Hospital

VOLUME 10 • ISSUE 5 / 2008 • December / January • €15
ISSN=1374-321X

22nd EAHM CONGRESS

> NEW LEADERSHIP FOR NEW CHALLENGES

Plus

> Focus: Denmark

OFFICIAL JOURNAL OF THE EUROPEAN ASSOCIATION OF HOSPITAL MANAGERS

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LESSONS OF A CRISIS

Willy Heuschen

The editorial in the April edition of Hospital posed a question about greater competition in the provision of healthcare services. While 600 delegates were gathering for the 22nd EAHM Congress in Graz to discuss the issue of leadership against the background of new challenges, the worldwide media was reporting on the collapse of the entire financial system. Bankers, we learned, had miscalculated risk and the survival of the financial sector hinged on the willingness of states to intervene. Some commentators even asked whether citizens were losing faith in the capitalist system.

The banking crisis and the recession it may yet produce offer a number of interesting parallels with the health sector. Since the end of the war, the freedom of banks and other commercial enterprises to manage their own affairs has been a fundamental tenet of the credo of market economics. Mindful of the importance of preserving social stability, governments in some European countries promoted the development of the social market economy. While the success of this model is not in doubt, the constant change it requires has produced many new challenges for the health sector.

Unlike the banking system, health systems, notably hospitals, rarely feature on Finance Ministers' lists of favourite institutions. Healthcare imposes a heavy burden on national budgets and is often an attractive option for securing savings.

For example, the under-funding of German hospitals triggered a recent demonstration in Berlin attended by tens of thousands of hospital employees. Regrettably, hospitals in many other European countries must contend with the same problem.

Many commentators view the privatisation of hospitals and a stronger focus on market economics in management as a panacea. Notwithstanding any refinements in the EAHM's position on this issue – the internal debate continues and a special seminar on the subject is planned for MEDICA 2009 - the association has already called for accompanying measures.

In light of recent events in the banking sector, it would be foolish to have blind trust in free markets. Even the regulatory bodies established by national governments failed to prevent the financial crisis. Is it then advisable to recklessly jeopardise the continued provision of health services? Should governments not instead provide sufficient, long-term financial support to safeguard the long-term future of our health services? A further parallel between the banking and health sectors is evident in two respects. The financial crisis has been blamed on the miscalculations of the bankers and the failure of the regulatory authorities overseeing the system to impose proper controls. In the case of a number of German "Landesbanken" (banks jointly run by regional governments and savings institutions), politicians responded to criticism of their role in the matter by pleading a lack of expertise. Although the generous remuneration packages available to senior banking executives and members of bank boards may be enviable from our perspective, from an ethical perspective they should not be emulated elsewhere and their existence adds to the culpability of the banking system.

The management structure in banks has been blamed for the crisis but differs little, in terms of responsibility, from hospital structures. We should therefore intensify our discussion about management at European level. Who should manage hospitals and how? Which competencies are essential in the performance of this role and who should oversee whom?

In addition to banking structures, critics have attacked the modus operandi of financial institutions and the lack of transparency for investors. Hospitals need quality because we owe it to our consumers - the patients. One cannot over-scrutinise quality given the imperative to constantly adapt to take account of new findings and changing expectations. This issue will be the focal point of the 2010 EAHM Congress in Davos.

Another no less important aspect of the banking crisis is the inadequacy of the counter measures being taken at national level. Intervention is necessary at European level. Heads of government have gathered several times at short notice recently to discuss possible solutions. Crises no longer stop at national borders. If a hospital crisis were to occur in an EU member state – for example, as a result of non-compliance with quality standards – neighbouring states would soon be engaged in crisis management. For this reason, the EAHM will intensify its ongoing efforts to develop European quality regulations for hospitals. We expect to receive support from national governments and European institutions. The European Union and its member states need to finally understand that prevention is the fastest, most efficient and in most cases least expensive option. We will continue our lobbying activities because we owe it to our patients to act. Prevention is definitely better than blind trust.

Willy Heuschen,
EAHM Secretary General
Editor-in-Chief

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

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22nd EAHM Congress

The 22nd Congress of the European Association of Hospital Managers took place September 25-26 in Graz (Austria) in the sumptuous Convention Center.

The chosen theme, "New Leadership for New Challenges", was divided into six sessions, dealing with the interactions between leadership and politics, economy, ethics, patients, employees and, last but not least, leaders.

This issue of Hospital will hopefully enable you to capture the flavour of the Congress in case you were unable to attend through a gallery of pictures, a vivid account of the opening ceremony and a thorough review of each presentation.

These presentations are also summarized in French and German towards the end of the journal.

Focus:Denmark

In terms of total health spending Denmark ranks above average in OECD countries spending 9.5 % of GDP in 2006. About 80% of Danish health spending is founded by public sources in 2002. The number of hospital beds per capita in Denmark has declined over time, in line with a reduction of average length of stays in hospitals and an increase of ambulatory procedures.

Annual negotiations between the central government and the regions and municipalities result in agreement on the economic framework for the health sector, including levels of taxation and expenditure and resource allocation. The hospital sector in Denmark, mostly public (95% of beds) is under the responsibility of the five regions. Regional authorities must offer free hospital treatment for the residents of the region, and emergency treatment for persons in need who are temporarily residents.

The citizens may choose among private hospitals or clinics in Denmark or abroad if the waiting time for treatment exceeds one month and the chosen hospital has an agreement with the region`s association regarding the offer for treatment. The Danish Association of Healthcare Management was founded in 1912 and is one of the oldest hospital management associations in Europe.It was also one of its six founding members in 1970. Since 1984, Denmark has represented Nordic countries on the EAHM Board.

FOCUS: DENMARK

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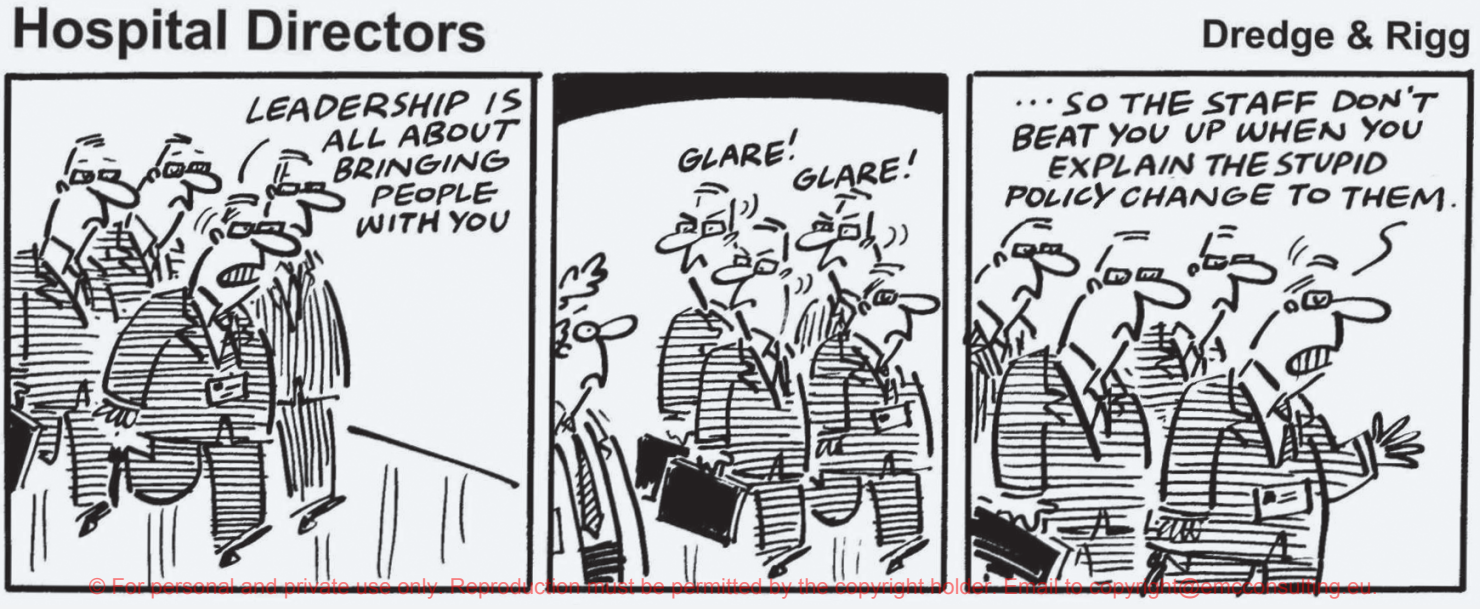

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38TH GENERAL ASSEMBLY **OF EAHM**

The 38th General Assembly of our association, the EAHM, focused mainly on two topics: the amendments of EAHM Statutes and the report on activities.

Activity Report

Being half way through the term of the current Board and Executive Committee, a report on the activities was given by the EAHM President, Mr. Paul Castel.

Reacting to a consultation on crossborder healthcare by the European Commission, EAHM called for a common approach to the definition, assessment and improvement of quality standards in healthcare (services) as well as for the development of a European accreditation model for healthcare services.

EAHM continued to explore this theme by organising the seminar "Quality Assessment Tools in Hospitals: towards a voluntary European Accreditation System?" on November 16, 2007 in Düsseldorf. This first seminar was a success and gathered about 70 delegates, with a follow-up in (E)*Hospital* 2007/5 and 2008/1.

The European Commission and stakeholders, including EAHM, are consulting and reviewing options on how to enhance the quality of healthcare in the European Union with a special focus on quality standards in hospitals.

A framework for common standards for European hospitals allowing the comparable assessment of hospitals is in the scope of this work. EAHM will continue to support this through its Scientific Subcommittee (SCC) and may call its members for action in the near future.

Since the exclusion of health services from the service directive (spring 2006) and given the many ECJ rulings, clarity and legal certainty is needed.

Therefore and also to support cooperation between national health systems, the Commission prepared a directive on the application of patients' rights related to crossborder healthcare, which provides a Community framework for safe, high quality and efficient crossborder healthcare (published July 2 2008).

This initiative is high on the agenda of our Subcommittee for European Affairs (SCEA) which will prepare a position on this draft directive in the near future.

In 2007, EAHM conducted a survey looking at the current situation of free mobility of health professionals and its impact in hospitals.

This revealed that most hospital managers would welcome measures to address current problems with foreign staff (e.g. trainee doctors) such as language barriers, bureaucratic barriers and lack of cultural integration. Various suggestions were submitted to EAHM in order to develop focused action: standardising training and/or professional standards, creating common registrars or relaying agencies.

EAHM is in the process of taking up the role of developing actor, creating awareness around financially and ethically related problems, taking note of regional projects in this area and generating debates around the issue.

At the start of French Presidency of the EU in June 2008, EAHM launched a call for moving health and hospital care forward within Europe, towards a balanced cooperation of public and private actors, towards an evaluation of quality and safety and towards a governed and managed healthcare.

The health programme 2008-2013 is in its first year. One of 3 main objectives of this programme is health information and knowledge.

While IT vendors are organised on a European scale and standardisation is done at European level (e.g. CEN), the need for a representation of hospital IT managers is growing, to ensure that hospitals are working together in the field of IT. Therefore the Executive Committee decided to launch a Working Party IT managers.

In the current economic situation, pressure on hospital budgets is strongly increasing. Many hospitals are facing deficits. So the demand for privatisation is getting higher.

But the delivery of healthcare involving the state and/or social insurance schemes is a complex exercise of balance. It uses price-setting, third parties (the payer) and includes the duty to provide services.

Therefore healthcare cannot be considered as a typical market. Introducing market competition and privatisation will not work without regulations by public authority.

The work started by the SCEA will be continued in order to come forward with a position. Given the importance of this topic, it will constitute the main theme of our 2009 seminar.

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More fundamental work has been done by the Scientific Subcommittee through its support of the ongoing European study on hospital governance.

Results, which will be available before the end of this year, will help us better understand the variation in governance settings across Europe and may provide our members with options to improve the governance within their hospitals.

On top of the seminar on accreditation, EAHM held its 2nd European Psychiatric Symposium, organised by the Working Party Psychiatry on 27-28 March 2008 in Berlin. About 100 delegates participated. The theme of the seminar was "How to improve productivity in mental healthcare?"

The Executive Committee decided furthermore to attribute the organisation of the 2012 congress to Greece.

Amendments of EAHM statutes and accounts

Modifications to the statutes are mainly made for two reasons. First, some modifications complete the existing rules or render them more precise.

This regards e.g. the status of elected members (as President, Vice-President, members of the Executive Committee or the Board) or decision powers of the General Assembly,

Furthermore some articles of the statutes needed to be brought in line with French law or needed to be rewritten to ensure the good functioning of the association. Examples are the tendering of accounts, the status of the Secretary General and the dissolution of the association.

The proposed modification of statutes has been accepted unanimously by the General Assembly.

The standing orders, dating from 1971, will need to be updated in order to implement the modification of statutes.

This gives also the opportunity to integrate the statutes of our subcommittees and working parties as well as the mission statement for organising the EAHM congress.

This work is in progress and will be presented for approval to the Executive Committee in early 2009.

In the absence of the Secretary General, accounts were presented by Asger Hansen:

The accounts for 2007 end with a surplus due to received sponsoring contributions and a decrease in personnel costs compared to the budget. Overall, expenditures remain within the foreseen budget.

The year-end financial statement contains provisions for doubtful clients and legal study, while the provision for new activities has been increased, resulting in around 8,500 euros being transferred from 2007.

The proposed budget for 2009 includes a small increase of income, leaving room for some new activities in expenditures. The auditors, Ms. Pelgrin from Luxembourg and Mr. Timmerman from the Netherlands, certified the accounts as accurate and they were approved by the General Assembly.

New members

The General Assembly has accepted the candidacy of Romania and of "All-Ukrainian Head Doctors' Association".

Three members of the Executive Committee have been replaced: Gianluigi Rossi (Switzerland) is replaced by Christoph Pachlatko, Radoslav Herman (Croatia) by Herman Haller and Seppo Tuomola (Finland) by Rauno Ihalainen. Mr. Rossi, Herman and Tuomola were warmly thanked for their active contribution to EAHM activities.

Conclusions

The president thanked the many people active in the association.

The programme for next year presents again many new challenges. He invited those present to join the congress in the afternoon.

The theme linked leadership with challenges, and the President expressed the hope that the participants would return home with many novel thoughts and ideas.

"Europe for Patients" initiative

At the end of September, Health Commissioner Androulla Vassiliou launched the "Europe for Patients' campaign in Brussels. This campaign outlines the future health policy the Commission intends to adopt in the following 6-9 months. The aim of this campaign is to provide "a tangible and readily understandable communication framework for the many different healthcare policies that we plan to adopt and undertake", according to Ms. Vassiliou.

This campaign follows the 2nd of July initiative for a directive on crossborder healthcare (see *(E)Hospital* 3/2008, p.7).

For more information on the "Europe for Patients" campaign visit their web address at:
http://ec.europa.eu/health-eu/ europe_for_patients/

Migration and the Blue Card scheme

The EU Parliament is scheduled to vote on the "Blue Card" Scheme this fall. This scheme was proposed last October by the Commission, and is a proposed plan to facilitate the migration of skilled workers to the European market. At present there are 27 different visa regimes in place making it extremely difficult for skilled migrants to legally immigrate. The harmonisation of "skilled migration" schemes would allow Europe to gain a much-needed edge in the recruitment of skilled labour.

Crossborder healthcare directive

Following the release of the Commission proposed directive on crossborder healthcare, an impact assessment was recently published by the Commission. Five different types of impacts have been analysed. First of all the impact on treatment costs and on treatment benefits due to patient mobility have been mapped. The assessment makes it clear that an increase of possibilities to receive healthcare abroad will create an increase in treatment costs. These costs remain nevertheless marginal compared to the increased treatment benefits, which also increase with the increase of possibilities to receive healthcare abroad. The compliance costs were also analysed. The impact assessment reveals that with the creation of more legal certainty these compliance costs decrease. The more legal certainty is created, the more those administrative costs can be reduced.

Option 4, for instance, goes beyond the proposed directive rules by establishing detailed legal rules at European level, which might be difficult to justify in the light of the subsidiarity principle. Under this option, treatment costs would amount to 30 mil. euros, treatment benefits to 585 mil. euros with 780,000 extra patients receiving treatment, but compliance costs would reach 20 billion euros. (GF)

NATIONAL DISCREPANCIES **IN CANCER TREATMENT**

By Rory Watson

The European Union should attach greater importance and recognition to medical oncology. That way specialists can improve their performance in multidisciplinary teams, move easily to areas where there is a shortage of suitably trained staff and help cancer patients receive the treatment they require.

This call from the European Society for Medical Oncology (ESMO) came with the publication of its new survey on the education of, and access to, cancer specialists. This revealed that the degree of care which people suffering from cancer - Europe's second biggest killer with 1.7 million deaths a year - can expect to receive varies considerably depending on where they live.

In some countries, the costs to patients of a second medical opinion are reimbursed, in others not. Some health systems require oncologists to remain abreast of latest scientific and medical developments, in others the facilities to allow this do not exist.

The status of multidisciplinary teams, which include surgical, radiation and medical oncologists and are considered crucial in producing the best outcomes for patients, varies from country to country as does the teaching of palliative care.

Dr Roberto Labianca, who chaired the task force that produced the Medical Oncology Status in Europe Survey III, said it highlighted the need for action to tackle the inequalities that exist across Europe. "When you are fighting for your life you want to know you are getting the best available care. This can be a stressful enough time for the patient and their families - patients should have specialists in reach or get reimbursed if they need to travel across EU borders for that care," he said.

The structure of multidisciplinary teams is regulated in Belgium and the Czech Republic, but not in Sweden and Poland. Palliative care is recognised as a separate speciality in just a handful of countries, ranging from the United Kingdom and Poland to Albania and Moldova, accounting for a shortage of specialists across Europe.

However, it now features more prominently on university curricula. It is included in undergraduate teaching in just over half (53%) the countries surveyed, compared to 28% in the previous survey two years ago.

Further discrepancies exist in the extent to which cancer specialists are expected to be aware of the advances made in their field to help them in their diagnosis and treatment of patients. In France and Ireland, for instance, it is required, while in other countries access to continuous medical education may not exist.

Overall, just 30% of countries require medical students to continue their education after they graduate in order to work in a private institution and only 22.5% if they work in the public sector.

When the results of the survey were presented at a conference in Brussels in October, Dr Adamos Adamou, a Greek member of the European Parliament and medical oncologist, told the audience they confirmed the inequality in cancer treatment across Europe. He said that the report "brings us a step closer towards defining what a fair level of treatment between nations should look like – something that will be welcomed by cancer patients and their families". He added: "A defined role for medical oncologists is vital in this context."

The EU has made a decisive step in a different area which will impact on all medical administrations. After six years' tough negotiations, pan-European legislation has been finally agreed which will ensure that temporary employees will enjoy the same pay and conditions as equivalent full-time staff.

This will apply not only to salaries, holidays, rest periods and parental leave, but also access to facilities such as canteens, child care and transport services and to training opportunities.

The equal rights for some three million temporary workers in Europe must be in place within three years at the latest, but some governments are certain to apply them earlier. In principle, this equality of treatment will apply from the first day of employment and countries such as France and Spain are planning to do so.

However, it is possible for an agreement between employers' and trade unionists' representatives to delay its introduction. That is the case with the UK where it will only apply after 12 weeks.

Surviving Sepsis: Medical Nutritional Intervention for Immediate Clinical and Economic Impact

EPA + GLA Is Clinically Proven to Save Lives and Provides an Immediate Return on Investment

By James A. Lee

Despite the awareness of sepsis for well over 2500 years, its incidence is increasing and it remains life threatening. Figure 1 presents the cascade of sepsis to severe sepsis and septic shock, a life-threatening form of systemic inflammatory response syndrome when organ dysfunction occurs.[1,2] While the epidemiology of severe sepsis is not fully understood, approximately 450,000 cases of severe sepsis are reported annually in European countries; between 11% (Netherlands) and 54% (UK) of intensive care unit patients are diagnosed with severe sepsis, and mortality rates of 27% (Norway) to 47% (UK) occur.[3]

Table 1 summarizes approximate annual incidence of severe sepsis in intensive care units (ICUs), total severe sepsis patients, and mortality rates for select European countries and the United States. Estimates vary to the degree that severe sepsis is community, hospital, and ICU-acquired, but ranges of 30 to 50% are observed for acquisition after admission to the hospital.[4]

The Surviving Sepsis Campaign (SSC), an initiative of the European Society of Intensive Care Medicine, the International Sepsis Forum, and the Society of Critical Care Medicine, seeks to improve

- Over 10% of all ICU patients have severe sepsis, with mortality rates of 25% to 50%
- Between 30% and 50% of sepsis cases may be the result of nosocomial infections
- EPA + GLA (Oxepa®) is clinically proven to reduce new organ failures, ICU and ventilator utilization, and mortality
- Oxepa® reduces absolute mortality in severe sepsis patients by 19.4%
- At less than €35 per day, Oxepa provides immediate clinical and financial benefits

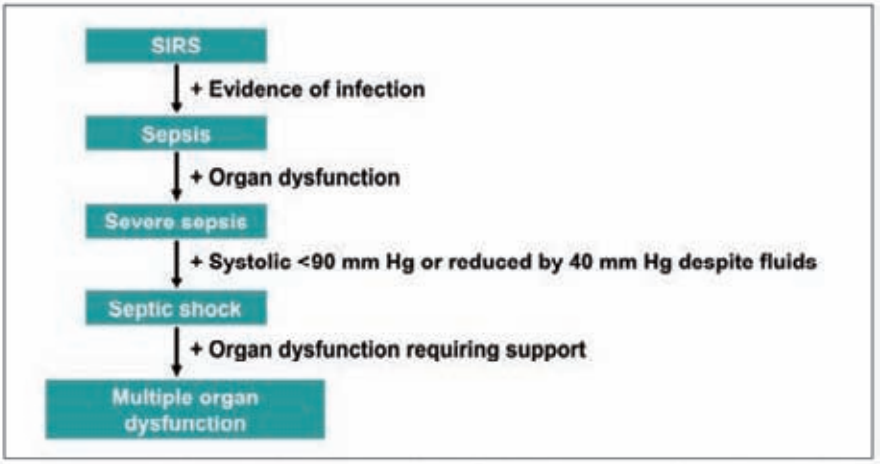

Figure 1. Systemic Inflammatory Response Syndrome (SIRS) and Its Related Syndromes.

Table 1. Severe Sepsis in Select European Nations and the United States

Country	Annual Severe Sepsis Cases	Incidence of Severe Sepsis in ICU	Hospital Mortality Rate
France	n/a	14.6%	41.9%
Germany	75,000	10.7%	47.0%
Italy	3,228	16.3%	36.0%
Norway	2,121	n/a	27.0%
Spain	36,000	14.8%	45.7%
United Kingdom	31,000	54.3%	47.3%
United States	396,000	n/a	37.8%

the management, diagnosis, and treatment of sepsis. Their past five-year goal was to decrease mortality due to sepsis by 25%. See www.survivingsepsis.org for further details.

EPA + GLA and Antioxidants Reduce Resource Intensity and Mortality

An enteral diet enriched with eicosapentaenoic acid (EPA), gamma-linolenic acid (GLA), and antioxidants — the ingredients of Oxepa® — has been shown to improve outcomes in patients with acute respiratory distress syndrome when severe sepsis or septic shock is present.[5] The diet used was an isonitrogenous and isocaloric enteral formula, differing from a control diet in lipid composition and level of antioxidant vitamins. Since there is evidence in the literature pointing toward the anti-inflammatory roles not only of EPA and GLA, but also of antioxidant vitamins alone, the differences between both groups may be explained not just by the effects of EPA, GLA, or antioxidants but also by a combination of them.

Figure 2 present key findings from the Pontes-Arruda study. During the 28-day study period, patients fed Oxepa were observed to have, on average:

- 7.6 days free of ventilator support
- 6.2 days free of ICU support
- a 19.4% absolute risk reduction in mortality

All of these observations were statistically significant ($p < 0.001$ for ventilator and ICU support, $p = 0.037$ for mortality).

Cost of Treating Severe Sepsis

There was limited data on the cost of treating severe sepsis until recent cost-effectiveness analyses related to evaluation of drotrecogin alfa (activated), or Xygris™, were prepared. A select set of costs from one recent United Kingdom technology assessment is presented in Table 2.[6]

Hospitalization costs for surviving patients with multiple organ failure were €1,830 higher per patient than those without multiple organ failure. It is noteworthy that the analysis presented by Green et al. showed that appropriately targeted drotrecogin alfa (activated) intervention is cost-effective (estimated to be €11,000 per

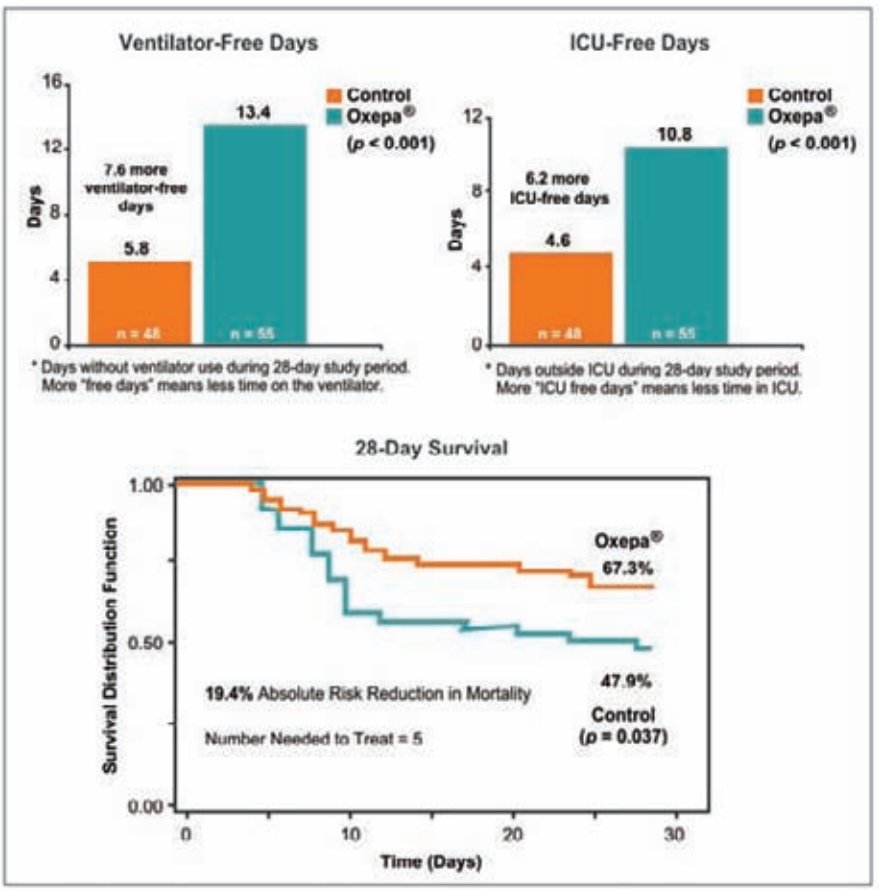

Figure 2. Clinical Outcomes When Using Oxepa.

Table 2. Select Costs of Treating Severe Sepsis

Element/Parameter	Value
Hospitalization Cost – Severe Sepsis Survivor	€19,658
Mean cost per ICU Day	€1,576
Mean cost per day in Other Ward	€256
ICU Length of Stay – Severe Sepsis Survivor	7.8 days
Overall Length of Stay – Severe Sepsis Survivor	36.6 days

quality-adjusted life year) at a price of over €6,000 per patient for intervention and a relative reduction in 28-day mortality of 20%.

Oxepa Return on Investment

Estimated savings through reducing the ICU stay (Figure 3) based on the conservative assumption that a patient will spend that day in a general ward, but at a much lower daily resource use. Previous clinical studies demonstrated that ICU-free days increased significantly, but overall length of stay did not decrease.[7] Based on these studies, a 27% reduction in the ICU length of stay is applied to estimate savings. A separate calculation assuming only a one-day reduction in the ICU length of stay is also presented.

The cost of intervention is conservatively estimated to be the cost of the immune-modulating diet, approximately €33 per ICU day, during the ICU stay prior to applying the likely reduction in the ICU stay or subtracting the costs of the standard diet. Using the mean costs per day and length of stay observed in severe sepsis patients presented in Table 2, economic savings resulting from Oxepa intervention are presented in Figure 3.

The resulting return on investment (ROI) is therefore 9.8 to 1, with a 2.1-day reduction in the ICU length of stay. Following similar calculations, if the ICU reduction is only one day, the estimated savings per patient is €1,063 with a 4.1 to 1 ROI. Table 3 summarizes data for the UK, Germany and Spain.[8,9]

Cost of Intervention	= €33 per ICU day x 7.8 days in ICU = €257.40
Reduction in ICU Stay	= 7.8 days in ICU x 27% Reduction = 2.1 days
Difference ICU and General Ward Day	= €1,576 – €256 = €1,320 per ICU day avoided
Estimated Cost Reduction	= 2.1 days x €1,320 per ICU day avoided = €2,772
Savings After Cost of Intervention	= €2,772 – €257.40 = €2,514.60 per patient treated

Figure 3. Economic Savings of Oxepa Intervention.

Table 3. ROI and Estimated Savings with Oxepa Intervention

Country	Per Patient Savings (ROI) with 1 Day Reduction in ICU Stay	Per Patient Savings (ROI) with 27% Reduction in ICU Stay
United Kingdom	€1,063 (4.1)	€2,515 (9.8)
Germany	€1,153 (3.7)	€3,450 (13.1)
Spain	€726 (2.0)	€2,000 (7.2)

For the United Kingdom and Germany, with approximately 10,000 to 20,000 severe sepsis patients admitted to the ICU annually, this translates into €10,600,000 to €21,200,000 in potential annual savings, assuming only a one-day reduction in ICU length of stay, and €25 to €50 million, given the expected reduction in ICU length of stay. For Spain, this translates into €13,068,000 to €36,000,000, assuming a one-day and 27% ICU stay reduction and 18,000 severe sepsis ICU admissions annually.

A substantial share of savings associated with the reductions in ICU stay are the costs of drugs, blood and blood products, ancillary services, disposable equipment, and staff costs due to reduced treatment intensity. These financial savings are in addition to the significant increase in severe sepsis patients who survive.

The financial return on investment for enterally feeding Oxepa to severe sepsis patients in the ICU is at least 2 to1 and immediate; most importantly, the lives saved are priceless.

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LEADERSHIP **FOR NEW CHALLENGES**

OPENING CEREMONY

Right after the EAHM General Assembly (see report on p. 7-8), the Congress got off to an amazing start with more than 600 hospital managers attending. The quality of the presentations perfectly matched the sumptuous main hall of the Graz Convention Centre that accommodated the delegates' lively exchanges for two days. Fittingly, Graz was the cultural capital of Europe in 2003.

Participants were welcomed by a spectacular choir and orchestra who delighted the audience with several musical interludes.

Nikolaus Koller, Chairman of the Association of Styrian Hospital Directors and organiser of the Congress warmly welcomed the delegates and emphasised the accuracy of the theme chosen for the 22nd edition of the EAHM Congress. He stated that the theme of leadership was especially relevant as healthcare in Europe is gaining in importance and the financial weight of the European hospital sector (350 billion euros) requires sound management and flawless governance. Mr. Koller was followed by Mr. Paul Castel, President of the European Association of Hospital Managers, who informed the audience of some of the decisions of the General Assembly that had just taken place and expressed his wish of seeing EAHM members share experiences and learn about each other during the two days.

High ranking Austrian officials graced the congress with their presence: Mag. Helmut Hirt, State Councillor for Public Health and Personnel, as well as Dr Andrea Kdolsky, Minister of Health. They both evoked the issues at stake for the Austrian healthcare system, which are common to other European countries.

Ms. Dominique Acker, representative of the French Minister of Health, Roselyne Bachelot, gave Congress participants a brief outline of the health-related priorities of the French presidency of the EU and assured EAHM representatives of the importance of the Association to European institutions and decision-making bodies.

The keynote address, entitled "Leadership in Hospitals – The Role of Values", was given by *Professor Eckard Nagel, the Director of the Institute of Medicine Management and Health Sciences at the University of Bayreuth* who also heads the surgery department at the Augsburg Medical Centre.

Professor Nagel understood perfectly how to engage an audience during his presentation, which focused on the current problems facing hospital managers. Hospitals are no longer managed in accordance with the authoritarian management principles associated with Professor Sauerbruch. Likewise, the work of medical and nursing staff cannot be determined by the economic objectives of the hospital operator or owner.

If they are to be effective in the long run, hospitals must establish a framework for action that is underpinned by values. It is safe to say that doctors and nurses are motivated primarily by values in the sense that they want to benefit patients. A competent management team will, therefore, create the conditions in which realising this goal becomes feasible, notwithstanding the financial constraints within which all hospitals must operate.

In many countries, it is impossible to sidestep the ongoing debate on rationing and rationalisation.

However, addressing this issue in a plausible manner requires those in positions of leadership to demonstrate characteristics other than insight and ability. They must also show social, emotional and spiritual intelligence, the qualities that turn a manager into a leader who can motivate and empower his staff to achieve the hospital's objectives.

In this context, Professor Nagel noted that leaders must:

> have a clear goal or mission;
> show determination;
> be prepared to make sacrifices;
> accept challenges;
> dare to break new ground; and
> learn from mistakes.

The Congress audience was visibly impressed by Professor Nagel's presentation. His contribution provided much food for thought, giving all those present an opportunity to reflect on their own work and providing an excellent starting point for the rest of the Congress programme.

All Congress pictures are available @ ***www.myhospital.eu***

Left to right: Dr Andrea Kdolsky, Austrian Minister of Health, Prof. Eckard Nagel, keynote speaker and Ms. Dominique Acker, adviser to the French Minister of Health

The Austrian organising team of the 22nd EAHM Congress

Gérard Vincent, FHF Chief representative, and Paul Castel, EAHM President

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LEADERSHIP **MEETS POLITICS**

Both speakers for this session strongly put forth the need for political decision makers to align health systems with societal changes.
They are also very lucid about structural obstacles to face in order to carry out that political mission. Medical savings accounts are a tool to enhance free movement of goods, services and people.

Gediminas Cerniauskas, MD, PhD, Minister of Health, Lithuania

Starting with a brief presentation on Lithuania and its healthcare system Mr. Gediminas Cerniauskas, the Lithuanian Minister of Health emphasised that change is just beginning in his country. Lithuania's low life expectancy illustrates the varying standards of healthcare within the EU but his presentation of the innovative scheme of medical savings accounts (MSA) demonstrates that things are evolving.

Mr. Cerniauskas believes that healthcare markets in Europe are fragmented due to high transaction costs and the prevalence of national insurance systems. These problems are not high enough on the political agenda as shown through discussions on the EU directive on services. Will compulsory health insurance ensure financial sustainability?

MSA are based on personal medical savings accounts used in the USA (voluntary health insurance model) and Singapore. They will be used to finance health services not covered by national statutory systems. If subsidised by tax breaks for the income used to pay contributions to MSA, the scheme will create a zone in between free-of-charge services and services fully paid by patients. The format is a debit card system, meaning that payments from MSA would not be costly and would lead to a substantial reduction of administration costs.

If approved, the scheme will start in 2009 with almost universal coverage of taxpayers and their families. The key objectives of medical savings accounts are an increased accessibility of services and poverty reduction. But these accounts could also pave the way for the development of integrated healthcare markets in the EU as the debit cards may be used both at home and abroad.

Reforming the Greek National Health System; many efforts with few results. Lessons to be learned

Yannis Tountas, MD, MPH, PhD, Chairman of the Governing Board of the International Network of Health Promoting Hospitals and Health Services, Medical School, University of Athens, Greece

Yannis Tountas spoke about reforms and their level of success in the Greek National Health System.
Mr. Tountas emphasised that health systems are social systems and one must change when the other does. Society is changing; an increasingly aging population means different needs must be met. Socio-economic changes such as migration, unemployment, globalisation and health inequalities increase the demand for healthcare and therefore also increase expenditure.

He highlighted the fundamental principles of the Ljubljana Charter on Reform: reform must be driven by values, targeted on health, centred on people, focused on quality, based on sound financing and orientated towards primary health care. He explained the two strategies available. The first is the delivery of cost effective health services and the second is hospitals in transition. Delivering cost effective health services includes initiatives such as decentralisation, coordination and integration, empowering the patient, enhancing quality, evidence based medicine and upgrading human resources. The hospital in transition strategy includes new services such as day care and home care, new public management, tailored purchasing mechanisms, new information and communication technology, and health promoting hospitals.

Mr. Tountas then illustrated the problems of the Greek National Health System. Controlled by the Minister of Health, public hospitals have underpriced services and insufficient personnel; there is a low quality of services, inadequate equipment and low public satisfaction. To rectify this situation both general and specific reforms were proposed. General reforms included increasing public health expenditure, decentralisation/regional organisation, developing a central purchasing organisation for social insurance and a comprehensive primary care health system. Specifically in hospitals, hospital management should be reinforced, there must be a productive hospital budget, private payments should be introduced and hospital information systems and quality improved.

Results however were varied. Although decentralisation and the reinforcement of hospital management were successful and some progress was made in the introduction of private payments, hospital information systems and quality improvement, the rest of the reforms were unsuccessful. The reasons for this failure include a lack of unified policy, a lack of consensus, a lack of continuity, a lack of resources and managerial skills and a lack of autonomy. So Greece remains in this continuous crisis: fragmented, lacking in quality and with inadequate public expenditure.

The lessons to be learned from this relative failure in Greece are without doubt the importance of the socioeconomic environment, of governmental health policy, of continuous and robust leadership and of having consensus among the main partners. What must be understood is that health systems are complex non-linear systems. (LC)

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Dr Delgado and Dr Lopes, delegates from Portugal

Exhibition Hall

Professor Peiro (left), Jan Aghina and Birgit Miesch (right)

LEADERSHIP **MEETS ECONOMY**

EAHM delegates focus on essential hospital management requirements.

Privatisation is one of the hottest topics on the European hospital scene right now, as it illustrates the vital need for hospitals to fit into a generalised market-driven economy. But an adequate registration of merging new professions is an equally important leadership requirement for hospital managers. Is the privatisation of hospitals in Belgium an answer to improve access and quality to hospital services?

Prof. Eric Engelbrecht, Catholic University Leuven, Belgium

To begin his presentation on the privatisation of hospitals in Belgium, Prof. Engelbrecht reminded the audience of the history of hospitals in Belgium and the fact that hospices, the predecessors to our hospitals, were private initiatives run by religious orders.

He noted that in Belgium even though local authorities, private people and organisations built hospitals, private and public hospitals have a completely different legal status. In the public institutions management was transferred to public assistance committees and later to public social assistance centres (CPAS) but this model for the public hospital system did not meet growing demands, so a new one was designed laying the foundations for a general redesign of the hospital sector in Flanders.

The previous system consisted of slow decision making procedures, meaning public hospitals were at a disadvantage; the management board was made up of politicians so decisions were taken according to political and not hospital priorities.

Public hospitals had a negative image compared to private hospitals, which were regarded as dynamic and quality-orientated and mostly not in deficit. A choice had thus to be made between different forms of management. Prof. Engelbrecht concluded from a study he carried out in 2003 that since 1999 the CPAS hospitals have made use of the possibilities provided by the decrees showing that adapting legislation and regulations was a real necessity.

It is apparent that the public hospitals now get more appropriate and more independent organisational structures and may also merge with private ASBL (not for profit) hospitals.

This independence movement has led to a fundamental reorganisation of the hospital landscape. The financial position of public hospitals is developing positively with the average size of hospitals increasing to 400 beds, allowing them to broaden their offer of care, diagnoses and treatment. On the other hand, in Wallonia, the number of hospital decreased from 47 to 31, and in Brussels from 14 to 7.

Professor Engelbrecht also stressed that in Belgium hospitals have a dual structure, in which diagnosis and treatment are generally privatised because doctors are independent, and that on the other hand, the hospital is responsible for care, paramedical services, catering and for lab service platforms.

Prof. Engelbrecht concluded that considering the development of hospital structures as well as their size since 2000, there will be sufficient resources available for the future to provide high quality care and treatment accessible to patients.

Establishing a new profession – Health Informatics – Registration, Regulation or Accreditation?

Mik Horswell, Director, Institute of Healthcare Management, United Kingdom

In order to practice as a clinical professional in the UK each individual must be registered as fit to practice. This is followed by annual checks ensuring that each person has undertaken continuing professional development and training to keep up to date with changes and improvements. If they do not adhere to these codes and checks, the consequence is a removal from the register and therefore disqualification from the profession.

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Delegates at the General Assembly

Exhibition Hall

Grand Opening

However, Mr. Horswell revealed that two very important groups of professionals in the healthcare sector operate without such guidelines. Healthcare managers and health informaticians do not undergo registration, good practice checks or obligatory continuing professional development. These two professions account for over 75,000 employees who work in management or health informatics; included in this number are the chief executives and directors of every NHS organisation, which means that their impact on standards and quality of care for patients and on individual patient care pathways is essential.

The speaker highlighted the fact that bad informatics kills; inaccurate patient Ids, incorrect clinical records, breaches of confidentiality, the unavailability of key clinical systems for consultation and everyday communications such as telephone calls and emails can jeopardise patient safety. Taking this into consideration and drawing on his own experience as a hospital manager and a health informatics professional, Mr. Horswell is attempting to rectify this anomaly through his involvement as director of both the Institute of Healthcare Management and the UK Council for Health Informatics Professions (UKCHIP).

UKCHIP was formed in 2002 to promote professionalism in health informatics (HI). It operates a registration scheme for HI professionals who agree to work to clearly defined standards. Initial registration is voluntary, although UKCHIP anticipates that in the future, the NHS will expect anyone working in HI to be registered.

Eventually it is envisaged that statutory registration will be introduced to protect the interests of patients and the public. UKCHIP is now a registration body, but plans to develop into an accreditation body as soon as a proper framework is established. (LC)

LEADERSHIP **MEETS ETHICS**

Ethics is one of the first concepts that comes to mind when one evokes leadership.

This session demystifies the notion of ethics and proves that ethics contributes to good governance but also to economic success.

Furthermore, ethical leaders are the ones who can truly motivate their staff.

CON-GORAL GUIDANCE- on congruency of goals and morals for successful leadership on healthcare

Dr. Gregor Hans-Erhard Becker, Associate Professor for Bioethics and Philosophy of Science and Technology, Jagiellonian University, Krakow, Poland

Dr Becker gave a very informative and entertaining presentation on CON-GORAL guidance. While exploring the topic of leadership in ethics he used multimedia clips to illustrate his ideas. Who would have thought Shakespeare and Star Trek had links to ethics in healthcare management!

Dr Becker believes that goals in healthcare can only be accomplished by leadership that is adjusted in a particular way; congruency of goals and morals is essential. Contrary to popular belief, morals have a strong practical background. Morals define the course of action to take among people and have their roots in superior needs, beliefs and goals.

Taking the example of the first humans on earth Dr Becker explained how moral codices are formed. Their basic need and goal was survival and they learned by experience that this is achieved by living in groups. The human group needed practical rules to organise the goal-orientated coexistence of individuals and the moral codex was born. Basic moral attitudes of groups are often adjusted in order to ensure they cover all necessary actions to accomplish the goal. This can be seen in cases of using violence to fight for the freedom of your country or treating patients without insurance to fulfil your Christian goal of a charitable hospital.

To enforce and achieve these goals adequate leadership structures are essential. The character of leadership and the character of leaders have to show a congruency of goals and morals to be successful. Incongruence

Yannis Tountas

A view of the Congress audience

The Lithuanian delegation with 2 prize draw winners

of goals and morals will not only decrease the productivity of coworkers involved, but the goals themselves will be corrupted. The goal defines the leader and how the group should be led and the longevity of an organisation is not dependent on ethics and morals but on the suitability of the leader.

Economic goals of a place of compassion like a hospital can cause moral conflicts. Dr Becker concludes however, with good morals, goals and good leaders there will always be success. He used the example of the present economic goals in many hospitals and how they are focused not on profit but in treating people equally and ensuring beds for everyone, therefore fulfilling their moral goal.

The secrets of successful leadership

Prof. Ddr. Michael Lehofer, medical director of the Sigmund Freud Neuro-Psychiatric Hospital Graz, Austria

Prof. Lehofer began his presentation with the question "what makes people allow themselves to be guided?" He believes that people will allow themselves to be led if their needs are being satisfied. Although everyone has varying needs and likes and dislikes we do have common basic needs and they play a prominent role in allowing to be led. The needs of desire, bonding, control and self-esteem are inherent in everyone and fulfilling these basic needs is a proof of good leadership and a tremendous incentive for professional motivation.

He defined the basic need for desire as a fundamental need for signalling when other needs and basic needs have been satisfied. If someone is well bonded his need for desire will lead to the fulfilment of secure bonding. Similarly the need for self-esteem can be regarded as a result of the satisfaction of all other basic needs.

Prof. Lehofer illustrated man's inherent need for bonding using the comparison with other mammals: human beings stay attached to their mothers considerably longer than any other species. Bonding remains important even during adult independence.

Control is also important. In a psychological sense, control means a person's ability to influence his/her environment in his/her own way. When his/her need for control is satisfied, a feeling of self-efficacy sets in. So we are self-efficacious when we experience ourselves as being autonomous. The feeling of autonomy is strongly connected to our identity as individuals. We are happy when we are bound and at the same time enjoy full autonomy over our lives.

But what do these needs have to do with management?

A good leader must convey all four of these ideas. Prof. Lehofer believes that the art of leadership is the secret of enabling people to commit themselves while at the same time allowing for sufficient creative scope for independent action.

It must be conveyed to employees that they have been seen, that their managers notice and appreciate the work that they do. Receiving praise raises self-esteem, which in turn increases productivity.

He concluded his presentation on the secrets of successful leadership emphasising the importance of the strategic side of leadership but also the need for adaptability, since leaders should not follow a goal too vehemently and be prepared to sway from it. (LC)

LEADERSHIP **MEETS PATIENTS**

One of the major differences between a hospital and most other corporate entities is that its customer is a patient. The last decade has seen a logical return to patient- centered healthcare; many structures and projects have thus highlighted the pivotal importance of managing efficiency and quality of care.

The effects of the behaviour of management on the behaviour of staff toward patients

Iris van Bennekom, General Manager, Federation of Patients and Consumer Organisations of the Netherlands

In the Netherlands the reform of the healthcare system is gaining widespread acceptance. The patient's position used to be secondary to that of the doctor's but things are changing: regulated market forces have been introduced and they are aiming for a more patient oriented system which will have a number of effects on quality, efficiency and cost-containment.

Ms. Van Bennekom explained that these reforms are needed due to issues such as costs, quality and transparency. Competitive health insurance companies are needed as are reforms on prices, transparency and consumer rights. There is already a website which compares prices and standards of healthcare products. The insurance companies are to play the role of mediator for patients, insuring value for money and a constant search to improve quality. She also emphasised the importance of patient's rights, which are now in fact consumer's rights. The positions of clients, care providers and insurance companies/ healthcare offices are changing.

There is therefore a need for new leadership; leaders who are aware of both patient and staff values. It is about looking from the patient's perspective, focusing on their choices, the quality of their care and the cost of this care. Therefore, Ms. Van Bennekom looks forward to personalised healthcare budgets, which would enable patients to manage their own life, to make informed choices concerning their healthcare and to be treated as clients. This would include a complaints procedure like there is for any other service.

Professional values are also important. Patients need to place their trust in these professionals so there is a need for professional autonomy and skills, but also a collective agreement ensuring quality of care. Healthcare organisations are businesses in transition. What is needed is stabilisation, segmentation of excellence and patient orientation. Ms. Van Bennekom believes the solution is strategic leadership. We need to ask three questions: what is our market? Who is our client? What difference can we make? She concluded by urging us to create our own reality.

The Danish Quality Model, a tool for better leadership

Karsten Hundborg, Director of the Danish Institute for Quality and Accreditation in Healthcare

Mr. Hundborg described the Danish Quality Programme as a method to generate persistent quality development across the entire healthcare sector in Denmark. The programme provides standards of high international quality and methods to measure and control this quality. He stressed the importance of patient's rights, how we need to assess what patients want but also that people need time and funding to assess this.

The Danish Healthcare Quality Programme is transparent; anyone can see the goals and results of these goals. The programme is a unique model for quality development and safety systems in hospitals. It includes all services (GPs, pharmacists) and promotes crossdepartmental communication. It is also a collaboration between the local and national government so as to cover all public hospital services, and will be implemented in all Danish hospitals in 2009. The strategy is to implement a system that will prevent errors and promote high quality, apply best practice to daily work, build bridges between the health sectors, improve the quality of the patient's journey and create continuous quality development. It is also based on accreditation, ensuring joint standards that are approved by the International Society for Quality in Healthcare.

Mr. Hundborg explained how the programme collects and combines information. It is always being updated with new goals being set. There are indicators to allow self-assessment of the staff and progress is registered in an electronic system (TAK) to provide an overview of progress made.

Thus the Danish Quality Programme is a valuable tool for better performance and for the support of better leadership. This programme could also support crossborder care between EU countries.

He concluded by mentioning another project linked with this subject: the twin hospital project between British and Danish hospitals. The aims of this project are to coordinate and develop excellent quality, create transnational relations and to make quality a legitimate topic. This strategy is extremely useful in developing a set of common standards. He asked if it was wise to take the lead instead of waiting for someone else and whether a "task force" should suggest a set of European crossborder standards. (LC)

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Left to right: Heinz Kölking, Asger Hansen, Nikolaus Koller, Christian Marolt and Jan Aghina

Delegates at the General Assembly

LEADERSHIP **MEETS EMPLOYEES**

Leadership is also about preventing high technology, cost pressures and even, to some extent, patient-centered care from affecting and demotivating the most precious resource of a hospital, namely its staff. Only healthy and content employees can fulfill their task of making the patient their priority.

Management, fuzzy logic and new hospital governance

Jean Luc Chassaniol, Director General of Saint Anne Hospital, President of the French association of Hospital Directors (ADH) and Guy Vallet, Honorary Director General of Rouen and Marseille Hospitals, France

Jean Luc Chassaniol and Guy Vallet challenged the audience with management clichés such as "an executive should delegate" and "he should motivate his staff".

Management fads and miracle solutions are difficult to apply and so they recommended that we turn our attentions elsewhere- to fuzzy logic.

The pyramid structures of the past have gone. Now each staff member should play an active role in the functioning of his or her team; and commitment must be encouraged and initiative rewarded. Cooperation is the key.

Fuzzy logic is a pragmatic approach. It is how our brains work. Fuzzy logic formalises the world exactly as the brain does. It assesses input and output variables approximately and enacts a set of rules allowing the determination of output as a function of input.

It has been used successfully in project management, demographic analysis and health insurance fraud detection among other things. The main weakness of fuzzy logic is the fact that it is impossible to prove the stability of the system on which it is based.

But when talking about management do we really need such proof? Or is it only the result that counts?

Jean Luc Chassaniol and Guy Vallet then went on to discuss how this idea of fuzzy logic can be adapted to university hospital centre management in the framework of new governance. Fuzzy logic should allow "sustainable management".

This includes recognising that the acceptance of ideas is the only driving force of change in an organisation, that the working man would like to know and understand before he accepts and that only man is able to adapt to a complex environment.

Sustainable management also concerns quality control, patient/client satisfaction, safeguarding public interest, recognising the individual responsibility of employees and having a flat and "reactive" organisation chart.

Innovation and leadership

Mag. Gottfried KOOS, member of the Executive Board, VAMED, Vienna, Austria

Mr. Koos began his presentation by describing the current state of the European healthcare industry and its domination by dynamic technical, technological, medical and demographic developments and, of course, by the available financial funding.

There is a lot of pressure to change; innovation in healthcare is the desire to be successful in the treatment of illness. It is about prevention, raising awareness and making healthcare available to everyone.

More often than not there are conflicts between the desire to save lives versus financial issues or economisation versus hu-

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Gala dinner

manisation. Mr. Koos stated that there are three categories of businesses: pushers, plodders and pioneers.

Pushers are strong in marketing but have less scope for innovation, plodders consistently work, they have a medium marketing and medium innovation level and pioneers are the real innovators, they concentrate on the process and try to implement what they have developed. He then went on to describe the four types of innovation: product and service, process, organisation and social.

There is an obvious correlation between sustainable success and innovation. But Mr. Koos maintained that the innovation of a system or enterprise could only be stimulated or maintained over long periods of time through strong leadership and organisation.

A new understanding of health is emerging, psychosocial aspects of health are now just as important as prevention, vitality and quality of life.

With this new understanding comes a new age of healthcare management and an opportunity to develop and offer new services.

Even with the new biotechnologies and computers, productivity can increase the most dramatically by the improvement of the way we collaborate, form networks and manage clusters.

According to Mr. Koos areas for future innovation include the migration of the health and illness markets, the remuneration of services becoming increasingly orientated to the quality of results and hospital locations evolving into health campuses.

The presentation was concluded with the emphasis that the "economisation" and "humanisation" of healthcare systems should not be a contradiction.

Only an efficient and economic healthcare system will be able to offer secure jobs and only healthy and content employees can fulfil their task, which is putting patients first.

The objective is not just to increase efficiency but to make innovation an essential part of our organisational culture. (LC)

The official handing over of the EAHM flag from the 2008 Graz Congress team to the 2012 Davos Congress team

LEADERSHIP **MEETS LEADERS**

The old saying goes: people don't leave a company, they leave a supervisor. In this era of scarce professional staff, it is essential for hospital managers to look into what makes their employees tick and what motivates them and to modulate their approach according to the type of individuals they supervise. It is definitely the best way to maintain the affective, continuance and normative compoments of professional commitment.

Building a high-performance organisation

Birgit Miesch, Director Human Resources, Ethicon Endo-Surgery Europe, Johnson & Johnson

"Caring for the world one person at a time" is the company's motto and it was also the starting point for Birgit Miesch's presentation on building a high performance organisation. She defined leadership as an equation: values + living them = leadership.

By having a set of values that serves as the foundation of everything that you do and living these values, giving consistency and credibility with your employees, you can become a great leader.

The Johnson & Johnson CREDO illustrates their responsibilities to customers, employees, committees and stockholders. It demands high quality, respect and inclusion of employees, being a good citizen, supporting societies and respecting the importance of education. This Credo is described as a living document for decision-making.

For Johnson & Johnson employees are a huge responsibility. Everyone is considered as an individual and their dignity must be respected and their merit recognised.

Quoting Linden Wood Ms. Miesch stated, "People don't care about how much you know until they know how much you care." Employees need to know that their contribution matters, that they are part of something broader than themselves. Good leadership means putting meaning into what people do everyday.

Good leadership is also about selecting the right person for the job, someone who will build on the legacy that you leave behind in your organisation. The ultimate goal is that you are not needed anymore. This means leaving your comfort zone and realising that your employee may have the potential to be your boss one day.

So how do we achieve this relationship with our staff? We must ask what makes them tick, strive to understand their motivations, their specific needs. Time must be taken to listen to employees and learn about them. Giving and receiving feedback is also essential. In most cases this is not done often enough due to the fear of damaging a good relationship but well thought out feedback can be very beneficial. Moreover, as a leader you need to be open to receiving feedback too. Showing your appreciation is of utmost importance. This is the fun part of leadership, a chance to be creative. Appreciation can be shown through monetary awards, a hand written note, praise in front of peers or even a simple thank you.

A good leader will also create opportunities for employees to shine. It is about unlocking potential and giving opportunities to less experienced members of staff. This can be challenging as it may mean waiting a little longer for results and providing more support to employees.

The presentation was concluded with the final prerequisite for being a good leader- being a role model. Consistency is extremely important, you must do what you said you would do, walk the walk. It is about being authentic and

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Professor Michael Lehofer

The Golden Helix Award winners

Iris van Bennekom

most importantly being yourself. Performance will improve when relationships in the work place are based on mutual respect and trust.

Doctors' commitment to the hospital and to their profession and management implications

Prof. Dr. Manel Peiro, Academic Vice Dean, ESADE Business School, Barcelona, Spain

Prof. Peiro's presentation explored the relationships between doctors and the hospitals in which they work.

Spain provided the framework for the survey as it has been remarked there and elsewhere that in general, hospital doctors feel disappointed and dissatisfied as professionals and show a lack of commitment to the hospital where they work.

For the study, organisational commitment was divided into three categories:

- affective commitment (personal and emotional),
- continuance commitment (perceiving costs), and
- normative commitment (moral obligation).

This commitment depends on age, sex and tenure in the organisation. He identified a conflict of divided loyalties. Professional norms and values often come up against organisational requests and demands.

The aims of his research were to discover the extent of organisation commitment, the commitment of doctors to establish links, the extent of professional commitment and the relationship between organisational and professional commitment as well as the patterns regarding their complicity.

His findings have shown that commitment to the organisation increases with time/age and promotion. It has been found that professional commitment is usually very strong.

They have also shown the relevance of the foci of commitment: the department and the department head, with a strong affective commitment to the department but a low level of commitment to the head of department.

There are four clusters of different degrees of professional and organisational commitment:

- the conditionally loyal, representing approximately 30% of the total, who feel a low commitment to the department,
- the resentful idealists, representing approximately 15% of the total, who are basically angry at the world and strongly reject the department head,
- the committed winners, about 28%, and the youths with qualities, representing about 27% of the total, often young doctors with a strong commitment towards the department.

There are significant management implications from these findings. They highlight that doctors are a diverse group and it is necessary to divide them into these clusters in order to manage them in different ways. Prof. Peiro believes that doctors' commitment can be managed; positive work experiences can be developed with rewards, a fair distribution of resources and supervisor support.

To conclude, Prof. Peiro highlighted some of the main problems and current trends effecting commitment. These can be looked at from a global perspective.

Large unions are prevalent in the current healthcare systems, which means various departments are being grouped together.

However, one must ensure that this does not weaken their commitment to their own department.

He also highlighted problems concerning heads of departments.

In the hospital sector promotion is the only recognition there is and there is also the question of whether heads of departments are really interested in management or simply the power and recognition that comes with the title.

Despite these problems doctors' commitment to the service is very strong as is their commitment to the profession.

The weakness lies in the bond with the service manager, which is weak and decreases throughout a doctor's professional career.(LC)

Left to right: Nikolaus Koller, Landtagspresident Siegfried Schrittwiese, Paul Castel

Snapshot at the J&J event in the Schlossberg

MÖLNLYCKE HEALTH CARE

The Use of Scanning Electron Microscopy to Analyse "Resistance to Wet Bacterial Penetration" for Surgical Gowns

*By Catarina Alenius Jensen, B.Sc, and Kristina Blom, Ph.D.**

Medical devices such as surgical gowns must resist wet bacterial penetration to prevent the transmission of infectious agents. Such resistance is described as a safety property in the European standard EN 13795[1]. This safety property has been found by the European Commission to harmonize with the essential requirements of the Medical Device Directive, MDD 93/42/EEC[2].

Bacterial penetration under wet conditions was ignored until Beck and Colette in 1952 reported that this feature is of clinical significance[3]. During use, the surgical gown can be exposed to body and other fluids and hence become wet. Beck and Colette found that surgical gowns made of cotton would resist dry bacterial penetration but, once the material got wet, bacteria easily penetrated resulting in an increased risk of surgical site infection[3]. The awareness of this safety property has influenced the development of surgical gowns.

Today, disposable and reusable surgical gowns are produced with different qualities. A number of clinical studies have compared disposable and reusable surgical gowns with regard to protection from bacterial infections[4-9]. Also, preclinical studies have been conducted to study the bacterial barrier properties of surgical gowns using different test methods[3, 10-13]. Then, in 2006, a standard test method, ISO EN 22610, was developed and approved to study wet bacterial penetration[14] using nutrient agar plates to analyze if bacteria penetrate the device under movable pressure and tension.

In this study, disposable and reusable surgical gowns are evaluated with regard to how well they resist wet bacterial penetration using the test method of ISO EN 22610 but applying a clinically relevant bacterial challenge. Furthermore, the results are analyzed with scanning electron microscopy (SEM), in addition to nutrient agar plates.

METHODS

Disposable surgical gowns made of non-woven, reinforced material and reusable surgical gowns made of cotton, synthetic and reinforced synthetic materials were used. Samples from the front of the surgical gowns were tested according to the test method ISO EN 22610 with a slight modification and analyzed with SEM and nutrient agar plates. The modification involved the gowns being challenged with 10^6 (=1,000 000) CFU of Staphylococcus aureus (S. aureus)/cm^2 sample, instead of $2x10^2$ (=200) CFU/cm^2 sample.

RESULTS

The disposable gown resisted wet bacterial penetration, while all the reusable gowns allowed bacterial penetration. The results were analyzed with agar plates (Figure 1) and confirmed with SEM (Figure 2).

DISCUSSION

This study challenged the surgical gowns with a clinical relevant bacterial load of S. aureus i.e. 10^6 CFU/cm^2[15], as opposed to that used in the standard test method ISO EN 22610, i.e. $2x10^2$CFU/cm^2. This greater bacterial challenge was applied to mirror what could happen during an intervention where

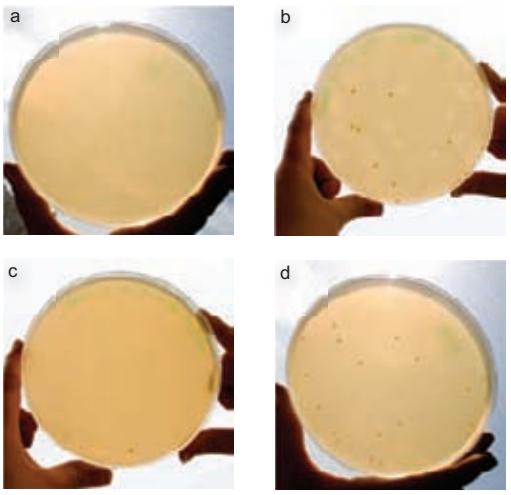

Figure 1. Wet bacterial penetration was analyzed with nutrient agar plates and showed that no bacteria penetrated the non-woven disposable gown (a) as opposed to the reusable gowns made of synthetic (b), reinforced synthetic (c) and cotton (d).

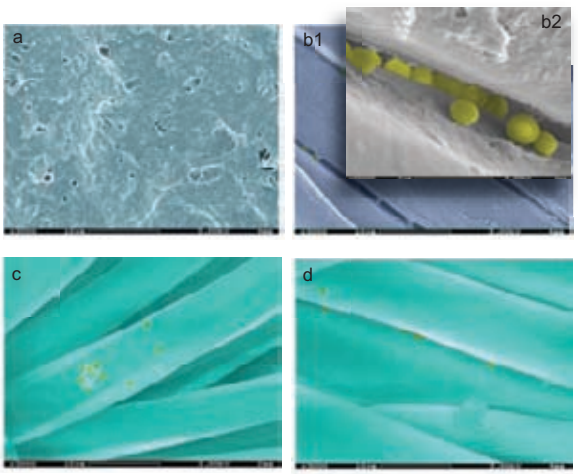

Figure 2. SEM analysis at 3,000 x magnification revealed that no bacteria penetrated the disposable gown (a) while S. aureus bacteria (colored yellow) were found to penetrate reusable gowns made of synthetic (b1 - b2 at 20,000 x magnification), reinforced synthetic (c) and cotton (d).

physical pressures and tension, together with fluids and staff's skin bacteria, could interact on the surgical gown.

We found that under tested clinical conditions, only disposable surgical gowns managed to resist wet bacterial penetration. In contrast, all of the tested reusable surgical gowns made of cotton, synthetic and reinforced synthetic, allowed bacterial penetration. Additional findings with the application of SEM provided insights into the physical properties of the different gowns. It was seen with SEM that all the reusable gowns were woven (Figure 3). The woven structure could partly explain why bacteria could penetrate between the fibers by 'wicking', as discussed by Leonas and Jinkins[16]. In the case of gowns made of cotton, the 'wicking' mechanism is probably not the only feature that allows bacteria to penetrate. The interstice of cotton textiles are between 10 and 50 micrometer in size[17], which can readily be penetrated by bacteria that are generally between 1 and 10 micrometer. It has also been found that pores are even larger in reusable surgical textiles that have been washed repeatedly[18]. In contrast, non-woven disposable surgical textiles have not been weaved and hence do not contain pores. Yet another factor that may have affected the barrier properties for reusable gowns could have been the reprocessing technique itself. It has been reported that reusable gowns progressively lose their bacterial barrier properties through repeated laundering cycles and, after a certain number of reprocessing cycles, they are not considered to be fit for use.[19].

CONCLUSION

This study revealed that, in contrast to disposable surgical gowns, reusable gowns made of cotton and synthetic and reinforced synthetic materials did not resist the penetration of a clinically relevant bacterial challenge. The bacterial barrier failure of the studied reusable gowns could be due to physical properties, such as pore size and the structure of the material, which could allow bacterial penetration by 'wicking'. It could also be due to each reprocessing cycle diminishing the gown's barrier quality.

These results highlight the infection risk of using reusable surgical gowns in a clinical setting. The findings also indicate that disposable surgical gowns will provide clinical staff with desired protection against the clinically relevant challenge of infectious agents.

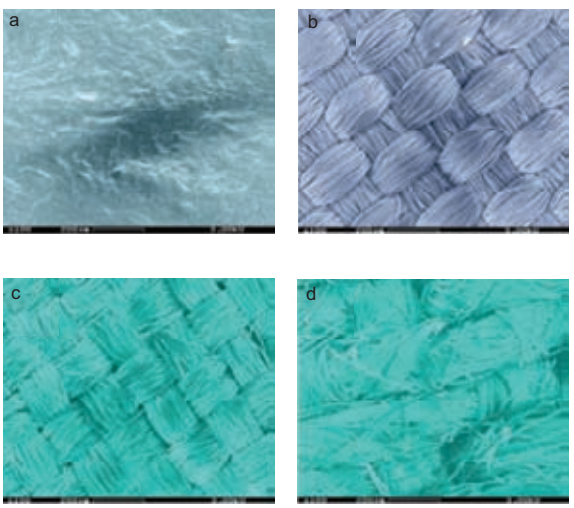

Figure 3. SEM pictures at 100 x magnification showing the physical structure of disposable gown (a) and reusable gowns made of synthetic (b) reinforced synthetic (c) and cotton (d).

ACKNOWLEDGEMENT

We would like to thank Prof. Bengt Johansson at the Institute for Biomedicine, Sahlgrenska Academy, University of Gothenburg, Sweden, who guided us in the world of scanning electron microscopy.

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Correction from (E)Hospital vol.10, issue 4: In the study on Cleanliness of Surgical Gowns with Scanning Electron Microscopy, it should say µm and not mm.

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HEALTHCARE IN DENMARK

By Asger Hansen

Denmark, a Scandanavian country consisting of a mainland peninsula and a number of islands, is a small country (43,000 km2) with few inhabitants (5.5 million). The capital city, Copenhagen, has around one million citizens. There are two off-shore territories, Greenland and the Faroe Islands, granted home rule in 1979 and 1948. Contrary to the rest of Denmark, Greenland is geographically very large, 50 times larger than the other areas of Denmark.

The demographic development is similar to other western European countries, with an aging population; the GDP in 2006 was 275,227 million USD (202,8 million euros) and 47,759 USD (35,202 euros) per capita (2005), with a fairly equal distribution of income across the population. The general level of education is fairly high, with 32% and 18% of the population between 20 and 69 years having attended secondary and tertiary education.

Denmark has a constitutional monarchy and a parliamentary democracy. The current government, in power since 2001, is a coalition between the Liberal and Conservative Party. Denmark has been a member of the European Union (EU) since 1973.
In terms of total health spending Denmark ranks above average in OECD countries, spending 9.5 % of GDP and 3,349 USD (2,468 euros) per capita in 2006. Health spending per capita in Denmark increased, in real terms, by 4,1% per year on average between 2000 and 2006. The public sector is the main source of health funding in most OECD countries and Denmark is no different, 83% of health spending was funded by public sources in 2002. In 2004, Denmark had 3,6 practicing physicians per 1,000 population, more than the OECD average of 3,1. The number of nurses per 1,000 population in Denmark was also well above average in 2006.

As in most OECD countries, the number of hospital beds per capita in Denmark has declined over time. The decline has coincided with a reduction of average length of stays in hospitals and an increase in number of surgical procedures performed on a same-day (or ambulatory) basis.

Like most OECD countries, Denmark has enjoyed large gains in life expectancy (75 years for men, 80 for women) over the past decade, thanks to improvements in living conditions, public health interventions and progress in medical care.

ORGANISATION

The healthcare service can be divided into two sectors, primary healthcare and the hospital sector. Primary healthcare, available to all, deals with general health problems and its services. This sector can be divided into two parts, treatment and care, and prevention.

When ill the first point of contact is the primary healthcare sector. The hospital sector deals with medical conditions that require more specialised treatment, equipment and intensive care. In addition to treatment of patients, both general practitioners and hospitals are involved in preventative treatment as well as health personnel training and medical research.

General practitioners act as the gate-keepers of hospital treatment. Patients usually start by consulting their general practitioners, whose job it is to ensure that they are offered the treatment they need. Self-employed general practitioners are paid via a combination of capitation (30%) and fee for service.

It is normally necessary to be referred by a general practitioner to a hospital for medical examination and treatment, unless it is a question of accident or acute illness. The same goes for treatment by a specialist. Specialists are paid on a fee for service basis.

A new local government reform came into effect on 1 January 2007, replacing the old system of 15 counties and 271 municipalities (from 1970) with five regions primarily focused on the healthcare sector and 98 municipalities responsible for a broad range of welfare services. The task of the state in healthcare provision is to initiate,

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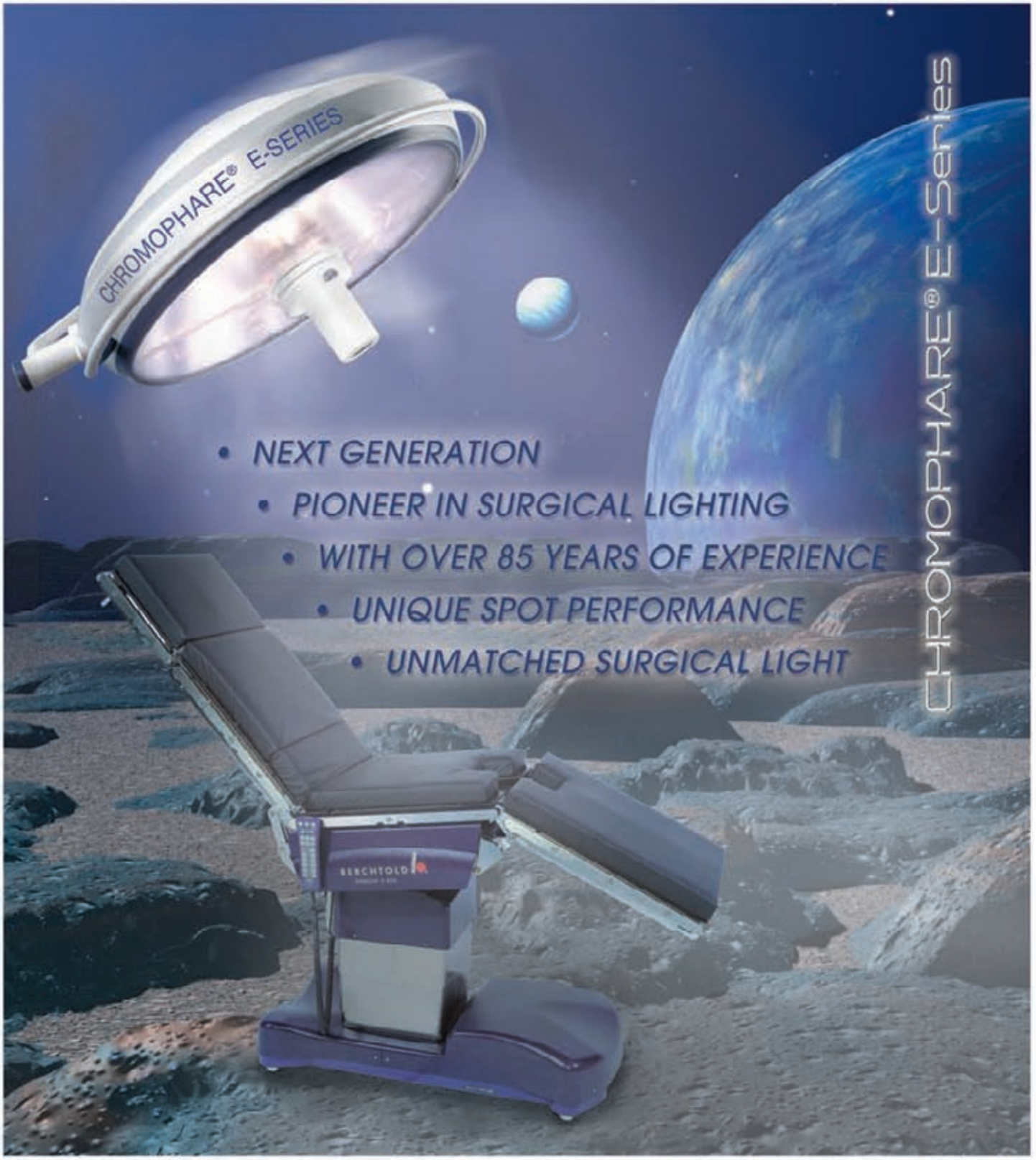

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coordinate and advise and to establish the goals for a national policy.

The Ministry of Health and Prevention, in its capacity of principal health authority, is responsible for healthcare legislation and also supports efforts to improve productivity and efficiency by promoting the professional exchange of information and by the introduction of economic incentives and activity-based payment.

FINANCING

The Danish healthcare system is based on a principle of free equal access for all.

In 2005 the public expenditure constituted 84% of the total health expenditure and private expenditure constituted 16% of total health expenditure. Private healthcare expenditure covers out-of-pocket expenditure for pharmaceuticals and dentistry. To finance the majority of the regional and local healthcare expenditure, the state imposes a healthcare contribution tax (8% on taxable income).

Annual negotiations between the central government and the regions and municipalities result in agreements on the economic framework for the health sector, including levels of taxation and expenditure and resource allocation.

THE REGIONS

Healthcare in the regions is financed by four kinds of subsidies. A block grant from the state (75%), a state activity-related subsidy (5 %), a local basic contribution (10%) and a local activity-related contribution (5%). The state block grant reflects expenditure needs e.g. demography and social structure of each region. The purpose of the state activity-related pool is to encourage the regions to increase the activity level at the hospitals, whereas the purpose of the local contributions is to encourage the municipalities to initiate efficient preventive measures.

At the regional and municipal level, various management tools are used to control expenditure, in particular contracts and agreements between hospitals and the regions, and ongoing monitoring of expenditure development.

PRIVATE HEALTH INSURANCE

Around 36% of the population purchases complementary private health insurance covering statutory cost sharing from the not-for-profit organisation "Danmark".

This private health insurance offers access to care in private hospitals in Denmark and abroad. It covers 13,5% of the population and is mainly purchased by employers as a fringe benefit for employees. In 2005, private health insurance accounted for 1,6% of total health expenditure and is rapidly increasing.

THE DANISH QUALITY IMPROVEMENT MODEL

A comprehensive standards-based programme for assessing quality is currently being implemented aiming to incorporate all healthcare delivery organisations and include both organisational and clinical standards. Organisations are assessed on their ability to improve performance measured against standards for processes and outcomes.

The assessment programme is a system of regular accreditation based on annual self-assessment and external evaluation (every third year) by a professional accreditation body. Self-assessment involves reporting of performance against national input, process and outcome standards allowing comparison over time and between organisations.

The external evaluation begins with self-assessment and goes on to assess status for quality development. Some data from the quality evaluation are already being published on the internet (www.sundhedskvalitet.dk) to facilitate patient choice of hospital and encourage hospitals to raise standards.

Every second year the Danish Regions and the Ministry of Health and Prevention conduct a survey of the patients experiences for comparison purposes.

In January 2004, a national reporting patient safety system for adverse events was established. The purpose of the system, based on the Danish Healthcare Act, is to improve patient safety and healthcare obliging healthcare professionals to report any adverse events in connection with a patient's treatment or stay in hospital.

The new National Strategy for Digitalisation of the Health Sector was adopted on 1 January 2008. The vision is that data shall follow the patient across organisational and sectoral boundaries.

To ensure patients' legal rights, new laws have been passed and new complaints and compensation procedures developed. Doctors are obliged to inform the patients about their illness, the treatment available and its side effects to gain the patient's "informed consent". It is also possible to set up a "living will". Patients also have a right to see their own medical records free of charge, and doctors or other medically trained staff are obliged to interpret case records if asked.

NEW INITIATIVES FOR THE FUTURE

The Danish government has introduced a reform for better services for citizens which includes the healthcare sector. There are 40 initiatives and almost 2 billion DKR (270 million euros) over a period of 4 years have been reserved for this purpose. Investments for the construction of specialised hospitals have also been made to ensure the hospital sector is future-proof. For this purpose the government have reserved 25 billion DKR (3.3 billion euros).

The National Board of Health is also obliged to lay down requirements of health specialty planning.

This year the Danish Regions have set up a Committee assessing the future role of general practitioners in the Danish healthcare system to ensure easy access to high quality treatment and effective utilisation of resources. The Ministry of Health and Prevention have set up a working group to investigate the proportion of administrative tasks among the staff in public hospitals in an attempt to reduce bureaucracy in the future.

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THE DANISH HOSPITAL SYSTEM

By Asger Hansen

The hospital sector in Denmark is under the responsibility of the five regions. Regional authorities must offer free hospital treatment for the residents of the region and emergency treatment for temporary residents in need. Almost all hospitals are publicly owned (95% of hospital beds are public).

The obligation to provide its citizens with hospital treatment is fulfilled in the vast majority of cases by the individual region's own hospitals, and to a certain extent by hospitals in other regions. Furthermore, private hospitals are resorted to in some cases, especially specialist hospitals which have an agreement with one or several regions.

HOSPITAL SERVICES

Hospitals are responsible for specialised examinations, treatment and care of somatic and mental illnesses that cannot be treated within the primary or social sector as they require specialist knowledge, equipment or intensive care and monitoring.

The main organisational framework for regional hospital services is prescribed in a plan setting out the structure and functioning of the region's activities in the health sector.

The Ministry of Health and Prevention, through the National Board of Health, contributes to healthcare planning in the form of guidance and regulations regarding basic and specialised treatments and functions within hospital services. Information is also provided on how different forms of treatment should be organised, including coordination of the different levels of treatment. The regions are obliged to set up mutual agreements among themselves regarding the use of highly specialised departments with a view to ensuring that inhabitants retain equal access to necessary specialised treatments. This reflects the conviction that the individual region cannot be expected to cover all hospital treatments in its own hospitals.

Furthermore, the regions may, after approval by the National Board of Health, refer patients to highly specialised treatment centres abroad paid at public expense. The regions have also the possibility of making agreements directly with a foreign hospital, in which case it is the region and not the state that will cover the costs.

Beyond treating illnesses, hospitals offer diagnostic support to the primary sector in the form of laboratory analyses, scanning and X-ray diagnoses etc. Furthermore, another important element is the hospital's permanent state of readiness: an appropriate number of hospitals are generally manned around the clock in order to deal with potential acute illnesses and accidents. Hospitals play an important role in the training of staff for the entire healthcare service and in the field of research; research results are traditionally put into clinical practice, particularly in university hospitals.

Hospitals are expected to coordinate closely with the primary sector regarding both the admission of patients and the discharge of patients back to the primary healthcare sector and the social sector (rehabilitation, care). The legislation orders formal collaboration between regional councils and municipalities in the different regions.

In the last few years, many national and regional initiatives have aimed at improving efficiency, with a particular focus on hospitals. For example, Denmark has been at the forefront of efforts to reduce average lengths of stay and to shift care from inpatient to outpatient settings.

FREEDOM OF CHOICE

Since January 1, 1993, citizens who need hospital treatment have the possibility, within certain limits, of choosing freely which hospital they wish to be treated in. Citizens may choose from all public hospitals that offer basic treatment and a number of smaller, specialist hospitals owned by associations that have agreements with the regions.

Danish citizens may also choose private hospitals or clinics in Denmark or abroad if the waiting time for treatment exceeds two months and the chosen hospital has an agreement with the region's association regarding the offer for treatment. From October 1, 2007 this waiting time was reduced to one month.

The number of patients who opt to use their extended possibility of receiving treatment in a private hospital or going for treatment abroad is increasing. Most of these patients receive orthopaedic surgery, eye surgery, and ear and nose treatments.

Alongside publicly owned hospitals and private hospitals owned by associations, which have made agreements with the counties, there are a limited number of private paying hospitals completely outside the public health service. At present this sector is very modest (0,2% of the total number of beds).

ORGANISATIONAL STRUCTURE AND MANAGEMENT

The organisational structure consists of a number of separate departmental units, each referring to a central hospital unit.

Many years ago it was common for the central hospital management to be entrusted to a single person. The hospital manager usually had a medical background at the time and was responsible for the overall operation of the hospital.

Nowadays the hospital director in Denmark is often assumed to have received training in business economics rather than medical training.

After the disastrous consequences of turning a blind eye to the educational aspects of hospital management in the past, most hospitals since the 1980's have attempted to organise a hospital management consisting of several health professionals, each one contributing financial or medical expertise.

An example is the so-called "Troika" management by a director with a business background, a medical director and a nursing director. There are many examples of the implementation of this particular management model in Denmark but it has been claimed that competencies and responsibilities are not defined clearly enough.

For instance problems concerning the delegation of power and decision-making, if the "Troika" management disagrees, management efficiency is reduced.

At the present moment, several smaller hospitals have merged or

CAPACITY AND ACTIVITY IN SOMATIC HOSPITALS					
YEAR	1978	1986	1994	2002	2005
NUMBER OF HOSPITALS	104	90	79	58	52
FIXED NUMBER OF BEDS	29,461	26,098	21,659	18,166	16,410
DISCHARGES	871,000	978,000	1,062,000	1,126,000	1,102,000
BED DAYS	8,573,000	7,681,000	6,516,000	5,471,000	4,998,000
AVERAGE LENGTH OF STAY (DAYS)	9,8	7,9	6,1	5,2	4,5

are about to merge under one unique hospital management, and in large hospitals a new model has been tested, the so-called "Executive Board" model.

This model involves top-level management by a Managing Director with exclusive responsibilities and assisted by a so-called "Executive Panel" which includes not only a Medical Director and a Nursing Director, but also a Financial Controller, a Personnel Manager, a Chief of Engineering, an R & D manager etc.

In Denmark, according to the departmental management model, wards are normally headed by two people, an administrative leading consultant and a head nurse, who co-manage the departmental administrative and financial affairs.

It is more and more usual that one of the two leaders, and normally the leading consultant, has the final power to make decisions concerning management and administrative affairs. In order to reduce the so-called "span of control" of hospital management in large university hospitals, comprising 30 – 40 separate departmental units, some of these hospitals have been split up in so-called "centres" according to treatment areas. This procedure has significantly reduced "span of control" issues.

But the replacement of departmental managements by centre management with an unchanged number of management levels has met heavy criticism from employees. They find that there is too much distance between them and the centre management.

Hospital management and political authorities conclude yearly agreements concerning financing and activities, as does top-level management and centre level management.
Future hospital management organisational structures will probably continue to be rather diverse.

However, the underlying principle remains the same: the acting management level must also be accountable for its actions, and decentralisation is considered to stimulate employee motivation and well-being along with the possibility of increased productivity.

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THE DANISH ASSOCIATION OF **HEALTHCARE MANAGEMENT**

By Asger Hansen

The Association was founded in 1912 and is one of the oldest hospital management associations in Europe; it will celebrate its 100th birthday in just 4 years time.

The statutes of the Association state that it is a professional forum for people employed in the hospital and healthcare sector with an interest in strategic management and operational management. The focus of attention is on areas such as the improvement of quality, organisation development, patient flow, administration, finance, human resource development and information.

MEMBERS

The Association has at present 398 ordinary personal members, and 37 institutional memberships, representing 760 members, bringing the total number of members to 1,183 individuals. The majority of the ordinary members are hospital managers, but membership also includes administrative chief doctors as well as chief and head nurses.

ORGANISATIONAL STRUCTURE

General Assembly

The members collectively have the ultimate authority, which, on a practical level they exercise at the annual ordinary General Assembly. The General Assembly is led by a Chairman elected by the participants at the beginning of the meeting. The annual report and latest accounts are always listed on the agenda for discussion and adoption, as well as the budget for the following year, membership fees and proposals from members.

The General Assembly also agrees on the election of a President and members of the Executive Committee to be entrusted, for a two-year period, with day-to-day business and with necessary initiatives for the planning and implementation of the objects clauses, including the detailing of specific action plans.

Executive Committee

The Executive Committee comprises nine members, including the President, and meets normally four or five times a year. The Treasurer and the Secretary of the Association also participate in these meetings, both of whom are employed on a part-time basis, as well as a member who is in charge of international affairs within the Association. These participants are not members of the Committee and only have an observer status in the meetings. The meetings are chaired by the President. The current President since 2006, Regional Hospital Director Per Christiansen, is the seventeenth president of the Association.

> Because of the rising importance of international hospital and healthcare affairs, the Association has recently decided to also to set up a new subcommittee in charge of following up on international developments concerning healthcare management.

Subcommittees

Many years ago, the Committee set up two subcommittees to deal with day-to-day business under the chairmanships: a publications committee for the magazine of the Association and a course committee. The chairmen of the subcommittees are members of the Executive Committee. The subcommittees each have normally about 7-8 participants, all of whom are members of the Association. They hold 4-5 meetings a year.

Moreover, because of the rising importance of international hospital and healthcare affairs, the Association has recently decided to also to set up a new subcommittee in charge of following up on international developments concerning healthcare management. They are also entrusted with the mission of publicising Danish experiences in an international context.

ACTIVITIES

The Association carries out activities of various kinds in accordance with its statutes. For instance it has published a magazine since 1925, which is distributed ten times a year to all association members and other interested parties who want to subscribe.

Another core area of activity for hospital and healthcare professionals is the organisation of seminars, courses and annual conferences, during which, according to a long-standing tradition, speakers will normally include the Danish Minister for Health.

And last but not least, the Association organises a one-week foreign study trip for 20-22 members of the Association each autumn.

These study trips, after which participants draft a study report for publication in the magazine of the Association, have occurred for more than 30 years. Last year the main theme was "Modern Hospital Constructions", and the destination was the Netherlands. The trip included visits to nine new and upgraded hospitals and was a great success.

Moreover, on an international level, the Association will continue its active participation in European cooperation within the framework of its membership in the European Association of Hospital Managers. The Danish Association was one of its six founding members in 1970. Since 1984, Denmark has represented Nordic countries on the EAHM Board.

FINANCES

The annual fee for ordinary members of the Association is about 65 euros. For institutions the fee depends on how many people are included in the membership.

Total membership fees amount to approximately 75,000 euros. Largest expenses go to administrative costs of the Association, the magazine, international affairs as well as to the development of activities for members, for instance the preparation of a homepage (www.dssnet.dk), including an electronic directory of magazine articles, courses etc.

OUTLOOK

Over the past few years the Association has experienced a steady increase of members and continues to have sound finances. The Association intends to develop and increase its activities for members in the coming years. It plans to continue to offer high-level professional content and will thus try to influence developments in the Danish hospital and healthcare sector, including assisting and advising authorities and political decision makers.

Moreover, the Association will continue its active participation in international cooperation within Europe, contributing relevant knowledge and advice, and will also apply knowledge gained from international exposure to its current operations.

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LES LEÇONS D'UNE CRISE

Willy Heuschen

Dans le numéro d'avril d'Hospital nous évoquions la question de l'intensification de la concurrence dans le monde des soins de santé. Tandis que plus de 600 participants débattaient des défis du leadership hospitalier pendant le 22ème Congrès de l'AEDH à Graz, les médias se faisaient l'écho de l'effondrement du système financier au niveau mondial. Les banquiers ont mésestimé les risques qu'ils affrontaient et le secteur n'a dû sa survie qu'à l'intervention d'aides de l'état. On s'est même démandé si le système capitaliste garderait son crédit auprès des citoyens.

Cette crise bancaire et la récession qui pourrait en découler présentent quelques similitudes avec l'actualité du secteur de la santé.

Depuis les années d'après-guerre, le crédo de l'économie de marché prévoit de laisser aux banques, comme d'ailleurs à toutes les entreprises, une marge de maoeuvre certaine. Dans quelques pays européens, l'état veille à la tolérance sociale et encourage ce qu'on appelle «l'économie sociale de marché». Le succès de cette formule est indubitable, même si les évolutions incessantes nous placent continuellement devant de nouveaux défis.

Par contre, le système de santé, et particulièrement les hôpitaux, ne sont pas toujours dans les petits papiers des ministres des finances Leur coût pèse lourd dans le budget de l'état et constitue un terrain d'exercice privilégié pour d'éventuelles économies. Une illustration parfaite est la récente manifestation de Berlin: elle a attiré des dizaines de millers de professionnels hospitaliers qui ont dénoncé le sous-financement des hôpitaux.

Il n'en va malheureusement pas de même partout. De nombreux pays considèrent la privatisation des hôpitaux et une gestion hospitalière basée de plus en plus sur l'économie de marché comme la panacée universelle. L'AEDH travaille actuellement sur une position tout en nuances qu'elle développera lors d'un séminaire spécial pendant Medica 2009, mais dont nous indiquons déjà quelques mesures d'accompagnement incontournables. Une confiance aveugle dans la liberté de manœuvre des acteurs de l'économie de marché n'est certainement pas à l'ordre du jour, comme le démontre l'expérience des banques. Même les instances officielles de surveillance n'ont pas pu empêcher la crise bancaire. Il vaut donc la peine de soutenir préventivement les soins de santé par le biais de mesures de financement public suffisantes et de longue durée plutôt que de mettre leur pérennité en danger de façon inconsidérée.

Une deuxième similitude avec le secteur bancaire provient d'un double constat. La crise est attribuée aux estimations faussées des banquiers mais aussi aux contrôles déficients des instances de surveillance internes subordonnées. Des politiciens sont également visés dans le cas de "Landesbanken" allemandes. Ceux-ci invoquent alors un manque d'expertise. Les généreuses rétributions du management bancaire et des directoires, enviables mais éthiquement inimitables par notre secteur renforcent encore les accusations. Ces reproches se rapportent à la structure de direction et ne sont, du point de vue de la responsabilité, pas très différents du secteur hospitalier. Il y a donc suffisamment de raisons pour approfondir la question, étant donné les interrogations soulevées au niveau européen. Qui devrait diriger l'hôpital et comment? Quelles compétences sont indispensables et qui contrôle qui?

En plus de leur structure, les méthodes de travail des banques et leur opacité sont déplorées par de nombreux investisseurs. On réclame de la qualité et tout simplement parce que nous la devons aux consommateurs, c'est à dire à nos patients. La qualité ne peut jamais être assez remise en question d'autant plus qu'elle doit s'adapter à de nouvelles découvertes et à des attentes qui évoluent. Le Congrès 2010 de l'AEDH qui se tiendra à Davos sera consacré à ce thème.

Enfin nous constatons, à l'occasion de cette crise bancaire, que des contre-mesures prises état par état ne suffisent plus et qu'il faut au moins des directives européennes. Les dirigeants européens se sont consultés à ce sujet lors de plusieurs sommets. Les crises ne s'arrêtent plus aux frontières. Si une crise hospitalière survient dans un état-membre, par exemple à cause d'un non respect des normes de qualité, les pays voisins seront très vite impliqués dans la gestion de la crise. Partant de là, nous intensifierons le travail déjà entamé autour des directives européennes de qualité hospitalière. Nous espérons un soutien national et européen. L'UE et ses états-membres devraient finalement comprendre que la prévention s'avérera plus une option rapide, plus efficace et également plus rentable. Nous poursuivrons notre travail de lobbying dans ce sens, car nos patients valent ces efforts. La prévention est de toute façon préférable à une confiance aveugle.

Willy Heuschen
Secrétaire Général de l'AEDH
Rédacteur en chef

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.

38ÈME ASSEMBLÉE GÉNÉRALE DE L'AEDH

La 38ème Assemblée générale de notre association, l'AEDH, s'est principalement concentrée sur deux questions : les amendements aux statuts de l'AEDH et le rapport d'activités.

Rapport d'activités

A la moitié du mandat du Bureau et Conseil d'Administration actuels, un rapport d'activités a été présenté par le Président, Mr Paul Castel.

En réponse à une consultation menée par la Commission européenne sur les soins transfrontaliers, l'AEDH a appelé à une approche commune de la définition, évaluation et amélioration des normes de qualité en soins de santé (services) ainsi qu'au développement d'un modèle européen d'accréditation des services de soins de santé.

L'AEDH a continué à explorer ce thème par le biais d'un séminaire qu'elle a organisé le 16 novembre 2007 à Düsseldorf sur le thème «Outils d'évaluation de la qualité hospitalière: vers un système européen d'accréditation?». Le premier séminaire de l'AEDH a rassemblé environ 70 délégués, un succès cautionné par des articles dans *Hospital* 5/2007 et 1/2008.

La Commission européenne et les acteurs du secteur, y compris l'AEDH, consultent sur les façons d'améliorer la qualité des soins de santé dans l'Union européenne, avec un accent particulier sur les normes de qualité hospitalière.

Ce travail vise entre autres à établir un cadre de normes communes aux hôpitaux européens, ce qui pourrait permettre leur évaluation par rapport à ces normes. L'AEDH continuera à soutenir cette mission par l'intermédiaire de son sous-comité scientifique (SCC) et pourrait très bientôt demander à ses membres d'agir.

Depuis l'exclusion des services de santé de la directive sur les services (printemps 2006) et étant donné les nombreuses décisions de la CEJ, une certaine clarté et certitude légale est indispensable. C'est pour cette raison et afin de soutenir une coopération entre systèmes de santé nationaux que la Commission a préparé une directive, publiée le 2 juillet 2008, sur l'application des droits des patients à des soins transfrontaliers sécurisés, efficients et de bonne qualité. Le sous-comité Affaires européennes suit le dossier de près et prépare une position sur le projet de directive, qui sera communiquée prochainement.

En 2007, l'AEDH a mené une enquête sur la situation actuelle de la mobilité des professionnels de santé et son impact sur les hôpitaux. Elle révèle que la plupart des gestionnaires hospitaliers accueilleraient favorablement des mesures s'attaquant aux problèmes liés au personnel étranger (p.ex. médecins en formation) tels que barrières des langues, obstacles bureaucratiques, manque d'intégration culturelle.

Plusieurs suggestions ont été soumises à l'AEDH afin de développer une action ciblée: standardisation des normes de formation/professionnelles, création de registres commun ou organismes de relais.

L'AEDH est en passe de devenir un acteur de développement et de provoquer une conscientisation autour des problèmes financiers et éthiques, en prenant note des projets régionaux dans ce domaine et en suscitant un débat autour de la question.

Au début de la présidence française de l'UE, en juin 2008, l'AEDH a lancé un appel pour faire avancer les soins de santé et hospitaliers au sein de l'Europe, pour promouvoir une coopération équilibrée des acteurs publics et privés, une évaluation de la qualité et de la sécurité ainsi que des soins de santé dirigés et gérés.

Le programme de santé 2008-2013 a un an. Un de ses trois objectifs principaux est l'information et la connaissance de santé. Tandis que les fournisseurs d'IT s'organisent au plan européen et que la standardisation européenne devient une réalité (p.ex. CEN), le besoin de représentation des gestionnaires IT hospitaliers grandit afin que les hôpitaux travaillent ensemble dans le domaine de l'IT. C'est pourquoi le Conseil d'Administration a décidé de lancer un Groupe de Travail des Gestionnaires IT.

Dans la situation actuelle, la pression sur les budgets hospitaliers va en s'accroissant. De nombreux hôpitaux font face à des déficits et la demande de privatisation s'intensifie.

Mais la prestation de soins de santé impliquant l'état et/ou des programmes d'assurance sociale est un exercice complexe d'équilibre qui inclut la fixation de

prix, le tiers payant et l'obligation d'offrir un service. C'est pourquoi les soins de santé ne peuvent pas s'envisager comme un marché ordinaire.

L'introduction de la concurrence et de la privatisation doit s'accompagner d'une réglementation par l'autorité publique. Le travail commencé par le sous-comité débouchera sur une position. Vu son importance, ce sujet sera le thème principal de notre séminaire en 2009.

Une mission plus fondamentale a été accomplie par le sous-comité scientifique à travers son soutien à l'étude européenne en cours sur la gouvernance hospitalière. Celle-ci sera disponible avant la fin de l'année et nous aidera à mieux comprendre la variation des configurations de gouvernance à travers l'Europe. Elle pourrait même offrir à nos membres de nouvelles options pour améliorer la gouvernance de leurs établissements.

En plus de son séminaire sur l'accréditation, l'AEDH a tenu son 2ème symposium psychiatrique européen, organisé par le groupe de travail Psychiatrie le 27et 28 mars 2008 à Berlin. Environ 100 personnes y ont participé sur le thème «Comment améliorer la productivité en soins de santé mentale?»

Le Conseil d'Administration a en outre décidé d'attribuer l'organisation du congrès 2012 à la Grèce.

Amendements aux statuts de l'AEDH et présentation des comptes

Les modifications aux statuts répondent à deux raisons. La première est une nécessité de compléter les règles existantes ou de les préciser. Ceci concerne, par exemple, le statut des membres élus (Président, Vice-Président, membre du Conseil d'Administration ou du Bureau) ou des pouvoirs de décision de l'Assemblée Générale.

De plus, certains articles des statuts devaient être mis en conformité avec la loi française ou réécrits pour garantir le bon fonctionnement de l'association, comme par exemple la soumission des comptes, le statut de Secrétaire Général et la dissolution de l'association. La proposition de modification des statuts a été acceptée à l'unanimité par l'Assemblée Générale.

Le règlement intérieur, qui date de 1971, devra être mis à jour pour appliquer la modification des statuts. Ceci donnera également l'occasion d'intégrer les status de nos sous-comités et groupes de travail, ainsi que la déclaration de mission pour l'organisation du congrès de l'AEDH. Ce travail est en cours et sera présenté pour approbation au Conseil d'Administration début 2009.

En l'absence du Secrétaire Général, les comptes ont été présentés par Asger Hansen:

Les comptes 2007 s'achèvent sur un surplus dû aux contributions de sponsoring reçues et à la diminution des dépenses en personnel. Finalement, les dépenses rentrent dans le budget prévisionnel.

Le rapport financier de fin d'année inclut des provisions pour les clients douteux et l'étude juridique, tandis que la provision pour activités nouvelles a été augmentée, ce qui laisse un excédent d'environ 8.500 euros transférés de 2007.

Le budget proposé pour 2009 inclut une légère augmentation de revenus ainsi que de dépenses, ce qui laisse une marge de manoeuvre pour de nouvelles activités.

Les auditeurs, Me Pelgrin du Luxembourg et Mr Timmerman des Pays-Bas ont certifié les comptes, qui ont été approuvés par l'Assemblée Générale.

Nouveaux membres

L'Assemblée Générale a accepté la candidature de la Roumanie et de l'Association ukrainienne des Médecins-Chefs. Trois members du Conseil d'Administration ont été remplacés: Gianluigi Rossi (Suisse) est remplacé par Christoph Pachlatko, Radoslav Herman (Croatie) par Herman Haller et Seppo Tuomola (Finlande) par Rauno Ihalainen. Mr Rossi, Herman et Tuomola ont été chaleureusement remerciés pour leur contribution active aux activités de l'AEDH.

Conclusions

Le programme de l'année prochaine présente de nouveau de nombreux défis. Le Président a remercié les nombreuses personnes activement impliquées dans l'association et les a invités à rejoindre le congrès l'après- midi. Il en a évoqué le thème et a souhaité que les participants rentrent chez eux, la tête pleine de projets et d'idées.

Cérémonie d'ouverture du 22ème Congrès de l'AEDH

Plus de 600 gestionnaires hospitaliers ont pris place dans la somptueuse grande salle du centre de congrès de Graz pour le 22ème Congrès de l'AEDH, intitulé: «un leadership nouveau pour de nouveaux défis».

Nikolaus Koller, Président de l'Association des Directeurs d'Hôpitaux de Styrie et organisateur du Congrès, a chaleureusement accueilli les délégués et a été rejoint par Mr Paul Castel, Président de l'AEDH, qui a exprimé son souhait de voir les membres de l'AEDH accumuler les expériences enrichissantes durant ces deux jours.
Mag. Helmut Hirt, Conseiller d'Etat autrichien pour la Santé publique et le Personnel, ainsi que le Dr. Andrea Kdolsky, Ministre autrichienne de la Santé, ont évoqué les questions d'actualité pour le système de soins de santé autrichien, qui présente bien des similitudes avec celles d'autres pays européens.

Me Dominique Acker, représentante de la Ministre française de la Santé, a brossé pour les participants au Congré une esquisse des priorités de la présidence française de l'UE en matière de santé. Le discours-programme a été prononcé par le Prof. Ddr. Eckhard Nagel de l'Institut de Gestion médicale et Sciences de la Santé de l'Université de Bayreuth, qui a donné sa vision du leadership en se concentrant sur la domination grandissante de la pensée économique et la précarisation des principes sociaux qui en découle.

Leadership et politique

Les deux orateurs de cette session ont accentué la nécessité pour les décideurs politiques d'harmoniser les systèmes de santé à l'évolution sociétale. Ils sont également très lucides quant aux obstacles structurels à dépasser pour accomplir cette mission politique.

Gediminas Cerniauskas, Ministre lituanien de la Santé, a expliqué comment la faible espérance de vie en Lituanie illustre les différences de normes sanitaires au sein de l'Union européenne. Toutefois, sa présentation du projet novateur de compte d'épargne médicale (medical savings accounts ou MSA) démontre que les choses bougent. Ils seront utilisés pour financer les services de santé non couverts par les systèmes nationaux. Le format est un système de carte de crédit, ce qui rend le système économique en termes de coûts administratifs.

Yannis Tountas, Président du Conseil de gouvernance du Réseau international des Hôpitaux promoteurs de santé, a ensuite évoqué les problèmes du système de santé grec. Contrôlés par le Ministre de la Santé, les hôpitaux publics proposent des services sous-payés et disposent d'un personnel insuffisant; la qualité des services est mauvaise, l'équipement inadéquat et la satisfaction du public faible. Pour corriger cette situation, des réformes générales et spécifiques ont été proposées. Bien que la décentralisation et le renforcement de la gestion hospitalière aient été améliorés et que des progrès ont été réalisés dans l'introduction de paiements privés, de systèmes d'information et d'améliorations de la qualité, le reste des réformes a échoué. Les leçons à tirer de cet échec relatif en Grèce sont indubitablement l'importance de l'environnement socio-économique, de la politique gouvernementale de santé, d'un leadership soutenu et robuste et d'un consensus entre partenaires principaux.

Leadership et économie

La privatisation est un des sujets chauds du paysage hospitalier européen actuel, car il illustre à merveille la nécessité vitale pour les hôpitaux de se conformer à une économie tirée par les marchés. Mais un enregistrement approprié de nouvelles professions émergentes est une exigence tout aussi importante pour les gestionnaires hospitaliers.

Le Prof. Eric Engelbrecht de l'Université catholique de Louvain (Belgique), a retracé l'histoire des hôpitaux belges et la dif-

férence entre hôpitaux publics et privés. Il a poursuivi en affirmant que la situation financière des hôpitaux publics évoluait favorablement avec une taille moyenne de 400 lits, en augmentation, ce qui leur permet d'élargir leur offre de soins. Cependant, le nombre d'hôpitaux a considérablement diminué. Les hôpitaux belges sont dotés d'une structure double, avec une structure diagnostique et thérapeutique généralement privatisée puisque les médecins sont indépendants. D'autre part, l'hôpital est responsable des soins, des services paramédicaux, de l'hôtellerie et des services de labo.

Mik Horswell, de l'Institute of Healthcare Management britannique, a fait remarquer que pour pratiquer en tant que professionnel clinique au Royaume-Uni, chaque individu doit être enregistré et breveté, sauf les gestionnaires et les informaticiens de santé. Pour corriger cette anomalie, UKCHIP (le Conseil britannique pour les Informaticiens de santé professionnels) a été créé en 2002. Il promeut le professionnalisme en informatique de santé et gère un registre pour les professionnels qui se conforment à des normes clairement définies.

Leadership et éthique

L'éthique est un des premiers concepts qui vient à l'esprit quand on traite du leadership. Cette session démystifie la notion d'éthique et prouve qu'elle contribue à la bonne gouvernance mais aussi à la réussite économique.

Le Dr Becker, Maître de Conférence en Ethique, Philosophie de la Science et de la Technologie à l'Université de Cracovie (Pologne), croit que les objectifs des soins de santé ne peuvent être atteints que si le leadership est parfaitement adapté. C'est pourquoi la congruence entre les objectifs et la morale est essentielle. Cependant, les buts économiques d'un lieu de compassion comme l'hôpital peuvent causer des conflits moraux. Le Dr Becker conclut cependant qu'avec une morale, des objectifs et des dirigeants adaptés, la congruence est possible.

Le Prof. Ddr. Lehofer, Directeur médial à l'Hôpital Neuro-psychiatrique Sigmund Freud de Graz (Autriche), croit que les gens se laisseront guider si leurs besoins sont satisfaits. Les besoins fondamentaux de désir, de lien, de contrôle et d'estime de soi sont présents chez tout un chacun, et la satisfaction de ces besoins basiques est une preuve de bon leadership et une cause puissante de motivation professionnelle. Un bon leader doit faire passer ces quatre messages. Le Prof. Lehofer est persuadé que l'art du leadeship est celui de permettre aux gens de s'impliquer tout en leur laissant suffisamment d'espace créatif pour une indépendance d'action.

Leadership et patients

Une des différences majeures entre un hôpital et d'autres entreprises et que le client est un patient. Cette dernière décennie a vu un retour logique vers des soins centrés sur le patient, qui doit être considéré comme un client qui veut dépenser son argent à bon escient.

Iris van Bennekom, Directrice générale à la Fédération néerlandaise des Organisations de Patients et de Consommateurs, est convaincue que les compagnies d'assurance doivent jouer un rôle de médiation pour les patients, assurer un bon rapport qualité-prix et une recherche constante de l'amélioration de la qualité. C'est pourquoi Me van Bennekom aspire à des budgets de santé personnalisés, qui permettraient aux patients de gérer leur vie, d'avoir des informations suffisantes pour faire des choix de santé, et d'être traités comme des clients. Ceci comprendrait une procédure de plainte, comme pour n'importe quel autre service.

Karsten Hundborg, Directeur de l'Institut danois de Qualité et d'Accréditation de Soins de Santé, a décrit le programme danois de qualité en tant que méthode de développement constant de la qualité pour tous les soins de santé au Danemark. Il inclut tous les services (généralistes, pharmaciens) et encourage une communication interdépartementale. Il est également le fruit d'une collaboration entre le gouvernement national et local et sera installé dans tous les hôpitaux danois en 2009. La stratégie consiste à adopter un système qui préviendra les erreurs et incitera à une grande qualité, qui appliquera les meilleurs pratiques au travail quotidien, qui construira des ponts entre les secteurs de santé, qui améliorera la qualité du parcours du patient et instaurera une développement continu de la qualité. Le système est basé sur l'accréditation et garantit des normes approuvées par l'International Society for Quality in Healthcare.

Leadership et employés

Le leadership consiste aussi à empêcher que la technologie, les pressions financières et même les clichés du management ou les soins centrés sur le patient n'affectent et ne démotivent la ressource la plus précieuse de l'hôpital, à savoir son personnel.

Jean Luc Chassaniol, Directeur Général de l'hôpital Sainte Anne et Président de l'Association française des Directeurs d'Hôpitaux, et Guy Vallet, Directeur Général honoraire des hôpitaux de Rouen et Marseille ont expliqué aux participants que les structures pyramidales appartiennent au

passé. La coopération est devenue la clé de tout. De ce point de vue, la fuzzy logic est une approche pragmatique car elle évalue les variables d'entrée et de sortir et en fait une série de règles qui permettent de déterminer l'output en fonction de l'input. Elle implique de reconnaître qu'accepter les idées nouvelles est la seule force de changement d'une organisation.

Mag. Gottfried Koos, membre du Conseil exécutif de VAMED à Vienne distingue trois genres d'entreprises: les «pousseurs», les «travailleurs assidus» et les pionniers. Les pousseurs ont un marketing fort mais moins d'espace pour l'innovation, les travailleurs assidus ont un niveau d'innovation et de marketing moyens et les pionniers sont les véritables innovateurs, ils se concentrent sur le processus et essaient d'implémenter ce qu'ils ont développé. La présentation s'est conclue sur un plaidoyer pour une économisation qui ne soit pas incompatible avec une humanisation de l'entreprise. Seul un système de santé efficace et économique pourra garantir les emplois, et seuls des employés en bonne santé et satisfaits pourront accomplir leur tâche, qui est de se concentrer sur le patient.

Leadership et leaders

Birgit Miesch, Directrice des ressources humaines chez Johnson & Johnson, définit le leadership comme une équation: avoir des valeurs+ les vivre=leadership. En disposant d'un ensemble de valeurs qui servent de socle à tout ce qu'on fait et en vivant ces valeurs, ce qui donne de la consistance et de la credibilité, on peut devenir un grand leader.

Nous devons donc nous demander ce qui pousse notre personnel, essayer de comprendre leurs motivations, leurs besoins spécifiques. Donner et recevoir du feedback est également essentiel. Montrer sa reconnaissance est tout aussi important et constitue également une opportunité de créativité.

Finalement, un bon leader aura à cœur de créer des occasions de briller pour son personnel et sera surtout cohérent et authentique.

Le Prof Manel Peiro, Vice Recteur de l'Ecole de Commerce ESADE à Barcelone (Espagne) a livré une présentation très remarquée sur la relation entre les médecins et les hôpitaux dans lesquels ils travaille. Selon l'étude qu'il a mené, l'attachement organisationnel peut se diviser en trois catégories: l'attachement affectif, financier et moral. Il distingue également quatre groupes de degrés d'attachement professionnel et organisationnel: les loyaux sous conditions, les idéalistes aigris, les gagnants impliqués et les jeunes à fort potentiel. Il y a des implications managériales attachées à ces résultats. Ils soulignent que les médecins constituent un groupe hétérogène qu'il faut répartir en catégories et gérer de façon différente et appropriée.

Focus: Danemark

Le Danemark a dépensé 9,5% de son PIB en soins de santé en 2006. Environ 80% des dépenses de santé danoises étaient financées par des sources publiques en 2002. Comme dans de nombreux pays de l'OCDE, le nombre de lits hospitaliers est en diminution constante, de même que la durée de séjour, alors que les procedures ambulatoires augmentent.

Des négociations annuelles entre le gouvernement central et les régions et municipalités aboutissent à un accord sur le cadre économique des soins de santé, y compris le niveau de taxation et les allocations de ressources.

Un programme basé des normes organisationnelles et cliniques d'évaluation de la qualité est en cours d'adoption dans toutes les structures de santé danoises.

Le secteur hospitalier est sous la responsabilité des 5 régions, qui doivent offrir des soins gratuits à leurs résidents et des soins d'urgence à leurs résidents temporaires. Presque tous les hôpitaux (95% des lits hospitaliers) sont publics.

Les citoyens peuvent se faire traiter dans des hôpitaux privés au Danemark ou à l'étranger si le temps d'attente pour leur traitement excède deux mois et si l'hôpital de leur choix a conclu un accord avec leur région. Depuis le 1er octobre 2007, le temps d'attente maximum a été réduit à un mois.

Les unités hospitalières danoises sont souvent co-gérées par un directeur administratif et une infirmière chef pour les questions administratives et financières. La gestion médicale et infirmière est cependant séparée.

L'association danoise de gestion des soins de santé a été créée en 1912, ce qui en fait une des plus anciennes associations européennes dans le secteur. L'association participe activement à la coopération européenne par le biais de son adhésion à l'AEDH. Le Danemark était un de ses membres fondateurs, et représente les pays nordiques au sein de son Bureau.

Willy Heuschen

LEKTIONEN EINER KRISE

In der April-Ausgabe von Hospital behandelten wir an dieser Stelle die Frage des Marktwettbewerbs in der Gesundheitsversorgung. Während über 600 Teilnehmer beim 22. EVKD-Kongress in Graz Führungsfragen der Krankenhäuser vor dem Hintergrund neuer Herausforderungen diskutierten, berichteten die Medien weltweit über den Kollaps des gesamten Finanzsystems. Die Banker hätten Risiken falsch eingeschätzt und die Branche könne ohne Staatshilfe nicht mehr überleben. Selbst die Frage wurde laut, ob das kapitalistische Wirtschaftssystem bei den Bürgern jeglichen Kredit verliere.

Bei dieser Bankenkrise und die sich hieraus möglicherweise ergebende Rezension drängen sich Parallelen mit der aktuellen Situation im Gesundheitsbereich auf.

Seit den Nachkriegsjahren gehörte es zum marktwirtschaftlichen Credo, den Banken, wie übrigens auch anderen Wirtschaftsunternehmen, freien Aktionsraum zu überlassen. In einigen europäischen Ländern achteten die Staaten auf die soziale Verträglichkeit und förderten die sogenannte „Soziale Marktwirtschaft". Die Erfolge dieses Rezeptes sind nicht anzuzweifeln, wenn auch der stetige Wandel uns immer wieder vor neue Herausforderungen stellt.

Das Gesundheitssystem hingegen und besonders die Krankenhäuser zählen nicht immer zu den Lieblingen der Finanzminister. Ihre Ausgaben belasteten die Staatshaushalte schwer und waren oft ein bevorzugtes Betätigungsfeld für Einsparungen. Ein Beispiel hierfür ist die bei einer Großdemonstration in Berlin von Zehntausenden Klinikmitarbeitern angeprangerte Unterfinanzierung der Krankenhäuser – und in anderen europäischen Ländern sieht es leider nicht anders aus. Vielerorts wird die Privatisierung der Krankenhäuser und die vermehrte Marktwirtschaft in der Führung als Allheilmittel gehandelt. Bei aller Nuancierung des EVKD-Standpunktes, den wir derzeit erarbeiten und bei einem Sonderseminar auf der Medica 2009 beleuchten werden, haben wir bereits auf unumgängliche Begleitmaßnahmen hingewiesen. Blindes Vertrauen in die Handlungsfreiheit der Akteure der Marktwirtschaft ist hier sicherlich nicht angesagt, was auch die Erfahrungen mit den Banken zeigen. Auch bestehende staatliche Aufsichtsbehörden haben die Bankkrise nicht verhindert. Lohnt es die Sicherheit einer gesundheitlichen Versorgung leichtfertig aufs Spiel zu setzen, anstatt diese vorbeugend durch langfristige und ausreichende Finanzierungsmaßnahmen staatlich zu stützen?

Eine zweite Ähnlichkeit mit dem Bankensektor ergibt sich in doppelter Hinsicht. Massiv wurde die Schuld der Bankkrise der Falscheinschätzung der Banker, aber auch der mangelnden Kontrolle der ihnen übergeordneten internen Aufsichtsbehörden zugeschrieben. Bei manchen deutschen Landesbanken sind dabei auch Politiker ins Visier geraten. Als Entschuldigung führen diese mangelnde Fachkenntnisse an. Die zwar aus Sicht unseres Sektors durchaus beneidenswerten, aber aus ethischer Sicht nicht nachahmenswerten großzügigen Bezüge des Bankenmanagements und der Vorstände verstärken noch die Schuldzuweisungen.

Diese Vorwürfe beziehen sich auf die Führungsstruktur, und unterscheiden sich aus der Sicht der Verantwortungsübernahme nur wenig vom Krankenhaussektor. Grund genug, diese Frage, ausgehend von der auf europäischer Ebene durchgeführten Erhebung, weiter zu vertiefen. Wer soll das Krankenhaus führen und wie, welche Kompetenzen sind Voraussetzung und wer kontrolliert wen?

Neben der Struktur wird die Arbeitsweise der Banken und die für manchen Anleger mangelnde Transparenz angeprangert. Qualität ist gefragt, wir schulden diese geradezu den Verbrauchern - sprich den Patienten. Die Qualität kann nicht oft genug hinterfragt werden, zumal sie sich neuen Erkenntnissen und den sich wandelnden Erwartungshaltungen anpassen muss. Der in 2010 in Davos stattfindende EVKD-Kongress wird dies als Hauptthema behandeln.

Nicht zuletzt stellen wir in der Bankenkrise fest, dass einzelstaatliche Gegenmaßnahmen nicht mehr genügen, zumindest müssen europäische Richtlinien her. Auf mehreren kurzfristig angesetzten Toptreffen haben sich europäische Regierungschefs darüber beraten.

Krisen machen vor Landesgrenzen keinen Halt. Käme es zu einer Krankenhauskrise in einem EU-Mitgliedsstaat, beispielsweise aufgrund mangelnder Einhaltung von Qualitätsstandards, würden die Nachbarstaaten sehr schnell in der Krisenbewältigung eingebunden werden. Wir werden daher die bereits begonnene Ausarbeitung europäischer Qualitätsrichtlinien für Kliniken intensivieren. Wir erwarten dazu auch eine staatliche und europäische Unterstützung.

Die EU und ihre Mitgliedsstaaten sollten endlich verstehen, dass hier Vorbeugung schneller, effizienter und kostengünstiger ist, als ein Reagieren. In diesem Sinn werden wir unsere Lobbyarbeit fortsetzen, diese Anstrengung sind wir unseren Patienten schuldig. Vorbeugen ist jedenfalls besser als blindes Vertrauen.

Willy Heuschen
EVKD Generalsekretär
Chefredakteur

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

38. EVKD GENERALVERSAMMLUNG

Die 38. Generalversammlung der EVKD war vor allem auf zwei Hauptpunkte ausgerichtet: den Veränderungen der EVKD-Statuten und dem Tätigkeitsbericht.

Der Tätigkeitsbericht

Zur Halbzeitbilanz des derzeitigen Präsidiums und Gremiums stellte Präsident Paul Castel einen Tätigkeitsbericht vor.

Als Antwort auf die Konsultation der Europäischen Kommission über die grenzüberschreitende Gesundheitsversorgung forderte die EVKD einen gemeinsamen Ansatz für die Definition, Bewertung und Verbesserung der Qualitätsstandards im Gesundheitswesen (Dienstleistungen), sowie für die Entwicklung eines Europäischen Akkreditierungsmodells für die Gesundheitsdienste.

Die EVKD beschäftigte sich mit diesem Thema auch bei dem Seminar „Qualitäts-Bewertungswerkzeuge in Krankenhäuser durch ein freiwilliges Europäisches Akkreditierungssystem" am 16. November 2007 in Düsseldorf. Dieses erste EVKD-Seminar mit rund 70 Delegierten war ein Erfolg – in *(E)Hospital* wurde darüber in den Ausgaben 2007/5 und 2008/1 berichtet.

Die Europäische Kommission und Stakeholders wie die EVKD beraten und überprüfen Optionen, wie man die Qualität im Gesundheitswesen innerhalb der EU – mit speziellem Fokus auf die Qualitätsstandards in den Krankenhäusern - verbessern kann. Das Ziel ist, ein Rahmenwerk für die allgemeinen Standards der europäischen Krankenhäuser zu schaffen, die eine vergleichende Bewertung der Krankenhäuser erlaubt. Die EVKD wird dies weiterhin durch seinen wissenschaftlichen Unterausschuss (SCC) unterstützen und wird seine Mitglieder in naher Zukunft um ihre Beiträge zu diesem Thema bitten.

Seit der Ausgliederung der Gesundheitsdienste von der Dienstleistungsrichtlinie (Frühjahr 2006) und wegen der vielen ECJ-Urteile, bedarf es an Klarheit und gesetzlicher Sicherheit. Deshalb, und auch um die Zusammenarbeit zwischen den nationalen Gesundheitssystemen zu unterstützen, bereitete die Kommission eine Richtlinie über die Anwendung von Patientenrechten und effizienter grenzüberschreitende Gesundheitsdienste (veröffentlicht am 2. Juli 2008) vor. Diese Initiative hat auf der Agenda unseres Unterausschusses für Europäische Angelegenheiten (SCEA) hohe Priorität und in Bälde wird zu diesem Richtlinienvorschlag eine Position präsentiert.

2007 führte die EVKD eine Umfrage bezüglich der derzeitigen Situation der freien Mobilität von Gesundheitsprofessionalisten und ihren Einfluss auf die Krankenhäuser durch. Es zeigte sich, dass die meisten Krankenhausdirektoren Maßnahmen begrüßen würden, die auf bestehende Probleme mit ausländischem Personal (z.B. Ausbildungsärzte) ausgerichtet sind. Dazu gehören Probleme wie sprachliche Barrieren und der Mangel an kultureller Integration. Verschiedene Vorschläge wurden diesbezüglich der EVKD unterbreitet: standardisierte Ausbildung und/oder professionelle Standards, Schaffung gemeinsamer Registratoren oder Vermittlungs-Agenturen.

Die EVKD übernimmt hier immer mehr die Rolle als Entwicklungsakteur, indem das Bewusstsein für finanzielle oder ethische Probleme sensibilisiert wird, regionale Projekte in diesem Bereich wahrgenommen werden und allgemeine Debatten rund um dieses Thema geführt werden.

Zu Beginn der französischen EU-Präsidentschaft im Juni 2008 wurde eine Ausschreibung gestartet, um die Gesundheits- und Krankenhauspflege voranzubringen – durch eine ausgewogene Kooperation zwischen öffentlichen und privaten Akteure, durch Evaluierung von Qualität und Sicherheit und durch ein geführtes und gemanagtes Gesundheitswesen.

Das Gesundheitsprogramm 2008-2013 ist in seinem ersten Bestandsjahr. Eines der drei Hauptziele ist dabei die Gesundheitsinformation und –wissen. Während IT-Anbieter nach europäischem Maßstab organisiert sind und die Standardisierung auf europäischem Niveau (z.B. CEN) abgewickelt ist, steigt die Notwendigkeit für eine Vertretung der IT-Manager im Krankenhausbereich, um sicherzustellen, dass die Krankenhäuser im Bereich IT zusammenarbeiten. Daher hat das Exekutivegremium beschlossen, die Arbeitsgruppe IT-Manager einzurichten.

In der derzeitigen wirtschaftlichen Situation nimmt der Druck auf die Krankenhausbudgets ständig zu. Viele Kliniken sehen sich mit Defiziten konfrontiert. Daher steigt auch die Nachfrage nach Privatisierung. Die Gesundheitsversorgung unter Beteiligung des

Staates und/oder der Sozialversicherungssysteme ist eine komplexe Frage der Ausgewogenheit. Es bedarf Preis-Festsetzungen, dritte Parteien (der Zahler) und beinhaltet die Pflicht der Dienstleistungsbereitstellung. Daher kann das Gesundheitswesen nicht als ein typischer Markt betrachtet werden. Die Einführung von Wettbewerb und Privatisierung wird ohne Regulierungen durch die öffentlichen Behörden nicht funktionieren.

Um vorwärtszukommen wird die von SCEA gestartete Arbeit fortgesetzt. Wegen der Wichtigkeit dieser Angelegenheit wird es bei unserem Seminar 2009 auch das Hauptthema sein.

Maßgebliche Arbeit wurde vom wissenschaftlichem Unterkomitee durch seine Unterstützung bei der laufenden europäischen Studie über Krankenhaus-Leitung geleistet.

Durch die Ergebnisse, die bis Jahresende verfügbar sein werden, werden wir die verschiedenen Ansatzpunkte bei den Leitungsstandpunkten in Europa besser verstehen lernen.

Unseren Mitgliedern werden wir möglicherweise verschiedene Alternativen für eine Verbesserung ihrer Krankenhausleitung vorstellen können.

Neben dem Seminar zum Thema Akkreditierung, hielt die EVKD auch ihr zweites Europäisches Psychiatrie-Symposium ab, das durch die Arbeitsgruppe Psychiatrie vom 27-28 März 2008 in Berlin abgehalten wurde und an dem rund 100 Menschen teilnahmen.

Das Thema des Seminars lautete: „Wie man die Produktivität bei der mentalen Gesundheitsversorgung verbessern kann."

Darüber hinaus entschied der Vorstand, dass für den Kongress 2012 Griechenland mit der Organisation betraut wird.

Veränderungen der EVKD -Statuten und Konten

Die Abänderungen der Statuten wurden vor allem aus zwei Gründen vorgenommen. Erstens haben einige Änderungen die bestehenden Regeln vervollständigt beziehungsweise diese präziser gemacht.

Dies betrifft unter anderem die Statuten der gewählten Funktionäre (wie z.B. Präsident, Vizepräsident, Mitglieder des Vorstandes oder Präsidiums) und es betrifft die Entscheidungsbefugnisse der Generalversammlung.

Darüber hinaus mussten einige Paragrafen der Statuten mit dem französischen Recht in Einklang gebracht werden beziehungsweise mussten neu formuliert werden, um ein reibungsloses Funktionieren unserer Vereinigung zu garantieren. Beispiele dafür sind die Ausschreibung der Konten, der Status des Generalsekretärs und die Auflösung der Vereinigung.

Die vorgeschlagenen Abänderungen der Statuten wurden von der Generalversammlung einstimmig angenommen.

Die Geschäftsordnung aus dem Jahr 1971 muss, um die Abänderungen der Statuten implementieren zu können, aktualisiert werden. Das bietet auch eine Gelegenheit zur Integration der Satzungen der Unterausschüsse und Arbeitsgruppen, sowie der Arbeitsanweisung für die Organisation der EVKD-Kongresse. Dieser Prozess ist in Arbeit und wird dem Vorstand Anfang 2009 zur Annahme vorgelegt.

Wegen Abwesenheit des Generalsekretärs wurden die Ergebnisse von Asger Hansen präsentiert:

Der Jahresabschluss für 2007 endet mit einem Überschuss aufgrund erhaltener Sponsoring-Beiträge und einem Rückgang der Ausgaben für Personalkosten im Vergleich zum Haushaltsvoranschlag.

Insgesamt bleiben die Ausgaben unterhalb der vorgesehenen Haushaltsmittel. Der Jahresabschluss enthält Bestimmungen für unsichere Kunden und rechtliche Studien, während die Ansätze für neue Aktivitäten erhöht wurden, was zu einer Übertragung von rund 8.500 Euro ab 2007 führte.

Das vorgeschlagene Budget für das Jahr 2009 beinhaltet eine kleine Erhöhung der Einkommen sowie für Ausgaben, die Raum für einige neue Aktivitäten lassen.

Die Rechnungsprüfer, Frau Pelgrin aus Luxemburg und Herr Timmerman aus den Niederlanden, beglaubigten die Buchführung als richtig und wurden von der Generalversammlung entlastet.

Neue Mitglieder

Die Generalversammlung hat die Kandidatur von Rumänien und des "Ukrainischer Verbandes der leitenden Ärzte" akzeptiert.

Drei Mitglieder des Exekutivkomitees wurden ersetzt: Gianluigi Rossi (Schweiz) wurde ersetzt durch Christoph Pachlatko, Radoslav Herman (Kroatien) durch Herman Haller und Seppo Tuomola (Finnland) durch Rauno Ihalainen. Es wurde den Herren Rossi, Herman and Tuomola herzlich für ihre aktive Teilnahme an den EVKD-Aktivitäten gedankt.

Schlussfolgerungen

Der Präsident dankte allen für die aktive Teilnahme im Verband. Das Programm für nächstes Jahr enthält viele Herausforderungen.

Er lud die Anwesenden zum Nachmittagsprogramm ein, welches dem Thema Führung und anstehenden Herausforderungen gewidmet war. Den Teilnehmern wurde eine sichere Heimkehr gewünscht und die Mitnahme vieler neuer Gedanken und guter Ideen.

22 EVKD-Kongress: Eröffnungszeremonie

Über 600 Krankenhausmanager konnten zum 22. EVKD-Kongress zum Thema „Neue Führung für neue Herausforderungen" in der prächtigen Haupthalle des Grazer Kongress-Zentrums begrüßt werden. Nikolaus Koller, Vorsitzende der Vereinigung der Krankenhausdirektoren Steiermarks und Organisator des Kongresses, begrüßte die Delegierten. Mag. Helmut Hirt, Landesrat für Gesundheit und Personal, und die österreichische Gesundheitsministerin Andrea Kdolsky unterstrichen in ihren Reden die Herausforderungen für das österreichische Gesundheitssystem, die jenen der anderen europäischen Länder gleichen würden.

Dominique Acker, Vertreterin des französischen Gesundheitsministers, stellte die gesundheitsbezogenen Prioritäten der französischen EU-Präsidentschaft dar. Die Hauptrede hielt Professor DDR. Eckhard Nagel, Direktor des Instituts für Medizinmanagement und Gesundheitswissenschaften an der Universität Bayreuth. Er wies unter anderem darauf hin, dass die zunehmende Dominanz wirtschaftlichen Denkens, soziale Grundsätze in eine prekäre Lage gebracht habe.

Führung trifft Politik

Beide Redner dieser Sitzung betonten, dass die politischen Entscheidungsträger die Gesundheitssysteme an den gesellschaftlichen Veränderungen anpassen müssen. Deutlich wiesen sie dabei auf die Überwindung von strukturellen Hindernissen bei der Durchführung dieses politischen Auftrages hin.

Gediminas Cerniauskas, litauischer Gesundheitsminister, erklärte wie Litauens geringere Lebenserwartung die unterschiedlichen Normen der Medizin innerhalb der Europäischen Union veranschaulicht. Seine Präsentation über innovative Regelung für Gesundheitssparkonten (MSA) zeigte aber auch, dass sich die Dinge entwickeln. Die erwähnten Gesundheitssparkonten werden zur Finanzierung von Gesundheitsdienstleistungen, die nicht unter die einzelstaatlichen gesetzlichen Systeme fallen, verwendet. Es handelt sich dabei um ein Leihsystem, das zu einer Verminderung der Zahlungen aus MSA führt und damit eine wesentliche Senkung der Verwaltungskosten bringt.

Yannis Tountas, Vorsitzender des Direktoriums des internationalen Netzwerkes gesundheitsfördernder Krankenhäuser und Gesundheitsdienste, illustrierte die Herausforderungen des griechischen nationalen Gesundheitssystems. Kontrolliert durch den Gesundheitsminister haben öffentliche Krankenhäuser unterbewertete Leistungen und unzureichendes Personal. Es gebe eine niedrige Qualität der Dienstleistungen oder auch geringere öffentliche Zufriedenheit. Um Abhilfe zu schaffen, wurden allgemeine und spezifische Reformen vorgeschlagen. Obwohl die Dezentralisierung und die Stärkung der Krankenhausverwaltung erfolgreich waren und einige Fortschritte bei der Einführung der privaten Zahlungen, Krankenhausinformationssysteme und Verbesserung der Qualität erzielt wurden, war der Rest der Reformen erfolglos.

Führung und Wirtschaft

Privatisierung ist gerade jetzt eines der heißesten Themen der europäischen Krankenhausszene, da es die grundlegende Notwendigkeit für Krankenhäuser verdeutlicht, sich in eine allgemeine marktorientierte Wirtschaft einzufügen. Auch die adäquate Erfassung von neuen Berufen ist eine wichtige Führungsanforderung für Krankenhausmanager.

Professor Eric Engelbrecht von der Katholischen Universität Leuven, Belgien, zeigte unter anderem auf, dass sich die finanzielle Lage der öffentlichen Krankenhäuser mit durchschnittlich 400 Betten positiv entwickelte, indem sie ihr Pflegeangebot erweitern konnten. Allerdings ist die Anzahl der Krankenhäuser stark zurückgegangen. Belgische Krankenhäuser haben eine duale Struktur, bei der Diagnose und Behandlung allgemein privatisiert sind, da die Ärzte unabhängig sind. Andererseits ist das Krankenhaus für die Betreuung, pflegerischen Dienstleistungen, Versorgung und Labordienst-Plattformen verantwortlich.

Mike Horswell, vom Institut für Gesundheitsdienst-Management, berichtete von den klinischen Professionalisten in Großbritannien. Um als solcher praktizieren zu können, muss er als „geeignet" für die Praxis registriert sei. Allerdings, so Horswell, würden zwei wichtige Gruppen von Fachleuten im Gesundheitswesen ohne solche Leitlinien praktizieren. Um diese Anomalie zu beseitigen, wurde 2002 der UKCHIP (Großbritanniens Rat für die Gesundheitsinformatik) gegründet. Er fördert Professionalität in der Gesundheitsinformatik und öffnet eine Registrierungsregelung für Fachleute, die nach klar definierten Standards arbeiten.

Führung und Ethik

Dr. Becker, Professor für Bioethik und Philosophie der Abteilung Wissenschaft und Technologie der Jagiellonen Universität von Krakau (Polen) glaubt, dass Ziele im Gesundheitswesen nur durch eine in besonderer Weise angepasste Führung erreicht werden. Daher sei eine Übereinstimmung von Zielen und Moral von wesentlicher Bedeutung. Allerdings könne das Anpeilen von wirtschaftlichen Ziele an einem Ort des Mitgefühls wie es ein Krankenhaus ist, auch Ursache von moralischen Konflikte sein. Dr. Becker stellt jedoch fest, dass gute Ethik, richtige Ziele und eine gute Leitung immer zum Erfolg führe.

Professor DDR. Lehofer, ärztlicher Direktor des Sigmund Freud neuro-psychiatrischen Klinikums in Graz (Österreich) ist überzeugt, dass Menschen sich dann führen lassen, wenn ihre Bedürfnisse erfüllt werden. Bedürfnisse nach Erfolg, Bindung oder Selbstachtung haben alle Menschen. Die Erfüllung dieser grundlegenden Bedürfnisse sei ein Beweis für gute Führung und stelle einen enormen Anreiz für professionelle Motivation dar. Er unterstrich die Bedeutung der strategischen Seite der Führung, aber auch der Notwendigkeit der Anpassungsfähigkeit. Die Führung sollte nämlich ein Ziel nicht zu starr verfolgen und auch bereit sein, davon abzuweichen.

Führung und Patienten

Eine der großen Unterschiede zwischen einem Krankenhaus und den meisten anderen Unternehmen ist, dass sein Kunde ein Patient ist. Im letzten Jahrzehnt gab es eine logische Rückkehr zu einem auf den Patienten konzentriertes Gesundheitswesen. Viele Strukturen und Projekte haben somit die zentrale Bedeutung einer effizienten Kontrolle der Pflegequalität und die Berücksichtigung des Patienten als Kunden, der für sein Geld einen Wert bekommen sollte, unterstrichen.

Iris van Bennekom, Generaldirektorin bei der niederländischen Patienten- und Verbraucherorganisation, ist überzeugt, dass für die Reformen der Preise, Transparenz- und Konsumentenrechte, wettbewerbsfähige Krankenkassen notwendig sind. Krankenkassen müssen zwischen Patienten, dem Versicherungswert des Geldes und einer konstanten Qualitätsverbesserung eine Vermittlerrolle spielen. Die Generaldirektorin begrüßt daher die personalisierten Gesundheitsbudgets, die es den Patienten ermöglichen, ihr Leben selbst zu managen und ihre eigene Entscheidung bezüglich ihrer Gesundheit zu treffen, um als Kunden behandelt zu werden. Dies würde auch - wie für jede andere Dienstleistung - das Beschwerdeverfahren betreffen.

Karsten Hundborg, Direktor des dänischen Instituts für Qualität und Akkreditierung im Gesundheitswesen, beschreibt das dänische Qualitätsprogramm als eine Methode, um im gesamten Gesundheitswesen in Dänemark eine dauerhafte Qualitätsentwicklung zu erreichen. Es sei ein transparentes Programm: Jeder könne die Folgen und Ergebnisse der angestrebten Ziele nachvollziehen. Es umfasse alle Dienstleistungseinrichtungen (Gps, Pharmazeuten) und fördere eine Kommunikation zwischen den Einrichtungen. Es sei aber auch eine Zusammenarbeit zwischen den lokalen und nationalen Verwaltungen und werde 2009 in allen dänischen Krankenhäusern implementiert. Die Ziele: Fehler sollen vermieden und hohe Qualität gefördert, die besten Praktiken in der täglichen Arbeit angewandt oder auch eine ständige Qualitätsverbesserung geschaffen werden.

Führung und Mitarbeiter

Führung bedeutet auch die Vermeidung von Hochtechnologie, Kostendruck, Managementklischees oder Patienten zentrierte Pflege, damit die wertvollste Ressource eines Krankenhauses – nämlich das Personal - nicht beeinträchtigt oder gar demotiviert wird.

Jean Luc Chassaniol, Generaldirektor des Saint Anne Krankenhauses und Präsident der französischen Krankenhausmanagervereinigung, und Guy Vallet, Honorardirektor der Krankenhäuser von Rouen und Marseille, erklärten, dass die Pyramidenstruktur der Vergangenheit angehört. Das Schlüsselwort jetzt heiße: Kooperation. In dieser Hinsicht sei die Fuzzy-Logik ein pragmatischer Ansatz, da sie Einnahmen- und Ausgaben-Variable durchschnittlich bewerte und eine Reihe von Regeln einführe, die die Festsetzung von Ausgaben als eine Funktion der Einnahmen erlaube. Die Fuzzy-Logik erlaube ein „nachhaltiges Management".

Mag. Gottfried Koos, Vorstandsmitglied der VAMED in Wien, erklärte, dass es drei Kategorien von Unternehmern gibt: Antreiber, Arbeitstiere und Pioniere. Antreiber sind stark im Marketing, haben aber wenig mit Innovation am Hut. Arbeitstiere arbeiten konstant, sie sind aber im Marketing und in der Innovation durchschnittlich. Und Pioniere sind die wahren Erneuerer, sie konzentrieren sich auf den Prozess und versuchen das zu implementieren, was sie entwickelt haben. Nur ein effizientes und wirtschaftliches Gesundheitswesen sei in der Lage, sichere Arbeitsstellen anbieten zu können. Und nur gesunde und zufriedene Mitarbeiter können ihre Herausforderungen erfüllen, was bedeute, dass für sie der Patient an erster Stelle stehe. Das Ziel sei nicht nur die Erhöhung der Effizienz, sondern dass die Innovation zu einem wichtigen Teil der Organisationskultur gemacht werde.

Führung und Führer

Birgit Miesch, Direktorin der Humanressourcen bei Johnson & Johnson, definierte die Führung als eine Gleichung: „Werte+das Leben dieser Werte=Führung". Man könne ein großartiger Führer sei, indem man eine Reihe von Werten habe, die als Grundlage für alles was man tut dienen, und indem man diese Werte lebt, was Bestand und Glaubwürdigkeit gebe. „Um zu verstehen, was unsere Mitarbeiter antreibt, müssen wir uns bemühen, ihre Motivationen und ihre spezifischen Bedürfnisse zu verstehen. Wichtig ist es auch, ein Feedback zu geben und von größter Wichtigkeit ist es, Annerkennung zu zeigen. Und schließlich wird ein guter Führer für seine Mitarbeiter Gelegenheiten schaffen, dass sie glänzen und darüber hinaus konsistent und authentisch sein zu können."

Professor Manel Peiro, akademischer Vizedekan der ESADE Wirtschaftsschule in Barcelona (Spanien), sprach über die Beziehung zwischen Ärzten und den Krankenhäuser, wo sie arbeiten. Für eine Studie, die er durchführte, wurde das organisatorische Engagement in drei Kategorien unterteilt: emotionales Engagement, beständiges (finanzielles) Engagement und normatives (moralisches) Engagement. Er unterschied zwischen vier Gruppen unterschiedlichen Grades von professionellen und organisatorischen Engagements: Der fallweise Loyale, der grollende Idealist, der engagierte Gewinner und die Jungen mit Qualitäten. Aus diesen Erkenntnissen leiten sich bedeutende Auswirkungen des Managements ab. Sie unterstreichen, dass die Ärzte eine ungleiche Gruppe sind und dass es notwendig ist, die Ärzte in diese Gruppen einzuteilen, um sie auf unterschiedliche Weise zu führen.

Fokus: Dänemark

Hinsichtlich der Ausgaben im Gesundheitswesen rangiert Dänemark mit 9,5% des BIP 2006 im oberen Durchschnitt der OECD-Länder. Rund 80% der dänischen Gesundheitsausgaben werden seit 2002 durch öffentliche Ressourcen finanziert. Wie in den meisten OECD-Ländern hat auch in Dänemark in den vergangenen Jahren die Anzahl der Krankenhausbetten pro Kopf abgenommen. Die Abnahme geht einher mit einer Abnahme der durchschnittlichen Krankenhausaufenthalte und einer Zunahme der Anzahl der ambulanten chirurgischen Eingriffe.

Jährliche Verhandlungen zwischen der Zentralregierung und den Regionen und Gemeinden mündeten in einem Abkommen über einen wirtschaftlichen Rahmen für das Gesundheitswesen, einschließlich der Besteuerung, der Ausgaben und Mittelzuweisungen.

Derzeit wird ein umfassendes auf Normen basierendes Programm für die Beurteilung von Qualität umgesetzt. Es zielt auf im Gesundheitswesen tätigen bereitstellende Organisationen ab, und umfasst alle organisatorischen und klinischen Standards. Organisationen werden daran beurteilt, ob sie in der Lage sind ihre Leistungen - gemessen an den Standards von Verfahren und ihren Ergebnissen – zu verbessern.

Fünf Regionen in Dänemark sind für den Krankenhaussektor verantwortlich. Die regionale Behörden müssen eine kostenlose Krankenhausbehandlung für die Bewohner ihrer Regionen bieten können und die Notbehandlung für jene Menschen gewährleisten können, die sich nur vorübergehend in der Region aufhalten.

Fast alle Krankenhäuser sind im öffentlichen Eigentum (95 % der Krankenhausbetten sind öffentlich).

Die Bürger können sich auch in einem privaten Krankenhaus in Dänemark oder im Ausland behandeln lassen, wenn die Wartezeit für die Behandlung zwei Monate überschreitet und es zwischen dem ausgewählten Krankenhaus und – falls die Wartezeit für die Behandlung zwei Monate überschreitet und es zwischen privaten Krankenhäuser in Dänemark oder im Ausland wählen, wenn die Wartezeiten für die Behandlung zwei Monate übersteigen und das auswählte Krankenhaus ein Abkommen mit der Regionsbehörde bezüglich des Behandlungsangebots hat. Seit 1. Oktober 2007 wurden die Wartezeiten auf ein Monat reduziert.

In Dänemark stehen nach dem Abteilungs-Managementmodell die Abteilungen normalerweise unter der Leitung von zwei Personen: einem administrativ führenden Berater und einer leitenden Krankenschwester, die für die administrativen und finanziellen Angelegenheiten der Abteilung mitverantwortlich ist. Dennoch gibt es eine Trennung zwischen dem Management der medizinischen und pflegerischen Bereiche.

Die dänische Vereinigung der Gesundheitsmanagements wurde 1912 gegründet und ist eines der ältesten Krankenhaus-Managementvereinigungen Europas.

November

e-Health Congress 18
Brussels, Belgium
www.e-healthcongress.be

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

Risk and patient safety 2008 25-26
London, UK
www.healthcare-events.co.uk

RSNA Annual meeting of the Radiological Society of North America 30-5
Chicago, USA
www.rsna2008.rsna.org/

December

1ère Journée nationale de la responsabilité infirmière 6
Nantes, France
www.congres-medical.com

10èmes Journées internationales de la qualité hospitalière 8-9
Paris, France
www.mateda.com/choix03.htm

February

Patienta 7-8
Essen, Germany
www.patienta.messe-essen.de

March

Medtec 3-5
Stuttgart, Germany
www.devicelink.com/expo

April

Medetel 1-3
Luxembourg
www.medetel.lu

May

52th Hospital management Congress of the Upper Austrian association of hospital managers 4-6
Linz, Austria
www.ovkd.at/ooe/kongress.htm

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

Production and Printing
Veszpremi Nyomda Zrt. Printed in Hungary.
Print run - 22,000

ISSN Hospital: E: 1374-321X

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.

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