forms (e.g., screening every year vs. every three years for cervical cancer); a new technology with the standard of care (e.g., laparoscopy vs. laparotomy); prevention of a problem versus treating it (e.g., behavioural school interventions to reduce rates of sexually transmitted diseases in teens vs. a school-based clinic to provide early treatment of these infections). These types of analyses define the "opportunity cost" of each choice, and provide important data to decision-makers in diverse settings for making informed decisions about interventions.

The particular type of cost-effectiveness analysis that uses Quality-Adjusted Life Years (QALYs) as the measure of outcome is sometimes referred to as a cost-utility analysis (CUA), although may alternatively be referred to as one type of cost-effectiveness analysis. Cost-utility analysis is a methodological approach to assessing the value of a given health technology programme, or intervention. As such, it can be considered a process innovation designed to inform decisions about utilisation and coverage of medical interventions.

Cost-Benefit Analysis

Cost-benefit analysis differs from CEA in that it values both health outcomes and costs of medical interventions in dollars. Because clinical benefit is measured in terms of currency, a net benefit or net cost can be calculated by subtracting the cost from the benefit. The criteria that cost-benefit analysis relies on is whether the benefits of a preventive, diagnostic or therapeutic programme outweigh the costs, the premise being that if clinical programmes that fulfil those criteria are adopted, decisions will be made that will result in an "optimal" solution within the economic welfare framework.

The most common methods of assigning dollar value to health outcomes are willingness to pay and human capital. Willingness to pay, a monetary measurement obtained by estimating an individuals willingness to pay for life-saving or health-improving interventions, can be assessed by a survey that relies on an approach called "contingent valuation", or it can be indirectly inferred from decisions that have actually been made that involve tradeoffs between health and money. Human capital values health in terms of the productive value of individuals in the economy.

Despite these difficult measurement issues (i.e., the assignment of a dollar value to outcomes like mortality, functional status and quality of life), cost benefit analyses do appear in clinical literature. Because

it requires valuing all outcomes in monetary terms, it allows for comparison to other sectors of society where benefits are not clinical health outcomes (i.e., environment, education, and defence spending).

Cost-Effectiveness Ratio

Cost-effectiveness ratio is the measure used to express the results of a cost-effectiveness analysis and represents the incremental price of obtaining a unit health effect (i.e., dollars per year of life saved or per quality-adjusted life year saved) as a result of a given clinical intervention when compared to the next best alternative. In this ratio, two alternatives are being compared with the difference in their costs being divided by the difference in their effectiveness. Cost-effectiveness ratios should be reported as dollar per unit of effectiveness stating the year of the costs, for example, 25,000 dollars per life year saved (1,998 dollars).

Cost-effectiveness analyses are always incremental with the ratios comparing each intervention to the next most effective alternative. This means that the costs and clinical benefits associated with the intervention of interest should be compared to existing practice and to all other reasonable options. When all possible alternatives are not included, there is a risk of coming to an incorrect conclusion that an intervention is cost-effective, but only because it was compared with a cost-ineffective alternative.

Cost-Effectiveness Analysis and Resource Allocation

A systematic consideration of cost-effectiveness in decisions concerning the implementation of healthcare technologies would contribute to the efficiency of the healthcare system. This goes further than the initial decision to finance a new healthcare technology based on a favourable cost-effectiveness ratio. A systematic approach should raise and solve questions of broader resource allocation. The opportunity costs involved with implementing a new technology should not be restricted to the 'old' substituted technology but to all resources available to the healthcare funder.

An imaging test with highest diagnostic accuracy is not necessarily the test of choice in clinical practice. The decision to order a diagnostic imaging test needs to be justified by its impact on downstream health outcomes. Decision analysis is a powerful tool for evaluating a diagnostic imaging test on the basis of long-term patient outcomes when only intermediate outcomes such as test sensitivity and specificity are known. The basic principles of decision analysis and "expected value" decision-making for diagnostic testing are introduced.

The appearance of more CEAs in literature in the future will create new insights into the reasons for the high cost of medical care and uncover ways to decrease unnecessary expenditures. Readers of this literature must become familiar with the basic vocabulary, rationale, and standard methods of CEA. By improving our knowledge and understanding of this state-of-the-art research tool, the healthcare community will have a greater ability to participate in healthcare policy setting and decision-making locally and nationally.

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European Health Systems and the Recession

The WHO Regional Office for Europe has released a new report documenting countries' measures to respond to the difficult economic times we are currently facing. The report tracks the changes in public health policies and documents the efforts made by the countries in the WHO European Region to respond to the crisis.

Findings show that downward revisions of state budgets for 2009 are expected to continue for 2010 budgets. This is will have an inevitable effect on health spending.

Some western European countries may tackle declines in revenue by increasing state subsidies to social health insurance and containing costs. The role of private funding is also important. Central and Eastern European countries are likely to increase their calls for private funding. Estonia has introduced VAT on pharmaceuticals and Croatia is planning increased user charges for pharmaceuticals.

Pressures are expected on recruitment and salaries of the healthcare workforce. No clear statistics are available on the impact of the crisis on migration but it is almost inevitable that there will be shifts in mobility and migration patterns as people will move to places where there are job prospects and leave places where job prospects have deteriorated.

The report also raises an important issue: Lifestyle. Increased prices of commodities can often force consumers to change their lifestyles- this can have both positive and negative effects. Fast food consumption, for example often increases in times of economic hardship but on the other hand people cut back on driving and choose public transport and increased physical activity. Unemployment often leads to stress and a deterioration of living conditions, which can in turn lead to less healthy lifestyle choices and increased use of alcohol and drugs.

The report also highlights that the main aim of the WHO Regional Office is working with Member States to improve their citizens' health by building stronger health systems and that this must continue during times of economic crisis as short-term reactions can often have a negative long-term effect.

For more information, please visit:
www.euro.who.int

"BUT THAT'S NOT IN MY JOB DESCRIPTION..."

Teaching Hospital Doctors about Finance

By Lee Campbell

The all too familiar get-out clause of " but that's not in my job description" could soon be a thing of the past in the NHS. This common phrase can be heard in any given workplace and the hospital sector is no different. We are talking specifically about hospital doctors and their role in financial matters. For many doctors it is very simple- it is their duty to deal with patients, to save lives, while it is the managers who deal with budgets and resources. This however, may be about to change with the publication of "A Guide to Finance for Hospital Doctors". It is an initiative to educate hospital doctors about how finance works in the NHS in a bid to reduce costs, improve cost-effectiveness and at the same time increase efficiency and the quality of care.

The guide, entitled "A Guide to Finance for Hospital Doctors" has been jointly prepared by the Academy of Medical Royal Colleges and the Audit Commission. Aimed at medical students and doctors in the early stages of their careers, it is a practical manual on how finance in the NHS works, and at 56 pages, it is a hefty read!

The guide stems from a joint statement, "Clinicians and Finance: Improving Patient Care" made in Feb 2009 by the Academy of Medical Royal Colleges, the Audit Commission, the Department of Health, the Royal College of Nursing, NHS Institute for Improvement and Innovation and the Healthcare Financial Management Association. The statement emphasises each organisation's commitment to supporting clinical engagement in the business processes of their organisations, how this should be achieved and how they are supporting it.

The statement highlights that the "purpose of the NHS is to serve patients and the public by whom it is funded" but that the best care can only be provided if the money available to the NHS is used effectively. A way to ensure this is by involving clinicians in the business processes of their organisations. The guide to finance for hospital doctors is just one initiative.

These organisations have also stated that they will produce practical guidance for finance staff on how to encourage this clinician engagement, as well as support the "Enhancing Engagement in Medical Leadership" project and the development of financial management competencies for nursing staff. They will also promote events to raise nurses' involvement, provide ward sisters with an introductory guide to financial matters, produce e-learning packages for non-finance staff and hold national and regional events to promote greater engagement and to stimulate local action.

> The best care can only be provided if the money available to the NHS is used effectively.

The release of the guide comes at a very fitting time. It is well accepted that the healthcare sector has, and will we affected by the recession. Healthcare budgets are suffering, resources are strained and although in certain European countries such as France and Germany the tide is already beginning to change, many countries are still in crisis.

Everywhere across the world businesses and organisations are thinking of ways to combat the recession. The leading article of this issue of *(E)Hospital* and its strategies to weather the recession confirms that hospitals have also had to tighten their belts, rethink processes and come up with innovative ways of saving money and improving cost effectiveness. The lessons learned and new strategies implemented during a recession will not cease to be useful when the situation changes for the better. In a similar vein many initiatives across Europe designed to improve cost-effectiveness have become increasingly important during this period of economic downturn. The guide is one of these initiatives.

Better Value and Better Care

According to the thinking behind the guide the general formula for success is: More clinician engagement in finances equals better value for money and better care for patients. The more senior the doctor the more important understanding finance and business becomes. Clinicians should be equipped with the understanding, tools and

the ability to manage resources effectively and in turn use these skills for the benefit of the patient. A greater understanding of financial issues has the potential to empower clinicians to be advocates for change and improve the state of NHS services. The ultimate goal is the better care of the patient.

As well as the objective of empowering clinicians, the guide emphasises the benefits of partnership and teamwork. It is not about turning doctors into accountants but about building a mutual partnership and understanding of financial issues. In many hospitals finance is left to the finance department with little cooperation between financial officers/managers and clinicians. Both departments must support each other due to the complicated financial situation of today.

The guide states that at a minimum level, all doctors should have an understanding of:

- How money flows round the NHS, in particular how their organisation receives income when patients are treated;
- The financial rules that exist in their organisation and the role of the finance department;
- How budgets are set and managed, and
- How to make the best use of the money available.

The five topics make up the chapters of the guide and comprehensively explain how exactly finance in the NHS works.

The "Three E's"- Economy, Efficiency and Effectiveness and their relevance to the healthcare sector are explained as are other key theories and processes. A glossary at the back "dejargonises" financial terms. The guide also features Q&A boxes with responses to likely questions, and objections of clinicians concerning their involvement and understanding of finance. These questions tackle issues such as why doctors should become involved, possible friction evolving from having to listen to less qualified junior finance staff, mistrust of service-level reporting and how hospital finance and value for money compares to the everyday financial decisions doctors are faced with in their personal lives (buying a car for example).

Conclusion

The Guide to Finance for Hospital Doctors seems to be a step in the right direction for the financial future of the NHS, providing clinicians with the information they need to make more informed decisions and a fostering a better understanding of the financial implications of their actions. Surely educating a new generation of hospital doctors on finance can only have a positive effect on the quality of care. A greater understanding of finance is also of particular importance during these times of economic uncertainty and budget cuts which will certainly occur again.

HOW TO PROVIDE **CULTURALLY COMPETENT HEALTHCARE**

By Geri-Ann Galanti and Aziz Sheikh

A patient's children believe it is their right to see their father's general practitioner to discuss the results of his recent investigations for weight loss; they are adamant that, if found to have cancer, their father should not be informed.

A woman calmly tells her doctor that she cannot sign consent form for the emergency laparoscopy being hurriedly organised to investigate her abdominal pain; she must wait for her husband to arrive before making that decision.

A man with diabetes refuses to take insulin, even though his doctor tells him it is necessary.

What do these three scenarios have in common? They represent typical examples of the kinds of situations that frequently arise in general practices and hospitals in many western countries reflecting the challenges inherent in the care of culturally diverse populations. Although such situations can be challenging, cultural knowledge and sensitivity can improve the quality of medical care by increasing patient trust, a key factor in adherence. At the same time, it can reduce stress on the part of the healthcare providers.

Stereotype vs. Generalisation

It is important to distinguish between a stereotype and a generalisation. Both are broad general statements about a group. The difference is that a stereotype is used as an ending point. The statement about the group is assumed to apply to all members of that group, without further investigation of the individual. A generalisation, however, is used as a starting point, recognising that individuals within a group will very often be heterogeneous. Effort is made to see whether or not the generalisation fits the individual in question. Any statements made about specific ethnic groups in this article should therefore be seen as starting points or generalisations that may or may not apply to any particular individual. For example, a widely held generalisation is that individuals from certain cultures tend to be more expressive than those from other traditions. Some of the former include Hispanic, Middle Eastern, and southern European cultures, while the latter include British, northern European, Asian, and Native American cultures. When patients and healthcare providers come from different cultures, this can create tensions, but it is also important to note that this is not inevitable. A British healthcare provider may be overly concerned (or annoyed) by the 'moaning and groaning' of an Iranian patient, while an Italian healthcare provider might not even be aware that her Japanese patient is in extreme pain, a condition manifested only by a tensing of the jaw. Knowledge of the generalisation could aid a healthcare provider in asking appropriate questions and better applying their knowledge of the typical levels of pain associated with particular conditions and procedures and offer analgesia appropriately. At the same time, it would be a grave mistake to stereotypically assume that because an Italian patient is complaining loudly, s/he can be ignored. Something serious could be wrong. Families are often a useful source of information.

Values

One of the keys to understanding people's behaviour is to understand their values. While each individual develops their own set of values, there are also values that are promoted by one's culture. For people belonging to minority traditions these values may come into conflict with biomedicine. For example, the North American culture values the individual, whereas in Asian and Hispanic cultures the primary unit is the group. This may for example manifest as clinicians expecting to talk to the patient about his/her diagnosis and prognosis. Many Chinese families, however, will be upset if the physician reveals a negative diagnosis such as cancer directly to the patient. They may expect the physician to present such a diagnosis to the family, who will then decide whether or not to tell the patient. How can such issues, which potentially involve breaching confidentiality, be

overcome? One strategy that many healthcare professionals now successfully use is to explicitly discuss with the patient beforehand whom he would like information about his condition to be given. If the patient prefers that it be given to a designated family member, make sure that all legal requirements are met.

Time Orientation

Cultures may have a past, present, or future time orientation. People from those with a past orientation (such as China or India) tend to prefer traditional remedies and treatments; those with a future time orientation (such as the United States) generally believe that newer is better, and want the latest treatments and drugs. Other cultures, particularly those of the developing world are, by and large, present-oriented. Members may be less likely to utilise preventive health measures reasoning, for example, that there is no point taking a pill for hypertension when they feel fine, especially if the pill is expensive and inconveniently causes unpleasant side effects. They do not look ahead in the hope of preventing a stroke or heart attack, or they may feel they will deal with it when it happens. In such cases, additional effort may be needed to explain the importance of prevention to increase the chances of patient cooperation. Similarly, it is also essential that physicians explain why an antibiotic must continue to be taken, even when symptoms have disappeared; present-oriented patients are most likely to discontinue medication with the cessation of symptoms.

Gender Roles

A failure to realise that males are thought to be dominant in many cultures can lead to delay in obtaining consent for medical procedures. A Mexican or Arab woman, for example, may want to wait until her husband arrives before signing consent for herself or her child. Seasoned healthcare providers will offer the opportunity to involve the husband from the outset, and discuss the situation with the couple together. It is, we believe, advisable for clinicians to consider consulting in advance with patients in order to ascertain whether they prefer family members to play an active-role in decisions regarding their care. This may be particularly relevant when caring for people of Hispanic, Asian or Middle-Eastern origin since the husband is typically involved in important decisions; in Gypsy culture it is usual practice to involve the elder males of the family.

Asking the Right Questions

The key to providing more culturally competent healthcare is understanding the patient's point of view. Ultimately, culturally sensitive care is patient-centred care and should be practiced with all patients. A way to understand the patient's perspective is to ask the right questions. There are many excellent examples, but one with an easy mnemonic is "The 4 C's of Culture":

- Call
- Cause
- Cope
- Concerns

1. What do you ***call*** your problem? (Remember to ask "What do you think is wrong?" It's getting at the patient's perception of the problem. You should not literally ask "What do you call your problem?") The same symptoms may have very different meanings in different cultures and may result in barriers to compliance. For example, among the Hmong, epilepsy is referred to as "the spirit catches you, and you fall down." Seeing epilepsy as spirit possession (which has some positive connotations for the possessed) is very different from seeing it as a disruption of the electrical signals in the brain. This should lead to a very different doctor-patient conversation and might help explain why such a patient may be less anxious than the physician to stop the seizures.

2. What do you think ***caused*** your problem? (This gets at the patient's beliefs regarding the source of the problem.) Not everyone shares the same beliefs with regard to the cause of disease, and thus they may not adhere to treatment recommendations that do not make sense to them. For example, an African American patient who believes their disease was caused by sin may feel the need for penance, not prescription medication. Bringing in clergy might greatly improve cooperation with medical recommendations. A Muslim Arab who believes that only medication derived from 'lawful' sources will facilitate cure may be reluctant to take capsules encased in gelatine derived from animals that have not been ritually slaughtered. A Chinese patient who believes that her illness is due to an upset in the balance between yin and yang may be resistant to specific medications which might be seen as exacerbating the imbalance. Healthcare professionals conversant with such beliefs may, in the case of the latter example, suggest an alternative medication, or that it be taken with a liquid other than water in order to 'neutralise' it.

3. How do you ***cope*** with your condition? (This is to remind the practitioner to ask, "What have you done to try to make it better? Who else have you been to for treatment?"). This will provide the healthcare provider with important information on the use of alternative healers and treatments. Most people will try home remedies before coming in to the physician; however, few will share such information due to fear of ridicule or chastisement. It's important that healthcare providers learn to ask – in a non-judgmental way – since the occasional traditional remedy may be dangerous, or could lead to a drug interaction with prescribed medications. This question can also help you discover if they've been unable to cope with whatever it is that's going on.

4. What are your ***concerns*** regarding the condition? (This should address questions such as "How serious do you think this is?" "What potential complications do you fear?" "How does it interfere with your life, or your ability to function?" and "What are your concerns regarding the recommended treatment?"). You want to understand their perception

of the course of the illness and the fears they may have about it so you can address their concerns and correct any misconceptions. You also want to know what aspects of the condition pose a particular problem for the patient; this may help you uncover something very different from what you might have expected. It is also important to know their concerns about any treatment you may prescribe. This can help avoid problems of non-adherence, since some patients may have misplaced concerns based upon past experience. For example, some patients may not be taking insulin because they believe insulin causes blindness. They've seen friends and family members go blind after going on insulin, and they incorrectly perceive that as the cause; it's a logical assumption based on observed cause and effect. Unless a healthcare provider asks, however, s/he may not elicit such beliefs from the patient, who will simply not take their insulin. By asking, the healthcare provider can correct any misconceptions that can interfere with treatment.

Conclusions

The practice of medicine in today's increasingly multicultural world requires more than just clinical expertise; it requires cultural competency as well. Understanding of and sensitivity to the cultures of the patient population can help healthcare providers provide more effective care while avoiding the frustration that stems from a lack of understanding.

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INTEGRATING **EUROPEAN HEALTHCARE WORKERS**

Perspective of a Polish Radiologist in the UK

By Jolanta Lapczynska

In recent years the NHS has struggled to retain sufficient numbers healthcare workers, leading to a shortage of medical staff. To combat this skills deficiency, the NHS set targets to attract 7,500 more consultants, 2,000 new GPs and 20,000 more nurses by March 2004. The Royal College of Physicians in particular noted that this shortage was due to early retirement deals and the European Working Time Directive, which limits the hours a doctor can work. In this article, I will share my experiences in coming to work as a radiologist in UK, highlighting both the positive and negative experiences as a result.

Before I decided to work in the UK, I had recently completed my radiology training and was working as a locum in a large hospital in Krakow, splitting my weekly workload between many different modalities. I then noticed in the Polish Medical Journal, advertisements recruiting for locums in UK healthcare facilities. In May 2005, I decided to apply for a three-month position as a radiologist at the imaging department of the Aberdeen Royal Infirmary in Scotland, one of the North-East's largest medical facilities. Subsequently when a full-time position as a consultant radiologist appeared, my husband who is a clinical researcher, and our three young children made a permanent move to the UK. In October 2005, I then began my full-time position as a consultant radiologist, specialising in breast imaging.

Changing Regulations for Foreign Healthcare Workers

Two years ago, when I first arrived here, all I had to do to take up my post was to fill out some registration paperwork for the Gen-

eral Medical Council (GMC) in London. There was no problem with my medical qualifications, which were taken as equivalent, or with my previous experience.

A recent addition to the requirements is an exam called the International English Language Testing System (IELTS) which demonstrates language equivalency in the range of medical jargon to ensure you do not have problems understanding your cases; this is not just for Polish workers though, but for any medical worker coming to the UK whose main language is not English.

A GMC Initiative is now in place since March 2007 to prevent growing identity theft. Once your application for registration has been assessed, you must undertake an identity check at the GMC offices in London. A photograph is taken during your identity check made available to employers so that they can be assured of your identity when you start work. Obligations for registration as a foreign medical worker with the right to work in Britain include an IELTS certificate to show you have taken this test and passed with a minimum score. You are also obliged to provide proof of identity, evidence of qualifications and what is known as a 'certificate of good standing'.

Specialised Versus General Radiology

In Poland, to become a consultant radiologist you have to train for five or six years and pass a final exam. As a locum working in Poland, in a big facility, your weekly schedule divides your time up within the different modalities of the department, giving you broad practical experience, but you are not specialised in anything. If you end up working in a smaller facility that offers a limited range of services, you may not even get the benefit of practicing your skills on a very wide range of modalities.

In the UK, when you become a consultant radiologist, you choose your subspecialty and then follow a fellowship in this area. You then follow seven clinical sessions of which four are based on your choice of subspecialty for at least the following four years. This has the effect of creating highly-specialised experts, and has a positive result for patients and co-workers. However, as your job plan doesn't leave you very much extra time it limits exposure to other radiological subspecialties and you risk losing these skills.

Despite having had such a positive experience integrating into life in the United Kingdom, I haven't forgotten that if we do ever decide to return to Poland while I am still in the job market, it may cause difficulties for me. Whereas my husband is working for the same company he did in Poland, and my children are receiving a sound education and not losing their language, I would not so easily slip back into the Polish healthcare system, due to a loss of general practical expertise – despite being a 'breast expert' I would still need a sound practical knowledge of the main modalities.

In the Vernacular

Language is by far the most difficult area in integrating into a foreign healthcare system, and indeed country. After two years I have not fully adapted to not only the casual Scottish vernacular spoken in the streets but also the medical abbreviations so beloved by UK doctors. As well as appalling handwriting, you have to decipher their own personal range of 'codes', in order to understand the request made by the referring physician.

My best experience working in the UK, has been getting involved in such a well-run breast imaging service, and I really feel that our patients could not possibly be better serviced. In fact the Scottish healthcare system in general is extremely well-run. My worst experience though, occurred regularly when I was on-call and in the middle of the night would get phone calls from consultants pestering me into performing exams which I did not believe were necessary. In my native country I would have no problem arguing my corner with my colleagues, but here, in the middle of the night, when my brain is dreaming in Polish, I ended up just giving in and performing the exam – I hope that with time, my language skills will give me the ability to disagree effectively when necessary.

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Cultural Exchanges

Most people in Europe know about the Erasmus/Socrates programme for university students; it is an opportunity to spend a number of months in another European university, learn the language and also learn about the culture of the host country. Young Europeans gather and interact, and often return to their home countries with a new outlook on life.

HOPE, The European Hospital and Healthcare Federation runs a similar programme for managers and other professionals working in hospitals and healthcare facilities: the HOPE Exchange Programme. The programme consists of a four-week training period and is neither medical nor technical. It is a multi professional programme aimed at professionals who are directly or indirectly involved in the management of European healthcare services and hospitals.

The programme starts in May of each year and is followed by an evaluation meeting and a seminar to which all professionals of the HOPE Exchange Programme are invited. Each year these meetings are organised in a different country by its national delegation of HOPE. During the evaluation meeting each professional is requested to contribute to a national presentation of his/her experiences abroad. The specific topic for this year's programme is "The chronic patient: A clinical and managerial challenge".

Such an exchange programme is clearly a great opportunity for professional development. Managers can gain a valuable insight into how healthcare facilities in other countries are organised, can share their experiences from their own hospitals and also learn of new initiatives/techniques to try on their return.

For more information, please visit: **www.hope.be**

ACCREDITATION FOR AMBULATORY FACILITIES

Value of International Recognition and Manager's Role

By Carlo Ramponi

Background

Several studies have demonstrated that the role of hospitals is changing; services formerly provided by hospitals are now provided by other kind of facilities, like community healthcare centres or ambulatory settings (also named outpatient clinics, policlinics, poliambulatory); further it is becoming more and more clear that hospitals are not closed systems but that there are connections with healthcare providers before and after hospital care, outside the hospital.

Hospitals in Europe are facing many different challenges like ageing populations, changing patterns of diseases, mobile healthcare professionals, new technologies and new financing mechanisms. Some recent trends, like a continuous compression of length of stay, efforts to improve quality of care, greater use of ambulatory care and home care, seem confirmed and destined to continue.

On the other hand, the concept of continuity of care is gaining more and more importance; this concept implies the development of policies to counterbalance the tendency towards overspecialisation. Monospecialty healthcare providers (like eye clinics, dialysis centres, endoscopy centres and so forth) may provide very efficient services, but this does not necessarily mean that the whole system will increase its efficiency; questions about patient safety may arise which need to be addressed.

Joint Commission International has developed several accreditation programmes covering different settings of care with the main aim of pursuing and recognising quality and continuity of care, safety of patients, and, at the same time, exploiting professional skills and organisation strengths.

Amongst JCI accreditation programmes there is a significant overlap with the main goal of integrating different phases of care, leveraging cooperation and integration among different providers, focusing on common areas of risk in addition to facility-specific risks.

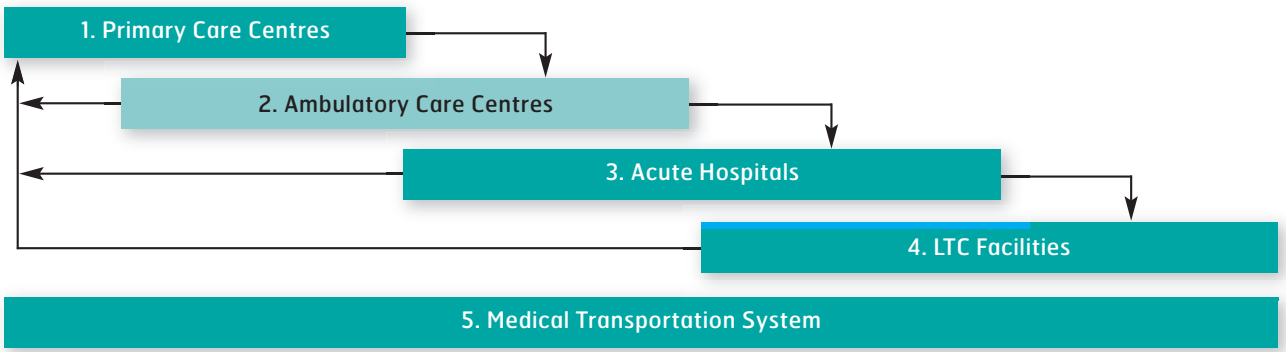
Ambulatory Care JCI International Accreditation Programme

It is quite difficult finding a definition of ambulatory care that fits with different healthcare systems, different cultures, social values and resources available. In general it can be said that the word can be used to identify a physical location where clinical services are provided to individuals on an outpatient basis. This kind of facility can be a free-standing organisation, or can be physically embedded in a facility for inpatients (hospitals, long term care facilities). And services provided may vary from basic diagnostic centres to very complex surgery or cardiac catheterisation centres. On the other hand, by outpatient JCI means persons who do not need the level of care associated with the more structured environment of an inpatient or residential programme.

Meaning of Accreditation

Accreditation is a process in which an entity, separate and distinct from the healthcare organisation, usually nongovernmental, assesses the healthcare organisation to determine if it meets a set of requirements (standards) designed to improve the safety and quality of care. Accreditation is usually voluntary. Accreditation standards are usually regarded as optimal and achievable. Accreditation provides a visible commitment by an organisation to improve the safety and quality of patient care, ensure a safe care environment, and continually work to reduce risks to patients and staff. Accreditation has

Figure 1. CONTINUITY OF CARE - JCI Accrediation Programmes



gained worldwide attention as an effective quality evaluation and management tool.

Value of Accreditation

The accreditation process is designed to create a culture of safety and quality within an organisation that strives to continually improve patient care processes and results. In doing so, organisations

- Improve public trust that the organisation is concerned for patient safety and the quality of care;
- Provide a safe and efficient work environment that contributes to worker satisfaction;
- Negotiate with sources of payment for care with data on the quality of care;
- Listen to patients and their families, respect their rights, and involve them in the care process as partners;
- Create a culture that is open to learning from the timely reporting of adverse events and safety concerns;
- Establish collaborative leadership that sets priorities for and ensures continuous leadership for quality and patient safety at all levels, and
- Grants recognition from third payers internationally and allows improvement of competitive strategies.

Ambulatory Programme Characteristics

JCI accreditation programmes are based on an international framework of standards adaptable to local needs. The programmes are characterised by:

- International consensus standards, developed and maintained by an international task force, and approved by an international Board, are the basis of the accreditation programme;
- The underlying philosophy of the standards is based on principles of quality management and continuous quality improvement;
- The accreditation process is designed to accommodate the legal, religious, and/or cultural factors within a country. Although the standards set uniform, high expectations for the safety and quality of patient care, country-specific considerations related to compliance with those expectations are part of the accreditation process;
- The on-site survey team and agenda will vary depending on the organisation's size and type of services provided. For example, a large multi-specialty ambulatory organisation may require a four-day survey by a physician, a nurse, and an administrator, while a smaller dental centre or diagnostic centre may only require a two- day survey by a smaller team, and
- JCI accreditation is designed to be valid, reliable and objective. Based on the analysis of the survey findings, final accreditation decisions are made by an international accreditation committee.

How the Standards are Organised

The standards are organised around the important functions common to all healthcare organisations. The functional organisation of standards is now the most widely used around the world and has been validated by scientific study, testing and application.

The standards are grouped by those functions related to providing patient care and those related to providing a safe, effective, and well-managed organisation. These functions apply to the entire organisation as well as to each department, unit, or service within the organisation.

Patient-Centred Standards
International Patient Safety Goals (IPSG)
Patient Access and Assessment (PAA)
Patient Care and Care Continuity (PCC)
Patient Rights and Responsibilities (PRR)
Patient Record and Information Flow (PRI)
Patient Services and Contracts (PSC)
Patient and Family Education (PFE)
Patient Anesthesia and Surgery (PAS)

Healthcare Organisation Management Standards
Improvement in Quality and Patient Safety (IQS)
Infection Control and Facility Safety (IFS)
Human Resource Management (HRM)
Governance and Leadership (GAL)

The survey process gathers standards compliance information throughout the entire organisation and the accreditation decision is based on the overall level of compliance found throughout the entire organisation.

Managers' Role

Providing excellent clinical services requires effective leadership. That leadership comes from many sources in a healthcare organisation, including governing leaders, and others who hold positions of leadership, responsibility, and trust. Each organisation must identify these individuals and involve them in ensuring that the organisation is an effective, efficient resource for the community and its patients.

In particular, these leaders must identify the organisation's mission and make sure that the resources needed to fulfil this mission are available. For many organisations, this does not mean adding new resources but more efficiently using current resources, even when they are scarce. Also, leaders must work together to coordinate and integrate all of the organisation's activities, including those designed to improve patient care and clinical services. Effective leadership begins with understanding the various responsibilities and authority of individuals in the organisation and how these individuals work together. Those who govern, manage, and lead an organisation have both authority and responsibility. Collectively and individually, they are responsible for complying with law and regulation and for meeting the organisation's responsibility to the patient population served.

Over time, effective leadership helps overcome perceived barriers and communication problems between departments and services in the organisation, and the organisation becomes more efficient and effective. Services become increasingly integrated. In particular, the integration of all quality management and improvement activities throughout the organisation results in improved patient outcomes.

Conclusions

Accreditation programmes for hospitals are quite widespread in Europe and the international programmes are increasing their penetration on the European market; the unrestrainable changes in the hospital sector parallel changes in the other healthcare sectors. The ambulatory sector is one of them and because of its increasing importance, it deserves the same kind of attention as far as quality and safety are concerned.

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THE EFFECTIVENESS OF NURSE-LED CLINICS

Increasing Patient Satisfaction

By Tamara Page and Tiffany Conroy

Coronary heart disease (CHD) and the impact it has on society will to continue to increase, as the average age of the population rises. Advances in prevention and treatment have increased survival rates in patients with CHD. Continuing interventions for patients already diagnosed with CHD impacts on further coronary events they may experience and ultimately impacts on their mortality. Many patients are aware of what they need to do to improve their health status and therefore decrease their morbidity. Nurses can assist patients to develop and maintain altered healthcare practices and this is recognised as an important advancement to their level of self-care.

One opportunity that is under-recognised in the management of CHD is the use of nurse-led clinics. A nurse-led clinic has been defined as having a focus on health rather than illness and an emphasis on life management rather than diagnosis and intervention. These attributes need to be clearly defined within the structure and function of the clinic. Nurse-led clinics are not new, but the benefits of these clinics and how they support positive outcomes for patients have not been well studied.

> A nurse-led clinic has a focus on health rather than illness and an emphasis on life management rather than diagnosis and intervention.

Reviews on Effectiveness of Nurse-Led Clinics

A systematic review on the topic of the effectiveness of nurse-led clinics for patients with CHD was completed in 2005 and identified five studies that had reviewed aspects of nurse-led clinics in relation to secondary preventative care of CHD (Page et al, 2005). These five studies evaluated interventions related to education, assessment and consultations. The interventions included the angina plan which was a nurse-led facilitated self help programme; nurse-led health education and motivational interviews for patients awaiting coronary artery bypass; audit and recall of patients initially assessed in a nurse-led clinic and recalled if the patients CHD symptoms or clinical assessment were poor; and two studies that provided secondary preventative care appointments by specialist cardiac nurses.

Clinical improvements were clearly demonstrated by the nurse-led clinics in all of the studies and these included a decrease in anxiety and depression; an improvement in quality of life, general health and lifestyle. Follow-up was improved in both nurse-led clinics and general practitioner groups of the studies and patients reported high levels of satisfaction. Other beneficial effects to patients were demonstrated, including a reduction in severity of angina and improved medication compliance. However, these were subjectively reported.

Subjective reporting has been questioned as to the reliability of self-reported outcomes (Kirvesoja 2000). However, subjectivity gives the patients perspective and ultimately this is what we want to influence and evaluate. It may be this perspective that will motivate the patient in improving their healthcare practices.

Motivating Patients for Self-Care

Many chronic disease sufferers will be motivated to attend a nurse-led clinic where they have the ability to improve life outcomes; whether it is a decrease in symptoms or an increase in the attribute they can undertake. Sometimes something as small as an improvement in how someone mobilises around their home or makes their own bed with no chest pain, is enough of an incentive for them to become involved in a service where they may be assisted to regain some function.

Additionally, general practitioners and nurses thought establishment of the clinics led to an enhanced service for patients. The nurse-led clinics are also viewed as an effective means to improve the scope and structure of care delivery, provide the ability to implement best evidence, and demonstrate a commitment to improving patient care. The benefits to patient care are what persuaded many clinicians to undertake the implementation of a nurse-led clinic. However, the sustainment of the clinics was affected by the lack of both training and resources available to both the nurse and the clinic.

Clinics Increase Job Satisfaction for Nurses

Nurse-led clinics provided benefits in addition to improved patient outcomes, including professional autonomy of nurse practitioners. In the systematic review both general practitioners and nurses thought that the clinics extended the nurses role, increased their confidence, skills and job satisfaction. Nurses also sensed that the nurse-led clinics enhanced their relationship with the patient, due to the increased amount of time spent with the patient and the enhanced continuity of care.

The review suggests that nurse-led care for secondary preventative care of CHD patients is an effective adjunct of supplementary care to general practitioner advice and care and is as beneficial as general practitioner care. The implementation of a successful nurse-led clinic is dependant on the nurse being adequately trained in the care of a patient with CHD and having clear and appropriate expectations formulated both within the clinic and within the relationship with the medical officer.

One of the studies included in the systematic review did a further follow up study and describes four themes associated with the successful implementation of a nurse-led clinic;

- Patient care (the perceived idea that the clinic will improve patient outcomes),
- Development of nursing skills (training and support issues),
- Team working (communication, support and sharing the same belief), and
- Infrastructure (staff shortages and financial incentives).

Conclusion

Nurse-led clinics have revealed both clinically sound and perceived benefits to the patient, by focussing on promoting health traits and putting emphasis on cardiac management. Nurse-led clinics are an effective adjunct to general practitioner clinics; however the nurses should be adequately trained to be able to manage each patient's preventative care effectively and according to previously defined clinic guidelines.

The financial benefits have not been adequately studied, but perceived benefits from improved cardiac health and possible decreased admission rates will equate to the increasing number of patients with CHD becoming less of a financial burden on the healthcare system. Current community requirements would support nurse-led clinics as a preferred model of care.

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Nurse-Led Clinics

Nurse-led clinics are an increasingly popular phenomenon that have been endorsed in the UK from the 1990s. They are often regarded as a key step in the modernisation of healthcare and are found in hospital out-patient departments, GP surgeries and health centres.

But why develop a nurse-led clinic?

For patients, such clinics can:

- Provide a patient-centred approach to the management of chronic diseases;
- Offer increased patient access;
- Provide quicker access to medicines;
- Shorten hospital stays, and
- Provide vital psychological support.

There are also benefits for doctors. Clinics:

- Free up doctors' time allowing them to see more patients, and
- Foster increased cooperation and collaboration between nurses and doctors.

For nurses, nurse-led clinics encourage professional development. Nurses have:

- More autonomy;
- The ability to make detailed care decisions (admit, discharge, refer), and
- The opportunity to focus on the key nursing activities (counselling, teaching and health promotion).

Richard Hatchett, author of Nurse-led Clinics: Practice Issues, outlines ten key steps for the successful running of a nurse-led clinic:

1. Build a business case
2. Define aims and objectives
3. Establish patient criteria
4. Plan publicity
5. Select location
6. Gain support from colleagues
7. Plan your professional development
8. Consider medicines management
9. Plan audit and evaluation
10. Facilitate ongoing improvement

For more information:

Please see Hatchett, R. (2008) Nurse-led clinics: 10 essential steps to setting up a service. Nursing Times; 104: 4, 62–64.

PAPT
— PATIENT ADMISSIONS PREDICTION TOOL

By Justin Boyle

Evidence-based research demonstrates that overcrowding in emergency departments causes ambulance diversion, increased hospital lengths of stay, medical errors, increased patient mortality, financial losses to hospital and physician, and medical negligence claims.

Many hospitals still do not anticipate and prepare for the next day's volume and admission through the emergency department. And yet, contrary to the conventional wisdom that emergency patient volume is highly unpredictable, the number of admissions per day can be predicted with remarkable accuracy.

Forecasting presentations and admissions is a relatively easy solution. When implemented, it can protect everyone's access to emergency care.

In April 2008, the American College of Emergency Physicians (ACEP) published a report identifying solutions to the practice of 'boarding', or holding, patients admitted to the hospital in the emergency department, which is the primary cause of overcrowding. A boarded patient was defined as a patient who remains in the emergency department after the decision to admit him or her to the hospital has been made. Most emergency departments in the world are critically overcrowded and unable to respond to day-to-day emergencies, and the proposed solutions address the growing global crisis that is harming public access to lifesaving emergency care.

Solutions with the highest impact in reducing boarding and improving the flow of patients through emergency departments are:

- Move emergency patients who have been admitted to the hospital out of the emergency department to inpatient areas, such as hallways, conference rooms;
- Coordinate the discharge of hospital patients before noon, and
- Coordinate the scheduling of elective patients and surgical patients.

Research Study: A Clinically Usable Software Package

The main aim of our study was to develop and validate a clinically usable software package that accurately predicts the number of admissions sourced from emergency department cases on any given day of the year, taking into account peak periods such as public holidays. The primary outcome measure was the accuracy of forecasts when validated against historical data from two differing hospitals. The resultant Patient Admissions Prediction Tool can assist with the allocation of inpatient beds to alleviate overcrowding.

The modelled data consisted of five years of ED presentations and admissions (1/7/02 – 30/6/07) from two hospitals chosen for their different demographic characteristics. Hospital A is a 280-bed regional facility, located 120km away from a major tertiary referral centre and services an area of approximately 410,000 km^2 with a resident population of about 280,000. Hospital B is a 750-bed busy urban facility and services a rather itinerant population of around 500,000. It is host to several annual events that attract large amounts of tourists. Despite their differences, presentations numbers for both hospitals across the five years

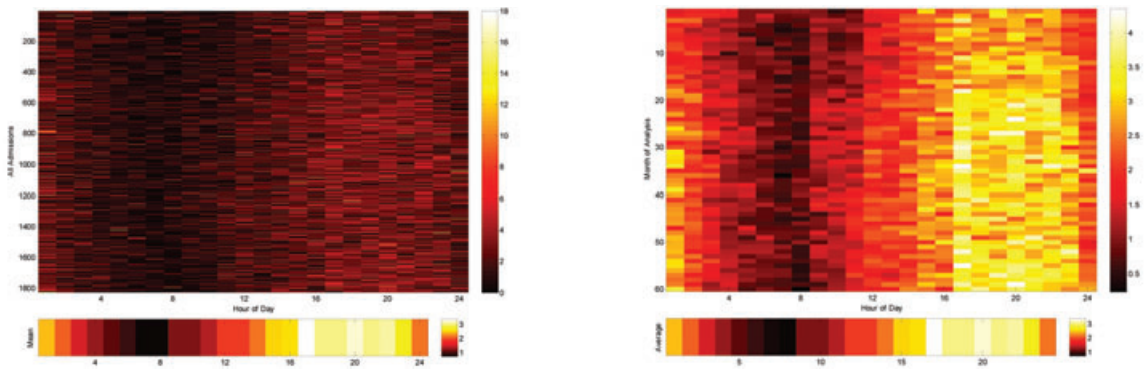

Figure 1. Peak admission times for patients leaving the ED;
Left: Admissions across every day in study period; Right: Monthly averages across study period.

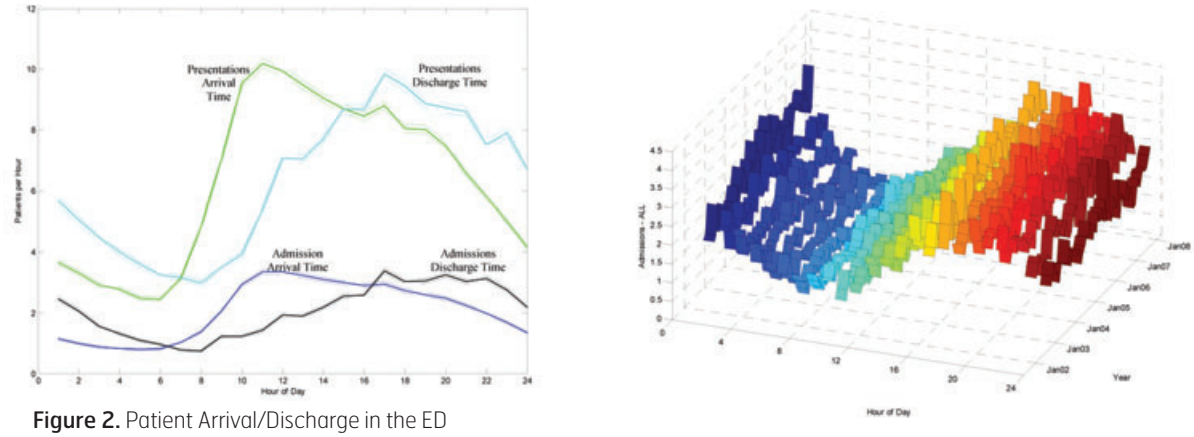

Figure 2. Patient Arrival/Discharge in the ED

were similar (218,000 – regional Hospital A, 278,000 – urban Hospital B). The urban hospital has a higher rate of admissions (33%) than the regional hospital (20%).

Many useful characteristics that can help shape health management practices have been identified from the data. For example, the date and time when admitted patients leave the ED, indicating the times of highest demand on hospital beds; patient arrival time in the ED, which represents a staffing impact with workload; and the days of the week which represent higher ED workloads and hospital bed demand. The data also enables the analysis of 'frequent-flyers' – those patients who presented multiple times during the analysis period.

From the analysis of this data, we have been generating forecast estimates and associated confidence intervals based on several forecasting approaches and validating the forecasts against actual data. The project also included packaging the most accurate technique into a stand-alone software application.

Data Analysis

The data includes date and time of admissions which provides useful information on peak admission times experienced within the EDs. Figure 1 indicates the times of highest demand on hospital beds (admitted patients leaving the ED), indicated by a brighter colour. The vertical columns of the plots indicate the hour of day, and admission numbers are indicated by the colour bar. It is apparent that the highest demand for hospital beds occurs in the afternoon and into the evening. Every row on the left-hand plot represents a day from 1/7/02 – 30/6/07, while the rows on the right-hand plot indicate monthly averages throughout the study period. Similar assessment has been done for discharge times of all presentations (not just those admitted) and also for arrival times within the ED. The skew of the data to the end of the day is apparent.

Another point of interest is the time of arrival in the ED, as this represents a staffing impact with workload. Figure 2 shows the ED discharge time for the admissions that are shown in Figure 1. This discharge time refers to the time patients leave the ED and require a bed, as opposed to discharges leaving hospital. It also indicates the arrival time for this group, which peaks around 11:00hrs. However, admitted patients make up only a small subset of all the patients seen in the ED, and the two curves in the upper portion of the plot represent all presentations. We can see that the mean peak discharge time lags behind the peak arrival time by around eight hours and again see the skew of the data to the end of the day.

The hourly fluctuations of the data has also been studied using box-plots as shown in Figure 3, which show, for example, the quietest time (8am) and the busiest time (5pm) for admissions. Median, upper and lower quartiles and outliers are represented in the plots.

It is also of interest to determine the days of the week that represent higher ED workloads and hospital bed demands. For example, Figure 4 shows the mean and 95% Confidence Interval band for the daily and monthly trends in the arrival time of all presentations (Left) and for admitted patients (Right) at the urban hospital. The busiest days for presentations are over the weekend and Mondays. Considering the arrival time for just those patients that are admitted, it can be seen that Mondays and Tuesdays are the busiest days. There has also been an overall increase (approximately 40%) in the number of patients presenting over the five years. Interestingly the trend over all the months-of-analysis for admitted patients shows a plateau effect, which could be attributed to bed capacity being reached, or the adoption of hospital avoidance strategies.

Forecasting

From the analysis of this data, we have been generating forecast estimates and associated confidence intervals based on several forecasting techniques. This modelling included stepwise multiple regression, exponential smoothing and Box-Jenkins Autoregressive Integrated Moving Average (ARIMA) models.

In our study, accuracy was treated as the main criterion for selecting a forecasting method, and the metric used in our evaluations was the Mean Absolute Percentage Error (MAPE). Data was divided into a training set and evaluated against a separate hold-out set. The evaluation dataset spanned one year (364 days), allowing accuracy to be measured across summer and winter months and varying forecast horizons. The effect of varying the size of the training dataset was analysed and training lengths of one, two, three, four and 4.3 years were assessed. Also computed were the width of 95% prediction intervals (± x admissions) and the number of misses outside this prediction interval. This provides the user of the forecasts with worst

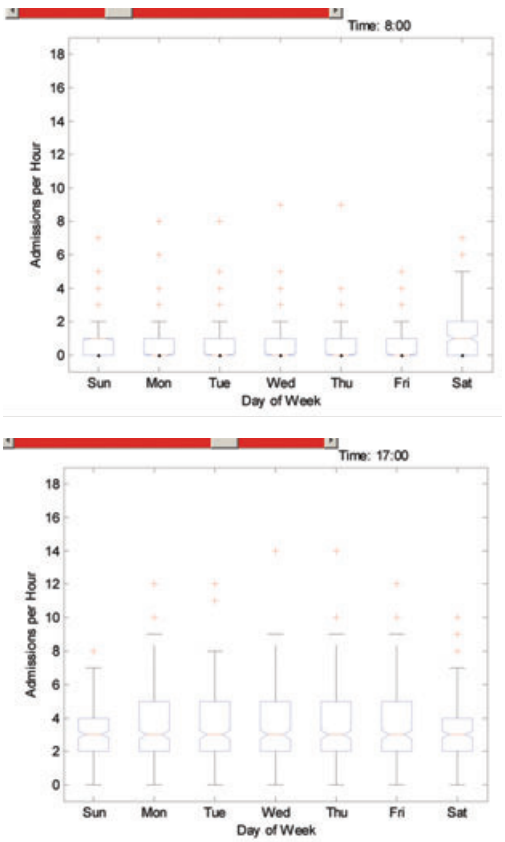

Figure 3. Box-plots of hourly admissions; Top: 08:00hrs, Bottom: 17:00hrs

and best case estimates and a sense of how dependable the forecast is.

Results

Presentations to the ED and subsequent admissions to hospital beds are not random and can be predicted. Forecast accuracy worsened as the forecast time intervals became smaller: when forecasting monthly admissions, the best MAPE was approximately 2%, whilst for daily admissions this was 11%, for four-hourly admissions: 41%, and for hourly admissions: 51%. Presentations were more easily forecast than admissions (daily MAPE ~7%). Subgroups within the data with more than 10 admissions or presentations per day had forecast errors statistically similar to the entire dataset.

The best method for forecasting data used in our study was averaging (smoothing) using a four-year training period, and potential exists for the model to be implemented in other facilities. Sensitivity analysis showed that smoothing techniques worked best with as much historical data as possible, but regression was best with the most recent data.

When compared to existing prediction models at one of the hospitals, the new techniques shave Mean Absolute Percentage Error of daily admission predictions from 20% to 11%. Based on a mean admission rate of 50 admissions per day, this improvement in forecasting performance corresponds to ±5 beds. When a new ED wing opened in the catchment area, the error from existing predictions worsened to 30%, whilst error from the new models was 11.8%. This improvement in forecasting performance corresponds to ±9 beds.

The admissions and presentations predictive modelling has been implemented as a standalone software application. The programme has been designed to run in an unsupervised manner, where forecasts for admissions and presentations are refreshed every hour. It is also possible to run the programme once or repeatedly for a specific date. Initially this choice is determined from the welcome screen, along with the confidence limits to adopt for prediction intervals. The project has also resulted in the development of a User Experience Base via detailed consultation with ED and bed management planning staff to identify user expectations and functional requirements for a prediction tool.

Conclusion

As a result of this study, it can be concluded that accurate forecasting tools are important aids to many areas of hospital management, including elective surgery scheduling, bed management, and staff resourcing. We have produced a tool that can predict ED admissions and thus allow appropriate allocation of in-patient beds and operating theatres. With regular feed of site specific retrospective data, this tool should have considerable utility for acute facility bed management and health service planning.

The project team have identified an extension of this project to formally evaluate the impact of the prediction tool in these areas. Such evaluation is essential to quantify the potential benefits of the model such as reduced ambulance bypass occurrences and elective surgery cancellations. Future research into this aspect has recently commenced.

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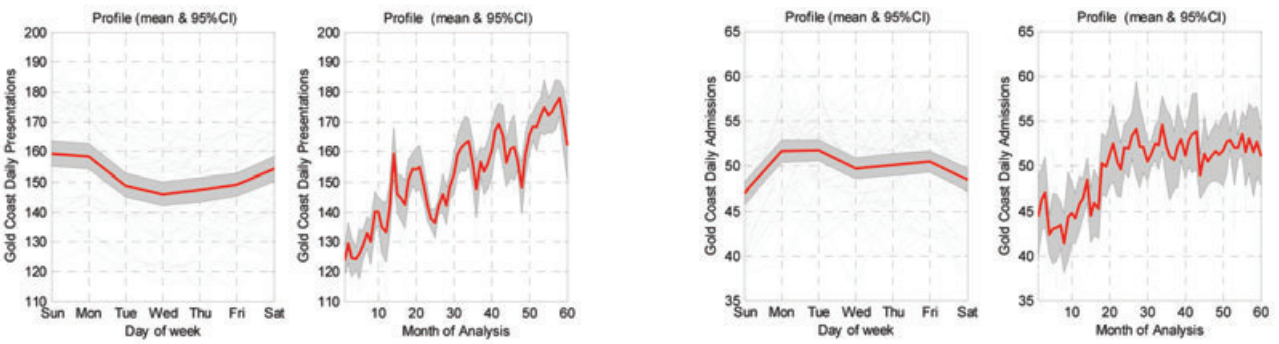

Figure 4. Peak admission times for patients leaving the ED; Left: Admissions across every day in study period; Right: Monthly averages across study period.

THE ITALIAN HEALTHCARE SYSTEM

The Italian National Health Service (INHS) was established in 1978 to grant universal access to a uniform level of care throughout Italy, financed by general taxation.

The INHS provides universal coverage and free healthcare at point of delivery to all Italian and European Union citizens. In spite of this, there are considerable variations in coverage and service quality between the richer and better covered regions of the north and the poorer ones in the south.

Key Actors

The key operational actors consist of 21 Regional Health Authorities (RHAs) and approximately 200 Local Health Authorities (LHAs) which serve geographical zones with mean populations of about 300,000. Together, they are responsible for ensuring the delivery of healthcare services by means of public and private accredited hospitals and other facilities.

Reforms Shake up Roles and Responsibilities

In Italy, a major reform of the Constitution (Constitutional Law number 3 of October 18th, 2001) radically modified the roles and responsibilities of the State and the Regions.

At the national level, authorities are responsible for ensuring that the general objectives and principles of the healthcare system are met, including definition of the basic benefits package ('livelli essenziali di assistenza' or LEA, which must be uniformly provided throughout the country). The traditional welfare state maxims of universal coverage, dignity and equity have in recent decades been joined by principles of effectiveness and cost-effectiveness.

The Regions now have law making powers on health protection, within the framework of fundamental principles defined by the State. All Regional Authorities have a considerable degree of powers to legislate on a regional basis and freely allocate funds received from the central government, in particular for healthcare delivery. Major policy decisions are however agreed by an inter-institutional 'State-Regions Conference', which is constituted by representatives of national Ministries and the Regional Authorities.

Full Spectrum Coverage

Healthcare services cover the whole spectrum, from visits to family doctors and specialists to in-patient treatment (tests, medication and surgery) and post-operative rehabilitation as well as ambulatory care and outpatient treatment. The INHS also pays for part or all, of the cost of drugs and medicines. Emergency health provision is available to all residents (as well as visitors).

Facts and numbers		Date
Population (million)	58.78	2006
Live births/1,000 pop	9.2	2003
Deaths/1,000 pop.	9.8	2000
Life expectancy (years)	78 (male) and 84 (female)	2006
GDP (billion EUR)	1,572.2	2008
Total healthcare expenditure (% GDP)	9.0%	2006
Total healthcare expenditure per capita (PPP USD)	2,623	2006
% of healthcare system financed by public funds	76.4%	2004
Number of CT scanners (per million inhabitants)	24	2004
Number of MRIs (per million inhabitants)	11.6	2004
Number of acute care hospital beds (per 1,000 inhabitants)	3.4	2005
Length of stay (average in days)	6.7	2006
Number of physicians (per 1,000 inhabitants)	6.2	2005

Source: OECD, Eurobarometer, WHO, Istituto Superiore di Sanita (Rome), Nielsen and International Telecommunications Union (for Internet statistics).

Tariffs, Reimbursement and Insurance

Hospitals are reimbursed by the INHS according to a national diagnosis-related group (DRG)-like system. National-level tariffs cover the cost of public hospital admissions throughout the country. The RHAs can add further tariffs for specific activities (such as psychiatric services) that are not covered by national tariffs. Private hospitals are reimbursed to the same DRG-specified level, and additional costs borne by patients – through private insurance schemes.

Many Italians and foreigners opt to take out private health insurance in addition to the basic State cover. Among other benefits, private insurance provides freedom in choice of family doctors and/or specialists and the right to be treated in private hospitals. In many cases, private facilities reduce the waiting time for a specialist appointment or a surgical intervention. They also offer more freedom in visitation rights and standards of accommodation. However, the quality of medical care in State and private hospitals are roughly similar (surgeons typically work for both the State and private sectors).

Mixed Private-Public Models - a Beginning?

Certain Regional Health Authorities have reached agreements with private hospitals allowing patients to be treated under the INHS. This has shortened waiting lists at public hospitals, but lengthened them at private facilities. In addition, a court decision sometime ago ruled that a patient whose life was endangered because of waiting lists could seek treatment at a private hospital without having to obtain advance permission from the Regional Health Authority, and still be covered for costs by the INHS.

Sources and Composition of Healthcare Financing

The financing of healthcare in Italy is mixed. The country has one of Europe's highest rates of private, out-of-pocket healthcare spending (about 25% of total). According to some estimates, almost 35% of Italians access private care in one form or another.

Although one of the principal goals behind the establishment of the INHS in 1978 was to quickly move toward a national tax-based system, social health insurance contributions still represented more than 50% of total public financing for another two and a half decades. In 1998, social contributions were replaced by a regional business tax; this is supplemented with a national grant financed by revenues from value-added tax (VAT) collections to ensure sufficient resources for each region.

Co-Payments

Out-of-pocket/private payments include co-payments for diagnostic procedures, medicines and ambulatory specialist consultations. Users have to pay costs of outpatient care up to a 36 Euro ceiling since 2000. Co-payments for drugs and ambulatory services have a restricted role, accounting for a 4.8% peak of total INHS revenues in 1996, and then declining to below 3% in 2002 after co-payments for prescription drugs were abolished.

Patients however continue to need to make out-of-pocket payments for non-prescription medicines and directly purchase private healthcare. An estimated 15% of the population has complementary private health insurance. This is either individually subscribed or offered by employers. About two out of three health insurance companies are for-profit while one third are non-profit organisations.

Private Insurance Still Loosely Coupled

In contrast to EU countries, such as Belgium, Germany and France, Italy's private insurance sector is very loosely integrated to the public sector. As a result, private insurers tend to mainly substitute for INHS services rather than complement them.

The most frequently used private health services covered by for-profit health insurance are diagnostic and outpatient visits, but their share in reimbursed monies is small. By contrast, in-patient surgical care accounts for only a fifth of demand but over two-thirds of total reimbursement.

The Second Best Healthcare System in the World: WHO

Overall, the Italian healthcare system is one of continuing transition. In spite of occasionally severe criticism, not least from within the country, the World Health Organisation ranked the country as having the world's second best healthcare system, after France. (The World Health Report 2000).

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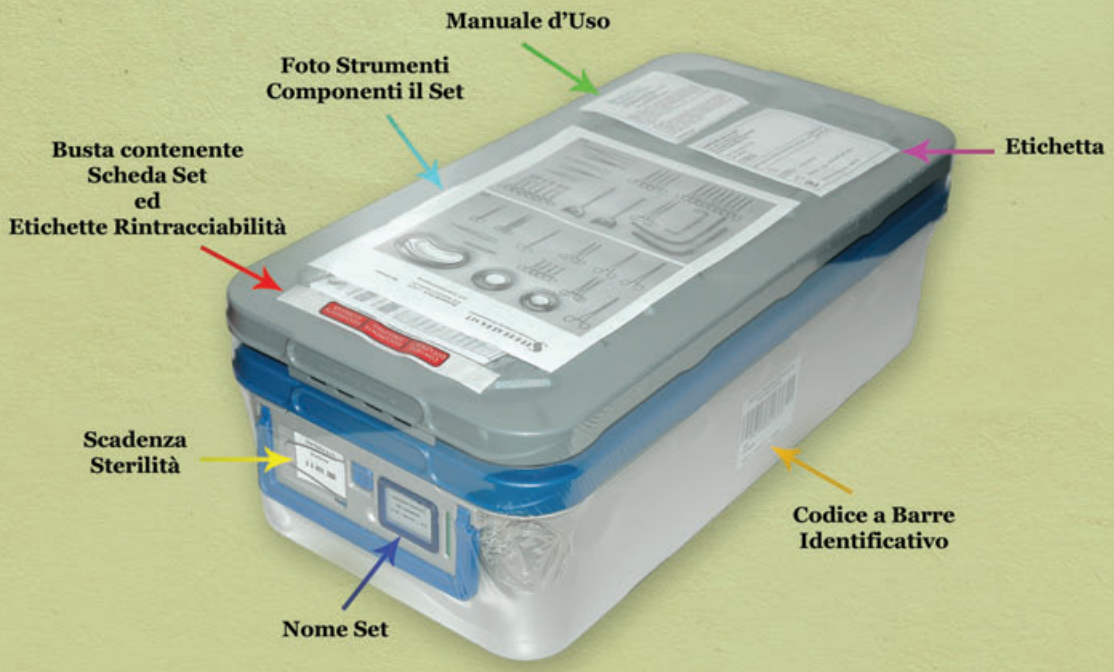

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Il prodotto è conforme alla **Direttiva 93/42/EEC – Allegato V (Marchio CE)** ed il servizio viene erogato in regime di qualità **UNI EN ISO 9001:2000 e UNI CEI EN ISO 13485-2004.**

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RECENT DEVELOPMENTS IN THE ITALIAN HEALTHCARE SYSTEM: A LOOK FROM DIFFERENT PERSPECTIVES

By Dario Rosini

The Italian healthcare system is changing. Like most other European countries, the system is suffering from a lack of resources. Italy is also experiencing the regionalisation of healthcare management, which in turn brings its own problems. Focus is shifting from inpatient towards primary care and cost rationalisation is fast becoming a new trend. This article will discuss these four main developments and how citizens, professionals, managers, politicians and private providers have often very different perceptions of these changes

Regionalisation of the Healthcare System

Healthcare is a regional matter in Italy. Since 1992, the Italian healthcare system has been regionalised but the national government still plays a key role. The government remains entitled to build the national strategic health plan (to be issued every three years) and to decide how many resources have to be assigned to the public healthcare system.

Agreements on these issues between the national and regional government are discussed and pursued in the National Board for Regional Health Policies Coordination and Affairs. The state role is designed to ensure common basic levels of assistance are provided in all regions but leaves the regional administrations free to increase those levels using their own resources.

Healthcare funding constitutes almost 70% of each regional budget and healthcare matters have often a strong impact on media and citizens. For these reasons, politics at both regional and local level tend to be very interested in controlling this sector. Indeed the regional administrations have become holdings with strong power in both steering demand and providing supply. This process pushes for a strong integration among managerial actors but on the other hand it tends to reduce their autonomy in facing the internal competitive market they operate in.

The main consequence of regionalisation is represented by the development of two different ways of thinking on how to deliver health to citizens and the role the regions play. The first one (mostly adopted in regions led by centre right parties) lets the market play a significant role by distinguishing providers from buyers and entitling the client to choose the provider he prefers, public or private. The second one (mostly adopted by centre left regional governments) is based on the network concept and tends to emphasise cooperation among actors operating in the demand and supply sides. This model tends to steer the citizen choice and considers private providers as supplementary actors to deal with when there is a clear need to increase public supply due to higher demand levels.

Also differentiation in the quality of service delivery has grown as a consequence of regionalisation and this has led to significant movement of patients mostly from southern regions to central and northern ones.

Reducing the negative effects of regionalisation is not easy; there is always the risk of punishing those regions that are more active in containing expenditure. Therefore the most important attempts made at central level to monitor and manage this trend are focused on signing agreements which aim both to create a common language among the 21 regional health systems and to help regions with poor performance records to improve their situation.

Performance measurement is another necessary consequence of regionalisation. Indeed, regions cannot be assessed solely on their ability to comply with economic and financial agreements signed with the central governments. Their efforts also have to be taken into consideration under parameters of output and outcome. For this reason many performance measuring systems are now being experimented.

Lack of Resources

Since Italians are getting older and chronic diseases are increasing, the growth of public funds annually assigned to the healthcare sector appears no longer adequate to ensure the present basic levels of assistance.

According to the latest OECD health data the Italian health expenditure in 2006 was 8,7% of GDP, less than the OECD average (8,9%). However it has to be highlighted that the public slice of this expenditure is 6,7% of GDP, more than the OECD average

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(6,5%). Moreover, from 2003 to 2007 regions have generated a deficit of about 22 billion euros. These problems will probably force the system to redefine levels of assistance ensured by public funds. The right to health will probably have to be redefined.

Other possible initiatives to counterbalance this trend already put into practice are cost rationalisation, an increase in taxation and other solutions like the introduction of supplementary health insurances.

At a central level, strict budget limits are continuously discussed by the National Board for Regional Health Policies Coordination and Affairs. In case acceptable agreements among regional administrations and national government are not reached, financial limits are imposed directly by national law. At a regional level these agreements or limits are implemented by designing interventions on the cost side (mostly based on appropriate reduction of hospitalisation and on rationalisation) or by acting on the revenue side. In this respect some regions (e.g. Toscana, Emilia Romagna and Marche) prefer to stress cost rationalisation and to emphasise appropriateness of treatment, others (e.g. Lombardia, Lazio) act mostly on the revenue side by raising taxation level or by imposing additional tickets for patients.

While the first way of approaching the problem is met with antagonism by professionals because of their disinclination to fix priorities and to consider costs as a limit to their activity, the second one tends to be less appreciated by citizens and creates the conditions for a heavier role for private providers in the national public healthcare system.

Shifting from Inpatient to Outpatient Treatments

One interesting way to reduce cost and to contribute to citizens' health consists of developing outpatient treatments and promoting a strong reduction in hospital admissions. To have an idea about actual dimension of effort requested to the regions, the new agreement on health now under discussion between central governments and regions talks about a reduction of 27,000 beds (public and private operating under licensing agreement) by 2014. In the meantime outpatient services should grow.

The real problem concerns the synchrony of changes. In most cases outpatient services need a considerable amount of time to be fully operative and capable of receiving the flow of patients from hospitals. At the same time, since resources are limited, it is not possible to invest more resources in outpatient services before disinvesting them from hospitals.

The appropriateness of treatments and the respect of scientific guidelines are signalled as the main drivers of this change process but political motivesplay a major role. Indeed reducing hospitalisation means a significant reduction of regional spending and possibility to comply with budget limits agreed with national government.

Shifting the focus from inpatient to outpatient is mostly about the need to lessen the burden on hospitals. Managers and hospital professionals see this change as a threat and it is quite difficult to ask them to spend necessary efforts to develop networks and to define common, more appropriate paths together with their outpatient colleagues.

One interesting consequence of this process concerns private providers. In the past they have mostly focussed on hospital services but now outpatient services have started appearing as an interesting business opportunity: less investments are required and demand for these kinds of services are growing very fast.

Cost Rationalisation

Due to the lack of resources, most regions are now looking for other solutions to reduce costs. One consists of rationalising the support processes not directly concerned with the core business of public companies providing health services. Supporters of this kind of intervention argue that these processes can be drained from the activities of public companies with no matter/little consequence or danger for citizens or the companies. Moreover, they expect the same to be managed efficiently at a higher integrated level. This attempt has some important consequences:

a) Professionals are losing their traditional contact with drug and equipment providers;

b) Trade unions tend to resist this trend because they see this change as a hidden attempt to privatise some public jobs, and

c) For private providers of support services new interesting business opportunities are growing.

Another cost cutting intervention being widely discussed now in the Italian healthcare system is a different organisation regarding the use of hospital space and beds. Traditionally hospitals were organised along the lines of clinical specialties or departments. The new way to organise allows the top managers to decide how to use space and beds while multi-disciplinary teams of clinicians are in charge of treating patients according to the level of care required.

As a consequence, significant parts of hospitals are now dedicated to week surgery: open days are Monday to Friday and the first part of the week is taken up with elective surgery and other planned treatments. After some days of recovery, patients can be discharged before the weekend. Evaluation of this model is ongoing.

Both health planners at regional level and managers are attracted by this kind of organisation but its implementation is not easy because medical middle managers, even though they would not admit it, don't want to lose control of their traditional resources (beds, nursing staff and equipment). At the same time, experiences of full implementation of this kind of organisation are very rare and best practices to be followed are difficult to find.

Conclusions

The Italian healthcare sector is changing rapidly and the new direction is quite clear: a stronger role for regions, more responsibility at managerial level, less hospitalisation for patients and outsourcing of all "no core" activities. All traditional actors are conscious of this new direction but their compliance to change is not fully ensured. On the other hand new actors are coming into view and seem more interested than traditional ones in speeding up this change process. How these changes will take place is still unclear but what is certain is that change is imminent.

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INTRODUCING **ANMDO**

L 'A.N.M.D.O. is the National Association of Physicians and Hospital Management in Italy. The President is Dr. Gianfranco Finzi of the University Hospital St. Orsola-Malpighi in Bologna. The Association was formed in Turin on March 21 1946, when the Constitutive Act of the Association was signed by Prof. Foltz and Prof. Giorgetto Pino Negri.

The Association is divided into two sections: union and scientific section. The purpose of the union section is to represent the Association on hygiene and organisational issues and to establish any relations and agreements with other professional unions.

The scientific objectives are as follows:
1) Improving the organisation of hospitals and public health in terms of planning, organisation and administration, hygiene and welfare;
2) Promoting, by means of training, management training courses in accordance with existing regulations, travel and study meetings, the best technical and professional training of doctors;
3) Work with the health authority also for the purpose of modernising the existing provisions on hospital and public health;
4) Issue specific cultural events in the interests of the whole body for hospitals and clinics and doctors;
5) Directly protect the reputation of managers and clinicians in all respects, and
6) Promote cultural exchanges with other similar foreign associations.

In carrying out its activities, the Association may make use of the partners of those people (members or non members) who voluntarily offer their collaboration, the work of its employees and consultants, contributions and funding of institutions, entities or third parties and supporters of constituted heritage.

In furtherance of the purposes of the Association and for the better organisational, managerial and programmatic functioning thereof, the governing bodies can draw on appropriate working groups and / or technical and / or study structured and organised as needed.

The following "ordinary members" may be enrolled in both sections (union and scientific):
a) The medical staff and / or contract staff serving in the Medical Office and Medical Management of Presidio Ospedaliero, the Hospitals, the University Hospitals, public hospitals heads of Local Health Agencies, the IRCCS public and private hospitals classified of the Foundations of public health and private hospitals of private law (nursing homes), and other nursing facilities, however denominated;
b) The Medical Director of hospitals under contract, the Local Health Agencies, the University Hospitals, the IRCCS public or private, public hospitals heads of Local Health Agencies, Hospitals classified conventions and hospitals under private law (nursing homes) and other nursing facilities, however denominated;
c) Physicians involved in the organisation of territorial services and district social health dependent both on five-year contract;
d) The medical specialists in Hygiene and Preventive Medicine or equivalent discipline unstructured, with a frequency continuously documented at the Health Department referred to the previous letters. a) and b), or from social and health districts;
e) Medical hygienists working as Managing Director of Hospitals and Local Health Agencies, doctors or public health workers in service planning and organisation of the regions and autonomous provinces, ministries and regional health agencies and national health institutions already belonging to careers in public health.

The Association is organised in regional bodies, inter-and Autonomous Provinces.

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Information: **info@anmdo.org**

Paul Castel

L'HÔPITAL ET LA CRISE

Le devenir des établissements de santé est une préoccupation forte de l'ensemble des citoyens européens qui transcende largement les différences des modèles d'organisation des soins existant au sein de l'Union. Pour autant, il est étonnant de constater que cette question a été presque totalement absente des récents débats qui ont précédé les élections au Parlement européen. Les thèmes de réflexion ne manquent pourtant pas et, s'il est vrai que le système hospitalier est encore un domaine que les instances européennes investiguent peu, nombreuses sont les problématiques communes qui mériteraient, si ce n'est des solutions, au moins une analyse commune, tant leurs logiques dépassent les cadres nationaux.

Il en est ainsi de la question des effets de la crise sur nos hôpitaux. La période que nous traversons actuellement soulève de ce point de vue bon nombre d'interrogations sur les moyens à mettre en œuvre au sein de nos établissements respectifs pour dépasser cette crise... ou plutôt ces crises. En effet, le mot « crise » revêt plusieurs acceptions qui sont autant de défis posés aux hôpitaux :

▸ Crise du modèle hospitalier lui-même, tout d'abord, qui renvoie partout en Europe à des débats passionnés sur le modèle d'organisation des soins le plus efficace et le plus efficient. Alors que les systèmes divergent sensiblement au sein de l'Europe, force est de constater que les interrogations sont les mêmes quant à la pertinence des choix d'organisation faits par le passé et les inquiétudes sont similaires quant à la capacité des systèmes à surmonter les difficultés.

▸ Crise économique et sociale ensuite, aucun des pays de l'Union n'étant épargné par la question fondamentale de l'équilibre économique de leur modèle. Partout, les déficits sociaux ne cessent de se creuser posant avec acuité la question de la pérennité des organisations et de la protection sociale.

▸ Crise financière également, qui loin d'être limitée à la seule sphère économique, a touché de plein fouet nos établissements. Ainsi, l'énorme ralentissement de l'activité que nous connaissons depuis bientôt un an présente des dangers graves pour la santé financière des hôpitaux : accentuation des déficits publics, difficulté à accéder à l'emprunt, réticence à investir dans des projets structurants, insuffisance de liquidités... La liste pourrait être encore allongée et démontre, s'il en était besoin, qu'une réflexion à l'échelle européenne serait nécessaire et pertinente face à une problématique qui dépasse largement le seul cadre national.

▸ Crises sanitaires enfin, auxquelles nos hôpitaux ont déjà eu à faire face au cours de leur riche histoire mais qui, à l'heure de la mondialisation, prend une dimension nouvelle. C'est ainsi que la pandémie grippale, qui devrait toucher le vieux continent cet automne, va une nouvelle fois mettre en première ligne les établissements de santé. Partout, ceux-ci se préparent activement à accueillir et à prendre en charge la population, à leur offrir les soins les plus adaptés, constituant ainsi un maillon essentiel de l'organisation des états et surtout de la solidarité nationale.

Crise : un seul mot, plusieurs réalités, mais à chaque fois le même constat, celui de l'extraordinaire capacité d'adaptation de nos hôpitaux et de la force des valeurs qu'ils incarnent : solidarité, protection des plus faibles et souci constant d'aller de l'avant malgré les difficultés.

À l'heure où l'Europe semble en quête de sens, gageons que ces valeurs hospitalières l'inspireront et lui permettront de redonner aux citoyens une vision commune de leur avenir.

Paul Castel
Président de l'AEDH

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VERS UNE COOPÉRATION ÉQUILIBRÉE DES ACTEURS PUBLICS ET PRIVÉS

L'Association européenne des directeurs d'hôpitaux « European Association of Hospital Managers (EAHM) » vous invite à assister à leur prochain séminaire qui se tiendra à Düsseldorf en Allemagne le 20 Novembre 2009.

La plupart des pays européens ont évolué vers un système hospitalier mixte. On distingue les hôpitaux publics, les hôpitaux privés à but lucratif et des hôpitaux privés à but non lucratif.

Les directeurs d'hôpitaux des différents pays d'Europe ont chacun leur propre expérience des pratiques publique et privée. Les hôpitaux privés sont souvent obligés de prendre part à la fonction publique tandis que les hôpitaux publics s'efforcent de développer des activités privées par souci de rentabilité.

Les gestionnaires des hôpitaux sont aussi soumis à des pressions différentes, depuis les contraintes financières jusqu'à la responsabilité de l'établissement. Ainsi, le benchmarking ou l'analyse comparative pourraient s'avérer extrêmement utiles, leur permettant de comparer les différentes possibilités d'organisation de la délivrance actuelle et future des soins dans leurs hôpitaux.

Quelles sont les différences (et l'impact) sur le niveau de qualité, d'équité, le budget, etc. ? Quelle est la meilleure solution pour le patient ? L'externalisation d'activités spécifiques dans les hôpitaux publics est-elle une bonne solution ? Quel est le meilleur développement de l'organisation des soins de santé en période de crise financière ? Quel est son impact sur les conditions de travail pour les hôpitaux publics et privés ?

Le but de ce séminaire est de favoriser la compréhension de ces différents modèles par leur présentation et explication, et d'aider les participants à rechercher les options qui s'accordent le mieux à leur situation particulière et au système, ceci afin d'être mieux préparés aux futures prises de décisions.

Le programme

Après un bref aperçu de la situation actuelle des acteurs publics et privés à travers l'Europe et sous la lumière des facteurs devant être pris en compte pour analyser l'organisation des soins de santé, nous écouterons les points de vue de deux intervenants, l'un défenseur du modèle hospitalier public, l'autre du modèle hospitalier privé, nous parler chacun de sa contribution et des avantages de son système dans la prestation de soins de santé.

Dans l'après-midi, trois intervenants venus de pays différents prendront le relai afin d'informer objectivement les participants de leurs expériences avec les acteurs publics et privés des soins de santé et de la coopération qui existe entre eux. Enfin, une table ronde se tiendra avec les intervenants, vous donnant l'occasion de leur poser des questions.

Le séminaire se tiendra simultanément aux assemblées générales 2009 de l'EAHM et du German Hospital Day pendant la plus grande foire commerciale médicale, MEDICA.

Le séminaire se fera en allemand et en anglais. La participation est gratuite mais l'inscription est requise. Vous trouverez tous les détails concernant le séminaire et le formulaire d'inscription sur le site de l'EAHM, **www.eahm.eu.org.**

Des stratégies pour surmonter la récession
Par Richard L. Gundling

La récession économique a été difficile pour les hôpitaux américains et européens à presque tous les niveaux mais un bon nombre de ses gestionnaires financiers ne s'avouent pas vaincus face à cette crise financière, reconnaissant que les mesures qu'ils prennent aujourd'hui pour réduire les coûts, maximiser leurs revenus et conserver des liquidités vont rendre leurs établissements plus forts, plus efficaces et suffisamment confiants pour répondre rapidement aux difficultés économiques de demain. HMFMA a découvert neuf stratégies clés pour surmonter la récession : garder l'accent sur la valeur, renégocier la conception et les coûts de la chaîne d'approvisionnement, être franc avec les employés et solliciter leur coopération, accorder la dotation en personnel au nombre de patients, poursuivre les innovations dans la gestion des recettes pour conserver des liquidités, établir d'étroites relations de travail avec les médecins, élaborer des plans budgétaires en prévision d'éventuelles urgences, modifier le plan d'immobilisation, et être résilient.

L'analyse coût-efficacité : ce que chaque dirigeant doit savoir
Par Silvia Ondategui-Parra

Le principe fondamental de l'analyse économique est que des choix doivent être faits entre toutes les ressources possibles, comme s'il y avait un réservoir limité de ressources pour fournir tous les soins médicaux possibles à chaque individu. C'est une réalité. En fournissant des estimations de coûts et de résultats, ces analyses illustrent les compromis liés à un choix parmi une variété d'interventions cliniques possibles afin de fournir les meilleurs soins de santé. Ces arbitrages sont inévitables, cela n'a jamais été plus tangible que dans notre environnement actuel.

D'une manière générale, les outils de l'économie médicale peuvent être appliqués à l'analyse de la pratique clinique pour améliorer les décisions sur la façon d'allouer des ressources pour des interventions.

Enseigner la finance aux médecins
Par Lee Campbell

Un guide intitulé « Guide financier pour les médecins hospitaliers » a été préparé conjointement par l'Academy of Medical Royal Colleges et la Commission de vérification au Royaume-Uni. Le NHS a reconnu l'influence positive que les cliniciens peuvent avoir et croit que leur formation sur les questions financières pourrait réduire les coûts, améliorer le rapport coût-efficacité et dans un même temps, augmenter l'efficience et la qualité des soins. Une telle initiative revêt une importance particulière dans la période actuelle de ralentissement économique et sera encore plus pertinente quand la situation s'améliorera. Le rapport coût-efficacité devrait toujours rester une priorité absolue dans le secteur hospitalier.

Fournir des soins de santé « compétents culturellement »
Par Geri-Ann Galanti, Aziz Sheikh

La pratique de la médecine aujourd'hui dans un monde de plus en plus multiculturel exige plus qu'une simple expertise clinique, elle exige également des compétences culturelles. La compréhension et une sensibilité interculturelle à la population des patients que l'on doit prendre en charge peuvent aider les acteurs de la santé à apporter des soins plus efficaces et dans un même temps éviter la frustration consécutive à un manque de compréhension.

La compréhension et la sensibilité interculturelles peuvent améliorer la qualité des soins médicaux en augmentant la confiance du patient, un facteur clé de son adhésion, et en même temps réduire le stress du prestataire des soins de santé. On devrait enseigner aux médecins et autres travailleurs de santé la différence entre les stéréotypes et les généralisations : les stéréotypes ont valeur de jugement définitif, ils n'engagent à aucun approfondissement supplémentaire sur la personne alors que les généralisations peuvent être utilisées comme points de départ de la connaissance de l'autre.

L'intégration européenne des travailleurs de santé *Par Dr Jolanta Lapczynska*

Depuis quelques années, le NHS doit faire face à une pénurie de personnel médical. Devant la difficulté pour conserver suffisamment de travailleurs des soins de santé et pour lutter contre ce déficit de compétences, le NHS s'est fixé pour objectif d'attirer des spécialistes, des généralistes et du personnel infirmier. Le Dr Jolanta Lapczynska nous fait part de son expérience.

Elle a constaté que son travail de radiologue au Royaume-Uni est très différent de celui qu'elle effectuait en Pologne. Une vaste expérience pratique est favorisée en Pologne alors qu'au Royaume-Uni, en devenant spécialiste, on doit choisir sa sous-spécialité et poursuivre uniquement dans le domaine choisi. Pour elle, cela signifie que revenir en Pologne serait délicat maintenant : à cause de sa perte de savoir-faire en pratique générale,

il lui serait difficile de retravailler dans le système de santé polonais. Bien que généralement satisfaite de son expérience au Royaume-Uni, elle regrette que la barrière linguistique lui ait causé quelques problèmes.

L'accréditation pour les services de soins ambulatoires *Par Carlo Ramponi*

Le vieillissement de la population et l'augmentation des contraintes que cela suppose pour les hôpitaux donne une place de plus en plus importante aux soins ambulatoires. Face à leur nombre croissant, des programmes d'accréditation sont mis en place. L'accréditation est un processus dans lequel une entité séparée et distincte de l'établissement de soins, en général non gouvernementale, évalue l'organisation des soins de santé afin de déterminer si elle répond à un ensemble d'exigences ou normes destinées à améliorer la sécurité et la qualité des soins. Les programmes d'accréditation JCI sont basés sur un cadre international de normes adaptables aux besoins locaux.

Les gestionnaires jouent un rôle important dans l'assurance d'une excellente qualité des services médicaux. Un leadership efficace commence par la compréhension des diverses responsabilités et de l'autorité de chacun dans l'organisation ainsi que de la façon dont ils travaillent ensemble.

L'efficacité des cliniques d'infirmières et infirmiers praticiens *Par Tamara Page, Tiffany Conroy*

On oublie souvent le rôle important des cliniques dirigées par du personnel infirmier dans la gestion des maladies coronariennes. Une « Nurse-Led Clinic » a été définie comme mettant l'accent sur la santé plutôt que sur la maladie et sur la gestion de la vie plutôt que sur le diagnostic et l'intervention. Les études sur l'efficacité de ces cliniques pour les patients atteints de maladies coronariennes ont révélé des améliorations cliniques dont une diminution de l'anxiété et de la dépression, une amélioration de la qualité de vie et des niveaux élevés de satisfaction. Les médecins généralistes et les infirmières et infirmiers pensent que leur action a conduit à une amélioration du service aux patients. Ces cliniques sont également perçues comme un moyen efficace d'améliorer l'amplitude et la structure des prestations de soins, d'offrir la possibilité de mettre en application les méthodes les plus éprouvées, et de démontrer un engagement à l'évolution des soins. Un autre avantage des cliniques d'infirmières et infirmiers praticiens est l'augmentation de l'autonomie professionnelle des infirmiers praticiens.

PAPT, Patient Admissions Prediction Tool : un outil de prévision des admissions *Par Justin Boyle*

Une recherche basée sur les faits démontre que le surpeuplement dans les départements d'urgence est cause de déviation d'ambulances vers d'autres centres, d'augmentation de la longueur du séjour hospitalier, d'erreurs médicales, de mortalité, de pertes financières pour l'hôpital et les médecins, et qu'il provoque une augmentation de la négligence médicale. Toutefois, le nombre quotidien d'admissions peut être prévu avec une remarquable précision.

L'objectif principal de l'étude était de développer et de valider un ensemble de logiciels utilisables médicalement permettant de prévoir avec précision le nombre d'admissions en provenance du service d'urgence, n'importe quel jour de l'année, en tenant compte des périodes de surcharge comme des jours fériés. Le critère d'évaluation principal était l'exactitude des prévisions validée par les données historiques provenant de deux hôpitaux différents. L'outil de prédiction des admissions de patients qui en découle peut aider une meilleure répartition des lits d'hospitalisation et remédier au surpeuplement. À la suite de cette étude, on peut conclure que des outils de prévision précis sont importants dans de nombreuses applications de la gestion des hôpitaux, dont la programmation chirurgicale élective, la gestion des lits et le recrutement de personnel.

Les récents développements dans le système de santé italien obéissent à différentes perspectives *Par Dario Rosini*

Le système de santé italien est en mutation. Comme dans la plupart des autres pays européens, le système souffre d'un manque de ressources. L'Italie expérimente également la régionalisation de la gestion des soins de santé qui apporte elle même ses propres difficultés. L'accent se déplace des patients hospitalisés vers les soins primaires et la rationalisation des coûts est en passe de devenir une nouvelle tendance.

La régionalisation a produit deux façons de penser très différentes sur la délivrance des soins de santé. Elles sont très « politiques » : les régions dirigées par des partis de centre droit font une distinction entre les fournisseurs et les acquéreurs, et autorisent le patient à choisir le prestataire qu'il préfère alors que régions de centre gauche basent les soins de santé sur le concept de réseau et ont tendance à diriger le choix des citoyens. Le manque de ressources et la nécessité qui en découle en matière de rationalisation des coûts ont été accueillis avec hostilité par les professionnels. La réorientation de patients hospitalisés vers des traitements ambulatoires alors que les taxes étaient augmentées a produit une réaction semblable dans le public.

Paul Castel

UNSERE KRANKENHÄUSER UND DIE KRISE

Die Zukunft des Gesundheitswesens beschäftigt wohl alle Bürger in Europa. Dieses Problem geht über die Unterschiede zwischen den Organisationsmodellen der Gesundheitsfürsorge in ganz Europa hinaus. Für viele ist es sehr überraschend zu erkennen, dass diese Frage in den jüngsten Debatten, die den Wahlen zum Europäischen Parlament vorausgingen, fast zur Gänze ignoriert wurde – obwohl es an Diskussionsthemen auf diesem Gebiet nun wahrlich nicht mangelt. Es stimmt zwar, dass die europäischen Behörden dem Krankenhaussektor nach wie vor nur ein marginales Interesse entgegenbringen, so vielfältig sind die Probleme, die der Aufmerksamkeit und der Lösungen bedürfen; doch eine gemeinsame europäische Analyse kann zumindest als Ausgangsbasis eingesetzt werden, da diese Themen doch nationale Rahmenkonzepte sprengen.

Zusätzlich stellt sich da noch die Frage nach den Auswirkungen, die die derzeitige Krise auf unsere Krankenhäuser hat. Die Zeit, in der wir leben, wirft die Frage auf, welche Methoden wir in unseren jeweiligen Betrieben einführen sollen, um diese Krise, oder vielmehr diese Krisen, zu überwinden. Und eigentlich gibt es mehrere Interpretationsmöglichkeiten des Wortes ‚Krise' – und alle sind sie Herausforderungen an unsere Krankenhäuser:

- Zunächst einmal die Krise des Krankenhausmodells selbst, die in ganz Europa zu hitzigen Debatten geführt hat, wie man die Gesundheitsfürsorge nun am effektivsten und effizientesten organisieren sollte. Obwohl die Gesundheitssysteme innerhalb Europas markante Unterschiede aufweisen, sind die Fragen doch dieselben – sowohl in Bezug auf die geeigneten Modelle, die in der Vergangenheit ausgewählt wurden, als auch bezüglich der Kapazität der gegenwärtig vorhandenen Systeme, diese Schwierigkeiten zu meistern.
- Dann die wirtschaftliche und soziale Krise. Kein Land in Europa wurde von der grundlegenden Frage verschont, wie es um die ökonomische Stabilität ihres Modells bestellt ist. Allerorten vergrößern sich die sozialen Defizite, und werfen somit immer stärker die Frage nach der Beständigkeit der Organisationen und der sozialen Wohlfahrt überhaupt auf.
- Desgleichen die finanzielle Krise, die mitnichten auf den wirtschaftlichen Sektor beschränkt ist, sondern auch unsere Einrichtungen voll getroffen hat. Die enorme Verlangsamung von Aktivität, die wir seit fast einem Jahr erleben, ist eine echte Gefahr für die finanzielle Gesundheit unserer Krankenhäuser: eine rasante Vermehrung des öffentlichen Defizits, Schwierigkeiten bei der Beschaffung von Darlehen, Widerstände gegen Investitionen in strukturelle Projekte, unzureichende Aktivposten... diese Liste könnte wesentlich länger sein, und die meisten hier genannten Kernpunkte sind in ganz Europa dieselben – eine Diskussion auf europäischer Ebene wäre daher hilfreich.
- Schlussendlich nehmen Gesundheitskrisen – denen unsere Krankenhäuser während ihrer glorreichen Geschichte schon so häufig die Stirn geboten haben –in Zeiten der Globalisierung ganz neue Dimensionen an. Und so werden mit der Grippe-Pandemie, welche unseren Kontinent in diesem Herbst erreichen wird, abermals Gesundheitseinrichtungen an vorderster Front stehen. In ganz Europa bereiten sich diese Einrichtungen aktiv darauf vor, die Bevölkerung aufzunehmen und sie zu versorgen; ihnen die bestmögliche Betreuung zu bieten und somit einen wesentliche Brücke zwischen staatlicher Organisation und nationaler Solidarität zu schlagen.

Krise – ein einziges Wort, das mehrere Wahrheiten beinhaltet, aber jedes Mal zum selben Ergebnis führt, nämlich die außerordentliche Fähigkeit unserer Krankenhäuser, sich anzupassen, und die Kraft der Werte, die sie verkörpern: Solidarität, Schutz der Schwachen und das immerwährende Bekenntnis, auch angesichts von Widrigkeiten durchzuhalten.

Zu einer Zeit, da Europa auf Sinnsuche ist, können wir davon ausgehen, dass diese Werte eine inspirierende Wirkung haben, und europäischen Bürgern eine gemeinsame Vision ihrer Zukunft zeigen werden.

Paul Castel – Präsident der EAHM

Leitartikel in *(E)Hospital* werden von Führungspersönlichkeiten der EVKD verfasst. Die hier veröffentlichten Beiträge geben dennoch ausschließlich die Meinung der Autoren wieder und sind nicht als offizielle Stellungnahme der EVKD zu werten.

"HIN ZU EINER AUSGEWOGENEN KOOPERATION ZWISCHEN ÖFFENTLICHEN UND PRIVATEN AKTEUREN"

Die European Association of Hospital Managers (EAHM) lädt zur Teilnahme ihres aktuellsten Seminars, welches am 20. November 2009 in Düsseldorf stattfindet.

Kontext und Sinn dieses Seminars

In den meisten europäischen Ländern hat sich ein gemischtes System mit zwei oder drei Krankenhaustypen entwickelt: öffentlich, privat gemeinnützig und privat gewerbsmäßig. Jeder Krankenhausmanager in den verschiedensten europäischen Ländern hat seine eigenen Erfahrungen mit öffentlichen und privaten Aktivitäten. Private Krankenhäuser sind oftmals verpflichtet, öffentliche Dienste anzubieten, während öffentliche Krankenhäuser versuchen, private Aktivitäten zu entwickeln, um den Rahmen ihres Budgets nicht zu sprengen.

Krankenhausmanager stehen außerdem von verschiedenen Seiten unter Druck, sei es wegen finanzieller Einschränkungen oder externer Rechenschaftspflicht. Nichtsdestoweniger könnte sich Benchmarking für Krankenhausmanager als extrem nützlich erweisen; es wäre für diese Experten sehr interessant, die verschiedenen Organisationsmöglichkeiten bezüglich der aktuellen und zukünftigen Bereitstellung von Gesundheitssorge zu vergleichen.

Was sind die Unterschiede (und der Impact) auf das Niveau von Qualität, Eigenkapital oder Budget? Wie sieht die beste Lösung für die Patienten aus? Ist das Outsourcen spezifischer Aktivitäten in öffentlichen Spitälern eine gute Idee? Wie sollte sich die Organisation von Gesundheitssorge angesichts der derzeitigen wirtschaftlichen Krise entwickeln? Was sind die Auswirkungen der finanziellen Krise auf die Arbeitsbedingungen für private und öffentliche Krankenhäuser?

Der Zweck dieses Seminars ist es, die entsprechenden verschiedenen Modelle vorzustellen und zu erklären und das Verständnis dafür zu verbessern. Das Seminar möchte den Teilnehmern außerdem dabei helfen, die für ihre spezielle Situation und ihr eigenes System optimale Auswahl zu treffen. Die verschiedenen Optionen zu analysieren und Lehren aus den verschiedenen Systemen zu ziehen – mithilfe dieser Grundlagen sollen die Teilnehmer besser auf künftige Entscheidungen vorbereitet sein, so die Hoffnung der EAHM.

Programmübersicht

Als Einstieg in das Seminar wird ein Überblick über die aktuelle Situation öffentlicher und privater Akteure in Europa geboten, außerdem werden diejenigen Faktoren vorgestellt, die bei der Analyse der Organisation der Gesundheitssorge in Betracht zu ziehen sind. Darauffolgend legen sowohl ein Verfechter des öffentlichen Krankenhaus-Modells als auch ein Vertreter des privaten Spitals-Modells ihre Standpunkte dar, sie berichten über den von ihnen geleisteten Beitrag und legen die Vorteile bei der Bereitstellung von Gesundheitssorge dar.

Am Nachmittag ergreifen drei Sprecher dieser Thematik aus verschiedenen Ländern das Wort. Sie werden den Teilnehmern objektive Informationen über ihre Erfahrungen mit öffentlichen und privaten Akteuren der Gesundheitsfürsorge liefern, und auch über verschiedene Kooperationen zwischen ihnen berichten.

Zu guter Letzt stellen sich die Redner eine Diskussion am Runden Tisch, wobei auch die Teilnehmer die Möglichkeit erhalten werden, Antworten auf alle Fragen zu erhalten, die sie noch interessieren.

Das Seminar wird gemeinsam mit der EAHM General Assembly 2009 und dem German Hospital Day abgehalten, wobei beide während der weltweit größten medizinischen Messe, der MEDICA, stattfinden.

Das Seminar wird auf Deutsch und Englisch gehalten. Die Teilnahme ist kostenlos, es ist aber eine Anmeldung erforderlich. Einzelheiten zum Seminar und das Teilnahmeformular sind auf der EAHM Website zu finden, **www.eahm.eu.org.**

Strategien, um die Rezession zu überstehen *Von Richard L. Gundling*

Die wirtschaftliche Rezession hat die US-Amerikanischen und europäischen Krankenhäuser auf nahezu jeder Ebene gefordert – und doch bleiben viele Finanzdirektoren der Spitäler standfest, im Wissen, dass die Schritte, die sie heute zur Kostensenkung, Gewinnmaximierung und Erhaltung des Cashflows einleiten, ihre Krankenhäuser im Endeffekt zu stärkeren, effizienteren Einrichtungen machen werden, die in der Lage sind, rasch auf die wirtschaftlich harte Zeiten der Zukunft zu reagieren. Basierend auf den Ergebnissen dieser Untersuchungen hat die HFMA neun Schlüsselstrategien gegen die Rezession ausfindig gemacht: Den Fokus auf Wert beibehalten; Design und Kosten der Zulieferkette neu verhandeln; Mit Angestellten offen und ehrlich sein, ihre Hilfe erbitten; Belegschaft laut Patientenzensus; Innovationen im Einkommensmanagement verfolgen, um Cash zu bewahren; Zu den Ärzten enge Arbeitsverhältnisse aufbauen; Budgetpläne für den Notfall erstellen; Den Kapitalplan anpassen, und belastbar sein.

Kosten-Effektivitäts-Analyse: Was jeder Manager wissen sollte *Von Silvia Ondategui-Parra*

Das fundamentale Prinzip jeder wirtschaftlichen Analyse ist, dass Entscheidungen gefällt werden müssen, auf welche Weise Ressourcen einzusetzen sind, und dass es einen begrenzten Pool an Ressourcen gibt, aus dem alle medizinische Versorgungen für jeden einzelnen geschöpft werden. Dieses Prinzip wird nicht angezweifelt. Durch Bereitstellung von Schätzungen der Outcomes und Kosten veranschaulichen diese Analysen die Kompromisse, die mit diesen Entscheidungen bezüglich einer Mehrzahl klinischer Interventionen einhergehen, um die beste Gesundheitsfürsorge zu bieten. Es war noch nie so klar wie in unserem derzeitigen Gesundheitsklima: Diese Kompromisse sind unvermeidbar.

Grob gesprochen können die Werkzeuge der klinischen Ökonomie auf die Analyse der medizinischen Praxis eingesetzt werden, um Entscheidungen bezüglich Ressourcenverteilung für klinische Interventionen zu verbessern.

Ärzte zu Finanzexperten ausbilden *Von Lee Campbell*

Ein Handbuch mit dem Titel ‚A Guide to Finance for Hospital Doctors' ist in Kooperation zwischen der Academy of Medical Royal Colleges und der Audit Commission des Vereinigten Königreichs ausgearbeitet worden. Die NHS (National Health Services) haben den positiven Einfluss anerkannt, den Ärzte haben können, und gehen davon aus, dass die Ausbildung von Klinikern bezüglich finanzieller Angelegenheiten zur Verminderung von Kosten führt, die Kosten-Effektivität erhöht und gleichzeitig die Effizienz und Qualität der Gesundheitsfürsorge verbessern wird. Eine Initiative wie diese ist in Zeiten des wirtschaftlichen Abschwungs von besonderer Bedeutung, und wird es auch dann noch sein, wenn sich die Situation wieder verbessert; auf dem Krankenhaussektor wird Kosten-Effektivität immer eine der wichtigsten Prioritäten sein.

Kulturell kompetente Gesundheitsfürsorge bieten *Von Geri-Ann Galanti, Aziz Sheikh*

Das Ausüben eines medizinischen Berufs in der heutigen multikulturellen Welt erfordert mehr als nur klinische Expertise; auch kulturelle Kompetenz ist gefragt. Verständnis für und Sensibilität gegenüber dem Kulturkreis der Patienten kann Gesundheitssystemen dabei helfen, eine effektivere Betreuung anzubieten, und gleichzeitig die Frustration zu vermeiden, die aus einem mangelnden Verständnis geboren wird.

Kulturelle Kenntnis und Sensibilität kann die Qualität einer medizinischen Behandlung verbessern, indem das Vertrauen des Patienten gestärkt wird – ein Schlüsselfaktor in der Compliance. Gleichzeitig kann der Stress des Gesundheitsanbieters vermindert werden. Allen im Gesundheitsbereich Tätigen sollte der Unterschied zwischen Stereotypien und Generalisationen nahegebracht werden; Stereotypien werden als Endpunkte eingesetzt, es gibt keine weitere Erforschung des Individuums, während Generalisationen als Startpunkte eingesetzt werden können. Werte sind ebenfalls von Bedeutung.

Die Integration europäischen Fachpersonals *Von Dr Jolanta Lapczynska*

In jüngeren Jahren haben die NHS Probleme damit gehabt, eine ausreichende Anzahl medizinischen Fachpersonals zu behalten, was zu einem Mangel in diesem Bereich geführt hat. Um dieses Defizit an Qualifikation zu bekämpfen, haben sich die NHS Ziele für das Gewinnen von Fachärzten, Allgemeinmedizinern und Krankenpflegepersonal gesetzt. Dr. Jolanta Lapczynska berichtet über ihre Erfahrungen als Radiologin in Großbritannien.

Sie erkannte, dass die Arbeit als Radiologin in Polen sich radikal von der Arbeit in Großbritannien unterscheidet. In Polen wird großen Wert auf umfassende allgemeinmedizinische praktische Erfahrung gelegt, während man in Großbritannien nach der Fachärzteprüfung eine Subspezialität auswählt und dann eine Karriere auf diesem Gebiet verfolgt. Eine Rückkehr nach Polen wird daher schwierig sein werden, da sich die Ärztin wegen des Verlustes des generellen allgemeinmedizinischen Wissens nicht so einfach wieder in das polnische Gesundheitssystem einfügen kann. Obwohl sie mit ihrer Erfahrung in Großbritannien generell zufrieden ist, hat die Sprachbarriere doch einige Probleme verursacht (medizinische Abkürzungen, unleserliche Handschriften).

Akkreditierung ambulanter Einrichtungen
Von Carlo Ramponi

Aufgrund der alternden Bevölkerung und dem verstärkten Druck, der damit auf Krankenhäuser ausgeübt wird, wird die ambulante Versorgung immer wichtiger. Nachdem diese mehr und mehr in Anspruch genommen wird, ist das Vorhandensein von Akkreditierungsprogrammen wichtig. Akkreditierung bedeutet einen Prozess, in dem eine Entität, separat und verschieden von der Gesundheitsorganisation – üblicherweise staatlich – die Gesundheitsorganisation bewertet, um festzustellen, ob diese gewisse Standards erfüllt, die dazu dienen, die Sicherheit und Qualität der Betreuung zu verbessern. JCI Akkreditierungsprogramme basieren auf einem internationalen Rahmenwerk von Standards, die auf örtliche Bedürfnisse angepasst werden können.

Manager spielen eine wichtige Rolle in der Bereitstellung ausgezeichneter klinischer Angebote. Eine effektive Führung beginnt mit dem Verständnis der unterschiedlichen Verantwortungen und Autoritäten der Individuen in der Organisation, und wie diese Individuen zusammen arbeiten.

Die Effektivität der von Pflegepersonal geführten Kliniken
Von Tamara Page, Tiffany Conroy

Eine zu wenig anerkannte Möglichkeit im Management der CHD (koronaren Herzerkrankung) ist der Einsatz von Kliniken, die von Pflegepersonal geleitet werden. Diese Kliniken wurden durch ihren Fokus auf Gesundheit – im Gegensatz zu Krankheit – und eine Betonung auf Lebensmanagement – im Gegensatz zu Diagnose und Intervention – definiert. Studien über die Effektivität der von Pflegepersonal geführten Kliniken für Patienten mit CHD haben klinische Verbesserungen ergeben, einschließlich einer Verminderung von Angst und Depression, einer Verbesserung von Lebensqualität und höherer Zufriedenheitswerte.

Laut Ansicht von Allgemeinmedizinern und Pflegepersonal hat die Errichtung dieser Kliniken zu einem verbesserten Service für Patienten geführt. Diese Einrichtungen werden auch als effektive Maßnahme gesehen, den Umfang und die Struktur der Gesundheitsversorgung zu verbessern, sie sind zudem fähig, die beste Evidenz einzusetzen, und geben ein Bekenntnis zur Verbesserung von Patientenbetreuung ab.

Ein weiterer Vorteil dieser Kliniken in die verbesserte berufliche Autonomie des Pflegepersonals. Sowohl Allgemeinmediziner als auch das Pflegepersonal sind der Meinung, dass diese Kliniken die Rolle des Pflegepersonals erweitern, und damit auch deren Selbstvertrauen, Fähigkeiten und Zufriedenheit mit dem Beruf.

PAPT – Patient Admissions Prediction Tool (Werkzeug zur Voraussage der Patientenaufnahmen) *Von Justin Boyle*

Evidenz-basierte Forschung zeigt, dass eine Überfüllung von Notfallabteilungen zur Umleitung von Rettungswägen führt, zu verlängerten Krankenhausaufenthalten, vermehrten medizinischen Fehlern und damit erhöhter Patientenmortalität, zu finanziellen Verlusten für Krankenhaus und Ärzte und zu vermehrten Klagen wegen Fahrlässigkeit. Die Anzahl an Aufnahmen pro Tag kann jedoch mit erstaunlicher Korrektheit vorausgesagt werden.

Das Hauptziel dieser Studie war die Entwicklung und Validierung einer klinisch einsetzbaren Software-Pakets, das die Anzahl von Aufnahme akkurat voraussagt, basierend auf der Anzahl von Patienten an Notfallabteilungen an jedem beliebigen Tag des Jahres, unter Berücksichtigung von Peak-Perioden wie etwa bei öffentlichen Feiertagen. Primärer Endpunkt war die Genauigkeit der Voraussagen bei Validierung gegen historische Daten von zwei verschiedenen Krankenhäusern. Das darauf resultierende 'Patient Admissions Prediction Tool' kann bei der Verteilung von stationären Patientenbetten helfen, um Überfüllung abzufedern.

Die Schlussfolgerungen der Studie: akkurate Werkzeuge zur Voraussage sind wichtige Hilfsmittel in vielen Bereichen von Krankenhausmanagement, einschließlich elektiver OP-Planung, Bettenmanagement und Bereitstellung von Personal.

Aktuelle Entwicklungen im italienischen Gesundheitssystem: eine Ansicht aus verschiedenen Perspektiven *Von Dario Rosini*

Das italienische Gesundheitssystem verändert sich. Ähnlich anderen europäischen Ländern leidet das System an einem Mangel an Ressourcen. Italien erlebt außerdem die Regionalisierung des Gesundheitsmanagements, was wiederum eigene Probleme mit sich bringt. Der Fokus verschiebt sich von stationärer Versorgung zu Erstversorgung bei einem Allgemeinmediziner, und die Kostenrationalisierung ist rasch zum neuen Trend geworden.

Die Regionalisierung hat zwei verschiedene Denkarten hervorgebracht, wie man dem Bürger Gesundheitsdienste anbietet. Dies ist eine stark politisierte Angelegenheit, wobei von rechten Parteien geführte Regionen zwischen Lieferanten und Abnehmern unterscheiden, und der Kunde das Recht hat, sich für den Anbieter seiner Wahl zu entscheiden, während mittelinks Regionen ihre Gesundheitsfürsorge auf eine Netzwerk-Konzept basieren und dazu neigen, einen Einfluss auf die Wahl des Bürgers zu nehmen. Der Mangel an Ressourcen und ein nachfolgender Bedarf für Kostenrationalisierung hat bei Ärzten zu Widerstand geführt, ebenso die Verschiebung des Fokus von stationärer zu ambulanter Betreuung; desgleichen hat eine erhöhte Besteuerung in der Bevölkerung eine ähnliche Reaktion hervorgerufen.

AGENDA 2009 / 2010

October

World Medical Tourism and Global Health Congress 26-28
Los Angeles, USA
www.medicaltourismcongress.com

IT@Networking Awards 2009 29-30
Brussels, Belgium
www.hitm.eu

November

IHF Rio 2009 36th World Hospital Congress 10-12
Rio de Janeiro, Brazil
www.ihfrio2009.com

HISI- 14th Annual Congress and Scientific Symposium 19-20
Dublin, Ireland
www.hisi.ie

Medica 2009 18-21
Düsseldorf, Germany
www.medica.de

EAHM Seminar «Towards a balanced cooperation of public and private actors» 19
Düsseldorf, Germany

RSNA 2009 29-4
Chicago, USA
www.rsna.org

January

Society of Critical Care Medicine (SCCM) 39th Annual Critical Care Congress 9-13
Miami, USA
www.sccm.org

February

International Health Expo ξ Conferences (IHEC) 5-8
Chandigarh, India
www.healthexposindia.com

March

ECR 2010 4-8
Vienna, Austria
www.myesr.org

ISICEM 2010 9-12
Brussels, Belgium
www.intensive.org

World of Health IT Conference and Exhibition 15-18
Barcelona, Spain
www.worldofhealthit.org

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- Healthcare and the Environment
- Country Focus: The Netherlands

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