Hospital

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

VOLUME 10 • ISSUE 1/2008 • FEBRUARY/MARCH• €15

ISSN=1374-321X

OUTSOURCING

Risk Management

PLUS

- Interview with EU Commission Director Rys
- Focus: Austria

OFFICIAL JOURNAL OF THE EUROPEAN ASSOCIATION OF HOSPITAL MANAGERS

Pioneers of Vision

Outstanding!
Up to 24-inch
detector diagonals

Sonialvision Safire II

High-performance RF universal system, remote-controlled

- world-wide first integrated large field flat-panel detector with direct conversion
- patented RSM-DSA technology (Real-time Smooth Mask DSA)
- outstanding image quality
- future-proof for new applications, for instance tomosynthesis

RADspeed Safire

High-tech radiographic system

BRANSIST Safire

Cardiology system

Opescope

Mobile surgical C-arm

MobileArt

Mobile X-ray system, motor-driven

With its visionary technology, Shimadzu has always offered physicians new possibilities for diagnosis, such as the development of the first commercial X-ray instrument in Japan soon after the discovery of X-rays. Countless patents and world premieres, setting the standard today, have contributed to Shimadzu's leading role in diagnostic imaging.

Shimadzu is also a pioneer in the groundbreaking direct-conversion FPD technology:

- direct conversion of X-rays to digital image data
- cassettes and X-ray films are unnecessary
- much higher image quality and expanded diagnostics
- radiation dose reduced by half
- fully digital and faster data handling
- full DICOM-compatibility.

Direct-conversion FPD is the technology of the 21st century. It is the present as well as the future. Shimadzu's X-ray and fluoroscopy systems are economical, meet the highest diagnostic requirements and are easy to operate.

Shimadzu Europa GmbH
Albert-Hahn-Str. 6-10 · 47269 Duisburg, Germany
Phone: +49(0)203-7687-0 · Fax: +49(0)203-766625

www.shimadzu.eu

SHIMADZU
Solutions for Science
since 1875

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

The year 2008

Heinz Kölking

2007 may be behind us but challenges remain in all areas of life. These include the need to continue to build our common European home. In 2008, Slovenia and, subsequently, France will assume the presidency of the European Council. In the field of health policy, the Board of the EAHM, assisted by its Subcommittee on European Affairs, will place vital issues affecting hospitals on the European agenda.

These include questions relating to cross-border cooperation between hospitals, funding for hospital services and accreditation of hospitals. A further issue arises from the different position in the EU member states regarding the role of the state in the provision of health services. In the final analysis, however, the key task from a hospital perspective is to determine critical success factors in terms of the quality of service delivery and the economic viability of hospitals. Does the profit motive or the public interest – or a combination of the two - optimise cost efficiency and quality? What should be the role of the state in the provision of medical and care services? How much privatisation and commercialisation can the inpatient care sector tolerate? What will be the future role of the so-called "third sector" – the not-for-profit healthcare providers? The EAHM and its member associations do not take an ideological position on these matters. Our organisation consists of hospital managers and chief executives from state, private and not-for-profit institutions.

This edition of *E-Hospital* focuses on risk management in hospital, a key, multi-dimensional issue that is also a vital building block for quality management. It is, therefore, a prerequisite for achieving lasting success in every hospital. A question repeatedly asked in hospitals is which services and tasks should be organised internally and which should be outsourced. This issue is addressed in all its complexity in this edition of *E-Hospital*.

The EAHM will hold its 22nd European Congress in 2008, this time in the beautiful Austrian city of Graz on 25 and 26 September. The focus of the agenda is the fascinating issue of leadership in and by hospitals, set against the backdrop of the wide-ranging challenges they face in the areas of patient care, human resources, politics, economics, management and ethics. This topic provides an excellent starting point for our congress and will advance our ongoing efforts to learn from one another, engage in meaningful debate and arrive at a common view of the future of our hospitals.

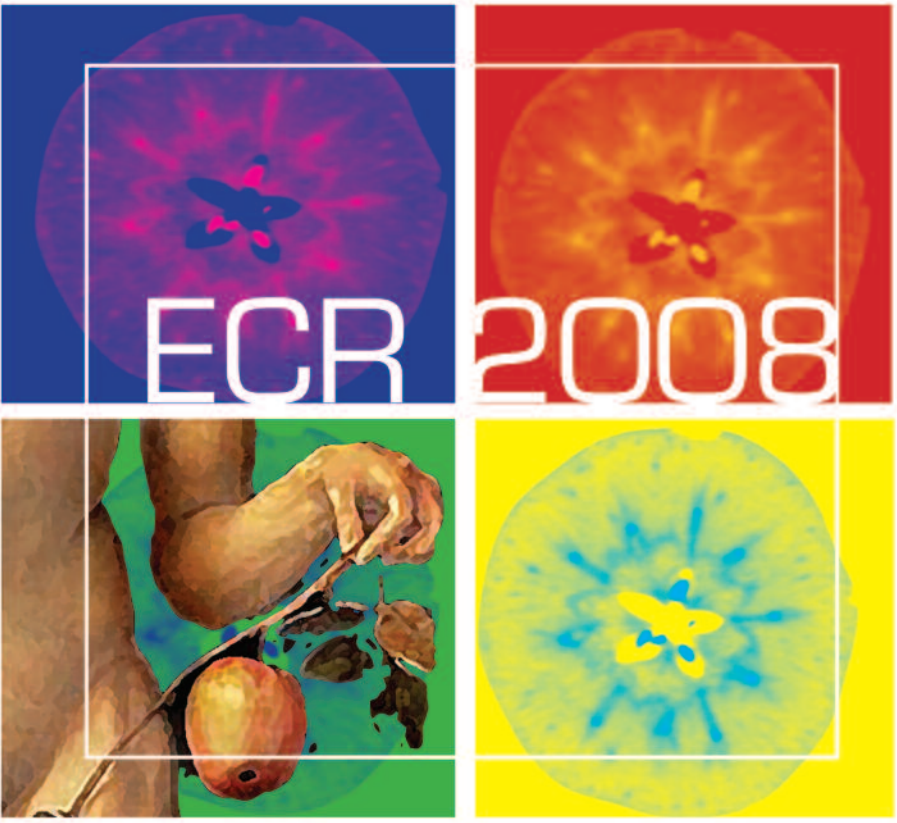
The country focus section provides an overview of the host country of Austria and its health system.
Against the background of our most recent congresses in Dublin and Oslo and our excellent seminar in Düsseldorf, we look forward to the forthcoming EAHM congress and cordially invite our readers to attend. Come to Graz!

Heinz Kölking
EAHM Vice-President

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

ESR
European Society of Radiology

Innovation builds talent

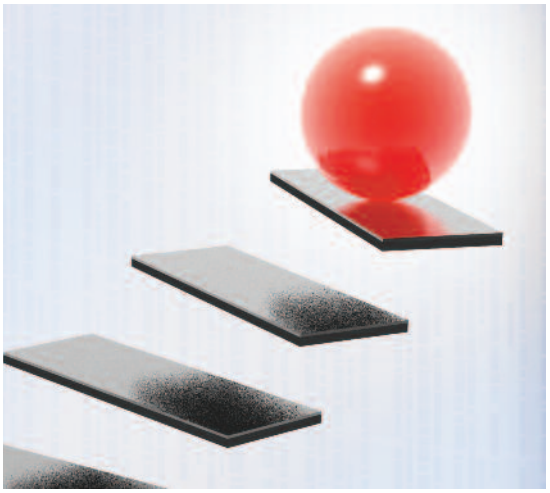


European Congress of Radiology
March 7–11, 2008, Vienna / Austria

See you in Vienna!

March 7–11, 2008

myESR.org



RISK MANAGEMENT

As technology becomes more and more sophisticated and patients increasingly informed and demanding, risk management should be an integral part of any hospital's strategy. Its many aspects are reflected in this issue: practical first, Mr Marzi's legal approach and Professor Fenn's study on the relationship between risk management incentives and MRSA levels; and more theoretical, with Ms. Cartes's six point plan for the efficient elaboration of a risk management plan. Professor Pliskin tells us about a special type of risk: high technology purchasing decisions.

PAGE 14-19

OUTSOURCING

Outsourcing is one of our recurring themes, as our readers will notice. It is definitely one of the pivotal trends of hospital management of the last decade. Professor Parvinen first analyses general outsourcing trends, while Professor Moschuris gives us a geographically narrower overview of the outsourcing situation in his country, Greece. Mr Dröscher practically illustrates this option by reporting on a direct delivery system to the OR.

PAGE 22-27

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

Editor-in-Chief and Publisher
Willy Heuschen
Secretary-General of the EAHM
willy.heuschen@eahm.eu.org
General Secretariat:
EAHM
Boulevard du Jardin Botanique, 32
B-1000 Brussels
Tel.: +32 (2) 733.69.01
Website: http://www.eahm.eu.org

VOLUME 10 - ISSUE 1/2008 - FEBRUARY/MARCH

FOCUS : AUSTRIA

Austria is a federal country whose health authorities have realised early on the challenges of demographics and evolving financing structures. The nine Länder have major competences in the health sector, and delivery of services is uneven in rural and urban areas. The Federal Con - ference of Austrian Hospital Managers (BUKO) is an extremely active association both on the national and international stage, and will host this year, and for the third time, the Congress of the European Association of European Managers.

PAGE 33-37

MEDTECH

FOCUS : AUSTRIA

Thinking of you

Electrolux

New

Boiling and braising pans
Cook in a new generation

With the new therma *line* boiling and braising pans excellent cooking results are always guaranteed thanks to its uniform and fast heat distribution on all surfaces which assures higher productivity in a shorter time.
The new boiling and braising pans have a protection 8 times higher against the strongest jets of water (IPX6).

www.electrolux.com/professional

Swiss made from 1871

therma *line*

Share more of our thinking at www.electrolux.com

37th EAHM General Assembly in Düsseldorf

Delegates from numerous EAHM member countries gathered in Düsseldorf on 16 November 2007 for the association's General Assembly, which was held in parallel with an EAHM seminar on accreditation (see report on page 7). Members were welcomed by their German colleagues and many availed of the opportunity to attend what was - as many participants later attested - a high quality continuing education seminar. A series of other simultaneous events - the German Hospital Conference, the Golden Helix Awards for 2007 and the MEDICA exhibition - also proved popular.

Opening the General Assembly, EAHM President Paul Castes announced that Willy Heuschen's term as General Secretary would be renewed for a further five years (2008-2012), a decision which was greeted with widespread approval among delegates. Mr. Heuschen expressed his pleasure at being able to continue in his current role and thanked delegates for their vote of confidence in him. He added that he hoped to be able to count on the support of EAHM members in the future.

The President then presented his activity report, a comprehensive account of the activities of the various organs of the association since Mr. Castel was elected to the position in September 2006. During this period, the EAHM work programme was largely devoted to organising the accreditation seminar held the previous day, circulating public statements on planned European Union measures in healthcare and plans to commence a partnership project with hospital IT managers around Europe.

In 2006, the EAHM carried out a survey of members, of which more are planned, on their efforts to measure patient satisfaction. This initiative was followed in 2007 by a survey on mobility among health service staff. This type of activity marks a new departure for the EAHM. Surveys of this nature are simple, unbureaucratic measures which allow the association to better determine members' positions on topical issues and help build a better picture of the organisation of healthcare in Europe.

Mr. Castel then briefed members on two position papers adopted by the EAHM as part of the European Commission's consultation exercise on health services.

The documents focused primarily on quality assurance and hospital accreditation. The latter issue was the driving force behind the previous day's seminar and further activities have been planned for 2008 to consolidate the association's ongoing work on both issues. Most of these will be organised during France's presidency of the European Council in the latter half of the year.

Mr. Castel then addressed proposals to extend EAHM membership to other national associations in Central and Eastern Europe, including Romania. Delegates approved Romania's application to join the EAHM pending a positive outcome to the President's visit to the country.

While Bosnia-Herzegovina's application has not been ruled out, it remains a long-term prospect.

The action programme also includes the continuation of current projects and, of course, the organisation of the 22nd EAHM Congress in Graz, the primary focus of all EAHM activities.

Moreover, the work programme will feature plans to hold a new event in 2009. The EAHM will also monitor EU activities and develop policy positions, where appropriate.

The activity report is available in full on the EAHM website.

General Secretary Willy Heuschen then reported on the 2006 financial accounts and the budget for 2008. He first noted the good news that the statement of accounts was closed with a surplus of approximately €4,000. With the agreement of the Board, additional reserves will be allocated for new EAHM activities in order to be able to provide members with a comprehensive package of services. Delegates unanimously approved the statement of accounts and budget, which the auditors had previously certified as accurate.

In conclusion, Mr. Nikolaus Koller, Austria's representative on the EAHM Board and President of the Federal Conference of Hospital Managers in Austria, briefed delegates about the forthcoming EAHM congress in Graz, providing details of the city, the congress agenda and the themes chosen. His invitation to attend what promises to be an excellent event was welcomed on all sides.

The next EAHM General Assembly will be held on the morning of 25 September 2008 in Graz, just before the official opening of the congress. We cordially invite all our readers to the event and look forward to a large attendance.

EAHM SEMINAR

Our association organised its first seminar on 16 November last, on the occasion of the MEDICA 2007 forum in Düsseldorf. Its theme was carefully selected for its up-to-the-minute nature and its pan-European and cross-border characteristics: hospital quality assessment tools. This general heading was followed by questions in the form of a debate to be initiated: towards a voluntary European accreditation system?

In addition, our previous edition discussed this same theme, in order to prepare our readers to tackle the issue in an informed manner.

This dense and extremely educational seminar was attended by some sixty EAHM members, who not only listened attentively to the high-quality speakers, but also actively participated in the round table discussion that took place in the afternoon.
The seminar opened with a word of welcome from Asger Hansen, chairman of the scientific subcommittee that selected the subject and speakers. He emphasised the necessity for a common European hospital accreditation system, which has already been the subject of a statement from the association following the consultation initiated by the European Commission. This accreditation system would contribute to the structuring of crossborder care that is increasingly present in the current reality of hospitals.

The first speaker, Dr. Charles Shaw, is considered an authority in the field of quality assessments. He painted a thorough picture of the national initiatives taken in this domain in several European countries and of the active role played by various international authorities (WHO, Council of Europe, etc.). He also spent time speaking about the different and complementary motivations of the various players in the healthcare sector: not only the patient who wants to be able to compare European hospitals on a common basis and healthcare professionals whose European recognition of qualifications encompasses a harmonisation of hospital organisation and services, but also insurance companies and governments.
In conclusion, Dr. Shaw expressed his enthusiasm for an initiative coming from an organisation such as the European Association of Hospital Managers in favour of an accreditation system. Such an initiative would respect the principle of subsidiarity and undoubtedly have a better chance of spreading quickly than intergovernmental negotiation.

Part of the audience during the seminar

Professor Vleugels also illustrated this path by describing a large-scale project in a Belgian hospital group to outline a possible future accreditation model.

Dr. Andrzej Rys, Director of the public health department of the DG Health and consumer protection at the European Commission listened to our members' opinions as technical experts on the European hospital situation and communicated the Commission's projects and initiatives on European public health. The Commission aims to provide a legal framework to healthcare services, particularly in a crossborder context, and to finance innovative projects in various domains of public health. You can learn more about the new directive regulating healthcare services and its contribution to hospital accreditation by reading the interview with Dr Rys on page 11.

The afternoon continued with the presentation of quality assessment projects in the Netherlands (Laurens Touwen), Denmark (Dorte Bagger) and Germany (Rainer Hilgenfeld) and an intensive dialogue between all the day's participants and the audience. There is no doubt that everyone came out of the event better informed and mobilised with this new path to be plotted out.

We also note that the Golden Helix Award 2007 ceremony was held that day under the aegis of the German association of hospital managers and two sponsors. The prize rewards innovative patient-oriented projects that aim to improve quality based on data and facts. This 15th edition rewarded a Styrian (Austria) quality development project for treating patients suffering from acute coronary syndrome and a German project on quality indicators in the domain of psychiatric care.

Slovenia takes on EU Presidency

Having taken over the Slovenian presidency on 1 January 2008, Slovenia announced the following main priorities for action during the next six months: a focus on Western Balkans relations, energy and climate change, and the implementation of the new Lisbon cycle for growth and jobs. Concerning the area of health, the Slovenian presidency programme stated:
"The EU wishes actively to promote health, prevent diseases and improve access to healthcare, particularly in the light of population ageing and the diversity of health outcomes within and between the member states. As cancer poses one of major health challenges in Europe, the Presidency will give special consideration to an integrated approach to tackling cancer through EU policies and activities.
In the context of health services, the Presidency will also seek to make progress with discussions on cross-border health care."

More information available at :
http://www.eu2008.si/includes/Downloads/misc/program/Programme_en.pdf

State aid for public hospitals in Germany – Commission response

On 20 January 2003, the Asklepios Clinics lodged a complaint with the European Commission to contest the award of allegedly unlawful aid to public hospitals by the German public authorities, comprising compensation, on a case-by-case basis, of any operating losses and the provision of a guarantee by the respective public bodies in favour of those hospitals.
The European Commission in November took the decision to no longer investigate in the case. Public subventions also for institutions of general interest are in principle in line with EU competition law.

The EU body recalled however that hospitals need to respect the Montipackages: this means that in their yearly accounts, hospitals have to clearly distinguish between services of general interest and all other services they offer, i.e. ambulatory services. No subventions would be allowed for these latter services.

Working time directive – no agreement

Meeting on 5 December in Brussels, the Employment, Social Policy, Health and Consumer Affairs Council sought to reach political agreement on the draft Directive on the organisation of working time.

The Presidency presented a compromise proposal, by suggesting to work on a simultaneous and integrated solution on two draft directives in connection to each other, and thus allowing member states to find a balance between the two.

The connection between the two directives, and more specifically the proposals presented by the Presidency, was considered a solid and viable basis for negotiation towards an agreement in both.

The Council agreed that the best option at this moment was to postpone a decision, in order to further pursue the dialogue.

The Presidency noted that a vast majority of member states had spoken in favour of an integrated solution for the directives, which is a major step forward, because they now open an adequate way to reach a solution in these files.

Commission launches job mobility action plan

On 10 December 2007, the European Commission presented a new action plan to promote job mobility. The plan aims to tackle the remaining obstacles faced by people seeking to work in another EU country. It puts forward a new integrated approach and lists 15 concrete actions for the period 2007-2010. Until today, worker mobility in the EU remains relatively low – around 2% of working age citizens from one of the 27 EU member states currently live and work in another member state. The action plan covers four main areas:

• Improving existing legislation and administrative practices on social security coordination and on the portability of supplementary pensions

• Ensure policy support from authorities at all levels, for example by supporting the implementation of the European Qualifications Framework

• Reinforce EURES (European Employment Services)

• Increase awareness of the possibilities and advantages of job mobility among the wider public, by organising European job fairs and supporting pilot projects.(HH)

More information at:
http://ec.europa.eu/employment_social/emplweb/news/news_en.cfm?id=325

European Commission modifies electromagnetic fields legislation before coming into force

In 2004, the European Union adopted the EU Physical Agents 2004/40/EC (EMF) Directive to reduce adverse health effects on workers linked to short-term exposure to electro-magnetic fields. Deadline for implementing this Directive in national law of EU member states was foreseen for April 2008.

At the end of October however, the European Commission proposed to postpone the transmission deadline for four years – until 30 April 2012, which would have affected the use of technologies such as Magnetic Resonance Imaging (MRI). MRI is currently the leading technique for detecting brain tumors and many other serious conditions. It allows doctors to help 8 million patients each year.

The EU's executive also announced plans to prepare a substantive amendment to the Directive, in order to take account of recent research findings on the possible impact of the exposure limits on MRI.

The European Commission's original impact assessment did not cover the social and economic consequences of legis - lating in this area.

As a result, the impact on the use of MRI, while unintended, would have had serious consequences for healthcare provision and patient welfare: it threatened clinical and research use of MRI and would have made it more difficult for healthcare staff to care for patients, such as children, the elderly or those who are anaesthetised, who need help or comfort during scans. Some of these patients would have been forced to use technologies with significant proven health risks, such as X-Rays or CT scanners. It would also have stopped the use of MRI for interventional and surgical procedures and curtailed cutting edge research in the field of MRI, denying patients innovative treatments in the future.

Having been alarmed by stakeholders, the Commission launched a study in 2006, to look into exactly what implications the Directive's exposure limits would have on MRI and identify potential problems that could arise. The study is currently underway in four installations across Europe (Germany, France, Belgium and the UK) with results to be finalised by end of January 2008.

"The Commission remains committed to the protection of the health and safety of workers. However, it was never the intention of this Directive to impede the practice of MRI. Obviously, the Commission recognises MRI as a technology offering clear benefits to patients, and continues to support MRI research financially", commented Vla - dimir Spidla, EU Commissioner for Employment, Social Affairs and Equal Opportunities.

The EU is a driving force behind new research in the field. As part of its 7th Framework Programme for Research, in 2007 it will invest roughly €6,000,000 in projects to develop hybrid imaging systems such as MRI/PET and MRI/ Ultrasound.

The future amendment will aim to ensure that limits will not have an adverse effect on the practice of MRI, whilst ensuring appropriate protection of personnel.

The proposed postponement will also allow sufficient time to take into account new recommendations from relevant international bodies. The International Commission on Non-Ionising Radiation Protection (ICNIRP) is currently revising its recommendations for occupational limit values for static and low frequency electromagnetic fields (such as MRI), while the World Health Organisation is also revising its Environmental Health Criteria for electromagnetic fields.

Those revisions are expected to yield results in the form of new, less stringent, recommended limit values for occupational exposure at the end of 2008.

While the review is ongoing, the Commission recommended that member states put the transposition of the current Directive on hold. (HH)

Sources:
EC Press release IP/07/1610
European Society of Radiology,_ESR,
http://www.myesr.org/

Slovenia

By Rory Watson

Slovenia, which at the beginning of January became the first former Communist state to take over the rotating European Union presidency, has made the fight against cancer its top health priority over the next six months. Justifying its choice, it explains that this is no random decision. Not only is cancer one of the most significant public health problems society is currently facing, but there are differences between EU countries in their ability to prevent and control the disease.

As Europe's population grows significantly older over the next 20 years, projections show that the incidence of cancer is set to increase. Projections suggest that in 2010, three million Europeans will develop cancer and nearly two million will die from the disease. By 2020, those figures are set to rise to 3.4 million and 2.1 million.

At the same time, other chronic, non-communicable diseases, often linked to the same risks as cancer will also place extra pressure on public health systems. "Attending to the long term environmental and lifestyle risk factors that underpin the chronic disease burden, including cancer, is therefore an economic as well as a social and health policy priority," the Slovenian government insists.

The importance that Slovenia attaches to tackling cancer can be gauged from the fact that the first major public health initiative in its EU presidency is a two day conference on "The burden of cancer – how can it be reduced?" on 7 and 8 February. This will be followed by another two-day conference in Brussels in April devoted to cancer patients and a formal meeting with European MPs on the subject. The events will bring together leading experts as well as policy makers and is intended not only to promote professional debate, but also to produce political commitments.

The proceedings are expected to stress the importance of adopting an integrated approach towards the disease, while taking account of the complexity of risk factors. This will range from disease prevention, organisation of screenings and early detection to optimising treatment, rehabilitation and palliative care. Slovenia will also encourage the active participation of civil society and non-governmental organisations, especially patient groups, in this work. "We are positive that, with increased political commitment, we will contribute to evening out some of the inequalities in the burden of this disease," the Slovenian presidency notes.

The second major item on the Slovenian agenda is antimicrobial resistance. It intends to give political impetus to measures to address what is regarded as one of the most serious threats in combating communicable diseases and which is becoming more acute as patient mobility increases. The government will also continue work on tackling alcohol-related harm, on promoting healthy diet and physical activity and on improving mental health.

As information technologies make a greater contribution towards more accessible, cost-effective and safe healthcare, attention is increasingly focusing on ways to develop ehealth. This will be the focus of another conference in May.

Alongside these specific initiatives, the Slovenian presidency will have to take forward two broader, potentially controversial, policy debates. The first revolves around patient mobility and the ability of people to receive reimbursable hospital treatment in a country other than their own. The European Commission was due to present proposals shortly before Christmas to ensure legal clarity in this highly complex area where the rights of patients and responsibilities of public health systems need to be carefully balanced.

However, the timetable had to be quickly revised when it emerged that several European Commissioners were not happy with the draft text. In particular, they pointed to unresolved issues such as how to ensure cross-border recognition of prescriptions and the status of a doctor or hospital's liability if treatment goes wrong once a patient has returned home. Despite the unexpected delay, the Commission is expected to table its proposal in the coming months and it will be up to the Slovenian presidency to start the initial political consideration of its contents.

The second debate will focus on the Commission's white paper setting out its thinking on a strategic approach towards health issues in the EU up to 2013. This identifies three main themes: population ageing, major threats to health and the development of new technologies. The aim of the strategy is to bring greater coherence over the long term to what Europe does on health issues, instead of each government setting certain priorities close to its own heart when it assumes the rotating EU presidency. This is likely to be the centrepiece of the debate when health ministers meet in June.

The country focus section in the next issue of E-Hospital will be devoted to Slovenia.

Interview with Andrzej Rys

Public Health Director, Health & Consumer Protection Directorate General,

European Commission

Mr. Andrzej Rys

Some of our readers may remember that Mr. Rys was one of the speakers at our association's seminar on accreditation last November in Düsseldorf. He took advantage of his address to emphasise the importance of regular and in depth contacts between EU institutions and stakeholders of the health sector. Hospital met him in his office to further discuss upcoming EU legislation and future prospects for an EU hospital accreditation model. The health services directive proposal was expected to be released last December….

Andrzej Rys: Due to time constraints, the directive proposal was taken off the agenda of the College of Commissioners on 19 December 2007. It might be adopted by the Commission in the beginning of this year.

In your view, what are the main obstacles, the areas of friction around that draft directive ?

Andrzej Rys : I can think of three major difficulties with that proposal. First it has to balance, comply and be consistent with existing pieces of legislation, i.e. the regulation covering social insurance and protection, and legal provisions for health professionals. Then, the Commission took jurisprudence into account and wanted to make sure the new directive would follow the decisions made by the Court of Justice (ECJ) over the years on this issue. Finally, the definitions which the new piece of legislation bases itself on are crucial and sometimes hard to formulate. There are so many differences between national health systems. But some EU countries, such as Sweden or Germany, are already adapting their legislation and even their way of thinking about crossborder care.

Can you tell us today how the draft framework will differ from the so-called Bolkestein directive in terms of 'health services'?

A.R.: The main difference is that the original proposal for a directive on services in the internal market addressed primarily issues of free movement of services providers; the new crossborder healthcare initiative focuses on the rights of patients and their effective exercise.

As regards more technical issues, under the original proposal for a directive on services in the internal market, the country of origin principal was applicable for the services provider. This would mean that providers providing services in another member state would be subject only to the national provisions of their member state of origin. That is not the case for this proposal. Under the new directive, wherever a patient is treated, the rules of the country where the treatment is provided apply. So this directive will not change the existing legal regime applicable to healthcare providers or their employees.

In addition, according to the Bolkestein proposal, member states were prohibited from making establishment of the services provider on their territory subject to requirements listed in that proposal. This was criticised by some stakeholders as liberalising the markets and restricting the tools available to member states for ensuring quality and safety of services provided on their territory. As the new directive does not address the issue of establishment of healthcare providers, it does not include any similar provisions.

I have already mentioned the importance of ECJ decisions in this proposal. Although both pieces of legislation include provisions codifying the rulings of the ECJ regarding the assumption of healthcare costs incurred in another member state, this proposal goes into more detail in order to provide greater clarity. Moreover, the Bolkestein proposal did not address uncertainties over how to apply the Court principles in practice: uncertainty about the quality and safety of health-

care provided in another member state, about which country is responsible for clinical oversight for crossborder healthcare,…

What will be the significance of the directive on crossborder healthcare for hospital management, in terms of services financing, mobility of healthcare staff, reimbursement of costs incurred through the treatment of patients from other member states?

A.R.: This directive will not affect existing provisions regarding the recognition of professional qualifications or create additional barriers to such recognition, nor will it affect the rights of health professionals to establish themselves in another member state. Furthermore, I personally don't think it will boost massive crossborder care. It is estimated that presently about 1% of EU health expenses are devoted to crossborder care. I don't expect this figure to grow significantly. Patients will still have to overcome distance, language and therapeutic procedures obstacles if they want to receive treatment in another country.
This proposal will nevertheless have implications for health professionals and healthcare providers. Healthcare providers will benefit from a clear set of rules about the quality and safety standards applicable when they treat patients from other member states or when they provide services in other member states.
Healthcare providers will benefit from set rules about which crossborder care is, or is not reimbursed. The proposal would also require clear and transparent procedures to be put in place by member states to ensure more security regarding timely payments to healthcare providers.
Moreover, this proposal will also enable healthcare providers to benefit from the economies of scale of European cooperation when this is useful, in areas such as cooperation in border regions and efficient use of spare capacity, cooperation through European networks of centres of reference, health technology assessment and on ehealth.

Finally, the proposal will fix the limits that member states can put on crossborder healthcare. By providing clarity about what those limits are, it will enable them to plan effectively their domestic healthcare systems. It is worth emphasising that patients' entitlements are limited to those defined domestically by their own member state authorities.
In any event, the organisation, financing and delivery of healthcare is a primary responsibility of the member state and the Commission proposal will change nothing in that respect. Member states may continue to organise their health systems as they wish, provided restrictions do not constitute unjustified discrimination against EU citizens.
Of course, managers who want to prepare their establishment to crossborder care will need to guarantee an access to information provided in a way that the patient can understand and find a way to follow up on their patients after they are discharged from hospital. Some EU hospitals might also want to develop e-health solutions, as a way to market their skills and competences while retaining their health professionals.
Some will say that the complementarity thus created between health establishements, for instance in border regions, could also turn into competition between hospitals…

You were present at the seminar our association organised last November on the theme of accreditation. How can the health services directive contribute to laying the foundation of a future European hospital accreditation model?

A.R.: Well, the directive itself would not contain any provisions on accreditation – the approach that we have in mind is that we simply state that it is up to the country where the treatment is provided to set and monitor their own standards, and we leave it up to individual countries to decide how to do that. However, when I was in Düsseldorf, I explained how the Commission values accreditation as a patient safety tool. One way of identifying high standards and assuring their application in practice is through accreditation of hospitals and other clinical centres. Many people in the healthcare sector favour accreditation for quality and safety. But it is essential to make sure that all the relevant stakeholders (e.g. healthcare managers and professionals) are of the same view and work towards con - sensus-building within the sector as the first step.

So rather than associating this with the directive, we want to use the current momentum around the separate patient safety area to promote accreditation. On 5 February, the Commission is holding a meeting of experts on the integration of accreditation into the patient safety package. We are bringing together experts in Brussels, with a triple mission: first, they have to collect European experience on the subject. Research has already been carried out on the subject with EU funding and results have to be thoroughly reviewed. Then, synergies will have to be found between the specific issue of accreditation and the broader patient safety question. Finally, experts will have to come up with an implementation procedure.

Finally, I would like to emphasise the importance of the upcoming French presidency. As you know, France will take over the presidency in the second semester of 2008. And France also has a very elaborate and regulated hospital accreditation policy, which could provide a good example for other countries to learn from – although legally, there will of course be no obligation to do so at Community level.

22 CONGRESS

22ème Congrès de l'Association Européenne des Directeurs d'Hôpitaux
22. Kongress der Europäischen Vereinigung der Krankenhausdirektoren
22nd Congress of the European Association of Hospital Managers

25. - 26. 9. 2008

www.evkd-kongress2008.eu

French | German | English

New Leadership for New Challenges

Grazer Congress | Austria

An integrated risk management approach

The experiences and objectives of a legal expert

By Dr. Leopold-Michael Marzi, Director of Vienna General Hospital's legal office

It goes without saying that the hospital is a world of its own, which outsiders find difficult to penetrate. For this reason, it is implausible to take the risk strategies of other systems as a model for the hospital sector without first subjecting them to scrutiny. Nevertheless, the prospect of teasing out and applying parallels – and differences - remains an appealing one.

Integrated approach at the Vienna General Hospital

For some time now, the Vienna General Hospital, with the assistance of its internal legal office, has been endeavouring to introduce an integrated risk management approach incorporating the following elements :

- Risk assessment of patient care in the broadest sense
- The legal aspects of hospital activities
- An error management culture
- Communications
- Raising awareness of error prevention
- Comparison of hospital activities with those sof similar risk-prone sectors such as civil aviation

It is not necessary to expand further on why effective risk management in hospital is not possible without the participation of all of the healthcare professions. With job demarcation a prominent feature of modern hospitals, it is imperative that all associated professions are also included in risk management. In the technical field, for example, a technological defect may contribute to or cause a medical error.

Proper handling of accurate information

While the parallel with civil aviation may appear misplaced at first sight, it is nonetheless highly promising. The decisions taken by doctors and pilots when performing tasks may have fatal consequences for patients or airline passengers. However, the risk of a fatal outcome is substantially reduced when appropriate safety precautions are taken. Given the distances involved, air travel is an extremely safe means of transport and mortality rates are low relative to road transport. Whereas pilots must complete a series of concrete safety checks, the interdisciplinary obligations applying to doctors are not spelt out with any degree of clarity, even though the medical profession is bound by a general code of conduct (for example, the principle that doctors do no harm).

Much of the information provided by patients is not properly scrutinised or assessed and decisions are often taken spontaneously based on what is considered predictable. For example, a patient may have nothing to hide when she indicates she is not pregnant but she may still be wrong. For safety reasons, therefore, her condition should be verified before surgery proceeds.

The argument that doctors have nothing to learn from pilots because flying an aircraft and performing surgery are fundamentally different occupations is bogus. Clearly, no serious pilot would try to tell a doctor what to do. A pilot could, however, offer a doctor advice on the tools available to minimise errors. For example, optical and acoustic signals can improve concentration. A quick double-check just before administering a drug drastically reduces the number of errors.

Contribution of hierarchies

The argument that hierarchical systems such as hospitals cannot adopt error prevention mechanisms similar to those operating in aviation is based on false assumptions. Hierarchies are by no means alien to the airline industry. As is clear from their uniforms, co-pilots are not the highest ranking members of an aircraft's crew. Nevertheless and despite some initial re-

sistance, the airline industry managed to require pilots to listen to their co-pilots, even where they are old enough to be their fathers.
Aviation law played a key role in prescribing a clear set of duties for every occupational group involved in air travel. Airline disasters may be rare but every pilot, co-pilot and crew member knows exactly what he must do in an emergency. This knowledge is not theoretical in nature but is tested and, therefore, updated at regular intervals.

Training process

During their medical training doctors do not learn what course of action to take when an error occurs. Although a general obligation to engage in lifelong learning exists, only a tiny minority of doctors are fully aware of their legal obligations in the event of a patient being harmed. This situation is conducive to increasing carelessness among doctors and making them even more fearful of making mistakes. Neither position is desirable.

Risk management in hospital is an ongoing process. It is inconceivable that it would apply only to specific professions or that it would be confined to a one-off training programme. A balance must be struck between avoiding unnecessary alarm and lulling staff into a false sense of security in which they believe errors have no repercussions, legal or otherwise. Many of the doctors who have come face to face with a public prosecutor never believed such an eventuality possible because they always acted with their patients' interests in mind. Even when medical errors do not result in court proceedings, the doctor involved may still pay dearly for failing to take out an insurance policy designed specifically to meet the legal costs arising from cases of medical error.

Even legal experts have come to doubt whether a hospital-based lawyer can do more than deal with the legal consequences of a critical incident, still less to contribute towards developing an internal risk management system.

Conclusion and perspectives

My experience as the director of the Vienna General Hospital's legal office has left me reasonably optimistic in this regard. As a lawyer, I do not expect the legal profession to perform miracles. For the legal expert, digging up old files on medical errors for use in training is as important in terms of error prevention as spending time dealing with cases in which patients have been harmed. Creating an error management culture is as important as providing access to all relevant information. Developing such a culture requires the formulation of explicit and comprehensible goals. All relevant actors must be made fully aware of the reasons they are required to act according to certain rules, even if the purpose of these rules only emerges after an incident occurs. Developments in the aviation industry make a formidable case for seeking to develop a strong focus on and awareness of risk management.

Author:
Dr. Leopold-Michael Marzi, Director of Vienna General Hospital's legal office, Vienna, Austria
Email: marzi@moser-marzi.at

NOSOCOMIAL INFECTIONS

Risk management standards in NHS hospitals and the frequency of hospital-acquired infections

By Paul Fenn, Alastair Gray, Neil Rickman, Dev Vencappa, Oliver Rivero and Emanuela Lotti

Hospital-acquired infections such as MRSA and clostridium difficile have increased markedly in the NHS over the last fifteen years, leading to the introduction of a mandatory surveillance system in England in 2001 (Health Protection Agency, 2006), vapour treatments in some hospitals, the specific employment of a hygiene company by the NHS and several ward closures. A total of 55,634 cases of C. difficile in patients aged 65 years or over in England was reported to the Health Protection Agency in 2006, an increase of 7% from the previous year. The Office for National Statistics has reported that the number of times C. difficile was mentioned on death certificates in England and Wales increased from 975 in 1999 to 3,807 in 2005. The comparable figure for MRSA in 2005 was 1,629. These developments, along with well-documented compensation payouts to a number of MRSA sufferers, additional treatment costs of approximately £1bn per year (National Audit Office, 2000) and reputation costs to the NHS itself make hospital-acquired infections a high profile and important focus for the patient safety debate in the NHS.

FINANCIAL INCENTIVES

In principle, one important mechanism for encouraging patient safety is through the provision of financial incentives to hospitals. The main body responsible for administering schemes allowing NHS trusts in England to pool the costs of liabilities to patients is the NHS Litigation Authority (NHSLA), a Special Health Authority established in November 1995. The NHSLA is responsible for administering the Clinical Negligence Scheme for Trusts (CNST), a voluntary scheme to which all English NHS Trusts and PCTs currently belong, and covers clinical incidents occurring on or after the date when the Trust joined the scheme. Contributions are based on the number of staff employed in different risk categories by each Trust member. The scheme also gives a role to the risk mana - gement processes that members have in place when determining contributions. Assessments are based on seven "core" standards . Trusts at level 1 are normally assessed against the CNST Standards once every two years and those at levels 2 and 3 at least once in any three year period, although trusts may request an earlier assessment if they wish to move up a level. Trusts which are assessed as complying with the standards will be entitled to a discount from their scheme contribution for the following two financial years. The discounts on CNST contributions are 10% (level 1 compliance), 20% (level 2 compliance) and 30% (level 3 compliance). The discount earned by members is applied to contributions in the financial year following a successful assessment and is valid for 2 years (unless, of course, the assessed level of compliance changes).

EFFICIENCY STUDIES

A recent example illustrates the potential importance of these incentives. In October 2007, the Healthcare Commission, the health "watchdog" for England, published a report which attributed the deaths of 90 patients at hospitals in the Maidstone and Tunbridge Wells NHS Trust in Kent to outbreaks of Clostridium difficile between April 2004 and September 2006. C. Difficile is a bacterial infection of the gut which causes severe diarrhoea and can be fatal in vulnerable patients such as the elderly. The report linked these deaths to significant failings in infection control at the Trust. In particular, the Commission's investigation identified inadequate measures to manage and prevent infection, poor staff training, staff shortages, and very high occupancy rates. The report noted that the clinical CNST had criticised the Trust in January 2006 for failing to have an infection control programme for the year ahead. The Trust had previously declared itself compliant on the set of standards that relate to infection control in the core standards laid down by the Department of Health.

In a recent study, funded by the Economic and Social Research Council, we sought to assess the extent to which the discounts offered to hospitals for reaching higher risk management standards have incentivised hospitals to improve their safety procedures, and the extent to which this has effected a reduction in the incidence of hospital-acquired infections. We are able to control for various observable measures of hospital risk type, including hospital throughput, bed utilisation, and casemix. To our knowledge this is the first study to examine the link between risk management standards and patient safety.

Data collected

Data on MRSA infection rates were extracted from the Health Protection Agency Communicable Disease Surveillance Centre. These cover the period from April 2001 (when mandatory surveillance began) to September 2005. Data were available for each NHS Trust by number of MRSA bacteraemia reports and MRSA rates per 1,000 bed days. Clearly, there are considerable differences across hospitals in the number of infections each year, which will be influenced by hospital throughput and casemix, as well as the extent to which the reported MRSA infections originated in the community rather than the hospital. Nevertheless, they may also be a function of the infection control measures introduced in these hospitals, which in turn may be given a higher priority in hospitals with good risk management procedures in place.

It is evident that the trend over time has been for an overall progressive improvement in the assessed standard of risk management procedures, although considerable variations between hospitals have existed, and remain throughout the period of observation. These differences in compliance with the NHSLA's standards presumably reflect the priority given by hospital management to the benefits of risk management (including the discount on contributions) relative to the investment costs involved.
We also obtained annual data for each hospital from the Hospital Episodes Statistics on activity levels (measured by the total number of bed days), bed utilisation rates (i.e. bed days relative to bed capacity), and casemix variables (i.e. the proportion of bed days allocated to the main treatment specialities). In our statistical analysis we used these variables as controls for the risk type of individual hospitals – that is, their exposure to risk of infection.

Findings

We found that improved CNST risk management standards (i.e. the attainment of levels 2 or 3) are associated with reductions in the region of 11%-20% in the MRSA infection rate, after controlling for the effect of observed variations in hospital activity levels, their casemix, and their bed utilisation rates (how "busy" a hospital is).

Ultimately, whether hospital care levels respond to the financial incentives explicitly incorporated into risk pooling contributions is an empirical matter, and we believe that the data available from the NHSLA has opened up a unique opportunity for research on this topic. A combination of financial autonomy at hospital level and risk management assessments in the years from 2001 to 2004 means that data exist on the extent to which hospitals responded differently to these incentives by implementing improved risk management procedures. Because of the progressive implementation and assessment of standards by the NHSLA, it has been possible to construct a panel of data in which the variations in these standards across hospitals and over time can be captured and related to the measurements in reported MRSA infections. The results reported in this paper are indeed consistent with the implementation of improved risk management procedures having a positive effect on patient safety (i.e. a reduction in the number of infections for given throughput and casemix). Moreover, our subsidiary results indicate that inter-hospital variation in throughput, casemix and capacity utilisation can help explain the incidence of MRSA infections, and consequently that there is a degree of predictability to the geographical distribution of these events.

Conclusions

Our results may have useful implications for policy makers. At a time when MRSA infection rates appear difficult to control, the results indicate that financial incentives could be given an important role in this area. Such insights are relevant to the wider evaluation of alternative mechanisms for compensating medical injuries as well as those directed at improving specific aspects of patient safety. It is perhaps unsurprising in the light of our findings that the risk management standard attained by the Maidstone and Tunbridge Wells NHS Trust was category 1 - the lowest available level. Managerial failings were identified by the Healthcare Commission as contributory factors in that outbreak. A way of providing financial incentives which signal areas where risk management can be improved is surely a positive contribution to the range of measures which have been debated in the wake of this event.

For references, please contact francais@hospital.be

Authors:
Professor Paul Fenn, Den Vencappa,
Nottingham University Business School
Alastair Gray, Oliver Rivero, Health Economics Research Centre,
University of Oxford
Neil Rickman, University of Surrey and CEPR
Emanuela Lotti, University of Surrey
Email: : paul.fenn@nottingham.ac.uk

The authors thank the National Health Service Litigation Authority for kindly permitting access to data. This research forms part of a project entitled "Public Services: liability, risk pooling and health care quality", which is funded by the ESRC as part of the Public Services Programme, and we are grateful to other participants in that programme for comments on our work.

ADOPTION AND USE OF NEW MEDICAL TECHNOLOGY AT THE HOSPITAL LEVEL

By Dan Greenberg and Joseph S. Pliskin

While innovative technologies drive modern healthcare and may dramatically improve patient outcomes, they also have been identified as the leading cause of increasing healthcare expenditures (2,3). Technology adoption decisions pose a challenge to decision-makers who are often forced to make timely decisions regarding new technologies, before there is definitive evidence on their clinical efficacy and economic merit. Hospitals, among other healthcare providers, have to develop their individual set of decision criteria for strategic technology planning with respect to their particular environment (5).

Hospital Decision-Making Systems for Technology Adoption

A number of theories have been suggested to describe hospital behaviour and adoption of new technology, yet these theories are not mutually exclusive and none of these perspectives alone has been able to satisfactorily explain technology adoption decisions (8).
The first set of models known as the profit-maximization model (15), or the price competition model (16), or the fiscal-managerial system (17) uses traditional economic theory to explain hospital behaviour. This approach assumes that hospitals evaluate new techno - logies from the perspective of hospital profitability.

The second perspective known as the technology competition model (16), or technological preeminence (8) or the strategic institutional approach (17), derives from three different theories of hospital behaviour: the sales maximization theory (hospitals want to be the largest), the conspicuous consumption theory (hospitals want to show that they are the most technologically advanced) and the physician cooperative theory (hospitals will acquire technology that maximizes physician income) (16).
According to the utility-maximization model, hospital managers invest in technology, subject to budget constraint, to enhance the quality and quantity of services the hospital provides (16). The medical-individualistic perspective (17) focuses on delivery of services according to the definition and demands of physicians and hospital medical administrations.

Strategic considerations

Regardless the decision-making structures, the considerations that go into such decisions are similar across different healthcare systems and different insurers and health services providers within a healthcare system. Cohen (4) has recently explored some of these considerations:

a) Availability of information (many decision makers emphasise that the most important barriers to optimal decision-making relate to timely data on safety, cost effectiveness and efficacy for the considered technology);

b) Clinical needs (hospitals will often act as their customers' agents and adopt technologies based on the clinical needs of the population they serve, supporting the medical-individualistic approach);

c) Estimation of costs and benefits (decision makers should consider the cost savings relative to alternative treatments already existing in the hospital and the averted costs of future treatment);

d) Appropriate staffing and site requirements (adopting a technology with the lack of appropriate additional training may result in serious complication rates and harmful consequences to the patient and the hospital. The potential adopter has to consider the trade-off between early adoption and potential profits and waiting upon expected profit later when additional scientific advances and increased experience emerge);

e) Regulatory controls

f) Reimbursement policies (the introduction of prospective payment systems, such as capitation, global budget, and diagnosis-related groups (DRGs) in many healthcare systems created disincentives to the adoption of technologies that are cost-increasing);

g) Timing of adoption (in many cases, early adoption occurs in periods where the technology is flux, its acquisition costs are high, the evidence on the capabilities, clinical use and outcomes associated with the use of the technology are incomplete and third-party payer reimbursement does not exist).

The Decision-Making Process

Many hospitals have decision-making structures for the adoption of new technologies, but the nature of the structure and the adoption process may vary depending on the type of technology considered. For therapeutic agents, a recent observational study of two general hospitals in the UK, Jenkings and Barber (23) found that the issues that affected the decision-making process were the availability of clinical trial data, cost, pre-existing prescription of the drug considered, pharmaceutical companies activities, decisions in other medical centres, patient demand and physician excitement. These factors were supplemented by local knowledge in the hospital.

The adoption decision is different when high-ticket technologies or new specialised services are involved. Cohen (4) states that since new technologies are becoming increasingly specialised and complex, the decision-making structures and processes for equipment purchases and service expansion are also becoming more complex and involve decision makers from different specialisation fields. An illustration of the decision-making process can be found in our recent study of medical centres in Israel (12). We found that the first initiative to use new technology comes, in most cases, from the chiefs of medical wards or other senior physicians, but the responsibility for the final decision to implement a new technology varies by its nature. The final decision may also be made by ad-hoc committees comprised, in addition to the medical director, of representatives of the non-clinical management, and the chief of the relevant medical division.

In recent years, several scholars have suggested that when making priority-setting decisions, decision-makers must ensure that they achieve two goals: legitimacy, defined as the moral authority to make resource allocation decisions, and fairness, which may be achieved when an individual has a sufficient reason to accept a priority-setting decision, because of the acceptability of the decision-making process (24).

Accountability for Reasonableness, a framework developed by Daniels and Sabin (24), has been used to examine priority-setting decisions at the hospital level (13,25,26). According to this framework, an institution's priority setting decision may be considered fair if it satisfies for conditions of publicity, relevance, appeals and enforcement. The publicity criterion suggests that decisions and their rationales must be publicly accessible. The relevance condition should ensure that these rationales are based on evidence-based reasons and principles that fair-minded parties agree are relevant to meet the disease and population needs under resource constraints. The appeals condition suggests that there should be a mechanism for challenge and dispute resolutions regarding priority-setting decisions, including the opportunity for revision of decisions when new evidence becomes available. Finally, the enforcement condition ensures public regulation of the process to ensure that the first three conditions are met.

More recently, Gibson et al (27) proposed a transdisciplinary, practical, four-step model (reasonableness, transparency, responsiveness, and accountability) to offer guidance to ensure that healthcare institutions achieve the goals of legitimacy and fairness in their decision-making process.

Conclusions

Several surveys suggest that decision makers have only limited training in areas of health economics, health technology assessment, and decision-making. These may limit their ability to truly understand the nature of the technology and the immediate and future implications of their adoption decisions. We therefore strongly recommend that hospital executives who may be involved in technology policy undergo some formal training in the above-mentioned fields.

For references, please contact francais@hospital.be

Authors:
Dan Greenberg, Ph.D., Joseph S. Pliskin, Ph.D.
Department of Health Systems Management, Ben-Gurion University of the Negev, Beer-Sheva, Israel
Email: dangr@bgu.ac.il

Trends in European hospital management

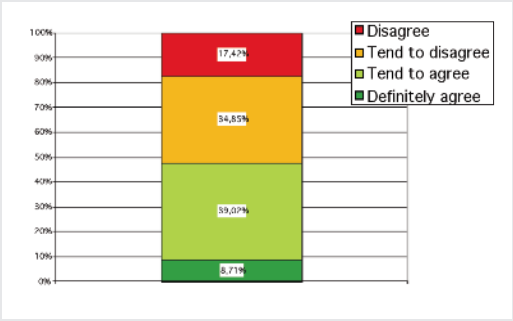
Results of the survey of European hospital managers

By Dr. Carsten Frank Hutt

The study "Trends in European Hospital Management" is the result of a collaboration between E-Hospital and Emergent Actio.
A personalised invitation containing a password protected link to the survey system was sent out with the July/August issue of E-Hospital. Additionally, the study was introduced within the journal including information on how to register and take part.
The online questionnaire was provided in three different languages: English, German and French, to reflect official languages of the European Association of Hospital Managers.
The survey was finally closed on 13 November 2007. 274 contributions sent by hospital managers from all over Europe were received.
The questionnaire covered a wide range of issues: from utilisation rates, patient information systems, technical medical equipment and financing to aspects of human resources, marketing and criteria of medical quality, to point out some of the aspects of the study.
We are now happy to present our analysis of the results, focusing mostly on the last part of the study, where we asked hospital managers about future perspectives and trends.

1. Size of a hospital and competitiveness.

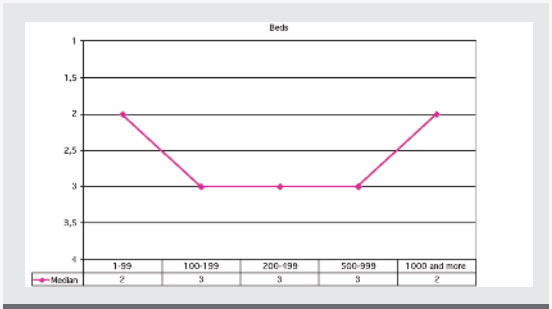
Thesis : The bigger the hospital, the more competitive it becomes.



N=264 Don't know=10 Median=Tend to disagree

This thesis is controversial. Half of the managers surveyed support this statement, while the other half disagree. When we carried out a deeper analysis of the answers, we realised that especially very small and very large hospitals tend to agree with the statement whereas hospital managers of middle sized hospitals tend to disagree. Also interesting to us was the fact that hospital managers with a medical background supported this thesis more often than their colleagues with a non medical background.

Differences by hospital size :

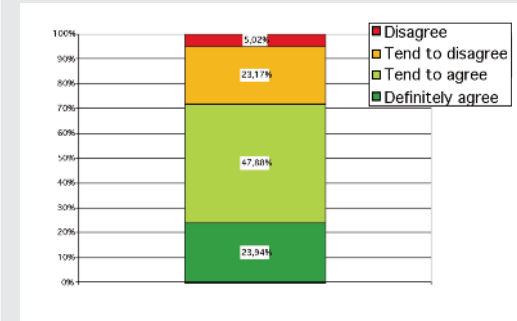


1=Definitely agree, 4=Disagree

Very small and very large hospitals tend to agree with the statement.

2. Medical quality and information technology

Thesis: As far as the improvement of medical quality is concerned, health establishments underestimate the importance of information technology.

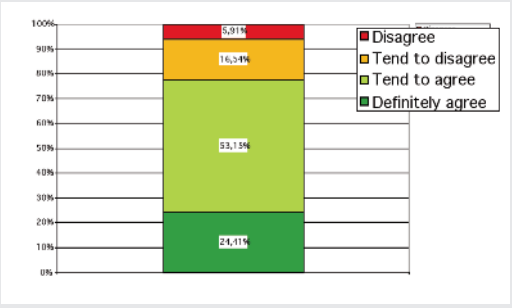


N=259 Don't know=15 Median=Tend to agree

More than 70 percent of the interviewed hospital managers think that hospitals and clinics underestimate the importance of information technology. This underlines the high value information technology already represents.

3. Profitability and information technology

Thesis: As far as profitability and cost-effectiveness is concerned, hospitals underestimate the importance of information technology.

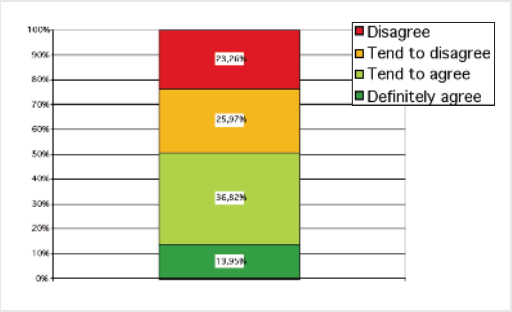


N=254 Don't know=20 Median=Tend to agree

Even more crucial, hospital managers emphasise the importance of information technology in terms of profitability and cost-effectiveness.

4. Diversification and number of hospitals

Thesis : Around 20 to 30 percent of the hospitals currently existing in my country will disappear by 2020.



N=258 Don't know=16 Median=Tend to agree

At first, we note a nearly balanced ratio of about 50 percent who agree and 50 percent who disagree with this thesis. This is astonishing if we take into account the consequences of this trend. But if we analyse the answers at national level, we get a more differentiated picture. The countries listed below show the median of the answers. In countries like Hungary and Poland, hospital managers totally agree with the statement, whereas their colleagues in the Czech Republic, Germany, France or Turkey are more nuanced in their support. The situation in countries like Russia, Spain or Greece is totally different. Also in Sweden, Italy or Austria, hospital managers tend to disagree with the statement.

Median by country:

Country	Median
Hungary	Definitely agree
Iceland	Definitely agree
Poland	Definitely agree
Denmark	Definitely agree/ Tend to agree
Latvia	Definitely agree/ Tend to agree
Czech Rep.	Tend to agree
Finland	Tend to agree
France	Tend to agree
Germany	Tend to agree
Lithuania	Tend to agree
Netherlands	Tend to agree
Norway	Tend to agree
Slovakia	Tend to agree
Switzerland	Tend to agree
UK	Tend to agree
Turkey	Tend to agree
Luxembourg	Tend to agree/ Tend to disagree
Austria	Tend to disagree
Ireland	Tend to disagree
Italy	Tend to disagree
Portugal	Tend to disagree
Sweden	Tend to disagree/ disagree
Belgium	Disagree
Croatia	Disagree
Estonia	Disagree
Greece	Disagree
Romania	Disagree
Russia	Disagree
Spain	Disagree

Infobox Median

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

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

Prospects to Outsourcing of Healthcare Services and Processes

The importance of good quality metrics

By Petri Parvinen and Olli Tolkki

Outsourcing is a hot topic in public healthcare related discussions, covering a number of different aspects: economic, political, quality, and productivity, among others. However, it should be noted that outsourcing does not mean the privatisation of an entire system so long as the control remains in the public sector, as those terms are often confused in political debate.

Outsourcing of services and processes has become an important phenomenon in the global economy. The recent advances in information and communication technology along with the rapid growth of the Internet have made even global outsourcing a reality, also in the field of healthcare. Healthcare providers have been outsourcing supportive functions such as real estate management or IT for decades, but now there is an increasing trend to also outsource some of the core competencies, such as some elective surgeries (joint replacement, cataract etc.) and diagnostics.

Outsourcing Framework

Discussions about outsourcing of healthcare services both in academic and popular media are anchored on cost savings, quality problems, and transaction cost theories. There are always good reasons to resist changes to the present service delivery model. Therefore it is crucial to separate arguments, which are solely change resistance related, from quality or control related argumentation. Too often it is not taken into consideration that a private entrepreneur or another public service provider with higher volumes or specialisation may be able to deliver better quality with lower costs. For example, how many clinicians would be ready to "in-source" all the laboratory analysis back to their own small units from high volume, often almost industrial central laboratories? Volume and specialisation often bring efficiency, quality and decrease unit costs. Of course, not everything can be outsourced or centralised. Inhibitors for outsourcing include the need for physical proximity, importance of local knowledge, and complex interaction between different healthcare providers.

Outsourcing Relationship

Our objective is to bring a new prospect to the outsourcing discussion and emphasise the impact of the outsourcing relationship between a customer and its vendor, while analysing the possibilities of outsourcing from an operational and policy development point of view.

In the past, literature on outsourcing focussed too heavily on the "splintering" (a word coined by Jagdish Bhagwati in the early 1980s) of the value chain and thus making outsourcing a zero sum game. A study published by IBM (2004) examined outsourcing from a different angle by looking at the relationship between the parties. This can also be applied to healthcare, although this categorisation tends to give a too static and stereotypic overview to outsourcing. In any case, this differing approach does provide a better overview of the entire field of outsourcing, and it broadens discussion and argumentation of outsourcing further than the traditional cost/quality centred approach. We compared the IBM model to current cases we have been researching to determine the pros and cons of this categorisation. The idea is to bring new ideas and concepts to the research and decision making in regards to outsourcing in healthcare.

Types of Outsourcing

According to the IBM study, outsourcing has been categorised in four types:

a. Transactional
b. Value-added
c. Specialised
d. Unique

Transactional value exchange is the simple exchange of commodity or service. The customers' priority is often price, accuracy of service, convenience and efficiency. In value-added exchange, greater supplier expertise is required to perform some customisation of service. The latter two models are fundamentally different from simple commodity exchange; they are based on innovation and value creation. They are often absent from arguments related to the outsourcing of public healthcare services. One reason may be the strict and bureaucratical public procurement legislation, which partially inhibits the creation of long lasting and innovative partnerships between public and private organisations. In the specialised value exchange, the spirit of collaboration and innovation becomes much more important. The supplier works to integrate processes with the client and other suppliers on behalf of the client. Value is derived from optimisation across organisations. In a unique value exchange, two or more organisa-

tions collaborate with customised expertise and process integration. The shared competitive capability is significantly greater than each organisation's individual capabilities.

The difference between these processes is the degree to which the responsibility to achieve the desired outcome is shared by all parties that have committed resources. It seems that the specialised and unique value exchange processes need to be guided by the interpretive process, while the analytic process guides the first two types, as defined by Lester and Piore (2004).

Application to Healthcare

From our point of view, this categorisation can be applied to healthcare and it helps to bring the level and modes of relationships between the outsourcing parties into the analysis of advantages or disadvantages of outsourcing. Although there may be several types of cooperation modes between buyer and vendor, interfaces between different categories are not clear. The level of relationship between buyer and vendor is especially significant because outsourcing relationships develop as a co-evolutionary process. There were four main findings from our study:

1) All relationships we have been researching have changed significantly in recent years; finding a static model is hard or impossible.

2) All relationships include a minimum of two types of outsourcing.

3) All types of outsourcing encounter problems and downsides. Outsourcing itself brings certain problems and difficulties, but we must analyse whether they are greater than in those in the concept where we keep almost everything as an in-house production.

4) Level of integration between buyer and vendor has a significant impact on the success of outsourcing.

We propose that to create benefit for both parties it is not enough to examine the present cost or quality, but also the relationship among the partners and how they are managed.

Problems with Outsourcing

A problem in the outsourcing of healthcare processes is that the patient process is not clearly defined. Sometimes healthcare organisations are even described as a "chain of independent players in a virtual organisation".

To outsource a certain part of the process efficiently (e.g. a surgical operation from the entire care process), there is a need to clearly define the previous and latter phases of the process - especially the interfaces. Also, quality control must remain in the hands of the outsourcer, often in the public sector. Therefore a lack of good quality metrics is actually a significant inhibitor of outsourcing in healthcare. Public service providers are afraid to lose control over the patient processes and episodes by outsourcing even a small part of it. Regardless, the rational answer is not to avoid it completely but rather to develop better quality metrics.

Successful outsourcing relationships need at least measurement of quality, measurement of total costs, definition of responsibility and liability, contracting management, definition of interfaces between outsourcer and service provider, and process management.

Conclusion

We think that a lack of good quality metrics, contracting management and lack of trust between outsourcer and service provider are actually the most significant inhibitors of outsourcing in healthcare. Public service providers are afraid to lose control over the patient processes and events by outsourcing even a small part of it. Anyway the rational answer is not to avoid it completely, but rather to develop better quality metrics.

Authors:
Prof. Petri Parvinen is Professor at Helsinki School of Economics, Department of Marketing and Management and Research Director at Helsinki University of Technology.
He has worked out of the Institute for Healthcare Engineering, Management and Architecture (HEMA).
A graduate of the London School of Economics and Political Science, Dr. Parvinen has been involved in over 90 healthcare-related research and development initiatives and is currently involved in a number of entrepreneurial activities.
In the past, he has been the Managing Director of MBA and Health MBA Programs at the Helsinki University of Technology.

Email: Petri.Parvinen@hse.fi

Olli Tolkki, MSc. (Econ.) is a researcher at the Helsinki University of Technology at the Institute for Healthcare Engineering, Management and Architecture (HEMA).
A graduate of the Helsinki School of Economics, Tolkki has been involved in over 80 healthcare-related research and development initiatives in both academic and entrepreneurial contexts.
Tolkki is also working as a manager in the healthcare oriented consulting agency Nordic Healthcare Group.

OPTIMAL RISK MANAGEMENT IN HEALTHCARE

A six point programme

By Maria Ines Cartes

The strong trend towards "economisation" in the German health system is rapidly leading to significant changes in the health sector. At the same time, the legislation governing the German health system (the Social Security Statute Book) imposes the following requirements: the establishment of quality management; participation in external, comparative quality assurance; and, under what is known as KonTraG (an amending act on control and transparency in business), the establishment of a monitoring system to ensure early detection of developments that pose a threat to society.

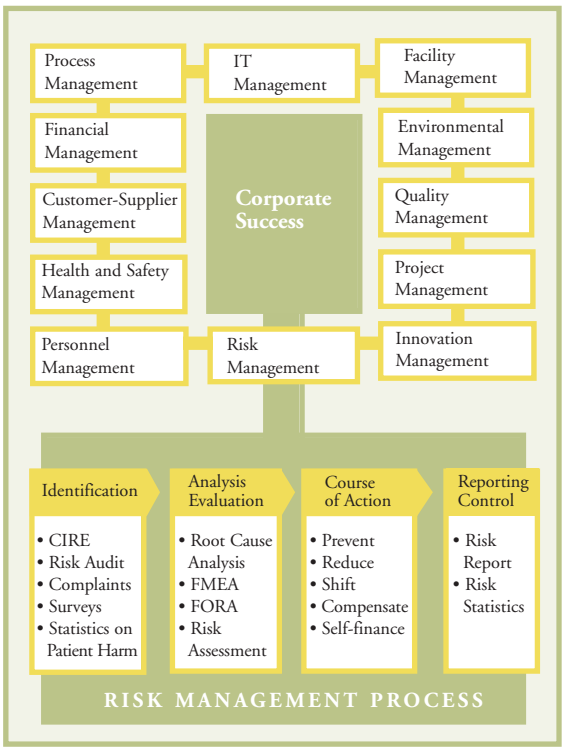
On the other hand, the growth of a high-expectation culture and changes in jurisprudence (patient rights) are contributing towards mounting compensation claims, higher payments by insurance providers and a substantial increase in liability premiums. While these developments have economic consequences for healthcare institutions, the damage to corporate reputation caused by compensation claims is becoming an increasingly important issue. For this reason, the insurance industry, specifically the international reinsurance industry, demands that risk management (RM) be used as a management tool to ensure the liability risk in healthcare remains insurable in the longterm. (Klocke 2005).

Furthermore, while treatments and surgical procedures are becoming more and more refined, not all associated work practices are following suit. In the context of the high degree of technologisation and the necessary division of labour in medicine and care, even minor errors in work processes can have disastrous consequences. For this reason, in addition to medical issues, insurance companies expect other considerations, primarily fire protection, issues of a legal, organisational and structural nature and other matters pertinent to liability, to be taken into account to ensure that the liability risk in healthcare remains insurable in the longterm (Gurcke 2006).

Prerequisites for the viability of hospitals are a good strategy, efficient use of resources and optimal process control. For this reason, management systems such as risk management must be applied in operative, tactical and strategic decision-making.

The challenge of risk management

The challenge of risk management lies in mapping the overall risk as a conglomeration of interconnected individual risks (Brennan et al 1991, Leape 1994, Vincent et al 1998). In so doing, the strategic importance of risk management as a leadership task emerges (Wolf, Runzheimer 2003, Gómez-Arnau et al 2006). In practical terms, this requires the strategic introduction of an efficient and effective risk management process with optimal resource allocation, which contributes to security of outcome. Realising this objective hinges on completing six concrete steps.



Step One: Take a Decision

The decision on the introduction of risk management must be made by management at the highest level. Consultation with the works council, where one exists, and the insurance provider is recommended. Consideration should be given to the advantages and disadvantages of risk management as well as external requirements (statutory and legal). In this context, the aims and objectives of the risk management process must be defined, e.g. the creation of a safety culture, improvements in patient safety, meeting statutory requirements and guaranteeing that staff are protected from third party liability claims.

Step Two: Effect a Change in Culture

It is necessary to bring about a cultural change with regard to communicating and addressing errors. Senior management, in consultation with the works council, must determine and assume responsibility for the general principles and values that will govern how the institution handles errors. The hospital, as an enterprise, must strive to make the transition from a blame culture, through an error culture to a safety culture.

Achieving this goal requires acceptance that errors occur in all walks of life and critical incidents and near misses should be treated as an opportunity for systematic learning (Meilwes 2002).

Step Three : Establish Requirements and Parameters

Implementing risk management requires securing the support of senior management and obtaining the approval of the works council. The aims, objectives and approaches underpinning the strategy must be defined. Before introducing risk management, senior managers must determine the position the process will have in the hospital. This implies that it will be a task for senior management and that accountability, responsibility and resource allocation issues will be clearly defined.
Ideally, risk management should be either embedded in or strongly linked to the hospital's quality management, process management and project management systems. Coordinated communications and cooperation should be maintained with other areas and departments, including legal affairs, administrative audit, disaster prevention, hygiene, finance and environmental services.
In this context, key factors in establishing risk management are the maturity of the hospital and the ability of its management culture to build confidence and lead by example. These factors influence the flow of information among staff, their flexibility and receptiveness towards innovation, including the establishment of a risk management process.
The availability of advanced IT infrastructure facilitates recording, analysis and communication of risk management data.

Step Four : Risk Management – Creating Expertise

One person should be appointed to the role of risk manager. He or she should perform the tasks associated with introducing RM tools and methods. The correct and appropriate expertise depends on the aims and objectives of the RM system in the hospital. A clinical medical or nursing qualification is a prerequisite. Further qualifications in areas such as quality management, process management, project management or risk management and sound knowledge of business management round off the job specifications of a risk manager. Given the confidential nature of the position and its strategic importance, he or she should be directly accountable to the hospital director.

Step Five : Establish an Organisational and Operational Structure

To ensure sustained, effective RM functionality, the responsibilities, communication structures and implementation concept should be defined with the person appointed to the position of risk manager. These depend on the size of the hospital and the RM aims and objectives. In larger hospitals, a central office with decentralised units and an RM task force is the ideal structure, as it allows the hospital to maximise synergy effects and use its resources in the most effective manner.

Step 6 : Utilise Tools and Methods

Every hospital uses a range of tools and methods for risk reduction purposes, although in many cases the approach is not coordinated and is not part of overall hospital strategy. The use of new tools and methods should complement rather than replicate the function of existing instruments used in the risk process. This means the hospital should examine whether effective and efficient tools are already in place for risk identification, analysis, assessment, management, control and reporting. In the event that these are not available, it should introduce new tools. In this regard, it is critical to link these tools to capitalise on synergies. The use of critical incident reporting systems or other reporting mechanisms offers considerable potential to identify risks and errors in a cost-effective manner (Cartes 2006). However, it is important to ensure optimal resource utilisation when managing these issues. In this respect, it is advisable to deal with reports on the basis of risk fields. Moreover, CIRS must be introduced throughout the hospital. Risk constellations can only be considered in a comprehensive, multi-dimensional manner when multiple departments are brought into the process. Further details can be found in an article entitled "Aus Fehlern lernen " (Learning from Mistakes) by Maria Ines Cartes in the "Niedersächsische Ärzteblatt" 1/08.

Conclusion

As a result of rapid changes in the health sector, new statutory requirements, increased expectations among patients and health insurers and the rising cost of insurance premiums, the implementation of innovative, efficient management tools such as risk management is an imperative in our hospitals. Management and employee representatives must collectively decide to implement risk management if it is to be effective and sustainable and secure the support of staff. A safety culture should be developed to enhance patient and institutional safety. A range of RM tools must be deployed, albeit in a manner consistent with the need to ensure effectiveness and efficiency. To prevent patient harm, it is vital that transparency and trust are established because patient safety and corporate safety go hand in hand.

Advantages

- Reduces liability risk
- Establishes facts regarding the need for action
- Enhances reputation
- Reduces costs in the medium and long term
- Guarantees liability insurance protection
- Promotes development of a safety culture

Disadvantages

- Creates additional workload
- Increases use of resources as RM can not be implemented in a cost-neutral manner. Staff, software and other costs arise at the outset.
- Viewed as "another form to be filled"

Author:
Maria Ines Cartes, Medical Quality Officer
Risk Manager, Hanover Medical School
Email : cartes.maria@mh-hannover.de
http://www.mh-hannover.de/risikomanagement.html

Outsourcing of Logistics Services in Hospital

By Wolfgang Dröscher

Founded in 1912 as a private institution, the Balgrist University Hospital/ Uniklinik Balgrist ranks among the pioneers of orthopaedic surgery in Europe. The hospital includes a spinal cord injury centre and the diagnosis, treatment and rehabilitation of patients suffering from musculoskeletal impairment is one of its core objectives. It also maintains an elaborate interdisciplinary network merging orthopaedics, paraplegiology, physical medicine, rheumatology, radiology, and anaesthesiology.

Restructuring of Logistical Procedures

In 2003, we reviewed the logistical process within our hospital. Results revealed that several staff members were inappropriately involved in logistics, leaving their core responsibilities unattended. This was unacceptable. We think that, for instance, nurses should take care of patients, including assistance to surgeons, instead of completing logistical tasks.

To relieve nurses of logistical duties, such as ordering, internal transportation, and refilling shelves, these functions were transferred to the department Purchasing & Logistics (P&L). In addition, we faced a decision with respect to our medical products warehouse: should we keep it in the hospital or source it out? As we did not intend to employ additional personnel for P&L, we decided to outsource this internal warehouse. Other motivations were to use the space for other purposes in our clinic. Since November 2004, a commercial partner affiliated with the Swiss post has managed our external warehouse, which is located near Zurich. This gives us the opportunity to integrate additional hospitals into this external warehouse and thereby generate economies of scale. As we already cooperate with two other general hospitals close to Zurich, we intend to share the external warehouse next year. In addition, all three hospitals will use the same internet-based order-platform.

Direct Delivery to the OR

We have also outsourced part of our logistics in the form of a direct delivery program to the operating room (OR). The requirements were:

- Reducing preparation time in the OR for OR personnel and relieving them of logistics functions;
- Identifying involved items, total volume of these items and integrating them into procedure kits for the OR;
- Concentrating this volume on one supplier (€ 330,000 per year);
- Building a continuous supply chain without employing additional personnel during evening hours.

As the costs for outsourcing the whole supply chain – from the supplier to the hospital shelves – within the OR were less than 5% of the total value of purchases, we outsourced this part of logistics separately. We signed two separate contracts with our commercial partner:

- One contract with the supplier concerned the items/kits, the availability, and the commissioning process including the timetable when the commissioned sets should be ready for pick up by the logistics partner;
- One contract covered transportation, unpacking, refilling the shelves in the OR during a fixed time slot (7-9 pm).

The advantage of two independent contracts is that if it is necessary to change the supplier, the logistics partner may remain unchanged. Conversely, if you are not satisfied with the logistics partner, you can easily opt for a new service company.

This relationship is a triangle: OR/user, logistics partner, supplier. We discussed the following details: responsibility for stock within the OR, how to transmit the needs of the OR, the regular flow of information between the three partners, packaging of items including the specifications of trolleys, labelling of items and trolleys (including their identification), transportation of full/empty trolleys including waste management, behavioural aspects within the hospital-specifically in the OR, as well as emergency situations.

To assure a continuous supply chain our OR will be refilled with 17 kits/ items three times weekly (110-120 deliveries per year) according to the following procedure:

- During the morning OR personnel transmit the inventory to the supplier via fax using a special order form for these particular items;
- The supplier generates the order, considering the available space in stock OR (the supplier knows the maximum quantity of each item which has to be stored in the OR);
- The supplier commissions all items using cleaned, closed, and sealed alu-trolleys without primary packaging and contacts the transportation partner (as the time needed by the logistics partner within the OR has been reduced to a minimum, and the items are well protected in the trolleys, primary packaging can be avoided);

• The transportation partner arranges transportation to the hospital, refills the shelves in the OR between 7-9 pm, while observing in-house hygiene regulations (between 7-9 pm the OR is running on low capacity! Consequently, there is a low patient flow between our OR and other departments within the hospital; our in-house hygiene regulations specify the behavioural aspects of people working in the OR including working clothes);

• Purchasing and Logistics return the alu-trolleys, including secondary packaging;

• Finally, OR personnel take the items / kits needed from the shelves.

These procedures also include an emergency contingency. In case of accident, the supplier has all detailed information about the damaged/lost order and can consequently generate an additional shipment, which can reach the OR either the same evening or at the latest, the following morning. If the replacement shipment fails again, our partner has an emergency stock of the eight most important kits/items. Hence, the OR workflow can be maintained continuously.

Conclusion

Summarising our three years of experience in delivering to OR directly, the major advantages are that medical staff can now concentrate on their core activities. We did not have to hire additional personnel within P&L to perform this tailor-made service for the OR. Instead, we generated a continuous flow of materials into the OR and reduced the number of items by creating kits. As the value per single item is low, the additional logistical costs, amounting to less than 5% of the purchasing volume, are not excessive. Outsourcing logistics converts fixed overheads into variable costs. The operational risks of outsourcing can be minimized to almost the same extent as an in-house service can guarantee. Outsourcing requires proper detailed planning of the whole process. Everything must be clearly defined, as to what will be done by internal and external staff. For instance, when the logistic partner approaches the OR, he must know where to park the trolley with the sets, in which sequence to unload the trolley, how to identify the items, as well as where to locate them exactly in the OR (considering FEFO—first expires first out). The supplier has to ensure that trolleys are filled with sets in a predetermined sequence, to assist a subsequent efficient and clear delivery by the logistic partner. In all, we are completely satisfied with the quality of this outsourcing and have failed to identify any drawbacks in our experiences over the last three years.

Author:
Wolfgang Dröscher,, Purchasing Manager,
Uniklinik Balgrist, Zürich, Switzerland
Email: wolfgang.droescher@balgrist.ch

Outsourcing in hospitals

A survey of decision-making factors, benefits and obstacles

By Socrates J. Moschuris and Michael N. Kondylis

Outsourcing is an increasingly popular strategy that healthcare organisations can use to control the rising costs of providing services. With outsourcing, an external contractor assumes responsibility for managing one or more of a healthcare organisation's business, clinical, or hospitality services. Because the contractor specialises in providing a specific service and can achieve economies of scale, he/she may be able to provide a service more efficiently and less expensively than the healthcare organisation.

Outsourcing services peripheral to the organisation's primary operations may also enable healthcare administrators and staff to concentrate more efficiently on their organisation's core business.

The aim of this paper is to present, based on the results of a study carried out in 60 hospitals operating in Greece, the decision-making factors, the impact and the obstacles associated with outsourcing in hospitals as well as to provide some managerial implications.

OUTSOURCING DECISION-MAKING FACTORS

To determine why hospitals decide to outsource activities, respondents were asked to evaluate the importance of a number of factors affecting the decision to outsource.

More than one-half of the respondents indicated that cost savings and customer satisfaction were the most important factors in their decision to outsource, whereas 50 percent of the users mentioned customisation as an important decision-making factor. Focus on core business, lack of personnel, and lack of funds were mentioned as important factors by the minority of the respondents.

IMPACT AND OBSTACLES OF OUTSOURCING

Regarding organisational impact, respondents were asked to assess the effect of outsourcing on cost reduction, on improvement in customer satisfaction and on the quality of the services provided by the hospitals.

The impact of outsourcing on cost reduction was assessed as high or very high by around two-fifths of the respondents. As far as customer satisfaction is concerned, 60 percent of the respondents indicated a positive or very positive impact.

Finally, around two-thirds of the respondents argued that outsourcing has led to a significant improvement of the services provided by hospitals operating in Greece.

Theoretically, the decision to outsource may lead to an elimination of a number of full-related positions in the healthcare organisation.

Two-thirds of the responding hospitals indicated that their decision to outsource did not lead to an elimination of full-time related positions, whereas around one-third of the users indicated that they have eliminated between 1 percent and 20 percent of their full-time staff. Only 1 healthcare organisation reported eliminating more than 21 percent of full-time positions due to outsourcing.

According to the survey respondents, healthcare organisations operating in Greece experience a number of benefits from outsourcing .

Improvement in service quality levels was mentioned as the most frequently obtained benefit. Economies of scale, the use of the external provider's infrastructure, the opportunity for the healthcare organisation to focus on its core business, and enhanced flexibility were also mentioned as important benefits by several other users.

In terms of implementing the decision to outsource, over 70 percent of the users indicated that they experienced significant difficulties/obstacles in bringing contract service providers on-line .

The most often mentioned difficulties included the lack of coordination and integration between the healthcare organisation and the external provider as well as the insufficient understanding of the provider about the user's operations.

Employees' resistance to changes as well as price negotiation and billing problems were also mentioned by a number of respondents.

MANAGERIAL IMPLICATIONS

The results of this research have important practical implications for those involved in outsourcing investigations in the healthcare sector. The benefits realised after the implementation of the outsourcing decision have explained the relatively high satisfaction level of the users and, hence, the increasing future trend of outsourcing. To those healthcare organisations considering outsourcing of their activities, this positive feedback should be reassuring. The number of experienced organisations provides an important source of information about how to proceed and what to expect.

The most significant reasons for outsourcing are to improve customer service, to reduce costs, to enable healthcare organisations to focus on core activities, and to increase flexibility to configure resources to meet changing market needs.

Some organisations do not achieve the expected benefits from outsourcing, due to lack of formal outsource decision-making process including medium and long-term cost-benefit analyses, resistance to changes, and the inability to formulate and quantify requirements.

The most significant risks of outsourcing lie in the need to develop new management competencies, capabilities and decision-making processes. These include decisions on which activities should remain within the healthcare organisation and which outsourced, whether all or part of the activity should be outsourced, and how to manage relationships rather than internal functions and processes. Mistakes in identifying core and non-core activities can lead healthcare organisations to outsource their competitive advantages. However, what is core one day may not be so the next. Moreover, once organisational competence is lost, it is difficult to rebuild. There is a difficult decision regarding how "close to core" outsourcing should be.

Failure to manage outsourcing relationships properly, perhaps through service level agreements, may reduce customer service, levels of control and contact with customers. The assessment of costs of "make or outsource" should include the additional cost burden of managing the outsource relationships.

Because the introduction of contract services into an organisation represents an important shift in the way in which business is conducted, the provision of appropriate training for employees is an important issue. The training efforts should typically focus on employees' ability to adjust into another environment and new roles. This includes use of computerised systems, higher skills/knowledge development, and systems support. Once the decision to outsource is accepted, there is little resistance to change by the employees.

The above analysis of the experience of healthcare organisations operating in Greece in their usage of contract service providers indicates that outsourcing in the healthcare sector has a good potential for further development.
This study provides contract service providers a framework, which, we hope, will help them in increasing their business in this dynamic and rapidly growing market.

Authors:
Socrates J. Moschuris, Assistant Professor in Logistics and Supply Management, Department of Industrial Management and Technology, University of Piraeus, Greece
Email: smosx@unipi.gr

Michael N. Kondylis, Chemist, Public Power Corporation S.A., Athens, Greece
Email: mkondylis@in.gr

Diagnosis Related Group (DRG) funding for intensive care

By Akos Csomos

Diagnosis Related Group (DRG) is, by definition, a case mix classification scheme, which was designed in the 1960s to evaluate hospital performance. It was then adopted some 20 years later as a base unit of payment in the Medicare system in the United States (Inglehart, 1983).

There were 467 DRG categories in its original form and these were defined by diagnosis, procedure and patient age information from a nationally representative sample of discharge records. Groups were intended to be clinically similar and to require similar amounts of hospital resources. To construct a hospital-specific index, the frequency of cases in each DRG was multiplied by a cost weight. These weights were constructed by converting the mean charge per DRG to cost.

In theory, as it can be found in the report to the Congress (Schweiker,1983), "hospitals can keep any surpluses they achieve, […] physicians can be expected to compete with each other for available resources," and the authors also hoped that "cost-ineffective practice patterns will be discouraged".

Has the DRG funding proven its advantages over the years? No, it has not. That is why there are no countries in Europe at present, which use solely DRG funding for intensive care.

The major inaccuracies were highlighted even after its introduction in 1983, as the President of the Association of American Medical Colleges was left with three major concerns (Inglehart, 1983) :

1. Lack of sensitivity of the DRGs in measuring differences between patients;
2. Inaccuracies resulting from the use of average cost and average prices;
3. Appropriate recognition of and payment for teaching hospitals.

DRG concerns

Why don't we want to use DRGs alone in intensive care? Let's just discuss the three "ageing" basic concerns outlined above. First, DRGs are designed for acute inpatient hospital care and the purpose is to group those patients who are similar clinically and who have a similar pattern of resource use. A large number of DRGs, however, do not describe resource use well and the average cost of treating a patient in any given DRG is higher for hospitals with than for hospitals without ICUs (Cooper and Linde-Zwirble, 2004).

Second, the average price for the average patient does not exist in the ICU; there are outliers, who cost disproportionably more than average. The study by Cooper (2004) shows this in a large database, involving 55.8% of all intensive care unit days for one year in the USA (see table below).

Finally, teaching hospitals are expensive places to treat patients. The higher cost of care has been attributed to a more complex case mix, the use of more sophisticated technology and the "legitimate" extra cost of teaching, which is not taken into account by DRG (Aardal et al. 2005).

Year 2000	*ICU*	*CCU*	*Floor*
Discharges (No.)	*2,353,208*	*934,459*	*7,369,920*
Outliers (%)	*10.4*	*5.1*	*1.3*
Overall profit (loss)	*(5.8 B) US$*	*(1.2 B) US$*	*2.0 B US$*

Possible improvement measures

Can the DRG funding be improved? Yes, it is possible to make it better by several different methods, including :

• Entering correct medical records. In a Norwegian study, the quality of medical records was checked in the authors' ICU (Neilson et al. 2004). They performed a retrospective analysis of submitted DRG codes in a year and found that an additional 18.4% DRG points could be retrieved, which corresponds to € 1.1 million!

• Identifying the outliers. It is well known that extended length of stay (LOS) significantly contributes to the ICU costs (Neilson et al. 2004). In order to improve DRG, we should try to identify the factors which can predict prolonged LOS in the ICU. Higgins et al (2003) analysed 12 variables against weighted LOS (n= 10,862) and found that mechanical ventilation and presence of infection on admission prolongs LOS.

• Taking into account other high cost drivers such as direct nursing hours, number of organ failures, expensive medications, certain procedures, etc. This will encourage us to concentrate on the individual differences between ICUs, which an ideal funding system should also take into account. Of course, this can only be done if detailed costing data is available.

What is the future of DRG in intensive care? DRG funding will only work if country-specific adjustments are made, depending on the structure of the healthcare system and the intensive care settings. In France, for example, DRG is combined with the activity-driven funding. This incurs additional funding for procedures performed in the ICU (Guidet et al. 2006). In Germany, however, a simplified Therapeutic Intervention Scoring System (TISS-28) is used for ICU funding in combination with DRG (Neilson et al. 2004).The continuing demand for intensive care combined with limited budget for healthcare expenditures will motivate us further to look for the ideal funding of intensive care.

Author:
Akos Csomos, MD, DEAA,
PhDSurgical Intensive Care Unit,
Semmelweis University,
Budapest, Hungary
Email: cosmos@sebl.sote.hu

Austrian health and hospital system

Towards managerial and financial convergence

FACTS & FIGURES

Total population :
8,189,000
GNP per capita :
33,140 usdols
Life expectancy (m/f) :
77/82
Live births :
9.7 per 1,000
Death rate :
9.4 per 1,000
Total health expenditure :
7.7% of GDP
Total expenditure on health per capita :
2,200 PPP euros
Percentage of healthcare system financed by public funds :
70%
Number of hospitals :
280 hospitals, including 180 acute care hospitals
Number of physicians working in hospitals :
27,000 (66% of the total number of physicians)

Austria is a democratic republic and a federal state which is composed of nine Länder. The Länder have their legislative competencies and also participate in legislation at a federal lervel in the Bundesrat (upper house of parliament).

Health system structure

The Austrian healthcare system is characterised by the federalist structure of the country, the delegation of competencies to self-governing stakeholders in the social insurance system as well as by cross-stakeholder structures at federal and Länder level which possess competencies in cooperative planning, coordination and financing. According to the Federal Constitution, almost all areas of the healthcare system are primarily the regulatory responsibility of the federal government. The most important exception is the hospital sector. In this area, the federal government is only responsible for enacting basic law; legislation on implementation and enforcement is the responsibility of the nine Länder.

The various sectors of the healthcare system have traditionally been characterised by different stakeholders and regulation- and financing mechanisms. However, in recent years there have been increased efforts to introduce decision-making and financing flows which are effective across all sectors.

Since 2002, all the Länder, except Vienna, as well as some of the private non-profit owners, have privatised their hospitals, mainly in the form of organisational privatisations. The various private operating companies have one thing in common: they are responsible for the management of hospitals, whereas the Länder or local authorities as (majority) owners usually act as a guarantor. The Austrian healthcare system has developed almost completely into a model which is mainly based on decentralised contracts with all service providers.

Healthcare financing

The financing of the healthcare system is pluralistic in accordance with the constitution and social insurance laws. The social health insurance system, which is the most important source of financing, provided a total of 45,3% of total healthcare expenditure in 2004. Mandatory insurance is based on membership of an occupational group or place of residence; thus, there is no competition between health insurance funds.

25% of total healthcare expenditure is financed by the federal government, the Länder and local authorities. 10% of this share was accounted for by tax financed long-term care cash benefits. The latter have been paid out to people in need of long-term care since 1993.

In 2004, around 25% of healthcare expenditure was financed privately. Private households bore 13,5% of healthcare expenditure by means of indirect cost-sharing (services whose costs were fully borne by the insured) and 7,6% by means of direct cost sharing (co-payments). Direct cost sharing was increased in recent years and affects almost every service provided by social health insurance; however, the outpatient clinics fee introduced in 2001 was withdrawn again in 2005 due to the high costs involved in its implementation and the considerable resistance it had encountered.

The future challenge facing the healthcare industry lies in the transition from acute to preventive healthcare.

Manfred Kösner is Vice President of T-Systems Austria and is responsible for healthcare sales. The expert can look back on 20 years' experience in the sector and offers insights into past developments and new challenges facing the healthcare industry.

The healthcare sector has undergone continuous, evolutionary development over the last 20 years. When I think back to the first projects that I worked on in the hospital sector, the main concerns at that time were administration and billing. The focus was on providing support for administrative processes and charging for services provided. Five years ago, discussion focused increasingly on the technologies deployed. Questions were asked about the technology platform on which a solution should be based, how it should be technically implemented, or how user-friendly it was. Today, it is automatically assumed that state-of-the-art products with a well-designed user interface will be employed.

Only with the passage of time did the requirements focus shift in the direction of medical/clinical concerns. People began to talk about procedures and processes and to look for solutions that would support these processes as ably and efficiently as possible. However, these projects were still focused entirely on IT and were not organizational projects. Other aspects now take center-stage in healthcare sector projects: Hospitals are increasingly run as business enterprises, large associations have grown up and individual hospitals have tended to be marginalized. This has led to optimizations in the medical services offered by the individual hospitals within an association, networking of hospitals has become an essential component of the projects and global planning is now an automatic requirement.

As an IT company, we have grasped this opportunity and have, in a manner of speaking, grown along with the changing nature of the tasks involved. It was and still is the greatest challenge, not only to work on the implementation of existing requirements, but also to come up with new ideas and contribute to efficiency increases, process optimizations, patient safety and user-friendliness. The challenges of the future lie in the transition from acute to preventive medical care.

Manfred Kösner

Most healthcare systems in Europe are currently designed to provide acute medical care. However, most problems occur in long-term illnesses such as diabetes. A move in the direction of preventive medicine and long-term treatment is required here. Demographic developments clearly show that we are an ageing population, and clinical symptoms will inherently change with these developments. Telemedicine, in particular telesupported preventive care, aftercare and long-term care will increasingly come to the fore. Benchmarking among doctors and healthcare service providers will become a matter of course. Patients will become actively involved in their treatment and will act as well-informed partners for healthcare providers. Lifelong medical records will become the norm. New financing models will be required to keep rising costs under control. Collaboration across regions and countries will become an essential requirement due to the increasing mobility of the population.

T-Systems Austria is heavily focused on healthcare, given that we can call upon many years' experience and expertise in this sector. For almost 20 years, we have been devising solutions for the healthcare sector and therefore know exactly what its requirements are. We have developed continuously from being purely a hospital information system provider to become an all-round service provider for the entire healthcare sector. T-Systems will remain a driving force behind the generation of new ideas in the eHealth domain. As an all-round IT company, we see ourselves here not only in the role of implementer of specific requirements, but also as a provider of innovative ideas.

www.t-systems.at
info@t-systems.at

T Systems

Delivery system

Those covered by health insurance can freely choose between service providers in the outpatient sector, of whom the majority work in individual practices. In addition, outpatient clinics and hospital outpatient departments offer outpatient care. Compared to 1980, the number of practising physicians and dentists has risen at an over-average rate, with the figures for both professions actually doubling. There is a considerable variation in the density of physicians between the Länder. The number of nursing staff also doubled between 1980 and 2003 to 6 per 1000 inhabitants. However, it was still clearly below the EU average of 7,3 in 2003.

Hospitals which are listed in the hospital plan of a Land are subject to public law ("fund hospitals") and have a statutory requirement to provide care and to admit patients. They are entitled to legally prescribed subsidies from public sources for investments, maintenance and running costs. The ratio of beds to inhabitants of 6,1 beds per 1,000 persons is clearly above the EU average. The average length of stay, 6 days is shorter than the EU average, the utilisation of bed capacity at 76% marginally below.

With the passing of the 1993 Federal Long-Term Care Act, Austria reacted comparatively early to the approaching demographic challenges. Like acute inpatient care, long term care too is a sector where federal cooperation instruments are used, specifically to ensure the uniformity of entitlement criteria and quality standards of long term care institutions.

Health reforms

Health reforms have primarily dealt with cost containment (by exploiting potential for more efficiency and raising cost sharing) and with structural reforms to improve the planning of capacities, the cooperation of stakeholders and the coordination of financing flows.In the acute hospital care sector organisational privatisations were performed which was essentially completed by 2002. The reimbursement of services and medicines by social health insurance has been more strongly linked to health technology assessment, but only a small number of benefits have been excluded. At the same time, new benefits have been introduced, such as federal long term care benefit, psychotherapy, preventive services, and new structures for community-based long term care.

Contribution revenue has increased and the contribution rates of some groups of the insured brought into line, but the revenue base has not fundamentally changed. Quality assurance requirements have been raised and patients' rights have been strengthened by a charter and patients' ombudpersons.

DRG system

The Austrian DRG system of hospital financing is developing. Its main focuses are the inclusion of the promotion of day care services and the updating of the model through calculations using a revised calculation guide based on updated hospital cost accounting. Furthermore, integrated supply concepts and the reduction of the burden on inpatient care are to be promoted by the development of a points model for medical follow-up care, transfers between departments and hospitals, and readmissions. The coordination of the Austrian DRG model with the services supplied in hospital outpatient departments and private practice is to be achieved through the harmonisation of documentation and the separation of the contents and the scoring of flat rates per case from other areas of care provision. In addition, a performance-orientated financing concept is to be developed for the outpatient sector which is coordinated with the inpatient sector.

The creation of a new instrument of cooperation designed to provide motivation for cooperation between financing bodies is closely linked to the structure of raising funding for hospital financing. Important impulses for cost-containment will result from this cooperation if the stakeholders involved interact in a constructive manner.

Conclusion

In the past 25 years, the stakeholders in the Austrian healthcare system have succeeded, characteristically by means of cooperative agreements and planning, in ensuring almost universal healthcare provision with a comprehensive benefit catalogue, in spite of considerable increases in expenditure and continuing cost containment measures.

Waiting times for medical treatment are rarely discussed in public and can be viewed as short in comparison to other countries, although there has been no precise evaluation of this. However, the supply structure is characterised by inequalities between the Länder and also between urban and rural areas. Altogether, life expectancy and most of the documented health indicators have improved markedly in the past 15 years. The level of satisfaction of the population with the healthcare system continues to be high in an international comparison.

Sectoral fragmentation, which also creates bias towards hospital care, is a long standing weakness of the Austrian healthcare system. In spite of numerous efforts, it has until now not been possible, in the sense of allocative efficiency, to allow funding to follow the services provided across sectoral borders. Nor has it been possible to structure the supply chain in a more needs-orientated way across these administrative and financial barriers at the sectoral borders, especially between outpatient and inpatient care or acute and long-term care.

The planning, structures and funds introduced since 2005 permit for the first time the cross-sectoral steering of capacities and financing flows. They also provide for incentives for improved interface management and integrated forms of care.

Sources: WHO, European Observatory on Health Systems and Policies, Dexia Bank survey on EU hospitals.

The Austrian Association of Hospital Managers

Host of the EAHM Congress in Graz in September 2008

By Josef Hradsky

Graz, Austria's second largest city and the capital of the state of Styria, has been chosen to host the 22nd EAHM congress due to be held on 25 and 26 September 2008. The Styrian Association of Hospital Managers has been entrusted with the task of organising the congress on behalf of the Federal Conference of Austrian Hospital Managers (BUKO) and the European Association of Hospital Managers (EAHM).

Structure and Functions

The Federal Conference of Austrian Hospital Managers (BUKO) is the official title of the Austrian association of hospital managers and the choice of name reflects the federal structure of the Austrian state. The country consists of nine federal states, each of which has a separate, independent association representing the interests of those engaged in the administrative and financial management of its hospitals. The nine state associations work collectively in the Federal Conference of Austrian Hospital Managers (BUKO). Although it was not registered as a legal entity until 2005, BUKO's origins date back to 1970 when a working group consisting of two representatives from each federal state was established. The BUKO board is made up of the chairpersons of all the state associations and their respective deputies as well as four honorary members. The current President is Nikolaus Koller from Styria. His two vice-presidents are Wolfgang Markl from Tyrol and Anton Pohl from Vienna.
BUKO can draw on the knowledge and experience of numerous Austrian hospital managers. In line with its mission statement, it acts as a service hub and platform for ideas, communication and information for the members of its affiliated working groups. Its motto – "By Practitioners, For Practi-

tioners" – is reflected in its work disseminating information and nurturing contacts in the hospital sector at national and international level.

BUKO is best known for organising the Austrian Congress on Hospital Management, the 52nd of which will be held in Linz, in Upper Austria, from 4 to 6 May 2009 – see *www.ovkd.at/ooe/kongress.htm.* Organised along interdisciplinary and interprofessional lines, these conferences are the most important events in the Austrian health professional's calendar. Their consistent high quality is also attracting an increasing number of visitors from abroad. BUKO fosters greater communication and information sharing through cooperative ventures with the ÖKZ (the Austrian Hospital Gazette), the magazine QUALITAS and a number of conference organisers. For many years, it has run the Austrian Institute for Hospital Management (ÖIK), a successful, recognised training centre for hospital management.

International Commitment and the EAHM Congress

Austria was among the founding members of EAHM and since then, BUKO and its constituent state associations have continued to play an active role on the European stage. Two Austrians, Rudolf Tornar and Horst Ingruber, are past Presidents of the EAHM. Nikolaus Koller is the country's representative on the EAHM Board and Scientific Committee, while Josef Hradsky is a member of the Editorial Board of Hospital.

Further evidence of BUKO's commitment to the European idea lies in the fact that Austria has already hosted two highly successful EAHM congresses, in 1992 and in 1988. That the EAHM congress will take place in Graz this year is indicative of the high esteem in which BUKO is held in Europe. Austria will become only the second country – alongside France – to host this key event on three occasions.

In 1999, UNESCO recognised the historic centre of Graz as a world heritage site and the city was the European capital of culture in 2003. This and the congress's excellent scientific programme – the overall theme is "New Leadership for New Challenges" - offer further incentives to European health professionals to attend the event on 25 and 26 September 2008. Registration is already possible at *www.evkd-kongress2008.eu*. Graz, Austria and the Federal Conference of Austrian Hospital Managers warmly invite readers of Hospital to attend the congress. We look forward to receiving many visitors come the autumn.

AUTHOR:
Regierungsrat Josef Hradsky,
BUKO Honorary Member and Press Spokesperson
Email: josef.hradsky@aon.at
Website: www.ovkd.at

Trends in Austrian Hospital Management

Older staff and environmental management

By Wilhelm Strmsek

The mission statement of the Vienna Hospital Association contains a commitment to pursue the ideals and objectives of universal health promotion. The association has adopted, as a core strategic principle, the need to maintain and promo - te the health of staff and patients and to empower them to improve their own health.

"Older" staff are a strategic priority for the Vienna network of health promoting hospitals. Of specific interest are ways in which younger and older staff can work together in a mutually beneficial manner and conditions that would facilitate employees to work until the prescribed retirement age. To this end, the recommendations of the "Council of Elders" and "Newcomer Forum" are systematically implemented. Other measures include age appropriate differentiation of activities and the creation of multifunctional roles.

A situation analysis has shown rising absenteeism rates, leading to a commensurate increase in the workload of younger staff, a lack of options for redeploying older staff to other areas and a lack of awareness at management level regarding the need to create and actively support health promoting jobs. Moreover, relations between younger and older staff are frequently characterised by mutual incomprehension and the value of work – specifically in the nursing profession – is too often measured in terms of physical ability. It is now a medium-term goal to improve conditions for older staff and adapt to their capabilities. In addition, hospitals will focus on enhancing cooperation between younger and older staff and integrating health promoting factors in the workplace. Managers must treat health promotion as an important management task and the areas of activity best suited to older staff must also be clearly defined.

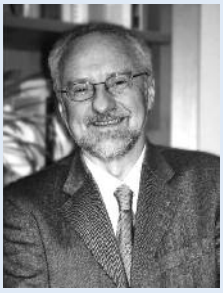
The Vienna Hospital Association has been committed to environment protection since 1990. On the basis of the precautionary principle, it seeks to protect the health of the population and promote well-being. In terms of sustainability, it focuses on measures that maintain air, water and soil quality and guarantee a responsible approach to the use of limited resources. The annual economic plans and target agreements with the various hospitals and healthcare institutions contain a wide range of environmental objectives. Specific measures include an ongoing commitment to increase the use of organic food products and reduce food purchases through waste reduction efforts (organic foods now account for more than 30% of food purchased, thus reducing CO2 emissions by more than 10,000 tonnes), a shift from bottled mineral water to tap water sourced from mountain springs, compliance with energy and ecological standards in the management of all construction works (refurbishment and new-build), including the provision of green spaces. The latter objective is achieved by means of a tree register with visual tree controls and the implementation of recommended tree management measures. Materials analysis and greater use of PVC free alternatives will deliver ongoing improvements in commodity use, while recycling collections will reduce waste volumes.

The first city-wide information day on the environment, which was held in 2007, offered patients, family members and hospital staff a detailed appraisal of the numerous environmental activities in which the Vienna Hospital Association is engaged.

Author:
OAR Wilhelm Strmsek, MAS,
Administrative Director, Hietzing Hospital
and Neurological Centre Rosenhügel, Vienna, Austria
Email: Wilhelm.strmsek@wienkav.at

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

L'année 2008



Heinz Kölking

L'année 2007 est derrière nous, mais les défis demeurent. Ceci est valable pour tous les domaines, et donc aussi pour le développement de notre espace européen. En 2008, la Slovénie, suivie de la France, assumera la présidence du conseil européen. En ce qui concerne les questions de politique sanitaire, le Bureau de l'AEDH, soutenu par le comité Affaires européennes, continuera à mettre les préoccupations hospitalières majeures à l'ordre du jour.

Celles-ci englobent, entre autres, le problème de la coopération transfrontalière entre hôpitaux, du financement des services hospitaliers et de l'accréditation des établissements de santé. Une problématique émerge également de l'évolution différente des pays de l'UE par rapport au rôle de l'Etat dans les soins de santé. Du point de vue des hôpitaux, il s'agit en fin de compte d'une lutte pour la prise en compte des facteurs de réussite d'un hôpital par rapport à la qualité et la rentabilité. Est-ce le taux de rendement et/ou l'intérêt général qui optimalisent la rentabilité et la qualité? Quel rôle l'Etat devrait-il assumer vis-à-vis de l'offre de services médicaux et infirmiers? Combien de privatisation et de commercialisation les soins hospitaliers peuvent-ils supporter? Quel rôle le 'secteur tertiaire' des services d'intérêt général va-t-il endosser à l'avenir? L'AEDH et ses pays membres ne sont pas idéologiquement homogènes sur ces questions. Notre association est composée de directeurs d'hôpitaux et de gestionnaires qui travaillent dans des établissements soit publics, soit privés ou d'intérêt général. Ce numéro d'E-Hospital se préoccupe précisément de la gestion du risque à l'hôpital. Thème important aux multiples ramifications, fondement essentiel de la gestion qualité, et donc condition sine qua non de la réussite durable de tout établissement. Revient aussi sans cesse la question des services ou missions qui doivent être organisés en mode interne par un hôpital et de ceux qui peuvent être externalisés. Ce thème aux mille facettes est également abordé dans ce numéro.

L'année 2008 amène également l'AEDH à son 22ème Congrès européen, du 25 au 26 septembre, dans la belle ville de Graz, en Autriche. Son thème tourne autour des questions passionnantes de leadership dans et de l'hôpital dans un contexte d'innombrables défis, que ce soit par rapport aux soins du patient, au personnel, à la politique, à l'économie, aux forces dirigeantes ou à l'éthique. Un excellent angle d'approche pour notre Congrès, qui de nouveau cette année nous aidera à communiquer, à apprendre, à débattre et à construire ensemble l'avenir de nos hôpitaux. Vous trouverez dans la rubrique focus de cette édition un aperçu concis de notre pays hôte, l'Autriche, et de son système de santé.
Après les congrès de Dublin et d'Oslo ainsi que le séminaire très réussi de Düsseldorf, nous nous réjouissons de vous y retrouver. Bienvenue à Graz!

Heinz Kölking
Vice-Président de l'AEDH

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

37ème Assembée générale à Düsseldorf

Le 16 novembre 2007, de nombreux pays membres ont convergé de toute l'Europe vers Düsseldorf, où se tenait l'assemblée générale de l'AEDH, à l'occasion de son séminaire sur l'accréditation (voir page suivante). Enchantés de profiter de l'hospitalité de leurs collègues allemands pour participer à un forum réputé de haut niveau comme le Deutschen Krankenhaustag, les délégués ont pu également assister à la remise du prix Golden Helix 2007 et visiter le salon Medica.

Au début de l'assemblée générale, le Président, Paul Castel, a immédiatement informé les délégués du renouvellement de mandat du Secrétaire général, Willy Heuschen, pour cinq ans supplémentaires (2008-2012). Cette décision a été très positivement accueillie. Mr Heuschen a souligné qu'il était très heureux de pouvoir poursuivre sa mission, a remercié de la confiance qui lui était accordée, et exprimé son espoir de pouvoir compter encore sur le soutien des membres de l'AEDH.

Le Président a ensuite présenté son rapport d'activités, qui a repris les tâches accomplies par chaque entité depuis son élection en septembre 2006. Le programme de travail incluait principalement l'organisation du séminaire de la veille, la communication de positions officielles sur les propositions d'actions communautaires autour des soins de santé, et le lancement possible d'un projet de collaboration avec les ges - tionnaires de l'IT hospitalier en Europe.

En outre, une rapide enquête à également eu lieu en 2006, et plusieurs autres sont prévues à l'avenir, à propos des activités d'évaluation de la satisfaction du patient, ainsi qu'un autre sondage datant de 2007 sur la mobilité du personnel de santé. Ce genre d'enquête constitue une nouvelle manière de procéder pour l'AEDH, qui peut mieux dégager, de façon simple et non bureaucratique, la position de l'AEDH sur des questions actuelles et créer de manière générale une perspective plus large sur l'organisation des soins de santé en Europe.

Monsieur Castel a également détaillé les deux prises de position de l'AEDH en réponse au processus de consultation de la Commission européenne à propos de services de santé.

Ceux-ci ont principalement traité du thème de la garantie de la qualité et de l'accréditation des hôpitaux, et contribué au lancement du projet de séminaire sur ce thème. Des actions supplémentaires sur la question sont prévues en 2008, surtout pendant la présidence française.

En conclusion, le Président a commenté les projets d'adhésions nouvelles en Europe centrale et orientale, par exemple en Roumanie. Pour la Roumanie, les délégués ont exceptionnellement accordé leur approbation sous condition de résultat positif d'une visite chez leurs collègues roumains. La candidature de la Bosnie-Herzégovine est également envisagée, même s'il n'existe encore aucune perspective concrète.

Le programme d'action englobe également la poursuite de projets actuels, et particulièrement l'organisation du 22ème Congrès de l'AEDH à Graz, une des activités principales de notre association. De plus, l'organisation d'un événement supplémentaire en 2009 est également à l'ordre du jour, ainsi que le suivi des activités de l'UE et d'éventuelles prises de position de l'AEDH autour de ces activités.

Le rapport d'activités complet est disponible sur le site de l'AEDH.

Le Secrétaire général, Willy Heuschen, a communiqué les comptes 2006 et le budget 2008. La bonne nouvelle qu'il a révélée est que les comptes se sont clôturés sur un crédit d'environ 4.000 euros. Après approbation du Bureau, une réserve a donc été constituée pour les activités futures de l'AEDH, afin d'offrir aux membres un maximum de prestations.

Après contrôle des commissaires, les comptes et le budget ont été approuvés à l'unanimité par les délégués.

Finalement, Mr Nikolaus Koller, représentant de l'Autriche au Bureau de l'AEDH et Président de la Conférence fédérale des Directeurs d'Hôpitaux autrichiens, a parlé du prochain congrès de l'AEDH à Graz en septembre 2008 et en a vanté l'endroit, le déroulement et les thèmes, de sorte que l'invitation a été largement appréciée.

La prochaine assemblée générale ordinaire de l'AEDH aura lieu à la veille du congrès de Graz, le matin du 25 septembre 2008.

Nous vous y invitons d'ores et déjà et nous réjouissons de vous y recontrer!

SÉMINAIRE DE L'AEDH

Notre association a organisé son premier séminaire le 16 novembre dernier à l'occasion du salon MEDICA 2007 à Düsseldorf. Le thème en avait été soigneusement choisi pour son actualité et son caractère paneuropéen et transfrontalier: les outils d'évaluation de la qualité hospitalière. Ce titre général était suivi d'une interrogation en forme de débat à lancer: vers un système d'accréditation européenne sur base volontaire?

En outre, notre édition précédente reprenait le même thème, afin de préparer nos lecteurs à aborder la question de manière informée.

Ce séminaire dense et extrêmement instructif a été suivi par une soixantaine de membres de l'AEDH, qui ont non seulement écouté attentivement les orateurs de grande qualité qui se sont succédé, mais ont aussi activement participé à la table ronde qui a eu lieu dans l'après-midi.

Le séminaire s'est ouvert sur l'accueil d'Asger Hansen, le président du sous-comité scientifique qui a sélectionné le sujet et les intervenants. Il a souligné la nécessité d'un système d'accréditation commun aux hopitaux européens, qui a déjà fait l'objet d'une prise de position de l'association suite à la consultation lancée par la Commission européenne. Ce système d'accréditation contribuerait à la structuration de soins transfronta - liers toujours plus présents dans la réalité hospitalière actuelle.
Le premier orateur, le Dr. Charles Shaw, fait figure d'autorité sur la scène des programmes d'évaluation de la qualité. Il a brossé un tableau exhaustif des initiatives prises dans ce domaine au niveau national dans plusieurs pays d'Europe, du rôle actif joué par différentes instances internationales (OMS, Conseil de l'Europe). Il s'est également attardé sur les motivations différentes et complémentaires des différents acteurs du secteur des soins de santé: le patient qui veut pouvoir comparer les hôpitaux européens sur une base commune, les professionnels de santé dont la reconnaissance des qualifications au niveau européen passe par une harmonisation de l'organisation et des services hospitaliers, mais aussi les organismes d'assurance et les gouvernements.

En conclusion, le Dr Shaw a exprimé son enthousiasme pour une initiative émanant d'une organisation telle que l'Association européenne des Directeurs d'Hôpitaux en faveur d'un système d'accréditation. Une telle initiative respecterait le principe de subsidiarité et aurait sans doute plus de chance de se répandre rapidement qu'une négociation intergouvernementale.

Le Professeur Vleugels a d'ailleurs illustré cette voie en décrivant un projet de grande envergure au sein d'un groupe d'hôpitaux belges sur les contours d'un futur modèle potentiel d'accréditation.

Le Dr. Andrzej Rys, Directeur au département de santé publique de la DG Santé et protection des consommateurs à la Commission européenne, a assumé un double rôle durant cette journée: écouter les opinions de nos membres en tant qu'experts techniques de la situation hospitalière en Europe et communiquer les projets et les initiatives de la Commission en matière de santé publique européenne. Même si le rôle des institutions européennes dans ce domaine reste limité et soumis à la compétence nationale des Èats-membres, la Commission vise à offrir un cadre juridique aux services de santé, en particulier dans un contexte transfrontalier, et à financer des projets novateurs dans différents domaines de santé publique. Vous en saurez plus sur la nouvelle directive réglementant les services de santé et sa contribution à l'accréditation hospitalière en lisant l'interview du Dr Rys en page 11.

L'après-midi s'est poursuivie avec la présentation de projets d'évaluation de la qualité aux Pays-Bas, au Danemark et en Allemagne et un dialogue intensif entre tous les intervenants de la journée et le public. Nul doute que tous en sont ressortis mieux informés et plus riches de cette nouvelle voie à tracer.

A noter aussi est que la journée a été interrompue par la cérémonie de remise des prix Golden Helix Award 2007, sous l'égide de l'Association allemande des directeurs d'hôpitaux et de deux sponsors. Le prix récompense des projets novateurs et orientés vers le patient et visant à améliorer la qualité sur base de données et de faits.

Cette 15ème édition a récompensé un projet styrien (Autriche) de développement de la qualité pour le traitement des patients atteints de syndrome coronarien sévère et un projet allemand d'indicateurs de qualité dans le domaine des soins psychiatriques.

Une approche intégrée de la gestion du risque

Par Leopold-Michael Marzi

Depuis quelque temps, l'Hôpital général de Vienne, avec l'aide de son propre service juridique, tente d'introduire une gestion du risque intégrée qui englobe l'évaluation du risque lié aux soins aux patients, les aspects légaux des activités hospitalières, une culture de la gestion de l'erreur, de la communication, une conscientisation de la prévention des erreurs, et une comparaison des activités hospitalières avec celles de secteurs sensibles au risque, comme l'aviation civile. La gestion du risque à l'hôpital est un processus continu. Il est inconcevable qu'il soit confiné à un programme unique de formation. Il faut atteindre un équilibre entre un état d'alerte excessif et l'illusion d'une sécurité trompeuse, où le personnel croit que ses erreurs n'ont aucunes répercussions, légales ou autres.

Infections nosocomiales

Par Paul Fenn, Alastair Gray, Neil Rickman, Dev Vencappa, Oliver Rivero et Emanuela Lotti

En principe, un mécanisme important en faveur de la sécurité du patient est l'offre d'incitants financiers aux hôpitaux. Le NHS Litigation Authority is responsable de l'administration du Clinical Negligence Scheme for Trusts (CNST), un programme sur base volontaire pour les négligences cliniques, auquel adhèrent tous les NHS Trusts britanniques. Il couvre tous les incidents cliniques qui se sont passés à partir de la date où le Trust a rejoint le programme. Ce programme accorde également une place au processus de gestion du risque que les membres ont adopté pour déterminer leur contribution. On a découvert que l'amélioration de normes de gestion du risque CNST est associée à des réductions pouvant aller de 11 à 20% du taux d'infection MRSA, après contrôle de l'effet des variations observées en termes de niveau d'activité hospitalière, de casuistique, et de taux d'occupation des lits.

Adoption et utilisation des nouvelles technologies médicales au niveau de l'hôpital

Par Dan Greenberg et Joseph Pliskin

Les décisions d'adoption d'une technologie constituent un risque et posent un défi aux décideurs, qui sont souvent forcés de prendre des décisions opportunes en ce qui concerne des technologies innovantes, sans avoir de preuves claires sur leur efficacité clinique et leur rentabilité économique.Ces dernières années, plusieurs experts ont suggéré que lors de la procédure décisionnelle établissant les priorités, les décideurs doivent s'assurer que deux objectifs soient atteints : la légitimité, définie en tant qu'autorité morale à prendre des décisions d'allocation de ressources, et l'équité, qui est obtenue quand un individu a des raisons suffisantes d'accepter de telles décisions, grâce à l'acceptabilité du processus décisionnel. Les décideurs hospitaliers devraient suivre une formation solide dans le domaine de l'économie de santé, de l'évaluation de la technologie sanitaire et de la prise de décisions.

Gestion du risque optimale en soins de santé

Par Maria Ines Cartes

Alors que les traitements et procédures chirurgicales deviennent de plus en plus sophistiqués, les pratiques qui leur sont associées ne suivent pas toujours. Dans un contexte de haute technologisation et d'une nécessaire division du travail médical et soignant, même des erreurs mineures peuvent avoir des conséquences désastreuses. Les conditions de viabilité d'un hôpital dépendent d'une bonne stratégie, d'une utilisation efficace des ressources et d'un contrôle optimal des processus. Des systèmes de management comme la gestion du risque doivent donc être appliqués au sein d'une démarche décisionnelle opérative, tactique et stratégique. On peut réaliser cet objectif en appliquant une méthode en six points: prendre une décision, réaliser un changement culturel, établir des exigences et des paramètres, créer une expertise, élaborer une culture organisationnelle et culturelle et faire usage d'outils et de méthodes.

Résultats de l'enquête sur la gestion hospitalière européene

Par Carsten Hutt

Une enquête a récemment été organisée par E-Hospital, en collaboration avec Emergent Actio. 274 contributions envoyées par des gestionnaires hospitaliers originaires de toute l'Europe ont été reçues et examinées. L'analyse des résultats est présentée ici, et se focalise principalement sur les réponses les plus significatives: la relation entre la taille d'un hôpital et sa compétitivité, ou entre la qualité médicale et la technologie de l'information. Il est également intéressant, et surprenant, de voir comment les gestionnaires hospitaliers européens voient l'avenir de leurs hôpitaux.

Perspectives d'externalisation des services et processus sanitaires

Par Petri Parvinen et Olli Tolkki

Les discussions autour de l'externalisation de services de soins de santé se concentrent souvent sur les économies

financières, les problèmes de qualité et les théories de transaction des coûts. Il est pourtant crucial de séparer les arguments qui relèvent uniquement d'une résistance au changement, de l'argumentation liée au contrôle ou à la qualité. Une nouvelle perspective doit être ajoutée au débat et l'impact de la relation contractuelle entre un client et son fournisseur mise en lumière tout en analysant les possibilités de l'externalisation d'un point de vue opérationnel et de développement. Cependant, les interfaces entre les différentes catégories d'externalisation (transactionnelles, à valeur ajoutée, spécialisées, et uniques) ne sont pas toujours claires, même si le niveau relationnel entre l'acheteur et le vendeur est particulièrement important et se développe comme un processus évolutif.

Externalisation des services logistiques de l'hôpital

Par Wolfgang Dröscher

Le processus logistique de l'hôpital universitaire Balgrist a été passé en revue en 2003. Afin de soulager les infirmières de tâches logistiques telles que commande, transport interne, restockage des fournitures, ces fonctions ont été transférées au département Achats et Logistique. Le stock interne a été externalisé, ainsi que les livraisons directes au bloc opératoire. Deux contrats séparés ont été conclu avec le partenaire commercial, l'un concernant les articles/kits, la disponibilité et le processus de commande, et l'autre couvrant le transport, le déballage et l'installation des fournitures. Les avantages majeurs sont que le personnel médical peut maintenant se concentrer sur ces activités de base. Ce service personnalisé vers le bloc opératoire n'a occasionné aucune embauche. Un flot ininterrompu de matériel a maintenant été créé vers les salles d'opération et le nombre d'articles a été réduit grâce à la confection de kits. En outre, la logistique externalisée a transformé des frais fixes en frais variables.

Externalisation des hôpitaux grecs

Par Socrates Moschuris et Michael Kondylis

Une étude a été effectuée dans 60 hôpitaux grecs sur les facteurs décisionnels, l'impact et les obstacles associés à l'externalisation dans les hôpitaux afin d'offrir des recommandations aux gestionnaires. Les arguments les plus significatifs en faveur de l'externalisation sont l'amélioration du service au client, la réduction des coûts, le recentrage sur les activités de base, et une plus grande flexibilité qui permet d'adapter les ressources aux besoins changeants du marché. Les risques les plus évidents résident dans le besoin de développer de nouvelles compétences managériales, des capacités et des processus décisionnels supplémentaires. Des erreurs dans l'identification d'activités fondamentales ou non peuvent amener les établissements de soins à externaliser certains de leurs avantages en termes de compétitivité. En outre, puisque l'introduction de services contractuels dans une organisation représente une modification importante des processus de travail, il faut absolument assurer une formation solide du personnel.

Financement DRG des soins intensifs

Par Akos Csomos

Le financement DRG a démontré quelques faiblesses au cours des dernières années. Il manque de sensibilité en ce qui concerne la différenciation entre patients, est parfois inadéquat parce qu'il utilise des prix et coûts moyens, et devrait intégrer une reconnaissance et une rétribution appropriées des hôpitaux d'enseignement.

Cette forme de financement pourrait cependant être améliorée: les mesures possibles incluent l'encodage correct des dossiers médicaux et la prise en compte de facteurs importants de coût, comme les heures infirmières directes et les médicaments onéreux. Il faudrait également essayer d'identifier les facteurs qui peuvent prédire une durée de séjour prolongée aux soins intensifs (ventilation mécanique, présence d'infections lors de l'hospitalisation). Une demande pressante de soins intensifs combinée à un budget limité pourra constituer un motif de recherche de financement idéal pour les soins intensifs.

Système sanitaire et hospitalier autrichien

Le système de santé autrichien est caractérisé par la structure fédéraliste du pays, la délégation des compétences à des autorités autonomes en ce qui concerne le système d'assurance sociale, ainsi que par des structures transversales au niveau fédéral et régional, qui possèdent des compétences en matière de planification, de coordination et de financement. Les citoyens autrichiens jouissent d'une couverture de santé universelle et d'une gamme étendue d'avantages. Grâce à plusieurs réformes de santé visant à renforcer la coopération, harmoniser les capacités et les rendre plus efficaces, le système autrichien a réussi à limiter les périodes d'attente et à maintenir la satisfaction des patients à un niveau élevé. Cependant, la répartition inégale des médecins dans les zones urbaines et rurales ainsi que la fragmentation sectorielle des soins de santé restent des problèmes actuels auxquels les autorités du pays doivent s'attaquer.

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

Das Jahr 2008

Das Jahr 2007 liegt hinter uns, die Herausforderungen bleiben. Dies gilt für alle Lebensbereiche. So auch für die Weiterentwicklung unseres gemeinsamen Europas. Im Jahr 2008 werden zunächst Slowenien und dann Frankreich den Vorsitz im Europäischen Rat übernehmen. Im Hinblick auf gesundheitspolitische Fragestellungen wird das Präsidium des EVKD mit Unterstützung des Beirats „Europäische Angelegenheiten“ wesentliche Punkte der Hospitäler auf die Agenda setzen.

Hierzu zählen beispielhaft Fragen der grenzüberschreitenden Kooperation zwischen Krankenhäusern, die Finanzierung von Krankenhausleistungen und die Akkreditierung von Krankenhäusern. Eine weitere Fragestellung ergibt sich aus den unterschiedlichen Entwicklungen in den Ländern der EU zur Rolle des Staates in der Gesundheitsversorgung. Aus Sicht der Krankenhäuser ist es letztlich das Ringen um die Bewertung der Erfolgsfaktoren für ein Krankenhaus im Hinblick auf Qualität und Wirtschaftlichkeit. Ist es die Rendite und/oder die Gemeinnützigkeit, die sowohl Kosteneffizienz als auch Qualität optimiert? Welche Rolle sollte der Staat auf der Seite des medizinischen und pflegerischen Leistungsangebotes übernehmen? Wie viel Privatisierung und Kommerzialisierung verträgt die stationäre Versorgung? Welche Rolle übernimmt künftig der so genannte "Dritte Sektor" der Gemeinnützigkeit? Die EVKD und ihre Mitgliedsverbände sind in diesen Fragen nicht ideologisch ausgerichtet. Unsere Vereinigung umfasst sowohl Krankenhausdirektoren und Geschäftsführer aus staatlichen als auch aus privaten und gemeinnützigen Einrichtungen.

Diese Ausgabe von E-HOSPITAL widmet sich schwerpunktmäßig dem Risikomanagement in Krankenhäusern. Ein wichtiges Thema mit vielen unterschiedlichen Dimensionen und ein wesentlicher Baustein für das Qualitätsmanagement und damit Voraussetzung für den nachhaltigen Erfolg eines jeden Krankenhauses. Immer wieder neu wird die Frage gestellt, welche Dienstleistungen bzw. Aufgaben in Eigenregie eines Hospitals organisiert werden und welche ausgegliedert werden können. Dieses Thema mit vielen Facetten finden Sie auch in dieser Ausgabe.

Das Jahr 2008 führt die EVKD auch zu seinem 22. Europäischen Kongress in der schönen Stadt Graz am 25. und 26. September 2008 in Österreich zusammen. Das Thema dreht sich rund um spannende Fragen zur Führung in und von Krankenhäusern vor dem Hintergrund der vielfältigen Herausforderungen, wie sie sich im Zusammenhang mit der Patientenversorgung, den Mitarbeitern, der Politik, der Wirtschaft, den Führungskräften und auch der Ethik ergeben. Ein sehr guter und wichtiger Ansatz für unseren Kongress, der uns auch in diesem Jahr wieder dabei helfen wird, voneinander zu lernen, eine interessante Diskussion zu führen und uns wieder ein Stück einer gemeinsamen Vorstellung von der Zukunft unserer Krankenhäuser geben wird. Einen kleinen Überblick zum Gastland Österreich und dessen Gesundheitswesen finden Sie im Länderfokus der vorliegenden Ausgabe.

Zurückblickend auf die letzten Kongresse in Dublin und Oslo und auch vor dem Hintergrund des erfolgreichen Seminars in Düsseldorf freuen wir uns auf die Veranstaltung. Sie alle sind herzlich eingeladen. Kommen Sie nach Graz !

Ihr Heinz Kölking
Vizepräsident 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.

37. EVKD-Mitgliederversammlung in Düsseldorf

Zahlreiche Mitgliedsländer aus ganz Europa sind in 2007 zur ordentlichen EVKD-Mitgliederversammlung, die anlässlich des EVKD-Seminars zum Thema Akkreditierung (siehe auch Bericht S. 45) am 16.11. in Düsseldorf stattfand, zusammengetreten. Glücklich darüber, Gast bei den deutschen Kollegen sein zu dürfen und anlässlich der Versammlung auch an einem, wie mehrfach bezeugt, hochgradigen Weiterbildungsseminar sowie dem Deutschen Krankenhaustag teilnehmen zu können, haben Delegierte die Gelegenheit nicht verpasst, auch der Verleihung des Golden Helix Award 2007 beizuwohnen und die Weltmesse Medica zu besuchen.

Zu Beginn der Mitgliederversammlung informierte Präsident Paul Castel Delegierte zunächst über die Mandatserneuerung Herrn Generalsekretärs Willy Heuschen für weitere fünf Jahre (2008-2012), was von allen Seiten mit sehr positiver Resonanz aufgenommen wurde. Herr Willy Heuschen bemerkte, dass er sich sehr glücklich schätze, die Aufgabe fortführen zu können, bedankte sich für das bezeugte Vertrauen und sagte, er hoffe auch weiterhin auf die Unterstützung der EVKD-Mitglieder zählen zu dürfen.

Der Präsident stellte sodann seinen Tätigkeitsbericht vor, der umfassend über die seit seiner Wahl im September 2006 erfolgte Aktivitäten der einzelnen Organe informierte. Das Arbeitsprogramm umfasste vor allem die Organisation des Seminars vom Vortage, die Abgabe öffentlicher Stellungnahmen zur geplanten Gemeinschaftsaktion in der Gesundheitsversorgung und die Initiierung eines möglichen Projekts der Zusammenarbeit mit Krankenhaus-IT Leitern in Europa.

Zusätzlich konnte noch in 2006 eine Blitzumfrage, von denen in Zukunft mehr geplant sind, zu Tätigkeiten im Bereich Messung der Patientenzufriedenheit stattfinden, sowie eine weitere Umfrage in 2007 zur Mobilität des Gesundheitspersonals. Diese Art Umfrage stellt eine neue Vorgehensweise der EVKD dar. Es kann einfach und unbürokratisch die jeweilige Position der EVKD zu aktuellen Fragen besser definiert werden und schafft im Allgemeinen mehr Überblick zur Organisation der Gesundheitswesen in Europa.

Herr Castel berichtete sodann detailliert über die beiden Positionspapiere der EVKD im Zusammenhang mit dem Konsultationsverfahren der Europäischen Kommission zu Gesundheitsdienstleistungen. Diese haben schwerpunktmäßig das Thema Qualitätssicherung und Akkreditierung von Krankenhäusern behandelt und somit auch das Seminarthema initiiert. Im Zuge einer weiteren Bearbeitung dieser Thematik sind nunmehr weitere Aktionen in 2008, vor allem während der Ratspräsidentschaft Frankreichs, angedacht.

Im Anschluss hieran erläuterte der Präsident die Projekte neuer Mitgliedschaften aus Ost und Zentraleuropa, wie z.B. Rumänien. Für Rumänien erteilten Delegierte eine Aufnahmegenehmigung unter dem Vorbehalt eines positiv verlaufenden Besuchs des Präsidenten bei den rumänischen Kollegen. Als weiterer Kandidat, allerdings derzeit noch ohne konkrete Aussichten wird Bosnien-Herzegowina nicht ausgeschlossen.
Das weitere Aktionsprogramm umfasst Punkte wie die Fortführung der derzeitigen Projekte und in ganz besonderem Maße natürlich die Organisation des 22. EVKD-Kongresses in Graz, als Hauptbestandteil aller Aktivitäten der EVKD. Daneben wird auch die Planung einer neuen Zusatzveranstaltung für 2009 wieder auf dem Programm stehen, sowie die Beobachtung der EU Aktivitäten und eventuellen Stellungnahmen der EVKD hierzu.

(Der Tätigkeitsbericht kann in voller Länge auf der EVKD-Hompage eingesehen werden).

Generalsekretär Willy Heuschen informierte sodann über die Rechnungslegung 2006 und Haushalt 2008. Als gute Nachricht schickte er vorweg, dass die Rechnungslegung mit einem Überschuss von ca. 4000 Euro abgeschlossen werden konnte. Unter Zustimmung des Vorstands, würden weiterhin Rücklagen für neue Tätigkeiten der EVKD gebildet, um Mitgliedern ein umfangreiches Maß an Leistung anbieten zu können. Von den Rechnungsprüfern als fehlerfrei attestiert, genehmigten Delegierte sodann Rechnungslegung und Haushalt einstimmig.

Schließlich informierte Herr Nikolaus Koller, Vertreter Österreichs im EVKD-Vorstand und Präsident der Bundeskonferenz für Krankenhausmanager in Österreich, über den bevorstehenden EVKD -Kongress in Graz im September 2008 und machte Delegierten Ort, Ablauf sowie Kongressthemen schmackhaft, sodass die nochmals ausdrücklich erfolgte Einladung allseits sehr begrüßt wurde.

Die nächste, ordentliche EVKD-Mitgliederversammlung findet im Vorfeld dieses Kongresses am Morgen des 25.9.2008 in Graz statt. Bereits heute möchten wir Sie zu dieser herzlich einladen und freuen uns auf Ihr zahlreiches Kommen !

EVKD Seminar – Rückblick

« Qualitätsbemessung in Krankenhäusern in Europa – auf dem Weg zu einem europäischen Akkreditierungsmodell ? »

Unsere Vereinigung hat ein erstes Fortbildungs- und Informationsseminar am 16. November 2007 anlässlich der Medica 2007 in Düsseldorf abgehalten. Das Thema war sorgfältig ausgewählt, auf Aktualität ausgerichtet und paneuropäisch besetzt: Qualitätsbemessungssysteme in Krankenhäusern in Europa. Der Haupttitel war ergänzt anhand einer Frage, die zu Diskussion anregen sollte: « Auf dem Weg zu einem freiwilligen europäischen Akkreditierungsmodell ? »

Daneben war die Akkreditierung auch Titelthema unserer letzten Journal-Ausgabe, nicht zuletzt um es unseren Lesern zu ermöglichen, informiert auf diese Frage antworten zu können.

Das intensive Seminar war sehr instruktiv und von mehr als 60 Teilnehmern besucht, die nicht nur den Vortragsrednern aufmerksam zuhörten, sondern auch aktiv am runden Tisch teilnahmen, der im Nachmittag statt fand.

Der Präsident des wissenschaftlichen Beirats Asger Hansen eröffnete den Seminartag, dessen Programm und Sprecher vom Beirat sorgfältig vorbereitet und ausgewählt waren.
Asger Hansen unterstrich die Notwendigkeit eines gemeinsamen Akkreditierungssystems für Krankenhäuser in Europa. Diese Position hatte die EVKD auch in ihrer Stellungnahme zur EU-Konsultation im Bereich grenzüberschreitende Gesundheitsdienstleistungen betont. Ein europäisches Akkreditierungssystem würde zu einer Strukturierung der grenzüberschreitenden Leistungen beitragen, die in der europäischen Krankenhauslandschaft stetig wachsen.
Der erste Sprecher, Dr. Charles Shaw, war dementsprechend auch ein Experte im Bereich des europäischen Akkreditierungswesens. Er stellte einen Überblick zu den verschiedenen Programmen zur Qualitätsbemessung in Europa dar und zeigte die verschiedenen Rollen auf, die internationale Organisationen spielen (WHO, Europarat…etc). Auch sprach er über die verschiedenen Gründe, die verschiedene Parteieln zur Nutzung eines Qualitätsbemessungssystems bewegen können: der Patient möchte europäische Krankenhäuser auf einer gemeinsamen Basis untereinander vergleichen können, den Angehörigen der Gesundheitsberufe ist daran gelegen, eine Harmonisierung der Dienste und damit auch der Anerkennung ihrer Ausbildung herbeizuführen, und Versicherer sowie Regierungsinstanzen haben ein Interesse an einer Vergleichbarkeit der Leistungen.

Dr. Shaw befürwortete sehr enthusiastisch die Initiative einer Organisation wie der EVKD zur Entwicklung eines europäischen Akkreditierungssystems. Diese Initiative respektiere das Subsidiaritätsprinzip und hätte sicherlich mehr Chancen als eine Verhandlung auf Regierungsebene.

Professor Vleugels illustrierte diesen Weg, in dem er ein Projekt großer Bedeutung in belgischen Krankenhäusern erläuterte, indem es ebenfalls um ein zukünftiges Akkreditierungssystem geht.

Dr. Andrzej Rys, Direktor in der Generaldirektion Öffentliche Gesundheit der Europäischen Kommission hatte während des Seminartages eine Doppelrolle: sich die Meinungen unserer Mitglieder als technische Experten zur Situation der Krankenhäuser in Europa anzuhören und die Aktivitäten der Kommission in Sachen Öffentliche Gesundheit vorzustellen. Auch wenn die Rolle der Europäischen Kommission in diesem Bereich eine gewisse Limitierung aufweist, da der Bereich der Organisation der Gesundheitsversorgung weiterhin im Zuständigkeitsbereich der Mitgliedsstaate liegt, möchte die Kommission einen juristischen Rahmen vor allem für grenzüberschreitenden Leistungen schaffen und verschiedene neue Projekte im Bereich Öffentliche Gesundheit finanzieren. Mehr über die neueste Initiative im grenzüberschreitenden Versorgungsverkehr lesen Sie in unserem Interview mit Dr. Rys auf S.11.

Den Nachmittag füllten Vorträge, die Projekte zur Qualitätsbemessung und gemachte Erfahrungen hierzu im Krankenhaus in den Niederlanden, Dänemark und Deutschland skizzierten. Es folgte ein intensiver Gedankenaustausch zwischen den Vortragsrednern und den Seminarbesuchern. Ohne Zweifel waren die Gäste hiernach um zahlreiche Informationen bereichert.

Auch zu verzeichnen war, dass während des Seminar die Verteilung des Golden Helix Awards 2007 unter Federführung des Verbandes der Krankenhausdirektoren Deutschlands und den zwei Sponsoren statt gefunden hat. Der Preis zeichnet Projekte im Bereich Qualitätsentwicklung aus, auszuzeichnenden Projekte sollten innovativ und patientenorientiert sein und die Qualitätsverbesserungen mit Daten und Fakten belegen können. Dieser 15. Preis ging an die Steiermärkischen Krankenanstalten für das die gesamte Steiermark umfassende Projekt “Das steirische Herz - Qualitätsentwicklung bei der Betreuung von Patientinnen mit akutem Koronarsyndrom ”. (CH)

Integrierter Ansatz zum Risikomanagement

Von Leopold-Michael Marzi

Am Allgemeinen Krankenhaus in Wien wird unter Mitwirkung des Rechtsbüros seit einiger Zeit versucht, ein vernetztes Risikomanagement zu etablieren, das folgende Elemente in sich vereinigt: Risikobetrachtung der Patientenversorgung im weitesten Sinn; Rechtliche Aspekte der Krankenhausaktivitäten; Fehlerkultur Kommunikation; Bewusstseinsbildung in Richtung Fehlervermeidung; Vergleich des Krankenhausbetriebes mit anderen risikogeneigten Systemen, etwa mit der zivilen Luftfahrt. Risikomanagement im Krankenhaus ist ein Dauerauftrag. Eine Beschränkung auf einzelne Berufsgruppen ist genauso wenig denkbar wie eine einmalige Schulung. Dabei muss aber der schwierige Balanceakt gelingen, niemanden unnötig zu verunsichern, gleichzeitig aber auch nicht in falscher Sicherheit zu wiegen, es könne (auch rechtlich!) nichts passieren.

Nosokomiale Infektionen

BVon Paul Fenn, Alastair Gray, Neil Rickman, Dev Vencappa, Oliver Rivero und Emanuela Lotti

Im Prinzip gibt es nur einen wichtigen Mechnismus, um die Patientensicherheit zu erhöhen, durch die Schaffung finanzieller Anreize. Die NHS Litigation Authority ist verantwortlich für die Verwaltung des Schemas „Klinische Fehlervermeidung", ein freiwilliges System, dem jedoch sämtlich NHS Trusts angehören, und welches klinische Vorfälle während der Mitgliedschaft der jeweiligen Klinik bearbeitet. Für zu leistenden Beiträge zum System, wird auch dem Risikomanagement Rechnung getragen, das im jeweiligen Krankenhaus implementiert ist. Im Ergebnis konnte belegt werden, dass verbesserte Standards zum Risikomanagement mit einer Reduzierung der MRSA-Infektionen von 11%-20% einhergehen, nachdem Unterschiede in den Krankenhäusern, deren Case-Mix und der Bettenbelegungsrate konstatiert wurden.

Beschaffung und Gebrauch neuer Medizintechnologie

Von Dan Greenberg und Joseph Pliskin

Entscheidungen über medizinische Technologie sind Risiko und zugleich Herausforderung für Entscheidungsebenen, die zeitnahe Beschaffungsentscheidungen treffen müssen, oft ohne genügenden Beweis für die klinische Effektivität oder den ökonomischen Wert eines neuen Produktes.
In den letzten Jahren wurde vielfach auf akademischer Ebene vorgeschlagen, dass bei Prioritätensetzung an zwei Ziele gedacht werden muss: Legitimität, als moralische Instanz, die Ausgabenentscheidung zu treffen und Fairness, welche erreicht wird, wenn ein Individuum genügend Grund hat, auf Grund des Entscheidungsprozesse Entscheidungen über Prioritäten zu akzeptieren. Entscheidungsträger in Krankenhäusern müssen ein Training in Gesundheitsökonomik, Health Technology Assessment und Entscheidungsfindung absolvieren.

Optimales Risikomanagement in der Gesundheitsversorgung

Von Maria Ines Cartes

Während Behandlungs- und Operationsmethoden ständig verfeinert werden, ist dies nicht immer der Fall für die damit verbundene Arbeitsorganisation. Bereits kleinere Fehler und Störungen in den Arbeitsabläufen können in Anbetracht des hohen Grades an Technisierung und notwendiger Arbeitsteilung in Medizin und Pflege katastrophale Folgen haben. Der zukünftige erfolgreiche Fortbestand der Krankenhäuser ist darum nur durch eine gute Strategie, den effizienten Ressourceneinsatz und optimale Prozessbeherrschung möglich. Deshalb ist es notwendig, Managementsysteme wie das Risikomanagement in den operativen, taktischen und strategischen Entscheidungen zu implementieren. Konkret bedeutet dieses die strategische Einführung eines effizienten und effektiven Risikomanagements unter optimaler Ressourcenallokation, das zur Ergebnissicherheit beiträgt. Dieses ist in 6 Schritten konkret und straff zu realisieren: Entscheidung treffen; Kulturwandel vornehmen; Voraussetzungen und Rahmenbedingungen aufbauen; Risikomanagement-Fachkompetenz schaffen und Aufbau- und Ablauforganisation bilden.

Ergebnisse der Studie zu Europäischem Krankenhausmanagement

Von Carsten Hutt

E-Hospital hat in Zusammenarbeit mit Emergent Actio jüngst eine Studie zum Europäischen Krankenhausmanagement durchgeführt. 274 Beiträge europäischer Krankenhausmanager aus ganz Europa wurden eingeschickt und ausgewertet. Diese Auswertung wird hier nun präsentiert, mit einem Fokus auf die erstaunlichsten Aussagen: den Zusammenhang zwischen Größe des Krankenhauses und dessen Wettbewerbsfähigkeit, oder zwischen medizinischer Qualität und Informationstechnologie. Auch interessant und überraschend war es zu sehen, wie europäische Krankenhausmanager die Zukunft Europas sehen, sowie deren Zahlen in ihren eigenen Ländern.

Erkenntnisse zum Outsourcing von Gesundheitsdienstleistungen

Von Petri Parvinen und Olli Tolkki

Diskussionen über das Outsourcing drehen sich häufig um Fragen der Kosteneinsparung, Qualitätsprobleme und Transaktionskostentheorien. Es ist aber wichtig, die Argumente nach Themen voneinander zu trennen: solche, die darauf basieren, einen Veränderung zu blockieren oder solche, die Bendenken hinsichtlich der Qualität oder Kontrolle äußern. Es muss eine neue Aussicht in diese Diskussionen gebracht werden und die Auswirkungen der Beziehung zwischen dem Kunden und Auftraggeber muss in den Vordergrund gestellt werden, sodass die Möglichkeiten des Outsourcing vom operationellen Standpunkt und auch vom Visionsstandpunkt aus abgeklopft werden können. Die Schnittstellen in den verschiedenen Kategorien sind jedoch nicht immer klar definiert, obwohl die Beziehung zwischen Kunden und Auftraggeber besonders bedeutungsvoll ist, da sie sich als entwickelnder Prozess zeigt.

Outsourcing der Logistik im Krankenhaus

V*on Wolfgang Dröscher*

Der logistische Prozess am Balgrist University Hospital wurde in 2003 einer Prüfung unterzogen. Um KrankenpflegerInnen von logistischen Aufgaben (wie der Bestellung, internem Transport und dem Auffüllen von Regalen) zu entbinden, wurden diese Aufgaben dem Bereich Beschaffung und Logistik übertragen. Das interne Lager wurde ausgelagert, wie auch die direkten Lieferungen an den OP-Bereich. Hierfür wurden zwei verschiedene Verträge mit einem kommerziellen Partner abgeschlossen, der eine betraf die Waren, die Verfügbarkeit und den Kommissionierungsprozess und der andere den Transport, das Auspacken und das Einfüllen in Regale. Die Hauptvorteile sind, dass sich medizinisches Personal nun um ihre eigentlichen Aufgaben kümmern kann. Es wurde kein zusätzliches Personal für die maßgeschneiderten Aufgaben im OP angestellt. Es wurde stattdessen ein kontinuierlicher Warenfluss an den OP-Bereich eingerichtet und die Anzahl der Waren dadurch verringert, dass Sammelbestellungen geschafft wurden. Das Outsourcing der Logistik hatte auch als Folge, Fixausgaben zu nunmehr variablen Kosten umzuändern.

Outsourcing in Krankenhäusern

Von Socrates Moschuris und Michael Kondylis

In Griechenland ist eine Studie ausgeführt worden in 60 Krankenhäusern, welche die Entscheidungskriterien, die Auswirkungen und die Hindernisse im Outsourcing-Prozess untersucht hat und einige managementbezogene Aussagen ergab. Die Hauptgründe für das Outsourcing sind, den Dienst am Kunden zu verbessern, Kosten zu verringern und es Gesundheitseinrichtungen zu ermöglichen, sich auf die Hauptaufgaben zu konzentrieren, die Flexibilität zu steigern, Ressourcen zu verteilen und damit den sich ändernden Ansprüchen des Marktes gerecht zu werden.
Die signifikantesten Risiken liegen in der Entwicklung neuer Managementtechniken, Fähigkeiten und Entscheidungsprozessen. Fehler in der Identifizierung wichtiger und weniger wichtiger Aktivitäten können Gesundheitseinrichtungen dazu verleiten, ihre Vorteile im Wettbewerb auszulagern. Auch ist die geeignete Ausbildung des Personals essentiell.

DRG-Finanzierung für Intensivmedizin

Von Akos Csomos

Die DRG-Finanzierung kann verbessert werden: mögliche Maßnahmen beinhalten die korrekte Eingabe von Patientenakten und die Berücksichtigung von Kostentreibern wie die Eingabe der tatsächlichen Arbeitsstunden von Pflegekräften und teurer Medikation. Es sollte auch versucht werden, Faktoren zu identifizieren, die einen verlängerten Aufenthalt auf der Intensivstation vorhersagen können (künstliche Beatmung, Infektionen bei der Aufnahme). Die Notwendigkeit der Intensivmedizin mit einem limitieren Budget wird die weitere Suche nach geeigneten Finanzierungsinstrumenten weiter motivieren.

Das österreichische Gesundheits- und Krankenhaussystem

Das österreichische Gesundheitssystem wird durch die föderale Struktur des Landes geprägt, die Delegation an Selbstverwaltungsinstanzen im Sozialversicherungssystem wie auch durch die Strukturen der Mitwirkenden auf föderaler und regionaler Ebene, die Kompetenzen in der kooperativen Planung, Koordination und Finanzierung haben. Österreichische Bürger genießen eine universelle Gesundheitsversorgung mit einem umfassenden Leistungskatalog. Aufgrund mehrerer Gesundheitsreformen, die eine Stärkung der Zusammenarbeit und der besseren Kapazitätennutzung sowie mehr Effizienz geführt haben, hat es das österreichische System geschafft, Wartezeiten weiterhin auf ein Minimum zu halten und die Zufriedenheit der Patienten auf hohem Niveau. Die ungleiche Verteilung der Ärzte in urbanen und ländlichen Gegenden, wie auch die sektorale Fragmentierung sind jedoch Themen, an denen österreichische Behörden weiterhin arbeiten.

2008

March

7-8 > TeleHealth 2008: International Conference and Exhibition for ICT solutions in the health sector, Hannover, Germany.
www.telehealth.de

7-11 > ECR 2008, Austria Centre, Vienna, Austria. Organisers: ESR
www.myesr.org
communications@myESR.org

10-12 > 4th Annual World Health Congress – Europe 2008, Berlin, Germany.
www.worldcongress.com

25-29 > Second International Patient Safety Congress, WOW Kremlin Palace, Antalaya, Turkey.
www.patientsafetycongress.net

27-28 > European Psychiatric Symposium, Berlin, Germany.
www.rochusfiches.de

April

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

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

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

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

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

May

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

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

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

June

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

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

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

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

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

September

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

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

October

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

November

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

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

VERIFIED CIRCULATION according to the standards of International Business Press Audits

(E-)Hospital is independently audited by Accountskantoor Closset on behalf of the European Association of Hospital Managers

Publishing Company
EMC Consulting Group
28 rue de la Loi
B-1040 Brussels
e-mail: office@hospital.be
homepage: www.myhospital.eu

Publisher
Christian Marolt - c@emcconsulting.eu

Project Communications Director
Luiza Kudelka - luiza@hospital.be

Art Director
Carola Mücke - ca.mue@emcconsulting.eu

Subscription rates
One year : Europe 60 euros Overseas 84 euros
Two years : Europe 110 euros Overseas 150 euros

Production and Printing
Xerox Print
Print run
Hospital - 22,000

ISSN *Hospital:* E: 1374-321X

Breast Care Solutions. A comprehensive approach – covering every step of the way.

Every breast cancer patient is different. That's why we provide you with a wide product portfolio, covering every step in breast care. Benefit from clearest image quality or anatomical and functional information. And deliver treatment with utmost precision. For women. For health. For life. **www.siemens.com/breastcare; contact center +49 69 797 6420**

Answers for life.

SIEMENS

CC-Z1055-1-7600