Hospital

ASSOCIATION EUROPEENNE DES DIRECTEURS D'HÔPITAUX
EUROPÄISCHE VEREINIGUNG DER KRANKENHAUSDIREKTOREN
EUROPEAN ASSOCIATION OF HOSPITAL MANAGERS

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More market competition in healthcare?

Willy Heuschen

The long-term impact of globalisation on the European single market is undeniable. Although competitive forces deliver benefits to consumers, the globalisation trend also causes displacement as companies shift production and employment to low-wage economies. The market for healthcare services is somewhat different however. The one-to-one nature of treatment, from both the patient and provider perspective, leaves only minimal scope for reducing manpower by moving the point of service delivery elsewhere. Healthcare services continue to be provided by people for people and most patients want to undergo medical treatment as near as possible to home.

The role of globalisation is evident in the growing private sector penetration of healthcare markets in a number of European countries where service providers compete for patients. In political circles this form of market orientation is widely viewed as a welcome opportunity to contain spiralling expenditure on healthcare. It is worth noting three interesting facts in this context.

First, the market system which dominates the US health system is the focus of a growing chorus of criticism. Critics note, for example, that rising healthcare costs have not been matched by increases in output. For this reason, demands for greater market orientation deserve scrutiny. Those who advocate a market approach must first produce data to show that this model for healthcare services and processes has improved the health status of populations. According to Professors M. E. Porter and E. Olmsted Teisberg, the goal of the principal players in the current US system is not to deliver added value for patients from each additional dollar spent but to generate additional revenue, increase their market share, cut costs and shrink services. In other words, the typical behaviour and rules of the market apply.

The German Hospital Association's (DKG) spring meeting in Berlin heard similar warnings about the consequences of blindly following the market. In an allusion to the recent experience of many German hospitals, DKG President, Dr. Rudolf Kösters, noted that "restructuring in the health insurance market has caused hospitals to go to the wall." In the inpatient sector alone, cost-cutting measures have produced a funding gap of 1.2 billion euros. Competition can only deliver cost reductions when hospitals are free to set prices and current legislation is amended to make the obligation to provide a service conditional on the ability to provide a service. The cap on reimbursement for hospitals precludes the introduction of market rules.

The French President, Nicholas Sarkozy, established the Larcher Commission to encourage new thinking on healthcare. Sarkozy noted the values hospitals embody. Serving the public, offering permanent access and, not least, being rooted in communities where they provide significant employment are all values to be protected in the face of emerging challenges, he said. High quality services must be maintained with a view to delivering top class services. Sarkozy also noted that half of all public hospitals are operating at a loss. To address this deficit and meet the imminent challenges, hospitals must be given greater autonomy, he said. This will mean providing more appropriate levels of funding based on actual levels of service. Hospital management is the second building block. Managers must be given greater discretion and responsibility and the hospital director must once again become the real boss. President Sarkozy stated it is unacceptable that certain interests can effectively veto the decisions taken by the hospital director. Directors must take responsibility for providing health services to the population in the hospital's catchment area. This includes partnerships with the private sector, which must become the rule.

It is unusual to hear such sentiments expressed by a head of state. They force us to think about the market position of hospitals. It is also interesting to note that France is next in line to take the Council Presidency. Perhaps this will stimulate debate across Europe. The EAHM certainly intends to stay ahead of the game.

Willy Heuschen
EAHM General Secretary
Editor-in-Chief

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GLOBALISATION OF HOSPITAL SERVICES

Nowadays, no hospital manager can afford to think nationally, let alone regionally. The world has become a village, and the hospital a component of the services industry. The consequences of globalisation on medical practice and patient experience might be considered, as Professor Leiss does in his contribution, or the impact on health demographics, as in the case of the migration of Polish doctors, explained by Dr. Duszczyk. Mr. Conill's project built on globalisation by taking advantage of the crossborder situation of his new hospital. Professor Oesterle finally illustrates some of the most typical features of globalisation at the European level.

PAGE 16-24

GLOBALISATION

CARE OF THE ELDERLY

People older than 75 already represent half of hospital admissions in France. The effect of an ageing population on hospital management cannot possibly be overestimated. Our authors present some of the options they experiment in their national context, but which could be transposed in most European countries. Karen Hedstrom underlines the contribution of IT to elderly care, Dr. de la Fournière points out how a regional network could relieve hospitals of some of their activities in that field and Arlene Wellman describes the rapid assessment clinic for older people she operates in the United Kingdom.

PAGE 26-31

ELDERLY CARE

(E-)Hospital is the Official Journal of the European Association of Hospital Managers

FOCUS : SLOVENIA

Slovenia is a country with 2 million citizens. Since 1991 it has been a democratic republic, with the full name of the Republic of Slovenia. Compulsory health insurance administered by the Health Insurance Institute of Slovenia (HIIS) is at the cornerstone of health financing in Slovenia, and is defined by the 1992 Law on Healthcare and Health Insurance. The number of doctors per 100,000 citizens in Slovenia is very low, and there is also a shortage of qualified nurses. Slovenia has 2 university medical centres, 7 specialised hospitals, 5 psychiatric hospitals, 2 gynaecology hospitals, and 2 private sanatoriums. During its EU presidency, Slovenia will, among other priorities, highlight IT systems development in healthcare, which will facilitate faster intervention and more effective information exchange between health institutions.

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Scientific Committee Meeting in Brussels

Meeting in Brussels on 7 March 2008, the EAHM Scientific Committee welcomed a new member, Mr. José Manuel Aldamiz Echevarria of Spain. Mr. Echevarria succeeds his compatriot, Mr. Manel Peiro. The EAHM took the opportunity to thank Mr. Peiro for his outstanding work on the committee and the dedication he has shown over the years.

The proceedings focused on three key issues. First, it considered possible themes for the scientific programme of the upcoming EAHM congress in Davos in 2010. It then discussed next moves in terms of planning for the establishment of a European accreditation system for hospitals. Finally, it examined the organisational arrangements and content of a further EAHM seminar anticipated in 2009. There was broad consensus that the committee should focus on appealing to hospital managers and it agreed on the need for lines of demarcation for the management function in hospitals. On that basis, the issues facing the EAHM revolve around leadership, communications and strategic development. With this in mind, members held a brainstorming session on themes for the 2010 congress and produced several suggestions for the content of the proposed seminar in 2009. The committee also agreed to contact our Swiss colleagues with a view to intensifying future co-operation. The proposals for the seminar in 2009 will be circulated to the EAHM Board and the list of possible topics will be whittled down thereafter.

Members of the committee were pleased to have a further meeting with Mr. Kristof Eekloo of the Catholic University of Leuven, who announced he would be in a position to publish the final results of a European study on hospital management within weeks, as his doctoral thesis was almost complete. An analysis of the study findings should be available at the Graz conference. Several committee members agreed to produce a booklet for delegates providing a concise summary of the results.

New Leadership for New Challenges

22nd Congress of the European Association of Hospital Manager

Discounts for early booking are available until 31 May 2008.

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www.evkd-kongress2008.eu

And the winner is...

The winning respondent to our survey on trends in European hospital management is Professor Derek Mowbray. His name was randomly selected during the latest editorial board meeting. He will receive his iphone shortly.

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*F. Lellouche et al., Intensive Care Medicine 2004, Vol. 30, Supplement 1, 234/P80.

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New Leadership for New Challenges

Thursday September 25, 2008

MORNING	
09.00-10.00	General Assembly, European Association of Hospital Managers
10.00-10.20	Press conference
10.30-12.30	Opening Ceremony
	Nikolaus Koller, Chair, Association of Styrian Hospital Directors President, Austrian Conference of Hospital Managers Paul Castel, President, European Association of Hospital Directors Franz Voves, Governor of Styria (to be confirmed) Andrea Kdolsky, Minister of Health, Republic of Austria (to be confirmed) Keynote Speaker: Eckhard Nagel, Institute for Medical Management and Health Sciences, University of Bayreuth, Germany

AFTERNOON	
14.00-14.30	Presentation Ceremony, Golden Helix Award
	Block 1: Leadership Meets Politics
14.30-15.00	Gediminas Cerniauskas, Advisor to the Prime Minister of Lithuania "Medical savings accounts as a tool to enhance free movement of goods, services, people and capital"
15.00-15.30	Yannis Tountas, Medical School, University of Athens, Greece "Reforming the Greek National Health System; many efforts with few results. Lessons to be learned"
15.30-16.00	Discussion
16.00-16.30	Break
	Block 2: Leadership Meets Economy
16.30-17.00	Prof. Eric Engelbrecht, Belgium Title to be announced
17.00-17.30	Mik Horswell, Institute of Healthcare Management, UK Title to be announced
17.30-18.00	Discussion
19.00	Governor's Reception, Auditorium of the Old University

Friday September 26, 2008

MORNING	
	Block 3: Leadership Meets Ethics
09.00-09.30	Dr. Gregor Becker, Associate Professor for Bioethics and Philosophy of Science and Technology, Jagiellonian University, Cracow, Title to be announced
09.30-10.00	Prof. DDr. Michael Lehofer, Graz, Austria Title to be confirmed, Charter of Patient Rights?
10.00-10.30	Discussion
10.30-11.00	Break
	Block 4: Leadership Meets Patients
11.00-11.30	Iris van Bennekom, General Manager, NPCF - Federation of Patients and Consumer Organisations of The Netherlands (represented by Jan Aghina of the same organisation) "The effects of the behavior of management on the behavior of staff toward patients"
11.30-12.00	Karsten Hundborg, Director, Danish Institute for Quality and Accreditation in Healthcare Title to be announced
12.00-12.30	Discussion
12.30-14.00	Lunch

AFTERNOON	
	Block 5: Leadership Meets Employees
14.00-14.30	Jean-Luc Chassagnol Guy Vallet, General Director, Marseille City Hospitals
14.30-15.00	Dr. Ernst Wastler, Chairman of the Executive Board, VAMED, Vienna Presentation on the aging workforce
15.00-15.30	Discussion
15.30-16.00	Break
	Block 6: Leadership Meets Leaders
16.00-16.30	Guy Lebeau, General Manager, Johnson & Johnson, Presentation on accreditation
16.30-17.00	Prof. Manuel Peiro, Vice Dean, ESADE Business School, Spain Presentation on hospital governance
17.00-17.30	Discussion
19.30	Gala Dinner, Helmut List Halle

Confusion surrounds health services directive

The proposal for a framework directive for crossborder healthcare in the EU has still not been published. Its initial publication date had been foreseen for 19 December 2007. It was shelved on 19 December due to internal disagreement within the European Commission. Several Commissioners' cabinets have reservations about the proposal, as well as criticism from some members of the European Parliament.

There exist fears that the proposal could be considered as yet another Bolkestein Directive, at a politically sensitive time for the EU in the run-up to the ratification of the Lisbon Treaty.

But the Commission has also been criticised for not having been more transparent over the proposal from the beginning, publishing it much earlier in order to launch discussions.

At a debate on patients' rights regarding crossborder healthcare, organised by the European Parliament on 4 March 2008, Philippe Brunet, head of cabinet for the recently appointed Health Commissioner Androulla Vassiliou (see below), said that "we have to rethink the schedule".

Brunet mentioned that the aim was "to ensure that the issue remains at the top of the agenda". A final proposal of the text would be “high on the agenda” the coming months. This could be either in April or June 2008.

New EU Commissioner for Health

In February Health Commissioner Markos Kyprianou announced his resignation in order to join the new Cypriot government as foreign minister.

Kyprianou was appointed EU Commissioner for health and consumer affairs in May 2004, but had to cede half of his portfolio following Bulgaria's entry to the EU, which led to the nomination of Meglena Kuneva as consumer affairs commissioner.

His successor is Mrs. Androulla Vassiliou, wife of former Cypriot president George Vassiliou. Mrs. Vassiliou has been reportedly very active in the environmental field and human rights. She is known for her outspoken support of women’s rights and their representation in politics and business.

Under current EU rules, each of the 27 member states is entitled to one commissioner's post. The new Lisbon treaty, which is to be ratified by all member states and expected to come into force in 2009, will reduce the number of commissioners to 18 by 2014, allowing only two thirds of the member states to send a commissioner to Brussels.

Commission acts on privacy concerns in RFID

On 21 February, the European Commission issued a draft recommendation (COM/2007/96 - Radio Frequency Identification (RFID) in Europe: steps towards a policy framework) to the operators which use RFID technology, setting up a list of guidelines to be respected in order to avoid privacy breaches.

At the same time, it opened a public consultation on the recommendation for a period of eight weeks, finishing on 25 April 2008. Following the review of submitted comments, the Recommendation is tentatively scheduled to be adopted before the summer of 2008.

According to the Commission, there is an urgent need to update the current legal situation due to the quick take-up of RFID devices. It proposes the introduction of the so-called 'opt-in' principle for RFID, which involves requesting the consent of users when personal data are contained in tags.

Court confirms legality of a risk equalisation system for private medical insurance sector

In a Judgment of the Court of First Instance in Case T-289/03 issued on 12 February 2008, the court approved Ireland’s risk equalisation system (RES) for the private medical insurance (PMI) sector.

Such a mechanism is a necessary and proportionate means of compensating the insurers. Indeed, those are required to cover, at the same price, all persons person living in Ireland, independently of their state of health, age or sex, the judges said.

Between 1994 and 1996 the Irish private health insurance market was liberalised. The provisions which liberalised the sector provided for the establishment of a RES, administered by the Health Insurance Authority (HIA).

The RES is a mechanism providing, first, for payment of a levy to the HIA by PMI insurers with a risk profile below the average market risk profile and, second, for a corresponding payment by the HIA to PMI insurers with a risk profile higher than the average.

The case was brought before the court by a PHI (BUPA), as application of the RES would essentially lead to funds being transferred from BUPA to the Voluntary Health Insurance Board, a competitor operator.

The court followed the view of the European Commission, according to which the compensation provided for by the RES constituted an amount intended as compensation for the obligations associated with a service in the general economic interest (SGEI).

According to the Commission, the conditions governing this had been fulfilled. (HH)

Migration

By Rory Watson

The challenges faced by countries with insufficient numbers of trained personnel due to the phenomenon of medical migration was one of the main themes to emerge from the conference on the future of the health sector organised by the European Federation of Public Service Employees (Eurofedop) in Brussels in early March.

"Of course, this is a problem. We do not see it with just one country, but also with a lot of new and old member states," explains Bert Van Caelenberg, Eurofedop's secretary general.

The Federation has recently completed a study examining best practices in five European cities – Bucharest, Bratislava, Madrid, Paris and London – to see how the authorities can attract and retain healthcare staff in large cities. One scheme which may attract wider interest is the initiative in the UK to help provide nurses with affordable accommodation.

"What we have found is that many medical professionals in central and eastern Europe will leave as soon a possible. This is not simply due to money. Other factors count as well, such as if politicians blame the sector for shortcomings," says Van Caelenberg.

A detailed presentation to the conference of the challenges facing policy makers from the brain drain of trained medical staff came from Miklos Szocska, the director of the management training centre at Semmelweiss university in Budapest. He contrasted the drivers which lead doctors and nurses to leave their home country with those that convince them to stay.

In the first category come financial incentives such as better pay, living and working conditions and quality of life; professional development and opportunities; public respect for the profession; and proficiency in the relevant foreign languages. The second contains more personal criteria: love for one's home country, family and friends; and a feeling of responsibility for Hungarian patients and the country's healthcare system.

He pointed out that there was a migration intention level of 70% among medical personnel in the country. This phenomenon is already leading to noticeable shortages of specialists in key areas. These reach just under 13% for radiology, over 10% for psychiatry and 7.4% for surgery.

As Marcela Gatciova, the president of the Slovakian organisation SLOVES, told the 100 or so participants, the phenomenon is spreading: "The lack of health professionals causes major problems for patients in Slovakia. A woman I know was diagnosed with breast cancer and faced exceptionally long waiting lists. Once under treatment, the process was very slow. This shows that even in the case of life-threatening diseases there is simply not enough personnel available."

Mr Szocska, who is currently conducting a study into medical migration, suggested policies which national authorities could implement to slow down, if not stem, the brain drain. He pointed to the need for local initiatives to improve career and living conditions. This should be backed by EU-wide debates on value conflict and the promotion of ethical frameworks for recruitment to prevent trained staff being poached.

He is also advocating that training systems take account of ways to retain staff once they have qualified and the promotion of international exchange schemes that emphasise the importance of retention in the long run. Finally, he would like to see evidence used to convince decision makers to compensate countries who receive personnel trained in other countries.

The same themes were emphasised by Anton Szalay, the chairman of the Slovak trade union of health and social services. He began by emphasising the need to improve salaries in a country where a physician typically earns less than 1,150 euro a month and a nurse below 500 euro.

He underlined the need to improve working conditions and to ensure that staff, and patients, had access to modern equipment that takes account of the latest trends in science and technology. Eurofedop is suggesting that an EU health platform should be established to focus on issues in the health sector that affect its employees.

This would provide a venue where trade unions, non-governmental organisations, politicians and regulators could examine together issues such as patient mobility which have wide-ranging implications for all concerned.

Speaking at the conference, Austrian Christian Democrat MEP Othmar Karas insisted that successive judgements from the European Court of Justice (ECJ) on this sensitive issue were not sufficient against a background of increasing patient and professional mobility.

Political prerequisites were also required, he said, calling for "a European policy approach".

The view is supported by the public services federation which believes that EU-wide legislation is necessary to clarify the implications of the ECJ's rulings on patient mobility.

France

«CHU, hôpital de tous les défis»
(University hospital, facing all challenges)

In 2008, all French university hospitals will celebrate their fifty years of existence. Medical reforms by Robert Debré and the creation of university hospitals in 1958 have given a major impulse to the modernisation of French medicine and medical research.

Reference hospitals, regional hospitals, they are also local focal points which are open to their environment. The 29 university hospitals take up more than a third of all hospital activities. Every year, they account for 3,000,000 ER visits. Almost 4 million French citizens are admitted in one of them, and 12 millions are outpatients. They train around 30,000 doctors and regularly invest in clinical research and innovation.
The association of university hospitals' general managers, of chairmen of medical committees and medical school deans (Conférence des directeurs généraux des CHU, des présidents de CME et des Doyens de facultés de médecine) have decided to publish a reference book on the occasion of the anniversary of university hospitals: «Le CHU, l'hôpital de tous les défis», published by Privat, for sale in all bookshops.
University hospitals have asked more than 40 experts of university health establishments to relate their experiences around three missions which became indissociable: care, teaching and research. They put forth the numerous and varied contributions university hospitals made to modern society: they create wealth, they enable knowledge sharing, they guarantee solidarity. They show that university hospitals are able to take up the challenges they are facing in the third millennium.

As biography of one of the noblest French institutions, this book also recounts the major phases of the creation of university hospitals and lists more than seventy world firsts carried out by university hospitals teams.

Germany/ The Netherlands

Internet portal to fight MRSA

A new information system on the Internet should support Germany and the Netherlands in their crossborder fight against antibiotics resistant hospital germs.

The information system set up within the «MRSA-net» EUREGIO project should improve the understanding of the necessary hospital hygiene measures and give MRSA related recommendations outside the hospital.

Luxemburg

Active euthanasia legalised

After the Netherlands (2001) and Belgium (2002), the Grand Duchy of Luxembourg is the third country in the world to have passed an active euthanasia law with a large majority.

The law was adopted on 19 February by 30 representatives who voted in favour, 26 again, and three abstentions.

The law guarantees doctors immunity, if they perform active euthanasia or assistance to suicide. The condition is that a patient who is either incurable or in extreme pain has expressed, in writing, a deliberate will to end his/her life. Doctors are obliged to hold repeated and in-depth conversations with their patients about that decision and to include another doctor for advice.

According to the legislation, all euthanasia cases should be examined by a reviewing commission. The constitutionality of the law must still be looked into by the Grand Duchy of Luxembourg's State Council, before it can enter into force.
Another piece of legislation foresees the development of palliative care, covered by health insurance funds.

Hungary

Hungarian Parliament Approves New Health Legislation

On 12 December 2007, the Hungarian Parliament adopted a controversial law on the partial privatisation of health insurance.
The new legislation, introduced under Minister President Ferenc Gyurcsany, foresees that in addition to state health insurance, 22 private insurances will be set up with a majority participation of the State. This measure is part of a savings package, which was conceived last year by the government.

The Netherlands

Hospital Bans on Mobiles Must Stay

Evidence that mobile phones can interfere with vital intensive care equipment has been strengthened. More than half the hospital ventilators tested by Dutch researchers stopped working properly when a mobile was switched on nearby. Critical care monitors were also vulnerable, with seven out of thirteen disrupted by mobile signals, while three out of seven syringe pumps were affected.

«3G» mobiles were less likely to cause problems compared with second generation mobiles, and while, on average, the mobile had to be only a few centimetres away to interfere with the device, one «hazardous» incident happened at a distance of three metres.

The British Medical Association has maintained that there is no significant evidence linking mobiles to problems with medical devices, and said that patients would benefit from doctors being able to communicate better with colleagues while on the wards.

Trends in European hospital management

Results of the survey of European hospital managers

By Dr. Carsten Frank Hutt

This is the second part of the analysis of the study "Trends in European Hospital Management". As you know, this study is the result of a collaboration between E-Hospital and Emergent Actio.

The first part dealt with the interpretation of answers to questions on the size of a hospital vis-a-vis its competitiveness, the impact of information technology on medical quality, the profitability of information technology and the foreseen number of hospitals by 2020.

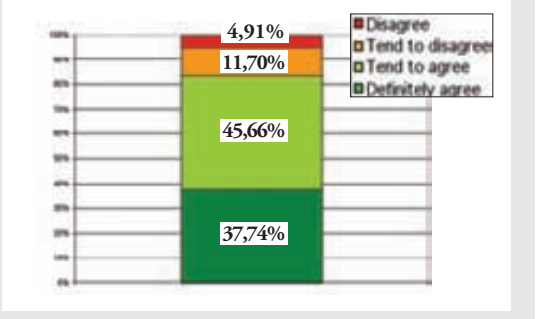
Infobox Median

Median is a statistical term. In comparison to average value, it has the advantage of being more robust against outliers that could occur e.g. by mistyping.

The median describes the value right in the middle of a finite list. That means half of the sample has a higher value than the median and the other half has a lower value.

5. Industrial standards in hospitals

Thesis: Hospitals must commit to industrial standards (for example by optimising processes and increasing profitability).

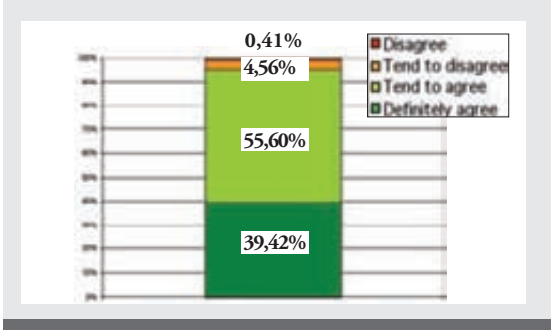


N=265 Don't know=9 Median=Tend to agree

When we asked about the implementation of industrial standards we perceived clear tendencies: the analysis of the data showed that especially private hospital chains agree with this statement (median = definitely agree), while all other hospital types answer with a median of 'tend to agree'.

6. Holistic diagnostic approach

Thesis: There is a trend towards a holistic diagnosis approach to the patient to be observed in healthcare and early diagnosis. The combination of in vitro (laboratory diagnosis) and in vivo (imaging diagnosis) stands for innovation and future.

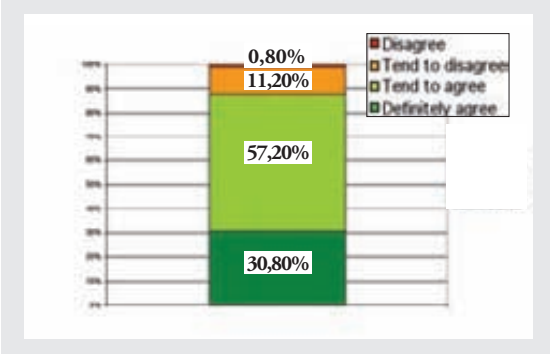


N=241 Don't know=33 Median=Tend to agree

This is the question with the most homogenous body of answers: about 95 percent agree or tend to agree with the statement. One could say that the combination of in vitro and in vivo diagnosis is already and will also remain a solid information management trend in European hospitals.Another obvious trend is confirmed in the next chapter.

7. Generation of knowledge from patient data

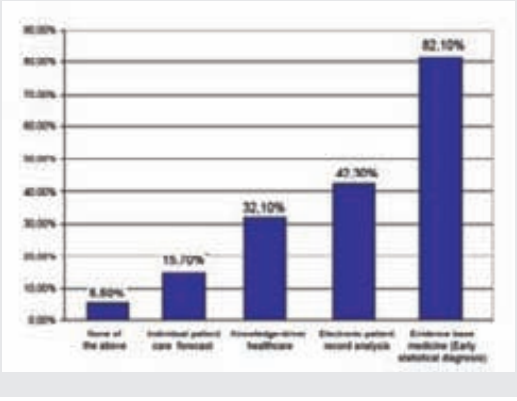
Thesis: The generation of knowledge from patient data with the help of statistical methods will drastically change the diagnosis quality in the coming years.



N=250 Don't know=24 Median=Tend to agree

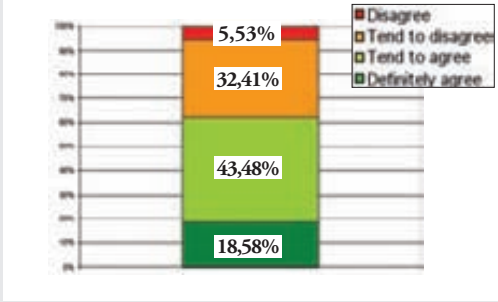
A secret treasure seems to be hidden in the volume of patient data. This treasure will be discovered, categorised and utilised for the improvement of diagnosis quality. Data mining and statistical methods will play an important role in this data analysis. Evidence based medicine, although still a young branch of science, is already well known to European hospital management. But other methods in this area have also achieved publicity.

Which term have you already heard in relation to knowledge generation from patient data for the improvement of diagnosis quality?



8. Influence of the European Union on hospital management

Thesis: Guidelines by the European Union are having a substantial influence on hospital management.



N=253 Don't know=21 Median=Tend to agree

As we can see, more than 60 percent of the interviewed hospital managers are aware of the strong influence the European Union already has on hospital management.

On the other hand, it is surprising that only 40 percent disagree or tend to disagree with this statement.

Globalisation in medicine

Who wins, who loses?

By Prof. Dr. med. Ottmar Leiß

According to the philosopher Odo Marquard (1), "The dominant trend of modern global change is towards uniformity. Distinctions are being neutralised. It is only through this process that the hard sciences can deliver globally verifiable results; it is only through this process that technology can replace global traditional realities with functional realities; it is only through this process - recourse to the one-size-fits-all mechanism of money for instance – that the modern economy can turn products into globally traded goods; only through alignment with the best in the world and the acquisition of the cheapest in the world is global progress possible."

This trend towards global uniformity and the increasing independence of the means of production, labour and capital from location and tradition are encapsulated in the buzzword "globalisation". It is precisely because modern science, technology and economics function in a tradition-neutral manner and modern information media, independently of traditional languages, communicate digitally and to an increasing extent globally that that which is new, the future, will become increasingly origin-neutral.

Aspects of globalisation

It is possible to formally differentiate various aspects of the globalisation process which are interdependently mutually reinforcing and contribute to the acceleration in the overall process (see table next page).
From the perspective of society as a whole, objectivisation, standardisation and normalisation in science and production encourage cooperation across borders and cultures. Rationality and the rationalisation of work processes facilitate automation and technologisation, which, in turn, fosters standardisation and internationalisation. Information technology is one of the prime catalysts in this process.

What does globalisation mean for medicine as a science?

Where medicine is an applied science and avails of new techniques and technologies (for example, information technologies), it benefits from globalisation, standardisation and progress. In many cases, technological innovations have been prerequisites for new insights. Through the use of macroscopes, microscopes and endoscopes, for example, we have gained new insights that have helped to create breakthroughs in our understanding (2). The trends towards objectivisation, uniformity and technologisation in the globalisation process make no allowances for the evolution of tradition, culture and life-history. In this respect, integrative concepts in medicine, such as Engel's biopsychosocial model (3), and health concepts which complement the pathogenetic orientation of medicine, such as Antonovsky's salutogenesis (4), are in a difficult position because they have not (yet?) entered mainstream current thought.

Is globalisation changing hospitals and medical practices?

Rationalisation, uniformity and technologisation encourage the transformation of hospitals into medical service centres (5). The hospital doctor is evolving into a technician and becoming increasingly dependent on medical technicians and IT specialists. The complexity of modern medicine requires close interdisciplinary cooperation and communication and participation in continuing education. Standards must be observed and evidence translated into practice. The economisation of internal hospital procedures reduces individual patients to cases, while colleagues become competitors. "Group egoism" must be rolled back, conflicts managed (6), hierarchies dismantled, goals achieved and quality safeguarded (7, 8). Political conditions, markets and competition among hospitals encourage cherry-picking and the "McDonaldisation" (9, 10) of the health service.

What does globalisation mean for doctors and patients?

From the patient's perspective, recent developments have delivered much that is positive. The objectification of medical services strengthens the autonomy of patients (12) and "demystifies" the doctor-patient relationship. Normative rules laid down by lawmakers (e.g. legislation on medical devices) have enhanced the safety of invasive interventions in which medical de-

vices are used, while guidelines (13, 14) encourage safety and prescribing security and offer patients transparency vis-à-vis the standards they can expect. As branding and specialisation among practices increase, more alternatives become available at local level, and organisational professionalism and customer-orientation improve (the introduction of after-hours consultations, for instance), the patient is assuming the role of client and the customer is becoming king. Old-fashioned notions of mutual trust and loyalty are in decline as changing social values create a "thrill-seeking society" in which temporary partnerships and "doctor shopping" (mainstream medicine, alternative therapies, acupuncture and so forth) are on the increase.

For doctors, too, progress and globalisation have both advantages and disadvantages. The Verwissenschaftlichung (scientification) of medicine means more rational and critical evaluation of diagnostic and therapeutic measures is indispensable. Only outcomes that have been achieved using placebo-controlled, double-blind studies may be described as evidence-based medicine and elevated to the standard or state-of-the-art approach. Because the experience of the individual is both deceptive and inadequate, technologies and options for accessing "objective knowledge" (databases) are becoming more and more important for rational action. Computer skills (the ability to perform electronic searches, download and update) are now more important than knowledge of percussion and auscultation.

Why the unease about progress and globalisation?

Science and technology, the engines of progress and globalisation, are Trojan horses: we do not know what is hiding inside. The explosion in rationalisation stokes emotional fears and fosters suspicion, while the diminishing marginal utility of further progress creates scepticism. Can people tolerate an infinite amount of innovation? No, they cannot (15). "Conditioned by the brevity of life, people can never emerge far or quickly from their "original skin", so to speak, and they certainly cannot shed it completely. For this reason, they are fundamentally lethargic in the face of change, in other words, while they may be experts in modernisation, people are essentially slow (16)."

If we want to avoid being overrun by globalisation and if want to survive in a world of accelerating change, we must – from a salutogenic perspective – create coherence between the old and the new.

Conclusion

The benefits of globalisation for medicine as a science and medical-technical system lie in information technology, the digitalisation of imaging processes and the internationalisation of scientific interpretation constructs. The danger facing medicine is that its role will diminish until and become one of disease management, doctors will become "strangers in medicine" (17) and people will no longer ask critical questions about how much medicine we really need (18). True medicine – medical help and relief (as well as the rare cases of healing) - is not global and universal but local and individual. The sick patient needs a doctor who is more than an illness manager or a brilliant technician or pill prescriber, he needs a doctor who will, to the limits of his ability and with empathy, endeavour to shape the way in which the patient copes with his illness (19).

To return to Odo Marquard: "The faster the process of modernisation, the more indispensable and important the slow among us become because the new world cannot exist without the old accomplishments. Humanity without modernity is lame; modernity without humanity is cold: modernity needs humanity because the future needs origin (16)."

Aspects of globalisation

Ratio	Scientification, standardisation, evidence-based.
Technology	Technologisation, standardisation, computerisation, digitalisation (including of information)
Time	Acceleration, synchronisation, decoupling of tradition, real-time (www)
Culture	Uniformity, loss of cultural diversity, scientific progress as uniform culture.
Market	Economisation, international multinationals (global players), stock exchange listing

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MIGRATION OF POLISH DOCTORS

The situation since 1 May 2004

By Maciej Duszczyk

For the last few years, discussions surrounding employment migration of medical staff have been intense and ongoing in Poland. At times, members of the medical community have used the threat of emigration against the ruling authorities in order to secure salary increases. The issue of threats to the Polish healthcare system ensuing from medical staff emigration was raised during negotiations of Poland's accession to the European Union. A large part of Polish society itself feared the "brain drain" phenomenon.

In recent weeks, the issue of emigration, however, has lost significance somewhat, because healthcare sector employees have been dealing with other troubling issues. For example, the necessity to be granted approval by hospital directors in order to work in excess of 48 hours weekly, has been a matter of grave concern. This is also related to the complications in the discussions on the working time directive and the necessity to harmonise Polish legislation with the verdict of the European Court of Justice in the Jaeger and Simap cases.

In my opinion, when we are discussing the situation in the Polish healthcare system, which is unfortunately counted among the most poorly remunerated amongst all EU member states, we must consider a much larger problem than migration. There is also the issue of the transition of doctors and nurses to other professions. From the point of view of the Polish healthcare system as a whole, it is preferable for a young medical doctor, who is not content with his/her salary level and opportunities to generate additional incomes, emigrate to another country, where he or she can follow up with their professional career. It is likely that they will return to Poland when their situation has changed, whereas if they were to change profession and then later decide to return to the practice of medicine, they would lack the skills and experience of those who were abroad, but continued to follow medical progress and improve their professional skills.

Let us have a look of the scale of migration of medical doctors after 1st May 2004.

The total number of professionally active medical doctors in Poland amounts to almost 117,000. As indicated by figures from Polish ministry of health, by the end of June 2007 it issued 5851 certificates confirming possession of formal qualifications. This means that 5,04 % of Polish medical doctors in various specialisations were interested in undertaking employment in other EU member states.

An analysis of the existing trends, however, suggests that the number of doctors interested in collecting a certificate authorising them to undertake employment abroad in medical doctor profession has been declining. Between July 2006 and July 2007, the number of issued certificates rose by a mere 737 persons. This was almost two times lower than the figure for the period July 2005-July 2006.

This signifies that a decisive majority of persons who used to link their professional career to employment abroad have already made the step and extinguishing of migration trend is currently very likely. This phenomenon is called the "migration hump" in the migration theory.

The largest number of certificates, taking account of the percentage share in the total number of professionally active medical doctors in a given specialisation, was granted to:

Anaesthesiologists and intensive care experts	735 persons (17.84 % of all active professions)
Chest surgeons	32 persons (14.88 %.)
Plastic surgeons	23 persons (15.13 %.)
Rescue medicine	59 (12.45%)
Vascular surgeons	25 persons (9.73 %.)
Radiology	197 (9.41%)
Pathomorphology	46 (9.16 %.)

The smallest interest in undertaking employment in other member states is voiced by neonatologists (0,09 %), clinical oncologists (0,25 %) and child neurologists (0,27 %).

The potential employment countries are: Germany, Italy, the United Kingdom, Sweden, Norway, and France. These are traditional emigration countries for Poles, as well as countries that were the first to open their labour markets to Polish nationals. Unfortunately, additional reliable information about destination countries is missing.

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At the same time it must be stressed that figures collected on the basis of issued certificates do not perfectly illustrate the scale of emigration. As an example, the system lacks information about persons who collected their certificate but did not decide to leave Poland. Moreover, information is also missing about persons who undertake only additional employment in other member states. This is the case, for example, with anaesthesiologists who sign contracts with a hospital in another member state to provide medical services only one week in a month, without giving up employment in Polish hospitals.

Moreover, many doctors treat the certificate confirming qualifications as a kind of additional policy and security, in cases of a significant deterioration of the situation in the Polish healthcare system. They have decided against emigration and continue to work in Poland, but they do not rule out making a decision to leave in the future.

Paradoxically, the current turmoil in the Polish healthcare system, which is related to the necessity to obtain doctors' consent for work in excess of 48 hours weekly, will result in higher salaries and can influence the migration potential of doctors. The salary rise will narrow the gap between salaries in Poland and those in states doctors traditionally emigrate to, which will in turn diminish current emigration trends.

In addition to the diminishing differences in salaries, a growing influence on lowering of the migration potential among Polish doctors is exerted by the negative experiences of Polish doctors who decided to leave. Many such doctors frequently perform work below their qualifications and have hampered access to training of most modern medical procedures due to cultural issues, such as language barriers.

In an analysis of the migration of Polish medical doctors one should also take note of the fact that this phenomenon has different consequences from a regional viewpoint. While the fact that a dozen or even several hundred doctors of a given specialty leave Poland permanently is not a problem from the viewpoint of the entire healthcare system, emigration of even a few doctors from a given region, having e.g. only one or two hospitals, may significantly worsen patients' access to medical services and force them to travel long way to obtain help.

Although those are not frequent cases, some regional hospitals experienced delays in scheduled surgeries due to absence e.g. of anaesthesiologists.

In conclusion, it must be stated that the emigration of Polish doctors, perhaps excluding anaesthesiologists, has not significantly affected the condition of the Polish healthcare system, but migration processes should continue to be monitored with particular care.

Number of issued certificates

As of	Number of anaesthesists and intensivists	Number of professional certificates from 1.05.2004	% issued certificates /number of doctors
31. 12. 2004	3663	282	7,7
30. 06.2005	3723	436	11,7
31.12.2005	3795	526	13,8
30.06.2006	3984	625	15,69
31.12.2006	3978	683	17,2

The table above represents the number of doctors-specialists in anaesthesiology and intensive care who are professionally active domestically and the number of issued certificates confirming qualifications to undertake employment in other states.

Presented figures must be treated as a presentation of particular migration potential and not as full information about the scale of migration.

Recapitulation

Migrations of medical doctors only moderately affect the situation of Polish healthcare system. At the same time this phenomenon needs to be monitored, particularly in regional dimension.

The scale of migration depends mainly on the specialty of a given doctor. Anaesthesiologists are the ones most interested in emigration. Paediatricians are those least interested in emigration.

The scale of migration is currently experiencing an extinguishing trend. In 2007 certificates authorising one to undertake employment in other EU member states were collected by fifty percent less doctors than in an analogous period of 2006.

Current legislative changes related to the necessity to implement into Polish law provisions of the working time directive result in significant rises of the salaries of Polish medical doctors. This should be a decisive factor in decisions to give up emigration.

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New Cerdanya hospital

A shared border project

By Xavier Conill, Cristina Rodriguez, Jordi Boix, Alain Corvez, Victoria Peralta and Enric Mayolas

The domain of La Cerdanya and Le Capcir is a geographically isolated area formed by a valley in the eastern Pyrenees. By the Treaty of the Pyrenees in 1659, Spain and France distributed the land, dividing it into two parts.
The territory has a population of approximately 32,000 inhabitants, with a practically equal parity between the north and the south. Its economy is essentially based on the service sector, especially on the tourism industry. During the holidays, the estimated resident population can reach up to 130,000 inhabitants.

Since 2003, and thanks to a research co-financed by the French district of Languedoc-Roussillon, Catalonia and the European Union (Interreg III), the idea of the construction, starting and joint management of a hospital for acute short-stay patients has strengthened. The hospital, a public property following agreements between the French Republic and the Generalitat de Catalunya (Catalan government), will be located in Puigcerdà, the natural capital city of La Cerdanya, replacing the current hospital which attends the Lower Cerdanya (Spain), and filling the actual gap and lack of service attending this kind of patients in the Upper Cerdanya and Capcir (France).

The work lines

1. The institutional and governing line. The upcoming hospital of La Cerdanya needs to set up an inter-administrative organisation with its own legal entity allowing the representation of all the involved actors. The Agrupació Europea de Cooperació Territorial (European Group of Territorial Co-operation), a model promoted by the European Union and the parliament, is the chosen instrument. In 2006 Cerdanya's Cross-Border Hospital Private Foundation was created as a temporary instrumental entity towards a better efficiency of the project management.

2. The joint planning line. Even though each health authority has its own instruments (Health Plan and Health Map in Catalonia and the SROSS 3 in France), a joint planning following the each partner's basic criteria has been developed.

3. The Hospital's construction line. Since the end of the year 2007 we already have an executive project for its construction as a result of a project chosen by the different involved administrations, and the open competition for its construction is planned to be called for in the beginning of 2008. The starting of the hospital is planned for the end of 2010.

It will be a hospital with a built area of 14,190 sq. m and an approximate cost of 32 million euros.

4. The Hospital's operation line. Even though the hospital will be ruled under the Catalan and Spanish jurisdiction it will be owned by two different states' administrations. Assistance patterns (both differing as far as development and organisation stages), admissions of two populations with two distinctive cultures in the use of different health resources (strongly influenced by the problems of professional demography in Europe and particularly in isolated areas), applicable legal frameworks, not only from the welfare point of view but also in the daily operations, contract models and case-mix, for instance, will have to be integrated.

Descriptive figures

Number of regular beds	50
Number of rooms	32
E.R boxes	16
Specialized doctor's offices	17
Day Care Hospital (medical – surgery) capacity	10
Haemodialysis capacity	11
Operating theatres	3
Birthing/delivery rooms	1
X-ray rooms	4
Scanner	1
Heliport	

5. The health territorial network's construction line. The standardisation of the clinic's relationship with health professionals through a performance protocol and clinical practice guidelines will make the hospital

a center of reference. Also, this territorial network will have to develop the functions of a territorial observatory and work on the health promotion, education and disease prevention fields.

The project's big challenges

Even though it is still on a design stage and soon under construction, the project features a set of big challenges:

Two health administrations, two planning models, two service portfolios… but one single project.

The health models in France and Catalonia are different, thus bringing up differences in the relationship systems between the administrations and the supply network as well as causing the rules of the game to use distinctive instruments. Even the citizen's legal benefits are different.

This shared project uses some basic premises focused on the citizen and his or her rights and obligations. It will be up to the hospital's organisation and both its clinical and administrative services to make the effort to adapt to this reality.

A good example is the information system being worked on which has to be able to answer to the needs of the professionals, of the organisation, of both administrations, of the different financing parties (public or private, insurance companies, benefit societies…), of the other actors in the territorial network… and on top of that in three languages.

Two different hospital cultures…in one single project

Let's take the example of ambulatory care both in specialists' consultations as in other spheres such as surgery without hospitalisation or with daytime hospitalisation. Whereas in Catalonia it has always been an efficiency sign conditioned to the different paying systems (paying upon process), in France this hadn't been introduced until very recently and yet in a very discrete way.

Different patterns of political and work relationships among the human resources…but one single project.

Finally, the third big challenge is that of the organisation's structure, which means attracting competent professionals to an isolated area.

We are working on the idea of a management and organisation based on the Catalan model ('droit du sol'), but we want to involve all health professionals (nurses, administrative staff…) more closely in the management of their work.

The hospital will be small. According to French law, some of these low-activity departments would not be authorised, but according to Catalan rules, they are allowed to operate. So, in order to maintain specialists' medical competences, the best option is to ensure partnerships with reference hospitals in both networks. This cooperation goes beyond mere patient transfers and gives doctors the opportunity to practice their specialties.

Conclusions

Even though the construction and management project of the "Hospital de la Cerdanya" has only started and has very important challenges to overcome, it also offers some advantages.

This is a necessary project for the area. Due to its current location, Puigcerdà's hospital has no growth possibilities and the patients from the Upper Cerdanya and Capcir (France) have to be cared for in hospitals situated more than 90 minutes away. Access to care has to be guaranteed based on a win-win relationship and mainly considering the people to whom this hospital will have to be of service.

For further information about the project's history and features, we recommend visiting the site http://www.hcerdanya.eu.

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Crossborder healthcare in Europe

Towards a European healthcare system

By August Österle

The European integration project is built on free movement of people, goods, services and capital. However, trust in regionally available healthcare provisions, free or low-cost access at the point of use, and a high level of identification with national healthcare schemes has limited the interest in alternative provisions across borders. In recent years, however, crossborder healthcare has gained in importance, on a practical level and in EU policy perspectives.

From a patient perspective, different types of crossborder treatments have to be distinguished. When EU citizens are visiting another member country, treatments not planned in advance are covered when the respective treatment becomes medically necessary during the visit. The underlying idea is that free mobility of people in the European Union should not be hindered by a risk of losing social protection when staying in another country. Over the past decades, provisions have been extended in terms of personal and material coverage and have recently been facilitated with the introduction of the Health Insurance Card.

Planned Health treatment abroad

Citizens may also want to travel for reasons of medical care. In this case, specific characteristics determine whether related costs are covered. Remuneration will be provided in the case of pre-authorisation by the social security system of the home country (a procedure covered by the aforementioned regulation) or in the context of bilateral agreements. In relation to overall health budgets the extent of these cases is rather limited, but they are playing a more significant role for interregional cooperation in some border regions and for specific agreements between health insurance funds and/or providers. Examples are known across Europe, including the Baltic States, cooperation in the Euregio Meuse-Rhine among Belgian, Dutch and German health insurance funds and hospitals, the UK National Health Service initiative to address long waiting lists by contracting hospitals in other countries, or novel developments in the border regions between old EU members and the 2004 accession countries.

Alternatively, individuals can also travel to another country without acting in any pre-arranged context. In these individually driven cases, there is, so far, no general rule for reimbursement. But, there are European Court of Justice decisions providing important general principles. Accordingly, costs for non-hospital treatment abroad have to be reimbursed according to the terms of the health insurance institution in the home country of the patient. In the case of hospital treatment abroad, as a general rule, there is no coverage without authorisation. The underlying objective is to maintain treatment capacity and competence at national level and to safeguard the financial balance of national social security systems. However, there are reasons when authorisation has to be given, in particular when waiting time is judged as unacceptable for medical reasons (see, e.g., Judgement Watts, 16 May 2006, case C-372/04).

Drivers of crossborder healthcare

Even if its financial scope is still limited in a macro-perspective, determinants of planned treatments abroad are demand and supply-sided. From the patient or consumer perspective, prices, quality and transaction costs are of key importance. Given the importance of good health, quality of care will generally be the major determinant. Differences in (expected) quality can, and are, inducing mobility across borders. In the 1990s, studies for Italy and Greece have shown that movements abroad have been mainly determined by the perception of inadequate infrastructure in the home country. Similar quality concerns are relevant, when patients from Eastern or South-Eastern European countries are searching for treatment in Western European countries. In these latter cases, treatments are mostly paid out-of-pocket.

Costs become directly relevant for patients where the financial burden for treatments abroad has to be fully or partially covered by the patient. This is the case for health treatments outside what is generally covered under social security schemes (e.g. aesthetic surgery), or health treatments that are only partially covered by such schemes (e.g. dental care). In the case of dental care, Hungary has developed into a major treatment centre in Central Europe, with some patients receiving partial reimbursement in their home countries, but many more patients paying out-of-pocket. It is estimated that about 160,000 Austrians are seeking dental treatment in Hungary every year. But, combining dental care treatments with spa treatments or other vacation arrangements has extended dental care tourism far beyond a regional phenomenon. Similar trends can be observed for treatments that are not covered by national health systems, such as aesthetic surgery, as well as treatments that allow some in advance planning, such as, e.g., orthopaedic surgeries, or eye and ear surgeries. Here, ability-to-pay and willingness-to-pay become

major co-determinants of movements abroad for the prime purpose of healthcare consumption. Hence, providers in receiving countries with relatively lower labour and infrastructure costs can benefit by attracting patients that could not afford similar treatments in their home country. Apart from medical quality and direct costs, any decision for treatment abroad will be strongly co-determined by the broader service quality including waiting times, language barriers or administrative hurdles. And it is these arguments that are often put forward by healthcare providers attempting to attract patients from other countries.

For a provider working in the private healthcare market, traditional market principles are decisive. In these sectors, the internationalisation of healthcare provision is not limited to the EU, but an increasingly global phenomenon. Hospital treatment centres in Asian countries, in particular Thailand or India, serving an international patient clientele, are an example for this trend. For providers working in the context of national social security systems, the respective European and national regulatory framework, the capacity that is or can be made available for patients travelling in from other countries and the principles of remuneration for these patients are major determinants for whether or not such providers can attract patients from other countries. Following recent trends, provision to patients from other countries and/or outsourcing of treatments to treatment centres in other countries, will become an increasingly important option to hospital management, in particular in border regions where infrastructure planning so far has been constricted to national borders. Similarly, national funding institutions might find it financially attractive to contract with providers across borders. At the same time, however, they have the objective to ensure capacity and competence at national level. The aforementioned Euregio Meuse Rhine cooperation is a long-standing example of success, but hurdles also have to be taken into account.

Towards a European healthcare system

The future development of crossborder healthcare will be driven bottom-up and top-down. Beyond interregional cooperation, there is substantial growth potential for treatments that allow some in advance planning, and even more so when patients are directly involved as payers of services. In a bottom-up process, individuals searching for cheaper and/or higher quality healthcare provisions across borders will induce reactions by potential providers. Top-down developments are reactions to these developments (e.g. by establishing bilateral agreements or through European Court of Justice decisions), but may also be proactive, such as current attempts of the European Commission towards facilitating crossborder healthcare. While respective developments improve choices for patients and are opening up new opportunities for organising healthcare, related problems are far from negligible. The enlarged European Union is characterised by substantial economic differences, at individual and on societal level. While national systems attempt to ensure equal access to a broad healthcare package to the entire population, economic differences across Europe would create inequalities in the opportunities to benefit from extended choices, at an individual and systemic level. If the common objective of high quality, accessible and sustainable healthcare is taken seriously, access and quality in crossborder healthcare have to be ensured for all EU citizens by an adequate institutional framework.

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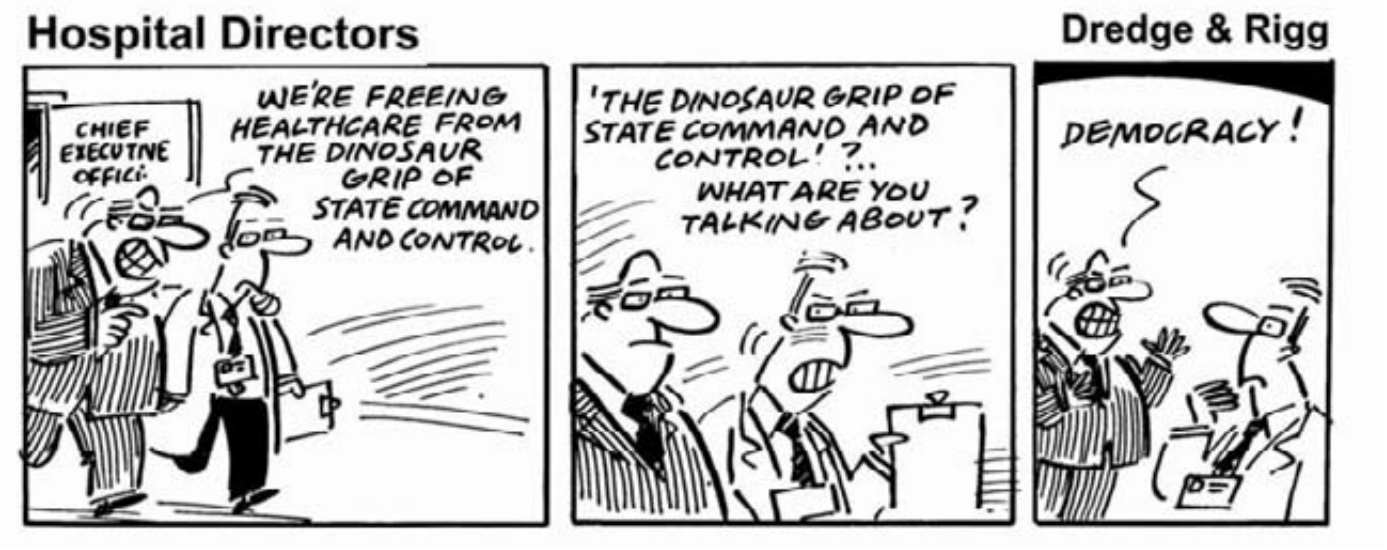

The importance of understanding IT values in elderly care

IT systems developed in Sweden

By Karin Hedström

Elderly care is one area where information technology (IT) is rapidly gaining ground. An increase in the number of elderly people, and a demand for more advanced help and support, together with a desire to make it possible for the elderly to live in their own houses for as long as possible, force decision makers and healthcare professionals to develop better and more efficient elderly care. Many advocate the use of IT for management and administration as a solution for coming to terms with many of the problems facing elderly care. An instrumental perspective is dominant in studies on IT such as the electronic health record (EHR), and values for stakeholders are often discussed in financial terms. However, in order to achieve successful implementation of IT it is also important to study the values of IT in a broader sense.
Using four IT projects as a basis, this article discusses the value of IT in elderly care, ending with a conclusion on the influence of values on IT in elderly care.

Sofia Omfale

Sofia Omfale is an organisation-wide, off-the-shelf IT system for the administration of elderly care, and consists of optional modules. The case-site organisation has chosen to use Sofia Omfale for 'assignments', 'living', 'clients', 'staff', 'debiting', 'population record', and 'miscellaneous'. The users are mainly section managers, nurse aids, LPNs (licensed practicing nurses), and administrative staff. The section managers use Sofia Omfale for accessing information about clients, accessing or reporting statistics and information on fees and charges. Nurse aids, LPNs, and administrative staff use Sofia Omfale mainly for registering and accessing client information. The IT project started in 1996, and was going to meet the following objective: "A modern IT support tailored for the organisation, together with appropriate technology for registration of time that electronically creates basic data for debiting and invoicing, will result in savings from a more efficient administration." Sofia Omfale was implemented and in use by 1998. Sofia Omfale has improved registered data, making information more accurate and up-to-date.

Mini-pAKT

Mini-pAKT was developed in-house by a section manager, nurse aids and LPNs in collaboration with the municipality's IT department. The section manager saw the need for an IT system as a support for the nurse aids' and LPNs' communication and documentation. Mini-pAKT supports documentation of elderly care carried out, as well as planning elderly care. Mini-pAKT consists of the following documents: 'client information', 'notes', and 'work plan'. 'Client information' gives details on the clients, were they live, and what type of help they are entitled to. 'Notes' is equivalent to a health record containing day-to-day record entries. The 'work plan' is a detailed account on how the client wants to be treated, and how to carry out the help needed. Every nurse aid, LPN, and section manager uses mini-pAKT on a daily basis. Mini-pAKT was introduced 1998-2000, and created a mutual organisational memory accessible to all authorised personnel. This contributed to improved client documentation, which resulted in better knowledge about clients and their needs, developing staff competences, and an increased awareness of their organisational roles. "You are a representative of the local government and cannot, therefore, write the documentation anyway you want. You have to be objective […] and the information has to concern the contact between the nurse aids and the client."

DocIT

DocIT is an off-the-shelf organisational wide IT system for administration and management of elderly care. One important objective with the new IT system was to create 'a mutual entrance for all', meaning that all authorised staff would access the same information. This would hopefully increase cooperation between staff, improve the quality of elderly care, and contribute to a more efficient administration. The system consists of a basic module that supports administration of clients and assignments according to the Swedish Social Services Act. The optional modules include 'debiting', 'living', 'social record', 'transportation service', etc. DocIT is used on a daily basis by all staff working with elderly care. The system was gradually implemented 2002-2003, and has contributed to an "Increased understanding for different professional groups as the users can see what various professional groups do vis-a-vis a client." The users also state that DocIT has made administration more efficient, as DocIT makes information available irrespective of time and place, decreasing the need for phone calls as well as eliminate double work in terms of recording information. "Only one person records information, making it available for all."

SAVA

SAVA is an IT system, developed in-house, by IS (information systems) researchers in collaboration with nurse aids, and section managers. SAVA supports communication between care professionals about clients, their needs, and events and actions related to their lives. The objective with SAVA was to improve knowledge transfer between care employees in order to ensure safe and adequate care, with a possibility of evaluation. SAVA supports documentation (so-

cial record and registering events), client information, planning, and follow up, and is used by nurse aids, LPNs, and section managers. SAVA is mainly used for documentation and client information. 'We use SAVA for documentation and client information or when you register a new client, search for family. We use SAVA several times every day. It is the first thing you do in the morning, so you know what has happened since you worked last.' The IT project started in 1999 and the system was gradually implemented in 2002. Using SAVA has resulted in a more efficient communication, as the information is accessible to all authorised personnel, irrespective of time and place. One major result of this IT project was the staff's relation to computers. This was a structure for users with none or little computer experience. Many were initially very hesitant about using IT systems for elderly care, but this changed completely. At the end of the project there was a dramatic increase in computer skills, and a very positive attitude towards using IT for the administration of elderly care.

IT values in elderly care

The values embraced by the new IT system depends on the initial goals, driving actors, and experienced problems, as illustrated by the case studies above. Sofia Omfale mainly relates to administrative values as administration and efficiency are the main problems addressed by the new IT system. Mini-pAKT on the other hand, has had a great impact on communication routines, and the nurse aids' knowledge of clients and their view on their professional role. This means that mini-pAKT is seen as an IT project that supports values related to administration, communication, care and the elderly care profession. The purpose of DocIT was to support co-operation, and information transfer, which would contribute to more correct care, cost savings, as well as a safer care.
DocIT therefore supports values related to efficiency, administration, cooperation, and care. SAVA, with its focus on quality assurance and knowledge transfer, embraces values related to communication, documentation, competence, as well as administration.

Conclusion

An IT system includes social as well as technical aspects that need to be considered. Implementation of IT invariably involves making decision about communication patterns and routines – elements that are by their very nature social. A successful IT system for elderly care needs to encompass not only values related to administration, efficiency, and cooperation, but also values such as improved care and correct care, as well as values related to the elderly care profession. Different actors are carriers of different values, depending on their organisational position. If we want to promote and support certain actors' interests and values by an IT system, it is necessary to include these early in the process. Otherwise they will be more difficult to embrace and incorporate in the design.

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Governance and geriatrics

Geriatric Unit at the Pau Hospital (France)

By Dr. François de la Fournière,
Professor Pierre Peyré and Régine Barthet

Can hospitals deal with an ageing population and a rising prevalence of Alzheimer's disease? The new governance structure, Hospital 2007, strives to meet this pressing challenge. It will undoubtedly produce other care sections, more gerontology networks, provide better support for the local hospital and regulations for general and regional hospitals.

However, beyond the structural level, these governance processes are complex and are torn between unity and diversity. Talk of transdisciplinary care must no longer be empty rhetoric between those who are responsible for service provision clusters and representatives for caregivers and administrators. This applies particularly to those on hospital executive boards, who are a new decision-making force.

A demographic overview

People over 75 years of age represent nearly half of all general hospital admittances and the majority of unscheduled early re-hospitalisations.

The PAQUID-Bordeaux study projects that this age segment will increase from 7.7% of the population in 2003 to 9.6% in 2010 and 18.1% in 2050. In conjunction, the prevalence of dementia (be it Alzheimer's or similar conditions) will increase from 6.5% between 75 and 79 years old, to 15.1% between 80 and 84, and to 27.9% between 85 and 89. For its part, life expectancy is still on average 3 years for 90 year-olds.

These figures are higher for rural areas, which is a particular cause for concern because in these outlying areas, health services are already offered at a lower level, with fewer general practitioners, fewer nurses, etc.

The main epidemiological conclusion made from both the PAQUID study coordinator and a parliamentary report is that the state is failing to institute measures aimed at prevention, early diagnosis and subsequent care of dementia.

There are cases of loss of opportunity for the patient and his or her family, disorganised recourse to the healthcare system and a lack of adequate study regarding those not seeking treatment. There are also increasingly high numbers of household accidents and maltreatment cases.

With the current numbers of vulnerable groups set to increase, the number of automobile accidents is also expected to rise, despite national campaigns set on prevention.

Hospital care and geriatrics

The level of geriatric care in hospitals is insufficient: few hospitals offer a complete range of short-term stay care (including Alzheimer's and daytime admittance beds), follow-up and rehabilitation care, long-term care, mobile units attached to the emergency ward, out-of-hospital gerontology networks with the hospitals' participation, among other necessary services.

Hospital missions are increasingly technical in nature, with a gradual divestment from their social role. Senior citizens take up a great deal of resources but count for few points under the new rating system. This situation has already been studied for two regions and as a test of new measures for resource distribution for the follow-up and rehabilitation care sectors.

However, our aim is to partner with the administrative, medical and care-giving stakeholders of the hospital sector to envision a new governance structure centred on gerontology.

Transdisciplinarity, intercultural approaches and geriatrics

Within hospitals, there are three subgroups: doctors, caregivers and administrators. Older patients who are hospitalised are cared for in a general hospital setting half the time, and much more often in a local hospital setting. It is not standard practice for executive boards to include a geriatric specialist among their 6 or 8 members, however the board must periodically define the institution's policy on geriatrics.

Therefore, hospital specialists in geriatrics wield little influence over decisions, even if they lead their departments. Whether they strive to create geriatric day beds (or increase their numbers); encourage investment of more resources into another typical aspect of geriatric hospital care or create specialised assessment consultations in liaison with networks within or beyond the hospital setting, often geriatric specialists are facing an uphill battle.

The commonality between all the hospital-based gerontology public health necessities is their real financial impact. This impact is minimal in comparison with that of an emergency room restructu-

ring or a capacity increase for an intensive care unit or an operating theatre, but as the medical and administrative community sees the field of geriatrics as being subordinate and a secondary priority, its value is often underrated and misunderstood.

What is then to be done in the case of those over 75, and even more urgently the "very old" in Anglo-Saxon parlance, those over 80, when they are no longer "capable" of leaving hospital for socio-medical reasons?

The Pau experiment

Let's study the real world case of the Pau Hospital, where despite having 40 short-term stay geriatric beds (over 2000 admittances a year) and 4 geriatric day hospitalisation beds, current needs for emergency and specialised services continue to outstrip geriatric care offerings. The coefficients of occupancy and length of stay are both incompressible. After 2 years of planning (2002-2004), an official working plan was signed at the Regional Hospitalisation Agency (ARH) in 2005. The objective was to replace 10 beds in a closing department with a short stay geriatric hospitalisation unit as of 2006.

Length of stay would be considerably shorter (4 days); services offered would be coordinated with other hospital departments (i.e. geriatric day beds, emergencies) and coordination with structures outside of the hospital (i.e. social and socio-medical services, developing local level gerontology networks) would be optimised.

Over 800 admittances were received over the first full year of operation (2007). All of these admittances were processed from emergency cases, thus alleviating the pressure on the latter service.

The unit has also implemented collaborative measures with other hospital departments and organisations outside the hospital setting (follow-up services, home care).

In fact, in cases in which a stay in this unit was initially meant to be brief but turned out to have been underestimated, a transfer to another branch of geriatric care can ensue.

In most cases, this short hospital stay allows for the main clinical diagnosis to take place without affecting the functional autonomy or worsening the level of dependency of these patients.

Nonetheless, the Achilles heel of the structure established in Pau and in all other institutions of this type is a significant readmittance rate (33% at approximately 6 months).

This leads one to question why there is a quasi-absence of home-based healthcare specific to geriatrics in France, and generally why the need for care before and after hospitalisation is not addressed.

This accomplishment shows that when doctors, even those in less common fields such as geriatrics, strive to communicate with administrators and caregivers, they can convey their messages and trigger change that benefits all.

Gerontology networks

Additionally, a Béarn-based gerontology network centred on palliative care has existed in one county since 1996, and in six counties since 2004.

Its survival depends on financing allocated by authorities according to decisions made by State service providers. In 2005, the region's social services promoted a network that complemented their programmes, though they did not finance it.

While it gathers together many health institutions, currently this network only exists at the institutional level. To be truly effective, it should enable real collaboration between general practitioners, independent nurses and hospitals as well create an easily accessible structure for all geriatric care providers.

Such networks act before and after hospitalisation:

- Assessment of the senior citizen;
- Coordination of caregivers in order to avoid certain hospitalisations (for example, admittance to retirement homes);
- Anticipation of problems (admittance without being processed by emergency services), and
- prevention of unnecessary rehospitalisation.

Gerontology networks are a highly desirable complement to short stay geriatric hospitalisation and are an important part of a good public health governance plan.

This example of the pairing of short stay geriatric units with gerontology networks illustrates:

- an alternative to standard hospitalisation;
- an attempt at finding answers to issues related to demographic aging for hospitals;
- a decompartmentalisation of hospital caregivers in relation to each other and to outside agencies, and finally,
- a genuine attempt to adopt interdisciplinarity.

This melding of expertise is indubitably at the core of Hospital 2007 and cannot be ignored in the fields of gerontology and geriatrics in particular.

Following the new hospital governance is clearly also a question of learning how to think and act with complexity in mind. It all flows from keeping track of the fundamental regulations which oversee its vital equilibriums.

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Developing A Rapid Assessment Clinic for Older People

Innovations in Practice

By Arlene Wellman

The Royal Berkshire and Battle Hospitals NHS Trust was originally based across two geographical sites and was consolidated onto one site in 2005. The Elderly Care Day Hospital (ECDH) transferred to the consolidated site in May 2005.

The EDCH had been established in the late 1970's, in an attempt to free up acute hospital beds, by providing day hospital care for older people. The initial focus of the day hospital was treatment. However, over the years, patients started to attend daily, received some physiotherapy and/or occupational therapy input in the morning, and spent the afternoon undergoing diversional therapy, such as playing bingo or scrabble.

Meetings with staff revealed that they had already tried various methods to increase the efficiency of the service, with little success. Similar informal discussions with patients and relatives also identified issues around transport as well as other concerns. A SWOB analysis (Ansoff, 1965) was done, with the involvement of the staff, to identify possible ways to improve the service. Included in this analysis was a literature review.

What the literature says

The literature review was conducted to establish the efficacy of day hospitals and obtain research evidence on improving its efficiency. Two large studies were found. The study done by Sui et al (1994), a retrospective cohort comparison study, found that many aspects of the day hospital were beneficial to patient care.

However, this study was unable to demonstrate better outcomes from assessment in a geriatric day hospital, when compared to such assessments received in a clinic without a day hospital. The more recent study, conducted by Forster et al (1999), was a systematic review of day hospital care for the elderly.

In this study, the authors had also concluded, that while day hospital care seemed to be an effective service for older people, it had no clear advantage over other forms of comprehensive care. They also highlighted the fact that seventy-five percent of the trials that had reported cost information had indicated that day hospital care was more expensive than the alternative treatment.

Standard 3 of the National Service Framework for Older People (DOH, 2001), stresses the need for intermediate care services to focus on responding to or averting a crisis. Barton and Mulley (2002) have criticised the concept of not admitting elderly patients to hospital, but acknowledged the benefit that these patients might gain from a comprehensive geriatric assessment.

After reviewing the available literature, Rubin (2000) concluded that a multidisciplinary team, with rapid access to services such as radiology, pathology and skilled geriatric personnel, was needed. Hanger et al (2004) have in fact proposed that older people prefer to 'age in place,' if at all possible. The government has already documented its plan to bring healthcare services closer to people's homes. (DOH 2006)

The British Geriatrics Society (BGS) (2003) also advocates that access to comprehensive non inpatient assessment, should be a key element of specialist services for older people. In this document, the BGS stipulated that any illness or change in health of an older person should trigger an assessment and investigation, where they could be expected to be seen within one week, if the problem requires urgent attention.

Tanaka (2003) therefore advocated that the multidisciplinary team assessment and intervention should play an increasingly important role in the management and care of elderly patients. He suggested that this assessment could be done in specialist clinics, such as rapid assessment clinics. A search of the national literature revealed that a few Rapid Assessment Clinics had already been implemented.

A joint medical and nursing proposal was taken to the trust board of directors, for approval to close the day hospital and transform the service into a Rapid Assessment Clinic for Older People.

When the proposal was accepted, a communication strategy and dedicated paperwork, were devised, which included the design of a process flow diagram for the new service. The EDCH closed its doors on 25 November and the RACOP was opened on 28 November 2005.

How the service works

There is a set of criteria for referral to the unit which has been communicated to all general practitioners in the area. Patients who have been living at home and are developing problems requiring rapid assessment and intervention to prevent admission to hospital, can be referred by GPs and community matrons. Referral is by fax to a dedicated fax number. Patients that are referred to the clinic can expect to be seen within 24-48 hours.

All patients are assessed by a nurse and a senior doctor in consultation with the consultant geriatrician of the day.

The patients also have access to occupational/physiotherapy and speech and language therapy assessments if required. There is also the facility for investigations such as x-rays, blood tests and CT scans, the results of which are reviewed before the patient leaves the department.

The outcome of the attendance is communicated to the GP via an electronic discharge letter system, ensuring that the GP is up to date with the progress of their patient and the outcome of the specialist assessments. This information is also available should the patient subsequently require further attendance or admission.

This ultimately means that the patient has a full specialist elderly care assessment, can have treatment started and return to the comfort of their own home by the end of the day. This prevents attendance in the clinical decision unit and/or the accident and emergency department for these patients and frees up beds for the patients that need to be admitted.

The Results

To date there have been in excess of 900 patient visits to this service.

The service operates and is staffed from an acute elderly care medical ward. This ensures that elderly patients who would have traditionally required admission for an intervention such as a blood transfusion or ascitic tap for example can now have this done as a day case.

Patients can come to the department in the morning, have their blood transfusion or other procedure done and return to their own home in the evening.

There is also no added pressure on the staff of the clinic to work beyond a defined 'closing time' of the clinic. If the transfusion is still in progress at the close of the clinic the patient can be monitored and cared for in their designated area on the ward, by the ward staff who are there 24/7. The same applies if the patient is awaiting collection by ambulance transport or a relative.

The Challenges

The development of this service required the closure of another unit, and the management of a period of rapid change in the working practices of a number of doctors, nurses, therapists and clerical officers.

In order to accommodate the service there was also the need to close two inpatient beds on an adjoining ward and transform these into consultation rooms.

There was also the added challenge to transform a riser room where 'excess equipment' was being stored into a room that is now used for nursing and therapy staff to assess patients.

All this was done within 6 weeks with a budget of less than £500 and minimum disruption to the wards and departments involved.

This service is an excellent example of delivery of services in a patient focused manner. The benefits of this service are highlighted by the excellent feedback from patients and GPs and the wide interest in the unit that has been expressed by other acute trusts in the south of England.

This clinic has revolutionised the way that older people living in the community can access comprehensive assessment and multidisciplinary management by elderly care specialists.

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MRSA MANAGEMENT
A cost efficiency problem in crossborder hospitals?

By Dr. Ellen Stobberingh and Dr. E. Nulens

There is a great variation in prevalence of Meticillin-resistant Staphylococcus Aureus (MRSA) in different countries in Europe, with the lowest rates in the Scandinavian countries and in the Netherlands. The prevalence ranged from more than 35% in the Southern part of Europe to around 1% in the Northern countries including the Netherlands. These variations have hampered, among other things, free access of patients to healthcare facilities in the different countries of the European Union, and more particularly the transfer of patients from hospitals in countries with a high to those with a low prevalence.

University Hospital Maastricht

The University hospital Maastricht (UHM), located in the Southern part of the Netherlands close to the border with Germany and Belgium, works in close cooperation in the field of surgery, especially cardiac surgery, with the University Hospital of Aachen (Germany) and the hospital of Tongeren (Belgium). Medical specialists working at UHM also perform surgery in Aachen and in Tongeren.

Within that context, it is interesting to look into the cost of the current MRSA policy at the UHM as well a into the impact of this policy on the crossborder transfer of patients between healthcare institutions and more generally, on the cooperation between crossborder hospitals.

MRSA policy at the UHM

The Netherlands (including the UHM) and the Scandinavian countries have implemented a so-called "Search and Destroy policy" against MRSA. Furthermore, patients at high risk to be a carrier of MRSA will be put in isolation (i. e. in a separate room) until the results excluding MRSA carriage are known.

This policy consists of

1. Actively screening patients and healthcare workers (HCWs) for the presence of MRSA. Both infections and colonisation (i.e. presence of MRSA without any complaints) of patients and HCW will be recorded. HCWs who appear to be MRSA positive are excluded from direct care of patients, and decolonised with mupirocin. They are allowed to return to patient care as soon as screening cultures are MRSA negative. MRSA positive patients are decolonised with mupirocin and attended to in a separate room with a separate nursing team. When the therapeutic treatment is finished, control cultures will be taken to ensure eradication of MRSA.

2. All patients admitted to the UHM and presenting MRSA risk factors upon admission will be screened for the presence of MRSA. According to the estimated risk of MRSA colonisation, patients will be categorised in low or high risk groups. High risk patients include patients admitted to a foreign hospital for at least 24 hours as well as additional risk factors such as a recent operation or mechanical ventilation.

These patients will be put in isolation (i.e. in a separate room) until the results excluding MRSA are known. If no MRSA is found, the isolation is discontinued. In case the patient is MSRA positive, the isolation will be continued until control cultures are negative after treatment, on average after at least 14 days. Furthermore, a separate nursing team will take care of the MRSA positive patient only.

This also applies to patients admitted to crossborder hospitals. Consequently, availability of isolation rooms and adequate staffing are prerequisites to transfer patients between crossborder hospitals, especially between countries with a different prevalence of MRSA such as in the Euregion Maas-Rhine:

Cost of the current Search and Destroy MRSA policy

The costs and the financial cost-benefit break-even point of the current MRSA policy was calculated using retrospective data from the UHM.

The annual costs of pro-active screening was 1,383,200 euros. MRSA prevention and treatment of S.aureus bloodstream infections amounted to 2,736,762 euros. The total costs for the Search and Destroy policy is lower than the costs of treating S. aureus blood stream infections. Simulation of different

ratios of MRSA and methicillin susceptible S. aureus showed that even if the MRSA prevalence is 8% or lower this policy is still cost-effective.

The Search and Destroy policy which includes pro-active screening for the presence of MRSA and isolation of patients at risk is expensive, but the policy contributes substantially to the containment of the MRSA problem in the Netherlands and Scandinavia. Without preventive measures the prevalence of MSRA will steadily increase as MRSA will spread between patients and between patients and HCWs.

In crossborder hospitals, the rate of patients at risk for MRSA will be higher compared to other hospitals and consequently more patients will be put in isolation until test results excluding MRSA are known. The implementation of (molecular) methods either "home-made" or commercially available to rapidly identify MRSA will reduce the number of isolation days substantially and thus healthcare expenses.

Conclusion

From an economic point of view, the Search and Destroy policy is an efficient way to maintain a low level of MRSA. Implementation of this policy which include actively searching for MRSA positive HCW and patients, both infected and colonised, is essential for crossborder hospitals. It facilitates crossborder healthcare and contributes to the reduction of the prevalence of MRSA and/or to the preservation of a low prevalence of MRSA.

Furthermore, a harmonisation of protocols for the detection of MRSA and for the screening of patients to transfer to another hospital, will facilitate crossborder healthcare.

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FACTS & FIGURES

Total population:
1,967,000
Life expectancy at birth m/f (years):
74/81
Birth rate:
8,6 per 1,000
Death rate:
9,4 per 1,000
GDP per capita:
12,300 euros
Total healthcare expenditure:
8,2% of GDP
Healthcare expenditure per capita:
1,600 PPP euros
% of healthcare financed by public funds:
87%
Number of beds:
8,300 acute care beds (99,8% public beds)
Number of beds for 1,000 population:
4,1
Length of stay:
6,6 days
Waiting lists:
Significant, up to 18 months for certain treatments
Physicians working in hospitals:
2,500
Total number of doctors:
4,550

The Slovenian health and hospital system

By Ana Polanc

Slovenia is a country with 2 million citizens. Since 1991 it has been a democratic republic, with the full name of the Republic of Slovenia. Slovenia covers 20,273 square kilometres, and its capital is Ljubljana. The official language is Slovenian, and Italian and Hungarian in areas populated with minorities. The official currency is the euro. Gross domestic product per capita in 2006 stood at 15,167 euros, and current economic growth is 6.3%.

Slovenia has a tradition of social solidarity and equity and this principle has guided health sector development throughout the transition period. The Slovenian Constitution states that rights to healthcare services are the realisation of the constitutional human right to social security, which has to be granted to everyone regardless of their personal circumstances, including their financial status.

Legislation enacted in 1992 was directed at addressing the most significant problems. In particular, it revised the methods of financing by replacing direct funding by the Ministry of Health from general revenue with mainly employment-based financing operated by a new government agency, the Health Insurance Institute of Slovenia (HIIS). The Act defined the roles of both the compulsory and universal insurance schemes, and additional optional insurance. On the supply side, the most important practical change was the privatisation of many parts of the public health network, and associated changes, such as the introduction of free choice of physicians and some elementary gate-keeping functions in primary healthcare. It also formalized and significantly restructured the processes of care provider contracting.

Health insurance

Compulsory health insurance administered by the Health Insurance Institute of Slovenia (HIIS) is at the cornerstone of health financing in Slovenia, and is defined by the 1992 Law on Healthcare and Health Insurance. HIIS is the sole provider of compulsory health insurance and is autonomous in its operation, although the government has influence over some elements of the structure of the scheme, such as the contribution rate and scope of benefits. By design, the health insurance scheme covers the entire population, and opting out is not permitted. There are 21 categories of insured people, and there are two main groups. The first group is employees (and their non-earning dependents) who pay contributions based on income, at the rate of 13.5% of gross salaries and wages. Contributions are shared between employers (6.89%) and employees (6.36%). Additional contributions may be required from employers to adjust for

claims that are excessive as a result of occupational diseases and injuries. The second group covers unemployed persons, other persons without a fixed income who are not registered as unemployed, pensioners, farmers and the self-employed, who pay a fixed contribution to the national fund. The National Institute for Employment pays fixed amounts for the registered unemployed, and self-governing communities are required to pay for persons without income. Pensioners pay a fixed contribution of 5.65 per cent of their gross pension.

Money is collected in a special fund of HIIS and is divided on the basis of regular annual negotiations between operators, the Ministry of Health and HIIS. The problem is to balance the financial sustainability of the system with the demands of the economy to ensure that the contribution rate does not increase, and in increasing needs due to ageing of the population, expensive medical technology and expensive biological drugs.

Beneficiaries are entitled to a very comprehensive package of primary, secondary and tertiary health services, as well as non-medical entitlements (cash benefits such as salary compensation after absence from work for 30 days). Essential services, which include services for children and adolescents, family planning and obstetric care, preventive care, diagnosis and the treatment of infectious diseases (including HIV), treatment and rehabilitation for a range of diseases including cancer, muscular and nervous diseases, mental diseases and disability, emergency care (including transport), nursing care visits and home care, the donation and transplantation of tissue and organs, long-term nursing care, are covered in full, while "less essential services" are subject to co-payment, ranging from 5 per cent to 50 per cent. Co-payments are paid by the patient, and can also be covered through voluntary health insurance.

Supplementary health insurance

Supplementary health insurance also covers numerous healthcare services which are not covered by compulsory health insurance, for example, corrective surgery, services regarded as experimental, routine examinations of employees, preventive medicine for children, adolescents and students, cancer, various disabilities, emergency medical assistance, etc.

The close connection between supplementary health insurance and compulsory health insurance can be seen in the fact that supplementary health insurance in the prescribed share covers only those healthcare services which are rights deriving from compulsory health insurance and not other forms of insurance.

By concluding a supplementary insurance contract, we cover the cost of all services defined in compulsory health insurance to the full extent and we do not have to pay for the share which is not covered by compulsory health insurance. Supplementary health insurance therefore presents an important pillar in the system of social security of the citizens of the Republic of Slovenia and is defined as a public interest which has to be particularly protected. More than 96% of the population have concluded a supplementary insurance contract.

Supplementary health insurance is provided by three insurance companies. The most important provider is Vzajemna, a private insurance company which does not put profit as a priority. All insurance companies which provide supplementary health insurance, regardless of their status, are obliged to earmark half of the potential operating surplus generated by supplementary health insurance services for the implementation and development of supplementary health insurance services.

The legislation determines the equalisation schemes designed to equalise differences under the principle of intergenerational reciprocity by gender and age in the volume of expenses of all three insurance companies. The levelling of differences is performed by the Ministry of Health every three months by issuing adequate provisions on equalisation.

Primary and secondary care

Health services are organised on a primary, secondary and tertiary level. Primary health services include basic health and dispensary services.

The secondary level is organised within hospitals and special outpatient clinic activities which are located in hospitals or forwarded from hospitals to individual health institutions. Since 1992, concessions for practice can be acquired in the public sector, while there is little pure private practice (140 dentists).

Health services on a tertiary level include services of clinics, clinical institutes or clinical departments and other authorised health institutions.

Socio-medical, hygiene, epidemiological and health-ecological services are performed as particular specialist services on the secondary and tertiary levels.

For the major part of primary healthcare services provided by chosen personal physicians (general physicians and primary level pediatricians), a combined capitation and fee-for-service system is in place. A part of the programme value in these activities is paid in accordance

with the number of declared patients ("capitation fee"), while the other part, in accordance with the volume of services provided.

The volumes of services payable by the Health Insurance Institute of Slovenia (hereafter HIIS) are bounded, and depend on the number of declared patients. Chosen physicians at the primary level have a gate-keeping role. Outpatient specialist services are remunerated by a fee-for services system according to a special book of services, but again bound within prospective yearly limits. Since 2003, two financial incentives have been introduced to improve the preventive services programme and to reduce referrals to specialist services.

Up to 2000, the planning and valuation of hospital services were based on the hospital care day payment method. For some extra expensive services in heart surgery and transplant surgery, specific intervention prices were agreed upon. In 2000, the "case mix" system was introduced for hospital programmes. Monitoring factors have been related to the patient and to the services actually provided.

The number of doctors per 100,000 citizens in Slovenia is very low, and there is also a shortage of qualified nurses. On average, there are 0.51 doctors per 1,000 adults in Slovenia in the field of general or family medicine, including those who cover nursing homes.

Slovenia has 2 university medical centres, 7 specialised hospitals, 5 psychiatric hospitals, 2 gynaecology hospitals, and 2 private sanatoriums.

EU presidency of Slovenia

The European Union and its member states seek to promote the good health and security of EU citizens. Every member state is responsible for the successful functioning of its own healthcare system at a national level; however, certain issues often need to be addressed at the EU level.

Thus, EU healthcare policy is directed towards expanding an open method of healthcare harmonisation by coordinating efforts in the fight against the spread of communicable diseases, as well as towards supporting national measures for raising awareness of healthcare issues.

During its presidency of the Council of the European Union, the Slovenian presidency continues to strive for the implementation of the joint priorities and commitments of the presiding "Troika". These joint commitments, developed within the framework of the 18-month programme of the German-Portuguese-Slovenian presidency, are based on the promotion of health by encouraging a healthy lifestyle, and in particular, healthy nutrition and physical activity, the prevention and control of communicable diseases such as HIV/AIDS and flu pandemics, innovations in healthcare and accessibility of healthcare services.

During its presidency, Slovenia as the presiding country concentrates on reducing the burden of cancerous diseases, which remain one of the more severe public health problems in the EU, despite the numerous activities and endeavours of member states.

It is our goal to promote certain activities further at a political level, and to adopt orientations in support of different measures both at the EU level and in member states, which will – given the existing discrepancies between the member states – contribute to the promotion of healthy lifestyle and the prevention of cancer, as well as to more successful treatment and better survival rates for this disease. Slovenia will strive to address the issue of cancer at a higher political level within the Community framework.

Besides addressing widespread disease such as cancer, during its presidency of the Council of EU, Slovenia will lay stress on the reduction of alcohol use, and the damage associated with alcohol abuse, the latter being the third most important causative factor of disease and premature death in the European Union. Apart from these priorities, we will highlight IT systems development in healthcare, which will facilitate faster intervention and more effective information exchange between health institutions. To this end, the Ministry of Health is to organize an eHealth conference within the framework of the presidency.

Besides the above listed priorities and further implementation of the joint commitments of Germany, Portugal and Slovenia, the dossiers on the agenda inherited from the preceding presidencies will be taken over.

The tentative, more demanding dossiers include: the provision of healthcare services, which would ensure the European citizens high quality and safe healthcare services and their flow; the European Health Strategy, with its basic objective of defining a balanced and comprehensive approach in the area of public health at the EU level, which will contribute to the better health of European citizens; and management of human organ donations and transplantation.

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SLOVENIA AND EHEALTH

The six health programme priorities of the Slovenian Ministry of Health are: health improvement and preventive activities; the formulation of national policies and strategies for enabling and promoting healthy lifestyles; healthcare; organisation of the healthcare system; healthcare financing and development of a model for monitoring and assessing quality in the healthcare system.

The ehealth objectives and activities are derived from the Action Plan for a European Ehealth Area and from experiences and current status of health informatics in Slovenia.

In December 2005 "Ehealth 2010 – Strategic plan for the Slovenian health sector informatisation" was published. It has three main activity lines:

-establish the basic informatics structure and define the basic health and social databases as a basis for the implementation of the national electronic health record by the end of 2007;

-interconnect health and social information systems on the national level through the development of the national health portal.

This portal will provide safe and reliable exchange of data between the relevant parties in the health system, will ensure eservices and transparent information to all relevant parties and could be connected to other similar systems across Europe by the end of 2010, and establish ebusiness as a common way of work in the Slovenian health sector by the end of 2010.

The National Health Informatics Council was established in June 2006, followed by the establishment of the Health Informatics Standardisation Board. The Health Informatics Council is the governing body that will ensure informatics is optimally applied in support of national health system goals.

A planned card system upgrade will be accomplished in the 2007-2009 period. Relevant examples of projects are:

-the NETC@RDS project, between (among others) Czech Republic, Italy and Slovenia, to improve mobile citizens' access to trans-European health services by using advanced web-oriented applications either based on IT systems, smart cards or combining both of them. It also aims to implement and evaluate technical solutions for electronic European Health Insurance Card and for improving additional services such as the inter-European health costs clearing and billing processing.

-the PRIMACOM project, collaboration between Hungary and Slovenia on exchange of medical data and experience with Italy and Denmark. It aims to supply healthcare professionals with systems and infrastructure which enhance communication between primary and secondary care. Another initiative is the NANSA project, which transfers distributed software technologies for open health, healthcare, hospital and insurance systems and adopted European standards to the CEE/NIS countries.

Plus de concurrence dans les soins de santé?


Willy Heuschen

La mondialisation marque indubitablement le marché européen de façon durable.

Malgré certaines conséquences positives de la concurrence pour le consommateur, il faut néanmoins déplorer les pertes d'emploi dues à la délocalisation vers des pays moins coûteux. Le marché des soins de santé est un peu différent. De par la nature personnelle des soins tant du côté du patient que du prestataire, une réduction du personnel suite à une relocalisation du poste de production n'est que rarement envisageable. La plupart des patients veulent bénéficier d'un traitement médical le plus près possible de leur lieu de résidence, et les soins de santé sont toujours assurés par des êtres humains pour des êtres humains. Les effets de la mondialisation se font pourtant sentir, lorsque des prestataires privés s'imposent de plus en plus sur le marché de la santé dans différents pays européens où ils se disputent les patients. Une telle évolution du marché éveille chez de nombreux décideurs politiques l'espoir de contrôler l'explosion des dépenses de santé. Arrêtons nous à trois événements intéressants.

En ce moment, des voix s'élèvent aux Etats-Unis pour critiquer la domination du système de marché. Une de ces critiques concerne l'escalade des coûts qui ne s'accompagne d'aucune amélioration des soins prestés. Il faut dès lors examnier cette orientation de marché. Sur base de résultats mesurables des prestations de soins de santé ou des procédures de soins, il faut montrer comment la situation sanitaire de la population a pu effectivement en être améliorée. Dans le système actuel, selon les Professeurs M.E. Porter et E. Olmsted Teisberg, il serait cependant assez peu question pour les acteurs du secteur de la santé d'offrir au patient une plus-value pour chaque dollar dépensé. Ils se focaliseraient plutôt sur des facteurs propres au marché, comme l'amélioration des recettes, l'augmentation des parts de marché, ou la réduction des coûts et des charges. Les mêmes avertissements critiques ont été exprimés à Berlin, lors de la réception de printemps de la Deutsche Krankenhausgesellschaft (DKG), l'association hospitalière allemande. Le Dr Kösters, président de la DKG, a résumé l'expérience de nombreux établissements sous le slogan «Caisses d'assurance maladie assainies, hôpitaux ruinés.» Rien que dans le secteur hospitalier, les conséquences des mesures législatives d'économies se traduisent par un sous-financement de 1,2 milliards d'euros. La vraie concurrence avec qui peut s'accompagner d'une baisse des coûts n'est alors possible que si les conditions politiques prévoient des prix librement calculés et le «pouvoir offrir» plutôt que le «devoir offrir». Le plafonnement actuel des remboursements ne permet pas ces règles de marché.

Le Président français Sarkozy nous donne également matière à réfléchir avec sa Commission Larcher. Il nous rappelle les valeurs que l'hôpital incarne. Le service à la population, l'ouverture permanente des établissements et leur ancrage territorial, souvent en tant qu'employeur principal, doivent être mis en valeur, surtout face aux défis qui s'annoncent. Il a donc réclamé des services de haute qualité et vise la performance hospitalière. Mr Starkozy a également confirmé que la moitié des hôpitaux publics étaient en déficit. Cette situation désastreuse mais aussi les défis nouveaux pourraient être contrecarrés par plus d'autonomie de gestion. Ceci suppose un financement adéquat, qui découle de prestations réellement effectuées. Un second élément est la gestion hospitalière, qui doit disposer d'une liberté et d'une responsabilité de manœuvre. Le directeur d'hôpital devrait redevenir le véritable dirigeant. Le fait que les acteurs d'un établissement puissent bloquer son fonctionnement rien qu'en disant non, est inacceptable. Le directeur devrait être responsable des soins de santé de la population de la zone couverte par son hôpital et avoir la liberté d'inclure des prestataires privés. Une telle coopération devrait être la règle. Ce genre de mots n'est pas habituel dans la bouche d'un Président. Ils nous font réfléchir à la situation de marché d'un hôpital. Il est également intéressant de prendre en compte le fait que France occupera bientôt la présidence de l'Union. Cela pourrait déboucher sur de nouvelles pistes au niveau européen. Quoi qu'il en soit, l'AEDH reste vigilante.

Willy Heuschen
EAHM Secrétaire Général
Rédacteur en Chef

Comité scientifique – réunion à Bruxelles

Lors de sa dernière réunion du 7 mars 2008 à Bruxelles, le comité scientifique de l'AEDH a accueilli un nouveau membre: José Manuel Aldamiz Echevarria, d'Espagne, remplace son concitoyen Manuel Peiro. L'AEDH se réjouit de l'arrivée de ce nouveau membre, mais souhaite également saisir l'occasion de remercier très sincèrement Monsieur Peiro pour son excellent travail et son engagement au sein du comité ces dernières années.

La réunion s'est concentrée autour des points suivants: d'abord une réflexion sur le programme scientifique du Congrès AEDH 2010 à Davos, des discussions sur le suivi et les actions envisagées sur le thème du système d'accréditation pour les hôpitaux européens, et pour finir le contenu et l'organisation possible d'un séminaire supplémentaire de l'AEDH en 2009. Le comité s'est accordé sur le fait qu'il fallait en priorité s'adresser aux gestionnaires hospitaliers. Il y là une distinction claire avec la gestion dans les hôpitaux.

Les thèmes principaux de l'AEDH concernent donc le leadership, la communication, le développement stratégique, entre autres. C'est dans ce contexte qu'a été mené un brainstorming autour du thème du Congrès 2010, et plusieurs propositions ont été énoncées pour le séminaire 2009.

A présent, il faut prendre contact avec nos collègues suisses et intensifier la collaboration future.

En ce qui concerne le séminaire 2009, le Bureau de l'AEDH se verra soumettre les propositions lors de sa prochaine réunion. Une sélection suivra.

Les membres du comité ont salué avec enthousiasme une nouvelle rencontre avec Kristof Eeckloo, de la KU Leuven, qui a annoncé qu'il pourrait révéler les résultats finaux de l'étude européenne sur la gouvernance hospitalière après la conclusion de sa thèse de doctorat dans les prochaines semaines. L'analyse sera rendue publique au Congrès de Graz. Certains membres du comité se sont d'ores et déjà déclarés prêts à résumer les résultats de façon concise pour les délégués de l'AEDH et de présenter ceux-ci vraisemblablement sous forme de brochure.

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Et le gagnant est...

La personne designée parmi toutes celles ayant répondu à notre enquête sur les tendances européennes en gestion hospitalière est le Professeur Derek Mowbray. Son nom a été tiré au sort lors de la dernière réunion de notre comité éditorial. Il recevra son iphone sous très prochainement.

Mondialisation médicale – qui y perd, qui y gagne?

Par le Prof. Dr Ottmar Leiss

La rationalisation, l'uniformité et la technologisation encouragent la transformation des hôpitaux en centres de services médicaux.

Du point de vue du patient, l'évolution récente a eu de nombreuses conséquences positives. L'objectivisation des services médicaux renforce l'autonomie des patients et démystifie la relation médecin-patient.

Les avantages de la mondialisation en médecine en tant que science et système médico-technique résident dans la technologie de l'information, la digitalisation des processus d'imagerie et l'internationalisation des interprétations scientifiques.

Mais si nous voulons éviter d'être écrasés par la mondialisation et survivre dans un monde de changements toujours plus rapides, nous devons créer une vraie cohérence entre l'ancien et le nouveau.

Migration des médecins polonais

Par le Dr Maciej Duszczyk

Une analyse des tendances actuelles suggère que le nombre de médecins en attente d'un certificat leur permettant d'exercer leur métier dans un pays étranger est en déclin. Ceci signifie que la plupart des professionnels désirant émigrer l'ont déjà fait et qu'une réduction des flux migratoires est très probable.

Il n'auront qu'un faible impact sur le système de soins de santé polonais. De toute façon, des modifications législatives en cours vont permettre à la loi polonaise de se mettre en conformité avec la directive sur le temps de travail et déboucher sur une augmentation significative des salaires des médecins polonais.

Parmi les médecins désirant émigrer, la majorité est constituée d'anesthésistes et d'intensivistes. Les principaux pays d'accueil potentiels sont l'Allemagne, l'Italie, le Royaume-Uni, la Suède, la Norvège et la France.

Le nouvel hôpital de Cerdanya

Par Xavier Conill, Cristina Rodriguez, Jordi Boix, Alain Corvez, Victoria Peralta et Enric Mayolas

Depuis 2003 et grâce à une recherche financée par la région française du Languedoc-Roussillon, la Catalogne et l'Union européenne (Interreg III), l'idée de construire et de gérer un hôpital aigu transfrontalier s'est concrétisée. La planification commence cette année et l'hôpital devrait entrer en fonction en 2010. Il sera placé sous juridiction catalane et espagnole mais restera la propriété des deux administrations nationales. La conception de cet hôpital reste un vrai défi, vu la différence entre les systèmes de santé français et catalan. Les modèles d'assistance différents, complètement hétérogènes du point de vue du développement autant que de l'organisation, l'hospitalisation de deux types de population régis par deux cultures distinctives et fortement influencées par les problèmes de démographie médicale en Europe, et particulièrement dans les régions reculées, les cadres législatifs qui sont d'application, non seulement dans le contexte de l'assistanat mais aussi pour le fonctionnement quotidien, les modèles de contrats et la casuistique, par exemple, devront être combinés. Il faudra également pouvoir attirer des professionnels de santé compétents dans cette région isolée.

Soins transfrontaliers en Europe

Par le Prof. August Oesterle

Même si l'impact financier des soins transfrontaliers est encore limité dans une perspective macro-économique, ce phénomène est à fois poussé par l'offre et la demande. Du point de vue du patient ou du consommateur, les prix, la qualité et les coûts de transaction sont des facteurs déterminants. L'évolution future des soins transfrontaliers se fera par le haut et par le bas. Au-delà de la coopération interrégionale, le potentiel de croissance est fort pour les traitements qui peuvent être planifiés, et d'autant plus si les patients sont directement impliqués en tant qu'intervenants financiers. En outre, les individus à la recherche de soins de meilleure qualité et/ou à un meilleur coût vont provoquer des réactions d'offre chez les prestataires potentiels.

Alors que les systèmes nationaux cherchent à assurer un accès équitable aux soins de santé pour toute la population, les différences économiques entre pays européens pourraient créer des inégalités en ce qui concerne les opportunités de bénéficier de choix plus larges, à un niveau individuel autant que systémique. Si l'objectif commun de soins de santé de haute qualité, accessibles et rentables est pris au sérieux, l'accès et la qualité des soins de santé transfrontaliers doivent être garantis à tous les citoyens de l'Union par le biais d'un cadre institutionnel adéquat.

L'importance de la compréhension des valeurs IT pour les soins aux personnes âgées

Par Karin Hedström

Les soins aux personnes âgées est un domaine où l'IT gagne rapidement de l'importance. Une augmentation du nombre de personnes âgées, une demande de soutien plus appuyé, ainsi qu'un désir de les laisser vivre à domicile le plus longtemps possible force les décideurs et les professionnels de santé à développer des soins de santé plus efficaces et efficients. Cependant, un bon système IT se doit d'embrasser non seulement des valeurs liées à l'administration adéquate, l'efficacité, la coopération mais aussi à des soins améliorés et correcte et des principes relevant de la profession gériatrique.

Gouvernance et gériatrie

Par le Dr François de la Fournière

En 2006, l'objectif de l'hôpital de Pau était de remplacer 10 lits d'un département amené à disparaître par une unité d'hospitalisation gériatrique de courte durée. La durée de séjour serait raccourcie (4 jours), les services offerts coordonnés avec d'autres unités hospitalières (lits ambulatoires gériatriques, urgences) et avec des structures extra-hospitalières (services sociaux…). Plus de 800 admissions ont été enregistrées la première année. Dans la plupart des cas, un court séjour hospitalier a permis de ne pas perturber l'autonomie fonctionnelle ou de ne pas aggraver le niveau de dépendance du patient. Néanmoins, le talon d'Achille de ce genre de structures reste le taux élevé (33% à 6 mois) de réhospitalisation.

Développement d'une clinique d'évaluation rapide pour personnes âgées

Par Arlene Wellman

Cette unité découle d'une proposition médicale et infirmière de remplacer l'hôpital de jour par ce genre de structures. Des critères d'orientation ont été établis et communiqués à tous les généralistes de la région. Les patients vivant chez eux et développant des problèmes nécessitant une évaluation et intervention rapides sans hospitalisation peuvent être orientés par leur généraliste sur base d'un fax. Les patients seront alors vus dans les 24 à 48 heures. Les résultats sont communiqués au généraliste par une lettre de sortie électronique.

Focus : Slovénie

La Slovénie est un pays de 2 millions d'habitants. C'est une république démocratique depuis 1991.
Une assurance maladie obligatoire est administrée par l'Institut slovène d'Assurance Maladie. Cet institut est le seul prestataire d'assurance maladie obligatoire et est autonomie, même si le gouvernement détermine le taux de contribution et la gamme de prestations couvertes.

Des assurances maladie complémentaires sont offertes par trois compagnies d'assurance.
La Slovénie compte 2 centres médicaux universitaires, 7 hôpitaux spécialisés, 5 hôpitaux psychiatrique, 2 hôpitaux gynécologiques et 2 sanatoriums privés.
Durant sa présidence du Conseil de l'Union européenne, la présidence slovène continue à tendre vers l'adoption de priorités et d'engagements de la Troika (Allemagne, Portugal, Slovénie). De plus, les dossiers hérités des présidences précédentes seront repris, y compris la prestation de services de santé et la Stratégie de Santé européenne.

Sur le plan de l'e-santé, la Slovénie poursuit une série de projets intéressants, parmi lesquels le projet Netc@rds entre la République tchèque, l'Italie et la Slovénie, destiné à améliorer l'accès des citoyens aux services de santé, et le projet Primacom, une collaboration entre la Hongrie et la Slovénie, d'un côté, et l'Italie et le Danemark de l'autre, sur l'échange de données médicales.

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Mehr Marktwettbewerb in der gesundheitlichen Versorgung?

Willy Heuschen

Die Globalisierung prägt zweifelsohne den europäischen Binnenmarkt nachhaltig.
Neben den Wettbewerb fördernden Vorteilen für Verbraucher gilt auch mitunter der Abbau von Arbeitsplätzen durch Verschiebung in Billigländer zu beklagen. Auf dem Markt der gesundheitlichen Versorgung liegen die Fakten etwas anders. Durch die personengebundene Behandlung sowohl auf Seiten des Patienten als auch des Leistungserbringers ist ein Personalabbau durch eine Verschiebung des Erbringungsortes nur sehr begrenzt möglich. Die meisten Patienten wünschen sich eine medizinische Behandlung so nahe wie möglich an ihrem Wohnort, die gesundheitliche Versorgung wird noch immer für Menschen von Menschen erbracht. Globalisierungstrends ergeben sich dennoch teilweise, wenn private Anbieter vermehrt auf den Gesundheitsmarkt verschiedener europäischer Länder vordringen, wo Konkurrenten um Patienten ringen. Eine solche Marktorientierung weckt bei vielen Politikern die willkommene Möglichkeit zum Einhalt der Kostenexplosion der Gesundheitsausgaben. Dazu sind drei interessante Fakten festzuhalten.
Zunächst werden in den Vereinigten Staaten kritische Stimmen laut, die das dort vorherrschende Marktsystem beklagen. Eine Kritik bezieht sich auf die Kostenentwicklung, die keine entsprechende Steigerung in den erbachten Gesundheitsleistungen erbracht hätten. Der Ruf nach einer Marktorientierung ist zu vernehmen. Anhand messbarer Resultate von Gesundheitsleistungen oder Versorgungsprozesse müsse aufgezeigt werden, wie der Gesundheitsstand der Bevölkerung effektiv verbessert worden sei. Im jetzigen System so die Professoren M.E.Porter und E. Olmsted Teisberg ginge es den Akteuren der Gesundheitsversorgung weniger jedoch darum, den Patienten einen Mehrwert pro zusätzlich ausgegebenem Dollar zu verschaffen. Vielmehr stünden Einkommenssteigerung, Erhöhung von Marktanteilen; Kosten- und Leistungseinschränkungen, also typisch marktgeprägte Verhalten im Vordergrund. Ähnlich kritische Warnungen vor einem blinden Marktverhalten waren in Berlin beim Frühlingsempfang der Deutschen Krankenhausgesellschaft (DKG) zu hören. Dr. Kösters, Vorsitzender der DKG, thematisierte die in Deutschland in vielen Kliniken gemachten Erfahrungen mit dem Schlagwort 'Krankenkassen saniert, Krankenhäuser ruiniert'. Allein im stationären Bereich läge als Folge der Spargesetze die finanzielle Unterdeckung bei 1,2 Milliarden. Wettbewerb mit hohen Rabatten sei nur dann möglich, wenn frei kalkulierte Preise und statt des Anbieten-Müssens ein Anbieten-Können zu den ordnungspolitischen Rahmenbedingungen gehörten. Die jetzige Deckelung der Kostenvergütung ließe solche Marktregeln nicht zu. Eine Lanze zum Umdenken brach auch der französische Staatspräsident Sarkozy bei der von ihm eingesetzten Kommission Larcher. Er erinnerte zunächst an die Werte, die das Krankenhaus verkörpere. Der Dienst an der Bevölkerung, die permanente Erreichbarkeit der Hospitäler und nicht ihre zuletzt geographische Verankerung, sehr oft auch als größte Arbeitgeber, seien Werte, die es zu festigen gelte, auch im Hinblick auf sich stellende Herausforderungen. So mahnte er eine qualitativ hochstehende Leistung und das Erreichen von Spitzenleistungen an. Sarkozy stellte auch fest, dass die Hälfte der öffentlichen Krankenhäuser finanzielle Verluste einfahren. Diesem Missstand aber auch den Herausforderungen möchte er durch mehr Führungsautonomie in den Krankenhäusern entgegentreten. Dazu gehört eine angepasstere Finanzierung, die von der wirklich erbrachten Leistung ausgeht. Ein zweiter Baustein ist das Krankenhausmanagement, dem eine Handlungsfreiheit und -verantwortung zugestanden werden müsste. Der Krankenhausdirektor sollte wieder der echte Chef werden. Die Tatsache, dass Akteure einer Einrichtung dessen Handlungsweise durch ihr Nein blockieren könnten, sei unannehmbar. Der Direktor müsse dann auch die gesundheitliche Versorgung der Bevölkerung des Einzugsgebietes seines Hospitals verantworten und private Anbieter einbeziehen. Eine solche Zusammenarbeit müsse zur Regel werden. Solche Worte sind nicht alltäglich aus dem Mund eines Staatspräsidenten. Sie lassen uns über die Marktstellung eines Krankenhauses nachdenken. Interessant ist auch, dass gerade Frankreich die nächste Ratspräsidentschaft innehat. Daraus könnten sich ja auch europaweit andere Denkanstöße ergeben. Die EVKD bleibt jedenfalls am Ball.

Willy Heuschen
EVKD Generalsekretär
Chefredakteur

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

Wissenschaftlicher Beirat – Sitzung in Brüssel

In seiner letzten Sitzung am 7. März 2008 in Brüssel hat der Wissenschaftliche Beirat der EVKD ein neues Mitglied begrüßt: Herr José Manuel Aldamiz Echevarria, Spanien, übernimmt den Platz seines Landsmanns Herrn Manel Peiro. Die EVKD freut sich über diesen Neuzugang, hat aber auch die Gelegenheit genutzt, Herrn Peiro für dessen hervorragende Arbeit und das Engagement im Beirat in den letzten Jahren ihren herzlichen Dank auszusprechen.

Die Sitzung hatte die folgenden Schwerpunkte: es wurden erste Überlegungen zum wissenschaftlichen Programm des EVKD-Kongresses 2010 in Davos angestrengt, das weitere Vorgehen und geplante Aktionen zum Thema „Europäisches Akkreditierungssystem für Krankenhäuser" besprochen und nicht zuletzt der Inhalt und die mögliche Organisation eines weiteren EVKD-Seminars in 2009 diskutiert.

Der Beirat war sich insgesamt einig, dass es in der Hauptsache darum geht, Manager der Krankenhäuser anzusprechen. Es wurde eine klare Abgrenzung zum „Management in Krankenhäusern" vollzogen. Themen der EVKD betreffen daher die Führung, die Kommunikation, die Strategieentwicklung usw..

Vor diesem Hintergrund erfolgte ein Brainstorming zum Kongressthema in 2010, und es wurden mehrere Vorschläge für Seminarinhalte in 2009 erarbeitet.

Nunmehr ist angedacht, Kontakt mit den schweizerischen Kollegen aufzunehmen und die zukünftige Zusammenarbeit zu intensivieren.

Was das Seminar 2009 anbetrifft, werden dem EVKD-Präsidium die Vorschläge in der nächsten Sitzung unterbreitet, hiernach erfolgt eine weitere Auswahl.
Die Beiratsmitglieder erfreuten sich auch an einer erneuten Zusammenkunft mit Herrn Kristof Eekloo von der KU Leuven, der ankündigen konnte, die Endergebnisse der europäischen Studie zur Krankenhausführung nach Abschluss seiner Doktorarbeit in den nächsten Wochen bekannt machen zu können. Die Auswertungen sollen zum Grazer Kongress publik gemacht werden können.

Einige Beiratsmitglieder haben sich daher bereit erklärt, die Ergebnisse für EVKD-Delegierte in verständlicher Form zusammenzufassen, und diese voraussichtlich in Form einer Broschüre zu präsentieren.

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22. Kongress der Europäischen Vereinigung der Krankenhausdirektoren

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Der Gewinner ist...

Der Gewinner unter den Teilnehmern an der Studie "Trends in Europäischem Krankenhausmanagement" ist Prof. Derek Mowbray. Sein Name wurde nach dem Zufallsprinzip während des letzten Treffens des E-Hospital Redaktionsbeirats gezogen. Den Gewinn - ein iPhone - wird Prof. Mowbray in Kürze erhalten.

GLOBALISIERUNG IN DER MEDIZIN – WEM NÜTZT, WEM SCHADET SIE?

Von Prof. Dr. Ottmar Leiß

Rationalisierung, Vereinheitlichung und Technisierung begünstigen die Krankenhaus-Transformation vom Hospital in ein Medizinisches Leistungszentrum. Vom Standpunkt des Patienten hat der Fortschritt viel Gutes gebracht. Die Versachlichung der ärztlichen Dienstleistung stärkt die Autonomie des Patienten und, entmystifiziert das Arzt-Patienten-Verhältnis.

Der Nutzen der Globalisierung für die Medizin als Wissenschaft, als medizinisch-technisches System, liegt in der Informationstechnologie, der Digitalisierung bildgebender Verfahren und der Internationalisierung wissenschaftlicher Interpretationskonstrukte. Wollen wir von der Globalisierung nicht überrollt werden, wollen wir in einer Welt der Wandlungsbeschleunigungen überleben, müssen wir – in salutogener Hinsicht – Kohärenz zwischen Altem und Neuem herstellen.

MIGRATION POLNISCHER ÄRZTE

Von Dr. Maciej Duszczyk

Eine Analyse aktueller Tendenzen suggeriert, dass die Anzahl von Ärzten, die auf eine Genehmigung warten, um ihren Beruf hiermit im Ausland ausüben zu können, zurückgeht. Dies zeigt auf, dass die meisten Berufsträger, die immigrieren möchten, dies bereits getan haben und dass eine Reduzierung der Migrationsflüsse sehr wahrscheinlich ist. Dies wird nur geringe Auswirkungen auf das polnische Gesundheitssystem haben.

Auf jeden Fall werden gesetzliche Änderungen das polnische Recht in Einklang bringen mit der Richtlinie zur Arbeitszeit und zu einer bedeutenden Steigerung der Gehälter polnischer Ärzte beitragen.

Unter den immigrierenden Ärzten ist der Hauptteil Anästhesisten und Intensivärzte. Die Hauptempfängerländer sind Deutschland, Italien und Großbritannien, Schweden, Norwegen und Frankreich.

DAS NEUE KRANKENHAUS IN CERDANYA

Von Xavier Conill, Cristina Rodriguez, Jordi Boix, Alain Corvez, Victoria Peralta und Enric Mayolas

Seit 2003 hat sich ein Dank eines durch die Europäische Union (Interreg III), Katalonien und die französische Region Languedoc-Roussillon finanziertes Forschungsobjekt für ein gemeinsames Krankenhaus der Akutversorgung konkretisiert. Die Planung beginnt in diesem Jahr und das Krankenhaus soll 2010 seine Funktionen aufnehmen. Das Objekt unterliegt katalonischer und spanischer Gesetzgebung, wird aber im Eigentum der beiden nationalen Verwaltungen stehen. Das Konzept bleibt eine echte Herausforderung aufgrund der Unterschiede zwischen des französischen und katalonischen Gesundheitssystems. Die verschiedenden Versorgungsmodelle, die in der Entwicklung wie auch in der Organisation vollkommen voneinander abweichen, die Hospitalisierung zweier unterschiedlicher Völker mit unterschiedlichen Kulturen, die zwei Rechtsrahmen, die auch das Tagesgeschäft voneinander differieren lassen, müssen miteinander kombiniert werden. Schließlich bleibt als Problem, kompetentes Personal in diese isolierte Region anzuziehen.

GRENZÜBERSCHREITENDE VERSORGUNG IN EUROPA

Von Prof. August Oesterle

Auch wenn der makro-finanzielle Aspekt der grenzüberschreitenden Versorgung begrenzt ist, wird dieses Phänomen von Angebot und Annahme bestimmt. Aus Sicht des Patienten oder Konsumenten, sind der Preis, die Qualität und die Transaktionskosten ausschlaggebend. Die zukünftige Entwicklung dieser Versorgung wird von unten und von oben beeinflusst. Neben der interregionalen Zusammenarbeit, ist das Wachstumspotential groß für geplante Eingriffe, vor allem wenn die Patienten direkt als finanzieller Partner involviert sind. Weiterhin werden Personen, die auf der Suche nach besserer Versorgung und einem besseren Preis verschiedene Reaktionen bei den potentiellen Leistungsanbietern auslösen. Während die nationalen Systeme darauf bedacht sind, einen gleichmäßigen Zugang zur Versorgung der gesamten Bevölkerung sicher

zu stellen, können die unterschiedlichen wirtschaftlichen Verhältnisse, Ungleichheiten schaffen, was die Wahl zwischen Leistungen betrifft. Auch wenn das gemeinsame Ziel ist, eine qualitativ hochwertige Versorgungzu schaffen, die zugänglich ist und rentabel, muss der grenzüberschreitende Zugang zur Gesundheitsversorgung allen europäischen Bürgern durch einen geeigneten institutionellen Rahmen ermöglicht werden

Die Bedeutung des Verständnisses der durch die IT geschaffenen Werte für die Versorgung älterer Patienten

Von Karin Hedström

Die Versorgung älterer Patienten ist ein Bereich, in dem die IT rapide an Bedeutung gewinnt. Eine Zunahme an älteren Patienten, eine Nachfrage nach besserer Versorgung und der Wunsch, die Patienten solange wie möglich zu Hause wohnen zu lassen, zwingen Entscheidungsträger und das Gesundheitspersonal eine effektivere und effizientere Versorgung bereit zu stellen. Ein gutes IT System bringt nicht nur reine gute Verwaltung, sondern auch eine bessere und korrekte Versorgung nach den für die Geriatrie geltenden Prinzipien.

Führung und Geriatrie

Von Dr. François de la Fournière

In 2006 war das Ziel des Krankenhauses in Pau, 10 Betten einer Abteilung durch eine geriatrische Abteilung für Kurzzeitversorgung zu ersetzen. Die Dauer des Aufenthalts wurde verkürzt (4 Tage), und die Dienste mit anderen Krankenhausleistungen (ambulante Betten der Geriatrie, Notfallversorgung...) sowie extramuralen Leistungen (soziale Dienste) vernetzt. Mehr als 800 Aufnahmen waren im ersten Jahr zu verzeichnen. In den meisten Fällen ist es gelungen, de funktionale Autonomie des Patienten nicht negativ zu beeinträchtigen. Die Achillessehne dieser Strukturen bleibt jedoch die hohe Zahl der Wiederaufnahmen (33% innerhalb von 6 Monaten).

Entwicklung einer Klinik für Schnellbeurteilung älterer Personen

Von Arlene Wellman

Diese Abteilung wurde auf Vorschlag von Ärzten und Pflegekräften entwickelt. Orientierungskriterien wurden etabliert und an alle Hausärzte der Region verteilt. Patienten, die zu Hause leben und eine rapide Beurteilung eines gesundheitlichen Problems benötigen können per Fax des Hausarztes in das Krankenhaus eingewiesen werden. Hiernach werden die Patienten innerhalb von 24-48 Stunden eingeschätzt. Die Ergebnisse werden dem Hausarzt per E-Mail mitgeteilt.

Fokus: Slowenien

Slowenien hat 2 Millionen Einwohner. Das Land ist eine Demokratie seit 1991. Eine verpflichtende Krankenversicherung wird vom slowenischen Institut für Krankenversicherung verwaltet. Dieses Institut ist der alleinige Krankenversicherer und ist autonom, auch wenn die Regierung die Beitragssätze sowie die Leistungen bestimmt. Komplementärversicherungen gibt es drei.
Slowenien hat 2 Universitätskrankenhäuser, 7 Spezialkrankenhäuser, 5 Krankenhäuser der Psychiatrie, 2 Krankenhäuser für Gynäkologie und 2 private Sanatorien.
Während der EU-Ratspräsidentschaft Sloweniens, legt dieses Gewicht auf die Fortführung der Prioritäten der sog. Troika (Deutschland, Portugal, Slowenien). Zudem sind die von den Vorgängern übernommenen Dossiers weiter zu bearbeiten, insbesondere was die Leistung von Gesundheitsversorgung angeht und die europäische Gesundheitsstrategie. Was das Thema eHealth anbelangt, verfolgt Slowenien eine Serie von interessanten Projekten, worunter das Projekt Netc@rds zwischen der Tschechischen Republik, Italien und Slowenien, welches dazu dienen soll, den Zugang der Bürger zu den Gesundheitsdiensten zu verbessern sowie das Projekt Primacom, welches eine Zusammenarbeit zwischen Ungarn und Slownenien auf der einen Seite und Italien und Dänemark auf der anderen Seite über den Austausch medizinischer Daten betrifft.

2008

April

16-18 > Med-e-tel, Luxembourg
www.medetel.lu

19-22 > ECCMID
(European Congress of clinical microbiology & Infection Diseases)
Barcelona
http://www.akm.ch/eccmid2008/

21-23 > HC2008
(Health and social care informatics),
Harrogate, United Kingdom
www.bcs.org/server.php?show=nav.9333

23 > Nursing in practice, Newcastle, United Kingdom.
www.nursinginpractice.com/events

23-24 > 4th International Forum on Quality and Safety in Healthcare, Paris, France
forum.eventsinteractive.com/bmj/em.esp?id=11032&pageid=_2540KH07D

23-24 >Healthcare in Ireland, Dublin, Ireland
www.healthcare-ireland.com

May

6-8 > Facility Management
Frankfurt, Germany
http://www.mesago.de/en/FM/main.htm

6-8 > Ehealth conference 2008
"ehealth without frontiers",
Portoroz, Slovenia
ec.europa.eu/information_society/newsroom

6-9 > ISSA Interclean
Amsterdam
http://www.amsterdam.issainterclean.com/intercleanamsterdam2008/e

27-30 > Hit (Health Information Technologies) 2008,
Paris, France
www.health-it.fr/docs/Plaquette_HIT_Bilan.pdf

27-30 > Hôpital Expo,
Paris, France
www.hopitalexpo-intermedica.com

June

9-11 > Tromso Telemedicine and ehealth conference «Innovation in ehealth», Tromso, Norway
www.telemed.no/index.php?cat=82316

11-14 > EAES
Stockholm , Sweden
http://congresses.eaes-eur.org/

13-14 > Telemed 2008,
Heidelberg, Germany
www.telemed-berlin.de

25 > 26th International EuroPACS meeting,
Barcelona, Spain
www.europacs.org

25-28 > HEPS (HC Systems Ergonomics & Patient Safety)
Strassbourg, France
http://www.heps2008.org/

25-28 > CAD - 10th International Workshop on Computer-Aided Diagnosis,
Barcelona, Spain.
www.cars-int.org

25-28 > CARS 2008 - Computer Assisted Radiology and Surgery - 22nd International Congress and Exhibition,
Barcelona, Spain.
www.cars-int.org

September

4-6 > Giseh 2008 Gestion et Ingénierie des Systèmes hospitaliers,
Lausanne, Switzerland
giseh08.epfl.ch

8-10 > MCC Hospital world «Strategic options for the hospital market», Berlin, Germany
http://www.mcc-seminare.de/index2.php?page=/kongresse/howo08_pre/howo08_pre.html

12 – 16 > ESMO
(European Society for Medical Oncology)
Stockholm, Sweden
http://www.esmo.org/activities/esmocongress/

21 – 24 > ESICM
Lisbon, Portugal
http://www.esicm.org/

25-26 > EAHM Congress
«New leadership for new challenges» ,
Graz, Austria
www.aedh.eu.org

October

15-16 7th International Hospital Hygiene Congress, Villach, Austria
www.krankenhaus-hygiene.at

19-23 > IFHE 2002
(20th Congress of International Federation of Hospital Engineering)
Barcelona, Spain
www.aeih.org/ih/Congresos/Congreso-26/Eng/2008ifhecongress.asp

24 – 28 > JFR
Paris, France
http://www.sfrnet.org/

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