Hospital

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PATIENT-CENTRED MANAGEMENT

Plus

- Financing
- Managing Hospital Mergers
- Prescribing Efficiency
- Focus: UK

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A STRONGER EUROPE

Heinz Kölking

Current times are marked by considerable problems and challenges in Europe. We are still suffering from the effects of the economic and financial crises. Discussions of public debt in the Member States still dominate activities. Crisis management is required. It is important that the overall perspective of Europe as a successful model for peace and freedom in an open society remains.

The economic and financial crises and their consequences also clearly show that Europe must strengthen and grow together, both politically and economically. Health policies will be increasingly concerned by it. An example of this is the new European Directive on cross-border healthcare and its effects on conditions of cross-border patient treatment. We are encouraged to shape this development from the hospital perspective.

As an association, we will have a good look at all of these questions in the context of our upcoming EAHM seminar in Düsseldorf held during MEDICA on November 18th, 2011. We can promise you an interesting programme with excellent contributions. On behalf of the organisers and particularly, the Executive Committee of the EAHM, I invite and encourage you to attend this meeting. We look forward to seeing as many members as possible in Düsseldorf.

This issue of *(E)Hospital* provides readers with interesting contributions on the important topic of patient-centred management. Successful management depends on good organisation, logistics and business administration but also on the leadership skills of executives, another topic featured this issue. Our country focus highlights healthcare in the UK. I hope you enjoy reading this issue.

Heinz Kölking
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.

Patient-Centred Management

This issue we focus on patient-centred management. Patients are becoming more and more involved in their care, taking an active interest in quality and safety. *(E)Hospital* spoke to Tomasz Szelagowski from the European Patients' Forum to find out the main issues affecting European patients and what hospital managers can do to improve patient experience. In other articles Walter Sermeus introduces us to the merits of care pathways and André Van Gossum tackles the important issue of dealing with malnutrition in our hospitals.

Prescribing Efficiency

Healthcare costs are increasing everywhere and pharmaceutical expenditure has always been high. These rising costs have led to many cost-containment initiatives, including the use of generic drugs. This issue we feature two articles on generics. Brian Godman and colleagues from across Europe discuss the use of generics to improve prescribing efficiency of existing products and Helle Håkonsen introduces us to pharmaceutical tendering in Norwegian hospitals, which does contain costs but can also increase the risk of medication errors.

Focus: UK

Healthcare in the United Kingdom (UK) is mainly provided by the National Health Service (NHS), a public health service, which provides healthcare that is free at the point of use to all permanent residents of the UK and is paid for from general taxation. The NHS employs more than 1.7 million people. Only the Chinese People's Liberation Army, the Wal-Mart supermarket chain and the Indian Railways directly employ more people.

EAHM: THE FIRST RESULTS OF OUR NEW DIRECTION

For the first time since its election and new formation after the 2010 congress in Zurich, Switzerland, the Executive Committee of the European Association of Hospital Managers (EAHM) came together. This 92nd meeting took place on May 20th 2011 at the General Secretariat in Brussels.

It was up to the new President, Mr. Heinz Kölking to welcome all delegates from the national associations coming from 17 different countries. Among them were many colleagues who were participating in their first Executive Committee meeting.

The detailed reports given on the activities of the Sub-Committees and the Working Groups of EAHM confirmed that the decisions made after the reflection process have not been left unheeded.

Mr. Gerry O'Dwyer announced the results of the two meetings of the Scientific Sub-Committee (SSC), which is concentrating on the preparation of the scientific programme for the 2012 EAHM congress in Athens, Greece. In addition, the SSC have defined their working method as a redefinition of the role of the hospital manager, one of the priorities of the new action plan. In his report on the Sub-Committee European Affairs (SCEA), Mr. Marc Hastert illustrated how the committee follows all hospital related news on a European level. The European Cross-Border Healthcare Directive is a priority. In collaboration with other European associations the SCEA is actively preparing the study day, which will take place in Düsseldorf during the Medica congress on 18 November 2011.

As for the Editorial Board, Mr. Nikolaus Koller outlined the work programme to make our journal *(E)Hospital* even more interesting. The Assistant to the Secretary General, Mr. Jos Vanlanduyt informed the Executive Committee about the programme proposed by the Working Party Hospital IT Managers. After due discussion, the members of the Executive Committee approved the prospective actions.

This year, the new partnerships with companies working in the healthcare sector will be implemented. The Secretary General, Mr. Willy Heuschen presented the Executive Committee with the partnership contract, which is proposed to companies within the sector. The focus is on the exchange and profit that both hospitals and companies can derive from the partnerships while keeping professional ethics and independence. Among the different contacts that EAHM and the national associations have with other companies, six are very interested and one contract is expected to be signed in the coming months. Nevertheless it was emphasised that all companies are welcome as long as they agree with the fixed objectives of the EAHM. The members of the Executive Committee firmly support this new form of partnership and are ready to help.

To Note/Coming Activities

September 15-16, 2011:
"Hospital success by optimised IT contribution – CEO Workshop"
Vienna *(Austria)*

November 18, 2011:
EAHM Seminar: European Cross-Border Directive
Dusseldorf *(Germany)*

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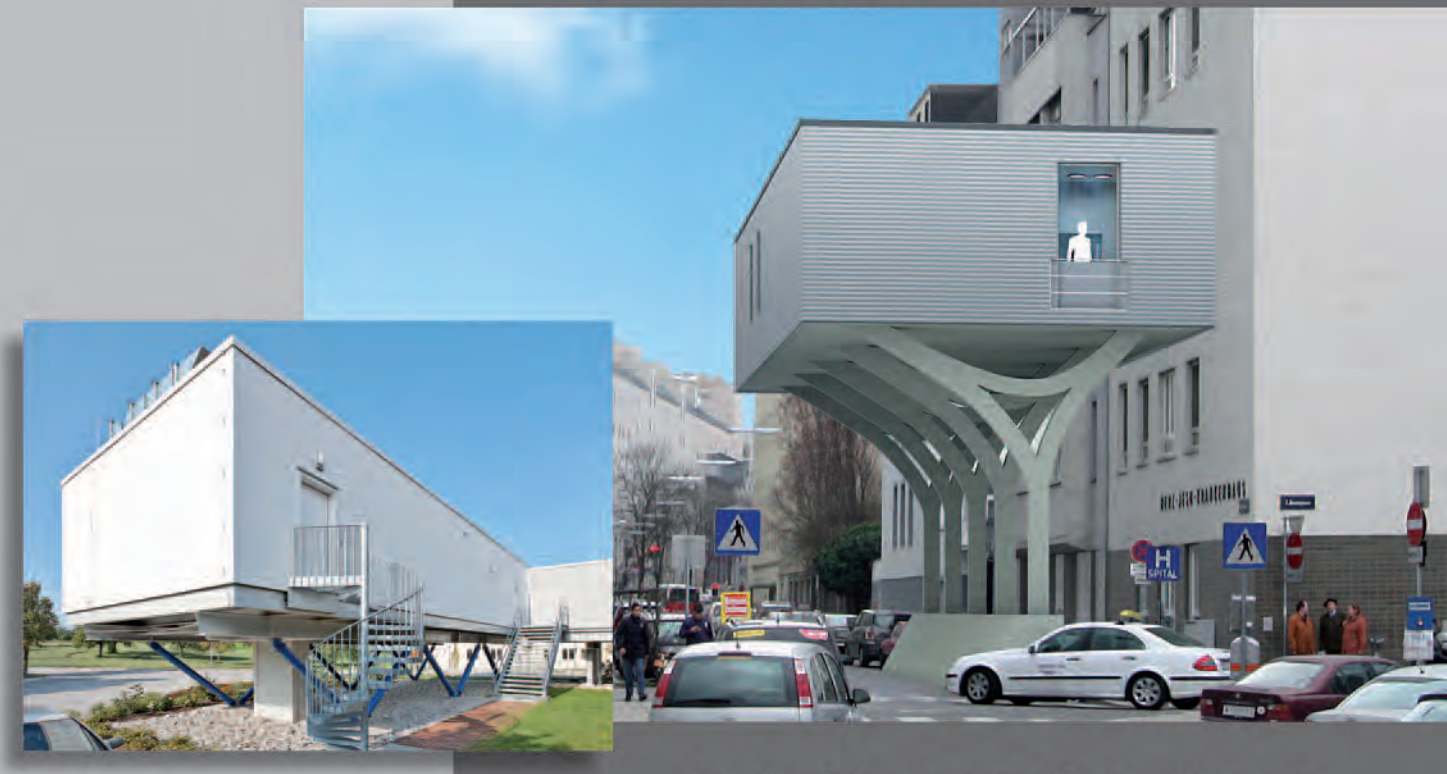

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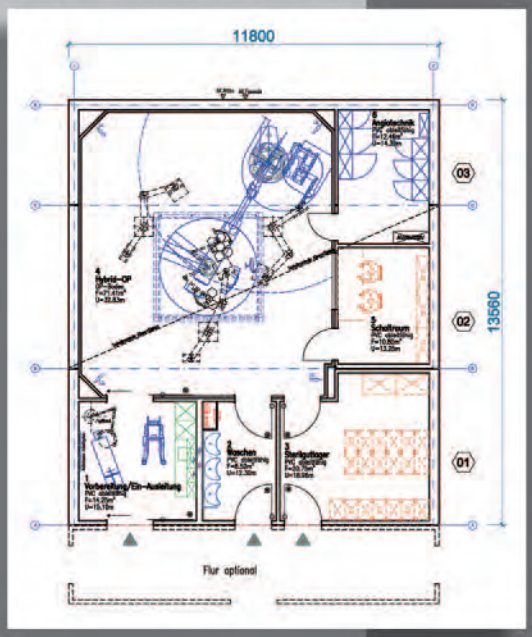

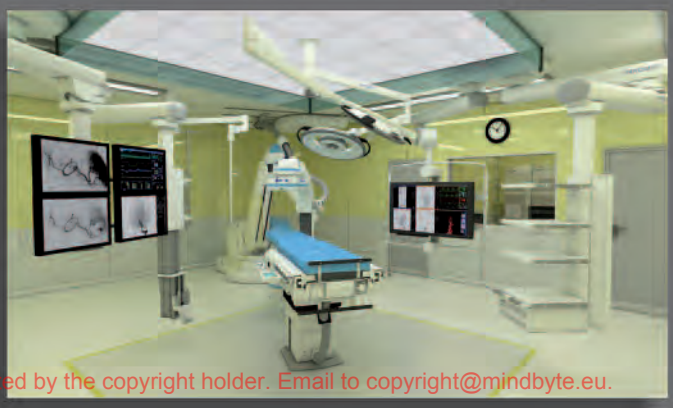

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Switzerland
Noise Triggers Post-Op Patient Infections

New research from Switzerland shows that noisy operating theatres have a negative effect on patients following surgery. Presented in the British Journal of Surgery, the study has found that surgical site infections (SSIs) result in patients who undergo surgery in theatres with significantly higher levels of noise, forcing them to extend their hospital stay by an average of seven to 13 days, and thus paying three times as much.

The researchers from the Universities of Neuchâtel and Bern in Switzerland assessed 35 patients that underwent planned, major abdominal surgery. They investigated the duration of the operation, the demographic parameters and the sound levels in the operating theatre. According to the team, 17 percent developed SSIs, and the sole variable was the level of noise in the operating theatre, which was significantly higher in the infected patients.

"SSIs lead to patients spending up to 13 days longer in hospital, making their stay cost up to 3 times as much," explains Dr. Guido Beldi, a senior author of the study from the Department of Visceral Surgery and Medicine, Bern University Hospital. "Having found a significant association between SSIs within 30 days of surgery and increased sound levels in the operating theatre, we can only conclude that noise is associated with a stressful environment or lack of concentration and this impacts on the surgical outcome."

The data show that median levels during surgery were much higher for patients who developed SSIs; 43.5 decibels (dB), compared to patients who did not develop SSIs, 25dB. The researchers found peak levels of at least 4dB above the median in 23 percent of the SSI patient operations, against 11 percent found in the other operations. According to the team, sound levels appeared to rise in both groups an hour after the first incision. They suggest the increase could be related to the complexity of the surgery, but talking about non-patient topics was also linked with a much higher level of noise, which is probably due to a lack of concentration by the surgical team. But the researchers point out that this interpretation is speculative because the timing of the non-patient-related conversations was not recorded.

"The results of our study suggest that increased sound levels in the operating theatre may point to issues such as surgical difficulty, a stressful environment, impaired discipline or concentration," Dr. Beldi says. "Each of these factors may increase the risk of SSIs and other complications and further studies looking at the source of operating theatre noise and its specific influence on the behaviour and performance of surgeons is warranted."

For more information, please visit:
British Journal of Surgery:
www.bjs.co.uk/view/index.html

Germany
CKM US Study Trip

CKM (Centrum für Krankenhausmanagement), the Centre for Hospital Management at the University of Munster has organised an international hospital management US study tour. Taking off in July, this year's destination is Phoenix, Arizona. Participants will visit three hospitals: St. Joseph's Hospital, Barrow Neurological Institute and the Mayo Clinic.

Entitled "best practice management in a care-driven healthcare environment", topics include strategic management, IT management, quality and risk assessment and hospital branding. Through lectures, site visits and discussions with some of the most reputable American hospital executives, attendees will gain insight into the management structures and clinical processes in the US.

UK
Fewer Patients Staying in Mixed-Sex Accommodation

Fewer patients are suffering the indignity of staying in mixed-sex accommodation, according to new figures released. Since December 2010, when the monthly collection of mixed-sex accommodation data was introduced, the number of breaches has dropped from 11,802 to 2,011 – a decrease of 83 percent.

In May 2011, hospitals reported that 2,011 patients were placed in mixed-sex accommodation without any justification. This compares to 2,660 for April 2011 – a decrease of 24 percent. The data, published online at individual hospital level, also shows that:

- 103 Acute Trusts (62 percent) reported zero sleeping breaches (compared to 59 percent in April 2011).
- 42 Acute Trusts reported a reduction in the number of breaches in May 2011.

Commenting on the statistics published today, Health Minister Simon Burns said: "Today's figures show that the tough action we have taken is having a sustained impact on reducing mixed-sex accommodation breaches. Greater transparency has now driven down breaches by more than 80 percent since December. I'd like to pay tribute to all the NHS staff across the country who have worked so hard to make this happen."

"However, there are still too many breaches. This is why hospitals face fines of 250 pounds for every breach, which can then be reinvested back into patient care."

Council of the European Union Reaches Conclusions on Innovation in Medical Device Sector

After a meeting of the Employment, Social Policy, Health and Consumer Affairs Council in Luxembourg on the 6th June 2011 the Council issued its conclusions on innovation in the medical device sector.

Taking into consideration the major long-term societal changes facing Europe, which will call for innovative healthcare systems, the Council of the European Union recognises the important role medical devices play in healthcare. These devices may deliver innovative solutions for the diagnosis, prevention, treatment and rehabilitation, improving the lives of patients and their families and could also contribute to mitigating the shortage of healthcare professionals and address the sustainability of our healthcare systems.

The Council also recognised the need to adapt EU medical device legislation to the needs of tomorrow with a transparent and sustainable regulatory framework and emphasised the important role the EU plays in the field of international regulatory convergence and best regulatory practice regarding medical devices.

It was stressed that innovation should be patient- and user-centred and demand driven, involving patients and their families in the process while also focusing on public health priorities, healthcare needs and cost-effectiveness. Future legislative actions in this area must, when adapting the European regulatory framework, specifically aim to increase patient safety while at the same time creating a sustainable legislative framework favourable to medical device innovation that can contribute to a healthy, active and independent life.

The Council invited the Commission and Member States to promote measures that make use of valuable innovative solutions with proven benefit, and improve information and training for healthcare professionals, patients and patients' families regarding their use. National and European best practices regarding innovation should be mapped and shared. Other top priorities include interoperability, safety issues and the notification of adverse events.

On a legislative level, the Council invites the Commission to take into consideration the following issues:

- Mechanisms to enhance reliability, predictability, speed and transparency in decision-making and make sure that it is based on scientifically validated data;
- A system of risk-based classification;
- Clinical data must be collected in a transparent way to provide the best clinical evidence;
- Clearer and simpler rules defining the obligations and responsibilities of all economic operators and role of other stakeholders; and
- A vigilance system to facilitate a rapid and coherent EU wide response to safety issues.

EU Funds Further Learning for Nurses

Qualified nurses seeking extra support in learning how to deal with people who are very distressed and disturbed can now take a course. Researchers led by Professor Mary Chambers of Kingston University and St George's, University of London in the United Kingdom developed a new course for nurses, helping them use effective and ethically sound approaches. Partial funding for the project was granted by the EU in the amount of 300,000 euro under the European Commission's Leonardo da Vinci Programme. The EU has awarded another 200,000 euro to the researchers so that they could update, test and quality assure the course in seven European countries.

The South West London and St George's Mental Health National Health Service (NHS) Trust, as well as three hospitals in Finland, are the locations where the course was already piloted. The curriculum includes are around 100 hours of training, as well as online learning and face–to–face instruction. The researchers say the course will be included in mental health training programmes across Europe.

The main objective of the course is to prevent qualified nurses from responding to very disturbed individuals via ineffective means like coercion (e.g. physical restraint) or significantly restricting their interaction with others. What the experts believe is that nurses should use approaches that are both effective and ethical, namely improved communication and letting people have a say in how their care and recovery process should be managed.

"This should ensure that those with mental health problems receive improved care and will help to make their treatment more effective", Professor Chambers says, adding that initial results indicate that the training resulted in the reduction of the numbers of violent incidents in inpatient wards.

The project partners developed the course with the help of people with mental health problems who had themselves been subjected to coercive treatment methods. The research findings suggest that nurses' attitudes were for the most part positive. A total of 810 nurses working in mental health in Ireland, Italy, Lithuania and Portugal were evaluated; they responded to a questionnaire about their attitudes towards people with mental health problems.

The data show that female nurses and those holding senior positions were more likely to be sympathetic towards people with mental health problems. From a geographical perspective, Portuguese nurses' attitudes were more positive while Lithuanian nurses' attitudes were more negative.

Healthcare's Moment of Truth.

In healthcare today, change is everywhere.

An aging population, an increasingly knowledgeable consumer, a growing sophistication in technology… not to mention a wave of legislation and fiscal restraint that is redefining how facilities are delivered, operated and maintained. Every point of the cycle demands singular expertise, and every point is a moment of truth—for operators, investors, clinicians, consumers.

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DIGITAL HEALTH

By Rory Watson

Over 90 percent of Europe's hospitals are connected to broadband and 80 percent have electronic patient record systems, but only 4 percent grant patients online access to those records. The findings emerge from an extensive investigation for the European Commission's Information Society and Media Directorate-General into the use acute hospitals make of e-health services.

The report, eHealth Benchmarking III, prepared by Deloitte & Ipsos in Belgium offers empirical evidence of the experiences of 906 public, private and university hospitals with the new technology on their own premises and in their dealings with external users and service providers. As part of the research, the survey also sought the views of hospital medical directors on electronic patient record systems and telemonitoring in all 27 EU countries plus Croatia, Iceland and Norway.

The former remain a top priority for investment in hospitals where there is still no common central information sharing system. The principle gain is considered to be efficiency. With the introduction of such systems, patient admissions are considered to have increased (55 percent of medical directors agree) and waiting lists reduced (49 percent agree). However, this does not appear to have been translated into higher quality treatment. Only 25 percent believe that the quality of the diagnosis has improved, 24 percent that treatment is better and 13 percent that medical errors have been reduced with the introduction of the electronic patient records.

One major reason given for the relatively low levels is interoperability between different departmental records – 46 percent of medical directors identified it as the largest barrier. Another is the absence of financial incentives for staff to use the new systems. The problem appears to be more acute in bigger hospitals, where 76 percent cited it as an obstacle compared to 46 percent for smaller ones.

Despite the low deployment of telemonitoring for outpatients (only 8 percent are covered), only 17 percent of medical directors consider it to be an investment priority over the next three years. According to the report, 78 percent of those surveyed believe that telemonitoring will have little or no impact on improving the quality of patients' lives.

Practically all (92 percent) of European hospitals are connected to broadband, but half of them have a bandwith below 50Mbps, while a higher one of up to 100Mbps would prove useful in advancing digital imaging and telemonitoring, the survey notes. Overall, the results show the best e-health practices are to be found in Denmark and Belgium. Across the 30 countries, there are differences in areas such as infrastructure, level of medical electronic external data exchanges with healthcare actors outside the hospital system and levels of access of e-health services directly to patients.

More specifically, videoconferencing facilities are relatively common, especially for contact between internal medical staff and external healthcare providers (almost 40 percent of hospitals have them). A majority (65 percent) have a common electronic patient record system and electronic exchange of radiology reports occurs in two hospitals out of five. Four out of five hospitals have electronic patient record systems in place, but the report notes, they "do not yet seem to have reached a level of sophistication that will translate into clinical transformation".

However, only four percent of hospitals give patients access to their electronic records. The European Commission is looking to increase this percentage. In its digital agenda for Europe it announced that it would table a recommendation next year to define a minimum common data set for the interoperability of patient records to be accessed or exchanged across member states, while respecting data protection requirements. The aim is that patients should have online access to their medical details by 2015.

E-Prescription is another area where use of the new technology could be increased. It is currently available in 30 percent of the hospitals surveyed. But it is used mainly (87 percent) to connect to pharmacies on the premises and far less to external ones (29 percent).

The report notes that the differences in e-health use between member states "is of concern to patients who might be travelling around Europe and to policy makers concerned to maintain equity and balance throughout the geographic areas of the Union". The European Commission is already addressing the many issues involved. It has established an EU e-health Task Force to assess how information and communication technology can help accelerate innovation in healthcare for the benefit of patients, carers and the sector itself. Under the chairmanship of the Estonian President, Toomas Hendrik Ilves, it held its first meeting in Budapest on 10 May and is due to present its recommendations to the informal meeting of e-health ministers in Copenhagen in May 2012.

Cadolto presents the operating room of the futureas a cost-effective, rational prefabricated solution

Complete Hybrid Operating Room Module

Hybrid operating room with Siemens Artis zeego angiography system Healthcare

The hybrid operating room is the standard of the future, on that medical opinion is largely unanimous. While the combination of conventional operating equipment and angiography has long posed enormous challenges for hospitals in terms of design and construction, only now is prefabrication being viewed as a solution: the prefabrication specialist Cadolto, based in Cadolzburg near Nuremberg, showcases a complete hybrid operating room module.

Room design challenge

The hybrid operating room is gaining ground everywhere. It is now no longer only cardiologists and heart surgeons who are enthusiastic at the prospect of performing minimally invasive, catheter-based and conventional operating procedures in one and the same operating room; this will sooner or later become the norm in the majority of surgical disciplines.

When image-guided diagnostics make their way into the traditional operating theatre environment, it is not simply a case of installing new equipment. Rather, the hybrid operating room revolutionises the whole layout and equipment of the room.

For example, the angiography units require a different arrangement of the operating room staff around the patient. This means that the paths taken by staff, for example in the event of complications, must be carefully thought through. The ceiling mounted screens affect the air flows in the room and also hygiene management. More space is required for ancillary rooms and storerooms, and much more besides.

The first prefabricated solution

In other words: hybrid technology is completely redesigning the operating room. The complex issues which arise have hitherto always been dealt with on a case by case basis by interdisciplinary teams in lengthy, complicated processes. In future, hospitals will no longer necessarily have to shoulder this extremely costly burden for each project.

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PUTTING PATIENTS FIRST

Listening to the Patient Perspective

Interview with Tomasz Szelagowski

With this issue's cover story on patient-centred management, who better to talk to than Tomasz Szelagowski, Board Member of the European Patients' Forum (EPF) and General Director of the Federation of Polish Patients. *(E)Hospital* spoke to Mr. Szelagowski to find out the main issues affecting European patients and what hospital managers can do to improve patient experience.

Firstly, tell us a bit about the European Patients' Forum

EPF was founded in 2003 to become the collective patients' voice at EU level, manifesting the solidarity, power and unity of the EU patients' movement. We currently represent 50 member organisations, which are chronic disease-specific patient organisations working at European level, and national coalitions of patient organisations. EPF's vision for the future is high quality, patient-centred, equitable healthcare throughout the European Union.

By pooling the resources of its members, EPF works on horizontal issues affecting all European patients and supports individual members' initiatives that will benefit the community. EPF facilitates exchange of good practice and challenging of bad practices on patients' rights, equitable access to treatment and care, and health-related quality of life between patient organisations at European level and at Member State level.

Our five core strategic goals are:

- To promote equal access to best quality information and healthcare for EU patients, their carers and their families;
- To ensure meaningful patient involvement in EU health-related policy making, programmes and projects;
- To ensure the patients' perspective, including issues around human rights and quality of life, is heard in developments at EU level on health economics and health efficacy (health, wealth and equity);
- To encourage inclusive, effective and sustainable representative patient organisations; and
- To nurture and promote solidarity and unity across the EU patients' movement. No patients' organisation is too small to contribute to our work.

We work closely with the European Institutions, and other stakeholders in the health area, for example through providing our input in public consultation or in legislative processes relevant for patients (thanks to our members' expertise), and in several European stakeholder groups such as the European Medicines Agency's Patients and Consumer Working Party, or the European health policy forum. We are also involved in several European projects in partnership with stakeholders at European level or/and with Member States.

What are the key activities of the EPF at the moment?

EPF is working on many health-related policy areas, to mention a few examples: Patient involvement in clinical trials and research and ageing (through the organisation of a conference on the Rights and Needs of older patients and through the European Partnership on active and healthy ageing).

We are also very involved in the discussions on the "pharmaceutical package", the last proposal still in discussion, information to the public on prescription medicines, is a key topic for patients. In this debate we have strongly advocated to uphold patients' right to clear, accurate, unbiased and accessible information. In our view this proposal should not be an end in itself but rather the first step in an EU wide health literacy strategy. We believe it is crucial to empower patients to manage their condition, to make choices in their daily life about their health, and to navigate the healthcare system. It is also a key strategy to tackle health inequalities.

EPF is also involved in projects and initiatives related to topics such as patient involvement in e-health and health technology assessment, safety and quality of care, young patients' involvement and patient education.

EPF also recently started to work with member organisations to help them participate in implementation at national level of recently adopted European directives.

In your opinion, what are the main issues affecting patients today?

Health inequalities across and within Member States are undoubtedly a major issue affecting patients. This can take very diverse forms:

- Unequal quality and safety of healthcare services across Europe. There are wide disparities in patient care outcomes in different Member States including within countries and regions.
- Unequal access to treatment (including disparities in pricing and reimbursement of treatment).
- Lack of patient education/poor health literacy in certain geographic areas or among vulnerable groups is another issue, strongly related to inequalities, with many negative consequences: Little or no knowledge of medical care and medical conditions, poorer compliance rates and health status, increased hospitalisations, increased healthcare costs, etc.
- Some disparities also come from a lack of capacity building for professionals.
- Discrimination/stigma in healthcare and other areas of life such as employment.

In addition there are various pressures on governments to control health expenditures, which ultimately can negatively affect patients. The economic crisis and some measures aimed at stabilising the economy have worsened the situation for patients in many countries and tend to widen the socio-economic disparities between groups. The demographic change which affects patients (the number of patients

with chronic diseases is growing), health professionals (shortage), and the healthcare system as a whole as demand grows, is an important challenge which, if not addressed adequately, can worsen the situation.

Though the role of patients is changing and they are increasingly empowered, they are also faced with new threats to their safety such as illegal online pharmacies. They have to face obstacles to their empowerment and involvement in health related decisions and research projects. Though they are expert in living with a chronic condition and have an experience of healthcare system, and though as end users they have a legitimate right to be involved, they are often not treated as adequate or equal partners.

This is your chance to speak directly to European hospital managers. What should they be doing to improve patient experience in their hospitals?

One key message we receive from our member organisations is the need for better coordination and integration in care. Patients have to face obstacles relating to the organisation and delivery of healthcare, which include financial structures, productivity targets and attitudinal barriers. The result of organisational and financial fragmentation is that patients need to spend significant time and energy in "fighting the system" just to get the services they need.

Our member organisations provided us with examples of the lack of coordination within the hospital: "the doctors may want to introduce a simple innovation that makes care better and cheaper, but the hospital laboratories may be against since because the system is organised in such a way that the laboratory will lose "productivity" and therefore related income".

Solutions should be found, in cooperation with patients, to enable them to manage their own situation for as long as possible, with sufficient support from professionals, as appropriate. Better collaboration between health and social care is important to achieve this, and hospital managers could have a role in encouraging it.

Hospital managers should also encourage the change in patient-healthcare professional relations, ensuring adequate training for healthcare professionals to work in concordance with patients, and effective dialogue. Better communication is a key issue, as currently patients don't receive as much information as they wish while healthcare professionals believe they supply enough information. This would lead to better adherence, better health outcomes and patient empowerment.

In addition, a more holistic approach to health, including physical, mental and societal aspects is needed. Taking into account comorbidities and long-term associated problems that affect patients such as functional limitations, psychological symptoms, social problems (isolation, impossibility to work, and financial impact of illness) is also fundamental. This can be achieved in hospitals through adequate organisation and training.

We would also generally advise hospital managers to gather and use patients' experience to improve access, quality and safety of care in the hospital: Patients can offer the richest source of information in relation to what they witness in the hospital during their stay, the failures in the systems and good practices, from beginning to end.

Is the EPF satisfied with the new European cross-border healthcare directive? Has it gone far enough in terms of ensuring patient reimbursement and safety and quality?

EPF believes the directive is an important milestone for patients: It creates a legal framework for the patients' right to seek healthcare in another Member State and to be reimbursed for it. It also provides a legal basis for enhanced European cooperation in key areas of healthcare. We have had a long and intense involvement in the draft directive, having worked closely with the Commission, the EU Presidencies, and MEPs throughout the first and the second readings to ensure that a patient perspective was strongly reflected.

However the directive falls short on some aspects we considered crucial:
Reimbursement is one area where we had a more ambitious vision. Throughout the process we strongly advocated for a system of direct cross-border payment, to prevent patients and their families having to bear the financial burden upfront. This was in our view crucial to ensure equal access. The directive does leave that option open, but on a voluntary basis. While the compromise is less than we asked for, this point did encounter a lot of resistance so its inclusion in the text is in itself an achievement.

In spite of this, the directive is still a step forwards for patients in this respect, as they are now entitled to reimbursement for the costs of cross-border healthcare as they would under the benefits of their national health insurance system. We welcomed in particular a flexible approach of reimbursement of "a similar healthcare" rather than strictly the same. There is a list of exceptions, but it is limited. One particular point is that application for prior authorisation from patients must receive an answer in a "reasonable time limit", which is not clearly defined. When implementing this, it is important to ensure that patients have access to treatment and care without unnecessary administrative delays.

EPF welcomed provisions for mutual cooperation and transparency on **safety and quality.** Member States will be required to make their national standards and guidelines publicly available. The directive also requires Member States to cooperate with each other on safety and quality standards and guidelines, and to ensure that information in their national/local registers on specific health professionals' right to practise is made available to other Member States. The directive also contains provision to ensure better continuity of care, patients who have received treatment in another Member State are entitled to a record of the treatment, and if medical follow-up proves necessary, the home country must provide the same follow-up as for treatment received in its territory. We believe this is also crucial for patient safety and quality of care. In summary, though we would have wanted more coordination at EU level on quality and safety standards, we believe these provisions can pave the way towards better cooperation between EU Member States, and ultimately towards better patient safety and quality of care across the Union

As for the **impact on patients,** it will depend a great deal on interpretation and implementation by Member States. Many provisions in the directive are optional, or leave room for interpretation. Ensuring that patient organisations at a national level are involved in implementation is in our view key to ensuring this directive is truly beneficial for patients.

One key provision of the Directive is the setting up of national contact points where patients can get information. Patients' organisations should be meaningfully involved to ensure the information given meets high quality principles, and corresponds to patient needs. In addition, the directive offers possibility to build on cooperation between Member States in areas such as e-health, rare diseases and HTA.

CARE PATHWAYS: **CUSTOMISING CARE TO MEET THE CHANGING DEMANDS OF TODAY'S PATIENTS**

By Walter Sermeus

The healthcare sector is undergoing major reform. Many shifts in practice and organisation are happening simultaneously. The role of patients is changing, moving from a more passive position into active consumers of care. Patients want to be informed and involved and there is growing attention to quality and safety.

The main driver for these changes comes from the « to Err is human » report from the Institute of Medicine (IOM) in 1999. The report was the result of a particular accident in which a young woman was given a lethal dose of chemotherapy. The report indicated that as many as "44,000 to 98,000 people die in hospitals each year as the result of medical errors". Discussed publicly in the US Senate, the report was the catalyst for an overall hospital reform across the United States. The main problem is the variable quality in healthcare organisations. McGlynn et al. (2003) documented the care for 30 different conditions using 439 indicators and found that the compliance to evidence-based practice was just 54 percent. Importantly, the cause of this poor performance is not the fault of the health professionals themselves but rather the system.

Healthcare systems have indeed become very complex. The individual patient-doctor relationship has been replaced by a team-patient approach. This is caused by the increasing specialisation of health professionals, technological developments and a wider range of patient expectations. These interdisciplinary and inter-professional teams can be very large indeed.

When Dr. Glenn Steele, CEO of the Geisinger Healthcare System was admitted for open heart surgery in his own hospital, many people were concerned about the confidentially of his health information. As a standard procedure, all access to his patient record was logged during his stay. They were very surprised to see that about 120 health professionals had been involved in the care for Mr. Steele. And this is probably only half of what it really is. Next to these front-office workers that meet with patients, there are as many people in the back-office such as those in administration, in lab, in pharmacy, etc.

The complexity of working in teams requires a strong protocol and evidence-based approach with clear communication on goals, roles and procedures. Interdisciplinary teamwork and communication are the buzzwords of the new healthcare systems. The WHO - World Alliance for Patient Safety identified the lack of communication and coordination as the first priority for patient safety (Bates et al. 2009). As these teams are being formed around patients and patients' problems, we see that these teams go well beyond the boundaries of organisations. It is what we expect of good patient care. When Mr. Steele goes home after his open heart surgery, we expect that he will recover at home, that he is monitored by his family doctor. There might be a community nurse visiting him or physiotherapists for exercising the injured thorax muscles, dieticians to adjust his diet and eating patterns. What we have come to expect is that these new teams are taking over with seamless communication and coordination. This is leading to a new type of healthcare in which these kinds of new rules will emerge (Rogers et al. 2009).

Care Pathways

It is in that context that care pathways have their rationale. Care pathways were developed mid eighties with a major focus on reducing length-of-stay, guaranteeing quality of care. The first systematic use was found in the New England Medical Center in Boston (USA) in 1985 as a response to the introduction of Diagnosis Related Groups (DRGs) in 1983.

Care pathways are defined by the European Pathway Association as "a complex intervention for the mutual decision making and organisation of predictable care for a well-defined group of patients during a well defined period." (Vanhaecht et al., 2007).

Defining characteristics of care pathways include:

1. An explicit statement of the goals and key elements of care based on evidence, best practice, and patient expectations;
2. The facilitation of the communication, coordination of roles, and sequencing the activities of the multidisciplinary care team, patients and their relatives;
3. The documentation, monitoring, and evaluation of variances and outcomes; and
4. The identification of the appropriate resources.

Although the use of care pathways in healthcare is still limited due to the slow but firm paradigm shift that is changing the nature of healthcare, I want to describe three examples to show how different healthcare can be with care pathways.

Example One: Surgery with a Warranty

For the first example we go back to the Geisinger Healthcare system and the care pathway they developed for coronary bypass surgery (CABG) (Berry et al. 2009). It started with the conclusion that Geisinger had no method to translate the results from new research and guidelines into daily practice. This resulted in 2004, in the development of ProvenCare programme as a means to create a replicable process of incorporating multiple EBM practices into acute episodic surgical interventions.

In ProvenCare 40 process elements were defined. The programme went live in February 2006 and resulted in compliance of just 59 percent to the 40 standards, although it was preceded by nine months of intensive discussions and preparations. After three

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months, the team already achieved a compliance rate of 100 percent. When the ProvenCare group was compared to a control group, there was a reduction in the number of postoperative adverse events, length-of-stay fell from 6.3 days to 5.3 days and charges were reduced by five percent. The most striking result was that Geisinger was advertising its approach to CABG with a 90-day warranty. The fact that for the first time in healthcare, an effort-commitment was replaced by a result-commitment, made the headlines of the New York Times, May 17, 2007, "In a Bid for Better Care, Surgery with a Warranty". In December 2007, the Harvard Health Newsletter listed it as one of the Top 10 health news stories of 2007.

> Patients were instructed for self-care and to become active participants in their recovery. It resulted in a highly satisfactory stay which is more like a club med style of holiday than hospitalisation.

Example Two: From the OR to the Putting Green

The second example is the introduction of Jointcare, a concept introduced by Biomet, an international biomedical company specialised in orthopedic devices and technology. About 10 years ago, they introduced the organisational concept of Jointcare in the Netherlands to their clients as a byproduct of their sales of devices. The concept was based on the ideas of James Heskett, professor at Harvard University in the US. James Heskett studied the Shouldice Hospital near Toronto which is specialised in hernia repair. The idea at Shouldice was not only to standardise the care process and deliver almost perfect care, but also to design a well-defined service concept using a surgical technique that allows early mobilisation. This permits the treatment of these patients not as sick, but rather as healthy, people who just need their hernias fixed. A programme was designed with many group sessions in which patients were instructed for self-care and to become active participants in their recovery. It resulted in a highly satisfactory stay which is more like a club med style of holiday than hospitalisation. Starting from day two, patients start to play golf on the nice putting green of the hospital. Moreover, patients were able to return to work much more quickly.

The success of this programme was transferred to Jointcare in which patients are invited on Friday for a first information session for the surgery the next week. Patients operated on that week share their experiences and stories; patients are carefully instructed and prepared for surgery in the weeks before. After surgery, patients do not simply stay in their rooms but exercise with the help of nurses and physiotherapists in group sessions. In 2011, around 45 Dutch hospitals offer the Jointcare programme. Length-of-stay is about 30 percent shorter than in traditional programmes, with better functional results. Health insurers in the Netherlands have decided not to contract any hospitals for hip or knee arthroplasty if they do not offer a Jointcare programme as one of the alternatives.

Example Three: Care Pathways Reducing In-Hospital Mortality

A third example is the development of a care pathway for heart failure (Panella et al., 2009). Forty hospitals located in four Italian regions were invited to participate. 14 of them were selected and randomised in an experimental group which agreed to implement a pathway for heart failure and a control group. Data were collected from March 2003 to October 2004. The final number of patients was 429 patients (214 in the care pathway group and 215 in the usual care group). The main result was that in-hospital mortality in the control group was 15.4 percent compared to 5.6 percent in the group receiving the care pathway, which is almost one third of expected mortality. The main explanation for this huge difference is probably the difference in compliance to evidence-based practice and the state-of-the-art in medicine. The use of diagnostic procedures, echocardiography, oximetry and diuresis monitoring was much more frequent in the care pathway group. Similarly, all medications were administered more frequently, with the exception of diuretics and anti-platelet agents. The proportion of patients receiving left ventricular function assessment, advice/counselling on smoking cessation and written discharge instructions was also higher in the care pathway group. The conclusion is obvious. Care delivered using care pathways based on current guidelines, as compared to usual care, is highly effective in reducing in-hospital mortality in heart failure patients.

Conclusion

The three examples show how healthcare may look very different in the years to come. The role of the patient is changing from less passive to more active. Health professionals will be working in interdisciplinary teams transcending the boundaries of organisations, based on care pathways defined by the best evidence available. There will be therapeutic freedom to deviate from the protocols to meet specific needs of patients or as a way of customising care, but not because lack of knowledge or underperforming organisations. This care might lead to more predictable results. Patient-centered healthcare is making the patient the top priority at all times. It surely will affect the way health professionals are working and how hospitals are managed but we all will benefit from it.

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TACKLING UNDERNUTRITION **IN HOSPITALISED PATIENTS:** The Belgian Experience

By André Van Gossum, Miguel Lardennois, Isabelle Laquiere, Patrick Coppens and Marianna Arvanitakis

Undernutrition is frequent but often unrecognised in hospitalised patients with nutritional status deteriorating during their stay. Consequences for undernourished patients include higher risks of infection, complications and an increased length of stay. This in turn is costly for healthcare institutions. Nutritional screening can improve both patient outcomes and cost-effectiveness.

Definition

Malnutrition is a broad term covering any imbalance in nutrition from over-nutrition or obesity to undernutrition.

Undernutrition is usually defined as a deficiency of energy, protein and other nutrients causing adverse effects on tissue, body form (body shape, size and composition) and function, as well as on clinical outcomes and quality of life. It is a condition that is characterised by clinical depletion, undesired weight loss or being underweight.

Nutrition deficits result in major body dysfunctions altering daily activities (autonomy), increasing the prevalence of additional pathologies (vulnerability) and delaying recovery after acute events (clinical outcome), and ultimately jeopardising the economic system of healthcare institutions.

Recently the definition of malnutrition (or undernutrition) has been clarified by ESPEN (European Society for Clinical Nutrition and Metabolism, www.espen.org) to underline the differences between cachexia, sarcopenia (loss of muscle mass and function in elderly persons) and undernutrition (Muscaritoli et al. 2010). Malnutrition observed in hospitalised patients is often a combination of cachexia (disease-related) and malnutrition (inadequate consumption of nutrients) as opposed to malnutrition alone. The definition of malnutrition refers to a complex interaction between underlying diseases, disease-related metabolic alterations and the reduced availability of nutrients (due to reduced intake, impaired absorption and/or increased losses).

Poor nutritional intake, physical inactivity, chronic diseases and ageing pave the way for undernutrition. These conditions are generally not recognised as "risk situations" and are therefore not medically taken into account in due time in order to allow optimal treatment, including timely nutritional support.

The diagnosis of severe undernutrition is based on the presence of at least one of the following criteria:

- Weight loss ≥ 10 percent over one month or ≥ 15 percent over six months;
- Body mass index (BMI) < 18 kg/m2;
- Serum albumin < 30 g/l.

Prevalence and Consequences

It has been demonstrated over many years that disease-related undernutrition occurs in 20-60 percent of hospitalised patients and that the nutritional status deteriorates during their hospital stay (Baker et al. 2011). The consequences of undernutrition are various: Increased morbidity including higher infection and complication rates; impaired wound healing; increased muscle loss; prolonged length-of-stay (LOS); delayed rehabilitation; impaired quality of life; and increased mortality rates.

Moreover, undernutrition dramatically increases the cost of healthcare. A recent study performed in UK showed that disease-related malnutrition accounts for about 10 percent of health expenditure in the country (7.3 billion pounds) (Elia et al. 2010).

Why Screen for Undernutrition?

Severe undernutrition is difficult and costly to cure. As prevention is both easier and more cost-effective, screening for the risk of undernutrition is therefore a first important public health measure to identify people at risk (Rasmussen et al. 2010).

In clinical practice it seems important to distinguish the tools that are used for evaluating the nutritional status of a patient (such as the subjective global assessment) and the tools or scores that have been developed for assessing the risk of undernutrition (Raslan et al. 2011).

Nutrition risk screening refers to a rapid and simple set of usually few questions that have been validated to predict malnutrition risk. Patients who are identified through screening "at risk" are subsequently referred for further nutritional assessment (Kyle et al. 2006).

Nutrition assessment is defined as a "comprehensive approach to define nutritional status using medical, nutritional and medication histories; physical examination, anthropometric measurements and laboratory data" (AD, 1994).

There are several tools for assessing the risk of malnutrition (Velasco et al. 2011). The Malnutrition Universal Screening Test that has been developed by the British Association for Parenteral and Enteral Nutrition (BAPEN) and the Nutritional risk score-2002 that has been developed and validated by ESPEN include nutritional parameters as well as severity of the underlying diseases (Kondrup et al. 2003). In both of the scores, involuntary weight loss within the few months before hospital admission is one major factor.

The Mini Nutritional Assessment (MNA) has been frequently used in the geriatric population (Persson et al. 2002). Comparing the MNA and the NRS-2002 and their association with markers of protein malnutrition, Dreschler et al reported that NRS-2002 seems to be superior compared to MNA and serum proteins in identifying patients at risk of malnutrition during acute undercurrent ill-

ness (Dreschler 2010). Other parameters may be used for screening undernutrition on a local or national level.

Is Systematic Nutritional Screening Routine Practice?

Schindler et al. recently reported the results of a survey of 21,007 patient findings from the 2007-2008 cross-sectional Nutrition Day survey (Schindler et al. 2010). 1217 units from 325 hospitals in 25 European countries were included in this survey. 52 percent of the units in the different regions reported a screening routine which was most often performed with locally developed methods and less often with national tools, the NRS-2002 or MUST. 27 percent (range 21-73 percent) of the patients were subjectively classified as being "at nutritional risk". Independent factors influencing the classification of nutritional risk included age, BMI < 18.5 kg/m2, unintentional weight loss, reduced food intake in the previous week.

In conclusion, this survey showed that frequency and type of nutritional risk assessment varied between units and countries. Moreover, because the units that participated in this survey have an interest in clinical nutrition, we may estimate that the real percentage of units doing a systematic nutritional screening is lower than 50 percent.

What are the Barriers for Implementing Nutrition Screening?

It is well recognised that undernutrition is frequent in hospitalised patients. It has been repeatedly shown that undernutrition may impair the global outcome of the patient and may deeply influence the cost of healthcare. However, recent survey indicated that a systematic screening tool is heterogeneously used in European units. Even if some screening tools are validated, they are not commonly used in daily practice. So what are the barriers for implementing screening of malnutrition?

Lack of Evidence-Based Data

Despite numerous data indicating that patients who are nutritionally compromised suffer worse outcomes, it is difficult to distinguish the role of the underlying disease and the role of undernutrition on the outcomes (Amaral et al. 2010).

The lack of an unequivocal findings of the benefits of nutritional intervention in malnourished patients is likely related to difficulties in performing high-quality randomised-controlled trials owing to the ethical concerns of withholding nutrition support to patients identified as at risk of undernutrition (Starke et al. 2011).

Additionally, parameters for assessing the impact of a nutritional support for hospitalised patients should be reviewed and adapted taking into account actual medical practice and economic concern that encourage to shorten the LOS. Social and professional rehabilitation after hospital discharge and quality of life should be more frequently used as parameters (Marin Caro et al. 2007).

Lack of Information and Awareness

Background on clinical nutrition and metabolism for care providers including physician, nurses and even dieticians is quite weak (Mowe et al, 2008). Moreover, awareness about the risk of malnutrition is low not only amongst caregivers but also for patients and their relatives and other stakeholders.

Lack of Human Resources

Asking a few questions to a patient for nutritional screening takes only a few minutes. However, screening thousands of patients/year may represent a significant increase of workload. Moreover, the screening procedure requires good organisation. Who is asking these questions? The nurse? The dieticians? The doctors?

In addition, the implementation of a screening programme for undernutrition requires simultaneous organisation of nutritional assessment, adequate nutritional support, monitoring of nutritional parameters and counselling at discharge. In other words, nutritional screening is useless if a global nutritional approach is not determined. For achieving such goals, any institution should have a multidisciplinary nutritional support team (NST).

Lack of Financial Support

A systematic nutrition screening programme followed by a global nutritional strategy has a cost not only for covering human resources but also for providing adequate food, oral nutritional supplement, enteral and parenteral nutrition.

Policy makers at the healthcare ministerial level as well the hospital administration should be convinced that investing in nutritional support may not only improve patient outcomes but also reduce the costs in the global healthcare system.

Actions in Belgium

Belgian medical and political players were concerned by the resolution of the Council of Europe on malnutrition in hospital and home care settings released in 2003. So when the Federal Public Service (FPS) of Public Health Food Chain Security and Environment decided to launch a National Food Health Plan for the period 2005-10, axe 5 devoted to "Malnutrition: prevention and treatment" was incorporated.

In the global axe 5 of the National Nutrition Health Plan, action 50 was to elaborate an action plan for identifying a nutrition responsible as well a multidisciplinary nutrition support team (NST) into each hospital. Action 55 was designed to define a strategy for transferring and exchanging nutritional data between hospitals, home care and care homes in the form of an individualised nutrition chart. This project includes implementation of nutrition screening, elaboration of protocols for selection and provision of adequate food and nutrition support, monitoring of nutrition strategy, information and sensitisation of caregivers and recommendations about nutrition at discharge. In brief, the goal was to include nutrition in the global journey of the patients. The scheme was prolonged and extended to 70 hospitals in 2009 and to 96 hospitals in 2010. These hospitals represent 60 percent of all Belgian hospital beds.

Alongside Nutrition Day 2009, a campaign of awareness was introduced in the Belgian hospitals involved in this action. Posters were created informing of the prevalence, impact and treatment of undernutrition in hospitalised patients. The posters were placed in the entrances and departments of each hospital and received significant media attention. These actions are still ongoing.

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CAPITAL IN THE CITY

Investing in the Hospital of the Future

By Stephen Wright, Bernd Rechel, Martin McKee and James Barlow

The European Observatory on Health Systems and Policies has published two sister volumes on the issues of capital investment in hospitals in Europe (see box). This article highlights two key aspects of the study – the encroachment of market principles into what is still largely a public sector-dominated activity and the financing models being increasingly used.

There is an inherent paradox in reviewing hospital projects. Given the timescales for hospital development, if a facility has been running long enough for it to have settled down and be generating evidence about its performance, it must have been conceived more than a decade before, and cannot represent state-of-the-art any longer. If, on the other hand, it embodies latest thinking, then it cannot yet have been tested in the real world. While there is no absolute way round the oxymoron of a proven modern hospital, carefully dipping into the stream of evidence provides suggestions about the direction of travel.

The Impact of the Global Economic Crisis

At present, the world (the West in particular) is suffering from the worst economic recession since the Great Depression of the 1930s. Adding to the problem is the fact that the recession overlaps with an incipient ageing crisis. This is both a healthcare and a pensions problem. Governments are certain to spend at least the next decade struggling to pay down high levels of debt while simultaneously increasing expenditure as baby boomers retire. This might expose health system spending to cutbacks. Broadly speaking, Western governments will have to shift overall spending by about five percent of GDP to reverse existing fiscal deficits, five percent to pay down legacy debt and five percent to rebalance spending towards the ageing. 15 percent of GDP is a massive switch of spending priorities. In this light, one obvious, and favoured, response by governments will be to cut capital investment, including that in the health sector. However, this would be a mistake, as ageing capital assets are unlikely to provide the best environment for innovative

Investing in hospitals of the future

The sponsoring organisations

The two books include a set of case studies[1] and a thematic treatment[2] of the decision to invest in hospitals, or rather in healthcare assets. The European Observatory on Health Systems and Policies is a partnership which brings together a number of international institutions, national and regional governments, universities and NGOs (www.euro.who.int/observatory). The Observatory promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe. The study was organised in conjunction with the European Health Property Network, the research work of which has been taken forward by the European Centre for Health Assets and Architecture (ECHAA), set up recently as a European centre of reference to advice on all dimensions of capital asset strategy in the health sector (www.echaa.eu).

The case studies

Capital investment for health is a compilation of case studies – seven individual hospital projects in Netherlands, Norway, Finland, Sweden and Spain, a private hospital group in Germany, regional planning in Italy and Northern Ireland, and a financing system in the UK. Some consistent themes emerge from the case studies: the increasing role of market mechanisms, the value of whole-systems approaches, systematisation of care pathways, integration of medical models of care with business models, importance of sustainability in the widest sense, and the requirement for flexibility in the financing as well as other aspects of a hospital's development and management.

The thematic book

Investing in hospitals of the future gleans lessons from the case studies as well as other sources, and attempts to deal systematically with the various dimensions and roles of a modern hospital: models of care, planning systems, workforce, markets (particularly in financing), life-cycle analysis, facility management, wider community impact, sustainable design, and the concepts of designing a stock of capital to deliver a flow of services. The principal message is the need for flexibility, in order to respond to the unknown (and very often unknowable) contingencies of the future; and the importance of understanding the variety of primary and secondary processes, the linkages between them and the nature of the capital assets which will support them.

1. Rechel, B, Erskine J, Wright S, Dowdeswell B and McKee M, Eds. (2009). Capital investment for health: case studies from Europe. Copenhagen, World Health Organization, on behalf of the European Observatory on Health Systems and Policies. www.euro.who.int/observatory/Publications/20090914_1

2. Rechel B, Wright S, Edwards N, Dowdeswell B, McKee M, Eds. (2009). Investing in hospitals of the future. Copenhagen: World Health Organization, on behalf of the European Observatory on Health Systems. www.euro.who.int/observatory/Publications/20090323_1

HOspITALs In THE n ETHERLAn Ds LOOk TO THE Fu Tu RE
WITH LONG-TERM PARTNERSHIP AGREEMENTS

Healthcare institutions are in a precarious situation across Europe. The healthcare market is changing: an ageing population means more patients, less staff and soaring costs. Competition is also increasing with patients becoming more involved with their own care, demanding high quality and affordable prices. Team all of these factors with widespread governmental cuts across Europe and the future for European hospitals does not look bright.

Two hospitals in the Netherlands are taking a more positive attitude to this increasingly challenging situation. Instead of looking for a quick fix by cutting costs and compromising on equipment, the Maas Hospital Pantein and the Rijnstate Hospital Arnhem have entered into long-term partnership agreements with Philips Healthcare.

Why Philips?

But how can Philips Healthcare help hospitals combat these financial and societal challenges? Well, these long-term agreements make the hospitals and Philips strategic partners, working together to ensure the current and future success of the hospitals. More than just supplier and service provider, as strategic advisor, Philips uses its global market and business knowledge to plan for the future of these hospitals.

Philips is well aware that controlling and reducing costs while maintaining quality of care is the top priority of all hospital managers. They believe innovative services focused on partnerships, new business models, processes and education can improve patient experience and quality of care within established financial frameworks. Hans Bossink, CEO of Philips Healthcare Benelux explains, "At a time when the demand increases and healthcare costs are under pressure, we see that our role is changing and goes beyond delivering technology."

These strategic long-term partnerships are about balancing the need for the best equipment with containing costs and minimising financial risks.

The Partnerships

Maas Hospital Pantein:
Ten Year Partnership Agreement for Medical Technology in Newly Built Hospital

Goal: Latest technological capabilities at minimal financial risk

The Maas Hospital Pantein, part of the Pantein holding, is a regional hospital with a wide range of specialist medical care and a strong focus on chronic diseases, prevention and early diagnosis. A new hospital was built in 2010, becoming operational in April of this year and Philips was chosen to supply all medical technology equipment for the radiology and nuclear medicine departments including x-ray, CT, MRI. Equipment for cardiology, gynaecology and patient monitoring are also included in the deal.

> "In the past it was just about providing, supplying equipment, now it is more about thinking with us about solutions."

Picture 1. Dr. Verreussel, *Maas Hospital*

Philips plays the dual role of global technology provider and strategic advisor. Philips supplies the latest technologies in line with demand and allows for the implementation of the latest innovations within a set financial framework. But the agreement goes beyond the supply and maintenance of equipment; equipment is upgraded and replaced when needed and specialists and their staff are trained throughout the ten-year period.

CEO Dr. Verreussel recognises the changing nature of the healthcare market, "In the past it was just about providing and supplying equipment, now it is more about thinking with us about solutions." The solutions in question include innovative business models, designing spaces for new systems, replacement processes, financing, maintenance and training. Through the partnership, the hospital ensures the optimal use of equipment and continuous improvements in workflow.

In the Maas hospital Pantein the partnership has four dominant aspects:

- Equipment
- Maintenance
- Education
- Leasing

For Verreussel the educational agreement is of particular importance due to the specific regulations for the use of medical equipment. Proper training of staff plays a large role in their risk management strategy. Philips has taken on this responsibility freeing the hospital management to concentrate on other issues.

Rijnstate Hospital:
Ten-Year Supply of Imaging Equipment for Radiology and Nuclear Medicine

Goal: Controlling costs while increasing efficiency

Rijnstate Hospital in Arnhem admits more than 40,000 patients per year with half a million attending the outpatient clinics. The hospital prides itself on high quality care through professionalism, commitment and innovation with the patient at the centre of everything.

Like the Maas Hospital, Rijnstate has entered into a ten-year partnership agreement with Philips Healthcare covering the supply and installation of imaging equipment with technical support and strategic advice. Equipment provided in the agreement includes ultrasound, radiography, mammography, CT, PET-CT and MRI. A key element of the partnership concerns radiological research, their goal is to optimise processes in the radiology department. CEO Dr. de Bey sees the partnership as a strategic move to improve the hospital and its reputation, "We want to be ahead, we want to be in the lead and this position needs strategic partners…who can help us solve the challenge."

> "We want to be ahead, we want to be in the lead and this position needs strategic partners…"

Picture 2. Dr. de Bey, *Rijnstate Hospital*

Picture 3. Rijnstate building in Arnhem

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Picture 4. Maas Hospital pantein

Resources are strained so the key is to use them more efficiently; this includes equipment. For radiology this means maximising the amount of time the scanner is used effectively and maximising the number of scans performed per day. Using detailed measurement and analysis, Philips can judge to what extent the capacity of the system is being used. Based on the results, the hospital can adjust working practices and protocols.

Rijnstate has been making use of this service for MRI since 2009. By optimising work processes and extending opening hours, the waiting time for an MRI has been reduced from six to two/three weeks. Through the new partnership agreement, Philips will analyse CT examinations too.

Dr. de Bey wanted more than just a supplier, he wanted a partner to develop new features and processes to improve quality and efficiency, "The main reason why we chose Philips was that the agreement we reached was about more than just the systems they supply. It was about the partnership, it was about innovation, it was about education."

Long-Term Partnerships: The key to a Successful Future

Philips healthcare believes that hospitals are not simply looking for the lowest price; they are looking for security, value and fixed prices in the long-term. Each hospital is unique, with different technological needs. A long-term partnership ensures the latest technologies are tailored to meet patient demand, are maintained and staff are trained appropriately while eliminating future financial risks. The partnership works together to improve efficiency, optimise processes and ensure the sustainability of the hospital.

For more information on Philips Healthcare Long-Term Partnership Agreements please contact: Sabine van Deursen, Philips Healthcare Communications

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PHILIPS
sense and simplicity

healthcare. The current economic circumstances, then, make wise investment choices in healthcare even more important, and more difficult, than before.

Marketisation

Market competition involves multiple developments in hospital care. It may be brought about by a government policy that is explicitly directed at creating competitive relationships. Pro-competition reforms are intended to increase the efficiency and innovativeness of hospital care, to improve its quality and make it more patient-oriented. Examples of these reforms are the introduction of competitive bidding models or the elimination of barriers to entry into the hospital market by new providers. Developing hospital information systems to support performance measurement, with the goal of improving the quality and efficiency of hospital care, fits perfectly within a market reform, because information is also a precondition for informed choice and more effective management and competition by providers. Furthermore, it would be wrong to view market competition only as the result of central government reforms. The picture is more complicated. 'Bottom-up' initiatives by private providers or local governments to provide services in new settings, such as those using remote patient monitoring technologies, or moves to privatise public hospitals, may also elicit competition.

Wide Range of Changes in Hospital Care

However, there have been various changes in hospital care: In the public-private mix; the role of new entrants; the reform of arrangements for funding; the introduction of new models of capital investment; and the development of information systems measuring hospital performance.

The public-private mix of healthcare delivery is diverse: France has substantial provision of elective care by private clinics; Germany has many not-for-profit hospitals and an increasing number of for-profit hospitals; in many countries with national health services, the share of private groups of any kind remains relatively low. But policy-makers in some countries are seeking to convert hospitals into private agencies through privatisation, and correspondingly to introduce competitive mechanisms into public sector provision. It is not clear whether the underlying belief that private for-profit hospitals are more efficient is correct; most economic research in the US market indicates this is not so. Indeed, several recent studies of the German hospital sector seem to corroborate that, even when corrected for quality, public hospitals are more cost-effective than the private sector.

Most hospitals in Europe are general hospitals offering a wide range of acute and elective care services. A recent development has been the rise of new providers that are mostly private single-specialty organisations delivering routine hospital care, in an ambulatory or stand-alone setting, such as the 'independent treatment centres' in the United Kingdom. This may be coinciding with splitting hospitals, even tertiary facilities, into multiple single-purpose 'factories'.

Hospital funding, mostly recurrent, is also changing. There is a strong trend away from global budgets towards case mix-based funding. While not a market reform in itself, it is a pre-condition for market competition. Diagnostic-Related Groups (DRGs) and the like do, however, have certain problems. The systems tend to be complex and have unintended consequences. Health insurers are not yet able to function as a countervailing power in price negotiations with dominant hospital providers. There is a lack of transparency and comparable data, even for yardstick competition. And finally, it is not clear that, as prices, DRGs are either appropriate in every-day resource management use (given the growing importance of chronic disorders for which episode-based measures are of limited relevance) or, in particular, give the right signals with respect to new capital investment. Hospital performance information is not only an instrument to inform stakeholders but also a tool to improve the efficiency and quality of hospital care. Initiatives invariably cover quantity, cost and productivity measures. It is also worth noting the increasing use of quality indices, such as the Patient-Reported Outcome Measurement – the patient's perception of the degree to which they felt better after treatment – now being rolled out in the English NHS.

Financing Models

Within the health systems of Europe, where financing and provision are dominated by the public sector, most of the financial resources are ultimately supplied by the state. Traditionally, with respect to capital investment in new or upgraded facilities, this was by means of something called public sector 'equity' – which bears, however, little resemblance to its private sector equivalent in that the value of the estate often did not need to be accounted for nor a financial return delivered to the shareholders. Public sector debt in principle introduces more discipline, though often where there is a so-called soft budget constraint, there are no sanctions for overspending.

EU Structural Funds

A new source of capital funding, which is particularly applicable to the new member states of the European Union, consists of 'Structural Funds', grants used largely for regional development. The majority of this funding is applied to transport, energy and environmental infrastructure, but in the current 2007-13 programming period it is thought that up to five percent of the total 347 billion euro may be used in the health sector. Projects and programmes go through an elaborate approvals procedure, from the EU through national down to local level. As a result of eligibility criteria, most funds will be focused on relatively poor areas, where they could well account for a substantial proportion of healthcare capital expenditure in coming years. The impact of this spending, and the degree to which its availability biases the choice of projects, are as yet unknown (see www.euregio3.eu).

Public-Private Partnership (PPP)

An encroaching concept for capital spending is the Public-Private Partnership (PPP) instrument. Concessions of one kind or another have been used for many years, and have included the health sector. However, the modern use of PPPs has expanded greatly with the UK's Private Finance Initiative (PFI). In a PFI hospital project, the hospital trust lets a contract for construction or redevelopment of accommodation on a site (sometimes including medical equipment), with the facilities leased from the private sector for up to 35 years.

The contractor designs the hospital according – in principle – to an output (not input) specification set by the public sector, raises the finance, arranges for construction, and carries out the 'hard facilities maintenance' (and sometimes other maintenance)

during the contract life. The facilities are returned to the hospital trust at the end of the term. In return, the contractor is paid a monthly unitary charge, offset by penalties for any unavailability of space or reduced standard. Variants of this model are used in France, Spain and Portugal.

The accommodation-only PFI model is complemented by others. One example has a clinical services company, paid mainly by volume of activity, operating alongside the infrastructure company (this scheme is used for some hospitals in Portugal). Some of the hospital privatisations in Germany amount to a concession, where a private company takes over a failing public hospital and operates it as a licensed facility within the region's public hospital plan (i.e. there is no cream-skimming of patients, but otherwise operational freedom exists). Similarly, there are arrangements in Spain where a company operates a full hospital concession but in addition runs the community care facilities in an area, and is reimbursed not by performance fees for the sites but rather through a capitation payment (that is, a fee per member of the regional population). This is effectively a version of the Health Maintenance Organisation framework used in the United States.

All of these PPP models attempt to incentivise the performance of the private sector contractor by the bundling of responsibility for the capital costs together with the recurrent costs – certainly at the level of the building (PFI), but sometimes additionally with other more general recurrent costs including hospital medical services or community services. There are pros and cons of each model, with the prime difficulty arising from the tendency for the private partner to capture the tangible (cost reduction) benefits of the contract while leaving the public sector hospital authorities struggling to ensure quality or to adapt the facilities to changes in medical provision over the very long durations in the contract.

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INDUSTRY ANALYSIS: **Alternative Financial Solutions and Technological Innovations**

Ms. Janani Narasimhan, Industry Analyst, Patient Monitoring Technologies, Healthcare Group, Frost & Sullivan

Certain factors, both economic and political, clearly influence short-term prospects for the successful development of technological innovations such as Remote Patient Monitoring. It is essential that companies evolve strategies to face inevitable challenges. Companies involved in patient monitoring have come a long way in building up a healthcare portfolio, which is needed to improve and extend the lives of millions of patients. Companies have also realised that despite economic slowdowns, to survive in a mature market, there is an ongoing need for innovation.

Healthcare providers are increasingly under pressure to provide high quality healthcare and, at the same time, adhere to high levels of cost containment. Medical equipment suppliers are under equal pressure to introduce and sell technologically sound devices. Keeping this in mind, alternative financial solutions were created to encourage the uptake of capital-intensive patient monitoring equipment.

One example is the managed services programme currently offered by Philips Healthcare. Recently, the company signed a ten-year agreement to manage the imaging technology needs (including maintenance, upgrades and replacements) of the Hospital de la Santa Creu i Sant Pau's medical imaging and monitoring capabilities at a fixed monthly rate.

Others within the patient monitoring space have also developed separate financial operations, whilst some offer working capital and instalment loans; the focus of the majority of these operations is on leasing contracts. These solutions further strengthen the expanding role of public-private partnership initiatives that are deemed to be of great importance across the healthcare sector.

Alternative financial solutions ensure that the hospitals and clinicians are equipped with solutions that cater to patients' needs without having to incur high initial expenditure. GE Healthcare has recently come up with investment solutions by funding companies with promising technologies and business models. GE's six billion dollar 'Healthymagination' fund provides prospective emerging companies a platform to shape the future of healthcare.

This text is an excerpt from the article, "The European Patient Monitoring Market: Life-Saving Technology Evolving at a Rapid Pace" published in Cardiology Management (volume 4, issue 2, 2010). To read the article in full, please visit: ***www.cardiologymanagement.eu***

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IT @ 2012 will recognise and promote outstanding healthcare IT and medical technology projects. 25 nominees from across Europe and beyond will compete in the *IT @ Networking Awards 2012* on January 18 – 19 2012. This high-level competition will see candidates go through two rounds of presentations in an effort to convince the expert audience and panel of judges why their solution deserves to win. If last year is anything to go by, attendees will not hold back in cross-examination of each presenter during the Q&A sessions before placing their vote for their favourite solutions.

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teria. Such criteria allows for a cross-departmental understanding of each solution.

Uniquely, *IT @ 2012* requires all presenters to talk about the key problems they have encountered in creation or implementation. By highlighting honestly the problems and obstacles encountered, they provide the audience with an excellent tool for advancing similar issues in their own institutions.

IT and medical technology is of key importance to hospital management, especially considering the current financial constraints and increasing pressure our healthcare systems are faced with. Intelligent IT solutions increase cost-effectiveness, productivity and safety.

HOW IT WORKS

IT @ 2012 is a two-day event comprising two rounds of presentations. During the first day, 25 projects will be showcased in a Mindbyte presentation. Mindbytes are short and straight to the point. In just five minutes, each presenter will highlight the main advantages of their project and convince the audience they want to know more. After each presentation you, the expert audience, and our panel of judges will place their votes. The top nine presentations make it through to the second day of competition where they are given the opportunity to present their projects in detail. This Workbench presentation has an allocated time of 30 minutes followed by 15 minutes of cross-examination.

WHAT SETS US APART

What differentiates *IT @ 2012* from other congresses? The main difference lies in the element of competition. Yes, *IT @2012* features presentations from across the world. But these are presentations with a difference, competitors are presenting to win; they have a completely different mindset. Each presenter will do the best to secure the top prize, to persuade the audience and judges that their solution deserves to win. The Q&A sessions also take on a new dimension with presenters having the opportunity to cross-examine their competitors.

HOW TO REGISTER

HITM members are eligible for a reduced rate. For this special fee you can enjoy two days of informative presentations of fully implemented and running IT and medical technology projects. Moreover, you will have a say in who will win the trophy. Refreshments, lunch and evening entertainment are also included, giving ample opportunity for networking.

To register, please visit:
https://www.conftool.net/itawards2012/

LOCATION

IT @ 2012 will take place in the famous Theatre de Vaudeville, a most stimulating environment in the Gallerie de la Reine, the centre of Brussels.

Hotel reservations can be obtained through www.booking.com.

For more information please visit our website www.itandnetworking.org or contact us on +32/2/2868501 or send an email to office@hitm.eu

We look forward to seeing you in Brussels in January!

HOSPITAL MERGERS: MANAGING COMPLEX CHANGE IN A COMPLEX ENVIRONMENT

Interview by Lee Campbell

Hospital mergers are an increasingly common phenomenon in the healthcare sector but how can we successfully manage such radical changes? *(E)Hospital* spoke to Dr. Soki Choi, a consultant, teacher and researcher from the Karolinska Institute to find out more about the topic. Dr. Choi performed an extensive study of the flagship merger of two Swedish university hospitals: The Karolinska Hospital and the Huddinge University Hospital in Stockholm, Sweden. Her results provide some very useful insights for hospital managers regarding mergers and also change management in general.

Mergers are commonplace in many industries but less so in the hospital sector. Why is this?

That is quite interesting as it is not true. There have been a lot of hospital mergers, in fact it has been described as "merger mania". Perhaps the reason is that the media are not reporting about hospital mergers in the same way they do with the private industry.

We have to remember that mergers in healthcare actually started already in the 1980s in the United States and came to Europe in the 1990s. You can see in my dissertation more specifically that mergers have taken place for a number of years in the UK and Sweden for example.

What are the main drivers for hospital mergers?

You can say that, in general, mergers have been justified by promising dramatic financial and operational improvements. When it comes to university hospitals, which are a special case, additional key drivers often include strengthening R&D in the international arena. Also, one other important circumstance is that if you look into Europe, where we have more publicly funded healthcare than in the US, there is often a political agenda behind hospital mergers: To win organisational legitimacy rather than organisational efficiency.

So it is important to be specific whether we are looking at private, public sector or university hospital mergers. But what is common with all these types of hospital mergers is that the main driver predominantly is to achieve quick and large financial savings.

And are mergers normally successful? Do hospitals achieve these large increases and savings?

Well no, what we can see from 30 years of international research is that it is quite common to have "small wins" initially in forms of savings from straight-forward consolidation of administration, but they are often eaten up by the larger bill of the change process itself. Decision makers and managers often underestimate the challenges, the cost and the time it takes to carry out such an extremely difficult operation. Actually, merging hospitals might be the most difficult change process you can deal with and it is very often that they do not fulfil the intended goals.

You have studied the merger process of the Karolinska Hospital and the Huddinge University Hospital in Stockholm, Sweden. Could you tell us a little about this merger?

I studied the merger from 1995 until 2010. I looked at both the pre-merger and at the post-merger processes. The thesis I have written is by international comparison extensive as most studies look only at a one to three year period. This short timeframe can be misleading, since it usually takes between seven to ten years to realise synergies. So, you might have to extend it for several more years to see the long-term effects.

The decision was extremely controversial from the outset. There was a historic rivalry between these two university hospitals in Stockholm and also political conditions were unfavourable with a change of political majority after every election. This meant that the region didn't have the long-term political stability supposedly needed to effect reforms and radical change such as mergers. Still, the final decision was made by the regional parliament and passed by one single vote. It was really dramatic in terms of voting.

It was very, very clear the goal was to reduce expenditures by 700 million kroner (the equivalent of 70 million euro) over three years in order to achieve budget in balance by the next election. So there was also a political agenda for the political majority to win the election in 2006. The second merger goal, which was more vague but still espoused, was to strengthen Stockholm's competitive position in the international research community by concentrating on highly specialised care through the merger.

Were these cost savings reached?

No, they were not reached. The original implementation plan was withdrawn by the next election period and in 2006 there was a new political majority in the regional government and the hospital director was fired. That was the outcome of the merger for the first three years. Costs were escalating instead of decreasing; people were calling the merger a "black hole" due to uncontrollable costs that continued for even two more years.

However, the new hospital director (still in the position today) at that point came in with a different change strategy in line with modern change management literature and was

able to turn and break this bad result. So Karolinska University Hospital has been going really well ever since, and even produced a financial surplus for the last two years.

When I visit clinics today, the integration seems to be going quite well and things seem to be coming into place seven years post-merger. Again we can see that it takes time to reap the benefits of a merger.

What were main obstacles to overcome within this merger?

If you look into the traditional industry merger research, which begins in the 1960s, the main obstacle pointed out is typically the horizontal tension or differences between the two organisation cultures. So, if you only look at recommendations from the traditional industry you might be misguided. You risk missing the primary obstacle, which is the vertical clash between managerialism and professionalism. We can see that this is one of the major mistakes that the first hospital director made. She immediately focused on the horizontal tension by for example putting a lot of effort into building one new brand, fairness by having two offices at each site, etc.

It doesn't mean that the horizontal tension doesn't exist but that it is dominated by the vertical conflict in a merger, at least initially. This is a very important conclusion from my dissertation, which is why I put it in the title: "Competing logics in hospital mergers". I think this is the main message that my long-term research project has been contributing to.

Could you define managerialism and professionalism?

To put it simply, these are the different working logics between managers and professionals. Using research terminology, managerialism and professionalism represent two competing institutional logics inherent within healthcare. Managerialism, which now dominates healthcare since 1980s, calls for hospitals to adopt "business-like" structures and managerial practices. From a market-managerial perspective, professionalism distorts the operation of markets, promotes rising costs, and encourages "producer capture" of services. Professionalism, which dominated healthcare 1945-1964, calls for hospitals to adopt traditional clinical working principles and medical practices based on discretion, autonomy, clinical expertise and academic credentials. In healthcare these two logics are inherently in conflict, which is why the vertical tension and not the horizontal created more problems in the case of the Karolinska University Hospital merger.

What role does the hospital manager play in the merger process?

First we have to be clear that the hospital management plays a critical role, which is not always given in professional service organisations, where physicians have a powerful position as a norm. In the private industry, senior managers usually take the role as the visionary, authoritarian figure actually executing radical change, such as mergers. But in the healthcare industry, managers seem to be limited to initiating radical change and then forced to take the role of the scapegoat. Research shows that the costs both emotionally and professionally are typically much higher for managers in the healthcare sector.

Merging two hospitals and their staff, each with their own way of working must be a key problem. In your opinion, what can the management do to ensure the process goes as smoothly as possible?

This goes back to the reasoning about horizontal and vertical tensions, that I was talking about before. Don't waste too much energy and time only handling the horizontal clash. Again, the prime obstacle seems to be – at least initially – the vertical conflict between managers and professionals, and not the horizontal conflict in radical change, such as hospital mergers.

If you look at the Karolinska case, the new hospital director invested a lot of time and money into the new common name, logo, brand, mission, vision etc. to handle the horizontal challenge. But business was going on as usual on the floor, who thought that upper management's strategy (i.e. managerialism) was incomprehensible and futile in comparison to saving lives (i.e. professionalism). So what you also can observe is that professionals seem to have double citizenship: One goes to the professionals and the other to the organisation. Research shows that physicians usually have stronger loyalties to their identity as medical professionals rather than the management and hospital as a whole. Hence, management in hospital mergers need to also have a strategy for handling the vertical conflict between managerialism and professionalism and not only a strategy for handling the two merging organisational cultures.

Top tips for hospital managers

1. **Be aware of how complicated the merger process is.** It is actually one of the most complicated organisational changes to deal with; three out of four mergers fail in the private industry, and failure rate is even higher in healthcare.
2. **Do not underestimate the extra support and external expertise needed to operate mergers.** Research suggests that hospital managers often underestimate the amount of time and support they need. Also when it comes to consultants you have to hire the right one, since management consultants tend to use advice from traditional industry only. By hiring the best advisers, unnecessary costs and suffering can be avoided along the way.
3. **Use the right methods.** Don't rely on examples and experiences from the traditional industry and grey literature. Use lessons learnt from 30 years of research in healthcare management i.e. evidence-based methods.
4. **Make small incremental step-by-step changes instead of big radical ones.** If you try to make large scale changes quickly in healthcare, you only risk to produce dysfunctional outcomes such as escalating and uncontrollable costs.
5. **Give it time.** Successful mergers take time. Research shows that it might take up to 7-10 years before you can enjoy the benefits from a merger.

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ENHANCING PRESCRIBING EFFICIENCY **THROUGH INCREASED UTILISATION OF GENERICS AT LOW PRICES**

By Brian Godman et al.

Pharmaceutical expenditure is increasingly scrutinised across all sectors due to its rapid growth outstripping other components of healthcare. This growth has been driven by well-known factors. These include changing demographics, strict clinical outcome targets, rising patient expectations, continued pressure from pharmaceutical companies and the continued launch of new expensive drugs.

Unsustainable growth has resulted in greater urgency among governments, professional medical organisations, health authorities and health insurance companies to introduce additional reforms to conserve resources. These are typically centred on generics to improve prescribing efficiency of existing products in a class or related classes, and include both supply and demand side initiatives (Table 1). The objective is to take advantage of the increasing availability of generics, with estimated global sales of products likely to lose their patents between 2008 and 2013 at $50bn to $100bn/year.

The reforms and initiatives also include measures to address concerns with the effectiveness and safety of generics when they occur. The result is enhanced savings with the increasing availability of generics to help maintain comprehensive and equitable healthcare in Europe.

Reform	Examples
Supply side reforms (affecting prices)	▸ Compulsory price cuts for continued reimbursement ▸ Aggressive tendering of drugs in hospitals ▸ Additional policies to obtain low prices for generics versus originators, which include compulsory generic substitution as well as increased transparency in the cost of manufacture of generics and/or rebates and discounts given the community pharmacists
Demand side reforms (affecting utilisation)	▸ Guidelines, prescribing guidance, e.g. 'Wise Drug List' in Stockholm County Council developed with professional input, academic detailing, benchmarking, and electronic support systems such as ScripSwitch in the UK, to influence treatment choices ▸ Professional quality circles on drug prescribing, including continual medical education, integrated into clinical practice ▸ Prescribing targets, e.g. % of generic Proton Pump Inhibitors (PPIs) prescribed versus all PPIs and % generic statins prescribed vs. all statins ▸ Financial incentives to physicians, pharmacists and patients to enhance the prescribing and dispensing of generics in a class/related class ▸ Price: Volume agreements with pay back mechanisms for over budget situations ▸ Prescribing restrictions for existing patent protected products in a class or related classes once generics become available, e.g. prescribing restrictions for atorvastatin and rosuvastatin in Austria and Finland

Table 1. Examples of current reforms across to enhance prescribing efficiency through increased utlisation of generics at low prices

Ongoing Initiatives to Lower the Prices of Generics

Each European country has introduced different measures to lower the price of generics. However, they can be categorised into three distinct approaches: Prescriptive pricing, market forces, or a combination of the two (mixed approach). Table 2 (page 30) contains the definitions and examples. Typically across Europe, patients have to pay the price difference for a more expensive molecule than the reference price themselves, which helps drive down generic prices where countries use market forces or mixed approaches.

The various measures helped reduce reimbursed expenditure for generic simvastatin by between 53% to 97% in 2007 versus 2001 originator prices among a range of European countries. Price reductions were typically less for generic omeprazole, i.e. in 2007 between 52% to 82% below 2001 originator prices.

However, there is still considerable variation in reimbursed prices for both generic omeprazole and generic simvastatin across Europe despite these reductions (Figure 1, page 31). This confirms earlier studies, which showed generic prices could vary up to 36 fold in the ambulatory care sector depending on the molecule. There are also considerable differences in drug prices among hospitals, with discounts and rebates up to 100% for certain products.

Addressing Concerns Regarding Generics

There have been concerns regarding the effectiveness and safety of generics among some physicians and patients, exacerbat-

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Generic pricing approach	Definition	Examples
Prescriptive pricing	Mandated price reductions for generics to be reimbursed	▸ France: Generics have to be priced 55% below originator prices to be reimbursed; a further 7% reduction after 10 months. ▸ Norway: Three step process with generics ultimately priced 65% to 85% below pre-patent loss originator prices depending on expenditure (i.e. only 15% to 35% of originator prices).
Market forces	Price reductions are left to market forces, with measures in place to enhance generic utilisation	▸ Germany: Complicated system to lower generic prices. Process helped by the abolishment of patient co-payments if patients are dispensed a generic which is 30% below the current referenced price molecule. ▸ Spain: Reimbursed prices based on the cheapest product in the homogeneous group. Price reductions helped by patients no longer able to pay the difference for a more expensive molecule, and since 2007 mandatory substitution with the cheapest molecule when International Nonproprietary Name (INN) prescribing. Prices of originators must fall to the reference price for the molecule within two years for reimbursement ▸ Sweden: Compulsory generic substitution (apart from a minority of situations). Additional measures in place to enhance the prescribing of generics to drive down prices. ▸ UK: Increased transparency in the pricing and distribution of generics, alongside INN prescribing, has resulted in low prices for generics compared with other European countries.
Mixed approach	Combination of the prescriptive pricing for first generic(s) with market forces after that	▸ Austria: First generic must be priced 48% below pre-patent loss originator prices to be reimbursed; second generic 15% below the first and the third generic 10% lower than the second to be reimbursed (overall 60% below pre-patent loss prices). Physicians incentivised to prescribe the cheapest branded generics to drive down prices of successive generics. ▸ Lithuania – The first generic must be priced at least 30% below the pre-patent loss originator price for reimbursement, the second generic at least 10% below this (pack basis), and the third 10% lower than the second. Obligatory INN prescribing unless concerns - compulsory from 2010 (unless prior authorisation from Hospital or Polyclinic Therapeutic Committee), combined with reference pricing by INN group, drives down prices of additional generics.

Table 2. Different approaches across Europe to help lower the prices of generics (and also originators)

ed by some originator companies questioning the quality of generics as part of their marketing strategies to reduce sales erosion post patent loss. These issues are being addressed by health authorities and health insurance agencies to fully capitalise financially from the availability of generics.

Activities include:

- **Physicians** – Medical product agencies and health authorities/health insurance agencies only licensing and approving generics where there are no concerns with their bioequivalence or therapeutic equivalence; encouraging INN prescribing from the outset; encouraging physicians to speak with patients where there is the potential for substitution to help allay fears; helping develop and adhere to an agreed list of non-substitutable product including for instance long acting opiods, digoxin, ciclosporin and warfarin.
- **Pharmacists** – encouraging pharmacists financially to speak with patients when substituting products, limiting the number of times products can be substituted where concerns and instigating databases in pharmacies. The latter to help avoid duplication if different branded generics are dispensed each time potentially causing confusion among patients.
- **Patients** – Promotional campaigns to allay fears regarding the effectiveness and safety of generics; information and other campaigns encouraging patients to accept INN prescribing; databases in pharmacies to check previous prescribing history to avoid duplication.
- **Regulators** – Only authorising substitution where no concerns with bioequivalence or therapeutic equivalence as well as acting quickly to recall generics from the market place where concerns with their quality, e.g. the recent recall of certain generic clopidogrel preparations.

Overall, concerns with the effectiveness and safety of generics typically only apply in a minority of situations, with physicians rarely forbidding substitution in practice if safeguards are in place. As a result, helping health authorities and health insurance agencies realise appreciable savings from the availability of generics. For instance in France, the recent measures to enhance the prescribing and dispensing of generics, coupled with their prescriptive pricing policy for generics (Table 2) and price cuts, led to estimated annual savings of one billion euro in 2007, up from 500 million euro in 2005.

Some European countries also look at the environmental aspects of drugs, including generics, in their decision making; however, currently this only applies to a very limited number.

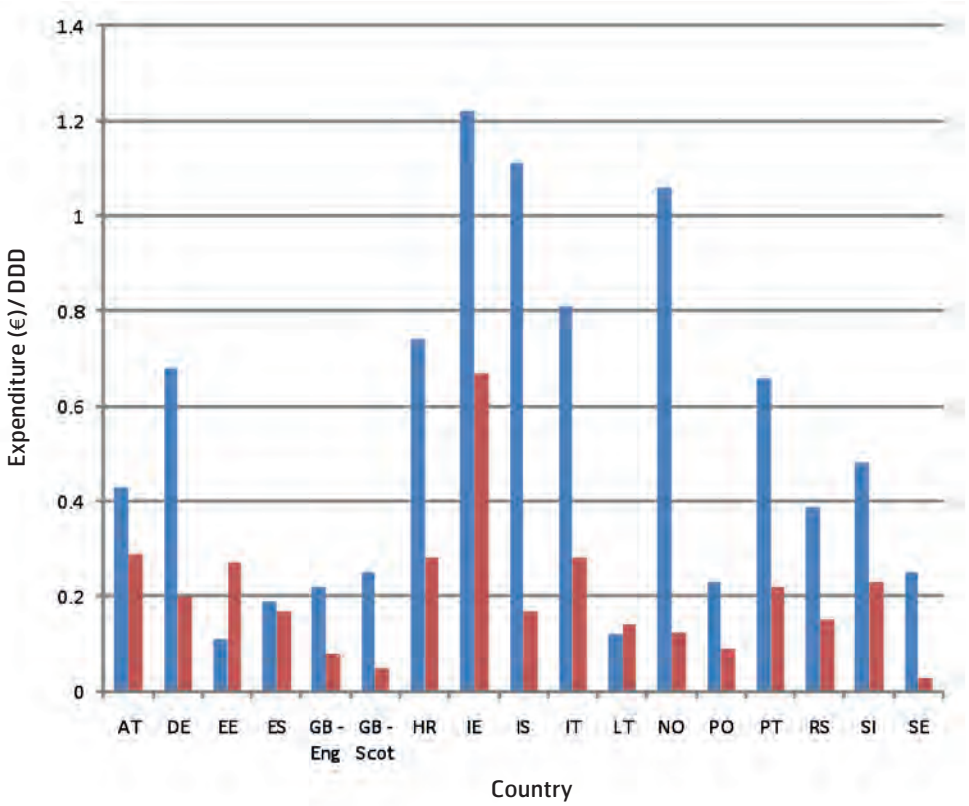

Figure 1. Reimbursed expenditure/ DDD (€) for generic omeprazole and generic simvastatin in 2007 among European countries (2008 DDDs). Patient co-payments in addition especially in France and among Central and Eastern European countries.

NB. *ES = Catalonia. Total expenditure in Austria, Germany and Norway. Standard EU country abbreviations used*

Conclusion

The various initiatives have lowered the price of generics throughout Europe. This includes countries with smaller populations such as Lithuania, Norway and Sweden, dispelling the myth that such countries cannot obtain low prices for drugs. These initiatives, coupled with measures to enhance generic utilisation, have also resulted in stabilisation of reimbursed expenditure for the PPIs and statins in recent years among the majority of Western European countries. This is despite appreciable increases in utilisation. These efficiency gains have been achieved without compromising care.

However, there has been increased expenditure among European countries with currently limited intensity of demand side measures to counteract pharmaceutical company activities such as France, Ireland and Portugal. These differences in the extent of both supply and demand side reforms led to over tenfold difference in reimbursed expenditure for the PPIs and statins in 2007 among European countries when adjusted for populations. However, there was greater morbidity among the Irish population studied. These savings have been enhanced by reducing concerns with generics among all key stakeholder groups.

There are still, however, considerable opportunities for all European countries to improve their prescribing efficiency with existing drugs. This includes additional measures to lower generic prices. In Germany for instance it is estimated there were potential savings of over one billon euro/year in 2007 alone just from lowering prices of generic PPIs and statins to those seen in Sweden and UK (Figure 1). France, Ireland and Portugal could benefit from initiatives to enhance the prescribing of generics in a class. European countries could also be more proactive where permitted with anticipating generic launches to maximise savings rather than waiting to their launch before instigating initiatives. Greater proactivity is envisaged to save over one billion pounds/ year in the UK (1.1 billion euro) alone.

It is likely that the pace of reforms will accelerate, especially given the current financial concerns in Europe coupled with ongoing pressures. As a result, countries will increasingly need to learn from each other when considering future measures. This is already happening.

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THE OBSTACLES TO SAFE MEDICATION ADMINISTRATION
PHARMACEUTICAL TENDERING IN NORWEGIAN HOSPITALS

By Helle Håkonsen, Heidi S. Hopen, Else-Lydia Toverud

In Norwegian hospitals pharmaceuticals are put out to tender in order to save costs. Each year a list of the hospital's drugs is prepared based on the results of these tenders. This article describes the practical consequences of this procedure, based on a study among hospital nurses. The results showed quite unanimously that the nurses were concerned about the current system as they encountered an increasing number of generic drugs. They believed that their performance of generic substitution on the wards represented a risk factor for medication errors.

Pharmaceutical Tendering in Norwegian Hospitals

In an era of rapidly rising healthcare costs, strategies for cost containment are high on every hospital manager's agenda. In most countries, the pharmaceutical costs are included in hospital budgets, and drugs are purchased through direct negotiations with manufacturers. Competitive tendering is a well-established and widely used tool to purchase rebated pharmaceuticals.

Following the entry of Norway into the European Economic Area in 1995, the Law of Public Procurement has regulated hospital purchases. Since the same year a nationwide organisation named the Drug Procurement Cooperation (DPC) has arranged for joint procurement and invited tenders on behalf of public hospitals. The cooperation consists of members of the hospital drug committees. The DPC is assigned to perform contracting, procurement, distribution, and logistical operations of all hospital pharmaceuticals and thereby enable the hospital organisations to improve efficiency and reduce costs. In 2009, DPC entered into an agreement on nearly all hospital pharmaceutical purchases and obtained a total price reduction of 600 million NOK. It is worth noting that all large hospitals in Norway are public. Besides being cost-effective, tendering may also enhance transparency of the use of public funds.

Pharmaceutical procurement in the neighbouring countries Denmark and Sweden is organised in a similar way through Amgros and Landstingene respectively.

What are the Practical Consequences of this Procedure in Hospitals?

The tendering procedures entail annual changes in the hospitals' drug inventories and consequent revisions of the drug list, which is to form the basis of the physicians' prescribing. Due to the extent of physicians failing to prescribe from this list, the nurses – who are responsible for administering drugs to the patients according to the medical charts – have to substitute the prescribed drug with a generic alternative (perform so-called generic substitution).

Our concern was that the nurses were too often left with this task and that they did not have the necessary skills to make these changes. We were also concerned that this would represent a risk factor for medication errors in hospitals. A study was therefore conducted to investigate how this situation was perceived by nurses who were involved in the medicine handling in a Norwegian hospital. Since the actual number of medication errors is difficult to detect ("tip of the iceberg"), the aim of our study was not to quantify the incidence of medication errors but rather to show how common it is for nurses to encounter problems related to generic substitution and their views on why these problems tend to occur.

We invited nurses from a large regional public hospital to take part in the study. Of those who were asked, 100 persons participated (constituting a 64 percent response rate) in a personal face-to-face interview during the autumn of 2008. They were all handling drugs in their everyday work on medical wards.

The results showed that discordance between physician's prescribing and the hospital's drug list was a frequent occurrence. According to the regulations of 2008, the nurses necessitate the physician's approval before a generically substituted drug is given to the patient. However, this procedure was seldom followed. As much as three-fourths of the nurses reported that they seldom or never verified the feasibility of the substitution with the physi-

Generic drugs

- Generic drugs are drugs for which the patent has expired including both branded and non-branded products.
- Generic drugs contain the same active ingredient in the same strength, dose, and formulation, are defined as bioequivalent*, and satisfy the same requirements for quality and safety.
- In Norway, generic drugs may be dispensed interchangeably as long as they are defined as equal generic alternatives by the Medicines Agency.
- Regulations of generic substitution in hospitals were implemented in 2008.

*The 90% confidence interval for the ratios of the test: Reference log-transformed mean AUC and Cmax values is in the range from 0.80 to 1.25. (The test drug is usually a non-branded drug; the reference drug is usually a branded/original drug.)

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Main findings of the study[1]

- About 50 percent of the nurses reported that they performed generic substitution on a daily basis.
- 71 percent believed that this substitution might cause dispensing of a wrong drug.
- Nine in ten thought generic substitution was time consuming and frustrating in a hectic workday.
- 42 percent of the nurses had experienced that mistakes had occurred as a result of the substitution.
- Few were familiar with the hospital's written procedure or the list of substitutable drugs prepared by the Medicines Agency.
- Seven out of ten requested more training in this part of the drug administration.

[1]Håkonsen H, Hopen HS, Abelsen L, Ek B, Toverud EL. Generic substitution: a potential risk factor for medication errors in hospitals. Advances in Therapy (2010).

cian. In addition, the changes were seldom documented in the patient medical charts.

The nurses were unambiguous about how they felt about the situation. Nearly all said they found it problematic that the drug inventory was subject to changes, and they expressed negative attitudes towards the increasing number of drugs available for substitution. Generally, they felt uncomfortable about carrying out substitution on the wards, and it was considered to be an uncertain part of drug administration. Many participants claimed that generic substitution prevented them from performing what they considered to be more important tasks. Furthermore, it was emphasised that they lacked sufficient training in order to perform generic substitution in a safe manner. Some of the nurses had had a short briefing about how to compare the names of the active compounds or the ATC numbers in "Felleskatalogen" (the Norwegian drug formulary). This is a very unsuitable tool in this regard as it only takes into account the active ingredient while strength, dosage, and bioavailability are ignored.

Confusion of Names and Other Risk Factors for Medication Errors

Medication errors in hospitals are widely covered in scientific literature. A common definition of these errors is "any preventable events that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer". Medication errors are important to identify and prevent since the consequences may be adverse drug events, increased morbidity and mortality, and thereby increased hospital costs at the end of the line.

The nurses in our study thought medication errors related to generic substitution were likely to occur since the process of interchanging drugs made them insecure and frustrated in an already hectic workday. First of all, the nurses struggled with the increasing number of generic drugs, frequent changes in the drug inventory, and, subsequently, the many difficult as well as similar drug names. Confusion of drug names due to phonetically and orthographically similar drug names and poor product labelling was at the core of the problem. The nurses problematised confusion between proprietary names (e.g. Apodorm and Alopam; Seloken and Selo-zok) as well as between non-proprietary names (e.g. metoprolol and metformin; enalapril, ramipril, and lisinopril; cefalotin, cefalexin, and cefotaxim). Some even reported that trying to find the correct substitute could make them forget about dosing and formulation (e.g. tablet and depot tablet).

Generally, non-branded drugs are assigned the generic (non-proprietary) names, which often are more difficult to memorise and pronounce. The positive side about using these names is that they are international and common for all generically equivalent drugs. In addition, they are indicative of the drug's pharmacology and medical indication. Consistent use of these names for prescribing purposes, often referred to as generic prescribing, will make health professionals more familiar with the drugs' "real names" and provide congruency between the names used in various contexts. It will also contribute to reduce the risk of misunderstandings when patients are transferred between primary and secondary healthcare.

Conclusion

In conclusion, this study of generic substitution in a Norwegian hospital indicates that hospital managers in search of means to restrict the pharmaceutical expenditures should keep in mind that such strategies may not only interfere with patient safety but also lead to costs associated with medication errors. In this scenario, with competitive tendering, it is important to remember that the physicians are responsible for prescribing according to the current drug list. Indeed, many medication errors could probably be prevented if the physicians related more to the current drug list or consistently prescribed by generic name. Strictly speaking, generic substitution should not be such a burden on the nurses. Ultimately, it is the hospital managers who are responsible for the implementation of new procedures and to provide appropriate training and information material to the hospital's employees.

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This short article is based on the original article by Håkonsen H, Hopen HS, Abelsen L, Ek B, Toverud EL entitled "Generic substitution: a potential risk factor for medication errors in hospitals" (published in Advances in Therapy 2010; 27(2): 118-26).

References available upon request, lee@myhospital.eu

Recommendations for Hospital Managers

- Provide training in accurate and safe drug administration.
- Supply physicians and nurses with, for instance, a pocket version of the hospital's drug list.
- Emphasise the importance of documenting all actions, including generic substitution, in the medical charts.
- Support consistent generic prescribing and the use of electronic prescribing systems linked to the hospital's drug list.

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OVERVIEW OF HEALTHCARE IN THE UNITED KINGDOM

Healthcare in the United Kingdom (UK) is mainly provided by the National Health Service, a public health service, which provides healthcare that is free at the point of use to all permanent residents of the UK, and is paid for from general taxation. Though the public system dominates healthcare provision in the UK, private healthcare and a wide variety of alternative and complementary treatments are available for those willing to pay.

Total population:	61,231,000
Gross national income per capita (PPP international $):	36,240
Life expectancy at birth m/f (years):	78/82
Healthy life expectancy at birth - both sexes (years, 2007):	72
Under-five mortality rate (per 1 000 live births):	6
Adult mortality rate – both sexes (per 1 000 adults 15-59 years):	78
Total expenditure on health per capita (Intl $, 2006):	2,784
Total expenditure on health as % of GDP (2006):	8.4

Figures are for 2008 unless indicated – www.who.int

History

Since its launch in 1948, the NHS has grown to become the world's largest publicly funded health service. The NHS was born out of a long-held ideal that good healthcare should be available to all, regardless of wealth. That principle remains at its core. With the exception of charges for some prescriptions and optical and dental services, the NHS remains free at the point of use for anyone who is resident in the UK, currently more than 60 million people. It covers everything from antenatal screening and routine treatments for coughs and colds to open heart surgery, accident and emergency treatment and end-of-life care.

Although funded centrally from national taxation, NHS services in England, Northern Ireland, Scotland and Wales are managed separately. While some differences have emerged between these systems in recent years, they remain similar in most respects and continue to be talked about as belonging to a single, unified system.

Employment

The NHS employs more than 1.7 million people. Of those, just under half are clinically qualified, including 120,000 hospital doctors, 40,000 general practitioners (GPs), 400,000 nurses and 25,000 ambulance staff. Only the Chinese People's Liberation Army, the Wal-Mart supermarket chain and the Indian Railways directly employ more people.

The NHS in England is the biggest part of the system by far, catering to a population of 51 million and employing more than 1.3 million people. The NHS in Scotland, Wales and Northern Ireland employ 165,000, 90,000 and 67,000 people respectively.

The number of patients using the NHS is equally huge. On average, it deals with 1 million patients every 36 hours. That's 463 people a minute or almost eight a second. Each week, 700,000 people will visit an NHS dentist, while a further 3,000 will have a heart operation. Each GP in the nation's 10,000-plus practices sees an average of 140 patients a week.

Funding

When the NHS was launched in 1948 it had a budget of 437million pounds (roughly 9billion pounds at today's value). In 2008/9 it received over 10 times that amount (more than 100billion pounds). This equates to an average rise in spending over the full 60-year period of about four percent a year once inflation has been taken into account. However, in recent years investment levels have been double that to fund a major modernisation programme.

- 60 percent of the NHS budget is used to pay staff
- 20 percent pays for drugs and other supplies, with the remaining
- 20 percent split between buildings, equipment and training costs on the one hand and medical equipment, catering and cleaning on the other.

Nearly 80 percent of the total budget is distributed by local trusts in line with the particular health priorities in their areas.

The money to pay for the NHS comes directly from taxation. According to independent bodies such as the King's Fund, this remains the "cheapest and fairest" way of funding health care when compared with other systems. The 2008/9 budget roughly equates to a contribution of 1,980 pounds for every man, woman and child in the UK.

NHS Structure

The Department of Health controls the NHS. The Secretary of State for health is the head of the Department of Health and reports to the Prime Minister. The Department of Health controls England's 10 Strategic Health Authorities (SHAs), which oversee all NHS activities in England. In turn, each SHA supervises all the NHS trusts in its area. The devolved administrations of Scotland, Wales and Northern Ireland run their local NHS services separately.

Only the Chinese People's Liberation Army, the Wal-Mart supermarket chain and the Indian Railways directly employ more people.

The National Health Service in the UK is divided into two sections: Primary and secondary care. Primary care is the first point of contact for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists.

Secondary care

Secondary care is known as acute healthcare and can be either elective care or emergency care. Elective care means planned specialist medical care or surgery, usually following referral from a primary or community health professional such as a GP.

Primary care trusts

Primary care trusts (PCTs) are in charge of primary care and have a major role around commissioning secondary care, providing community care services. They are central to the NHS and control 80 percent of the NHS budget.

As they are local organisations, they understand what members of their community need, so they can make sure that the organisations providing health and social care services are working effectively. The PCTs oversee 37,000 GPs and 21,000 NHS dentists.

Adapted from information available at **www.nhs.uk**

Modernising the NHS: Health and Social Care Bill 2011

Like all European countries the UK was hit hard by the financial crisis. Since its formation, the new coalition government has announced widespread cuts across public sector spending. Although the healthcare budget was exempt, the government announced plans in January 2011 to modernise the National Health Service in the hopes of improving care and making long-term financial savings.

The modernised NHS is described as the patient-centred NHS, putting patients at the heart of everything it does. The proposed changes should lead to better quality of care, more choice and improved outcomes for patients as well as long-term financial savings allowing for reinvestment in care. With the bill, for the first time, there will be a defined legal duty for the NHS to continuously improve quality. Proposals include:

- Giving more responsibility to GP-led groups;
- Increasing accountability for patients through local health and wellbeing boards within local councils;
- Liberating the NHS from political micromanagement by allowing all trusts to become foundation trusts and establish independent regulation; and
- Reducing bureaucracy by streamlining arm's-length bodies.

These proposals will potentially improve the NHS in five key ways:

- Patients will be more involved in decisions;
- More focus on results that are meaningful to patients (success of treatment and quality of life instead of waiting list targets);
- Local GPs will commission services depending on what local communities need;
- Democratic legitimacy with councils and clinicians shaping local services; and
- The best people will deliver the best care for patients, putting those on the front-line in control, not ministers or bureaucrats.

The department of health believes these modernisation measures will save the NHS over five billion pounds by 2014/2015 and 1.7 billion every year after that. If successful, this amounts to enough money to pay for 40,000 extra nurses, 17,000 extra doctors or over 11,000 senior doctors every year. But where do these savings come from? It is said the majority of the savings would come from the reduction in bureaucracy following the abolition of strategic health authorities and primary care trusts and a reduction in management staff by an estimated 24,500 posts.

Unsurprisingly, when the bill was announced in January, it was met with widespread criticism from the press, the opposition party and many of those in the healthcare sector. This opposition led to a pause in reform plans in April of this year. The government realised the need to stop, reflect and listen to people's concerns and did so using the independent NHS Future Forum.

The Future Forum listened to over 6,700 people face to face at over 200 separate events. Over 25,00 emails were received along with 2,400 comments online and 1,500 other electronic responses. These responses came from both organisations and individuals. Many of the recommendations made by the Future Forum have been accepted by the government and changed in the original bill.

Key changes include:

- Wider involvement in clinical commissioning groups;
- Stronger safeguards against a market free-for-all;
- Additional safeguards against privatisation;
- Evolution, not revolution (clinical commissioning groups will take charge when they are able in a more phased approach);
- Greater information and choice for patients;
- Breaking down barriers within and beyond the NHS;
- Investing for the future of the NHS (costs of education and training of NHS staff changes will be introduced carefully).

The NHS Future Forum will continue to listen to patients and other stakeholders ensuring an effective communication channel with the NHS. The Health and Social Care Bill, with these changes, will be scrutinised in Parliament.

THE INSTITUTE OF HEALTHCARE MANAGEMENT

The Institute of Healthcare Management (IHM) is the professional organisation for managers throughout health and social care in the UK, including: the NHS; independent providers; healthcare consultants and the armed forces.

IHM's focus is improving patient/user care wherever and whenever they need healthcare. The route to achieving this is through the promotion of excellence in healthcare management. They achieve this by:

- Publishing standards of management practice;
- Promoting the IHM Management Code of Conduct (covering behavioural and ethical aspects of management practice);
- Initiating and delivering an Accredited Manager Scheme;
- Establishing a Professional and Educational Development framework;
- Promoting Continuous Professional Development and implementing an online CPD validation and recording mechanism;
- Holding CPD events in the four UK countries: England, Scotland, Wales and Northern Ireland;
- Offering Recognition and Centre Approval Schemes that endorse and sanction the highest quality levels and standards of learning and training; and
- Establishing a coaches database to support members when they choose an executive coach.

The IHM is an influential organisation. It has access to the highest offices of the NHS, many of the senior players in the NHS are members and, more importantly, by promoting CPD the IHM has a direct influence on management practice of thousands of managers.

The IHM is continuously developing its educational portfolio and has developed a number of products – such as the Milestones Programme, the Vocational Training Scheme for Practice Managers, and the new MHSC postgraduate Certificate and Diploma.

Divisions and Regions

Every IHM member is allocated to a Division, or in England, a Region. There are separate divisions for Scotland, Wales and Northern Ireland and regions in England are separated into East Midlands, East of England, London, North East, Yorkshire & the Humber, North West, South Central, South East Coast, South West and West Midlands.

Each Divisional or Regional Council arranges a programme of local events, meetings, management clubs and other networking activities. Members may attend events in other Divisions and Regions and are actively encouraged to participate and put forward ideas and comments. There are also opportunities to represent the Institute at national level on other professional bodies or consultative groups.

Networks

In addition to the geographical breakdown of members, which helps provide localised networking and support, IHM also recognises the need for managers to strengthen links with colleagues in similar settings as well as exchange expertise and information that is sector or interest specific. To this end IHM has established a growing number of Networks and Special Interest Groups (SIGs) based on work sectors, interest or expertise.

These networks and groups are both UK wide and international, formally constituted and can help shape and focus IHM's knowledge, direction and planning with regard to these areas. Members can join more than one group if they wish to. Some of the SIGs and Networks are for IHM Members only.

The current Special Interest Groups are:

- Independent Sector;
- Primary Care;
- Estates and Facilities.

There is also a number of Networks available (or being planned), including:

- Management Network;
- IHM/CCHSE Learning Partnership;
- Fellowship;
- Accredited Managers;
- Coaching;
- Primary Care Managers; and
- Student.

Both the SIGs and the Networks will include interactive forums, discussions groups, news, and events.

IHM Code of Conduct

The original IHM Code was created in 2001, after expectations about the role and quality of healthcare management in the public, private and independent sectors was brought into focus.

Media coverage of exceptional cases of bad healthcare professionals' performance not only dented public confidence in healthcare, it also bruised individual managers and their confidence in a vocation, which had previously been held with such conviction.

The IHM was invited to join a Steering Group chaired by Lord Newton of Braintree in 1999. A wide range of organisations considered whether a national code for managers to cover ethics, social and environmental responsibility, diversity and respect for others and lifelong learning should be drafted. Research indicated that there was general support for the development of a nationally recognised source of guidance for a Management Code for all sizes of organisations in the UK. The IHM Healthcare Management Code of Conduct was founded on these principles.

In developing the Code members stressed importance of ensuring that the key principles were founded upon relevant existing standards, such as the 'Seven Principles of Public Life' (the Nolan Principles).

The key themes of the IHM Code became:

- Integrity;
- Honesty and openness;
- Probity;
- Accountability; and
- Respect.

Each member has a responsibility to the environment; to society; and to lead by example.

This information was adapted from the IHM website, **www.ihm.org.uk**.

UNE EUROPE **PLUS FORTE**

Heinz Kölking

L'europe doit actuellement faire face à de grandes difficultés. Nous souffrons toujours des effets de la crise économique et financière et les discussions concernant la dette publique dans les États membres contraignent encore nos activités. Une gestion de crise est nécessaire. Il fondamental que l'Europe reste pour tous un modèle réussi qui place au sommet de ses valeurs la paix et la liberté dans une société tolérante.

Les crises économiques et financières et leurs conséquences montrent aussi clairement que l'Europe doit à la fois se renforcer et évoluer, politiquement et économiquement. Elle aura une influence de plus en plus prépondérante sur les politiques de santé nationales. La nouvelle directive européenne sur les soins de santé transfrontaliers et ses effets sur les conditions de traitement des patients transfrontaliers en est un remarquable exemple. Nous sommes invités à participer à cette évolution en faisant valoir notre point de vue de gestionnaires hospitaliers.

Nous aurons un bon aperçu de tous ces questionnements par l'intermédiaire de l'association au cours de notre futur séminaire AEDH qui se tiendra à Düsseldorf le 18 Novembre prochain dans le cadre de MEDICA. Nous pouvons vous garantir un intéressant programme ainsi que d'excellentes présentations. Au nom des organisateurs et du Conseil d'administration de l'AEDH, je vous invite et vous encourage à assister à cette réunion. Nous sommes impatients de vous y rencontrer aussi nombreux que possible.

Ce numéro d'*(E)Hospital* fournit aux lecteurs d'intéressants articles sur le thème important de la gestion axée sur le patient, le patient étant placé au centre des soins de santé. Si une gestion réussie repose sur une bonne organisation, une bonne logistique et une bonne administration des affaires, elle s'appuie également sur les compétences en leadership des cadres, un autre sujet important de ce magazine. Notre country focus met en lumière les soins de santé au Royaume-Uni. J'espère que vous apprécierez la lecture de ce numéro.

Heinz Kölking
Président de l'AEDH

Les éditoriaux d'*(E)Hospital* sont rédigés par des membres des instances dirigeantes de l'AEDH. Les contributions publiées ici ne reflètent cependant que l'opinion de leur auteur et ne représentent en aucune façon la position officielle de l'AEDH.

AEDH : LES PREMIERS RÉSULTATS D'UN NOUVEAU SOUFFLE

Le Conseil d'administration de l'Association européenne des directeurs d'hôpitaux s'est réuni pour la première fois après les élections et sa nouvelle constitution lors du congrès de Zurich en 2010. Cette 92ème réunion dans l'histoire de l'AEDH s'est tenue le 20 mai 2011 au secrétariat général, à Bruxelles.

C'est le nouveau président, M. Heinz Kölking, qui a souhaité la bienvenue aux délégués des associations nationales venus de 17 pays différents. C'était la première réunion du Conseil d'administration à laquelle participaient un grand nombre d'entre eux.

Les rapports détaillés des travaux des Sous-commission et des groupes de travail de l'AEDH ont montré que les décisions prises lors du processus de réflexion ne sont pas restées lettre morte.

Ainsi, M. Gerry O'Dwyer a fait part du résultat des deux réunions de la Sous-commission scientifique (SCSC) dont le rôle est de préparer le programme scientifique du congrès de l'AEDH qui se tiendra en 2012 à Athènes. Par ailleurs, le SCSC a précisé sa méthode de travail pour une redéfinition de la mission du directeur d'hôpital, l'une des priorités du nouveau programme d'action.

M. Marc Hastert a montré dans son rapport de la Sous-commission des affaires européennes (SCAE) comment celle-ci suit l'actualité hospitalière au niveau européen. La directive des soins de santé transfrontaliers y figure en priorité. En collaboration avec d'autres organisations européennes, la SCAE prépare activement la journée d'étude qui sera organisée au cours de MEDICA, à Düsseldorf, le 18 novembre prochain. Quant à la Sous-commission de rédaction, M. Nikolaus Koller esquissait le programme de travail pour rendre la revue *(E)HOSPITALS* encore plus intéressante.

L'assistant du secrétaire général, M. Jos Vanlanduyt, a tenu le Conseil d'administration informé du programme proposé par le groupe de travail « informatique hospitalière ». Les membres du Conseil d'administration ont approuvé, après discussion, les perspectives d'action esquissées.

Cette année, un nouveau partenariat avec des entreprises travaillant dans le secteur de la santé sera mis sur pied. M. Willy Heuschen, secrétaire général, a présenté le contrat de partenariat qui est proposé aux entreprises de notre secteur. L'accent est mis sur l'échange et le profit que les hôpitaux et les entreprises peuvent en tirer et ce dans les respect des règles de déontologie et d'indépendance. Suite aux différents contacts que l'AEDH et les associations nationales entretiennent avec différentes entreprises, six d'entre elles se sont montrées très intéressées et une signature est attendue dans les prochains mois. Toutefois, il a été précisé que toute entreprise est la bienvenue, pour autant que le partenariat corresponde aux objectifs que l'AEDH s'est fixés.

Les membres du Conseil d'administration soutiennent cette nouvelle forme de partenariat et se sont engagés à y apporter leur soutien.

Pour note, nos prochaines activités :

15 et 16 septembre 2011 :
« Hospital success by optimised IT contribution – CEO Workshop »
Vienne (Autriche)

18 novembre 2011 :
EAHM Seminar: European Cross-Border Directive
Dusseldorf (Allemagne)

« Putting Patients First », le patient au centre des soins de santé :
Interview avec Tomasz Szelagowski, membre du bureau du Forum des patients européen

Le Forum des patients européen (European Patients' Forum, EPF) a été fondé en 2003 afin de devenir « la voix des patients » au niveau européen, manifestant la solidarité, la puissance et l'unité du mouvement des patients en Europe. Ses cinq objectifs stratégiques sont l'égalité d'accès, l'implication des patients et la prise en compte de leur point de vue, des associations de patients efficaces, et l'unité des patients. M. Szelagowski a souligné que les patients souhaitaient une meilleure coordination des services ainsi que l'intégration des soins. Ils ont la conviction qu'une meilleure relation entre patients et professionnels de santé leur serait très profitable. La communication est primordiale et les gestionnaires hospitaliers devraient pouvoir recueillir et utiliser l'expérience des patients pour améliorer l'accès, la qualité et la sécurité des soins à l'hôpital. Après tout, les patients sont encore ceux qui sont les mieux placés pour souligner les défaillances du système.

Tomasz Szelagowski a également souligné l'importance de la directive les soins de santé transfrontaliers, la décrivant comme une étape importante pour les patients. Le Forum des patients européen se félicite des dispositions prises en vue d'une coopération mutuelle et de la transparence concernant la sécurité et la qualité. Il a souligné les progrès accomplis, regrettant que la directive ne réponde pas aux questions concernant le remboursement.

Les « Care Pathways » : des programmes de soins intégrés proposent une personnalisation des soins pour répondre aux exigences des patients.
Par Walter Sermeus

Les systèmes de santé sont en évolution et le rôle des patients également. Ils sont passés d'un comportement passif d'acceptation à celui de consommateurs actifs en ce qui concerne les soins de santé. Ils veulent être informés et impliqués et font montre d'une préoccupation croissante pour la qualité et la sécurité. Au sein des organisations de soins, la relation individuelle patient-médecin a été remplacée par une approche équipe-patient. On doit cette évolution à la spécialisation croissante des professionnels de la santé, aux développements technologiques et aux exigences de plus en plus grandes des patients.

Les programmes de soins intégrés sont de plus en plus appréciés. Ils peuvent être définis comme « une intervention complexe afin que la prise de décision et l'organisation des soins de santé prévisibles soient commune pour un groupe donné de patients et pendant une période définie ».

Les programmes de soins intégrés sont élaborés à partir de la médecine fondée sur les faits. Ils prennent en compte la liberté qu'a le thérapeute de s'écarter des protocoles pour répondre aux besoins spécifiques des patients ou pour personnaliser les soins. Les soins de santé axés sur la personne donnent au patient à tout moment la priorité absolue. Cette pratique va certainement affecter la façon dont les professionnels de santé sont appelés à travailler ainsi que la manière de gérer les hôpitaux dans un futur proche, mais c'est un bénéfice dont nous allons tous profiter.

Évaluer la dénutrition chez les patients hospitalisés
Par André Van Gossum

Les patients hospitalisés dont l'état nutritionnel s'est dégradé au cours de leur séjour souffrent fréquemment de dénutrition mais elle est souvent méconnue. Les conséquences en sont des risques plus élevés d'infections, de complications et une augmentation de la durée d'hospitalisation, occasionnant par là des frais supplémentaires aux établissements de santé. Le dépistage nutritionnel peut améliorer à la fois la santé des patients et la rentabilité des services hospitaliers.

Même si le dépistage nutritionnel semble très intéressant, plusieurs obstacles s'opposent à sa mise en œuvre parmi lesquels un manque de données probantes, un manque d'informations et de moyens, un manque de ressources humaines ainsi qu'un manque de soutien financier. L'expérience belge s'est révélée positive grâce au Plan national nutrition santé qui a créé le poste de responsable nutrition. Il a également mis en place une équipe de soutien multidisciplinaire de nutrition (comité de nutrition) dans chaque hôpital et défini une stratégie pour le transfert et l'échange de données nutritionnelles entre les hôpitaux, les équipes de soins à domicile et les foyers de soins sous la forme d'un carnet alimentaire individuel.

Fusions hospitalières : comment gérer des changements complexes dans un environnement complexe
Interview avec Soki Choi

Les fusions hospitalières sont un phénomène de plus en plus courant dans le secteur de la santé, mais comment pouvons-nous réussir à gérer ces changements radicaux ? Le Dr Soki Choi, enseignant et chercheur à l'Institut Karolinska, à Stockholm, a effectué une étude approfondie lors de la fusion de deux hôpitaux suédois : l'Hôpital Karolinska et l'Hospital universitaire Huddinge.

Les meilleurs conseils qu'il donne aux gestionnaires hospitaliers en matière de fusions sont d'abord d'avoir conscience de la complexité du processus de fusion et également de ne pas sous-estimer l'expertise externe indispensable à leur bon fonction-

nement. Le Dr Choi insiste sur le fait que les fusions prennent du temps, que les avantages réels ne sont visibles qu'après cinq à dix ans seulement, et que les hôpitaux doivent utiliser les méthodes appropriées et ne pas se baser uniquement sur la recherche et l'expérience d'autres secteurs, le secteur de la santé se révélant bien plus complexe. Enfin, il conseille d'effectuer de petits changements, étape par étape. Ils sont préférables aux changements plus imposants ou plus radicaux.

Investissements de capitaux : investir dans l'hôpital du futur
Par Stephen Wright, Bernd Rechel, Martin McKee, James Barlow

L'Observatoire européen des systèmes et des politiques de santé a publié deux volumes concernant les investissement de capitaux dans des hôpitaux en Europe. Il a insisté sur l'empiètement des principes du marché dans une activité qui est encore largement dominée par le secteur public. Il a également présenté les différents modèles de financement de plus en plus utilisés : dans les circonstances économiques actuelles, effectuer un choix d'investissement judicieux dans les soins de santé est devenu encore plus important, et aussi plus difficile, que par le passé.

Le financement des hôpitaux évolue également et principalement celui qui concerne les coûts récurrents. On observe une forte tendance à s'écarter du budget global pour aller vers un financement basé sur le mélange de cas. Les formes les plus courantes comprennent les fonds structurels européens et les partenariats public-privé. En raison de critères d'éligibilité, la plupart des fonds structurels sont maintenant alloués à des zones relativement pauvres, qui pourraient bien attirer une proportion importante des dépenses de capital de santé dans les années à venir. Les modèles de partenariats public-privé se font fort d'encourager les performances des entrepreneurs du secteur privé en leur donnant à la fois la responsabilité qui a trait aux dépenses d'investissement et celle des coûts récurrents.

Améliorer l'efficacité de la prescription grâce à l'utilisation accrue des produits génériques à bas prix
Par Brian Godman et al

La croissance rapide des dépenses pharmaceutiques devance les autres composantes des soins de santé. Aussi les dépenses pharmaceutiques sont-elles sont de plus en plus sérieusement examinées dans tous les secteurs. Cette croissance a poussé les gouvernements, les organisations médicales professionnelles, les autorités sanitaires et les compagnies d'assurance de santé à introduire des réformes supplémentaires pour préserver les ressources. Ces réformes se sont généralement focalisées sur les médicaments génériques. Elles visent à améliorer l'efficacité de la prescription de produits existants dans une classe ou des classes connexes, et prennent en compte les initiatives qui viennent de l'offre autant que celles de la demande.

Diverses initiatives ont abaissé le prix des médicaments génériques en Europe. Ces initiatives concernent également les pays les moins peuplés comme la Lituanie, la Norvège et la Suède, dissipant le mythe que de tels pays ne pouvaient pas obtenir des prix de médicaments plus bas. En couplant ces initiatives avec des mesures visant à accroître l'utilisation des génériques, on assiste également ces dernières années à la stabilisation des dépenses remboursées pour les IPP (inhibiteurs de la pompe à protons) et les statines dans la majorité des pays d'Europe occidentale, ceci en dépit d'une augmentation appréciable de leur utilisation. Les gains d'efficacité auront été atteints sans compromettre les soins.

Obstacles à l'administration sécuritaire des médicaments : appels d'offres pharmaceutiques dans les hôpitaux norvégiens
Par Helle Håkonsen, Heidi S. Hopen, Else-Lydia Toverud

Dans les hôpitaux norvégiens, un système d'appel d'offre pour les produits pharmaceutiques permet de réduire les coûts. Chaque année, la liste de médicaments disponibles à l'hôpital est préparée sur la base des résultats de ces offres. Une étude a été réalisée pour mettre en évidence les conséquences pratiques de cette procédure. Les résultats ont très clairement démontré que les infirmier(e)s ont commencé à être très préoccupé(e)s par le système mis en place quand ils se sont trouvé en contact avec un nombre de plus en plus important de médicaments génériques.

Ils ont admis que la substitution des médicaments précédemment utilisés par des médicaments génériques a représenté un facteur de risque d'erreurs de médication. C'est une leçon pour les gestionnaires d'hôpitaux : le système d'appel d'offres a beau avoir un important impact positif sur les budgets des hôpitaux, de telles stratégies devraient être suivies par la mise en œuvre de procédures visant à assurer la sécurité du patient. Elles permettraient également d'éviter les coûts d'erreurs de médication.

Heinz Kölking

EIN STÄRKERES **EUROPA**

Diese Zeit ist geprägt von erheblichen Problemen und Herausforderungen in Europa. Noch immer leiden wir unter den Folgen der Wirtschafts- und Finanzkrise. Die Diskussionen um die Verschuldung der öffentlichen Haushalte in den Mitgliedsstaaten dominieren das Geschehen. Krisenmanagement ist erforderlich. Dabei wird es darauf ankommen, dass dabei die Gesamtperspektive für Europa als Erfolgsmodell für Frieden und Freiheit in einer offenen Gesellschaft erhalten bleibt.

Die Wirtschafts- und Finanzkrise und die Folgen zeigen auch deutlich, dass Europa wirtschaftspolitisch stärker zusammenwachsen muss. Davon wird auch zunehmend die Gesundheitspolitik betroffen sein. Ein Beispiel dafür ist die neue Patientenrichtlinie mit ihren Auswirkungen auf Bedingungen der grenzüberschreitenden Patientenbehandlung in der Europäischen Union. Wir sind aufgefordert diese Entwicklung aus der Perspektive der Krankenhäuser mit zu gestalten.

Mit all diesen Fragen werden wir uns im Rahmen einer gemeinsamen Veranstaltung am 18. November 2011 in Düsseldorf im Rahmen des diesjährigen Krankenhaustages und der MEDICA auseinandersetzen. Wir versprechen uns ein interessantes Programm mit exzellenten Beiträgen. Im Namen der Veranstalter und insbesondere des Präsidiums des EVKD möchte auch diese Konferenz hinweisen und einladen. Wir freuen uns darauf möglichst viele Kolleginnen und Kollegen in Düsseldorf zu treffen.

Diese Ausgabe bringt den Lesern interessante Beiträge zu Fragen des patientenorientierten Managements. Für das Management kommt es neben dem Einsatz von Instrumenten der Organisation, Logistik und Betriebswirtschaft entscheidend auf Führungsqualität der Führungskräfte an, ein weiterer Schwerpunkt in diese Ausgabe. Unser Länderfocus kommt diesmal von unseren Freunden Frankreich. Allen Lesern wünsche ich viel Freude und eine interessante Lektüre.

Heinz Kölking / Präsident EVKD

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

EAHM: ERSTE ERGEBNISSE UNSERER NEUEN DIREKTION

Erstmals seit seiner Wahl und der Neuformierung nach dem Kongress 2010 in Zürich ist der Vorstand der Europäischen Vereinigung der Krankenhausdirektoren (EAHM) zusammengekommen. Diese 92. Sitzung fand am 20. Mai 2011 im Generalsekretariat in Brüssel statt. Es war Aufgabe des neuen Präsidenten, Hrn. Heinz Kolking, alle Delegierten der 17 Ländervereinigungen auf das herzlichste zu begrüßen. Unter ihnen waren viele Kollegen, die erstmals an einer Vorstandssitzung teilnahmen.

Die detaillierten Berichte der Aktivitäten der Unterausschüsse und der Arbeitsgruppen der EAHM bestätigten, dass die nach einem Reflexionsprozess getroffenen Entscheidungen nicht unbeachtet geblieben waren.

Hr. Gerry O'Dwyer kündigte die Ergebnisse zweier Sitzungen des wissenschaftlichen Unterausschusses an (Scientific Subcommittee SCC), der sich derzeit auf die Vorbereitung des wissenschaftlichen Programms für den EAHM Kongress 2012 in Athen, Griechenland, vorbereitet. Zusätzlich hat der SCC seine Arbeitsmethode als Neu-Definierung der Rolle des Krankenhausmanagers festgelegt, eine der vielen Prioritäten des neuen Aktionsplans. In seinem Bericht über den Unterausschuss europäische Angelegenheiten (SCEA) führte Hr. Marc Hastert aus, wie der Ausschuss alle krankenhausbezogenen Nachrichten auf europäischem Niveau verfolgt. Die Europäische Direktive zur grenzüberschreitenden Gesundheitsversorgung ist dabei eine Priorität. In Zusammenarbeit mit anderen europäischen Vereinigungen bereitet der SCEA aktiv den Studientag vor, der in Düsseldorf während des Medica Kongresses am 18. November 2011 stattfinden wird.

Was den Redaktionsausschuss betrifft: Hier gab Hr. Nikolaus Koller einen Überblick über das Arbeitsprogramm, das dazu dienen soll, unser Magazin *(E)Hospital* noch interessanter zu gestalten. Der Assistent des Generalsekretärs, Hr. Jos Vanlanduyt, informierte den Vorstand über das vom Arbeitskreis ‚Hospital IT-Manager' vorgeschlagene Programm. Nach der entsprechenden Diskussion genehmigte der Vorstand die zukünftigen Vorgehensweisen.

In diesem Jahr werden neue Partnerschaften mit Unternehmen im Bereich der Gesundheitssorge implementiert. Der Generalsekretär, Hr. Willy Heuschen, stellte dem Vorstand den Partnerschaftsvertrag vor, der Unternehmen dieses Sektors vorgeschlagen wird. Der Fokus liegt auf dem Austausch und den Vorteilen, den sowohl Krankenhäuser als auch Unternehmen aus diesen Partnerschaften ziehen können, während sie ihre berufliche Ethik und Unabhängigkeit bewahren. Die EAHM und die Ländervereinigungen haben verschiedene Kontakte mit anderen Unternehmen. Davon haben sechs ein starkes Interesse bekundet, und mit einem Unternehmen soll der Vertrag voraussichtlich in den nächsten Monaten unterschrieben werden. Nichtsdestoweniger wurde betont, dass alle Unternehmen willkommen sind, solange sie den festgelegten Zielen der EAHM zustimmen. Die Vorstandsmitglieder unterstützen diese neue Form der Partnerschaft ausdrücklich und stehen jederzeit für Hilfestellung zur Verfügung.

Merkblatt / bevorstehende Aktivitäten

15.-16. September 2011:
"Hospital success by optimised IT contribution – CEO Workshop"
Wien (Österreich)

18. November 2011:
EAHM Seminar: European Cross-Border Directive
Dusseldorf (Deutschland)

ASSOCIATION EUROPÉENNE DES DIRECTEURS D'HÔPITEAUX
EUROPÄISCHE VEREINIGUNG DER KRANKENHAUSDIREKTOREN
EUROPEAN ASSOCIATION OF HOSPITAL MANAGERS

Klinik Direktoren Workshop

Klinikerfolg durch optimalen IT-Einsatz

15 SEPTEMBER WIEN, ÖSTERREICH

Donauspital,
Sozial Medizinisches Zentrum Ost
(SMZ-Ost)

14:30
BEGRÜSSUNG UND VORSITZ
W. Heuschen,
Generalsekretär, EVKD
Dr. P.-M. Meier,
Präsident Working Party IT, EVKD

—

ZIEL DES ERSTEN TAGES:
Definition der Klinik individuellen "IT Governance"
G. Kostka, CIO, Az Sint Lucas & Volkskliniek

15:00
"Herausforderung im IT-Einsatz in Kliniken"
Dr. P.-M. Meier,
Präsident Working Party IT, EVKD

15:30
"Wie entwickle ich aus der Klinik- / Unternehmensstrategie die IT-Strategie ?"
Dr. C. Dujat, CEO Promedtheus

16:30 ☕
KAFFEEPAUSE UND GRUPPENBILDUNG FÜR DEN WORKSHOP

16:45
"Wie entwickle ich aus der IT-Strategie einen IT-Masterplan und wie erhalte ich eine "Sicherheit", dass diese IT-Kosten marktgerecht sind ?"
Dr. C. Dujat, CEO Promedtheus

17:45
WORKSHOP:
"Abgleich von Klinik Strategie und IT Strategie"

19:00 🍴
NETWORKING ABENDESSEN
Dinner Speach:
A. Steidel, CEO, KMS AG

16 SEPTEMBER WIEN, ÖSTERREICH

Für weitere Informationen:
www.evkd.eu.org
www.ovkd.at
www.vkd-online.de
www.spitaldirektoren.ch
www.ehl.lu

09:00
BEGRÜSSUNG UND VORSITZ
G. Kostka,
CIO, Az Sint Lucas & Volkskliniek

—

ZIEL DES ZWEITEN TAGES:
Definition der Klinik individuellen "IT Governance "
J. Vanlanduyt,
Assistent des Generalsekretärs, EVKD

09:15
SPEED PRÄSENTATIONEN, PRÄSENTATION DER GRUPPENARBEITEN AUS DEM WORKSHOP
Feedback geber:
J. Vanlanduyt,
Assistent des Generalsekretärs, EVKD
Dr. P.-M. Meier,
Präsident Working Party IT, EVKD

09:45
Aufstellung und Controlling eines IT Masterplans
G. Härdter, Leiter Service Center IT, Klinikum Stuttgart

10:45 ☕
KAFFEEPAUSE UND GRUPPENBILDUNG FÜR DEN WORKSHOP

11:00
WORKSHOP:
"Aufstellung eines IT Masterplanes"

12:00
SPEED PRÄSENTATIONEN, PRÄSENTATION DER GRUPPENARBEITEN AUS DEM WORKSHOP
Feedback Geber:
J. Vanlanduyt,
Assistent des Generalsekretärs, EVKD
Dr. P.-M. Meier,
Präsident Working Party IT, EVKD

12:30 🍴 **MITTAGESSEN**

13:15
WORKSHOP:
"Controlling eines IT Masterplanes"

14:30
Speed Präsentationen, Präsentation der Gruppenarbeiten aus dem Workshop
Feedback Geber:
J. Vanlanduyt,
Assistent des Generalsekretärs, EVKD
Dr. P.-M. Meier,
Präsident Working Party IT, EVKD

15:30
Ende der Veranstaltung

Die Patienten an erster Stelle
Interview mit Tomasz Szelagowski, Vorstandsmitglied des Europäischen Patientenforums (EPF)

Das EPF wurde im Jahr 2003 gegründet und entwickelte sich in weiterer Folge EU-weit zur Stimme aller Patienten. Darin manifestiert sind die Solidarität, Macht und Einheit der EU-weiten Patientenbewegung. Die fünf strategischen Ziele lauten: gleicher Zugang für alle Patienten, Beteiligung der Patienten, die Patientenperspektive, nachhaltige Patientenvereinigungen und Geschlossenheit der Patienten. Hr. Szelagowski unterstrich den Bedarf der Patienten für bessere Koordination und Integration in der Betreuung und die Tatsache, dass sie von besseren Beziehungen zwischen Patienten und medizinischem Fachpersonal profitieren könnten. Kommunikation ist hier der Schlüsselfaktor, und Krankenhausmanager sollten die Erfahrungsberichte von Patienten sammeln und dazu einsetzen, den Zugang, die Qualität und die Sicherheit der Betreuung im Krankenhaus zu verbessern. Schließlich sind Patienten die Experten, wenn es darum geht, Mängel im System aufzuzeigen. Im Gespräch über die grenzüberschreitende Gesundheitssorge betonte Tomasz Szelagowski die Wichtigkeit der Richtlinie und nannte sie einen „Meilenstein" für Patienten. Das EPF begrüßt Regelungen für eine wechselseitige Zusammenarbeit und Transparenz bei Sicherheit und Qualität der Gesundheitsversorgung. Doch obwohl bereits viele Fortschritte erzielt wurden, greift die Direktive bei Fragen der Kostenrückerstattung zu kurz.

Betreuungspfade: maßgeschneiderte Pflege für die wechselnden Ansprüche des modernen Patienten
Von Walter Sermeus

Die Gesundheitssysteme verändern sich. Die Rolle der Patienten verändert sich ebenso, von einer passiveren Stellung hin zum aktiven Konsumenten der Gesundheitsversorgung. Patienten möchten informiert und einbezogen werden, und legen gesteigerten Wert auf Qualität und Sicherheit. Innerhalb von Pflegeeinrichtungen wurde die individuelle Patient-Arzt-Beziehung von einem Team-Patient-Ansatz abgelöst. Die Ursache dafür liegt in der gesteigerten Spezialisierung der Gesundheitsberufe, der technologischen Entwicklungen und in einer höheren Bandbreite der Erwartungen von Patientenseite.

Betreuungspfade erfreuen sich zunehmender Beliebtheit und können folgendermaßen definiert werden: „Eine komplexe Intervention für den gemeinsamen Entscheidungsprozess und die gemeinsame Organisation einer berechenbaren Betreuung für eine klar definierte Patientengruppe während eines klar definierten Zeitraums." Die Betreuungspfade bauen auf Evidenz-basierter Medizin auf. Sie haben einen therapeutischen Entscheidungsspielraum, von starren Schemata abzuweichen, um auf die speziellen Bedürfnisse eines Patienten besser eingehen und die Therapie so maßschneidern zu können. Diese Betreuung könnte zu besser vorhersehbaren Ergebnissen führen. Die Patienten-zentrierte Gesundheitssorge hat den Patienten zu allen Zeiten im Mittelpunkt. Sicherlich wird dieser Ansatz die Arbeit medizinischer Fachkräfte und des Krankenhausmanagements beeinflussen, doch schlussendlich werden wir alle davon profitieren.

Der Umgang mit mangelernährten Patienten
Von André Van Gossum

Eine Unterernährung kommt bei stationär aufgenommenen Patienten häufig vor, wird jedoch fast ebenso häufig nicht wahrgenommen. Der Ernährungsstatus der Patienten verschlechtert sich während des Aufenthalts zunehmend. Die Folgen für mangelernährte Patienten sind höhere Infektionsrisiken, Komplikationen und eine verlängerte Aufenthaltsdauer. Dies wiederum bedeutet höhere Kosten für die Krankenhäuser selbst.

Das Überprüfen des Ernährungszustands im Sinne eines Screenings kann die Outcomes vom Patienten und die Kosteneffektivität verbessern. Obwohl der Vorgang also viele Vorteile bietet, gibt es verschiedene Hindernisse, die sich der Implementierung eines Screenings in den Weg stellen. Dazu zählen ein Mangel an evidenzbasierten Daten, an Information und Ressourcen, an Arbeitskräften und auch ein Mangel an finanzieller Unterstützung. Die belgische Erfahrung war hingegen positiv: der nationale ‚Nutrition Health Plan' bestimmte in jedem Krankenhaus einen verantwortlichen Ernährungsbeauftragten und ein multidisziplinäres ‚Nutrition Support Team' (NST). Zudem wurde eine Strategie definiert, mit der ernährungsbezogene Daten zwischen Krankenhäusern, Pflegeheimen und zu Hause betreuten Menschen in Form einer individualisierten Ernährungstabelle ausgetauscht werden konnten.

Krankenhaus-Zusammenschlüsse: Komplexe Veränderungen in einem komplexen Umfeld
Interview mit Soki Choi

Im Gesundheitssektor kommt es immer häufiger zu Zusammenschlüssen von Krankenhäusern, doch wie kann man solche radikalen Veränderungen managen? Dr. Soki Choi, Beraterin, Lehrerin und Forscherin am Karolinska Institut, führte eine umfassende Studie über die Fusion zweier schwedischer Krankenhäuser durch: das Karolinska Krankenhaus und das Huddinge Universitätsspital in Stockholm. Ihre wichtigsten Ratschläge für Krankenhausmanager, die sich mit Fusionen beschäftigen, sind: sich bewusst zu sein, wie kompliziert ein Fusionsverfahren ist, und nicht die externe Expertise unterschätzen, die zur Durchführung von Zusammenschlüssen benötigt wird. Dr. Choi betont, dass Zusammenschlüsse Zeit brauchen; meist zeigen sich die wahren Vorteile erst nach fünf bis zehn Jahren. Auch sollten Krankenhäuser die richtigen Methoden auswählen und sich nicht ausschließlich auf Forschungsergebnisse aus anderen Bereichen verlassen – der Gesundheitssektor ist einfach komplizierter. Und schließlich sollte der Prozess nicht in großen, radikalen, sondern in kleinen Schritten abgehandelt werden.

Kapital in der City: In das Krankenhaus der Zukunft investieren Von Stephen Wright, Bernd Rechel, Martin McKee, James Barlow

Das ‚European Observatory on Health Systems and Policies' hat zwei Bände über Kapitalanlagen in europäischen Krankenhäusern herausgebracht, die das Vordringen marktwirtschaftlicher Prinzipien in eine großteils immer noch von öffentlicher Hand geleiteter Aktivität beleuchten, und die verschiedenen, zunehmend eingesetzten Finanzierungsmodelle untersuchen. Aufgrund der derzeitigen ökonomischen Umstände sind kluge Investierungsentscheidungen in der Gesundheitssorge wichtiger denn je, und auch schwieriger denn je zuvor.

Auch im Bereich der Krankenhausfinanzierung treten Veränderungen auf. Es gibt einen starken Trend weg von einem Gesamthaushalt und eher hin zur gemischten Förderung. Die häufigsten Formen der Finanzierung sind unter anderem die Strukturfonds der EU und öffentlich-private Partnerschaften (PPP). Aufgrund der Auswahlkriterien liegt der Fokus der meisten Strukturfonds auf relativ armen Gebieten, und es ist durchaus möglich, dass sie dort in den nächsten Jahren den Großteil des Kapitalaufkommens in der Gesundheitssorge tragen. PPP Modelle versuchten, Anreize für private Auftragnehmer zu schaffen, in dem die Verantwortung für die Investitionskosten zusammen mit den laufenden Kosten gebündelt wird.

Hindernisse der sicheren Medikamentenverabreichung: Medikamentöse Auftragsvergabe in norwegischen Spitälern Von Brian Godman et al

In norwegischen Krankenhäusern werden Medikamente zwecks Kostenersparnis ausgeschrieben. Jedes Jahr wird auf Basis der Ergebnisse dieser Ausschreibungen eine Liste von Medikamenten zusammengestellt. Eine Studie untersuchte die praktischen Folgen dieses Vorgehens. Die Ergebnisse zeigen übereinstimmend, dass das Krankenpflegepersonal über das aktuelle System beunruhigt war, da sie auf eine zunehmende Zahl von Generika stießen. Die Krankenschwestern und -pfleger gehen davon aus, dass die generischen Ersatzprodukte auf den Abteilungen ein Risikofaktor für Fehler in der Medikamentenverschreibung sind. Krankenhausmanager können daraus lernen: Obwohl sich das wettbewerbsmäßige Ausschreiben stark positiv auf die Krankenhausfinanzen auswirkt, sollten im Anschluss an solche Strategien Vorgehensweisen implementiert werden, welche die Patientensicherheit gewährleisten und Kosten aufgrund von Medikationsfehlern vermeiden.

Verbesserung der Verschreibungseffizienz durch erhöhten Einsatz von Niedrigpreis-Generika Von Helle Håkonsen, Heidi S. Hopen, Else-Lydia Toverud

Ausgaben für Arzneimittel werden in allen Bereichen zunehmend strenger überwacht, da das schnelle Wachstum auf diesem Gebiet andere Bereiche überholt. Unhaltbare Steigerungen haben dazu geführt, dass Regierungen, medizinische Berufsorganisationen, Gesundheitsbehörden und Krankenkassen mit größerem Nachdruck Reformen einführen, um Ressourcen zu sparen. Diese beziehen sich meist auf Generika, um die Verschreibungseffizienz bereits existierender Produkte in einer Klasse oder einer verwandten Klasse zu verbessern, und umfassen Initiativen von Angebot und Nachfrage-Seite.

Verschiedene Initiativen haben europaweit zu einer Senkung der Generikapreise geführt. Dies geschah auch in Ländern mit geringeren Bevölkerungszahlen wie Litauen, Norwegen und Schweden, womit mit dem Mythos aufgeräumt wird, dass solche Länder keine niedrigen Arzneimittelpreise durchsetzen können. Diese Initiativen, gekoppelt mit Maßnahmen zur Förderung des Einsatzes von Generika, haben in den letzten Jahren zu einer Stabilisierung der Kostenrückerstattung für Protonenpumpenhemmer und Statine in den meisten westeuropäischen Ländern geführt. Diese gesteigerte Effizienz wurde ohne Gefährdung der Gesundheitssorge erreicht.

AGENDA 2011

September

MCC Hospital World 2011 22-23
Berlin, Germany
http://hospitalworld.info/

ESMO 2011 23-27
Stockholm, Sweden
www.esmo.org

October

ESICM 1- 5
Berlin, Germany
www.esicm.org

Global E-Health Forum - Designing Personalized Healthcare 11-13
Hamburg, Germany
www.global-ehealth-forum.com

10th European Healthcare Congress 13-14
Munich, Germany
www.gesundheitskongress.de

The Lancet / ESCMID Conference on Healthcare-Associated Infections and Antimicrobial Resistance 15-16
Beijing, China
www.escmid.org

JFR 21-25
Paris, France
www.sfrnet.org

EAHM EVENTS COMING SOON

September 15-16, 2011 / *Vienna, Austria*
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November 18, 2011 / *Düsseldorf, Germany*
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September 27-28, 2012 / *Athens, Greece*
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- Personnel Management
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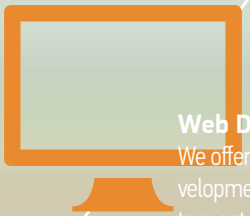

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