Hospital HE

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> SUPPORT TECHNOLOGY FOR MANAGERS

> BUSINESS MODELS

PLUS

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> FOCUS: France

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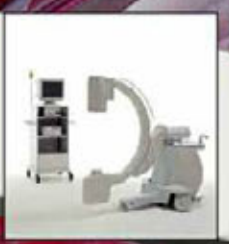

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Paul Castel

COMMON VISIONS

Since its creation in 1972, the objective and main mission of the European Association of Hospital Managers has been to be at the leading edge of evolutions in the European hospital sector and to encourage exchanges among member states. It is in this way that, following on from technological and managerial developments, as well as further to the hospital reforms carried out in the various European countries, the EAHM has significantly contributed to discussions and the exchange of ideas and experiences. The Association has also made it possible for a European vision of the organisation of healthcare systems to emerge.

From this point of view, there have been considerable changes over the last 30 years with regard to the financing of hospital systems, their internal organisation or even the dynamics put in place everywhere to constantly improve the quality of healthcare and assess the level of quality reached.

For each of these subjects, the EAHM took part in discussions and was able to encourage exchanges among European hospital mangers in order to present common visions, which reach beyond the differences and particularities specific to each member country.

The work done by the Association on accreditation and certification systems provides a convincing illustration in that respect. It is in fact from analysing the systems put into place in the various states to evaluate and continuously improve the quality of the organisations, and from reflecting on the differences and strengths of each party involved, that the EAHM is able to make an important contribution to the emergence of a European standard on the subject. This was shown in the discussions held at our latest seminar in Düsseldorf.

This new issue of *(E)Hospital* gives pride of place to current or future developments in hospital organisations. These far-reaching changes will inevitably have consequences on our managerial practices and require, more than ever, common analyses since the challenges to overcome are so large and complex. For example, this is the case with new manager support technologies mentioned in several articles (multimedia data management, eBusiness, etc.) or even new technologies for the operating rooms of the future, which are also discussed in this issue.

Moreover, with the upcoming French presidency of the European Union, *(E)Hospital* chose to focus on the French hospital system which, like those of its European neighbours, has been involved in a vast reform and reorganisation drive for several years.

The various articles focussing on these developments will make it possible to see that, beyond organisational specifics, this same fundamental movement is underway in the various European states, whether it concerns the financing methods of hospitals, their governance or even the training of executive officers.

Faced with these developments and staying true to its tradition, the EAHM will promote the exchange of ideas and formulate proposals. It will thus actively participate in the discussions that will be initiated when France took on the rotating presidency of the European Union, which promises to be an important moment for the advancement of European policies with regard to healthcare. It will also be keen on making its next conference, to be held next September in Graz, a new high time for exchanges among hospital managers.

For this, and now more than ever as a result of the critical nature of the discussions underway, the EAHM is counting on your active participation.

Paul Castel, EAHM President

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

TECHNOLOGY TO SUPPORT MANAGERS

Technology is not the manager's enemy. It can help him cope with today's unavoidable developments, as illustrated by Mr Müller in his article on multimedia medical data and even take advantage of new possibilities. Professor Hübner depicts the huge potential of eBusiness for healthcare in general and a Canadian project specifically demonstrates how using technology to unite forces can result in financial savings for hospitals.

BUSINESS MODELS

Even if it is centered around the human being in general, and the patient in particular, a hospital is nevertheless a business and has to be run like one.

Professor Schinnenburg explains how target agreements can help merged hospitals evolve towards a common corporate culture. Mr Müller attempts to differentiate two strategic concepts, rationing and rationalisation, in order to help hospitals become more effective. Finally, Robin Alma gives a consultant's overview on the common business trends between hospitals from all over Europe.

FRANCE

The French health system faces numerous challenges, many of which are common to other European countries.

Several major reforms have hence been introduced since 2004. The 2004 Public Health Policy and Health Insurance Reform Acts insist on the role of the state and parliament in priority setting in the health sector. They give more power to local and/or dedicated structures for implementation.

The new hospital governance gives more flexibility and relative internal organisational freedom to public hospitals. After Hôpital 2007, a new process of reform is underway to encourage hospitals to put together their infrastructure regionally and merge their skills. Hospital directors should also be given additional managerial responsibilities.

FOCUS: FRANCE

FRENCH

GERMAN

AGENDA

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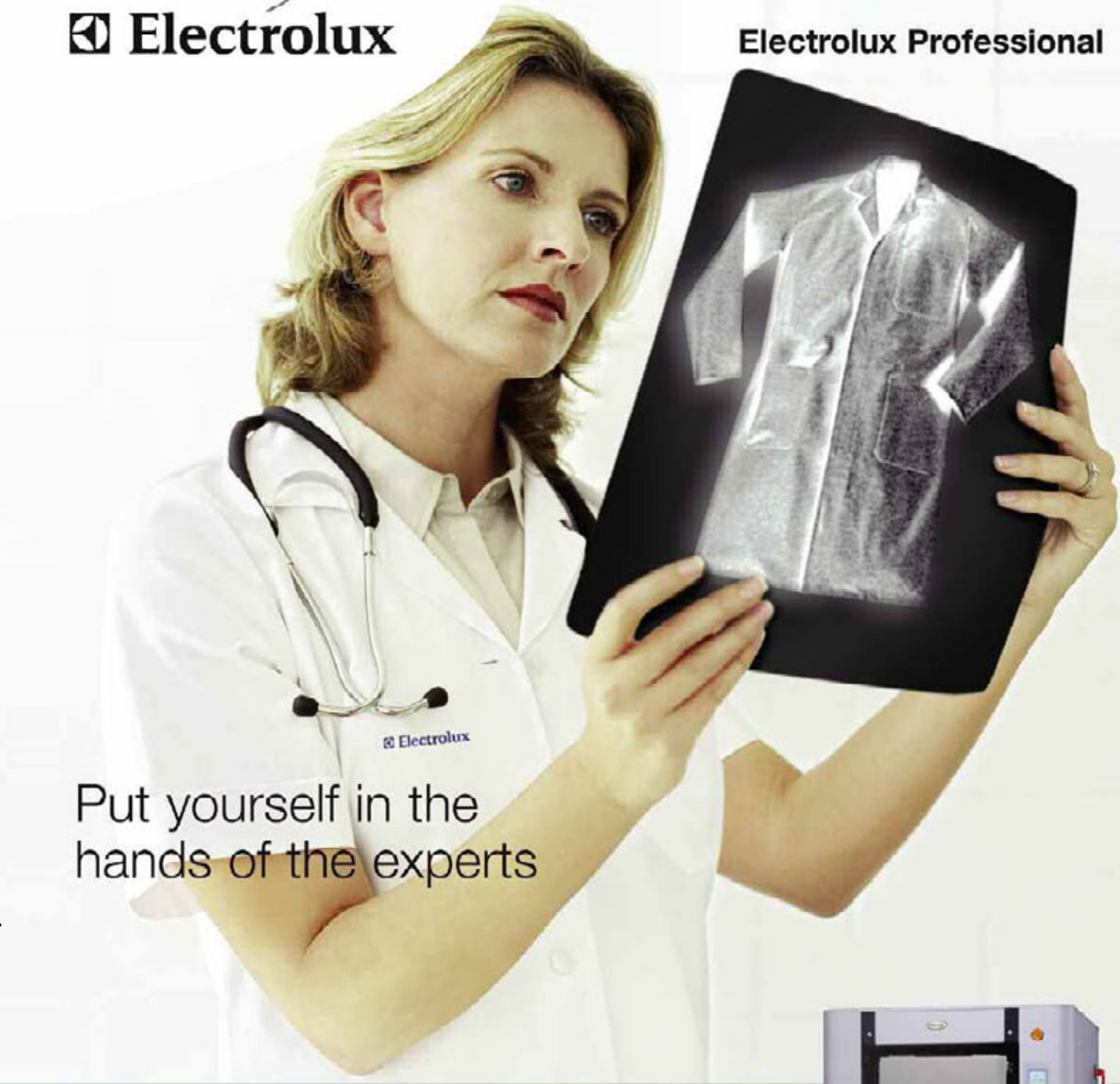

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AGENDA FOR THE 38TH EAHM
ORDINARY GENERAL ASSEMBLY

to be held on Thursday, 25 September 2008 from 9 am – 10.30 am, at Landhaus Graz, Herrengasse 16, Graz.

1.	Approval of the agenda
2.	Approval of the minutes of the 37th Ordinary General Assembly, held on Friday, 16 November 2007 in Düsseldorf, Germany
3.	President activity report 2007-2008
4.	Approval of amendments of EAHM statutes
5.	Tendering of accounts for 2007
5.1.	Presentation by the Secretary General
5.2.	Auditors' report
5.3.	Approval of accounts for 2007 and discharge of the Board and the Secretary General
6.	Economic plan for 2009
6.1.	Genehmigung der Beitragsordnung der ordentlichen und assoziierten Mitglieder (Art. 2.4.c. der Statuten)
6.2.	Genehmigung des Wirtschaftsplanes für das Jahr 2009
7.	Election of auditors for the year 2008
8.	Admission of new members
9.	EAHM Congress 2010, Davos: Presentation of main theme
10.	Next Ordinary General Assembly 2009

2ND EAHM PSYCHIATRY
SYMPOSIUM IN BERLIN

On March 27 and 28 the Working Party on Psychiatry of the European Association of Hospital Managers had invited European managers and professionals of psychiatric care to join them on the banks of the Spree in Berlin, in order to attend the second cross-border psychiatry symposium entitled "How to reinforce the efficiency of mental healthcare?"

The organisation of this meeting at the beautiful Maritim Hotel had been entrusted to a well-known Baden-Baden company.

Numerous participants, coming from 12 different European countries, listened to presentations of a high scientific level, but also to testimonies by patients and relatives.

Let's mention some recurring topics, such as hospital and mental healthcare accreditation/certification (United Kingdom and France),

Lean Management and efficiency improvement (Denmark), early detection of psychoses thanks to prevention through the TIPS project (Norway), perspectives of patients and their difficulties in overcoming their disease (Norway), care program assessment through patient data collection (Netherlands).

Were also discussed questions around the improvement of efficiency through better organised funding systems (Germany), or an optimal match between available human resources and actual patient needs (United Kingdom).

These very rich exchanges and knowledge gathering sessions were followed the next day by workshops around most of the issues listed above.

In conclusion, one can say that participants to this excellent symposium have unanimously acknowledged its great quality and particularly its high scientific level. Many have expressed the wish to see another conference of the same kind organised in 2009 or 2010, probably under sunnier European skies.

(Symposium review by Jean Teheux, Former Chairman of EAHM'S Working Party on Psychiatry, Hospital Director, Lierneux, Belgium).

Ministers agree on working time directive

The latest Slovenian Presidency can be proud of its success in finding an agreement within the Ministers Council after three years of debate on the reform of the working time directive.

Under the newly found deal, workers are limited to a weekly maximum of 48 hours, but the social partners are allowed to find 'flexible arrangements' if granted approval by the employer. Workers could effectively put in up to 60-65 weekly hours, which was one of the UK government's main demands, while Spain and other nations lobbied heavily against it and voted against.

The main points of agreement in the working time directive are:

- on-call time to be split into active and inactive on-call time. Active on-call time to be counted as working time;
- inactive on-call time may not be counted as rest time and can be counted as working time if national laws or social partners agree;
- standard maximum limit remains at 48 working hours per week unless an individual worker chooses otherwise (opt-out);
- new protective limit (cap) for workers who opt out: maximum working week of 60 hours unless social partners agree otherwise;
- new cap for workers who opt-out if inactive on-call time is counted as working time: maximum working week of 65 hours;
- the cap protects all workers employed for longer than 10 weeks with one employer;
- opt-out only under certain conditions, such as: no signature during first month of employment, no victimisation for not signing or withdrawing opt-out, employers must keep records on working hours of opted-out workers.

It is now up to the European Parliament to wave the proposal through. Already today, the agreement paves the way for the Commission to present a comprehensive social package in the coming weeks.

At the same time, agreement was also reached on strengthening the rights of temporary agency workers, granting them the same rights in areas like holiday and sick pay as their permanent colleagues.

EU crossborder healthcare directive

Beginning July, the Comission adopted a proposal for a directive to facilitate the application of European patients' rights in relation to crossborder healthcare. Despite several clear European Court of Justice rulings confirming that the EU Treaty gives individual patients the right to seek healthcare in other member states and be reimbursed at home, uncertainty remains over how to apply the principles of this jurisprudence more generally. With this proposal the Commission aims to provide legal certainty on this issue.

This directive, once adopted by the Council and the European Parliament, will provide a clear framework for crossborder care. It will provide clarity over how these rights can be exercised and the level of financial coverage that is provided for crossborder care. The directive will also facilitate European cooperation on healthcare.

Healthcare was excluded from the scope of the directive on services in the internal market. The Council and the Parliament asked the Commission to address issues relating to crossborder healthcare in a separate instrument.

MEPs call for European organ donor card

On 22 April, the European Parliament adopted a report on the Commission's proposals for EU action on organ donation. The intitiative aims to improve cooperation between member states on the issue and make recommendations on the way forward. Reducing the organ and donor shortage is "the main challenge that EU member states face with regard to organ transplantation", found MEPs. They proposed a wide range of measures, including a European donor card, to tackle problems like organ shortage, transplantation risks and organ trafficking.

The European Parliament stressed that organ donation must stay "strictly non-commercial" and should be made altruistically and voluntarily, ruling out payments between donors and recipients.

Proposing the introduction of a European donor card, complementary to existing national systems, MEPs also noted that those who are not suitable donors should be encouraged to carry a card to that effect as well in order to facilitate a swift identification of organs. Additionally, member states should make it possible to appoint a legal representative who can decide on donation after one's death, states the report.

Finally, MEPs recognised that it is "vitally important to improve the quality and safety of organ donation and transplantation" to reduce transplant risks. Hence, the Parliament looks forward to the Commission's proposal for a directive setting requirements to assure the quality and safety for organ donation across the EU.

EU to act on health security

During the current French Presidency, the Commission is to launch discussions on health security issues and how the EU action should be structured in this field.

The EU executive has presented a specific 'health security package' including on the long-awaited cross-border health care proposal (see next item and *(E)Hospital* 2/2008). This has been confirmed by Public health director Andrzej Rysz at DG Sanco at the European Commission.

Defining some of the future EU health priorities, Dr. Rys said these were to ensure a safe, efficient and equitable access to crosborder healthcare and tackling major health threats.

According to Commission sources, there could also be important developments in the implementation mechanism of the EU health strategy, including an increased EU involvement. In particular, a specific Commission-Council group could be established to plan the strategy and assure its overall coherence with the real health problems faced by member states.

TOWARDS A REAL EUROPEAN **EHEALTH AREA**

By Rory Watson

European Union governments have set themselves a triple target as they try to promote the use of the latest technological developments to help tackle the health challenges in the years ahead.

Firstly, they are looking to make greater use of telemedicine and innovative information and communication technology (ICT) in planning for chronic disease management. Ways in which this can be achieved will become clearer in the autumn when the European Commission intends to publish a paper on the subject.

Secondly, efforts will be made both to stimulate more adventurous and innovative research and to encourage policy makers to better appreciate how these developments can be used in healthcare decisions over a ten-year time frame and to plan accordingly.

Finally, special attention will be paid to the legal, practical and other issues which will arise as eHealth – as the combination of new technology and healthcare is being dubbed – is more widely used. Moves are afoot to establish a clear legal framework which will define the rights, responsibilities and obligations of all those concerned from national and local health authorities to patients and insurance companies.

The exercise will also establish the impact that existing legislation on issues such as data protection, privacy and electronic commerce will have in this area.

The three priorities were agreed at a two-day conference on "eHealth without frontiers" organised by the Slovenian EU presidency and set out in the Portoroz Declaration. Opening the proceedings, Zofija Mazej Kukovic, the Slovenian Health Minister, pointed out that the use of the new possibilities offered by the Internet, mobile phones and television meant greater patient involvement and more effective healthcare providers.

The role of patients was also changing and they were becoming more involved in the treatment process. Telemedicine, or the delivery of medicine at a distance, helped to eliminate all sorts of boundaries and so improve the quality of healthcare, she added.

The conference was an opportunity for participants from almost 40 countries to compare experiences in this fast growing area of healthcare which the European Commission is keen to project. Moves in this area were given a boost in 2004 when the Commission adopted an eHealth action plan. This set out the objective of creating a European eHealth area and identified practical steps to achieve electronic health records, patient identifiers, health cards and the gradual rollout of high speed internet access for health systems.

Already all 27 EU countries have established national eHealth road maps containing their policy priorities. The European Commission, with the cooperation of some national authorities and ICT companies, is involved in the development, design and validation of an electronic health services pilot project. This is focusing on two distinct situations: crossborder access to electronic patient summaries and e-prescription.

In similar vein, the Commission will soon table advice on how to ensure national health record systems can be interoperable with each other, enabling patients and medical staff to access the data they require at any time, no matter where they are based. This will emphasise the importance of standardised systems and of ensuring patient welfare remains a priority.

The conference noted that throughout the different EU initiatives the ICT industry and patient groups had to be involved at the earliest possible stage and be regularly consulted so that policy makers had the benefit of their input.

As the host country, Slovenia has been leading by example. It presented participants with a 24-page brochure describing some of the ways in which ICT is being used by the country's health authorities. In one case, it is used to treat depression, an illness that affects 12% of all patients. In another, the technology can monitor and provide home medical care for people suffering from chronic lung disease.

On the administrative front, Slovenia is using ICT to register new births and to update its health insurance card system. It aims to start introducing the new electronic card this autumn.

The growth in eHealth care services has also been underlined in a recent European Commission survey. This shows that 87% of general practitioners use a computer and that 48% have a broadband connection. While the equipment is overwhelmingly used to store patient information, 40% of doctors now transfer data to and from laboratories electronically.

The survey suggests there is still considerable scope for electronic prescriptions. While this is well developed in Denmark (97%) and Sweden (81%), the average across the EU is only 6%.

For more information, please visit:
http://ec.europa.eu/information_society/eeurope/i2010/benchmarking?inex_en.html

22 CONGRESS

22ème Congrès de l'Association Européenne des Directeurs d'Hôpitaux
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FRANCE

Commission report on hospital missions

In April, Gérard Larcher and the 22 other members of the commission appointed by the President turned in their final report. Their work started six months before and their task revolved around a formulation of hospital missions. 16 proposals have been articulated in order to better organise hospitals and energise public hospitals.

The commission recommends the creation of territorial hospital communities, and the elaboration of public service contracts. The status of hospitals should also be modernised. The hospital director should be the ultimate decision-maker for hospital management, which would enable a more reactive management in cooperation with the other hospital managers.

Territorial hospital communities would allow public hospitals to merge, based on common medical activities. Financial incentives would be put in place and the whole project reviewed after 2 years. Private for profit hospitals would also benefit from a new contractual framework for taking on public hospital services. Financial accessibility would be guaranteed.

As far as hospital personnel is concerned, the status of hospital doctors would be amended, in order to take their activity into account to calculate their remuneration. This would make hospitals more attractive to doctors, as compared to private clinics which offer better pay.

Public hospitals would become more flexible and autonomous in order to improve their performances.

All these measures would enable hospitals to be financially sound as of 2012. These proposals might serve as a basis for the bill which should be presented by the Minister of Health in the fall.

SOUTH KOREA

The new Asian medical travel hub?

After building its economy on semiconductors, ships and steel, South Korea is touting its surgeons' skills in the beauty business to carve out a new niche. Helped by active government support, a boom in cosmetic surgery and a pool of experienced surgeons, the country wants to surpass Singapore, Thailand and India to become Asia's new medical tourism hub. The Korean Minister of Health has recently stated that the government would step up efforts to win parliamentary approval of a bill that would legalise profit-oriented medical brokerages linking hospitals and patients.

Hospitals have set an ambitious goal of 100,000 foreign patients annually by 2012. In March last year, 36 hospitals and state agencies formed the Council for Korean Medicine Overseas Promotion (CKMP) to tap the fast-growing market.

BELGIUM

A thousand future doctors saved by the Minister of Health

Laurette Onkelinx, the new Belgian Minister of Health, is going to publish a royal decree allowing all medical graduates, without exception, to practice medicine.

Since 2004, the numerus clausus established in 1997 limited to 700 a year the number of Belgian medical graduates who were legally allowed to practice medicine.

Until now, about a thousand students were thus considered as 'surplus'. This situation will be corrected through a spreading of the excess over a number of years instead of a strict application of yearly quotas.

UNITED KINGDOM

Hospitals are using marketing techniques for the first time

The National Health Service (NHS) may soon and for the first time use marketing tools for its various services.

Medical success stories must also be made public by hospitals, within an appropriate framework, and marketing expenses must, according to the directive, be "proportional".

Until now, hospitals were not allowed to canvass patients directly. But since patients, as of April, may for the first time freely choose their hospital and specialist, a liberalisation of marketing regulations was in order, as Minister in charge Johnson argued.

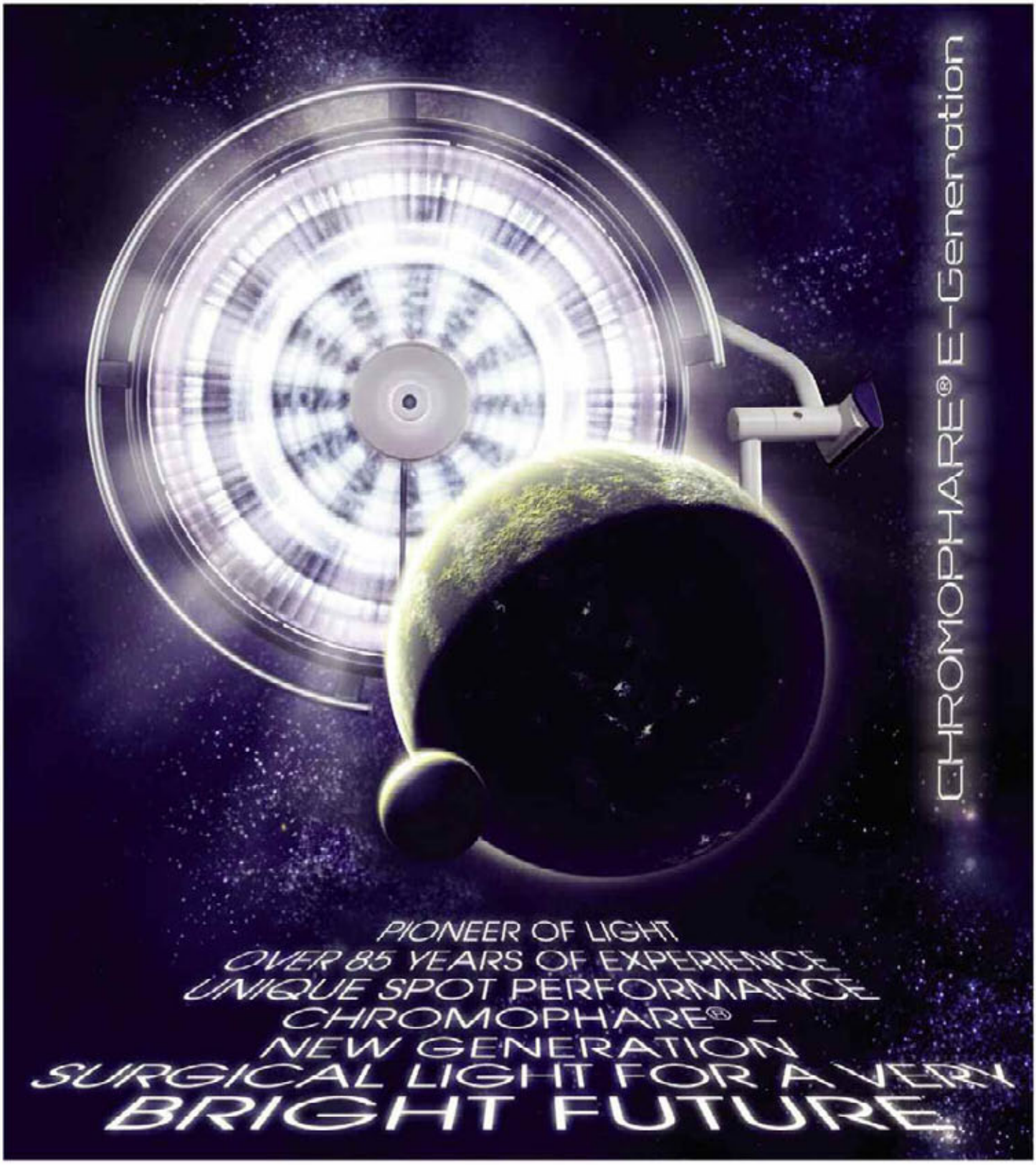
GERMANY

Many health establishments are facing insolvency

The German association of hospital directors (VKD, Verband der Krankenhausdirektoren Deutschlands) has expressed its concern over massive closures of German hospitals. According to indications from its president, Heinz Kölking, the capping of budgets should be lifted urgently and hospitals should clearly be awarded additional funding.

The unjustifiable stabilisation levy, which hospitals are now paying to health insurance to the amount of 300 million euros per year, should also disappear. If nothing is done, several hundreds health establishments might have to close down within the next five years. Some hospitals have already had to transfer their property in order to be able to survive financially.

BERCHTOLD



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Management of Medical **Multimedia Data**

By Henning Müller, David Bandon and Antoine Geissbuhler

Digital production of medical data in almost all medical institutions is increasing exponentially (Geneva University Hospitals' radiology produced on average 12,000 images per day in 2004, 40,000 in 2006, and over 70,000 in 2007). These data are an integral part of aiding diagnosis and treatment planning.

At the same time as data production is increasing, the variety of data produced and diagnostic tests available is increasing as well, creating sometimes an overload of information for the clinicians.

All data are now directly accessible within the electronic patient record and are not mostly reviewed by specialists in radiology or nuclear medicine as was the case in the past [1].

All patient data are now accessible in digital form, so it can also be reused to exploit the important information stored in it and help clinicians for similar patients in the future [2]. This secondary use of medical data is currently a hot and high potential topic in medical informatics. Legal guidelines still need to be developed for data reuse respecting the private sphere of patient.

Multimedia Data Sources

When thinking about the electronic patient record, structured textual data come to mind first. However, the situation is much more complex as graphics, images, 3D volumes and video streams are equally available and need to be analysed. Here is a short list of sources commonly stored in medical patient records that could benefit from automatic visual analysis, here ordered by increasing complexity:

- free text (release letter, anamnesis, ...) often stored in pdf format, sometimes scanned;
- one-dimensional signals that are often time-based such as ECG (Electrocardiogram) and EEG (Electroencephalogram);
- two-dimensional signals or images: x-rays, dermatology images, pathology images, ...;
- series of images belonging together such as several photographs of the entire body for dermatology;
- series of pseudo-3D image slices such as tomographies (CT, MRI, PET, SPECT);
- videos: sleeping laboratory, cardiology, endoscopy, ...;
- 3-dimensional images: reconstructions from tomographic images or ultrasound creating surface or volume images;
- 4-dimensional images: flow simulations based on 3D datasets, for example to show flow in aneurisms, or functional MRI (fMRI);
- n-dimensional combinations of modalities: PET/CT combined modalities, for example.

This list can only give starting points and the problem of treating videos in the Picture Archival and Communication System (PACS) is currently only starting.

The Geneva sleeping laboratory, as an example, produces currently over 1,000 DVDs of video data per year and no automatic analysis of these data is performed at the moment.

Content-Based Information Search

Content-based image retrieval (CBIR) has been an extremely active research domain [3] in the non-medical field as data production has risen strongly through the availability of digital cameras. Many of the image archives had little or no annotation, creating the need to navigate among large data sets directly by viewing the visual content of the images and not through textual annotation.

In the medical field CBIR was proposed very early [4]. Nevertheless, and even after many years of research, only a few prototypes exist in clinical practice, although a first clinical study showed a significant gain in diagnostic quality [5].

An extensive review of current image retrieval techniques can be found in [6]. Generally, visual methods attempt to find visually similar images to one or several example image(s) supplied by clinicians. This allows searching for similar cases based on visual data or automatically pre-classifying images for further analysis. Other clinical data, or the context in which the image was taken, also needs to be taken into account.

Teaching searches such as "Show me x-ray images similar to tuberculosis" can easily be performed with a visual example but hardly with text.

> Instead of using textual data for retrieval, CBIR automatically analyses the image content and extracts features that represent the images for retrieval.

Visual Features

Instead of using textual data for retrieval, CBIR automatically analyses the image content and extracts features that represent the images for retrieval. These are supposed to be similar to words extracted from free text but in general some information is lost when automatically extracting visual features.

The most commonly used visual features are:

- color or grey level features globally in the form of a histogram or locally in image regions;

- texture features describing the repetitiveness in local homogeneous patterns, for example for describing the texture of lung CTs to aid the diagnosis of interstitial lung diseases;
- shape features describing the form of identified objects often after a segmentation of the image into homogeneous regions, and
- salient points or interest points have emerged as a powerful feature over the last years including invariance with respect to small changes in the images, for example rotations, shifts, or in intensity.

All these features describe the content of the images itself, albeit with an information loss. To obtain good retrieval results other clinical data or the context in which the images were taken need to be taken into account, such as the age of the patient, the weight, the reasons for taking the image, or the medication use.

User Interfaces

An extremely important aspect of visual search is the user interface with which the clinician communicates. In most interfaces a query is performed with an example image or case, and then the most similar images are shown in decreasing order of similarity comparable to a Web search engine. Newer interfaces also allow marking regions of interest in the images to concentrate the analysis and search on a small part of the image.

Conclusions and Outlook

The electronic patient record is increasingly becoming a multimedia patient record. These new data sources need to be included into an automatic data analysis circle to fully exploit the knowledge stored in them.

Content-based image retrieval in connection with clinical data has the potential to help particularly - less experienced clinicians in the decision making process and to exploit knowledge stored inherently in past cases in an efficient way. Still, to make these tools a success, access to large data repositories needs to be made possible and this includes organisational as well as legal changes in the system.

Once these barriers are overcome, image retrieval need to take into account visual features as well as the entire clinical context of the patient to retrieve similar cases in order to aid diagnosis and plan treatment by extracting knowledge from the patient record including visual information.

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Figure 1 (a) **Figure 1 (b)**

Two user interfaces for image retrieval, one using a single image as an example (a) and a second one allowing the annotation of regions in a 3D volume for retrieval (b).

Improving Performance with Business Diagnostics

The best way to appreciate a product's contribution to hospital management is to ask an end-user. Mrs Schoonderwoerd, from the Gouda Hospital, talks about the advantages of Business Diagnostics from Carestream Health.

HOSPITAL: ***Mrs Anita Schoonderwoerd, you are the manager of the radiology department at the Gouda Groene Hart Ziekenhuis (Netherlands) and have been utilising CARESTREAM Business Diagnostics to improve your processes. Let's get to the core of the matter right away. What is Business Diagnostics?***

ANITA SCHOONDERWOERD: Business Diagnostics enables a workflow enhancement of a radiology department by determining the optimal workflow. Several complex contributing factors, such as modality, patient and staffing schedules are combined and integrated in order to obtain the best possible workflow.

HOSP: ***How does Business Diagnostics relate to modern administration tools, such as the Radiology Information System (RIS)?***

A.S.: Business Diagnostics extracts all the necessary data from the RIS, for example number of patients, examination time, waiting time, and time between arrival and start of examination. This allows a thorough comparison of all relevant data and an integration of the logistical experience. As RIS provides optimal radiology intelligence, one can analyse which workflow is the best, compared with an actual workflow in the field.

HOSP: ***If Business Diagnostics improves the radiology workflow, can it help save money as well?***

A.S.: Saving money is indeed a very definite possibility and it fully justifies the purchase of these services. Cost reduction actually comes from the reduction or avoidance of problems in the workflow and an improved allocation of resources. This in turn has an unexpected advantage, i.e. a much better working atmosphere within the department, due to reduced stress and a smoother work process.

HOSP: ***How does Business Diagnostics from Carestream Health work practically?***

A.S.: The procedure can be divided into five phases:

- The optimum workflow is determined and the required data is retrieved from the RIS.
- Extracted data is analysed with regards to scheduling, staffing, workflow, timetables, and modalities.
- Responsible staff are interviewed about preliminary results of the analysis.
- Results of the first research and outcome of the interviews are combined and integrated.
- Final conclusions and recommendations are released in a report.

HOSP: ***As far as the extraction phase of all the RIS data is concerned, what kind of data did you extract?***

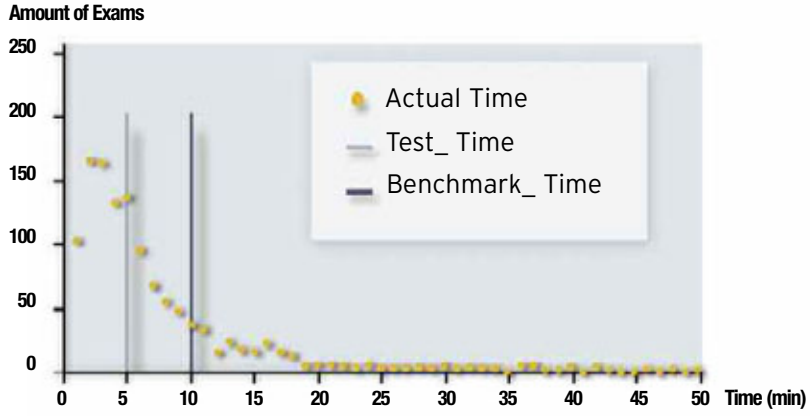
A.S.: In our hospital, we used a database export of the RIS for two different periods. One was a very busy timeframe (4,739 exams) and the other a quiet, holiday timeframe (4,277). We used a two-week period in October and a two-week period in July, both in 2007.

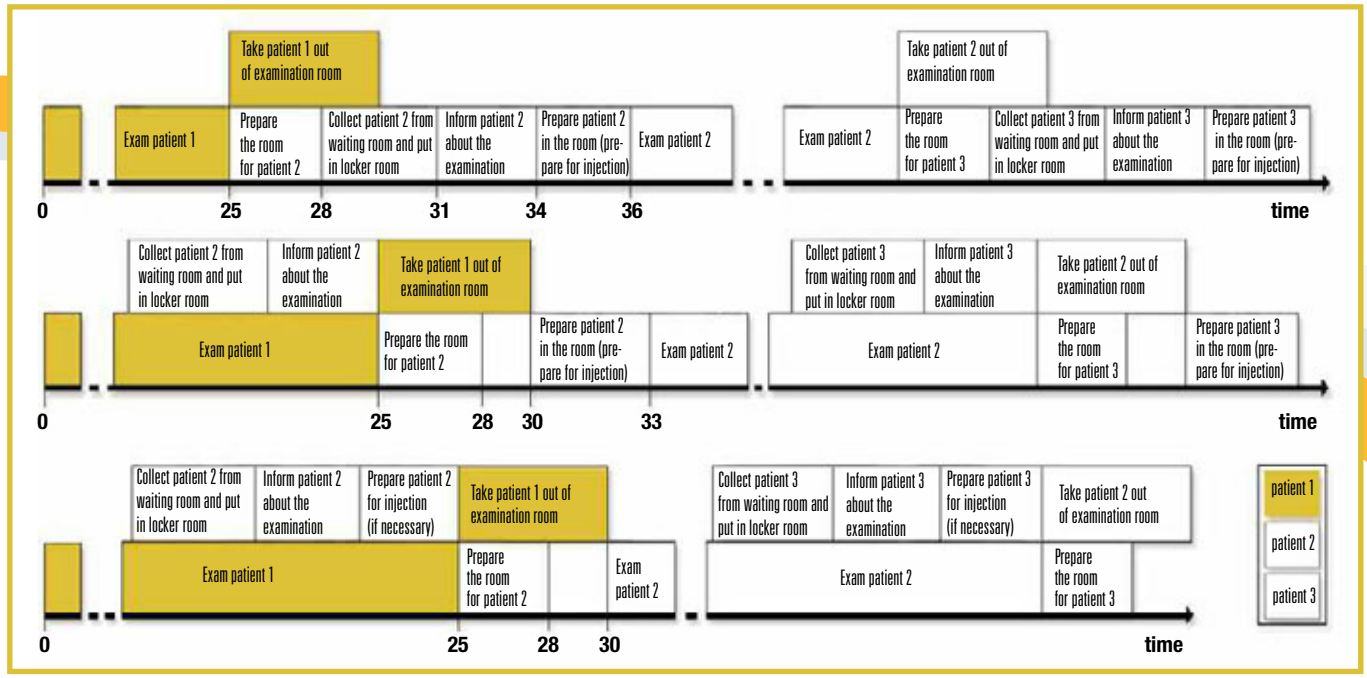
HOSP: ***When you talk about data consistency, how did you determine "normal values"?***

A.S.: Normal values were determined based on several factors: a survey of logistical experts, a discussion with Carestream Health experts, interviews with responsible staff, and also more factual data such as historical statistical values.

In this context, it is worth pointing out a slightly paradoxical situation: normal values are supposed to be partly determined by experience, which motivates interviews of active professionals. However, workflow issues, which are the very object of Business Diagnostic procedures, are sometimes caused by the short-sightedness of employees in the department.

Variations in Exam Time: Thorax





HOSP: ***So interviews with department employees constitute the essential human factor of the Business Diagnostic procedure?***

A.S.: The whole procedure is set up by professionals for professionals. These interviews target employees (such as radiologist, technician, management, administration and referring specialist) who participate in the process on a daily basis, and involve them in the development of the new procedure. The feedback from these interviews is therefore a true representation of the entire work process, an essential element if staff are to accept the report's conclusions and recommendations.

HOSP: ***Beyond the existing Business Diagnostic process, what is the next step for workflow improvement?***

A.S.: Indeed, the process as it now exists is the starting point of a whole series of developments. Among other things, optimal scheduling is an item that requires further investigation. Business Diagnostics will also focus in the future on cross-scheduling consistency, an optimisation of staffing resources, and improved occupancy of the modalities.

HOSP: ***As a conclusion, how would you describe the advantages of Business Diagnostics from Carestream Health?***

A.S.: The advantages are varied and numerous: improvement of the workflow by identification and reduction of anomalies, long term savings, efficient staffing and enhanced scheduling scheme. Another advantage is that it leads hospitals to reduce costs and establish a more efficient workflow. Business Diagnostics contributes to the fast establishment of efficient work procedures, as management alone cannot single-handedly enhance workflow. It is thus an additional resource at the disposal of hospital managers. Furthermore, Business Diagnostics also gives insight into modality occupancy. When these are optimised, more exams can be carried out within the same timeframe and resources, leading to increased revenue.

For more information visit:
www.carestreamhealth.com
Or send an email to:
robert.ashby@carestreamhealth.com

CARESTREAM Business Diagnostics enables healthcare facilities to reduce waste and improve productivity with the potential for revenue gains and increased delivery of services.
These services are offered independently and do not require the purchase of Carestream Health products and systems.

Groene Hart Ziekenhuis

Serving a community of 73,000 inhabitants, it is a general hospital (foundation) with 450 beds on three sites (two hospitals in Gouda and 1 polyclinic in Nieuwerkerk a/d IJssel).
It employs 125 medical specialists, 2100 employees and 80 volunteers.
The radiology department was digitalised in 2006 (working with RIS, PACS, CR and DR from Carestream Health).

	2004	2005	2006	2007
Mammography	3,426	3,345	3,421	4,023
Fluroscopy	2,702	2,699	2,319	2,297
Ultrasound	12,751	13,194	14,509	15,303
Outside department			8,549	6,712
Bucky	56,828	60,333	64,765	63,340
Angiography	1,066	1,049	1,026	985
CT	6,286	6,603	7,458	8,115
MRI	3,536	3,706	3,964	4,196
Operation room	623	682	1,281	1,467
Total	87,218	91,611	98,743	106,438

Streamlined and automated
contracting system for Canadian hospitals

By Alex Yazdani

Krista Logan is walking on air these days. She works for Medbuy Corporation, a Canadian group purchasing group, and organising Request for Proposal (sent by vendors/suppliers who might be interested in submitting a bid for the contracted item) bids is a big part of her job as Senior Program Manager. The RPF process used to be very manual and time-consuming, but Logan recently created a report summarising the submissions in 20 minutes. Before Medbuy's new electronic procurement system it could take her two weeks.

Medbuy negotiates long-term supply contracts o, which are Canadian publicly-funded hospitals and healthcare organisations. The company essentially operates as a non-profit organisation, flowing rebates and co-marketing discounts back to its members once its operating expenses, which are shared on a pro-rated basis, have been recovered.

During the last fiscal year, Medbuy members purchased more than $600 million in contracted items and received almost $32 million in rebates.

Since its incorporation in 1989, the size and volume of Medbuy's contracts has grown significantly – to the point where manual processing was becoming overly time-consuming and inefficient. In 2005, the company underwent an overhaul of its contracting systems and moved to an e-procurement model.

"We had seven legacy systems that we were using in the sourcing process that were all running independently," said Rick Cochrane, Medbuy's President and CEO. "Each system picked up the job where the last one finished, but they didn't link together. We needed something that was totally integrated, fully scalable and able to meet our increased contracting demands."

The mSourcing Project

The result is mSourcing, a new spend management system comprised of multiple software applications that strengthen and streamline the contracting process from start to finish. It also provides members with analytical capabilities that were previously unavailable to Canadian hospitals.

In order to make the implementation manageable, the mSourcing project is being rolled out in five phases. For some members, this is the first automated portion of their materials management system, and therefore, they need significantly more time and investment to bring their end of the system—including the people, the processes and the technology—up to speed.

The first phase was mSourcing's Sourcing and Contract Management modules. The Sourcing module provides an automated, online system for the RFP stage. Suppliers can access the system to upload their responses, which automatically populates Medbuy's database and enables faster reporting for the evaluation stage. Once the RFP is awarded, the contract data flows seamlessly into the Contract Management module without having to re-enter the information and with limited follow up to ensure data standardisation. Here, all the contracts are stored in a fully searchable database that is accessible by Medbuy and member hospital staff.

The second phase involved a data cleansing process to ensure product description standardisation. "Any system is only as good as the data within it," said DJ Robins, Medbuy's Director of Information Technology. "And the lack of standardised data was one of our biggest challenges, which is why the data cleansing phase was so essential. Now we know – as do our members – that our data is accurate and reliable, and can confidently be used to make important business decisions."

Medbuy members spent countless person hours manually updating their own contracting systems when new information or updates became available.

There was also a higher chance of data entry error due to the manual process multiplied by each of the member institutions. Reducing time and error was the driving force behind the third mSourcing phase called Item Master Update. This module virtually eliminates manual data entry by utilising a scripting software to automate the transfer of the cleansed contract information from Medbuy's system to members, ensuring 100 per cent data consistency.

"Medbuy worked collaboratively with us to implement the data scripting solution at our site," said Ross Adams, Director of Materials Management at Atlantic Health Sciences Corporation, in Saint John, New Brunswick.

"This enhancement turns a task that used to take up to three days to complete into a 20 minute automated activity that provides 100 per cent data accuracy for items that are transferred. Everything that can't be transferred automatically due to data integrity issues is flagged for manual follow up later as necessary.

"The biggest benefit of automating highly manual transactions," he added, "is that it enables our supply chain management staff to better utilise their time and focus on more strategic supply chain issues."

mSourcing's fourth phase has two major components—the eCatalogue and the Data Management tool. The eCatalogue application provides a fully searchable database, using a variety of attributes, of all products and services under contract at Medbuy. In the past, if staff wanted to look up a specific item, they would have to remember what contract it was on, then find that contract—usually a paper copy. If the item wasn't on that contract, the process would continue until the right contract with the correct line item was identified.

To Medbuy's Chief Contracting Officer, Cyndy Donnell, the online eCatalogue is the single biggest advantage to members. "It enables them to go in and search among 22,000 line items with just a key word. Before it was like looking for a needle in a haystack," she said.

Kathy Adam, Purchasing Manager at Windsor Regional Hospital in Windsor, Ontario, knows firsthand how difficult it was to search for product information before the eCatalogue went online. "I would have to look through my filing cabinet to see whether we had a contract," she said. "And I had to rely on my suppliers to tell me the contract pricing.

"Now with the eCatalogue, all my local and Medbuy contracts are online and I can verify the most recent pricing so my purchase orders go out with the correct prices. Before we would use the price from the last contract and wait until the invoice came in. Usually there would be some discrepancy, but now I have full control."

Feedback Prospects

The second component of this phase is a highly strategic tool aimed at guiding future purchasing activities and providing members with additional sources of funds by identifying potential new areas for savings. In the past, information has flowed out of Medbuy, but rarely would it flow back in.

The Data Management module, currently being rolled out, includes a web-based strategic information portal that captures members' raw purchasing transaction data and sends it back to Medbuy for further analysis. The investigation determines whether contracts are being adhered to, whether members are getting the rebates they are entitled to, and where there are additional opportunities to put contracts in place.

The fifth phase, yet to take effect, will launch the Rebate Management module, which will track and manage the rebate dollars to be returned to the Member healthcare organisations. The application will fully integrate with Medbuy's accounting systems and provide real-time rebate reporting.

Conclusion

"mSourcing has been a significant paradigm shift in our working processes," said Donnell. "We've had to do a lot of change management, training, and reinforcing the message about the benefits. But the response from staff and our members has been outstanding. Once they see the system in action, the benefits speak for themselves."

"It was a lot of work," echoed Adam. "But I knew there was a big light at the end of the tunnel. I love what mSourcing has done for my hospital and the additional time I now have to do other things."

Medbuy's Krista Logan agreed. "I'm very pleased with mSourcing's capabilities," she said. "We're able to do so much more in much less time. And I believe we've only just started to tap into the power of the system."

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The full potential of eBusiness in healthcare

By Prof. Dr. Ursula Hübner

When speaking about eBusiness as applied to the healthcare market two questions arise immediately. Firstly, what is eBusiness? Secondly, why is eBusiness in Healthcare different from eBusiness in other sectors?

Answers should be given to these two questions against the economic, technical and patient care related background of the topic. It includes the perspective of the healthcare providers and that of the suppliers, showing the interdependencies between the two and developing concepts for a new synergistic cooperation. By taking an international approach one can demonstrate the many similarities of eBusiness problems and their solutions among the different countries and permit analysis of the differences which are often defined by the national healthcare systems and their rules. Case studies from healthcare institutions and from suppliers in the US, the UK and Germany illustrate the achievements, barriers and future plans, thus enabling newcomers to learn from previous experiences. Clinicians should be explicitly shown the interconnection between patient care processes and management issues at the level of medical supplies.

Added Value of eBusiness

Switching from a paper-based to an electronic paradigm always combines yet unknown opportunities with the necessity of re-engineering major structures and processes of an enterprise. eBusiness, in particular, allows thinking in terms of new and altered business relationships and networked cooperation between customers and suppliers.

In contrast to the days of the internet hype, today healthcare providers and suppliers assume a down-to-earth pragmatic attitude towards eBusiness. They look back at a good amount of work and considerable success and they know what needs to be done next –with the understanding that eBusiness is the key for a number of solutions. Having started primarily as a means for process automation, to date eBusiness is spawning a series of opportunities for both parties. Standardisation of procurement in terms of processes and goods, greater contract compliance and finally business analysis based on recent accurate data highlight the opportunities for the healthcare providers. They are aware that the incentives for doing eBusiness are already there. Beyond benefiting from all steps of an electronic transaction (from order to invoice), with eBusiness, suppliers get into a position where they can move towards providing more comprehensive services ("helping our customers"). These services may affect all processes within the organisation, including procurement and logistics in addition to patient care, depending on the scope of the company. For the first time the business partners in healthcare are able to think about implementing a supply chain due to the information flow enabled by eBusiness. The enhanced catalogue containing clinical and business information acts as a turntable for distributing information to clinicians and purchasers at the same time.

eBusiness is Already Essential

Nowadays, stakeholders are of the opinion that eBusiness will move from a "nice to have" to a "must have" - the consequence being that those who don't have it will be out of the game - which applies to suppliers and healthcare providers alike. Those still hesitating with regard to eBusiness should keep in mind that eBusiness is not only about buying some pieces of new hardware and software but is about changing the organisation and its processes for the better. In contrast to earlier interpretations of eBusiness as a cost saver, experts in this field have learned to recognise eBusiness as an instrument for generating structured error-free data and thus for reducing process errors significantly, enabling them for the first time to

perform business analysis on a large scale. This of course may lead to cost reductions but also safer patient care.

The success of eBusiness is strongly coupled with the use of standards at any level from product identification to catalogue formats and from messaging to process orchestration. Therefore a case can be made for concerted standardisation efforts in order to achieve an unrestricted information flow between the systems in the supply chain. Available standards such as EAN*UCC, EANCOM, UNSPSC and many more, each with their technical context, should be discussed and implemented.

Different eBusiness Models

Finally, an outlook to "eBusiness beyond transactions" is also helpful in order to illuminate the full potential of eBusiness including aspects of decision-making and collaboration. This outlook should be presented as the supply chain model of eBusiness in healthcare. It integrates a process, a document and a function model which are all geared to the combined view of clinical and economic issues related to the procurement, provision and use of medical supplies.

The first of the three sub-models, the supply chain process model, is split into two parts, the strategic model and the operations model, which both distinguish between healthcare provider and supplier-specific processes. The second model, the document model, concentrates on data related to the product and shows the various data sources, namely the documents, which become relevant in the product life cycle. Again, these documents embrace clinical as well as economic cases of use. Finally, the function model, the third model, integrates the process and the document models. Similar functions are grouped into layers. The function model describes a Content, a Contract, an Order-to-Payment, a Service, a Clinical Process, a Clinical Outcome and a Knowledge layer. These layers are arranged as a stack which roughly follows the product's path from the manufacturer to the healthcare providers where the product is used and where knowledge is accumulated about the products clinical usefulness and the cost-benefit-ratio.

Conclusion

The supply chain model of eBusiness in healthcare is meant to support practitioners in assessing how supply chain concepts and eBusiness can strengthen their organisation and to help them develop an appropriate strategy to achieve this goal.

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AGREEMENTS ON OBJECTIVES,

AN INTEGRAL PART OF HOSPITAL MANAGEMENT SYSTEMS

By Melanie Bolenz and Heike Schinnenburg

Competitive pressures in the health sector are encouraging the formation of larger companies, some of which are internationally active. The integration of previously independent entities is a significant challenge, particularly where there are different corporate cultures.

Surveys have consistently shown that around 50% of mergers and acquisitions fail, often because so-called "soft facts". These factors include the internal, unconscious rules of a company, the communication style employed and the tools used for human resources management.

Organisations, however, have to find experts in a tightening labour market in which new recruits are scarce.

Against this background, a team from the University of Applied Sciences of Osnabrück carried out a study of how management instruments are used in selected hospitals in Sweden, England and Germany and how staff perceived these tools (fig. 1). Taking "agreements on objectives" as an example of a management instrument that has been established both in theory and practice, the team identified significant variations.

Examples from Three Countries

In Germany, hospitals in the public and voluntary sectors were selected for the study because these sectors are considered likely to be most affected by the consolidation process under way in the healthcare market. The German sample was compared to English and Swedish hospitals run by a private healthcare company, which has been operating at pan-European level since making a series of acquisitions.

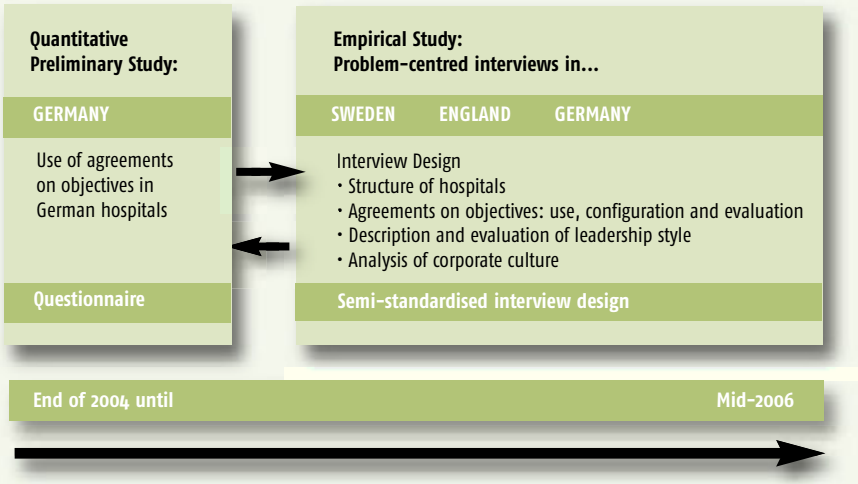
The company could be considered a "typical" buyer in a privatised German hospital market.

The starting point of the study is a quantitative analysis of the use of agreements on objectives in German hospitals in 2004 (n=53). This indicated that while 51% of respondents (primarily managers) had experienced these agreements, their managerial integration was minimal.

The three-country study built on these initial results by carrying out problem-centred interviews (n=23) in 11 different hospitals. Physicians, nurses and administrators – were questioned.

The chosen research method offers a good insight into the factors to be considered when a private investor acquires hospitals in international markets – in this case, Sweden, England and Germany. In interpreting the research results,

Figure 1: Study Design



Source:
authors' analysis and presentation

it is nonetheless important to note that the differences identified are not necessarily specific to the countries under review. On the contrary, these differences are influenced to a significant degree by the relevant parent company.

Staff Perceptions

Agreements on objectives are an established management tool in Sweden and England where they are used more widely than in Germany. This is important in light of the finding that many members of staff in the German hospitals were unfamiliar with the corporate objectives of their institution. However, the most significant differences were found in the evaluation of agreements on objectives as a management instrument (fig. 2).

The findings show that agreements on objectives are rarely perceived as an instrument of control in the Swedish hospitals. On the contrary, their positive features are accentuated and respondents ascribe to them the following characteristics: they contribute to the success of the institution, enhance motivation and greatly facilitate communication. In contrast, the data show that employees in Germany tend to perceive agreements on objectives as an instrument of control, although German respondents also ascribed a measure of success to them provided they are used appropriately.

Leadership Style and Corporate Culture

A broader analysis of leadership style in the hospitals in the three countries is useful in attempting to explain the differences that emerged in the perception of agreements on objectives.

This analysis shows that leadership styles in the institutions studied in Sweden and England, all of which are owned by corporations, were based on similar values and visions. In most cases, tools such as agreements on objectives, employee appraisal and continuing education are considered useful and applied in a systematic manner. In the German hospitals the team was unable to identify universally applied management systems or strategies that focused on human capital. The only positive rating in Germany was recorded in nursing.

The absence of universality means leadership is evaluated differently in the various hospitals (fig. 3). Leadership style is rated significantly better in Sweden and England than in Germany. Factors that are considered to be a direct consequence of a particular leadership style are helpful in terms of decision-making, awareness and integration. It was noted that the experience of leadership style in England and Germany is an ambiguous one. On the whole, leadership is perceived by Swedish respondents in a more supportive and integrative light. It is interesting from this perspective that leadership positions in Swedish and British institutions are frequently occupied not by experts in particular fields but by qualified managers, an otherwise uncommon practice in German hospitals.

Respondents in Sweden and England also underlined the fact that the positive, supportive corporate culture based on clear values and visions was a result of the acquisition of their hospital by a multinational company.

In England, in particular, this culture was described as unusual when considered in the context of the national culture. It can be assumed that this culture is attributable to the internal characteristics of the parent company. Country-specific cultural differences do not, therefore, exert a decisive influence on corporate culture, even against this background. This assumption is supported by the finding that, notwithstanding a number of organisational and structural distinctions, strong similarities were found in the corporate cultures of the hospitals in Sweden and England operated by corporations. However, in Sweden communication is described as less formal and hierarchies are noticeably flatter than in England.

In the German public and voluntary hospitals which featured in the study, rigid hierarchies and deep-seated conflicts strongly influence the corporate culture. It can be assumed that the strong focus of the various occupational

Figure 2: Comparison of assessments of agreements on objectives in hospitals in three countries

Agreements on objectives...	Sweden	England	Germany
... are an instrument of control	1,6	2,5	3,6
... make processes in the company more transparent	4,3	3,8	3,6
... help ensure all staff are familiar with corporate goals	4,5	4,0	3,5
... are fully accepted in our company	3,3	3,0	2,4
... make a significant contribution to the company's success	4,0	3,9	3,6
... strongly motivate me	4,0	3,9	3,5
... are management diktats	2,0	2,9	2,5

key: 1 = completely disagree,
5 = completely agree (arithmetical mean).

Figure 3: Comparison of assessments of agreements on objectives in hospitals in three countries

The leadership style in our hospital ...	Sweden	England	Germany
... helps me to reach autonomous decisions	4,0	3,8	2,7
... is clear and powerful and gives direction to my work	3,6	3,6	3,1
... leads to lengthy discussions without clear decisions	1,7	2,9	2,9
... means I always feel well informed and integrated	4,1	3,6	2,4

key: 1 = completely disagree,
5 = completely agree (arithmetical mean).

groups on their own interests is a key factor in this regard. The "three pillars" model of administration, medicine and nursing is reflected in parallel, internal organisational structures. The lack of transparency in communication and decision-making suggests a culture of mistrust in the German hospitals. The strongest efforts to achieve a positive corporate culture appear to be under way in nursing. In contrast, the merged hospitals in Sweden and England have, since their realignment, already opted for new organisational structures and a stronger focus on processes and patients is discernible.

Conclusion and Outlook

The findings of the study cannot be universally applied. However, they can be used to raise awareness of the fact that, notwithstanding cultural differences between countries, management tools can be deployed effectively during company mergers.

The British and Swedish interviewees emphasised the gradual introduction of value-oriented corporate leadership following the acquisition of their hospital by a large corporation. They also noted that the consistent use of participative management instruments - specifically agreements on objectives - had positively changed highly diverse hospital structures.

The successful use of agreements on objectives requires the creation of sound foundations. For example, managers must be offered personal development training to prepare them for performing their role. They must be given time to manage and should agree on objectives. A rolling information and communication strategy based on a culture of openness is a further critical success factor for the staff to understand and contribute.

The iceberg model is frequently used in characterisations of corporate culture to illustrate the fact that underneath the visible surface of "hard facts", unspoken and even unconscious rules apply. These rules are essential if agreements on objectives are to be used effectively.

The implementation of individual management tools is not sufficient to guarantee the success of mergers and acquisitions in the hospital sector. In the planning and implementation phases it is vital to pay greater attention to "submerged" factors (fig. 4). In this regard, it is essential to carry out an analysis of corporate culture - known as cultural due diligence - and set clear objectives for the future. These imperatives are particularly acute in international mergers.

The research findings demonstrate that corporate culture can be positively stimulated across national boundaries by value-oriented management, which also allows a basis to be established for the implementation of uniform management systems. The success of mergers and acquisitions in a hospital market in which the European dimension is becoming increasingly important will depend on whether employees feel valued by managers and management tools are experienced in this context.

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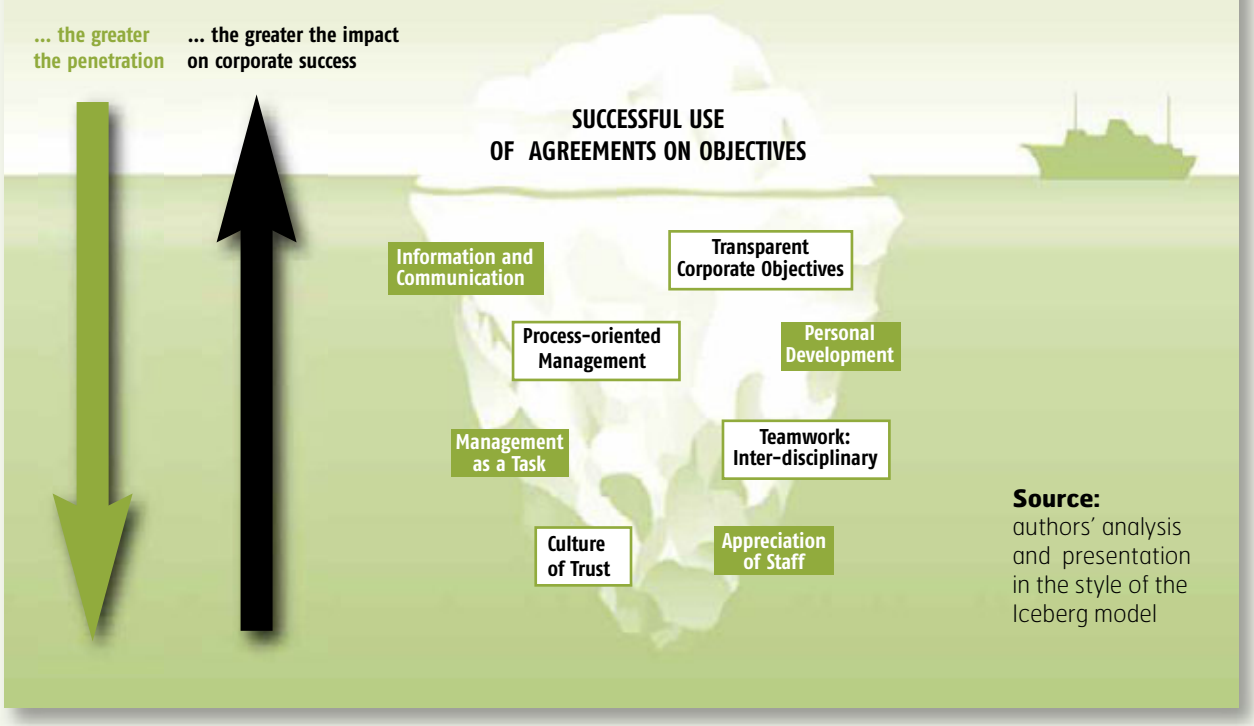
Figure 4: The complex nature of success implementation of agreements on objectives



Source: authors' analysis and presentation in the style of the Iceberg model

RATIONALISATION OR RATIONING
A WAY OUT OF THE CRISIS?

By Hardy Müller

Strategies for increasing efficiency and quality in inpatient care

"One third of hospitals operating at a loss". Thus ran the headline of a recent news item by the German Press Agency. The 2007 German Hospital Barometer survey of German hospitals has again highlighted that hospitals continue to wrestle with economic problems.

However, closer scrutiny of the economic situation reveals a more complex picture. According to the study cited above, 44.5% of the hospitals surveyed were undecided about their future economic prospects, while more than 23% rated them as good.

Some hospitals are more economically successful than others. This is a trivial observation; the interesting question is whether the longstanding demands and agitation for rationalisation as opposed to rationing in the health service are helpful or beneficial to hospitals and if they are the reason for the economic success of some hospitals. Can and should hospitals choose between these alternatives?

An Inextricable Dilemma

For more than 15 years the German health system has been continually offered a choice between "rationalisation" and "rationing". Thus far, no clear response has been forthcoming, primarily because the implications of making this choice range from the trivial to the monstrous. A number of definitions developed by the philosopher and medical ethicist, G. Marckmann, are set out to help facilitate objective consideration of this issue and, hopefully, give answers to this unresolved question.

Rationing

According to Marckmann, rationing triction of services. It arises from the tension between limited resources and infinite demand. In this respect, it is neither a confrontational term, a "declaration of war" on the health system or, as many politicians would argue, a means of differentiating between "valued" and "less valued" patients. On the contrary, it is a simple statement of fact. Services must be circumscribed because resources are scarce. The choices made and the constraints imposed as a result are not academic decisions but value judgments, which must be taken in the context of a broad political and societal debate. Individual service providers and those who bear the costs of healthcare cannot take responsibility for these decisions because it is not within their capabilities to do so. Such decisions must be preceded by a discussion about values, both at political and societal level.

Rationalisation

When resources are limited, the goal must be to deliver the same medical and care effect using fewer resources or deliver a larger medical and care effect using the same resources. The goal, therefore, is to increase efficiency, which is the hallmark of rationalisation.

Rationalisation is the primary strategy available for dealing with scarce resources. It stands to reason then that those who deliver the service are most familiar with the processes involved and best placed to identify potential improvements. Rationalisation measures should be administered at the service provider level, including in hospitals. Significant efforts are being made to secure efficiency improvements and substantial successes have been achieved. Organisational changes such as the establishment of specialist centres in medicine have delivered measurable rationalisation outcomes. There follows an analysis of new rationalisation approaches.

Rationalisation Potential: Evidence based Medicine

Evidence based medicine (EBM) is a relatively new concept, which was first introduced in German healthcare only a decade or so ago. Despite its relatively recent origins, it has emerged from an intense and often divisive debate between methodologists and service providers as a key healthcare strategy. In a British Medical Journal readers' poll evidence based medicine was rated the eighth most important medical advance since 1840. Implementing bodies in many health systems (for instance, G-BA, IQWiG, NICE) have adopted EBM approaches as their legal and organisational modus operandi. Greater application of the principles of EBM offers further potential for rationalisation.

In the absence of other indicators, conclusions about the effects of medical interventions have frequently been based on surrogate parameters. A series of false conclusions were reached for certain drug therapies and certain hospital treatments have also been found wanting when subjected to rigorous scrutiny (primarily randomised clinical trials). For example, the initial euphoria which greeted the use of robots in endoprostheses gradually gave way to the realisation that the procedure's shortcomings outweighed its benefits. The use of these robots has been suspended and most of them now languish in hospital basements. Gastric freezing for stomach ulcers, transmyocardial laser revascularisation and the use of MRT to diagnose multiple sclerosis have all suffered similar fates. Studies using EBM criteria showed that the disadvantages of these often expensive therapeutic and diagnostic procedures outweighed their utility.
Evidence based utility assessment offers significant rationalisation >

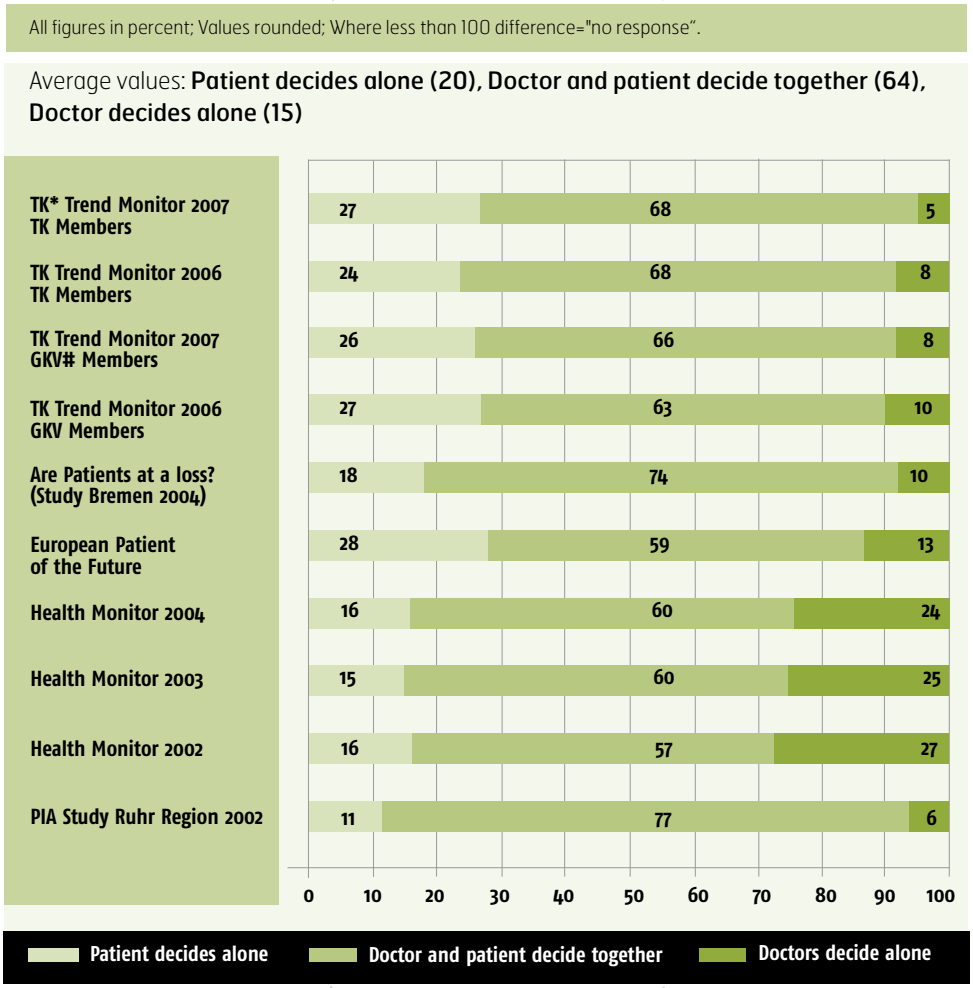


Figure 1:
Desire of Policy Holders to Participate in Medical Decisions

> potential. The instrument was established in German law through legislation enacted in 2004 to modernise the statutory health insurance system and extended in a 2007 health reform which introduced cost-benefit analysis in the pharmaceutical sector.

It must be assumed that the use of these principles for utility assessment would contribute to rationalisation in hospital treatment.

"Knowledge Creates Health": The Rationalisation Potential of Critical Health Literacy

The courts did not censure the use of robots in surgery per se but noted the requirement to provide patients with complete and comprehensive information. Pressure from patients for greater involvement in decisions on medical treatment is also increasing. Patient surveys carried out by the Technicians Sickness Fund show that only 5% of patients want treatment decisions to be left solely in the hands of medics.

These findings are replicated in all age groups and medical conditions and provide evidence of a new and frequently ignored patient wish (Figure 1).

In view of the growing importance of patient and customer orientation, this wish should be taken seriously and addressed through appropriate measures. Some sickness funds have already started to take action in this respect.

Not only do enhanced patient participation and improved information reduce liability risks, they can also improve treatment outcomes. For this reason, health education should be developed.

The idea that "knowledge creates health" lies at the heart of strategies aimed at improving "health literacy". The focus must be on improving access to and understanding of existing information, rather than on providing more information.

From information, education must emerge. Improvements in the economic efficiency of treatments can also be expected from such measures.

The results of patient education courses developed for diabetes treatments are a good case in point. This concept has been internalised in the mission statements of successful hospital operators.

Conclusion

Rationalisation and rationing are both indispensable strategies for the responsible organisation of medical care in an era of scarce resources. The dominant strategy is rationalisation for which service providers, owing to their in-depth knowledge of care processes, should have responsibility. Hospitals are also required to make a contribution towards rationalisation.

Explicit rationing measures cannot be implemented in a responsible manner by individual service providers or those who bear the costs of healthcare. These decisions are contingent on the outcome of a political and society-wide debate on values. Individual hospitals cannot be given responsibility for taking such decisions.

It is high time that Germany engaged in a public debate on the values that will determine prioritisation in medicine. This means all sides must adopt unambiguous positions on what we will and will not pay for in our health system.

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HOW TO CREATE VALUE

IN THE DYNAMIC HEALTH CARE ENVIRONMENT

By Robin Alma, Eric Baart, Patrick Biecheler, Oliver Rong and Aleksandar Ruzicic

In the changing European healthcare landscape, organisations are redefining their strategies and business models. Nine trends are common in this transition, and these should be taken into account when organizations align their business models to their new strategies on the cost-quality frontier. Privatisation can be used to fuel this evolution.

The changing healthcare landscape requires new business models

The issue and question of healthcare has probably never been as urgent as it is today: with economies shifting from an industrial to a more service-orientated approach, this sector is allocated a very high percentage of Gross Domestic Product (GDP). Healthcare also has a huge impact on employment, as most of its activities are still provided by local people.

The industry and its players, however, are facing a multitude of obstacles. Macroeconomic factors, such as ageing populations or insufficient public funding, are challenging both payors and providers. Anyone wishing to succeed in this new market environment must redefine and adapt their business models accordingly. Our recent study of Western European countries reveals nine common trends in the healthcare landscape that players should take into account when redefining their strategies.

Trend 1: Chose your position on the cost-quality frontier

Whereas in the past, healthcare providers focused solely on quality, they have shifted towards balancing quality and cost in order to differentiate themselves in the increasingly competitive healthcare environment.

Companies can either increase quality and price levels, in order to fulfill already existing customer demand, or reduce cost and level of quality – and meet the demands of a different customer segment. In order to fully implement the chosen strategy and reap its benefits, organisations must take on a business model that supports the strategy.

Trend 2-5: Adapt your offerings to changing market circumstances

From products to services – *Providers* of traditional healthcare products have recently begun to offer services, which address patient needs. By offering services linked to the product portfolio of a certain therapeutic area, healthcare product suppliers can reach more customers and achieve top line growth. Beyond seizing new business opportunities, service delivery implies direct and intimate contact with patients, allowing continuous observation and adaptation of their ever-changing needs.

Taking good care of yourself – In recent years, health has grown in importance across the population, regardless of age or income. Health is becoming an integral part of all aspects of our lives: probiotic yogurt, non-irritable clothing and healthcare tourism have been added to the traditional extras, such as homeopathy or voluntary preventive medical checkups. A new healthcare market is called for, a "secondary healthcare market", as opposed to the primary market of statutory health insurance. In Germany, the secondary healthcare market has already achieved an annual volume of 60 billion euros – or 2.5% of German GDP – and demonstrated continual annual growth of 6% since 2000. At present, every German adult spends approximately 900 euros a year on medical checkups, alternative medicine, wellness, sports and health food.

The rise of the specialist – With increasing scientific knowledge on health issues available, the industry is becoming more complex – and the generalist approach of the past is evolving into a more specialised one. In addition, pharmaceutical companies are focusing their research and expanding their product portfolio by acquiring licenses. One example is the Dutch ZBC, an independent treatment center. A ZBC is specialised in standard procedures, yet independent from hospitals.

> In the past, general medicines covered several diseases, but each specific illness now requires its own treatment.

Pay for Performance – Since performance indicators on quality are becoming more and more available, health insurance companies have begun to issue both targets and financial incentives to their service and product providers. In these circumstances, offering higher quality against higher costs can prove to be more profitable. Already the case management fees such as Diagnostic Related Groups (DRGs), common across Europe, promote higher quality, if they are well structured,

by for example punishing providers with patients that have to be re-hospitalized again due to complications.

Trend 6-8: Bring your products to the market

From institution to brand – In an effort to win over increasingly well-informed patients, healthcare players should develop a 'brand' which allows them to distinguish themselves. Despite the detailed information available to them, the majority of patients are still unable to correctly assess the perceived or expected quality of their medical treatment. In order to make branding effective, the chosen marketing mix needs to be consistent with the expectations and potentials of the target consumers.

The new virtual value chain – Due to mounting cost pressure, hospitals across Europe have already outsourced many non-core activities, such as catering, sterilisation and laboratory services, to specialist providers. This trend has recently spread to core activities. New providers are pushing into the market, and have developed innovative forms of cooperation with traditional players. Collaboration will prove to be a business model that allows a larger product mix with lower costs.

Moving beyond boundaries – Traditionally, pharmaceutical and medtech companies have operated internationally. Recently, other stakeholders, such as patients, health care workers, hospitals and centers, have followed their example – and moved beyond local and national boundaries.

Trend 9: Privatise to meet your goals

As business models change to fit market demands, the cost of innovation is growing fast. In these days of public deficit containment and rising costs, the funding of healthcare is becoming more challenging. This has prompted a trend towards privatisation among both payors and providers. As long as a sound business plan underlines the business rationale of the necessary investment, additional funding is accessible to private entities. Furthermore, private entities generally perform better in turnover growth, profitability, quality of positioning and services. European countries differ greatly in pace toward privatisation, but the general trend is unmistaken.

Healthcare organisations need to step up to the challenge

Although the healthcare market is facing some challenging times, there are companies who have already adapted to the new drivers. Providers such as Charité, the largest European university hospital, or Fresenius Medical Care, the global dialysis leader, have established themselves as a brand, or have completed the transition from offering products to offering services.

Payors, such as Axa Santé or Santéclair (France) on the other hand, have taken some measures to contain cost, while at the same time guaranteeing the quality of their service. Last but not least, Philips & Achmea (The Netherlands) are a prime example for an innovative form of cooperation between a provider and a payor.

Conclusion

Changes in the healthcare sector are forcing hospital management towards increasingly commercial operations. As the free-market principles of regulated competition begin to take effect, hospitals will have to adjust their approaches even more. It is time to step up to this challenge.

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HÔPITAL EXPO 2008 REVIEW

This biannual event, which has now become pivotal to the hospital world in France, took place in Paris on April 27-30, 2008. It is organised jointly by the Fédération hospitalière de France and Intermedica.

Hôpital Expo is an excellent opportunity to bring together stakeholders from the hospital sector and get them to exchange options and experiences in a professional context.

The basic theme of this 22nd edition was change and change management. On top of the 750 exhibitors present at Paris Expo, numerous information sessions were organised around actual issues such as sustainable management, purchasing or catering.

IT issues were also highlighted at Hit (Health Information Technologies) Paris on the same premises.

What makes Hôpital Expo so unique, beside its size (24,000 visitors) is the pragmatic character of most presentations, and the quality of the exchanges between the speaker and the audience.

Actors on the field, hospital managers or medical representatives explain in a very concrete manner how they try to improve the efficiency of their health establishment by identifying bottlenecks and shortcomings, and how they implement solutions.

A very realistic analysis of the situation preceding and following the restructuring is often provided, on the basis of figures, graphs and tables. Results are then reviewed and negative points are brought forward as prominently and honestly as positive ones.

The demonstration is followed by questions from the audience, emphasising either similar experiences or asking for clarifications on certain details. This simple, yet lively organisation was perfectly illustrated by Dr. Gérard Leroy, who was testifying on the management of bed occupancy in his cardiology department.

The situation of his unit was clearly explained, and the analysis of contributing factors simply reported. He then went to explain how a solution was worked out and applied and the positive change that ensued in terms of spreading of activity throughout the week, early determination of foreseen release of patients, and positive financial consequences.

The audience reacted promptly and required additional information, for instance, on human factors, such as the best way to convince professionals active in the department to effectively participate in the evolution of management procedures.

Orange,

At the centre of Health Issues

By 2010, one in four Europeans will be over 60 years old. And healthcare expenditures currently represent between 10 and 15% of the GDP of European countries and are increasing by 7% a year. To counter these daunting trends, emerging Healthcare techniques combined with Information and Communication Technologies (ICT) have merged into a new discipline: eHealth. No wonder eHealth in Europe is now one of the fastest growing sectors, between 15 and 20% a year. EHealth is expected to help optimise practices ensuring quality and access to healthcare for all.

As a worldwide supplier of services, Orange relies on its long experience and vast networks to impact healthcare. Its specific healthcare department was created in 2007 but draws upon over 10 years of experience of the Group in healthcare. It decided at the onset to cooperate with professionals in hospitals, software and health insurance companies as well as associations to come up with user-friendly and custom-made solutions.

In the face of multiple issues at stake and tremendous expectations, Orange Healthcare has organised its strategy around three essential axes:

1. The doctor-patient relationship:

New technologies facilitate the relationship between the doctor and its patient and optimise the care process.

Connected Emergency Response is a complete information system that speeds up communication between the three main players in the emergency system: the ambulance, the hospital and local coordinators. It allows real-time communication between the emergency service centre and medical technicians in the field. The system makes it possible for paramedics to arrive on the scene quickly thanks to automated navigation, then take the patient's history, transmit vital medical data to the patient's medical file (assessment, diagnosis, monitoring of vital signs, treatment, medical acts, etc.), decide which hospital is best equipped to treat the patient and ensure that needed supplies are available.

Connected Hospital proposes global and modular telecommunications solutions. IP networks unite and secure care: patient calls, location of staff and equipment, online access to medical records. It also brings the triple play comfort (television, telephone and Internet) to the patient's bed.

2. The organisation of care and the articulation of post-hospital follow-up treatments:

As healthcare tends to migrate towards urban areas, its specialisation requires an extensive and reliable exchange of information. Hospitals are interested in videoconferences for the exchange and sharing of information for remote diagnosis, particularly for multidisciplinary discussions in oncology, perinatal care and surgery, on a national as well as international level.

Business Everywhere enables health professionals to work on their laptops via wireless service – wherever they are. It allows them to manage their professional emails in real time and gives them easy access to their hospital information system.

3. The development of home care services:

To maintain elderly or chronically ill people at home, personal services need to be optimised and these patients need to remain in constant communication with a whole range of health professionals.

Connected Hospital at Home coordinates home care thanks to a secure access to the hospital information system. Health Monitor is an innovative way of following up on chronic patients by favouring the patient's involvement in his/her own treatment in coordination with the health professionals responsible for their care.

With its international Orange Labs network, Orange has an innovation capacity relying on 5,000 experts (marketing, researchers and engineers) working to invent and develop tomorrow's telecommunications services. Orange listens to the market, understands its needs and anticipates optimal solutions.

Visit www.orange.com/healthcare

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The Experimental OR

An Opportunity for Manufacturers, Surgeons and Users

By Martin Scherrer and Ülrich Matern

Operating rooms – ORs – show deficits in a wide range of areas. As a workplace, they do not meet today's ergonomic standards. In economic terms, they offer potential to exploit substantial additional resources. Moreover, interaction between the different medical-technical centres, facilities management and work processes could be improved.

The experimental OR at the University Hospital Tübingen is a unique, interdisciplinary project designed to deliver an integrated, holistic system for future operating theatres which will optimise future theatre planning. It will allow hospitals to realise long-term cost savings in their most expensive functional unit while achieving sustained improvements in theatre working conditions.

OR personnel give their workplace a poor report card. In a survey carried out at the German Surgery Congress in 2004, almost 70% of the surgeons interviewed indicated that they could not intuitively operate equipment properly.

Although air conditioning systems are supposed to guarantee sterile air in ORs, they create draughts and do not provide a pleasant indoor climate for everyone in theatre. Cables and tubes create trip hazards that cause falls, while identifying appropriate locations for sockets can present problems.

The different operating philosophies of manufacturers can result in accidental misuse of equipment. For example, many devices feature unintelligible symbols or have specular displays. In addition, the positioning of equipment may prevent simultaneous observation of the patient and the device. Not only is this disruptive from an ergonomic perspective, it is also relevant from a safety point of view.

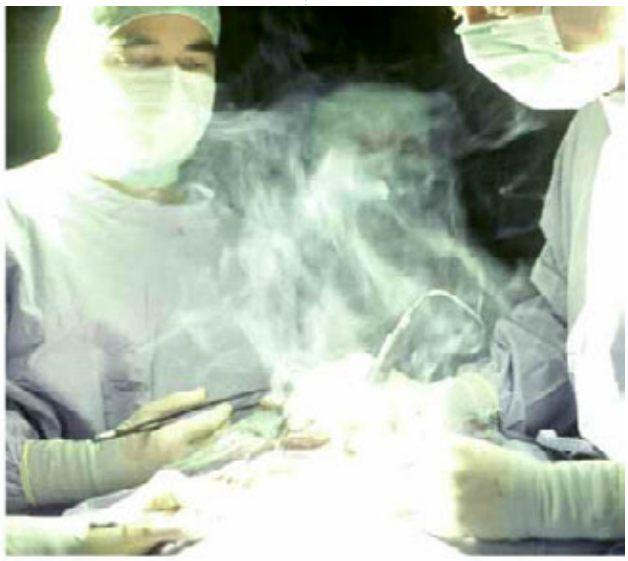
An evaluation of cases referred to the Federal Institute for Drugs and Medical Devices in Germany under medical device safety plan regulations found that between 2000 and 2006, the institute received 1,330 reports related to the use of medical devices in operating theatres. Of these cases, 42% were caused by problems in human-to-machine communications and in 90% of these incidents patient health was put at risk (Montag, 2007).

Fitness for Purpose

It is estimated that adverse events attributable to medical and technical equipment cause between 44,000 and 98,000 deaths in US hospitals each year (Kohn, 1999). Von der Mosel (1971) and Bleyer (1992) noted that two thirds of equipment errors were attributable to interaction between devices and users, as opposed to technical defects. It is estimated that the treatment of complications arising from problems with the use of equipment in intensive care wards costs German hospitals 396 million euros per annum (Backhaus, 2004).

Air Conditioning Technology

Similar problems occur in medical technology, architecture and building services engineering. Air conditioning technology is a good example of the incompatibility of components. Substantial technical and financial resources are expended on providing an air supply that should allow pure air to flow downwards from the ceiling into the operating area, thus avoiding contamination. Despite this, smoke rises during coagulation, a sure sign that the air flow is moving in the wrong direction. This fault is facilitated by the OR team and OR lighting.



Air conditioning technology: pure air and HF surgery

Conductive Flooring

The installation of conductive flooring is now standard in operating theatres. This measure was adopted to protect against the risk of explosion. However, advances in anaesthesia have eliminated the need to use anaesthetic gases that can produce combustible mixtures. For this reason, it is no longer necessary to spend large sums on the installation and maintenance of conductive flooring in operating rooms (Scherrer 2008).

Efficiency Improvements

To improve efficiency in a theatre block, the focus must be on reducing changeover times rather than the surgical intervention itself. Previous initiatives aimed at optimising changeover times have reduced turnaround by between 15% and 45% (Sokolovic 2002, Sandberg 2005, Hanss 2005, Cendan 2006). Increases in staff resources were a factor in realising these reductions. Spatial chan-

ges were confined to establishing induction and exit zones.

While every staff member knows what actions need to be performed before an operation can be successfully completed, the constituent steps do not proceed in an ordered fashion and are, therefore, inefficient. A video-based analysis of the individual steps involved in a short changeover procedure lasting just 33 minutes demonstrates the potential for structured optimisation. Activities that require the attention of staff, for example, record-keeping by clinicians and nursing staff, are repeatedly interrupted, while subprocesses, including the preparation of instruments, X-rays and so forth, can be performed outside the theatre (Kutz 2006),

Changeover procedures

An unbiased and, where appropriate, video-based analysis of the various measures, combined with training in optimised processes, could significantly improve the effectiveness of the surgical team. Sufficient architectural, building services engineering, medical-technical and staff resources are not always available to manage the process efficiently and ergonomically. In this context, investment in structures, technology and staff would be cost-effective and save staff time. The time saved by avoiding unnecessary waiting for subsequent operations can be used to provide patient care, thus improving quality and safety and enhancing patient perceptions of their treatment (establishing good customer relations). Parallel processes are required to achieve this goal, which means, for example, administering an anaesthetic to the next patient scheduled for an operation outside theatre while another patient is undergoing surgery. Patients should also emerge from anaesthesia and instruments should be removed from the instrument table outside theatre. Ideally, these steps will reduce changeover times to as little as ten minutes, while complying fully with hygiene standards. Storage activities and the application of antiseptic can be performed in induction. The patient reaches theatre after the room has been cleaned and "just in time" for his operation.

If one minute of theatre time costs 7 euros, a 25-minute reduction in changeover time would save approximately 132,000 euros per annum. Of course, more staff are required to cater to the needs of patients. However, any increase in staffing costs will be compensated for by optimised processes and associated value added. The case of a surgical area in which data on processes are recorded in exacting detail highlights the potential for success. Each week, 25 patients are operated on in two theatres and changeover times, at 30 to 35 minutes, are already very good. Nevertheless, the OR must be used for 15 hours each day before its allotted workload is complete. The data on floor plan and personnel was entered in simulation software, analysed and superimposed on the experimental OR. The simulation shows that the same number of patients could be processed in one 12-hour shift.

An additional advantage is that the full programme for the week is completed by Thursday evening at 6 p.m., leaving a day free to reduce overtime, care for outpatients and patients on the wards or increase the number of operations performed.

Against the background of these initial research findings for the experimental OR, the sensible course of action for hospital operators would appear to be to analyse and simulate their own processes to determine whether their theatres could be operated more profitably, safely and humanely with additional staff and an optimised layout.

The Experimental OR in Tübingen

To examine and further develop the issues cited above, Experimental OR and Ergonomics constructed two theatres in a 1,000 sq. m. hall, each of which was fitted out with the most advanced equipment and technologies.

Companies from the medical-technical industry, architects, planners, research structures of the state government of Baden-Wurttemberg and medical staff will work together on this live international platform to develop, realise and validate the operating room system of the future.

Workshops on specialist subjects will run alongside this process and assist the development of the project. Participating groups will also use these installations for training and education purposes. This new OR system will deliver long-term improvements in the ergonomics, safety and profitability of operating rooms over their life cycles.

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MÖLNLYCKE HEALTH CARE

Potential for improving efficiency in all areas of surgery

By Nigel Braithwaite

Whilst pressure on health care budgets increases, patients are queuing for operations. Time is therefore a valuable and limited resource in the operating theatre. Consequently, a more process oriented approach to working practices and logistics is needed to meet demands for increased efficiency and patient safety during surgical interventions.

It is a well-known fact that hospital infections cause suffering to patients and lead to additional treatment costs. If these infections can be minimised, resources could be used in a more efficient way. The battle against bacteria includes a number of preventive measures. By minimizing the number of packages containing the sterile items required for an operation, and also having as few staff in the operating room as possible for preparation work, the risk of spreading air-borne particles will be reduced. This is one important part of the asepsis procedure.

In order to offer patients safe, good quality treatment in reasonable time it is necessary to make the most of available resources. Preventing hospital acquired infections is one part of this. Another vital issue is working processes, such as set-up times for operations. Studies show that custom procedure trays, containing all the single-use medical devices needed for a specific intervention, offer significant potential for improving efficiency.

Time savings and increased efficiency

In France, a government initiative, the “Hospital 2007 Plan”, has been launched to promote modern hospital management techniques and increase efficiency in public hospitals – including purchasing methods. This, and other legal and political issues, has led to a greater focus on efficiency in the health care sector.

Related to this, in 2004 an independent French advisory board, consisting of clinical directors, pharmacists, theatre managers and nurses, compiled an inventory of the advantages of custom procedure trays in order to get a clearer picture of the benefits of their uses.

One of the overall conclusions was that custom procedure trays offer potential to improve efficiency in purchasing, storing and handling medical devices ahead of interventions. Cost reductions can be achieved as a result of simplified logistics processes, minimised waste through reduced packaging, significantly shorter preparation times and faster theatre turnarounds.

Another issue highlighted by the advisory board was that devices in a tray must comply with European Standards, both individually and as an entire package. It was also emphasised that the risk of infection can be reduced by having fewer individual packages of medical devices for an operation. Traceability can also be improved.

In Germany, a study conducted at three hospitals in 2002, the Protestant-Lutheran Hospital in Flensburg, the Georgius-Agricola Hospital in Zeitz and the Steinfurt Hospital showed great potential to save costs by the use of custom procedure. The following savings were estimated:

- Cost of in-house supply processes: reduced by 31.8 %
- Cost of procurement: reduced by 76.3 %
- Cost of daily pre-selection of surgical products: reduced by 31.1 %
- Cost of product-picking for individual surgical procedures: reduced by 57.0 %
- Operating room set-up time: reduced by 36.6 %

The study, conducted over several weeks, showed that the most substantial savings potential was linked to procurement. In addition, it concluded that in-house supply and product picking costs for individual surgical procedures can be halved.

Considerable improvements in cost-efficiency, hygiene and patient safety have also been experienced at the Starnberg Hospital, outside Munich:

“In 2005, we started to switch from multiple-use cotton textiles to single-use products and custom procedure trays to achieve the greatest possible standardisation of single-use medical devices. In my experience, the expected substantial saving in set-up time, especially in complex procedures requiring more than 30 single-use medical devices, has been accomplished. Other advantages have also come to light, such as simplified and more valid documentation, as well as simplified procurement with a significant reduction in the number of articles. This is especially true in out-patient operations performed by our consultants. The reduction of set-up times and the reliable, standardised procurement of the medical devices required, has created new efficiencies, which benefit both the hospital and the consultant performing the operations.

Altogether, operating procedures for our patients became safer, were better prepared and were carried out with a higher level of hygiene as a result of using procedure trays increasingly over the last two years.

Nevertheless we are still trying to improve our custom procedure trays and we want to extend the current usage. Today single-use custom procedure trays are used in about 80 % of our more than 500 standardised operating procedures in eleven disciplines.

Identifying total costs has become much easier with custom procedure trays and they help to meet the challenge of economising in a 'high-cost-area' such as the operating theatre" (Dr. med. Ulrich Wenning, Head of Operating Room Functions at Starnberg Hospital).

And in the UK, another study conducted in the Day Surgery Unit at Kingston Hospital, Surrey, in 2005 revealed that the total estimated average time saved for three different procedures in one year could be over 65 hours, or more than eight working days. Three procedures, treating ACLs (anterior cruciate ligament repair), hernia repair and laparoscopic cholecystectomies, were included in the study.

The authors of the study concluded that "even cautious interpretation of the data suggests that the widespread introduction of custom procedure trays would go some way to improving efficiency targets in UK day surgery units, thereby addressing one of the Healthcare Commission's major concerns".

According to the data, there is potential for faster pick and set-up times for theatre staff, increased patient throughput, faster response times for emergency procedures and a reduced risk of infection. By reducing the number of items that have to be opened for each procedure there is a potential to reduce the risk of infection for the patients. Another advantage that was highlighted in the study is that with correctly specified custom procedure trays the risk of picking errors is almost eliminated.

Applicable to all areas of surgery

Historically, surgical procedures most suited for conversion to custom procedure trays are those that require many medical devices to be routinely picked every time. However, custom procedure trays should not be limited to certain specialitievironments, such as day case surgery or emergency surgery.

This is the experience of Helen Staples, Procedure Pack Coordinator, Southampton University Hospitals NHS Trust in the UK, which have completely converted to the use of custom procedure trays. She says: "Day case surgery is the ideal scenario for the implementation of custom procedure trays, as proved in the Kingston Hospital NHS Trust time and motion study. However, in projects at other NHS Hospital trusts, it has been demonstrated that the principles and benefits can be adopted in all areas of surgery where many medical devices are routinely 'picked' for a given procedure."

She continues: "In the high spend preoperative environment, widespread acceptance of custom procedure trays across all specialties and procedures, whether major or minor, ensures consistency in practice and quality standards. The switch from multiple-use theatre textiles to single-use products also assures a constant standard in infection control for the patient and surgical team at all times."

Opportunity

The studies show that the use of custom procedure trays increases efficiency in terms of working procedures for theatre staff, logistics systems, theatre turnaround and cost control. All areas of surgery could benefit from their use and the most efficient step is to convert an entire hospital, not only parts of it.

It is vital that healthcare units and authorities in European countries exploit this potential. They should also constantly strive to further improve systems and processes so that the health care sector can meet the challenges that lie ahead. Custom procedure trays represent an important step in helping hospitals to satisfy greater demands for efficiency, while also ensuring a high level of patient safety.

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THE FRENCH HEALTHCARE **AND HOSPITAL SYSTEM**

By Jean-Luc Chassaniol, Philippe El Sair and Michel Hédouin

Social Protection System

The social protection system created in 1945 aimed primarily at workers and their families. The expansion of health insurance coverage was implemented in stages during the 1960s. The Universal Health Coverage Act (CMU) concluded this process in 1999 by establishing universal health coverage.

Today, three main health insurance schemes are dominant: the general scheme for employees and their families (84% of the population) and for CMU beneficiaries (1.6% of the population); the agricultural scheme for farmers and agricultural employees and their families (7.2% of the population); the scheme for non-agricultural self-employed people (5% of the population).

Although run by employers and employees, the social protection system always faced a strong influence of the State in the financial and operational management of health insurance.

This was reinforced by two aspects of the 1996 reform: a new income tax to fund the system instead of full financing by wage contributions; a more active role for parliament in determining policy directions and expenditure targets.

Health Policy Management

The responsibility to define the health policy and to regulate the healthcare system is divided between the State, the statutory health insurance funds and the local communities.

Since 1996, the Parliament adopts every year an Act that defines a projected ceiling for health insurance spending for the following year, known as the ONDAM. The Ministry of Health then controls a large part of the regulation of healthcare expenditure. It divides the budgeted expenditure between the different sectors and for hospital care between the different regions. It approves the agreements signed between the health insurance funds and the unions representing self-employed healthcare professionals and sets the prices of specific medical procedures and drugs. The State also defines the number of medical students to be admitted to medical school each year (numerus clausus), the planning of equipment and priority areas for national health programmes.

The Ministry of Health has services at local level: directorates of health and social affairs in the regions and departments. A process of deconcentration of the organisation and management of the French healthcare system began in the early 1990s. Regional hospital agencies are responsible since 1996 for hospital planning (for both public and private hospitals), financial allocation to public hospitals and adjustment of tariffs for private for-profit hospitals (within the framework of national agreements). The directors of those agencies are appointed by the Council of Ministers and are directly responsible to the Minister of Health.

Until 2003, hospital planning involved a combination of two tools: the healthcare mapping as a quantitative tool and the regional strategic health plan as a more qualitative tool. The healthcare mapping divided each region into healthcare sectors and psychiatric sectors. In 2003, the government decided to integrate all planning tools into the regional strategic health plan. It sets out the goals for the development of regional provision over a five-year period in areas corresponding to national or regional boundaries.

Trends and Reforms

The health system faces numerous challenges, many of which are common to other European countries. Health expenditures continue to increase more than resour-

ces, leading to budget deficits. The number of doctors will significantly decrease in the near future, coupled with the persistent unequal distribution in existing medical professionals across the country. The excessively high rates of mortality in the population under 65 show an urgent need to develop preventive actions within a coherent public health framework.

To tackle these challenges and to improve health system organisation and management, several major reforms have been introduced since 2004. They aim to change the behaviour of the stakeholders, focusing on the renewal of the organisation and management of the health system and on financial measures and incentives. The 2004 Public Health Policy and Health Insurance Reform Acts insist on the role of the state and parliament in priority setting in the health sector. They give more power to local and/or dedicated structures for implementation.

The 'new hospital governance' gives more flexibility and relative internal organisational freedom to public hospitals, despite relatively strict controls on hospital management. At a higher level, a strategic plan for health workforce development promotes group practice and also experiments with the transfer of tasks away from doctors to paramedical staff. The reforms also focussed on health information systems with the creation of a comprehensive electronic patient record, coupled with the referring doctor system in primary care.The implementation of a French-type non man - datory gatekeeping system is also built on a system of financial in - centives mainly directed towards patients. Healthcare "franchises", a new out-of-pocket payment, have been put in place in 2007 and 2008 on medical consultation, medicines, non-medical care and transports Pharmaceutical regulations also include financial incentives for pharmacists to substitute generic products for original medications when these are prescribed by doctors, as well as charging levies on the pharmaceutical industry related to advertising, sales promotion expenditures and turnover.

A new process of reform should start following the publication in the first semester 2008 of several reports on various aspects of the healthcare system (see national news p. 10).

The French Hospital System

Hospitals in France can be public, private non-profit or for-profit. But in any case patients are free to choose their hospital and will get more or less the same social insurance coverage.

Public hospitals account for a third of the 2,890 hospitals (1,599 of which acute care hospitals) but for two thirds of inpatient beds. They are legally autonomous and manage their own budget. There are four levels of public hospitals: local, general, regional and specialised. Local hospitals are providing health and social care at community level. Most of their doctors are self-employed private practitioners. General hospitals provide a range of acute care services (medicine, surgery, and obstetrics), rehabilitation, long-term care and in some cases psychiatric care. 32 regional hospitals, with a higher level of specialisation and technical capacity are in charge of more complex cases. 29 of them are linked to a university and operate as teaching and research hospitals. In addition, there are 93 psychiatric hospitals.

Non-profit hospitals are owned by religious organisations, foundations or mutual insurance associations.

They represent one third of hospitals and 15% of inpatient beds. Most non-profit hospitals are "collaborating to public service" (PSH), since they carry out public activities such as emergency care, teaching and social programmes for deprived populations.

The range of services provided by non-profit hospitals varies. In total, they account for one third of rehabilitation capacities, but less than 10% of acute care beds. 20 specific non-profit private hospitals are specialised in cancer treatment.

Private for-profit hospitals account for 40% of all hospitals in France but 20% of all inpatient beds. They tend to specialise in certain areas such as elective surgery, where they cover 2/3 of the activity. This sector invested in relatively minor surgical procedures, carrying out three quarters of cataract surgical procedures for example, but more than 60% of admissions for digestive system disorders.

FRANCE: FACTS & FIGURES

- Total population: 61,330,000
- Life expectancy at birth m/f (years): 77/84
- Birth rate: 13.5 per 1,000
- Death rate: 9 per 1,000
- GDP per capita: 26,100 euros
- Total healthcare expenditure: 11,2% of GDP
- Healthcare expenditure per capita: 3,314 $
- % of healthcare financed by public funds: 76%
- Number of beds: 235,800 acute care beds (65% public beds)
- Length of stay: 5,5 days
- Waiting lists: Negligible
- Physicians working in hospitals: 56,400 Representing 28% of all physicians

Resources and Activities

Hospitals, public and private, employ more than one million people: 80% of them in public hospitals. 14% of these employees are medical staff. Part-time work is increasing and concerns for example 20% of non-medical staff in public hospitals.

With an average of 8.4 hospital beds (including long-term care) per 1,000 inhabitants, less than half of which are acute beds, France faced a rapid downward trend in the number of hospital beds between 1980 and 2000, linked to a reduction in the average length of stay. However, there are important inequalities in bed numbers. The number of acute beds in the departments varies from 2.5 to 6 beds per 1,000 inhabitants, excluding Paris, which has more than 9.

During the same period, the number of people admitted to hospitals continued to increase. A number of policies have been implemented to encourage methods of providing care that are alternatives to in-patient care, such as day care surgery or home care. The private for-profit sector is particularly active in this field.

Since the 1960s, mental health policy in France has been based on a continuous movement towards de-institutionalisation. A key process in this movement has been to divide the country into geographical zones or areas serving a particular population and to establish a multi-disciplinary team in each zone to provide preventive care, treatment, follow-up care and rehabilitation for people living in that area and suffering from psychiatric disorders.

Each psychiatric zone is linked to a hospital (either a public hospital or a private hospital participating in the public hospital service). Quality of care has become a significant concern since the 1990s. Since 1996, all hospitals have been following a certification process, originally called accreditation.

This mandatory procedure, carried out by a specific agency, the Haute Autorité de Santé, is an external evaluation of procedures. The hospital is evaluated on several dimensions: quality of care, information given to the patient, medical records, general management (human resources, information systems, and logistics), risk prevention strategies, etc.

Reforms

A reform plan, known as 'Hôpital 2007', had set major changes in the late 1990s with the objective of improving overall efficiency and management within the hospital sector.

The first element was the modernisation of healthcare facilities by boosting investment on buildings and equipments. Total investment in hospitals has doubled between 2003 and 2006. In parallel, the organisational structure and planning of healthcare facilities have been simplified, and the health mapping, that controlled the number of beds and medical equipment authorised for each hospital was stopped. Regulatory powers have been shifted from the central level to the re - gional hospital agencies.

The second measure was the introduction of an activity-based payment system both for public and private hospitals. Previously, resources were allocated to public and private hospitals by two different methods. The public and most private non-profit hospitals had budgets allocated by the regional hospital agencies based on historical costs, with limited incentive for efficiency. Private for-profit hospitals had a billing system with different components: daily tariffs and a separate payment based on diagnostic and treatment procedures. In addition, doctors working in for-profit private hospitals were (and still are) paid on a fee-for service basis unlike those working in public and non-profit hospitals, who are salaried.
A new activity-based payment system has been implemented step by step for public and private non-profit hospitals from January 2004. A payment is made for each patient treated in acute care based on the Groupes Homogènes de Séjour (an equivalent of diagnosis-related groups) prices for the public sector. The activity-based element of the payment was supposed to increase gradually each year: 10% in 2004, 25% in 2005 and 35% in 2006.

Private for-profit hospitals have been paid entirely using the new case-mix based system since 1 March 2005. However, a transition period was allowed where 'national prices' have been adjusted, first taking into account the prices for the private sector, and second using a transition coefficient for each provider based on its own historical costs. The objective was to harmonise the prices for all providers (public and private) by 2012.

The third element has been to give public hospitals flexibility to deal with this new financial environment. The goal was to simplify the management of public hospitals and to integrate medical staff in managerial decisions. Hospitals now have the opportunity to create large clinical departments in order to organise their medical activities in a more efficient way.

Although public hospitals have obtained some freedom over their internal organisation, their autonomy is still strictly limited in other ways. The boards and executives of hospitals are still under the control of the Ministry of Health and the ARHs (Agences régionales de l'Hospitalisation). Resource allocation and most of the management rules concerning recruitment, investment strategy and the use of new interventions are still constrained.

More recently, several committees and working groups have been involved in designing a new set of reforms on the healthcare system organisation, on the creation of Health (instead of Hospital) Regional Agencies, on health inequalities and on hospitals. The issues range from geographic repartition of doctors, the demography of specialist practitioners to out-of-hours coverage.

More precisely, the main items for hospitals are: the planning of operating theatres and maternities; the new management mechanisms for public hospitals and the extension of the implementation of DRGs that already started with a case mix-based financing representing 100 % of medicine, surgery and obstetrics activities from 1 January 2008.

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AFRADESS

A catalyst for the private non-profit hospital sector

By Denis Thomas

The French Association of Managers of Healthcare, social and medical-social Institutions AFRADESS (Association française des Directeurs d'Etablissements sanitaires et sociaux) is a non-profit association open to managers and executive managers active in the private non-profit sector of healthcare (hospitals, clinics, etc), social care (emergency drop-in centres, legal placement centres, etc.) and medical-social establishments (for the disabled and elderly).
This sector covers more than 3,000 establishments and services in France.

AFRADESS aims to bring together the various components making up the non-profit sector and to work in conjunction with managing executives to take an active part in the changes affecting governance and management in the area of non-profit establishments and services.

Based on the principle that management needs to adapt to changes in the social sector and that executive managers must broaden their skills, AFRADESS aims to contribute to these changes, which can even be seen as a cultural revolution, by providing executive managers with support in the form of advice, assistance and representation in a profession which is increasingly at the forefront of developments and as such exposed to multiple unknowns.

AFRADESS has therefore set up its "SABRE" project based on the principles of Solidarity, Assistance, Benchmarking, Networking and Mutual Aid.

AFRADESS aims to:

- represent executive managers active in the various social fields involving healthcare, the disabled and elderly, as well as social care establishments;
- provide assistance to executive managers in their various functions involving the managing of establishments;
- promote the exchange of ideas, experiences, the emergence of innovative ideas and information on experimental approaches;
- develop knowledge networks, lobbying and networking between players in the various management domains;
- also provide support to executive managers who are experiencing difficulties in their managerial functions.

For this purpose, AFRADESS is:

- setting up a website, which will enable executive managers to contact the association;
- developing the "SOS Manager" unit, which has representatives in all major regions. This is a dedicated tool to promote solidarity among its members and through which a manager can obtain free, confidential assistance from colleagues when facing unexpected challenges in exercising his functions.
- helping to grow membership among executive managers in CADR'AS (insurance and legal aid contract), which is insurance coverage for criminal and civil defence in the event a manager is involved in a legal dispute with his Board of Directors;
- working to bring together within its association the various managers representing the social sector and active in the management of establishments;
- launching a new AFRADESS membership drive.

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SNCH

An advocate of public service

By Philippe El Sair

The National union of hospital managerial staff (SNCH for Syndicat national des Cadres hospitaliers) is an organisation which exclusively represents managerial staff working in hospitals.

The SNCH was founded in 1947 by financial directors. Gradually, it started accepting all hospital managerial staff. It now covers administrative and technical staff, as well as doctors and nurses.

The definition of "manager" was already set out in our charter in 1994: "a manager is a person who, as a result of a certain level of training and his hierarchical position, manages, leads, encourages, coordinates and decides. He may have operational (financial, legal, technical, etc.), human, relational or medical or care giving responsibilities which translate in particular to exercising functions involving people management."

Its independence

The SNCH provides the opportunity to join or become actively involved in an independent organisation set up to defend the interests of managerial staff, and which actively listens to its members.

The organisation is the only hospital trade union exclusively devoted to managerial staff, and the only one to be fully independent with no connection to a confederation and no political affiliation. It is financed by its members. Its national leaders are elected by all members.

The SNCH's values and effectiveness reinforce its representative character. More hospital managers are represented by the SNCH than by any other organisation. It draws in 50% of votes in professional elections and holds seats in national committees consulted by the ministry with regard to legislation and reforms which affect hospitals and their staff.

Its values

The values advocated by the SNCH are based on:

1. Its political independence, enabling it to act freely
2. The defence of its members with regard to professional ethics and statutory rights
3. The desire to promote and have recognised the value of managerial staff in hospitals
4. The involvement and participation of managerial staff in decisions concerning the operation of their hospital
5. The effectiveness of the public service in hospitals
6. The promotion of public hospitals in a social and healthcare system suited to the needs of patrons

Its action

The SNCH sets itself apart with its drive for progress and the link it maintains between hospital modernisation and statutory improvements for hospital managerial staff.

The reform of the governance of healthcare establishments and the introduction of a new pricing structure constituted an opportunity for the SNCH to put forward a modern and innovative approach to management.

The SNCH pushed for negotiations on the statutes applicable to hospital managers, and this led to a very important development in 2005 which placed their professional category in a top position.

The SNCH is an advocate of a Public service which guarantees access to healthcare and equal treatment for all and that adapts its methods. In the opinion of the SNCH, hospital staff have the responsibility of continuing to educate themselves throughout their career.

The quality of individual and group internal management is the condition sine qua non for the quality of service which patients deserve.

The SNCH is at the forefront of new ideas on managing methods for the Public service and the healthcare system. It campaigns to reform management tools in order to make them more effective.
SNCH's reflections affect all areas: hospital environment, role of the State, place and role of financing providers and elected officials, methods of regulation, scope of activity, status of facilities, etc.

ADH, SNCH and AFRADESS are all French members of the European Association of Healthcare Managers

The SNCH sees itself as a laboratory which generates suggestions that should become part and parcel of the developments of public hospitals. Its members are aware that public services are now in a context where performance requirements and international comparison are the norm.

Through its actions, the SNCH demonstrates the sense of responsibility of hospital managerial staff and their commitment to defending a humanistic and efficient idea of national solidarity in public service hospitals.

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ADH

A think tank

By Jean-Luc Chassaniol

The ADH (Association des Directeurs d'Hôpitaux) is constantly questioning the various ways of governing, sketching out healthcare "leadership skills", developing hospital executives' proficiency, supporting adjustment to ongoing reforms...

Through education programs, collective thinking, professional and institutional partnership, ADH is committed to guiding hospital directors in challenging situations and providing answers to the question: How to manage for today and tomorrow?

ADH is a professional society, founded in 1961, gathering close to half hospital executives in France (1,200 subscribers out of 2,900) .

Its composition is fully representative of the general body of hospital executives, according to geographical, generational, and statutory criteria.

Among ADH subscribers, 34% run institutions (Chief executives, "General hospital directors", District Health Agency directors), 60% are adjunct directors and 6% study at ENSP (Ecole nationale de Santé publique).

Missions : advancement, protection and guidance

ADH is dedicated to promoting the hospital director profession, defending its rights and specificities, and devising proposals concerning healthcare policy and management.

Those fundamental goals are fulfilled through various activities :

- education programs and seminars
- institutional and professional partnership (national and international)
- health policy and reforms supporting and monitoring

The Association is ruled by a Directorate composed of thirty members, whose board is in charge of strategic fields (education, current issues, communication, international affairs...). It is led by President Jean-Luc Chassaniol.

Network

ADH ensures respect of its members' religious, philosophical, political, and unionist beliefs.

It provides many resources to the whole community of hospital directors:

- A national structure and district sections in each region of France
- A proactive international program
- A communication system (DH database, yearly directory, Website, bimonthly review – 5000 prints)
- Attendance at major events (national meetings - Hopital Expo, international congresses – FIH...)

Education

- National events : "New governance" (2004), "Change management" (2005), "Sustainable Management" (2006)
- Regional seminars : crisis communications, sanitary risks, strategy, work sociology...
- MH+ department: focused on chief executives (decision-making, talent detection...)
- Peer-coaching

Collective thinking

Working groups, research, surveys : ADH produces useful references that help shaping hospital directors'identity.

- Référentiel métier : professional guideline devising the function of hospital director, based on surveys
- Grande cause fraternité : contribution to the national campaign on public service's founding value
- National survey on Hospital Directors'evaluation : conducted in 2006, this investigation examined the state system of competence assessment

Partner of Public authorities

ADH helped create a Management Institute for Hospital Directors in the future High Studies in Public Health School. ADH is also involved in the major public health issues, for instance the Avian flu State committee or the National Health organization Plan 2007-2012. Furthermore, it contributes to building links with other high civil servants body (National Education, Research...)

ADH joined EAHM in January 2006. The Association was introduced to the Board during the EAHM Dublin Congress in 2006.

By getting involved in the European community of hospital executives, ADH seeks to improve its own members' practice by referencing the variety of health management cultures, generating partnerships and joint experiences, and sharing views on public health issues. Accordingly, it wishes to get French public health executives specificities and values acknowledged.

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Paul Castel

VISIONS COMMUNES

Depuis sa création en 1972, l'Association Européenne des Directeurs d'Hôpitaux a eu pour objectif et pour mission centrale d'être à la pointe des évolutions du monde hospitalier européen et de favoriser les échanges entre les pays membres. C'est ainsi qu'au gré des évolutions technologiques, managériales, mais aussi des réformes hospitalières conduites dans les différents pays du continent, l'AEDH a largement contribué aux débats, à l'échange des idées et des expériences et permis l'émergence d'une vision européenne de l'organisation des systèmes de santé.

Les 30 dernières années ont, de ce point de vue, connu des changements considérables, qu'il s'agisse du financement des systèmes hospitaliers, de leur organisation interne ou encore des dynamiques mises en place partout pour améliorer sans relâche la qualité des soins et mesurer le niveau de qualité atteint.

Sur chacun de ces sujets, l'AEDH a pris part aux débats, a su favoriser les échanges entre les managers hospitaliers européens afin d'afficher, au-delà des différences et des spécificités propres à chaque pays membre, des visions communes. Le travail conduit par l'Association sur les systèmes d'accréditation et de certification apporte à ce titre une illustration probante. C'est en effet à partir d'une analyse des systèmes mis en place dans les différents états pour évaluer et améliorer en continu la qualité des organisations, d'une réflexion sur les différences et les points forts de chacun, que l'AEDH est en mesure d'apporter une contribution importante à l'émergence d'un standard européen en la matière, ainsi qu'en ont témoigné les débats tenus lors du dernier séminaire à Düsseldorf.

Ce nouveau numéro d'*(E)Hospital* accorde une large place aux évolutions actuelles ou à venir dans les organisations hospitalières. Des changements de fond qui auront inévitablement des conséquences sur nos pratiques managériales et nécessiteront plus que jamais des analyses communes, tant les défis à relever sont importants et complexes. C'est par exemple le cas des nouvelles technologies de soutien aux managers dont plusieurs articles se font l'écho (gestion des données multimédia, e-business...) ou encore de la salle d'opération du futur qui nous est également présentée dans ces colonnes. Par ailleurs, à la veille de la Présidence Française de l'Union européenne, *(E)Hospital* a choisi de consacrer son focus au système hospitalier français qui, à l'image de ses voisins européens, est engagé depuis plusieurs années dans un vaste mouvement de réforme et de réorganisation.

Les différents articles consacrés à ces évolutions permettront de constater, qu'au delà des spécificités organisationnelles, le même mouvement de fond est à l'œuvre dans les différents états européens, qu'il s'agisse du mode de financement des hôpitaux, de leur gouvernance ou encore de la formation des cadres dirigeants. Devant ces évolutions, l'AEDH aura, fidèle à sa tradition, le souci constant de l'échange et de la formulation de propositions. Elle participera ainsi activement aux débats qui seront initiés à l'occasion de la Présidence Française de l'Union Européenne, qui s'annonce comme un moment important pour l'avancée des politiques européennes en matière de santé, et aura à cœur de faire de son prochain Congrès, en septembre prochain à Graz, un nouveau temps fort d'échange entre les managers hospitaliers.

Pour cela, plus que jamais compte tenu de l'importance des débats en cours, l'AEDH compte sur votre participation active.

Paul Castel,
Président de l'AEDH

ORDRE DU JOUR DE LA 38 ÈME ASSEMBLÉE GÉNÉRALE ORDINAIRE DE L'AEDH

Jeudi, 25 Septembre 2008 de 9h00 – 10h30, au Landhaus Graz, Herrengasse 16, Graz.

1.	Approbation de l'ordre du jour
2.	Approbation du compte-rendu de la 37ième Assemblée générale du 16 novembre 2007 à Düsseldorf, Allemagne
3.	Rapport périodique du Président 2007-2008
4.	Approbation de modifications aux statuts de l'AEDH
5.	Soumission des comptes 2007
5.1.	Présentation par le Secrétaire général
5.2.	Rapport des Commissaires aux comptes
5.3.	Approbation des comptes 2007 et décharge du Bureau et du Secrétaire général
6.	Plan économique pour 2009
6.1	Approbation des cotisations des membres ordinaires et associés (Art. 2.4.c. des statuts)
6.2.	Approbation du budget de l'année 2009
7.	Désignation des Commissaires aux comptes pour l'année 2008
8.	Admission de nouveaux membres
9.	Congrès de l'AEDH 2010, Davos: Presentation du titre
10.	Fixation de la date de la prochaine Assemblée générale 2009

2 ÈME SYMPOSIUM DE PSYCHIATRIE A BERLIN

Les 27 et 28 mars derniers, c'est sur les rives de la rivière Spree à Berlin que la Commission « Psychiatrie » de l'Association Européenne des Directeurs d'Hôpitaux (AEDH) avait invité les managers et les professionnels européens de la prise en charge psychiatrique à assister au 2 ème symposium transfrontalier de psychiatrie intitulé « Comment renforcer l'efficience des services de santé mentale ».

L'organisation de cette rencontre dans le superbe Maritim Hotel avait une nouvelle fois été confiée à la société Rochus Fisches GmbH de Baden-Baden, véritable spécialiste du genre.

Les nombreux participants, originaires de 12 pays européens différents, ont pu entendre des exposés d'un haut niveau scientifique, mais aussi des témoignages de patients ou de parents.

Citons des thèmes tels que l'accréditation/certification des hôpitaux et des services de santé mentale (Grande-Bretagne et France), le Lean Management et sa minimisation des gaspillages (Danemark), la détection précoce des psychoses grâce à la prévention et au projet TIPS (Norvège), le point de vue des patients et de leurs difficultés à surmonter la maladie (Norvège), l'évaluation des programmes de soins via la collecte des données auprès des patients (Pays-Bas), une plus grande efficience grâce à des systèmes de financement mieux pensés (Allemagne) ou encore la plus parfaite adéquation entre les ressources humaines disponibles et les réels besoins des patients (Grande-Bretagne).

Cette journée très riche en enseignements et en échanges d'expériences a été suivie le vendredi matin par des ateliers de travail reprenant pratiquement tous les thèmes traités la veille.

En conclusion de cet excellent symposium, on peut dire sans risque de se tromper que les participants ont unanimement reconnu la qualité de son organisation mais aussi et surtout le caractère scientifique de son contenu.

Beaucoup ont souhaité l'organisation en 2009 ou en 2010 d'une 3ème rencontre du genre, sans doute sous d'autres cieux européens, encore plus ensoleillés.

Jean TEHEUX, Ancien Président de la Commission Psychiatrie de l'AEDH
Directeur d'hôpital, Lierneux - Belgique

Gestion des données médicales multimédias

Par Henning Müller, David Bandon et Antoine Geissbuhler

La production digitale de données médicales augmente de façon exponentielle dans presque tous les établissements de santé. Ces données font partie intégrante de l'aide au diagnostic et de la planification thérapeutique.

Le dossier patient électronique devient progressivement un dossier patient multimédias. Ces nouvelles sources de données doivent être incluses dans un cycle d'analyse automatique de données si on veut en exploiter tout le potentiel cognitif. La recherche d'images sur base de leur contenu en relation avec les données cliniques peut aider les cliniciens, particulièrement les moins expérimentés, à prendre des décisions et à faire usage des connaissances accumulées de façon efficace. Ceci présuppose l'accès à de larges réservoirs de données et des modifications organisationnelles ainsi que juridiques du système.

Un système de contrats harmonisé et automatisé pour les hôpitaux canadiens

Par Alex Yazdani

Medbuy négocie des contrats d'approvisionnement au nom de ses 350 membres, qui sont des hôpitaux et établissements de santé publics canadiens. La société fonctionne comme un organisme sans but lucratif, retournant réductions et abattements de co-marketing à ses membres une fois que ses frais de fonctionnement, couverts au pro rata, ont été payés. L'année dernière, Medbuy a acheté pour 600 millions de dollars et reçu presque 32 millions sous forme de réductions.

Le projet mSourcing est un nouveau système de gestion des dépenses comprenant un ensemble de logiciels qui renforce et harmonise la procédure de contractualisation du début à la fin. Il offre également et pour la première fois aux hôpitaux canadiens de véritables capacités analytiques.

Le potentiel du eBusiness pour les soins de santé

Par Ursula Hübner

Passer d'un paradigme papier à un support électronique combine toujours des opportunités inconnues avec la nécessité de réorganiser des structures et des processus de base de l'entreprise. Au contraire de la grande période d'Internet, les prestataires et fournisseurs de soins de santé d'aujourd'hui adoptent une attitude pragmatique et réaliste envers l'eBusiness. Ils se rendent compte que les incitants sont déjà présents: en plus de bénéficier de toutes les phases d'une transaction électronique (depuis la commande jusqu'à la facturation), l'eBusiness permet aux fournisseurs d'offrir des services plus complets pour aider leurs clients.

Par rapport aux premières interprétations de l'eBusiness en tant que réducteur de coûts, les experts ont appris à le reconnaître en tant qu'instrument générant des données exactes qui minimisent les erreurs de processus. Ceci débouche naturellement sur des réductions de coût mais aussi sur une sécurité accrue des soins au patient.

Les accords d'objectifs au sein des systèmes de gestion hospitalière

Par Melanie Bolenz et Heike Schinnenburg

La concurrence pressante dans le secteur de la santé encourage la formation de sociétés toujours plus importantes, dont certaines s'impliquent sur les marchés internationaux.

L'intégration d'entités jadis indépendantes représente un défi considérable, particulièrement quand leurs cultures d'entreprise sont opposées. Des études ont prouvé qu'environ 50% des fusions et acquisitions échouent, surtout parce qu'on ne tient pas suffisamment compte des «réalités douces» (soft facts).

Dans une étude comparant les styles de management au Royaume-Uni, en Suède et en Allemagne, les professionnels britanniques et suédois interrogés ont souligné l'introduction progressive d'un management orienté valeur après l'achat de leur hôpital par une grande société.

L'utilisation réussie d'accords d'objectifs exige des fondations solides. Par exemple, les managers doivent bénéficier d'une formation en développement personnel pour les aider à jouer leur rôle. Il faut leur accorder du temps et gagner leur approbation à propos des objectifs.

Rationalisation ou rationnement, un moyen pour sortir de la crise?

Par Hardy Müller

Certains hôpitaux réussissent économiquement mieux que d'autres. La question est de savoir si les exigences de rationalisation, par opposition au rationnement des services de santé, les aident et si elles sont la raison de la réussite économique de certains hôpitaux.

Le rationnement peut se définir comme une restriction de services. Il provient de la tension entre ressources limitées et exigences infinies. Quand les ressources sont limitées, l'objectif doit être d'assurer les mêmes effets médicaux et infirmiers en utilisant moins de ressources, ou de fournir un

meilleur effet avec les mêmes ressources. Le but est donc d'améliorer l'efficacité, qui est la marque de la rationalisation. La rationalisation et le rationnement sont donc deux stratégies indispensables quand les ressources sont rares. La stratégie dominante est la rationalisation dont les prestataires de services devraient porter la responsabilité, étant donné leur connaissance approfondie des processus de soins.

Comment créer de la valeur dans un environnement dynamique pour les soins de santé ?

Par Robin Alma, Eric Baart, Patrick Biecheler, Oliver Rong et Aleksandar Ruzicic

Dans un paysage européen des soins de santé en pleine mutation, les organisations redéfinissent leurs stratégies et leurs modèles de gestion. Neuf tendances sont communes à cette transition, et elles devraient être prises en compte lorsque les organisation alignent leur mode de fonctionnement sur leurs nouvelles stratégies à la frontière coût-qualité. Ces commandements communs sont: choisissez votre position sur la frontière coût-qualité, adaptez votre offre à des marchés fluctuants, mettez vos produits sur le marché et privatisez pour atteindre vos objectifs.

Bien que le marché des soins de santé doive faire face à de nombreux défis, certaines sociétés ont déjà intégré ces principes, par exemple Charité, le plus grand hôpital universitaire européen, ou Fresenius Medical Care, le leader mondial de la dialyse, se sont établis en tant que marque ou proposent des services plutôt que des produits.

Salle d'opération expérimentale à Tübingen

Par Martin Scherrer

Les salles d'opération souffrent de lacunes à plusieurs niveaux. En tant que lieu de travail, elles ne satisfont pas aux normes ergonomiques. En termes économiques, elles ont le potentiel d'exploiter des ressources supplémentaires conséquentes. De plus, l'interaction entre les différents centres médico-techniques, la gestion des équipements et les processus de travail pourrait être améliorée.

C'est pourquoi l'objectif lors de l'installation d'une salle d'opération expérimentale à l'hôpital universitaire de Tübingen était d'établir un nouveau centre qui pourrait résoudre ces problèmes et en éviter de nouveaux à l'avenir. Ceci impliquait de développer des technologies en partenariat avec l'industrie. Cette salle d'opérations est un projet unique et interdisciplinaire destiné à créer un système intégré et holistique qui améliorera la planification opératoire future. Elle permettre à l'hôpital de réaliser des économies à long terme dans leur unité fonctionnelle la plus coûteuse.

Focus France

Depuis 1996, le Parlement adopte chaque année une loi qui définit un plafond provisionnel des dépenses d'assurance maladie pour l'année suivante, sous le nom d'ONDAM. Le ministère de la santé contrôle ainsi une large part des dépenses de santé.

Jusqu'en 2003 la planification hospitalière impliquait la combinaison de deux instruments: la carte sanitaire en tant qu'outil quantitatif et le plan sanitaire stratégique régional en tant qu'outil plus qualitatif. La carte sanitaire divisait chaque région en secteurs sanitaires et psychiatriques. En 2003, le gouvernement a décidé d'intégrer tous les outils de planification dans le plan sanitaire stratégique régional. Il fixe les objectifs de services régionaux pour une période de cinq ans.

Différentes réformes ont été introduites depuis 2004. Elles visent à changer le comportement des acteurs de santé, et se focalisent sur le renouvellement de l'organisation et de la gestion du systèmes de santé, et sur les mesures et incitants financiers. Un nouveau processus de réforme est prévu pour 2008 à propos de différents aspects du système de santé.

Les hôpitaux français peuvent être publics, privés sans but lucratif ou à but lucratif. Les patients sont libres de choisir leur hôpitaux où ils bénéficieront plus ou moins de la même couverture sociale.

Les hôpitaux publics comptent environ pour un tiers des 2890 hôpitaux (dont 1599 d'hôpitaux aigus) mais pour deux tiers des lits hospitaliers.

Les hôpitaux publics et privés emploient plus d'un million de personnes, dont 80% dans les hôpitaux publics. 14% de ce personnel est médical. L'emploi à temps partiel est en augmentation et concerne, par exemple, 20% du personnel non médical des hôpitaux publics.

Un plan de réforme, appelé Hôpital 2007, a provoqué des changements importants à la fin des années 90 en voulant améliorer l'efficience générale du secteur hospitalier.

Son premier élément était la modernisation des infrastructures de santé par le biais des investissements en bâtiments et équipements. Il s'agissait ensuite d'introduire le paiement basé sur l'activité pour les hôpitaux publics et privés. On voulait également donner aux hôpitaux publics la flexibilité nécessaire pour s'adapter à ce nouvel environnement financier.

Différents commissions et groupes de travail mettent en place un nouvel ensemble de réformes sur l'organisation des soins de santé, sur la création d'Agences régionales de la Santé (plutôt que de l'Hospitalisation), sur les inégalités en matière de santé, et sur les hôpitaux.

Paul Castel

GEMEINSAME VISIONEN

Seit ihrer Gründung in 1972 hat die Europäische Vereinigung der Krankenhausdirektoren (EVKD) das Ziel gehabt, an der Spitze der Entwicklungen im europäischen Krankenhausbereich zu sein und den Austausch zwischen den Mitgliedsländern zu fördern. In diesem Sinne hat die EVKD während der technologischen Entwicklungen, den Entwicklungen im Management aber auch bei verschiedenen Reformen in den Ländern, in großem Maße zu den Debatten beigetragen, sowie den Ideen- und Erfahrungsaustausch einer europäischen Vision der Organisation der Gesundheitssysteme gefördert.

In den letzten 30 Jahren sind große Veränderungen aufgetreten, sowohl was die Finanzierung der Krankenhäuser anbelangt als auch deren interne Organisation mit einer Dynamik, die zur Verbesserung der Qualität der Versorgung sowie der Beurteilung derselben eingesetzt wird.

Bei jedem dieser Themen hat die EVKD zur Diskussion entscheidend beigetragen und hat den Austausch zwischen Krankenhausdirektoren gefördert, und hat somit über die Herausarbeitung der Unterschiede zwischen den einzelnen Ländern hinausgehend, gemeinsame Visionen aufgezeigt.

Die Arbeit der Vereinigung im Bereich Akkreditierung/Zertifizierung kann hierfür beispielhaft herangezogen werden. Ausgehend von einer Analyse der Systeme, die zur Evaluierung und Verbesserung der Qualität der Einrichtungen eingesetzt werden, wurden Stärken und Schwächen erarbeitet und die EVKD ist fähig eine bedeutenden Beitrag zu einem europäischen Standard in der Sache zu schaffen, wie dies die Debatten des hierzu organisierten Seminars in Düsseldorf gezeigt haben.

Die vorliegende Ausgabe von *(E)Hospital* zeigt in großem Maße die aktuellen und zukünftigen Entwicklungen in der europäischen Krankenhauslandschaft auf. Grundlegende Änderungen, die sich auf unser Management auswirken, machen mehr denn je eine gemeinsame Analyse nötig, zumal die Herausforderungen wichtig und komplex sind. Dies gilt z.B. für die neuen Technologien, die Manager unterstützen sollen und hier in mehreren Beiträgen (Management von Multi - mediadaten, eBusiness...) besprochen werden. Auch ein Beitrag zum OP-Saal der Zukunft sollte unsere Aufmerksamkeit genießen.

Just während der Übernahme der Ratspräsidentschaft durch Frankreich hat *(E)Hospital* auch den Länderfokus auf dieses Land und sein Gesundheitssystem gerichtet. Es zeigt sich abermals, in welchem Maße in diesem Nachbarland Reformen zur Reorganisation angestrengt werden.

Die Artikel zu diesen Entwicklungen zeigen auf, dass trotz der großen Unterschiede in der Orga - nisation der Gesundheitssysteme die gleichen Bewegungen in den verschiedenen europäischen Mitgliedsländern statt finden, sei es zum Thema Krankenhausfinanzierung, der Krankenhausführung oder der Ausbildung der Führungskräfte.

Diesen Herausforderungen gegenüber gestellt wird die EVKD, ihrer Tradition treu, den Austausch weiter voran bringen und gemeinsame Positionen erarbeiten. Die EVKD wird also aktiv an den Diskussionen z.B. innerhalb der französischen Ratspräsidentschaft teilnehmen, die sich als politisch wichtiger Moment für das Fortführen einer europäischen Gesundheitspolitik ankündigt. Sehr am Herzen liegt der EVKD natürlich auch der kommende eigene Kongress im September in Graz, bei dem der Austausch zwischen den europäischen Kollegen ein Hoch erfahren wird.

Hierfür benötigt die EVKD mehr denn je aufgrund der Bedeutung aktueller Diskussionen Ihre aktive Teilnahme.

Paul Castel
Präsident der EVKD

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.

TAGESORDNUNG DER 38. ORDENTLICHEN MITGLIEDERVERSAMMLUNG DER EVKD

abzuhalten am Donnerstag, den 25. September 2008, von 9.00-10.30 Uhr im Landhaus Graz, Herrengasse 16, Graz.

1.	Genehmigung der Tagesordnung
2.	Genehmigung des Sitzungsprotokolls der 37. Mitgliederversammlung vom 16. November 2007 in Düsseldorf, Deutschland
3.	Tätigkeitsbericht des Präsidenten 2007-2008
4.	Genehmigung der Änderungen zu den EVKD Statuten
5.	Rechnungslegung des Jahres 2007
5.1.	Vorstellung durch den Generalsekretär der EVKD
5.2.	Prüfungsbericht der Rechnungsprüfer
5.3.	Genehmigung der Rechnungslegung und Entlastung des Präsidiums und des Generalsekretärs
6.	Wirtschaftsplan für das Jahr 2009
6.1	Genehmigung der Beitragsordnung der ordentlichen und assoziierten Mitglieder (Art. 2.4.c. der Statuten)
6.2.	Genehmigung des Wirtschaftsplanes für das Jahr 2009
7.	Wahl der Wirtschaftsprüfer für das Jahr 2008
8.	Aufnahme neuer Mitglieder
9.	EVKD Kongress 2010, Davos: Präsentation des Haupthemas
10.	Nächste Ordentliche Mitgliederversammlung 2009

2. EVKD PSYCHIATRIE SYMPOSIUM IN BERLIN

Am 27./28. März hat die Arbeitsgruppe Psychiatrie der Europäischen Vereinigung der Krankenhausdirektoren Manager aus der Psychiatrieversorgung nach Berlin eingeladen, um das zweite grenzüberschreitende Symposium „Wie die Effizienz der Psychiatrie gesteigert wird" abzuhalten.

Die Organisation des Treffens im schönen Hotel Maritim war einem gut bekannten Baden-Badener Unternehmen übertragen. Zahlreiche Teilnehmer aus 12 verschiedenen europäischen Ländern, hörten den Vorträgen mit hohem wissenschaftlichen Niveau zu, aber auch den Aussagen von Patienten und Angehörigen.

Einige wiederkehrende Themen waren Akkreditierung/Zertifizierung für Krankenhaus- und mentale Versorgung (Großbritannien und Frankreich), Lean Management und Effizienzsteigerung (Dänemark), Früherkennung von Psychosen durch Prävention durch das TIPS-Projekt (Norwegen), die Perspektive von Patienten und deren Schwierigkeiten, die Krankheit zu besiegen, und die Beurteilung von Pflegeprogrammen durch das Sammeln von Patientendaten (Niederlande).

Weiterhin wurde diskutiert, wie die Effizienz verbessert werden kann durch ein besser organisiertes Finanzierungssystem (Deutschland) oder eine optimale Verknüpfung von Humanressourcen und tatsächlichen Patientenbedürfnissen (Großbritannien).

Dieser sehr reiche Austausch und Wissensvermittlung wurden am nächsten Tag in Workshops zu obig genannten Themen noch fortgesetzt. Im Fazit kann man sagen, dass die Teilnehmer zu diesem hochwertigen Symposium einstimmig dessen hohe Qualität und vor allem den hohen wissenschaftlichen Wert anerkannt haben.

Viele haben den Wunsch geäußert, an einer weiteren Konferenz teilzunehmen, die in 2009 oder 2010 organisiert werden könnten, vielleicht in einem sonnigeren Teil Europas.

(Rückblick von Jean Teheux, ehemaliger Vorsitzender der EVKD Arbeitsgruppe Psychiatrie, Krankenhausdirektor, Lierneux, Belgien)

Das Potential des eBusiness für Gesundheitsdienste

Von Ursula Hübner

Das Wechseln von Papier- zu elektronischen Prozessen birgt ungeahnte Möglichkeiten, aber auch die Notwendigkeit, Strukturen und Prozesse neu zu überdenken. Im Gegensatz zum Wachstum des Internet haben Gesundheitsdienstleister und Hersteller im Gesundheitsbereich eine eher pragmatische und realistische Einstellung zum eBusiness. Sie erkennen, dass es bereits genügend Gründe für einen Wechsel gibt: zusätzlich zu den Vorteilen einer elektronischen Transaktion (von dem Order bis zur Rechnung), bietet das eBusiness den Dienstleistern die Möglichkeit, eine umfassende Leistung anzubieten.

Im Vergleich zum ersten Ansatz, dem eBusiness als Möglichkeit, Kosten einzusparen, haben die Experten zwischenzeitlich erkannt, dass es auch die Möglichkeit bietet, Daten zu generieren, die Fehler in den Prozessen reduzieren. Dies bringt natürlich ebenfalls eine Kostenersparnis mit sich, aber auch eine erhöhte Patientensicherheit.

Das Management medizinischer Multimediadaten

Von Henning Müller, David Bandon und Antoine Geissbuhler

In fast allen medizinischen Einrichtungen erhöht sich die digitale Produktion medizinischer Multimediadaten um ein Vielfaches. Diese Daten sind integrierter Bestandteil der Diagnostik und der therapeutischen Planung. Die elektronische Patientenakte wird zunehmend eine Multimediaakte des Patienten. Diese neuen Datenquellen müssen in einem Zyklus der automatischen Datenanalyse überprüft werden, um das gesamte Potential ausnutzen zu können. Die Suche nach Bildern aufgrund ihres Inhalts im Zusammenhang mit klinischen Daten kann Klinikern helfen, vor allem den weniger erfahrenen, Entscheidungen zu treffen und effektiv von gesammeltem Wissen zu profitieren. Dies setzt den Zugang zu einem großen Datenpool voraus, sowie Veränderungen in der Organisation sowie dem juristischen System.

Harmonisierte und automatisierte Einkaufs - verträge für kanadische Krankenhäuser

Von Alex Yazdani

Medbuy verhandelt Einkaufsverträge im Namen von 350 Mitgliedern: Krankenhäuser und Gesundheitseinrichtungen im kanadischen Gesundheitssystem. Die Gesellschaft funktio - niert wie ein Verein ohne Absicht auf Gewinnerzielung, der Preisabschläge und gemeinsames Marketing an seine Mitglieder weiter gibt, sobald die eigenen Kosten bezahlt sind.

Im letzten Jahr hat Medbuy für 600 Millionen Dollar eingekauft und fast 32 Millionen Dollar dabei in Form von Preisreduzierungen an Einsparungen erzielen können. Das Projekt mSourcing ist ein neues Managementsystem für Ausgaben, bestehend aus mehreren Softwares, welche die Einkaufsverfahren vom Anfang bis zum Ende harmonisieren. Auch bietet das System kanadischen Krankenhäusern zum ersten Mal veritable Analysemöglichkeiten.

Zielvereinbarungen als Bestandteil von Führungssystemen in Krankenhäusern

Von Melanie Bolenz und Heike Schinnenburg

Der Wettbewerbsdruck im Gesundheitsbereich fördert zunehmend die Bildung von größeren Konzernen, die teilweise auch international agieren. Die Integration bisher selbstständiger Einheiten stellt jedoch gerade bei sehr unterschiedlichen Unternehmenskulturen eine Herausforderung dar. So weisen Studien immer wieder darauf hin, dass die Misserfolgsrate für Mergers & Acquisitions bei ca. 50% liegt, weil insbesondere die so genannten „soft facts" zu wenig Beachtung finden.

Die hier besprochene Studie beschäftigt sich mit der Frage, wie Führungsinstrumente in ausgewählten Krankenhäusern in Schweden, England und Deutschland genutzt und von den Mitarbeitern wahrgenommen werden. Am Beispiel des Instrumentes „Zielvereinbarung", das in Theorie und Praxis als etabliert gilt, lassen sich erhebliche Unterschiede innerhalb dieser Krankenhäuser feststellen.

Für die erfolgreiche Anwendung von Zielvereinbarungen müssen zunächst Grundlagen geschaffen werden. Dazu gehörte beispielsweise, Führungskräfte auf ihre Aufgabe durch entsprechende Personalentwicklung vorzubereiten, ihnen Zeit für Führung zu geben und mit ihnen selbst Ziele zu vereinbaren.

Rationalisierung oder Einteilung – eine Weg aus der Krise?

Von Hardy Müller

Manche Krankenhäuser erzielen bessere wirtschaftliche Ergebnisse als andere. Die Frage ist, ob Rationalisierung im Vergleich zur besseren Einteilung der Gesundheitsdienste diesen dabei helfen und der entscheidende Faktor für den Erfolg einiger Krankenhäuser sind.

Die Einteilung definiert sich als eine Restriktion in Diensten. Sie entsteht durch das Verhältnis von limitierten Ressourcen und steigenden Ansprüchen. Wenn Ressourcen limitiert sind, muss das Ziel sein, gleiche medizinische Ergebnisse zu erzielen oder ein besseres Ergebnis mit den gleichen Ressourcen zu erzielen. Das Ziel ist also, die Effektivität zu steigern, die der

Hauptfaktor in der Rationalisierung darstellt. Rationalisierung und Einteilung sind zwei erforderliche Strategien, wenn Ressourcen schmäler werden. Die dominierende Strategie ist die Rationalisierung, wofür die Gesundheitsdienstleister die Verantwortung tragen sollten, da sie über profunde Kenntnisse in diesen Bereichen verfügen.

Wie können Werte in einem dynamischen Umfeld für Gesundheitsdienste geschaffen werden?

Von Robin Alma, Eric Baart, Patrick Biecheler, Oliver Rong und Aleksandar Ruzicic

In einem stetig wachsenden, europäischen Umfeld der Gesundheitsdienste, definieren Dienstleister ihre Strategien und Managementsysteme neu. Neun Trends gilt es hier zu beachten, die einer Adaptierung an neue Strategien und mit dem Ziel Qualität-Kosten vor Augen: zunächst muss eine Positionierung im Bereich Qualität-Kosten erfolgen, das Angebot muss den Schwankungen des Marktes angepasst werden, die Produkte müssen vermarktet werden und es gilt sich zu privatisieren, um die Ziele zu erreichen.

Obwohl der Gesundheitsmarkt zahlreichen Herausforderungen gegenüber steht, haben einige Anbieter diese Prinzipien schon verinnerlicht, z. B. Charité, das größte Universitätskrankenhaus in Europa oder Fresenius Medical Care, der weltweite Leader in der Dialyse: sie haben sich als Marke etabliert und bieten eher Dienste als Produkte an.

Experimenteller OP in Tübingen

Von Martin Scherrer

OP-Säle leiden unter mancher Vernachlässigung. Als Arbeitsort entsprechen sie ergonomischen Normen nicht. Unter wirtschaftlichen Gesichtspunkten haben sie das Potential zusätzliche Ressourcen auszunutzen. Die Interaktion zwischen den verschiedenen medizin-technischen Zentren, das Management der Teams und die Arbeitsverfahren könnten verbessert werden.

Aus diesen Gründen war das Ziel bei der Errichtung eines neuen, experimentellen OP-Saals in Tübingen, ein neues Zentrum zu schaffen, das diese Probleme beseitigen und zukünftige Probleme vermeiden könnte. Dies implizierte, dass Technologien in Zusammenarbeit mit der Industrie erarbeitet werden mussten. Der OP-Saal ist ein einmaliges, interdisziplinäres Projekt, das ein integriertes und holistisches System schafft, das die OP-Planung verbessern wird. Dies wird dem Krankenhaus auf lange Sicht Kosteneinsparungen in einem der kostenintensivsten Bereiche ermöglichen.

Focus Frankreich

Seit 1996 verabschiedet das französische Parlament jedes Jahr ein Gesetz, das die Ausgaben, welches das vorläufige Budget der Krankenversicherung für das kommende Jahr festlegt. Dies geschieht unter dem Namen ONDAM. Der Gesundheitsminister hat hiermit eine große Kontrolle über die Gesundheitsausgaben.

Bis 2003 implizierte die Krankenhausplanung eine Kombination zweiter Instrumente: die Gesundheitskarte als quantitatives Instrument und den Gesundheitsplan, eine regionale Strategie, die sich mehr auf die Qualität bezieht. Die Gesundheitskarte unterteilte jede Region in Gesundheitsbereiche und Bereiche der Psychiatrie. In 2003 entschied sodann die Regierung, alle Planungsinstrumente in den strategischen regionalen Plan zu integrieren. Dieser setzt nunmehr die Ziele der regionalen Dienste für fünf Jahre fest.

Verschiedene Reformen sind seit 2004 erfolgt. Diese verändern die Verhaltensweisen der Gesundheitsakteure und zielen darauf ab, die Organisation und das Management des Gesundheitssystems sowie finanzielle Aspekte zu erneuern. Ein neuer Reformprozess zu mehreren Themen ist in 2008 geplant.

Französische Krankenhäuser können öffentlich privat mit oder ohne Gewinnerzielungsabsicht sein. Patienten können ihre Krankenhäuser selber aussuchen und haben in diesen mehr oder weniger den gleichen Versorgungsanspruch.

Die öffentlichen Krankenhäuser machen ca. 1/3 der 2.890 Krankenhäuser aus (von denen 1599 Krankenhäuser in der Akutversorgung) aber für 2/3 der Krankenhausbetten.

Öffentliche und private Krankenhäuser beschäftigen zusammen mehr als eine Million Menschen, 80% hiervon in öffentlichen Krankenhäusern. 14% des Personals ist medizinisches Personal. Teilzeitarbeit nimmt zu und betrifft 20% des nicht medizinischen Personals in den öffentlichen Krankenhäusern.

Ein Reformplan, genannt „Hôpital 2007“, hat Ende der 90er Jahre bedeutende Veränderungen mit sich gebracht, und hatte das Ziel, die generelle Effizienz im Krankenhausbereich zu steigern.Das erste Element war die Modernisierung der Infrastrukturen im Gesundheitsbereich durch mehr Investitionen in Gebäude und Ausrüstung. Es gab weiterhin eine Reform der Finanzierung, die nunmehr nach Tätigkeit des (öffentlichen oder privaten) Krankenhauses erfolgt. Krankenhäusern wurde eine gewisse Flexibilität eingeräumt, um sich an diese neue Finanzierungsart anpassen zu können.

Verschiedene Kommissionen und Arbeitsgruppen setzen nun einen neuen Reformplan zur Organisation der Gesundheitsversorgung auf, wie das Einrichten regionaler Gesundheitsagenturen (im Gegensatz zur stationären Aufnahme) und bezüglich der Ungleichheiten in der Versorgung....

September

9ème Conférence internationale sur la Science des Systèmes de Santé 3-5
Lyon, France
(Nouvelles technologies de l'information et gouvernance des systèmes de santé)
www.icsshc2008.org/index.htm

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

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

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

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

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

October

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

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

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

November

World of Health IT 2008 4-6
Bella Center, Denmark
www.worldofhealthit.org

Internationaler Kongress der Oö. Ordenspitäler "Wertewandel in der Medizin – Ein neuer medizinischer Wertekanon?" 6
Linz, Austria
www.okh.at (Aktuelles)

Medica - 40th World Forum For Medicine 19-22
Düsseldorf, Germany
www.medica.de

RSNA 30-5
Chicago, US
http://rsna2008.rsna.org/

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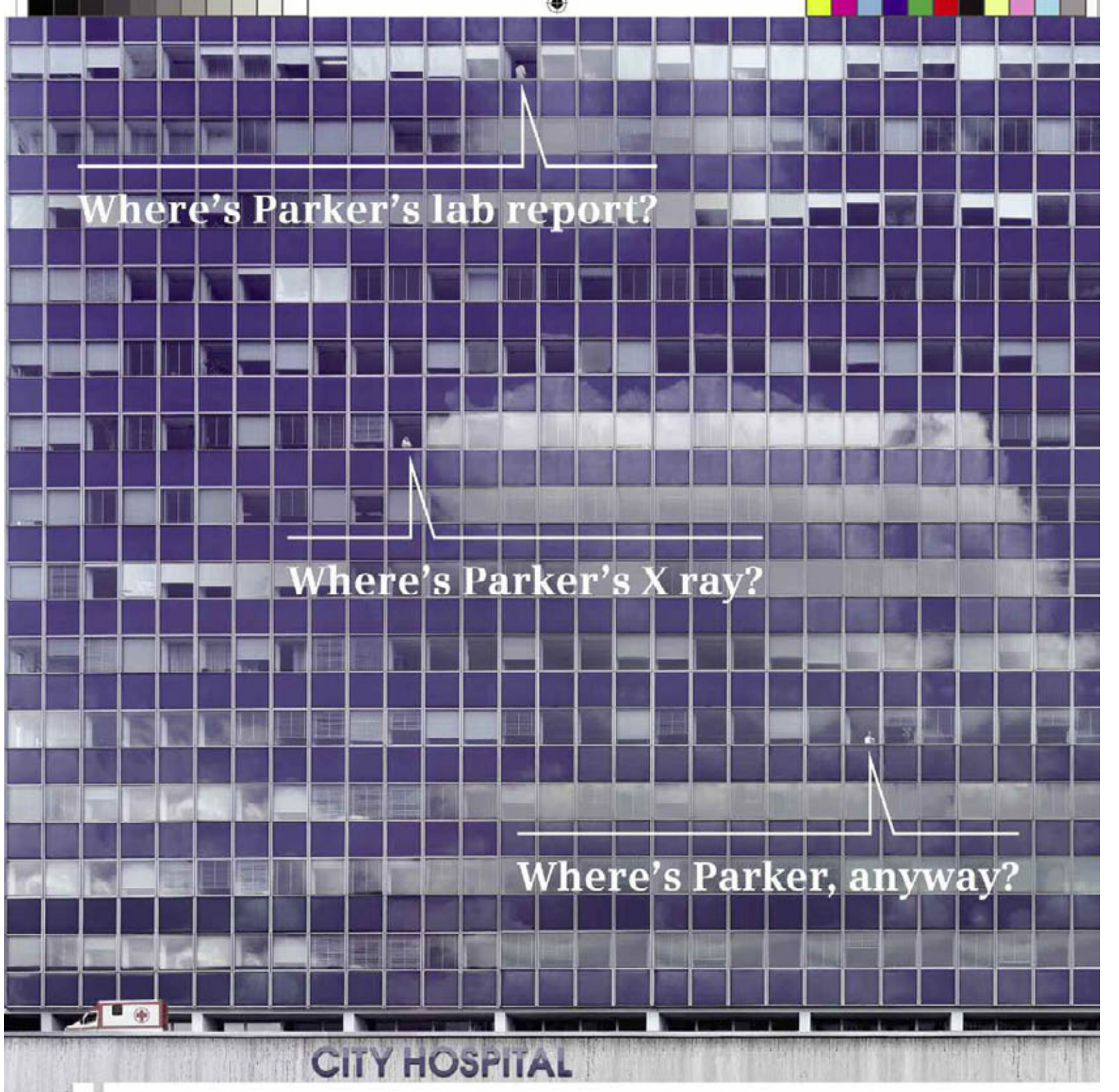

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