Hospital

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PUBLIC RELATIONS AND COMMUNICATION

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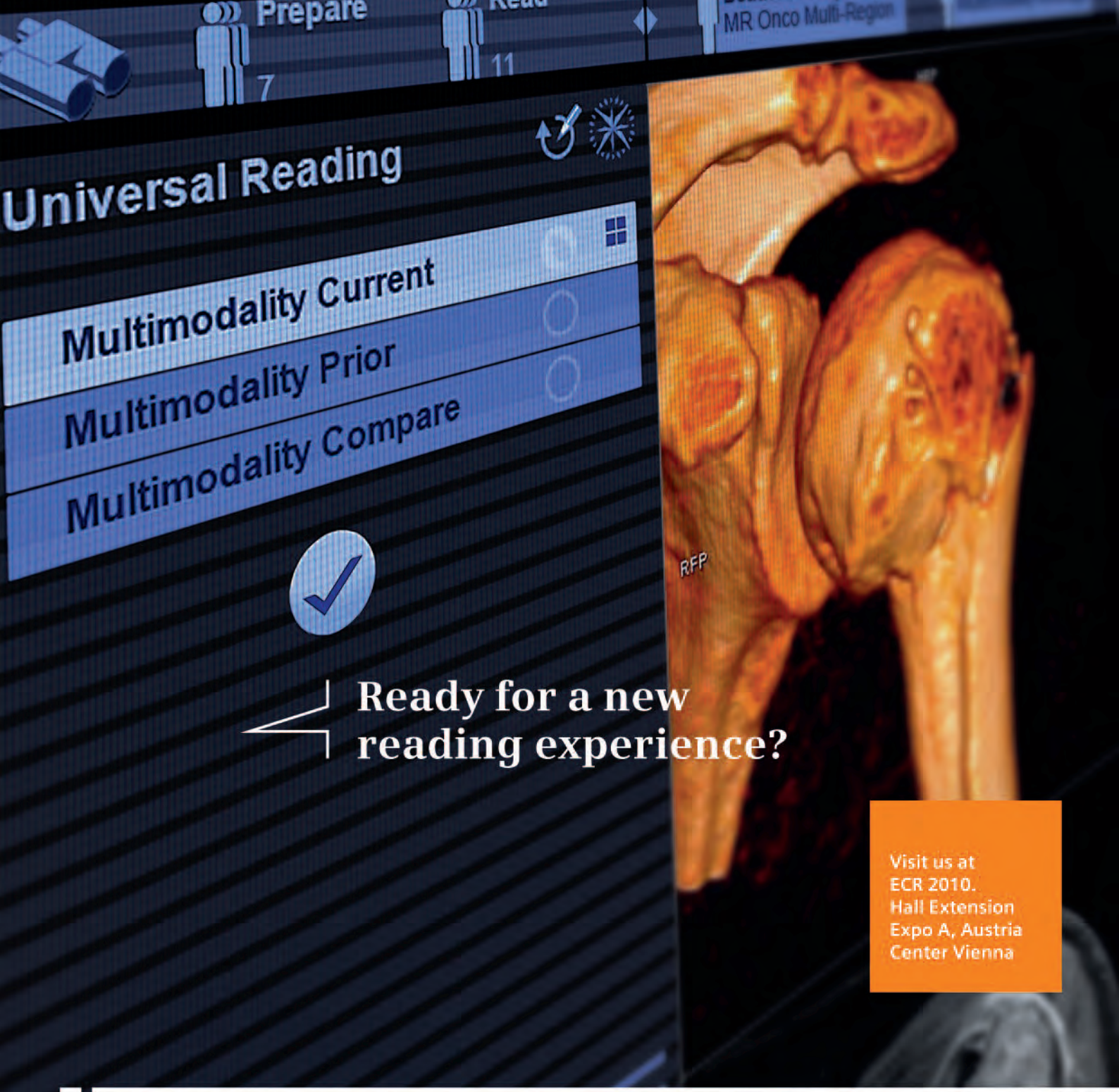
OFFICIAL JOURNAL OF THE EUROPEAN ASSOCIATION OF HOSPITAL MANAGERS



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REORIENTATION OF EAHM

Willy Heuschen

The year 2010 will be important for EAHM. Firstly, the 23rd EAHM congress in Zurich entitled "Roadmap to Top Quality" will allow us to continue our work on this theme. During the 2007 seminar in Dusseldorf we made this the central point of our work. This was the starting point for the development of European standards of quality for hospitals. The next congress will see its continuation thanks to our participation in a working group with other similar organisations from across Europe.

During the 2010 congress the mandates of the current Presidency and Executive Committee will end. It is time to make an assessment, to identify the perspectives for the next four years and to develop the three principal themes. As well as the question of quality already mentioned, we are also committed to the question of managing a hospital or "corporate governance". Following the investigation and the proposals opened by the theoretical research of Prof. K. Eeklo (KUL-Louvain, Belgium), this issue remains a top priority for our scientific committee.

During last year's EAHM seminar in Dusseldorf, the speakers presented their experiences and gave their opinions on the different aspects of the privatisation of hospitals (please see our seminar report pg. 7-9). The choice of this theme was not a coincidence: we must demystify the term "privatisation". This is what Prof. Maarse did in describing the different forms and various contents it covers. The other speakers told of their experiences, underlining the risks of hospital services turning exclusively to the profitability of healthcare, especially concerning the offer of funds to the most socially vulnerable patients. If we want to follow the rules of "corporate governance", a strategy geared towards a profit should be clearly stated in the hospital's mission. Like in all companies, the strategies and therefore the management should be inspired by the principles and values of the hospital.

Beside the Board of Directors who determine the mission of the hospital and establish the framework and resources, it is the responsibility of the hospital manager and his team to lead the day to day management. It is here he plays an important role. Given the evolution of patient expectations and the consistent decrease in financial resources, the manager and his team must make decisions that could have ethical and social implications. They could for example, make a selection of services based solely on profitability. This shows just how well balanced a hospital manager needs to be. This task has already changed and is in constant evolution.

This reasoning brings us to EAHM's action plan for the next four years. During the General Assembly, our President, Paul Castel announced the decision by the Executive Committee to start a new reflection group. This group will be in charge of developing proposals aiming to concretise EAHM's objectives in relation to the evolution and the demands imposed on hospitals and their managers. It is important that it keeps the spirit of EAHM as a professional organisation tasked with orientating its services in function of the needs of its members including information, knowledge and the sharing of experiences.

A successful change in direction comes from the bottom up, from national association members to management bodies. Emphasis must be placed in particular on the needs of young and future colleagues. We must give them the necessary professional tools to ensure that in the future, our hospitals will be able to offer patients the best treatments. Moreover, the reflection group will develop these proposals, which, after consultation with the national associations, will be considered as priorities in our work programme. Your ideas and suggestions are from now very welcome.

Willy Heuschen
Secretary General EAHM
Editor-in-Chief

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

PR and Communication

Often overlooked by the management, public relations and communication are important elements in the running of any hospital. Our dossier on the subject focuses on several different aspects of communication starting with effective media training for hospital managers. John Illman illustrates how difficult dealing with the press can be and the values of media training. Social media is the focus of the second article. (E)Hospital spoke to two leading healthcare social media moguls to find out why social media is so important and why hospitals should be using it. The final two articles move on to marketing; Stephen Willcocks stresses the links between clinical leadership and marketing while Michael Hall, in the first of a two part series, introduces us to concept mapping for healthcare organisations.

EAHM Seminar
Towards a balanced cooperation of public and private actors

Most countries in Europe have evolved to a mixed system with two or three types of hospitals: public, private not-for-profit and private for-profit hospitals. The purpose of the seminar was to create understanding of these different models and how they can work together helping participants in their search for the options best suited to their particular hospital. Our report summarises each of the presentations including a European overview, a view from public hospitals, a view from private hospitals and three experiences from specific countries.

Focus: Germany

The German health system is divided into an insurance sector with public and private insurance funds, and a healthcare sector. The healthcare sector covers a range of services and departments, including ambulatory outpatient care (provided mainly by individual doctors at their offices), pharmaceutical care distributed by pharmacists, inpatient care in hospitals and rehabilitation clinics, and a nursing care sector (caring for the increasing elderly population).

The hospital sector is a powerful economic factor. One million people in 2,000 hospitals care for 17 million inpatient cases and 18 million outpatient cases. The turnover is close to 65 billion euro, nearly three percent of the GDP.

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GROUP C

All other industry professionals.

MORE INFORMATION

For further information on *IT @ Networking Awards 2010* please visit our website www.hitm.eu, contact us via email at awards@hitm.eu or call +32 / 2 / 286 8501.

ORGANISERS

IT @ 2010 is organised by the European Association of Healthcare IT Managers and the European Association of Hospital Managers, supported by Excellent Event and EMC Consulting Group.

Friday, 20 November 2009

39TH ORDINARY GENERAL ASSEMBLY

The 39th Ordinary General Assembly of EAHM, held in Dusseldorf after this year's successful seminar "Towards a balanced cooperation of public and private actors" focused mainly on two topics: The report on activities and the upcoming EAHM seminar in Zurich 2010.

Activity Report

After thanking Mr. Kölking and his team for their organisation of this year's seminar, Mr. Paul Castel, President of EAHM reported on the activities of 2008-2009. Before commencing the report, Mr. Castel called for a minute silence in memory of Georg Schäfer, the 7th president of EAHM from 1983 to 1985 and Theo van der Zanden, the 10th president of EAHM from 1989 to 1992. Both men played large roles in the construction of EAHM and have been nominated as honorary members.

He began by applauding the success of the 2008 EAHM congress "New Leadership for New Challenges" held in Graz; an excellent panel of speakers and a learning experience for all who attended.

Financial Crisis

Mr. Castel highlighted the impact of the financial crisis on the hospital sector. Many hospitals and healthcare institutions have suffered and have had to cut costs and reorganise. The same is true of some of our national associations who have been unable to pay association fees. EAHM must in turn be cautious to ensure financial stability and in this vein, stricter statutes regarding membership were implemented.

(E)Hospital- the official journal of EAHM has also suffered from the crisis with shrinking advertising. The board is happy that the journal has surmounted this difficulty and give special thanks to the Editorial Board, Christian Marolt and the editorial team.

On the European Level

Another challenge of 2008-2009 was undoubtedly the Treaty of Lisbon. Controversial and delayed by the European Elections and the Irish Referendum, the treaty was finally ratified by all Member States. It is now hoped that the European Union can progress in its work.

The year also saw the implementation of the European Working Time Directive. Again, another controversial issue for the EU and indeed the hospital sector with working hours being decreased to 48 hours per week from 31 July 2009. This Directive is especially difficult regarding trainee doctors' working hours. Hungary, the Netherlands and the UK are simply unable to meet this target and have been granted an extension until 2011 but in interim may not exceed 52 hours.

The Services Directive adopted in 2006 should also be implemented into law by 31 December 2009 respecting clauses on social and health matters. It is expected that many Member States will be unable to meet this deadline and the Commission has been invited to develop special proposals in this area.

Crossborder healthcare and patients' rights were also on the European agenda. Along with the other directives previously mentioned, this is being closely monitored by the EAHM subcommittee on EU affairs.

EAHM were also proud co-organisers of the *IT @ Networking Awards 2009*. First prize went to Dr. Pierre Biron and his team from the Rhone Alpes region of France for the SISRA Health Information System and DPPR Shared and Distributed Patient Record. Mr. Castel stressed the diversity of European healthcare IT solutions and projects and how benchmarking of healthcare IT on a European level could be very useful. This awards event encouraged EAHM to push forward with the Working Party on IT.

Towards Next Year

2010 will see the 23rd edition of the EAHM congress "Roadmap to Top Quality"— this time in Zurich, Switzerland. Mr. Castel also called for a period of reflection and the Board decided to set up a reflection group. The upcoming year is an opportunity to create new dynamics in the organisation and to develop national association groups. The General Assembly in September 2010 will elect a new board, President and Vice-President.

Conclusion

In Conclusion, Mr. Castel called for all members to join and become involved in EAHM projects. The association needs the help of all the national associations to achieve its ultimate goal of providing Europe with its expertise. He suggested becoming more of a think tank; setting up a younger managers group to capitalise on their enthusiasm and expertise stressing that EAHM needs more propositions than it currently has.

Accounts and Economic Plan

The accounts for 2008 were presented by the Secretary General followed by the report from the auditors. These accounts were approved and the Board and Secretary General were discharged. The economic plan for 2010 and membership subscription fees of full members and associate members were both proposed and accepted.

New Members

The Italian Association ANMDO, an association of medical doctors who are also general directors, was accepted as a new full member of EAHM. As protocol requires, the Italian Association of Hospital Managers were

first asked if they had any objections to the acceptance of ANMDO. They had no objections and it was put to vote during the General Assembly and unanimously accepted. The Ecclesia Group (insurance and risk management) was also unanimously accepted as an associate member of EAHM.

2010 Congress

The Swiss Organisation Committee are very excited about the upcoming EAHM Congress in Zurich, 9-10 September 2010. The first announcement has already been printed and copies are available in English, German and French. The website www.zurich2010-EAHM.ch, also available in three languages, is up and running and contains a wealth of information on the congress. Cristoph Pachlatko from the Swiss Organising Committee stressed that each national association should encourage and motivate colleagues and friends to attend.

The programme has been jointly prepared by EAHM's Scientific Subcommittee and the Swiss Organising Committee with the speakers being finalised after the Board's visit to Zurich.

Online registration was made available from 1st January. Mr. Pachlatko finished his report on the congress with a short but informative promotional video of the congress. This marked the end of the 39th Ordinary General Assembly.

It was agreed that the next Ordinary General Assembly will take place on 9 September 2010 at 9am in Zurich.

TOWARDS A BALANCED COOPERATION OF PUBLIC AND PRIVATE ACTORS

Most countries in Europe have evolved to a mixed system with two or three types of hospitals: public, private not-for-profit and private for-profit. The purpose of this seminar was to create an understanding of these different models and illustrate how they can work together.

European (Over) View
Prof. Hans Maarse, University of Maastricht

Prof. Maarse gave the first presentation of the day, providing us with a European overview of the situation of public and private actors. Describing the landscape of healthcare and its history he explained the roots of both public and private healthcare but stressed that there has always been inter-country variations.

For Prof. Maarse the public-private distinction is too simple; it is not an either-or distinction, but a mix with no clear dividing lines. For example, in Germany public regulations ensure access to private health insurance for the elderly and in France, complementary health insurance is mandatory. There are more distinctions than just public and private- private not for profit, private for profit, etc. Financial arrangements, political administration structures and the degree of management autonomy also vary between institutions and countries and public and private establishments.

Which is best? Some countries have successful public systems, others successful private systems. Success depends on concrete arrangements and institutional context; there is no clear evidence for which is best, what works in one country will not necessarily work in another. There is also a European dimension: the more private elements in place in the hospital sector, the higher the probability that EU competition law applies. Public agencies can be engaged in activities regulated by EU competition law. There is a considerable amount of legal uncertainty.

Prof. Maarse concluded that there are no clear cut dividing lines with many public institutions moving to a public-private mix (outsourcing etc). Diversity is a big issue: public-private relationships are embedded in a complex political, socio-cultural and economic context that creates and constrains scope for further developments.

Round table discussion with Paul Castel, Prof. Maarse and Heinz Kölking

View From Public Hospitals
Paul Castel, Director General of Hospices Civils de Lyon, President of EAHM

For Mr. Castel the hospital landscape varies appreciably from one European state to an-

other making an analysis of public hospitals extremely complex. There are differences in access, weight and models of financing.

He stressed the shared values of public hospitals- humanism, respect for the dignity of every individual, no discrimination and equal treatment for all. Public institutions focus on the social link- their mission is the reception and care of patients, teaching and formation and clinical research.

Public and private is a complex and often difficult relationship. In essence they are competitors. Increased competition does in fact bring advantages although always badly perceived by public hospitals. Competition incites the development of new models of care, the revising and modernising organisations and optimising costs of care. It also leads to the necessary distinction of their missions and does not have to lead to the loss of specificities of the sectors. They do not do the same thing. Mr Castel views the main danger as the evolution of the models of financing. Financing models are based on activity and many people now assume that the same price rates apply to public and private. But the question remains whether these services are comparable. Castel also highlighted that both public and private hospitals need to make a surplus.

Are public and private condemned to oppose? Public hospitals are transforming-questioning their values, missions and financing. This period of doubt can strengthen public hospitals, they can learn from their competitors and transform their services towards greater efficiency.

Secretary General Willy Heuschen

Attendees at the EAHM seminar 2009

In conclusion public hospitals must reaffirm their values and the honour of hospital public utility: quality, equity and efficiency. Recent crises have led to questions regarding the role of public hospitals in the coverage of the most deprived, modes of financing and emphasised the importance of quality care. We must accept models that recognise the specificities of each and are the base of a balanced cooperation between the actors.

View from Private Hospitals

Dr. Paul Garassus, European Union of Private Hospitals (UEPH)

Dr. Garassus introduced us to the European Union of Private Hospitals and explained the view from private hospitals. He stressed the obvious necessity of cooperation between public and private hospitals in the European Union in respect to patients' free choice. He believes the complementarities and specificities of both sectors have to be respected in an economic stability model. Important increases in medical activity of European private hospitals have been seen in the past few years especially in Germany but also in newer European countries such as Poland. Their goal is to ensure fair competition as a provider according to health priorities determined by national regulators.

Quality of healthcare depends on a stable economic model. Wide application of DRG prospective payment in 27 EU countries determined new benchmarking references but we have to participate in a cost containment discussion determined by DRG tariffs even if tariff discrepancies between the two sectors still exist (e.g. Austria, Portugal and France). Private hospitals would like to see equality in DRG tariffs and have the opportunity to receive more money.

Dr. Garassus stressed that the development and rebuilding of a modern healthcare system in countries that have recently joined the EU such as Hungary clearly depends on private investment. We have to support such enterprise to achieve the right balance for quality of care improvement and social insurance budget affordability in respect of common welfare.

The conclusion from the private perspective was that there is no "gold standard" for healthcare. Private activity is growing across Europe and hospital organisation requires a "community of interest" between managers and medical staff; collaboration is key to success. Public healthcare reforms need to be coached by the application of private management expertise.

The key solution appears to be a clear collaboration between regulator and operator (public and private). We must balance value creation and cost containment, regulator and provider, specialised and global, actual and long term, cure and care and demand and needs.

Experiences from Portugal

Artur Vaz, Director, Hospital Fernando Fonseca

Mr. Vaz explained that cooperation between public and private sectors in Portugal has always been characterised by mistrust and a lack of transparency. Although the Portuguese private health sector does play a relevant role in healthcare provision and funding, it is the National Health Service and the public perspective that is stressed. This is mainly because public hospitals dominate while private activity mostly offers ambulatory care. However, both sectors are changing and some experiences of a

wider and more clarified cooperation between them were launched during the last few years.

He stressed three key areas of cooperation between public and private health sectors. The first is the contracting out of private healthcare provision by the public sector. This is non-competitive; a list of prices is distributed by the government and private institutions submit an application to the regional health authority. The second area concerns the programme to reduce surgical waiting lists. The third and final area is the Public Private Partnership Programme for the conception, funding, construction, maintenance and management of public hospitals launched in 2003.

Each of these areas has suffered the impact of political changes and of the characteristics of the relationship between the two sectors. Contracting out has been almost paralysed for years, the participation of the private sector in the programme to reduce surgical waiting lists is still very small, the Partnership Programme was recently reduced from 10 to four hospitals and the only experience of private management of a public hospital (Hospital Fernando Fonseca, in Amadora) finished at the end of 2008.

During recent years, the private sector has shown a significant improvement with the creation of several private hospitals and the adoption of a real hospital model for these units but the public sector is also developing internal reforms to improve the quality and efficiency of public primary and hospital healthcare. Mr. Vaz would like to be optimistic but fears that in Portugal, public and private actors do not have an adult relationship. Complexities and regulations teamed with mistrust mean that the balanced cooperation of public and private is extremely difficult.

Experiences in Public-Private Partnerships- Ireland, Italy, UK

Michael Costelloe, Senior Vice President-International, UPMC International and Commercial Services

While discussions of public-private partnerships in healthcare usually focus on financing, construction and management of physical infrastructure, public health authorities in Europe have begun to explore new partnerships with private institutions for the management and operation of public healthcare programmes.

Mr. Costelloe emphasised that although often complex, true operating partnerships can offer the best of both worlds to patients and the public health service with universal access to privately-operated facilities, accelerated access to the latest treatment technologies and protocols, significant reductions in waiting times, and an overall improvement in the patient experience.

UPMC have been implementing PPPs for over ten years now. Costello cited the main challenges facing PPPs as different perceptions of value for money, governance issues (clinical and managerial), timeliness of payment, differing expectations around operating margins and the task of maintaining government support for the project at both the political and bureaucratic levels. He claims that private healthcare organisations that know how to work with the public sector and are capable of managing the risks, can find significant opportunities in operating public-private partnership arrangements.

How to go forward? Costello believes that PPP projects can expand clinical operations to a broader array of services but successfull PPPs require a special managerial skill-set, and a great deal of patience. He also stressed the importance of accounting for financial and political risks. Rewards include the ability to serve the entire population on an equitable basis and also profitability- PPPs can be profitable if well managed.

Board Members at the 39th General Assembly

Experiences From Germany

Dr. Ralf-Michael Schmitz, Managing Director, Klinikum Stuttgart

Speaking of today's hospital market, Dr. Schmitz believes that in the next 15 years 25 percent of hospitals and 40 to 50 percent of beds will disappear from the market due to increased competition. Many feel that within this market share it is the private hospitals that will prosper. This is not Dr. Schmitz's opinion; he believes the main driver is management. Private providers are not always commercially successful– there are well-managed hospitals and there are badly-managed hospitals.

Describing his experiences in Klinikum Stuttgart, there, the objective is long-term economic security of existence through goal-oriented positioning in the healthcare market. This is a task for the management. With the goals being a positive operating result and an increase in turnover and services on the market. So instead of outsourcing catering services they built their own kitchen and supply eight institutions within one hospital. There is a similar set up for blood- producing it themselves and then supplying other hospitals.

For Dr. Schmitz there are benefits and limitations to PPPs; they are not always the best possible solution. There are limitations regarding complex procurement and contract procedures, dependencies, inflexibility of long-term use of payments and falling real estate and bond deterioration. For example, loans for PPPs are not as advantageous as subsidies, which provide favourable loan conditions. PPPs can be advantageous if you have no equity and are better for bigger building projects for periods in excess of 25 years. They are also favourable when a hospital does not have its own facility management expertise (construction, operation). Schmitz also expressed concerns regarding the ethical issue of hospitals making a surplus; should the money be reimbursed or reinvested?

In conclusion, Dr. Schmitz stated that cooperation between industry and hospitals can be fruitful and it is possible to safeguard your position on the market. Indeed with Germany's new liberal government competition will only increase.

JOHN DALLI
COMMISSIONER FOR HEALTH

By Rory Watson

Public health has moved higher up the European Commission's political agenda following a major internal administrative shake-up. The outcome means that the new commissioner, former Maltese economy and social affairs minister, John Dalli, who took over the post on 9 February will have more resources and influence than any of his predecessors.

His department has grown to 1,100 officials as policy on pharmaceuticals, cosmetics, medical devices, biotechnology and pesticides are transferred to the public health directorate-general's existing responsibilities.

In one sense, the changes are logical. They bring all health-related issues under one roof within the Commission for the first time. This brings the institution into line with national practice in all European countries, apart from Greece, whereby medical legislation is handled by health ministries. A contributory factor was the fact that the Lisbon Treaty, which took effect from the beginning of December, places pharmaceuticals and medical devices under the health policy heading.

In another sense, they reflect a significant change of thinking. Until now, pharmaceuticals, medical devices and cosmetics had been the responsibility of the enterprise and industry directorate-general. As a result, any initiatives involving these sectors were invariably seen initially from a commercial point of view. Although health and safety concerns were not neglected, greater importance was attached to assessing whether particular measures would strengthen business competitiveness or not.

Now, as Dalli told the European Parliament during public hearings last month to determine whether he was a suitable candidate for the health and consumer affairs portfolio, this order of priorities is being reversed. The interests of patients come first.

But as someone who has been his country's economy and finance minister for over a decade, he is also acutely aware of the importance of nurturing a strong European industrial base. The two, he insists, are not incompatible, "Patient interests rest on a strong profitable pharmaceutical industry. Support for the industry and patients are not contradictory. You can get synergy between the two. I will push the industry to do more to put patients in the frontline", he told MEPs.

The former minister's previous responsibility for national purse strings also suggests that he will carefully weigh up the cost-benefit consequences of any course of action before adopting it – a cautious approach which may disappoint some single issue health lobbyists.

He gave a clear hint of this during the parliamentary hearings when asked whether he would use the powers given by the Lisbon Treaty to target action on specific diseases, and in particular whether rheumatic diseases would be among his priorities.

His reply was instructive. "With limited finance, it is very important to address the consequences of decisions", he said. He then confirmed that he will aim to tackle broad health determinants such as alcohol, tobacco and obesity, using information and educational programmes, rather than focus on individual areas.

"Health determinants cut across diseases. To concentrate on specific diseases would give a short-term and narrow outcome. Heath determinants will give us health equality more quickly", he explained.

Moves to give patients more choice by creating a transparent system to allow them to have reimbursable hospital treatment in another EU country will feature prominently on his early agenda, despite being blocked by a handful of countries, led by Spain, shortly before Christmas.

"I believe the dossier needs to move forward. There is a problem in the Council of Ministers. I will make every effort to ensure an understanding is reached for an effective policy on patient rights and mobility", he told MEPs.

Mr. Dalli plans to meet the Spanish health minister early in his five-year mandate to try and break the deadlock. Realistically, however, little progress will come before the second half of the year when Belgium takes over the six-month rotating EU presidency from Spain.

Nor are there likely to be any major developments affecting medical devices before next year when the framework legislation is due to be overhauled.

Instead, the first items the new commissioner can expect to see on the statute book are two pieces of relatively non-controversial pieces of pharmaceutical legislation. One aims to clamp down on counterfeit drugs, the other to improve pharmacovigilance.

However, he has already called a halt to the third element in the package which, as it stands, would allow pharmaceutical companies to provide information directly to the public under certain conditions. Critics say this would be tantamount to advertising. Mr. Dalli appears to agree. He intends to reassess the existing proposal, to strengthen a patient perspective and make a clear demarcation between information and advertising.

During an assured three-hour hearing before the European Parliament, the new public health commissioner also revealed the political style he intends to use in Brussels. "My experience shows me that sometimes a gradual approach works better and faster", he said.

Spain Takes Over Presidency of EU Council

Spain has pledged to drive forward the realisation of the European Research Area (ERA) during its six-month Presidency of the Council of the EU, which started on January 1st. Innovation and equality are at the heart of the Spanish Presidency programme, explained Science and Innovation Minister Cristina Garmendia who added that "Promoting the construction of the ERA is key to the success of this programme.

It is only by having a common shared space for knowledge, the ERA, in which scientists and ideas can move freely, that research and innovation will be able to act as engines for economic and social progress over the coming decades", she writes. "For this reason, they should be at the heart of European Union policies."

Spain has identified three 'axes' to drive the ERA forward: integration, involvement and inclusion. The integration axis refers to the importance of integrating research and development (R&D) policies into other policies - and specifically into the EU's strategy for 2020. Through the involvement axis, Spain will seek to ensure that all instruments supporting R&D and innovation in Europe, whether they are regional, national or pan-European in nature, address the major challenges faced by society today. These include climate change, the search for new sources of energy, ageing and disease, and globalisation. Finally, the inclusion axis focuses on the role science and innovation can play in promoting social cohesion and tackling poverty and exclusion.

Writing on CORDIS, the Spanish Presidency explains that "Europe has the duty and the opportunity to lead the battle against inequality and to put science and technology to use in this fight". Looked at more broadly, Spain's priorities for the next six months include: consolidating Europe's social agenda, paying special attention to gender equality and the fight against domestic violence; getting out of the economic crisis; energy security and climate change; creating a safer EU, particularly with regard to the challenge of immigration; and enabling Europe to speak with its own voice on the international scene. Spain will head up the EU Council for the first half of 2010, before handing over the reins to Belgium on 1 July.

For more information, please visit: **www.eu2010.es**

ICT Profiles Supports R&D Players to Find Appropriate Partners

Austria has launched a new on-line directory called ICTprofiles, which provides the user with a professional and entirely web-based platform for successful partner searches. ICTprofiles allows its users to find collaboration partners with a focus on Information and Communication Technology (ICT):

- In all relevant research areas (e.g. FP7);
- In commercial areas; and
- In governmental areas.

This directory enables R&D players from all over the world to review the R&D core competencies and publications of the Austrian Information and Communication Technology community. The clearly represented profiles inform the visitors about expertise, interests and aims of the organisation.

In order to ensure the continuous high quality of the database, all published profiles are updated on a regular basis. In the past few months approximately 300 Austrian R&D profiles have passed the quality check and were published by the Austrian ICT National Contact Point, who is also the operator of this database. A newly developed search mechanism allows expeditious searching or browsing through more than 60 different ICT sectors. In addition, a keyword search application is available, which is progressively filled up by the user and is monitored by an operator.

Interested parties benefit from this broad pool of R&D profiles for potential strategic partnerships and international R&D cooperation. Also, all previous involvements in EU funded projects, of the potential partners and their contact details are published in detail on this database. ICTprofiles is a free-of-charge, on-line service and is operated by the Austrian Research Promotion Agency (FFG), European and International Programmes Division.

For more information, please visit: **www.ictprofiles.at**

FACING **THE PRESS**

Effective Media Training for Hospital Managers

By John Illman

Imagine you are a hospital manager about to appear on TV to answer allegations over lapses in patient safety. You have never been on TV before, but you pride yourself on your communication skills. (You really know your subject and have been invited to lecture all over the world.) In the studio, you find yourself competing for airtime against an earthquake in Chile, a world summit at the UN, the death of a Hollywood star and arms negotiations in Geneva.

You have only three minutes on air and feel upset because you make every possible effort to answer the questions – and explain the complex background to the story. But the correspondent isn't interested in this. Moreover, you spend so much time answering his questions there is no time to say what you want to say. He has a different agenda.

This is a common experience. Effective media communication means turning what you do normally on its head and forgetting conventional structure - "beginning, middle and end".

A news story will almost invariably begin with the "conclusion". There is a good reason for this. If every news story included background information of the kind many managers routinely provide by way of introductory information in presentations, we would need wheelbarrows for our daily newspapers and the average broadcast interview would last 10-15 minutes. Enough news already arrives each day at any large media outlet to fill four or five fat novels and flood column and air space several times over.

Thus, the interviewee needs not only to know his subject, but how much the audience needs to know. Think of this page as representing the sum total of your specialist knowledge. Now take a pin and insert it into any one of the words of the last sentence. That tiny pin-prick will probably represent all you need for a typical consumer media interview.

For example, take a BBC TV interview with a haemophilia specialist about a 12 year old boy who had a blood transfusion from a donor with Creutzfeldt-Jakob disease (CJD). The interview ran for two minutes 20 seconds (452 words). The doctor had 238 words to explain "this terribly distressing case". (By way of comparison, this paragraph contains 79 words). His problem was compounded by interruptions and the need to correct the interviewer twice.

Communications and media training programmes are designed to identify which pinpricks of knowledge are needed for particular audiences. Consumer audiences, for example, will want to know about the benefits rather than features. This critical distinction between features and benefits will become apparent when you think how we react as consumers.

For example, your interest in a new oven will probably be restricted to the benefits it produces in terms of cooked food, whether it is safe, what it looks like, how much it costs and whether it will fit into your kitchen. You will probably not be interested in its internal features, such as how the gas gets to the saucepan or how the design varies the intensity of the heat.

Similarly patients are not interested in the features that make up the day-to-day professional lives of hospital managers. They will not be interested, for example, to hear that you have read this article. Their concern is for patient care and safety.

Media Training Programmes

A typical media training programme includes:

- Introductions: participants describe their media perceptions and experience;
- How the media operates and what makes news?
- Key messages and sound-bites;
- Preparing for an interview; and
- Filmed interviews with participants, followed by analysis.

The introductory session: Most participants feel nervous about "performing" in front of colleagues. Training can actually be more nerve-wracking than a live interview in a TV studio or outside a hospital, but this session usually helps to break the ice and allay fears - but some anxiety is inevitable and indeed desirable.

What makes news? We all know what makes news, but what about why it does so? It is not always enough to have a compelling story. News does not occur in a vacuum. Each published story should be seen within the context of the daily news agenda. There will only be so many stories about medical advances or hospital administration on any one day. A story which is "big" in the late afternoon may quickly become "small". A story I wrote as a UK national newspaper medical correspondent was to have been the page one "splash" or "lead story". In the event, the "splash" was a tragedy which claimed 31 lives – a fire at the King's Cross railway station in London. My story was reduced to just five column inches on page 57.

Key messages: A key message is a take home message, ideally short, snappy and simple. Think of "the elevator test" – getting your message across between the first and third floor of a hotel, when the person you are talking to will get out. Allow 10-15 seconds or so per message. Stick to two or three key messages in an interview. Key messages can either be simple statements of fact or wrapped up in sound-bites – a short summary of the story. A vivid sound-bite may provide a headline or a broadcast clip. The paradox is that preparing simple key messages can be notoriously difficult and time consuming. Many scientists and healthcare professionals and administra-

tors spend far more time preparing for lecture presentations than for media interviews, even though they have significantly more control over the former (until question time). Key messages should be supported by evidence.

Preparing for an interview: Most interviewees are "one-dimensional" and think what's in it for me? Good interviewees think in three dimensions: What's good for the journalist? What's good for the audience? What's good for me? No, of course, you cannot please all the people all of the time. But one dimensional-thinking is unlikely to please anyone,

Everyday conversation conditions us to answer questions – and, overall, we try to do an honest job. A common error is to treat a media interview like an everyday conversation even though you may have only two or three minutes to get your key messages across. Your time will run out if the journalist has a different agenda to you and you try to answer his/ her questions in full. A large part of training programmes is dedicated to techniques to help interviewees drive their agenda and put across their key messages.

Interviews: Performance analysis takes up most of the time. Interviews are usually filmed. This may seem inappropriate because about 90 percent of media interviews are done on the phone, but the camera is widely recognised as a highly effective training tool, and it gives sessions an invaluable sharp edge.

Training interviews last about four minutes even though most print interviews last much longer. The idea is to encourage participants to get their key messages across quickly, simply and succinctly. Participants are given their film clips. On seeing her father on screen at home, the daughter of one trainee asked: "Daddy, why is that man being so horrible to you?"

Do we try to be 'horrible'? The emphasis is on a broad spectrum approach embracing the three main styles of interviewing: 'collaborative', 'informational' and 'confrontational'. Overall, we try and make the sessions a little harder than they are likely to be in a live interview. Preparation is the key to success. It is hard to prepare unless you know what you are being prepared for – and it is best to prepare for the worst possible scenario.

Risk Benefit Ratio

Irresponsible reporting and the constraints of working with the media discourage good potential spokespeople, but think of the risk-benefit ratio. Overall, publicity works and generates significant benefit. This is why governments and industry all over the world invest so much time and money on it. Moreover, what would happen if hospital managers and executives were to turn their backs on the media?

The answer was summed up by the London psychiatrist Dr. Philip Timms who warned: "Psychiatrists should not be discouraged from talking to or writing for the media. If we do not represent our position, it will be misrepresented by the media." What he said is as true for any other discipline as it is for psychiatry, but dealing with the media does not come naturally to most people. Healthcare and the media are disparate culture. The right kind of preparation and training can help to bridge the gap.

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SOCIAL MEDIA: AN ESSENTIAL TOOL OR PASSING TREND?

By Lee Campbell

Social media is taking the world by storm. Everywhere people are increasingly communicating online; writing blogs, creating Facebook profiles, sharing videos on YouTube and tweeting on Twitter. I spoke to two leading healthcare social media moguls, Ed Bennett from the US and Lucien Engelen from the Netherlands to find out why exactly social media is so important to healthcare.

Contrary to popular belief, social networking is not just for teenagers planning their social lives. Now even companies have Facebook profiles and Twitter accounts; politicians need to blog and secure a strong online presence to win elections, especially to attract the 18-30 vote. But do hospitals really need to get involved?

Well, Bennett and Engelen are the men to ask. Very passionate about the subject, both are charting the use of social media in hospitals. Ed Bennett started his Hospital Social Network List in December 2008, to monitor hospitals in the US and list those with Facebook, YouTube and Twitter accounts (ebennett.org/hsnl). Inspired by the American list, Lucien Engelen started with a list of Dutch hospitals using social media and then expanded this to a European list (hospitalseu.wordpress.com). Engelen's list focuses less on marketing and communication and more on the use of social media to dialogue with the patient.

So Why Social Media?

Ed Bennett has been working on the web since 1993 and at the University of Maryland Medical System (UMMS) since 1999. Wary of how slow hospitals were to understand the value of the Internet, he does not want to see the same situation with social media, "When I realised that social media was just as important as the invention of the web- that is how I feel. I feel that the development of social media, its adoption by people, is that fundamental a change. I was concerned that once again, hospitals would be five to six years behind everybody else." He decided that social media was something to be taken seriously and so came the motivation for his list.

Bennett uses social media as an extension of his hospital's normal communication activities, "In addition to press releases and other media we are also making ourselves available on Facebook and Twitter, on YouTube and on our blog and welcoming conversations. I don't see it as being that dramatic a shift, it is simply an extension of what we have been doing." UMMS uses Facebook, Twitter and YouTube. There is also an active blog, "Life in a Medical Center", and an application for the iPhone. Different departments have their own accounts to keep their patients updated on the latest news and developments.

For Engelen, (Health 2.0 Ambassador and Head of Emergency Healthcare Network at Radboud University Nijmegen Medical Centre) social media is less about public relations and more about the care process. It is about how patients can use the tools to gather information and have more say in their care pathway; social media promotes participatory healthcare. He believes that with new technologies and increased patient participation, healthcare delivery is possible in online healthcare networks and importantly that this is happening now and it is not simply something for the future.

Speaking of his professional use of social media at the Radboud University Nijmegen Medical Centre, Engelen cited two examples illustrating the importance and benefits of social media. His colleague, Prof. Dr. Jan Kremer invented the digital IVF Clinic where "IVF couples can interact with each other about their experiences, problems and also just socialise in a chatbox-like environment."

The virtual clinic allows patients to ask questions to the doctor or nurses or other patients in an open or private chat. The benefits of the digital clinic include a decline in the number of appointments needed as within 24 hours the doctor/nurse will respond online. Patient satisfaction also increases as patients have the opportunity to participate in their care. As well as these proven advantages, according to Engelen's colleague, Dr. Kremer, programmes like these make "healthcare more sexy".

Engelen also praised the networking capabilities of social media. When looking for someone to help him programme a website in Google maps and an iPhone app for his project www.aed4.eu he would normally have to ask one of his team to scout the market. Thanks to Twitter, he just tweeted and asked his followers who could be of any help. It was a great success, " Within the hour I had six leads, researched them on the Internet, choose the best two, one didn't pick up the phone but the other one was a catch. Within 3 weeks I had a running beta and we presented at reshape 2009".

Social media incites conversations, promotes discussion. In the same way Engelen and his colleagues discuss technical problems and search for professional advice, patients can communicate directly with hospitals, they can ask questions, make complaints, thank their caregivers and find out more about their diseases.

Control vs. Conversation

Social media is a relatively new concept and for many hospital managers a frightening one. An account on a social networking site can have a huge impact in a very short period of time; for example videos posted on YouTube can become overnight successes with thousands of people watching and commenting.

With this open communication comes the opportunity for criticism, which is a daunting prospect for hospitals. Why are so many hospitals wary of social media?

Engelen cites three reasons why hospitals are wary of social media. Firstly, "the unknown" aspect; it is new and many are unaware of the power and spread of social media and of Internet use. The second reason concerns evidence; in healthcare we look for evidence-based solutions: evidence of success, real numbers, cost efficiency and medical facts. But this is not available for social media, which is only starting to make an impact on healthcare. The third issue is control; healthcare boards and management tend to control information but social media, as Engelen puts it, "has the taste of the uncontrollable". Conceding that this is partially true he does however emphasise that with good policy and strategy it is possible to increase interaction with patients and their informal care without jeopardising reputation.

For Bennett, managers shouldn't be hesitant, "we are simply doing the same thing we have always been doing but now we are utilising new tools that people want". The control issue however, produces a much stronger response. On asking Bennett the control question he went straight to the point, "Get over it! You never had control, it was an illusion". He stressed that the common concern of what happens if someone says something bad about you isn't that important and that people have always been criticising services and staff.

"No one is perfect. There is always someone who is not happy with your organisation or some aspect of it. And up until now they have been able to talk to their neighbours, friends and co-workers...they were always talking about you. Now they are out there on the web talking about you, talking to their Facebook friends and their Twitter friends. So you have a choice as an organisation: you can ignore them and pretend that they are not talking about you, or, you can join the conversation and try to resolve the problem."

Yes, the criticism is out there for everyone to see but so is your response, turning a negative situation into a positive, "If you do that then everyone else in that community is going to see that interaction. They are going to see that someone had a complaint and that you stepped up and said sorry that you have a problem, how can we help you".

Bennett makes a good point, how can we defend ourselves, and our services if we neglect to join the conversation? Facing up to criticism, listening to those who use our services and their opinion can help improve services and increase customer satisfaction. Social media also allows us to see positive comments and success stories that we might not have seen before.

Top Tips for Getting Started (Ed Bennett)

1. Look at your particular audience and determine who you are trying to reach. Consumers? The average citizen/ customer? Other businesses?

2. Look at what social media tools these people use. In general the answer is going to be Facebook as it is the most common social media tool.

3. Look internally. In any medium to large-sized organisation, there will be people who use social media and they will be willing to help. If you decide you should be on Facebook look internally look at your staff, find a good, appropriate person who knows how to do communications, how to speak for the organisation. Find someone who uses Facebook all the time and they will be your native guide. Empower them to manage the account for your organisation.

Finance and Practicalities

So far we have seen a lot of positives: increased communication and interaction with patients, increased visibility and transparency and a wide variety of networking opportunities. But what about the practicalities? Two vital questions must be answered: firstly, how much will it cost? And secondly who will take care of it?

For Ed Bennett the extraordinary thing about social media is that these tools are essentially free, you can set up an account on YouTube, Twitter and Facebook or start a blog for free and reach a worldwide audience. Indeed, because these tools are free and relatively easy to start up and maintain they are often overlooked, their value underestimated.

The main investment is not financial but peoples' time; someone needs to update the blog, post on Twitter and respond to queries. UMMS does not have a specific staff member solely in charge of social media, instead several people in the communications office spend a small portion of their day updating on one of the social media sites. For example one person maintains and monitors the Facebook account. This is just simply one of their duties and not a full time job. Bennett estimates that a half hour a day updating, taking a look at comments, maybe responding to comments or passing them on is all that is needed. The great thing being you can spend as little or as much time as you want but you don't have to invest a lot.

Outlook for the Future

Social media will only grow in importance, and new, more advanced methods of social networking will undoubtedly be developed. For Bennett, in the next few years it will become expected of hospitals to use social media. While at the minute patients still find it pleasantly surprising to find hospitals on Facebook, in the future the surprise will be not being able to find them on there, "I think you are going to see a very quick change in what the expectations of your community are and the reaction isn't going to be 'oh that's really great they have a Facebook account!' the reaction is going to be 'what is the matter with these people, why don't they have a Facebook account?'"

Bennett likens this situation to conversations he had in the late 90s when hospitals were debating setting up websites, a decade later it is unthinkable that a hospital wouldn't have a website, he believes the same thing will happen with social media and the great part is it doesn't involve spending any money!

Engelen is also very sure of the importance and the future of social media in healthcare, not just in PR and communication but also in patient care. I asked him for a few words of wisdom for any hospital managers considering branching into social media, his answer: "Yes. Three things: start, start and start!" He recommends starting small and broadening afterwards instead of diving into social media with a big bang; most of all he stresses not to be afraid.

From talking to Bennett and Engelen it is clear that social media has already made an impact in the healthcare sector and that there is also great potential for further development. Their lists show how more and more hospitals are using social networking sites in both the US and Europe and how it is becoming part and parcel of everyday hospital activity. It would seem that social media is not just a passing trend but an extremely useful, and soon to be essential tool for hospitals and healthcare institutions.

MARKETING AND CLINICAL LEADERSHIP

By S. G. Willcocks

Marketing has not always been considered relevant or appropriate within the public sector of healthcare, not least by healthcare professionals. However, policy reform in the public health sector has introduced competition and customer choice as a mechanism for improving services, which has in turn renewed interest in marketing. Leaders in healthcare organisations, therefore, are more likely to perceive marketing as a relevant approach but there may be a need to overcome resistance to a subject perceived as only relevant to commercial organisations.

In private sector organisations, marketing is accepted as a core function, associated with strategic development, and as a way of dealing with competition and responding to the needs of customers. Up until recently it has not been considered appropriate in the public sector because of differences in context, lack of competition and problems in defining the customer. For example, in some countries the public sector is in a monopoly position as provider; the "customer" may not be an individual; and there is the distinction between "services" provided for patients and "products" sold to customers. But this is changing thanks to increased competition and customer choice. This article introduces two well-known approaches to marketing, and applies these to the public healthcare sector.

Marketing is one of many disciplines emanating from the private sector being put forward as having potential for application in the public sector. In recent years, this has tended to be a one way transfer of knowledge from the private to the public sector.

Policy changes in recent years, for example, in the UK health sector, have increasingly shifted away from state provision towards a mixed economy of public and private sector providers or in some countries entirely from the private sector. Alongside this change has been a related emphasis on competition between providers as a mechanism for improving performance and quality. The involvement of the "customer" or patient in healthcare- is increasingly perceived as a central, although it will vary, depending upon whether the system involves a direct customer -supplier exchange or indirect via insurance companies or state sponsored organisations acting on behalf of the customer. Regardless of this, the new competitive market context represents a challenge to those with leadership responsibilities in healthcare organisations.

Leadership

Alongside the new market context, there has been a renewed interest in leadership in healthcare, in particular clinical leadership. It is noted that leadership is of vital importance to the delivery of high quality healthcare services. The link between quality and effective leadership has been made explicit in recent policy, for example, in the UK health service.

In healthcare, the trend is to focus on leadership at the level of the clinical team, and thus the emphasis is on developing clinical leadership. The latter is based on shared or team-based leadership, as opposed to individual, top down, "heroic" models of leadership. Clinical leadership is essentially about empowering clinicians to assume leadership roles within their specialist domains, or teams, at the same time ensuring integration with other teams, and contributing to the delivery of high quality services to their patients.

Leaders within these teams need to have, or acquire, a range of skills, for example,-
(1) Influencing skills, to influence clinical peers and ensure they are responsive to change;
(2) Motivational skills, to provide motivation and developmental support for colleagues within teams;
(3) The skills to promote clinical engagement, ensuring clinicians are committed to healthcare reforms;
(4) Diagnostic skills to understand and diagnose organisational problems; and
(5) Strategic skills to provide strategic direction and vision for the team.

These skills are important to leaders of clinical teams. The latter need to be fully part of their organisations and willing and able to contribute to service development and change; ensuring that services are continuing to meet the needs of patients, and are of high quality and fit for purpose; and that the clinical unit or division is responsive to external demands and changing market conditions.

These core objectives are also compatible with, and a part of, the marketing approach. The next section will introduce two well-known approaches to marketing: the classical approach based on the marketing mix; and relationship marketing.

Marketing

It can be noted at this point that there are many different approaches to marketing, with differing emphasis and a range of different variables. The classical tradition in marketing is centred on the idea of the "marketing mix", that is the emphasis on the 4 Ps (sometimes extended to the 7 Ps). This has been around for many years but is still relevant, particularly as a strategic framework.

The Marketing Mix
(1) Product;
(2) Price;
(3) Place; and
(4) Promotion.

These variables, although somewhat simplistic, provide a framework for conducting a diagnostic analysis of the healthcare organisation. They enable the clinical leader to assess the current situation and provide an evidence base to inform the strategic direction of the clinical unit or division.

Thus, the "product" or service requires an analysis of core attributes relating to service delivery; the "price" requires either an understanding of costing or adjustment to price, depending upon healthcare system (in the UK price is fixed by national tariff); the "place" requires scrutiny of the quality of the delivery setting; and "promotion" requires attention to the way in which services are promoted and communicated to those commissioning or buying the service.

This exercise is crucial in terms of understanding how effective your services are, from a multiple perspective i.e. from the perspective of different stakeholders. It is also an important prerequisite for formulating strategic goals and direction, and therefore, marketing is part of the strategy process.

Relationship Marketing

Another, more recent tradition in marketing is centred on the importance of building and sustaining longer term relationships with customers and is, therefore, termed "relationship marketing". The main emphasis is the relationship building process, and the impact this will have on "customer retention" and obtaining new customers or in the case of healthcare, patients.

Central to success in the process shown in figure 1 (see below) is quality, the latter being a mechanism for establishing and sustaining the relationship and it is seen as a collaborative and iterative process, involving both customer and supplier. This means that leaders need to develop relationship building skills, for example:

- Communication and listening skills;
- Influencing and persuasive skills;
- Negotiating skills;
- Empathy and understanding; and
- Ability to sustain relationships and credibility with partners.

A relationship marketing approach is not incompatible with a competitive market context. Whilst competition is increasingly used as a mechanism for improving service quality, alongside this is an emphasis on partnership working, collaboration, and networking with key stakeholders.

With the latter in mind, relationship marketing has the potential to provide a framework for exploring the key issues and informing the future strategic direction of the organisation or clinical unit. It is a way of developing collaborative working between healthcare and partner organisations, with a view to improving quality and performance.

How is Marketing Perceived in Healthcare?

Historically, marketing, like other private sector managerial approaches, has not been viewed favourably in the public healthcare sector. Clinicians, in particular, are cynical about the focus on "selling products to customers" and not services to patients. Even the language used in marketing is perceived as alien to clinicians (hence the reason the term "social marketing" has been used in healthcare to distinguish it from commercial marketing).

It is not surprising therefore, that marketing has been perceived with considerable scepticism. However, as stated earlier, marketing is increasingly one of several approaches being adopted in the public sector, alongside others, such as Japanese approaches to quality, Lean, the Learning Organisation, Six Sigma, etc.

Overcoming Resistance

It is important to promote marketing with due recognition of its limitations, for example, it is not another managerial fad or panacea designed to "fix" the problems faced by public sector healthcare organisations. Therefore, the concepts inherent in this approach have to be adapted for use in specific contexts, and this means taking account of cultural, political, and historical differences between public and private sectors.

There are several ways to overcome the resistance to or scepticism about marketing, for example:

- Raise awareness of the purpose and underlying philosophy;
- Ensure that it does not seek to displace traditional clinical values about patient care;
- Develop ownership amongst clinicians and clinical teams- change champions;
- Utilise core techniques in team building and training sessions;
- Ensure it gives due regard to evidence-based practice, that is marketing needs to be based on sound evidence; and
- Makie it clear that marketing is just one of many approaches, with emphasis on ensuring a fit with specific contexts.

Conclusion

As an approach marketing offers one way of exploring and analysing issues of central importance to the effectiveness of public sector healthcare organisations. These issues include:

- Emphasis on being "customer" or patient-centred;
- Involving patients in delivery and planning of services;
- Designing services with quality and patient satisfaction in mind;
- Identifying core attributes of services in terms of developing competitive advantage; and
- Building and sustaining long term relationships with "customers", thus ensuring survival of the organisation.

This article has only discussed two well known approaches, each with a particular emphasis and set of tools and techniques. There are many more but outside the scope of this short article. Marketing may be relevant to those occupying clinical leadership roles, given the centrality of the above issues in healthcare delivery. It is unlikely that the market context will change in the foreseeable future and indeed will become even more important, given the current economic climate and the world recession. It will be necessary to embrace a more commercial and "customer" focused approach in order to ensure effectiveness and long-term survival.

(This article is based on and acknowledges material/references used in Willcocks, S.G.(2008)Clinical leadership in UK healthcare: exploring a marketing perspective, Leadership in Health Services, 21, 3)

Figure 1. Relationship process

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CONCEPT MAPPING FOR HEALTHCARE ORGANISATIONS IN THE 21ST CENTURY

Marketing/Outreach, Persuasive Messages, and Theory Building

By Michael Hall

The marketing and outreach for healthcare organisations in the 21st century will face many of the same challenges faced by marketers of commercial services and products. The media used by potential end users of healthcare, hospital, allied healthcare, wellness programmes, and the like are shaped by the Internet, social networking, and a growing distrust of traditional marketing messages. Nonetheless, the outreach programmes of all of these healthcare organisation types must still contain content that is potent enough to persuade potential end users of services that the organisation is oriented to "them".

No matter whether the medium is a Google banner ad, a social networking link, a YouTube video, or all of the above, the message must be persuasive enough to move the potential end user to action. The content must be informative and must create the strong intention to act on the message, use the service, or move the end user to seek a referral from a provider.

The presence of a mix of health insurers in European marketplaces means the persuasive message must also be placed well on whatever the medium may be, now or in the future. Consequently, persuasive messages cannot be well served by creativity alone. Nor will the presence of focus group data alone be sufficient to guide the content. A combination of measurement, focus group data, and an ability to adapt the content as the market changes will also be required.

Using communication theory and sound methodology will be the real tools to cope with the changes in the marketing environment faced by healthcare in the 21st century. This kind of approach has shown success when operationalised well. Yet, as Aggleton points out, the success of healthcare messages must be judged by behaviour change and behavioural change must be preceded by the intention to act.

Singh and Smith have investigated advertising in the prescription drug market for this very reason. They research product knowledge, behaviour regarding prescription drugs, and behavioural intentions. They found that behavioural intentions are influenced by brand awareness and feel empowered when messages about such products are directed at them. Importantly, they suggest that their findings mean that the quality of advertising of these products along with other important factors influence consumer motivation to purchase.

Using communication theory and sound methodology can also improve theory building. To have theory in the context of marketing, communication, and behavioural intention involves a theory of the mind, according to Braithewaite, et al. Building theory about communication and persuasive messages in healthcare can inform decisions about content, placement, and related outreach/marketing decisions. Theory of this kind can also position the healthcare outreach professional for changes in the environment and in the minds of end users in order to adapt as circumstances change.

The intention of this study is to illustrate how the sound methodology of concept combined with direct magnitude estimation (DME) can be the basis for creativity in message formation, focus group informed content, and the individual consumer orientation important in creating behavioural intentions to purchase.

Marketing and Outreach

Literature on marketing combines the traditional aspects of marketing such as advertising with outreach. In fact, in practice both need content for delivery. The delivery process often is done through various forms of media, including print, internet, television, and radio. In healthcare, hospitals, clinics, allied health facilities conduct both. Hospitals market image, community commitment, quality providers and staff, and the like. Hospitals, clinics, dental providers, behavioural health providers, physical therapists, and others perform community based screen and programming which is marketed as outreach. Drawing from the extant literature in these areas provides best practices, analysis of product knowledge research, purchase intention, and in healthcare in particular, behavioural change to seek treatment, stay in treatment, perform self screening, and other intentions regarding prevention.

The messages to deliver visibility, image, and product knowledge must have the content necessary to create product knowledge. The generation of intention must also be part of the content and its delivery. Consequently, the content must be extraordinarily strong to create both results for marketing and outreach.

The use of traditional media, such as newspapers, is often chosen because it is straightforward and generally well understood by hospital or other healthcare facility "marketers". But consumers or patients are becoming even more complex. Using creativity alone to trigger product knowledge and intention to act is likely to lead to rather expensive trial and error at best. Even if the placement of ads is somehow traced to increase in patient volume or revenue or other such "counts" rather than measure-

ments, which is methodologically inaccurate unless patients are researched for exposure to any ads from the organisation, there remain several questions about the marketing. They would be:

- What elements of the message "worked"?
- How much exposure to the message was enough to make it "work"?
- Can the message effects on product knowledge and intent to act be replicated?

Equally important to message content is that there may be content material available from those managing and delivering the healthcare services, prevention screenings, and outreach programmes "hidden" from those in charge of marketing. Ohsawa and Ishii discovered this problem in their research: product designers' concepts are hidden from those inside and outside of the company. Yet, it was the designers whose concepts were more closely aligned with brand identity. The designers in the Ohsawa and Ishii research are analogous to providers, nurses, wellness trainers, and other direct care personnel. Providers are closer to the patient and more often so, than marketers. Thus, they are more likely to be able to understand the dimensions of the psychology of patients than marketers are. Nonetheless, the concepts reported by providers are unlikely to be systematically gathered.

Persuasive Messages

The creation of persuasive messages for marketing and outreach requires being systematic, methodologically sound, and in touch with the "market". The psychology of market members is the territory that must be understood or mapped to create the results in the areas of product knowledge and intent to act on the product knowledge. Persuasion refers to any attempt to reconfigure belief, intention, attitude, and/or behaviour.

Kang and Cappella have researched the impact of emotions on message effectiveness in public service announcements. They were seeking ways to increase the effectiveness of such messages. They report that once several discrete emotions, i.e., concepts, were uncovered they turned out to be more "persuasive" than some others. Finding such emotions was determined to increase message effectiveness.

Attitudes do not exist in linear alignment. There are dimensions of consumer psychology. Jewell and Unnava note that the dimensions of attitudes research has been "fruitful". The consideration of dimensions of attitudes is important in the development of advertising or persuasive messages. Based on the dimensions of psychology research, then, recognising the dimensions of attitudes must be considered in developing marketing messages.

Theory Building

Coltman, et al., point out the importance of relying only on "reflective" measurement in building theory for marketing and business. Their work is applicable to marketing of healthcare. They note that practitioners and researchers will both benefit from developing constructs and measurement useful enough to bring theory to practical use.

Measurement and methodology combined will yield the kind of constructs necessary to build theory for marketing, advertising, branding, and other persuasive messages. Psychological dimensions should be added for the theory to have practicality.

Concept Mapping and Direct Magnitude Estimation

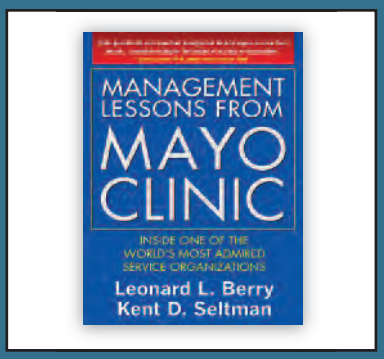
A promising approach to achieving all of the necessary elements of marketing, i.e., message content, dimensions of consumer psychology, and theory building is Concept Mapping combined with Direct Magnitude Estimation. Concept mapping using direct magnitude estimation applies both focus group and measurement data analysis to create a diagrammatic representation of the concepts gathered from consumers through open ended interview questions and follows the analysis of those questions with a perceptual measurement questionnaire based on the answers given in the interviews.

There is a great deal of literature on the concept: Bigne, et al describe the technique as cluster analysis using multidimensional scaling and Stanton and Lowenhar illustrate how concept mapping allows interpretation of complex stimuli, e.g., marketing messages, on consumers. Shewchuk and O'Connor have applied concept mapping to healthcare marketing directed at the elderly. Their method can inform

***Books** in Review

Management Lessons from Mayo Clinic: Inside one of the World's Most Admired Service Organizations

Leonard L. Berry and Kent D. Seltman



Management Lessons from Mayo Clinic reveals for the first time how this complex service organisation fosters a culture that exceeds customer expectations and earns deep loyalty from both customers and employees. Service business authority Leonard Berry and Mayo Clinic marketing administrator Kent Seltman explain how the Clinic implements and maintains its strategy, adheres to its management system, executes its care model, and embraces new knowledge – invaluable lessons for managers and service providers of all industries.

Drs. Berry and Seltman had the rare opportunity to study Mayo Clinic's service culture and systems from the inside by conducting personal interviews with leaders, clinicians, staff, and patients, as well as observing hundreds of clinician-patient interactions. The result is a book about how the Clinic's business concept produces stellar clinical results, organisational efficiency, and interpersonal service.

By examining the operating principles that guide every management decision at this legendary healthcare institution, the authors:

- Demonstrate how a great service brand evolves from the core values that nourish and protect it;
- Extrapolate instructive business lessons that apply outside healthcare;
- Illustrate the benefits of pooling talent and encouraging teamwork;
- Relate historical events and perspectives to the present-day Mayo Clinic; and
- Share inspiring stories from staff and patients.

marketing of healthcare. It can also be used for outreach programming. Trochim, et al., applied concept mapping to public health. They were seeking information to improve public health and to find data for addressing some of the challenges in public health.

Directed Magnitude Estimation

Direct magnitude estimation (DME) provides additional information to concept mapping methodology. DME information becomes important in the analysis of concept maps providing additional mathematically based information for the interpretation of the resulting map and the selection of concepts from that interpretation to be used in marketing messages. Importantly, using DME allows additions to the map as subsequent data become available.

The concept mapping methodology combined with DME can assist in interpreting how important a concept or product attribute is to a potential patient, doctor, or healthcare administrator. The product attribute is placed in distance contrast to a criterion. The respondent is, therefore, asked to determine how far apart or different a product attribute is from another product attribute using the criterion. In doing so, the measurement of product attributes or concepts is following the well established measurement principle of a reference.

DME Based Concept Mapping

The DME Concept mapping methodology adds to the traditional focus group research and follows the patterns of open-ended questioning of other marketing concept map developers. As in a focus group, researchers choose potential market respondents. Respondents are asked a series of open-ended questions intended to solicit important product attributes and/or concepts.

The responses from the open-ended questions are then analysed through cluster analysis software to determine frequency of responses but, more importantly, co-occurrence of responses. In doing so, this part of the analysis is applying a form of neural network analysis or pattern analysis. That is to say, respondents' answers to the open-ended questions are counted but are also analysed for how respondents are thinking about the concepts. The analysis is seeking to examine how respondents connect their thoughts about the product's attributes.

Once the software has analysed the concepts in this fashion, the researchers are able to determine clusters of concepts. The clusters are then used to develop a series of seven to ten key product attributes or concepts. To these product attributes are added the two key concepts of the product itself or, in the case of coordinated care, the service, and the respondent/customer, referred to in DME concept mapping methodology as the self. The key concepts/attributes, along with the product or service, are arrayed in pairs one against the other.

The respondent is then asked to apply the DME based measurement by indicating the distance or dissimilarity perceived between each pair after being given a related concept pair as the reference point.

Part two of this series (Issue 2 2010) will put the theory into practice with some working examples of concept mapping.

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SUPPLIER RELATIONSHIP MANAGEMENT IN PRACTICE **(SRM PRACTICE)**

Changing Business Environment of Hospital Purchasing Departments

By Tobias Mettler and Peter Rohner

The structural transformation of modern societies (e.g. aging of population, mobility), as well as continuously increasing market dynamics (e.g. mergers, technological advancement) induce healthcare organisations, more than ever, to reduce their costs while enhancing service delivery at the same time. Although labour costs constitute the major share of the total costs of a medical treatment, there is still a high economic potential in improving expenditure on products and services.

Supplier Relationship Management (SRM), understood as an approach to systematically managing an organisation's interactions with the companies that supply products and services to it, can help to reduce costs and enhance quality of service delivery. However, since hospital buying agents were only expected to attain the best price for the needed goods in the recent past, the trust between the buyer and the supplier is weak and the relationship is antagonistic. Therefore, and in contrast to industries with intense competition like for example the automotive or the consumer electronics industry, SRM has not yet received much attention in healthcare academia and practice.

Although the adoption of electronic services saves the costs of the preparation and transmission of paper requests and invoices and eliminates costly, time-consuming errors from manual data entry by connecting ordering systems with production systems, only 38 percent of the German hospitals implemented an electronic purchasing order and 35 percent an electronic invoice. In Switzerland, the origin of the authors, no such evidence exists so far, but considering the similarities between the health systems the adoption rate should be more or less at the same level. This ratio is diminutive compared to the aviation industry where 85 percent of the organisations actively use e-procurement in their daily business. Between 35 and 40 percent of hospital supply related costs are caused by handling and processing material and purchasing orders. In competitive industries this amount is less than 10 percent.

Some evidence suggests that this is going to change. To some extent hospital purchasing departments already are stipulated to contribute to revenue increases and to knowledge acquisition. Hence, the role of the supplier who was formerly considered to be an opponent (e.g. within price negotiations) will change to a business partner who contributes an added value to the hospital and therefore needs to be better involved in terms of cooperation, coordination, and communication.

Services for SRM

As we believe that SRM consists of both technical and social components, a holistic approach is needed. On the one hand, our process framework for SRM consists of the prevalent business and management processes to handle supplier relationships:

- Governance, i.e. development and implementation of a sourcing strategy, monitoring and controlling of the defined targets and work practices, and reaction and change of plans in case disruption;
- Strategic sourcing, i.e. initiation, negotiation and stabilisation of a supplier relationship; and

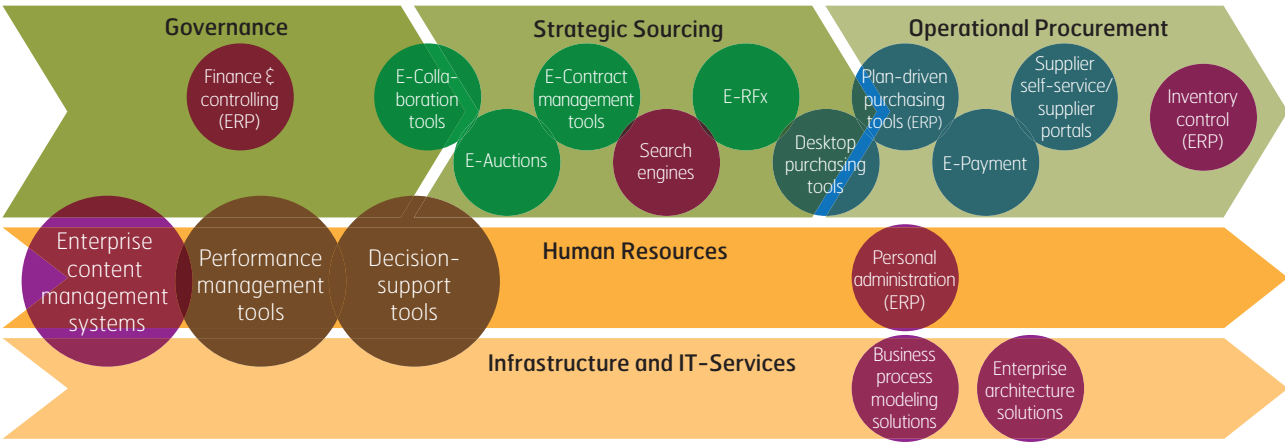

Figure 1. Process Framework for Supplier Relationship Management in Hospitals

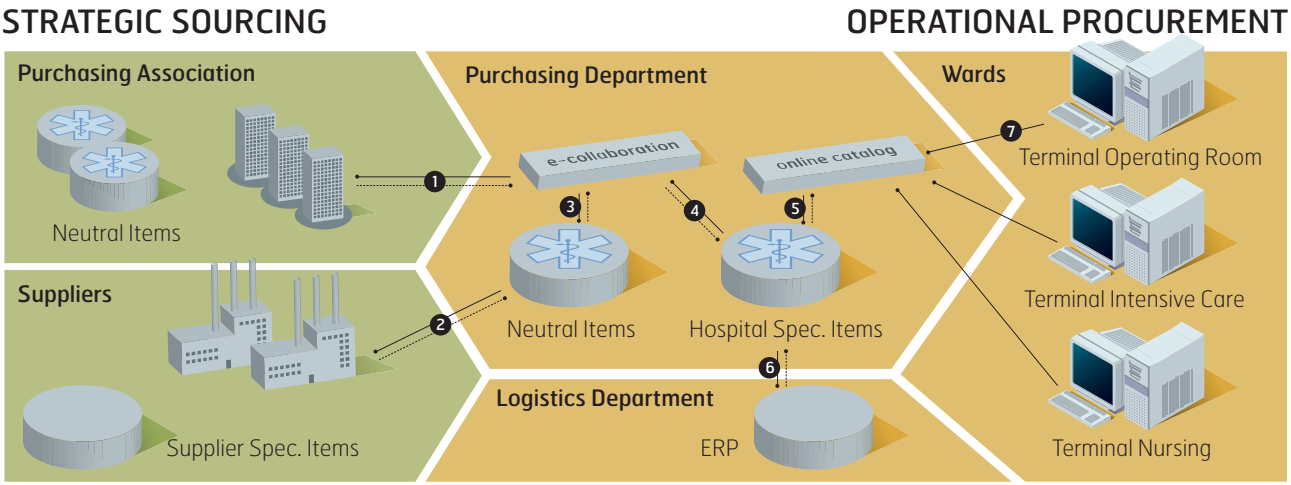

Figure 2. Implemented SRM-Tools

- Operational procurement, i.e. determination of the needed goods, ordering the requested goods, and settlement of trading.

On the other hand, the framework includes supportive processes that are crucial for social and technical networking:

- Human resources, i.e. recruiting of new professionals, development of the present staff, evaluation of the capabilities and performance of the present staff, and reward in case of satisfactory performance; and
- Infrastructure and IT-Services, i.e. documentation of enterprise architecture, alignment of IT capabilities with business needs, optimisation of information and material flows and renewal of the infrastructure.

Software services for SRM are used to process and disseminate information within and between organisations and thus support the accomplishment of the defined processes. However, people are still needed to make sense of the processed data and to 'integrate' the information of non-digital channels (such as voice communication by telephone or typing of hand-written forms).

For Customer Relationship Management (CRM), that is technical and social capabilities that help a hospital manage customer relationships in an organised way, different types of computer-based information systems exist (e.g. patient database). Comparably, there is also a differentiation in SRM.

Analytical SRM (brown circles, figure 1) aim at storing, analysing, and applying knowledge about suppliers and personnel dedicated to manage the supplier's relationship. For this, typically performance management and decision support tools (e.g. business intelligence, on-line analytical processing, statistical tools, data warehousing, data mining) are used.

The purpose of collaborative SRM (green cicles, figure 1) is to improve the quality of supplier collaboration, and, as a result, increase supplier performance and reliability. E-Collaboration tools (e.g. collaborative forecasting and planning), E-Contract management tools, E-Auctions, E-Tendering, and E-RFx tools (e.g. electronic request for information, quotation, and proposal) fall into this category.

Operational SRM (blue circles, figure 1), commonly referred to as E-Procurement, includes all necessary tools for ordering and conclusion of a contract such as payment, invoice verification. Typical examples are plan-driven purchasing and desktop purchasing tools (e.g. E-Catalogue), E-Payment, supplier self-service, and supplier portals.

Alongside analytical, collaborative, and operational SRM, other tools are needed (pink circles, figure 1) to support activities, which are not in the core of procurement. For instance, search engines to retrieve all kinds of internal and external information related to sourcing, inventory control systems to build the crucial bridge to the logistics department and requester of goods, business process modelling and enterprise architecture solutions for visualising, simulating and analysing different structural aspects of the purchasing department, personnel administration systems for managing workforce related information, finance and controlling systems to define targets and supervise the achievement of objectives, enterprise content management systems to dispense all kind of documentation or enterprise resource planning (ERP) systems that include application modules for the finance and human resources aspects of a hospital.

SRM in Swiss Hospitals

The implementation of SRM in Swiss hospitals is still in the fledgling stages. Therefore the case study at hand simply presents a first field report. Nevertheless, it can provide guidance for other hospitals when implementing SRM and helps to get a better understanding of the importance of SRM in day-to-day business of a purchasing department.

With an average of 31,000 inpatient and 161,000 outpatient treatments and about 4,800 employees the hospital under study is one of the largest in Switzerland. Every day, 950 orders were handled by the purchasing department, either by phone or by fax. So, the great part of a buying agent's labour time was used to (manually) process these orders. In 2006, the purchasing department manager decided to implement SRM as an organisational and technical response to the actual drawbacks. Thereby two major objectives should be attained: first, cost of supplies should be reduced through better prices and second, not only should the procurement process be optimised but the overall logistical processes

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from ordering to in-house delivery in order to actively contribute to the health service delivery of the hospital.

Strategic Sourcing: Enabling Demand Pooling Through E-Collaboration

In order to accomplish the first objective and because of the close margins for price negotiations of a single hospital, a purchasing association (with three other hospitals) was founded. One major problem, however, was the comparison of products, prices, and suppliers since they had differently administered master data. In order to make the data comparable and to pool the demand of the four hospitals for the joint sourcing of defined materials, a common terminology was needed (see figure 2, relationship 1).

However, the development of a proprietary terminology can result in a lengthy debate about field names and properties, etc., and boost the cost for deployment and maintenance. Therefore the purchasing managers decided to implement an off-the-shelf, e-collaboration tool that classified items neutrally, and free of manufacturer-specific terms (relationship 3). Thereby the transparency about product prices, trade allowances, and consumption was enhanced. Today, this improved information basis is actively used when negotiating with suppliers (relationship 2). At the same time, the implementation of the e-collaboration tool lead to a simplification of the structures of the product master data and to a reduction of the cost for administration as this is done by the software-producer.

Operational Procurement: Use of an Online Product Catalogue for In-house Ordering

With the aim of optimising efficiency of the overall logistical processes two major deficiencies were addressed within the project. First, to ease the buying agents of unprofitable work (e.g. to manually process the incoming paper-based orders from the wards) the ordering procedure was automated as much as possible. Thus, the entire in-house ordering procedure was outsourced to the wards (relationship 7). For this purpose, an online product catalogue was implemented, which contained all product data with the hospital-specific denomination of the items (relationship 5), since this was one of the key requirements to ensure the acceptability of the new solution. To guarantee the consistency of the neutral, as well as the hospital-specific product master data, a synchronisation mechanism between the two databases was needed (relationship 4). On the other hand, simplicity of handling was another essential requirement. For this reason, the whole ordering procedure on the part of the wards had to be effected on a simple web browser.

Second, to enhance the overall logistical process, an interface to the ERP system was implemented (relationship 6). As the incoming goods are registered in the ERP, an important feedback loop for the sourcing process was automated which formerly was done by hand. Due to better information about the reliability of suppliers, stock management was improved and the delivery of the needed goods was accelerated. However, another essential feedback loop – the factual use of the requested material within the medical treatment – still remains unconsidered.

Resulting Benefits of the Project

By implementing the above mentioned SRM-tools several benefits for both the purchasing department and the wards have been generated:

- With the constitution of a purchasing association (and with the corresponding implementation of the e-collaboration tool) data quality is enhanced and transparency of prices and variety of products of the different hospitals is obtained;
- By using off-the-shelf software for communication with suppliers unnecessary media breaks were eliminated;
- Due to the implementation of an interface between the online catalogue and the ERP, the parts of the process (from ordering to the registration of incoming goods) could be digitised, thus media breaks are avoided again. Moreover buying agents could be deployed for more beneficial tasks. By using an online product catalogue the search for determined products is significantly simplified. Furthermore, extensive add-on information about products, suppliers etc., is available. This facilitates the comparison of products, reduces the rate of purchasing errors and enhances the order pattern. In addition, most purchasing orders can be placed within the same application by simply using a web browser. Thereby costs for education are being significantly reduced; and
- Manual ordering is cut down to a minimum. After the implementation of a desktop purchasing tool, more than 80 percent of the in-house orders are processed electronically. Hence, nursing staff has actual information concerning the status of the order and in most cases the order is placed within the same day.

Conclusions

Although today's reason for implementing SRM is mostly driven by cost-savings and efficiency increase propositions, substantial improvements in efficacy and quality in different hospital departments can be achieved. By exchanging product information with other hospitals, the purchasing department under study has made the first move to establish strategic aspects of SRM. The availability of comprehensive and up-to-date product information can definitely enhance the bargaining power of the hospital's purchasing department. By improving the in-house ordering procedures, sustainable benefits in terms of efficiency, efficacy and quality of the functional procurement were obtained, as 80 percent of the former paper-based orders are now processed electronically.

Perceptions are vital in healthcare; the opinions of the various actors are key to the success of any effort for change and industrial approaches to procurement are rather unusual. A significant success factor when implementing the new online product catalogue was its simplicity (i.e. using web technology) and the utilisation of the well-known, hospital-specific denomination of the items instead of a new terminology. Furthermore, when looking at the entire healthcare material management, most benefits will certainly emerge through the centralisation of procurement and logistics by intensification of the collaboration between the hospitals and through outsourcing of certain activities to the supplier (e.g. vendor managed inventories, cross docking). However, this will cause new problems and will need advanced knowledge of both managerial and technical nature.

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FRENCH HEALTHCARE REFORM: HOSPITAL, PATIENT, HEALTH AND REGIONS

Interview by Lee Campbell

(E)Hospital spoke to Paul Castel, Director General of Hospices Civils de Lyon and President of EAHM to find out more about the changes being made to public hospital governance in France. These changes are taking place thanks to the new HPST Law (Hôpital, Patient, Santé et Territoire/ Hospital, Patient, Health and Regions) passed in June 2009. A controversial reform involving six months of heated debate and several demonstrations in the street, Mr. Castel explains what the law entails and why it was so controversial.

Was it necessary to once again reform the hospital?

These past few years, in particular with the reform put into place by Professor Mattei, then Minister of Health and Environment, the regulations for the running of the health system have been subjected to significant upheavals. But it was necessary to go further. Due to the reform of hospital governance and the new cluster-based organisation of medical activity and especially the price setting of this activity, it was of great urgency to give healthcare establishments the right tools to increase flexibility in order to adapt to these new regulations and to fully implement the reforms already adopted these past few years.

This need for the evolution of existing regulations was moreover, largely thanks to the discussions led by Senator Gérard Larcher and his mission. More broadly speaking, the attempts by health professionals go beyond the framework of internal organisation of hospitals and call for a thorough evolution of organisation and regulation of the provision of care in this country. Therefore we can only praise the creation of Regional Health Agencies that should allow the overall organisation of care on a regional scale and also develop complementarities between the healthcare and social sectors.

How has the new law affected your hospital in particular?

It is too early to answer this question as the law was only voted in July and it is not entirely in application (it lacks in fact several important application decrees).

Is the law HPST part of Hôpital 2012? What exactly is Hôpital 2012?

The HPST law is not part of Hôpital 2012. Hôpital 2012 is in fact a project linked to the revival of hospital investment in France. The law HPST is a law requested by the President of the Republic, Nicolas Sarkozy, to modernise and simplify the running of hospitals and to improve patient access to care.

Was the law passed easily or was it met by opposition at an early stage?

The preparation of the law HPST forced large debates among both the political class and the general public. The French are very attached to their public hospitals; they recognise unanimously their quality, efficiency and also the public service values they incarnate: equality of all patients, round-the-clock care, excellence in research... As HPST is a major law

What is the HPST law?

HPST is the acronym for Hopital, Patient, Sante, Regions or Hospital, Patient, Health and Regions in English. It is also commonly referred to as the loi Bacehelot as it was prepared at the end of 2008 by the Minister for Health Roselyne Bachelot. Promulgated 21 July 2009 the law aims to guarantee a better and equal access to care for all French people.

The bill consists of four main themes as indicated in its name. It is about modernising hospitals giving them more financial resources to carry out their services, reorganising structures and guaranteeing access to care.

1. Hospital Governance. Management is reorganised with a new board of directors, a medical commission and a supervisory council.
2. The Regionalisation of Healthcare. Regional health agencies are to be implemented centralising powers from existing agencies and bodies.
3. Access to Healthcare. The law fights against inequality and aims to combat the uneven spread of healthcare professionals across the country ensuring care is available for everyone.
4. Prevention. Focusing on ways to improve the health of young people the bill includes a total ban on selling alcohol to minors and the promotion of healthy eating.

for hospital organisation it is only natural that the French people would mobilise to express their expectations and their needs concerning hospitals and that the debates would be numerous. However, beyond the inevitable oppositions to the text, I think that the consultation that preceded this law and the debates in Parliament allowed a rich exchange on the future of French public hospitals and certainly facilitated the creation of a balanced text bringing strong and concrete answers to the problems our public hospitals are suffering from today.

Nicolas Sarkozy has said every organisation needs a strong leader, a "boss". The new law appears to reflect this with the press calling hospital CEOs "super bosses"- what new powers do CEOs have and do you think the law gives the correct tools to CEOs?

Unquestionably, the HPST law brings important innovations to alleviate the constraints weighing down on healthcare establishments and simplifies their internal and external functioning. It is about tightening the composition of decision-making bodies (Supervisory Council and Board of Directors), clarifying internal responsibilities but also the increasing medicalisation of hospital management through the development of responsibilities entrusted on the President of the Medical Board of the establishment, Vice-President of the Executive Board and to department managers. The dispositions contained in the HPST text are going in the right direction. Having only been promulgated last July and its application decrees not yet released, it is too early to measure whether HPST really provides hospitals with the tools they are in great need of today.

How do hospital directors feel about this new law?

HPST certainly does not solve all the problems in French public hospitals but the principles upon which it lies and the solutions it introduces into the health sector respond to the expectations of hospital managers for greater flexibility in the running of hospitals, for more reactivity and for more efficiency. Thanks to the consultation that preceded the drafting of the text, there are now concrete responses to the problems in healthcare institutions today. Already since December 2008, in terms of public spending, the regulations that apply to public hospitals could finally be simplified and be almost aligned with European regulations of the 6th of June 2005 Directive. Such an advance has been called for for many years by public buyers and should permit establishments to gain in responsiveness and flexibility, to make better purchases, and to construct more quickly. The management should, with this law, gain in efficacy thanks to the modernisation of management tools and moreover, thanks to the profound renovation of management boards. The HPST project also allows several interesting mechanisms designed to ameliorate the attractiveness of careers in public hospitals.

The management should, with this law, gain in efficacy thanks to the modernisation of management tools

The law applies only to public hospitals- how will this affect the relationship between public and private hospitals? Could the changes result in doctors and managers making the switch to the private sector?

One of the principal objectives of the creation of the law HPST is precisely to improve the competitiveness of public hospitals. In fact, it was of great urgency to provide them with the correct tools to increase responsiveness, efficacy, flexibility and to give them the ability to compete with the private sector, particularly in regards to the recruitment of medical personnel. Indeed, a key point of the law is without doubt the promotion of hospital careers for doctors. The law introduces, alongside the classic statutory framework, profit-sharing tools and the contractualisation of practitioners. Concretely, this means that it will now be possible for a hospital, under certain conditions, to recruit a doctor by contract and to pay him according to the achievement of pre-set objectives. It is a fundamental point designed to place value on the best practitioners, and more broadly, to attract and retain the best doctors in public hospitals.

What the Law Means for Hospitals

Example: *Hospices Civils de Lyon*

Previously the Hospices Civils de Lyon had:

- A director with directorates (about 80 persons)
- A medical committee with an elected president (40 to 60 persons)
- Executive Committee (up to 40 persons)

With the new law this will be changed into:

- A board: 7 to 9 persons from the hospital, composed of the hospital director, a majority of doctors (including the president of the Medical committee) and the rest are appointed by the hospital director. It is a consultative body, the general manager takes the final decision.
- Medical commission: elected by all doctors of the hospital. Medical commission can nominate their representatives for the board. If there is no agreement after 2 nominations, decision is taken by the general manager.
- Supervisory council (about 15 persons with 5 elected from the city, region or département, 5 persons with qualifications to represent the customers, 5 from the hospital (2 from the trade unions, 2 doctors, chief of nurse). It has less power than the previous executive committee and has only a supervisory role.

THE NATIONAL **PAEDIATRIC TOOLKIT**

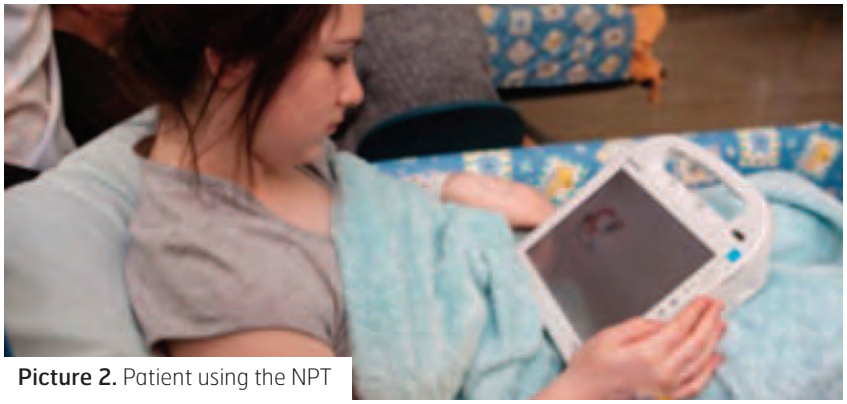
Engaging with Children, Young People and Patients with Complex Needs

By Ian Roberton

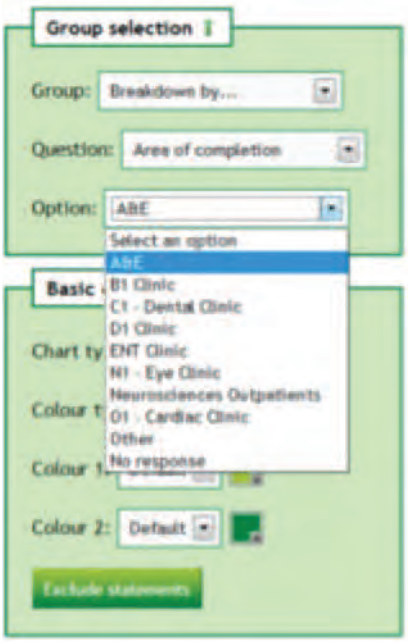
The National Paediatric Toolkit (NPT) is a unique innovation that uses animated methodology to capture the opinions and experiences of children and young people in settings such as healthcare, education and social services – in fact anywhere where the opinions of this traditionally hard-to-engage audience are sought.

The NPT is a hand-held, computer based survey tool developed at Alder Hey Children's NHS Foundation Trust, one of Europe's biggest specialist children's hospitals, designed by children for children. It features the charming Fabio the Frog and Alder Hey children have been hard at work developing his mannerisms and an army of equally charming friends!

The NPT has been developed at Alder Hey in response to the Trust's own mission for best practice engagement methodology with its young patients. In addition, with the advent of World-Class Commissioning, healthcare providers in both the primary and secondary care sectors are being increasingly evaluated on patient related outcome measures. Indeed, in 2008 health minister Lord Darzi outlined plans for the routine collection of patient recorded outcome measures (PROMs) in his Next Stage Review of the NHS. Collecting patient feedback has become a key requirement for all NHS organisations.



Picture 2. Patient using the NPT



Picture 1. The survey previewer

Background

Priority Research has been working together with Alder Hey for over seven years developing patient feedback and engagement. Following a traumatic period for the hospital, a group was set up to address the need for children and young people to be able to work in partnership with the Trust in developing services. From this initial work, the group was tasked with developing a Trust wide model for consulting with children and young people about their healthcare in the broadest sense.

Alder Hey had traditionally utilised paper-based questionnaires that were time consuming and generally resulted in poor response rates. In many cases, patients' parents completed the forms on their behalf resulting in survey results that did not reflect patients' views or experiences at all.

Having trialled a number of patient experience survey tools, which the Trust found to have too many shortcomings with their young patients, Alder Hey decided to work with Priority Research in designing their own product – The NPT.

Working with patients, families and staff over a period of three years has resulted in the development of a product which is easy to use, features animations developed with the patients, is totally inclusive and provides staff with "real time" patient experience feedback at the click of a button.

Subsequently surveys carried out across the Trust using the NPT have enabled the hospital to gain an Investing In Children Accreditation in their Oncology Department as well as providing evidence to access charitable funding streams to improve services and facilities for patients, including the employment of a chef in the same unit to provide patients with "food that we want when we want it".

The NPT

The system has been designed to be as clinically inclusive as possible. It has been tested with patients with severe head injuries, burns, spasticity, mental health issues, dexterity problems and physical disabilities and special educational needs, ensuring that many patients who would not normally be able to participate in patient experience surveys can now have their opinions taken into account.

Patients are simply handed the touch screen device and then select their answers using a finger, head pointer or the stylus supplied. They can choose the environment they want to complete the survey in (Fabio the Frog® or standard animated), the language they prefer to complete in and then press go and work their way through the questions.

The NPT has been developed to be used by patients in both primary and secondary care environments. Questions are available for three key developmental age groups: children up to nine years, young people up to 17 years and adult patients aged 18 and above. It is a patient experience survey system that has elements specially developed with children and young people for use by children and young people. The NPT also allows patient experience surveys to be run with parents and carers, staff and adult patients using different levels of questions. Each individual question is worded in five different ways – three developmental age levels as detailed above, as well as the parent/carer or staff options. It can be run online or offline in a number of different environments (including Fabio the Frog®) which respondents select from in order to complete the surveys.

There is an extensive list of templates to choose from on numerous topics from general areas such as appointments, transport, waiting and reception areas, treatment areas, wards, play and learning and entertainment, visiting, family accommodation, ward food, cafe and restaurants, confidentiality and consent, communication, information, complaints, pain management, overall experience, teenage pregnancy and sexual health. It also has specialised templates for conditions such as Sickle Cell, Renal, Oncology, Cardiology, and CAMHS. Clients can chose their own demographic data fields from GP/Consultant seen, procedure through to ethnic group and religion etc., and link the information to their own internal reporting systems.

Every question, answer and instruction has 11 language variants to choose from both verbally (to assist with dyslexia, literacy issues and Special Educational Needs) and textually. The NPT also has built in audio and visual impairment facilities to comply with DDA.

It allows patients to communicate their individual priorities for care in a way that they find simple and easy, yet provides much more detail than they could otherwise give. Using the unique Priority Search™ the NPT enables users to define patients' priorities for changes to services, which can define future strategies and spending plans. The Priority Search™ can also be used to define an individual patient's long-term care plan thus feeding into the Individual Patient Plan (IPP).

The survey previewer allows users to set up a survey with just three presses of a button. Select your preferred template and the questions you want to include, decide on the demographic groups you are targeting, and press go. There are currently 2000 questions that are continuously growing in number.

Picture 4. Touch screen device

The NPT provides real time bespoke charts and graphs and also has an automated reporting function with pre-defined commentary. A powerful chart wizard gives immediate results, allows the creation of user defined filters and includes a 'snapshot' function that provides survey results between two changeable time frames.

Conclusion

Dr. Steve Ryan, Alder Hey's Medical Director and Chair of the Children's Pathway Group describes the NPT as "a unique innovation for involving young patients in their care plans and their overall patient journey", which is fun for the children to complete and "effective in getting the essential feedback that we need to continuously improve what we do". Indeed, the NPT is the only application that specifically provides commissioners with the opportunity to respond to and improve the service experience of children, young people, BME communities, looked after children and young people, patients with complex needs, geriatric patients, all ages of SEN and other hard to reach groups both now and in the future.

Picture 3. The charming Fabio the Frog

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THE ENGLISH NATIONAL PACS PROGRAMME

Building on the Successful National Roll-out of PACS and Moving Forward with Image Sharing

By Mary Barber

Picture and archiving communication systems (PACS) are now embedded into the day-to-day work of the NHS in England. By December 2007 all hospital trusts in England were using PACS, digital imaging technology which enables x-rays and scans to be made available simultaneously at multiple locations within a hospital trust.

PACS has been helping to support major improvements in both the speed and quality of diagnosis and treatment of patients and they are getting faster, safer treatment as a result.

Now that the technology is in use across England it's easy to forget how big an achievement the national roll-out of PACS actually was. While it was a massive undertaking, involving hospital trusts across the country, it took just three years to complete.

Compare this to the fact that, prior to the national PACS programme, only 50 trusts had implemented digital imaging systems of some form, and many of these were confined to radiology departments rather than being site or enterprise-wide. It took 14 years to reach that point and of these 50 trusts, 18 eventually switched to the solutions provided under the national PACS programme.

The picture prior to the national programme was therefore very patchy, with no real momentum on a national basis to deploy PACS. The national PACS programme saw a team from NHS Connecting for Health –part of England's Department of Health - work closely with colleagues in the Strategic Health Authorities, individual hospital trusts, clinicians and their representative bodies and IT service providers to ensure that trusts were able to implement the technology, and therefore benefit from film-less working, as quickly as possible.

The national programme's collaborative approach has seen it win recognition both nationally and internationally, with many foreign health services keen to learn from our experiences.

Moving Forward with Image Sharing

Now that countrywide PACs coverage has been achieved, the national PACS programme has been working to 'join up the dots' by increasingly focusing on the safe sharing of diagnostic images and reports across trusts in order to support patient clinical pathways.

The long term ambition is for clinicians to be able to gain access to images and reports via the use of the patients' electronic care records – otherwise known as the 'NHS Care Records Service'. However, the feasibility and timescales of this depends on the roll-out of summary care and detailed care records in England, plus other factors including the wider adoption of the NHS Number (the unique patient identifier for NHS patients in England).

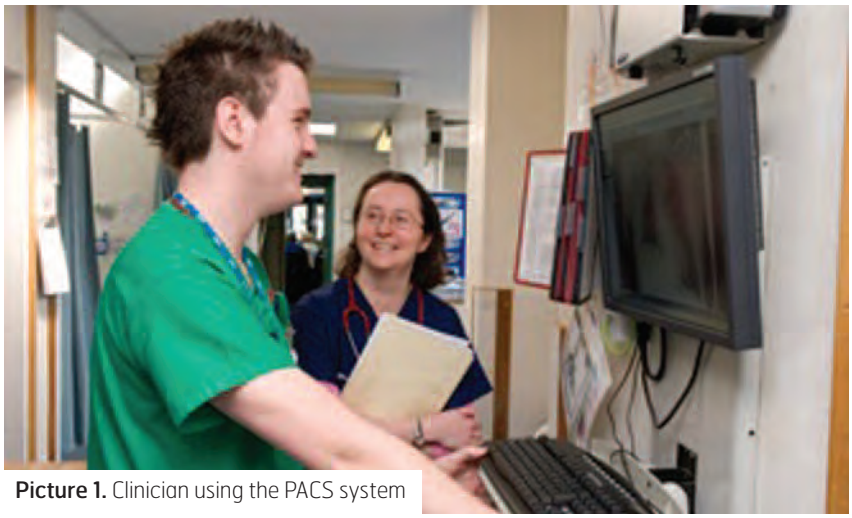
There is however a golden opportunity and a clinical imperative to share images and reports to support patient pathways in England, particularly with the growth of stroke, trauma and cancer networks, by implementing technology available today that would allow clinical staff to find, view and source diagnostic images and reports when required.

Rather than be held back by the availability of future technology, the programme has been working with its many stakeholders in a creative, pragmatic and cost-conscious way to implement solutions which meet many of clinicians' most pressing requirements now. The major advancements today are in the "View it, Source it" area and a mechanism to signpost clinicians to the trust where the patient was last treated is being investigated.

The "View it, Source it" concept is extremely straightforward. As the images with PACS are digital they can be viewed via secure web links; this is already standard within hospital trusts and can with some PACS be expanded for trust-to-trust viewing. Then, if the clinicians believe they need the 'image and report', the images can be transferred to them via a number of mechanisms. Because clinicians are choosing to look for images and reports in specific locations they can ensure they have the necessary patient consent and have a legitimate right to view the information locally.

Many trusts have been using the 'web view' facility offered by their PACS in order to view images acquired at other trusts as part of a patient's care pathway. An initiative known as the North West PACS Web Portal builds on this approach. It was conceived by Dr. Rhidian Bramley, part of the national PACS programme's clinical team and a champion for PACS both in the North West of England and nationally.

The portal provides a single point of access to the local PACS of any participating site, enabling clinicians to request remote web



Picture 1. Clinician using the PACS system

access to trusts' PACS where this supports patient care. Access requests are sponsored by the Caldicott Guardians at each organisation through an agreed data sharing protocol. Authorised users are given a PACS logon ID for the trust they wish to access and the trust firewalls are configured to allow remote access. The portal overcomes the issue of users having to remember multiple logon IDs, through an agreement whereby trusts cooperate to provide each user a single unique user login ID for all PACS access via the portal.

Using the portal, clinicians can review images and reports remotely but also arrange point-to-point transfer of images where further analysis is required.

As of today, the portal has 44 participant trusts, most of which are in the North West and West Midlands, although interest further afield has seen a number of trusts from outside the region 'sign up' too.

Being able to view the image before acquiring it for your trust reduces network traffic and volume of image transfer, however it may be that the clinician does require the image and report and this is where image routing technologies come in to play. Image routing technologies are mechanisms by which trusts can share images, and sometimes reports, with agreed and trusted partners via a hub and spoke arrangement – these have emerged as an important element in our image sharing approach. The aim is to initially link up known clinical pathways, where trusts have an agreed referral pattern. It is felt by a number of clinicians that, equipped with a web viewing tool and an image router, they would be able to meet the majority of clinical requirements supported by data sharing.

In London, for example, the programme has been rolling-out a system called PACS Exchange, which enables the hospital trusts' existing PACS to post images to and access images from a centralised point.

So, if one London trust refers a patient to a different London trust for a specific scan, all the relevant x-rays and images can be called up on PACS. The referring trust simply searches for their patient, highlights the images needed and selects PACS Exchange on the menu to send them to the receiving trust.

Images are sent to one of two folders on PACS Exchange – the 'emergency folder' or the 'elective folder'. Images in the emergency folder are available for 18 hours, and images in the elective folder are available for eight days. The 'receiving' trust can then access the images during whatever period for which they are available.

Following successful pilots at the Royal Marsden and Mayday hospital trusts, 11 trusts were using PACS Exchange as at the beginning of February 2010, and more will follow during the course of this year. The system is starting to make a real difference, particularly to multidisciplinary team meetings, where clinicians at different trusts and sites need to discuss particular cases. The only drawback is that this solution is for London only and many patients are referred to the major London hospitals from other parts of the country. So a more nationally available solution is required.

A further image sharing initiative – one with a more national outlook - is the Image Exchange Portal (IEP). Initially conceived as a means of supporting the sharing of images and associated reports between hospital trusts and NHS-commissioned independent sector healthcare providers, NHS feedback led to the scope of the IEP to be widened so that it can be used to support image sharing between NHS trusts.

As with PACS Exchange, IEP involves the routing of images (and reports) via a centrally managed router. The service is based on an established referral relationship between the requester, sender and recipient

By the end of January there were 54 trusts and four independent sector healthcare providers able to use IEP for sending and receiving imaging studies and we are working to have 120 trusts live with the system by the end of March.

Image router solutions like the Image Exchange Portal and PACS Exchange are set to become the prime image sharing solutions within England, at least for the next few years.

Meeting Needs Now

In conclusion, solutions that allow clinicians to "View it, Source it" are meeting a need at local, regional and – in the future – national level. The missing part of the equation is "Find it" and the feasibility of including a patient's imaging history in the summary care record is being investigated. The current available solutions are helping trusts to reduce the time, cost and effort of moving images around, protecting patient information and freeing-up staff to perform other activities In the past, many of these images would have been burned onto CDs, requiring many hours of staff time. Now, electronic solutions are beginning to ensure that images and reports are safely shared electronically in a matter of minutes.

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CROSS BORDER TREATMENT: FOCUS ARZTFEHLER

Nach einer Studie von HOPE ist die internationale Zusammenarbeit in den EU-Grenzregionen auf über 300 Kooperationen angewachsen. Die vermehrte Patientenmobilität hat die EU zum Anlass genommen, eine Richtlinie zum sog. Cross Border Treatment vorzuschlagen. Erleichterter Zugang zu medizinischen Dienstleistungen und einheitliche Abrechnungsmodi standen im Vordergrund – eine endgültige Richtlinie liegt noch nicht vor.

Der Ersatz von Behandlungskosten ist eine Sache. Was aber ist „im Fall des Falles" bei Arztfehlern mit ausländischen Patienten? Was gibt es da zu beachten?

1. Welches Gericht zuständig ist, regelt die EuGVVO aus 2001 (EG-Verordnung Nr. 44/2001, (www.eur-lex.europa.eu, dort L 12 S.1) in Art. 2: „[…] in aller Regel der Sitz des Beklagten" und damit der Ort des Krankenhauses. Werden deliktische Ansprüche geltend gemacht und das Schadenereignis hat sich in einem anderen Land verwirklicht, könnte auch dort der Anspruch geltend gemacht werden (z.B. Medikamentenverabreichung).
2. Egal welches Gericht angerufen wird, richtet sich die Frage des anzuwendenden Rechts für deliktische Ansprüche nach dem „Rom II"-Abkommen, Art. 4 Abs.1: „… das Recht des Staates ist anzuwenden, in dem der Schaden eintritt, unabhängig davon, in welchem Staat das schadensbegründende Ereignis stattfand […]".
Verbindet den Schädiger und den Geschädigten z.B. ein Vertrag - das wird zwischen Krankenhaus und Patient die Regel sein - so gilt nach Rom II, Art. 4 Abs.3, das Recht des Landes, in dem die vertragliche Leistung erbracht wurde.
ZU IHRER SICHERHEIT: In der Praxis sollten deutsche Leistungserbringer das Wesentliche bereits im Behandlungsvertrag festzurren. Darin ist die Verwendung ausschließlich deutschen Rechts und die Zuständigkeit deutscher Gerichte gleich mit aufzunehmen. Alternativ bieten sich Schiedsgerichtsklauseln an, die auch außerhalb Europas gelten (Risiko US-Patienten!).
Der Umfang zumindest der Rechtsschutz- und der Betriebshaftpflichtversicherung hinsichtlich der Auslandsdeckung sollte überprüft und gegebenenfalls angepasst werden.

CROSS BORDER TREATMENT: FOCUS MED MAL

What if a medical malpracitice occurs?

1. The court of justice in charge is governed by the EC regulation No. 44/2001 on the jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (cp. www.eur-lex.europa.eu, see: L 12 p.1): "[…] the domicile of the defendant", hence the domicile of the hospital. In case of tortious claims being made and the damaging event occurred in another country, the claims may be forwarded in that country, too (e.g. medication).
2. Irrelevant of the court in charge, the applicable law is regulated by Art. 4 sub.1 of the "Rome II"-Agreement: "[…] the law applicable shall be the law of the country in which the damage occurs irrespective of the country in which the event giving rise to the damage occurred […]".
In case the tortfeasor is bound by contractual provisions to the claimant, which is rather often the case between hospitals and patients, Art. 4 sub.3 states that these bounds always take precedent - the law of the country where the services were provided is applicable.

HEALTH PROVIDERS BE AWARE: As early as in the contract of medical treatment, the exclusive application of national law and jurisdiction of national courts should be tied down. Alternatively, arbitration clauses can be taken into account as they enjoy validity outside of Europe (risk with US patients!).
The extent of the cross border cover of your legal protection insurance and your public liability insurance should be assessed and where needed amended.

ECCLESIA Group, Detmold (Germany),
2/2010 : mildenberger, dammann, jaklin

OVERVIEW OF THE GERMAN HEALTHCARE SYSTEM

The new Federal Minister of Health, Philipp Rösler (Free Democrats), is a doctor. This is a good precondition for understanding the complexities of the healthcare system and for appropriate decision making. It is, however, not only the Federal Minister who influences the development of the health system, but multiple interest groups and important demographic, medical and economic changes.

The German health system is divided into an insurance sector with public and private insurance funds, and a healthcare sector. The healthcare sector covers a range of services and departments, including ambulatory outpatient care (provided mainly by individual doctors at their offices), pharmaceutical care distributed by pharmacists, inpatient care in hospitals and rehabilitation clinics, and a nursing care sector (caring for the increasing elderly population).

It is the complex network of interest groups that form the connection between this structure and the political arena. The 2000 hospitals, for instance, are represented by the German Hospital Federation, Deutsche Krankenhausgesellschaft. These interest groups act as legitimate partners of the political and democratic process in opinion and decision-making.

Insurance Sector and the Central Health Fund

There are 82 million people living in Germany; 85 percent are insured by statutory insurance funds, 11 percent by private insurance funds, and four percent are supported by different institutions or pay out of pocket. In Germany 250 billion euro is spent each year on healthcare, 10 percent of the gross domestic product. In international comparison, Germany ranked third in healthcare spending compared to GDP, following France with 11 percent and USA with 16 percent. The United Kingdom ranked fourteenth with eight percent.

Since January 2009 a central health fund collects and distributes the money for statutory insured people, in total 50 million members and 20 million relatives. The fund gets its financial volume of about 174 billion euro (2010) largely from member payments. Currently, the employer of a member pays seven percent of the gross income of his employees. The employee pays 7.9 percent. Before 2009 insurance rates differed according to the fund, but today all rates are standard. Since 2004, funding also comes from the federal budget, supplementing 12 billion euro per year, and an expected increase to 14 billion euro in 2012.

At an income level of 4,162.50 euro per month (2010) an employee can switch to a private insurance fund. If one chooses to use a private fund, only under certain conditions such as job loss can he or she return to be covered by a statutory fund. Relatives, partners and children need an additional private insurance. If employees exceed this level they are under no obligation to leave the statutory fund. Such members pay 14.9 percent, including the employers´ fee only up to 3,750 euro per month (2010). Relatives, partners and children, are insured for free.

There were 170 insurance funds in Germany at the end of 2009. Their income from member payments goes directly to the central fund to be redistributed to the insurance funds according to specific morbidity criteria. These compensational payments reflect the population that each fund serves. Some funds for instance have a higher portion of elderly people or of people with expensive diseases. The evaluation and distribution procedure works on a daily basis with administrative expenses exceeding 10 billion euro per year.

Additional Fees

If an individual fund is unable to balance income and expenses – despite the criteria and the additional money – it is allowed to claim an additional fee by its members. Without checking the income of its members, the fund may require up to eight euro per month (with a check, up to one percent of the gross income). Currently, several funds have announced to do this in 2010. The members are then allowed to quit their membership and shift to a fund without additional cost. It is predominantly young people with low health risks and people with higher income who tend to leave their fund. Rösler, Federal Minister of Health, plans to expand this possibility with the next health reform, expected in the second half of 2010.

By introducing the right to claim additional fees, the legislator wanted more competition among funds at the advantage of the insured. In total, the funds can increase their income up to five billion euro per year (eight euro per insured member per month), but at high administrative expenses of about one billion euro. Moreover, the funds have a small additional income by the doctor's office fee. This is 10 euro per quarter per patient, in total about two billion euro per year.

A fund can get into serious financial difficulties by claiming an additional fee. Therefore, the main balancing strategy of the insurance funds is to reduce healthcare costs, not only by themselves in negotiations with the providers but also by influencing legislation, to make laws curtailing healthcare providers.

23rd Congress of the European Association of Hospital Managers

Topic: Roadmap to Top Quality

09/10 September 2010, Zurich Congress Center (Switzerland)

Call for Posters

The European Association of Hospital Managers (EAHM) and the organisers, the Swiss Association of Hospital Managers, invite decision-makers, experts and researchers to present their findings, results and views gained from their projects and activities on the road to achieving top quality in hospitals at the 23rd Congress of the European Association of Hospital Managers.

Aim: To promote exchange and facilitate networking on the topics of accreditation, certification, quality measurement, patient safety, communication, quality and cost-effectiveness

Important note: The focus must be on the practical benefits for and their ability to be implemented by hospital management.

Language: English, French or German
Deadline for poster registration: 31 May 2010
Total prize fund: € 6,000

Visit our homepage for further information and the registration form:

www.zurich2010-eahm.ch

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Ambulatory Outpatient Care

Traditionally, doctors have provided ambulatory outpatient care from their offices. Legally defined, there are instances where specialised care can also be provided in hospitals, for instance ambulatory surgery, therapy for cancer patients and social paediatric therapy.

In Germany, the doctors' associations contribute their income. They are public corporations and negotiate the overall budgets for their doctors in a defined region with the insurance funds. According to the medical services and other criteria, the corporations distribute the budget to individual doctors quarterly. Before the last health reform in 2008, the services were weighted by points, or appointments per doctor. The weakness in this system was a decline of euro per point when services and points increased while the global budget remained nearly constant. Now the doctors have defined fees in euro and it seems easier for them to calculate their income. If a patient visits a doctor, the doctor on the average gets 50 euro per quarter. If the patient has more visits, the fee, however remains constant. The physician can help himself only by controlling the number of visits. In the former system there was not such an incentive.

In 2008 the doctors had 7.5 cases per quarter per insured per year. In total, this is about 500 million ambulatory cases. Each case has 2.5 appointments on average per insured (total 1.2 billion appointments). The number of patient contacts with about 18 per insured per year is the highest in international comparison. It is nearly twice as high as in comparable OECD countries. People in Sweden for instance have about three appointments per insured per year (OECD data 2006).

GP Contracts

After the last health reform the insurance funds were obliged to offer their members a General Practitioner (GP) contract. The GP should act as a gatekeeper as it is the case in many other European health systems. The members are free to subscribe to this offer, but give up their free choice of doctors and hospitals. In return they get financial advantages, such as no doctors´ office fee. The negotiation of the contracts led to great differences within the doctors´ corporations. The GP-Group is attempting to establish a main GP corporation for withdraws, but the development is not settled yet.

About 135,000 physicians work in the ambulatory sector; while 120,000 work in an office of their own, 40,000 as GPs and 80,000 as specialists. Additionally, about 10,000 doctors, mainly chief physicians at hospitals, have the right to provide services in a small and specific range of ambulatory services. In the last few years the number of medical care centres (MCC) has increased dramatically. Ambulatory care evolved into stronger organisational structures. In total, about 6,000 doctors work in MCCs, with 500 out of 1,300 MCCs in the ownership of hospitals (2009).

Care in Hospitals

The hospital sector is a powerful economic factor. One million people in 2,000 hospi-tals care for 17 million inpatient cases and 18 million outpatient cases. The turnover is close to 65 billion euro, nearly three percent of the GDP.

Inpatient cases are remunerated by German Diagnosis Related Groups (G-DRG), a system which is adapted on a yearly basis. It comprises about 1,200 categories. The main idea is that money follows service. Before the introduction of the budget effect of the G-DRG in 2005 additional patients were cost factors for a hospital. The budget was negotiated annually with a calculated number of days plus a change rate, mostly below 1 percent. If a hospital had a plus in admissions – for instance about 10 percent – it had to pay back about 75 percent of the additional income in next years´ budget negotiations. The costs of the additional treatments remained the responsibility of the hospital. These internal costs increased to a higher extent than the income of the hospital causing many efficient hospitals serious financial difficulties during that time period.

With the budget effect of the G-DRG since 2005 the remaining pay of addi-tional inpatient cases increases. Moreover, the hospital has the right to consent additional inpatient cases with the insurance funds – if there is a higher need for hospital care respectively. If the funds reject an agreement the hospital can go to the court. The remaining pay for contracted additional inpatient cases increases from 35 percent in 2005 to 100 percent in 2010.

Investment in Hospitals

Whereas the patient treatments are paid mainly by the insurance funds via G-DRG and via further remunerating fees (95 percent of the hospital budget), investments are paid by the Bundesländer (five percent). This divided responsibility has been introduced 1972 and is called the dualistic financing system. The Bundesländer are responsible for the development, planning and investment financing of hospitals. Over many years, however, the investment rate has declined from 25 to five percent. This is due to shortages of public budgets and changing priorities. The idea of hospitals as institutions with over-capacity and over-utilisation led to a political neglect of the hospital sector.

Currently, the DRG-Institute develops a comprehensive approach to hospital financing by integrating the investment components into the DRG-system. At the end of 2010 the self-government – German Hospital Federation and the Federation of Insurance Funds – shall discuss proposals of the DRG-Institute in cooperation with the Bundesländer.

Looking Ahead

The political discussion about the hospital sector in the past mainly concentrated on the "cost factor"; hospital admissions, hospital beds and how to contain costs. In recent years however, the focus has changed. The political realm is quickly realising the future challenges within German healthcare due to changing demands of society. The need for highly qualified medical and nursing care will continue to increase, our society is aging as the portion of elderly people increases, and medical innovations shall accelerate. The amount of wealth and health production by the hospital sector shall become a decisive factor in the development of modern society.

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RECENT DEVELOPMENTS IN THE GERMAN HOSPITAL MARKET

By Peter Asché

For two decades the German hospital market has seen numerous healthcare reforms. These dynamics have led to a fundamental change – and to an enormous complexity within the healthcare system. This was especially true after the introduction of the nationwide German-DRG-system in 2002. With this initiative, strategic, performance-oriented and competitive targets made their way into the German hospital market.

Today, with continual extensions in healthcare supply, the DRG-system has allowed adaptation to the changes in demand. In 2008, 17.2 million inpatient cases were registered in 2,087 German hospitals with 506,954 beds. The number of cases is still increasing whereas the length of stay is decreasing from an average of 8.3 days. The German DRG-system has more than 1200 DRG- groups and additional fees to its disposal. The mean costs per inpatient stay amount to 4,251 euro.

There is an increase in demand in both outpatient and inpatient care due to an aging demographic (25 percent of the patients are older than 75), as well as advances in the medical treatment and technologies.

Thinking in Sectors

There are legal and financial boundaries present between the different sectors of German healthcare. Outpatient treatment is provided by primary care physicians and specialists within their own practice. Their budget is administered by the Regional Association of SHI-Accredited Physicians while health insurance funds provided by DRGs cover hospital inpatient treatment costs. The DRG base rate differs from state to state, but will be standardised in the next few years.

Officials in office before the last parliamentary elections tried to open the boundaries between inpatient and outpatient healthcare. For example hospitals, now are able to establish medical healthcare centres in order to supply outpatient treatment.

From the point of view of the hospital as well as VKD, these boundaries should be made much less stringent or abolished completely in order to achieve better performance and fair competition. However, it appears that the present officials intend to keep this distinction between sectors.

Investment and Innovation

Experts estimate that in the last few years there had been a lack of nearly six billion euros in investments. This directly affects the amount of innovation within the market. Patient care units were not brought up to date and modern technologies were not introduced. Diagnostics, therapy and most of all the optimisation of work and treatment flow depend on structural investments. Without investments Germany is placed at a disadvantage in international competition, making it a priority in order to strengthen our position.

Within the last few decades, public and political discussion surrounding the healthcare market moved from "rising expenditures" to "driving economic growth". The recent economic crisis has proved the stability of the healthcare trade, including providing three to four million jobs in Germany. This contributed to the transition of public and political opinion toward prioritsing investments in innovation. This insight found theoretical expression in the coalition agreement of the new government with emphasis on strengthening innovation within Germany and the promotion of medical technology although actual growth has yet to be realised.

Lack of Qualified Employees

More and more, the labour market has become an issue for German healthcare, in particular concerning the nursing staff within intensive care and surgical. Even though the salaries have increased considerably during the last years, the attractiveness of the jobs has decreased due to the work load, increased administration and burdens of documentation.

As a consequence, in certain regions, it becomes more and more difficult to keep the human resources structure within a hospital complete. Because of this, there has been a discussion focusing on the education of nurses and physicians, their basic working conditions, and the attractiveness of such careers.
If the demand for medical and nursing care services is greater than offered, the working time of medical specialists and qualified nurses should be used exclusively for activities in which their special competences are required. Many theoretical models and practical projects have focused on reduction or shifting of workload, from tasks that aren't closely related to the job outline to those that concentrate on key skills.

Consequences

German healthcare faces challenges in adapting the existing system to current demand. An increase of investment will lead to optimisation of work flow, which in turn becomes added-value by employees.

The competition in the healthcare market will become an issue due to an increased demand of medical achievements decreased amount of available public funding and qualified personal. Alternatively, competition will lead to enhanced networking with other healthcare sectors and more efforts in marketing and quality management. It will become pertinent to establish lean structures and optimise the net product in hospitals. With competition one must adapt, replacing uneconomic structures.

The German hospital market is prepared for these challenges. Whether and how politics will make concessions to the economic and socio-political issues within the hospital market remains to be seen.

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GERMAN MEDTECH PRESENTS 10-POINT-PLAN

TO STRENGTHEN ALLIANCES FOR MEDICAL PROGRESS AND QUALITY

By Manfred Beeres

In Germany healthcare spending in the medical technology sector amounts to more than 23 billion euro. The medical technology industry employs 170,000 people in more than 11,000 companies in the country.

Outstanding Innovative Capability

The medical technology industry is dynamic and highly innovative. German medical technology manufacturers achieve approximately a third of their business volume with products that are less than three years old. The researching companies in the medtech sector invest an average of about nine percent of their sales revenues in research and development.

10 Points for Providing Patients with Advanced Medical Technology

BVMed has published a "10 point plan" for the care of patients with advanced medical technology" as discussion points for the health policy negotiations of the new government.

1. The quality rating of medical devices must be demonstrated by means of a CE-Med quality mark
The CE quality mark for medical devices differs from that for other products in that it does not only guarantee the safety of the product, but in addition stands for a proven performance capability. A distinctive CE-Med quality mark should, therefore, be introduced for all medical devices.

2. Access to medical-technical innovations should be designed to be unbureaucratic and flexible
In order to enable patients to gain more flexible and faster access to medical-technical progress, BVMed suggests simplifying and deregulating the remuneration of new examination and treatment methods (Neue Untersuchungs- und Behandlungsmethoden, NUB) within the Statutory Health Insurance (SHI).

3. It must be possible to introduce medical-technical innovations into hospitals without restrictions
When launched onto the market, many medical-technical innovations are first used in hospitals because these have suitable staff and adequate technical infrastructure. This process must be continued in order to make innovative medical technologies available to all patients in Germany who need them, without delay. If similar structures exist in the outpatient sector, the same procedure should be possible for this sector as well.

4. We advocate an innovation pool to accelerate the introduction of medical-technological innovations into the SHI
Medical-technical progress should be made available to patients as soon as possible. At present, it takes up to four years to assure adequate remuneration. In order to accelerate the introduction into the SHI service catalogue, funds should be paid by the SHI into a so-called "innovation pool" to be used for the purpose of medical-technical innovations. The inclusion of additional funds, e.g. from research funding, should be considered as well.

5. We campaign for a tax-advantaged innovation savings scheme (Steuerbegünstigtes InnovationsSparen, SIS)
There is great demand for additional services outside the range of the SHI service catalogue. In this context, we suggest granting tax privileges for savings schemes in the healthcare sector, similar to those for the pension savings scheme "Riester-Rente". This would create an important incentive to make provisions in time, especially for younger people. Certain innovative and desirable services that exceed the care provided by the SHI benefits would be supported. Such optional schemes increase the freedom of choice for patients.

6. We consider health services research a useful and necessary joint task for all players in the healthcare system
Health services research is the basis for decisions that are relevant to health and can increase the planning assurance for all those involved in the healthcare system. Actively involving all players in the healthcare system in the process is important if health service research is to be generally accepted.

7. Cooperation between medical institutions and industry is desired and essential for the improvement of patient care
An idea for a device or procedure is often jointly realised by physicians and the engineers in the companies. The cooperation leads to excellent products. Together with its partners in the hospitals and among physicians, BVMed has been working for many years on providing a secure and transparent basis for the necessary cooperation in the healthcare market. This includes extensive information and advisory services.

In the area of medical care, profitable cooperation takes place between companies, service providers, SHI-physicians, hospital physicians, hospital operators. This is now being restricted unnecessarily by the amendment of section 128 Social Security Code V (SGB V). Regarding this situation there is urgent need for action.

8. Emphasis must again be on the quality of medical devices (e.g. regarding aids and appliances). Patients must be able to freely choose their service provider and their products
The medtech companies recommend a competition for the best quality in medical care, not for the lowest price without consideration of quality and qualification. Therefore, we advocate developing and establishing criteria for a proper quality competition in cooperation with the health insurance funds, in order to counter the trend towards cheap medical care.

9. Homecare should become a regular part of SHI
Six million people in Germany use aids and appliances supplied by homecare companies – and the number is rising daily. We live in a soci-

ety where people are getting older and older, not least thanks to medical-technical advances. Older patients mostly have several chronic diseases. Changes in hospitals mean that they are transferred to ambulatory care as soon as possible. Homecare companies have been successfully meeting the challenges this poses for years. Trust and professional counselling require that services are provided close to home. Therefore, the patient should be entitled not only to the product (medical device) but also to comprehensive homecare treatment.

10. Telemedicine should become part of regular care
E-Health, telemedicine and telemonitoring by means of medical technologies and the required networking lead to better, safer, optimised, and more cost-effective care and must therefore become part of standard care.

Information Campaign on Healthcare Compliance

Another important issue for hospitals and the medtech industry is healthcare compliance. The medical technology companies and their trade association BVMed seek to provide orientation with a new information campaign called "MedTech Compass" to promote transparent and good cooperation between industry, medical facilities and physicians. The "Compass" uses its own website (www.medtech-kompass.de), an informative flyer, regular newsletters, e-learning tools and films to advocate the existing recommendations for cooperation in the healthcare market, with the help of clear principles and real-life examples.

Cooperation Between Industry and Hospitals as Innovation Motor

This topic is particularly important for Medtech companies and hospitals, since the cooperation between medical facilities, physicians and industry is a prerequisite for medical advances. Together with partners in the hospitals and the medical profession, the Medtech companies in Germany have endeavored for many years to provide a secure and transparent basis for cooperation in the healthcare market.

In order to offer clear recommendations for an effective and transparent cooperation the "Medical Device Code of Ethics", the "Common Viewpoint" and numerous model contracts have developed in Germany.

Four principles as "pillars" of healthcare compliance

The basis of an effective and transparent cooperation between industry, medical facilities and physicians are the following four principles:

- **Separation principle:** We advocate the strict separation of donations, benefits and sales.
- **Transparency principle:** Every donation and reimbursement received must be disclosed.
- **Equivalence principle:** Performance and recompense must have a reasonable relationship to each other.
- **Documentation principle:** All services must be documented in writing.

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Willy Heuschen

RÉORIENTATION DE L'AEDH

L'année 2010 sera importante pour l' AEDH. Tout d'abord le 23ème Congrès de l'AEDH à Zurich intitulé « Une feuille de route pour la qualité » nous permettra de poursuivre nos travaux sur ce thème. Pendant le séminaire de l'AEDH à Düsseldorf en 2007, nous en avions fait le point central de notre travail et le démarrage pour l'élaboration de normes européennes de qualité pour les hôpitaux. Le prochain congrès verra sa continuation grâce à notre participation à un groupe de travail avec de semblables organisations originaires d'autres pays européens.

Au cours du congrès 2010 se termineront les mandats de l'actuelle présidence et du conseil d'administration. Il est temps de faire le bilan, d'identifier les perspectives pour les quatre prochaines années et de désigner les trois principaux thèmes. Outre la question déjà mentionnée de la qualité, nous nous sommes consacré au problème de la gestion d'un hôpital ou « corporate governance ». À la suite de l'enquête et des perspectives ouvertes par le travail théorique du Prof. K. Eeklo (UCL-Louvain, Belgique), cette problématique reste à l'ordre du jour de notre conseil scientifique.

Lors du précédent séminaire de l'AEDH l'année dernière à Düsseldorf, les conférenciers – vous êtes invités à consulter le compte rendu dans ce numéro - ont témoigné et donné leurs points de vue au sujet des différents aspects de la privatisation des hôpitaux. Le choix de ce thème n'était pas une coïncidence : nous devions d'abord démystifier le vocable « privatisation ». C'est ce qu'a fait le Prof. Maarse en décrivant les différentes formes et les contenus variés qu'il recouvre. Les autres intervenants ont rapporté leur expérience, soulignant les risques de services hospitaliers tournés exclusivement sur la rentabilité des soins de santé, surtout en ce qui concerne l'offre de prestations aux patients les plus vulnérables socialement. Si on veut suivre les règles de la « corporate governance », une stratégie orientée vers un but lucratif devrait être clairement stipulée dans la mission de l'hôpital. Car, comme dans toute entreprise, les stratégies et donc la gestion qui en résulte devraient s'inspirer des principes et des valeurs de l'hôpital.

À côté du conseil de surveillance qui détermine la mission de l'hôpital et en établit le cadre et les moyens, il est de la responsabilité du directeur de l'hôpital et de son équipe de mener à bien la gestion journalière. C'est là qu'il joue un rôle important. Étant donné l'évolution rapide des attentes des patients et la constante diminution des ressources financières, le directeur et son équipe doivent prendre des décisions qui pourraient affecter les aspects éthiques et sociaux. Ils pourraient, par exemple, effectuer une sélection de services médicaux axés uniquement sur la rentabilité. Cela montre, comme dans nombre de questions de fond ou concernant les personnes, l'équilibre que doit appliquer le directeur d'un hôpital. Sa tâche a d'ores et déjà changé et est en constante évolution.

Ce raisonnement nous conduit au programme d'action de l'AEDH des quatre prochaines années. Lors de l'assemblée générale, notre président Paul Castel a déclaré la décision du conseil d'administration de mettre en place un groupe d'étude. Celui-ci sera chargé d'élaborer des propositions visant à concrétiser les objectifs de l'AEDH en fonction de l'évolution et des nouvelles exigences qui se posent aux hôpitaux et notamment à leurs dirigeants. Il est important qu'il garde à l'esprit que l'AEDH est une association professionnelle chargée d'orienter son offre en fonction des attentes de ses membres en ce qui concerne l'information, les nouvelles connaissances et le partage des expériences.

Un changement d'orientation réussi se fait à partir du bas vers le haut, depuis les membres des associations nationales vers les organes directeurs. L'accent devrait être mis en particulier sur les besoins des jeunes et futurs collègues. On doit leur donner les outils nécessaires aux défis professionnels présents et à venir afin de s'assurer que nos hôpitaux pourront, dans le futur, offrir aux patients les meilleurs traitements. En outre, le groupe de réflexion élaborera des propositions qui, après consultation avec les associations nationales, seront considérées comme des priorités au sein de notre programme de travail. Vos idées et suggestions sont dès à présent les bienvenues.

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.

Vendredi 20 novembre 2009

39ÈME ASSEMBLÉE GÉNÉRALE ORDINAIRE

La 39ème assemblée générale ordinaire de l'AEDH s'est tenue à Düsseldorf après un séminaire très apprécié sur le thème « Vers une coopération équilibrée des acteurs publics et privés » et axé principalement sur deux sujets : le rapport d'activités et le prochain séminaire de l'AEDH à Zurich en 2010.

Rapport d'activité

Après avoir remercié M. Kolking et son équipe pour l'organisation du séminaire en 2009, M. Paul Castel, président de l'AEDH, a procédé au rapport d'activités de 2008-2009. Il a commencé par saluer le succès du Congrès 2008 de l'AEDH qui s'est tenue à Graz, en Autriche. Sur le thème « Un nouveau leadership pour de nouveaux défis », il a rassemblé un panel remarquable de conférenciers et a été riche en enseignements pour tous ceux qui y ont assisté.

Crise financière

M. Castel a souligné l'impact de la crise financière sur le secteur hospitalier. De nombreux hôpitaux et établissements de santé ont souffert et ont dû réduire leurs coûts et réorganiser. Il en va de même pour certaines de nos associations nationales qui se voient dans l'impossibilité de s'acquitter des frais d'association. L'AEDH doit à son tour faire preuve de prudence pour assurer sa stabilité financière et des statuts plus stricts concernant l'adhésion ont été mis en œuvre.

Au niveau européen

Un autre défi de 2008-2009 fut sans doute le traité de Lisbonne. Controversé et retardé par les élections européennes et le référendum irlandais, le traité a finalement été ratifié par tous les États membres. On espère maintenant que l'Union européenne pourra faire progresser ses travaux.

L'année a également vu la mise en œuvre de la directive européenne sur le temps de travail. Encore une autre question controversée dans l'UE si ce n'est dans le secteur hospitalier avec des horaires de travail diminués à 48 heures par semaine à partir du 31 Juillet 2009. Cette directive est particulièrement exigeante en ce qui concerne les heures de travail des médecins en formation. La Hongrie, les Pays-Bas et le Royaume-Uni sont tout simplement dans l'incapacité d'atteindre cet objectif et ont obtenu une prolongation jusqu'en 2011, entendu que le travail hebdomadaire ne devrait pas excéder les 52 heures. Les soins de santé transfrontaliers et les droits des patients faisaient également partie de l'agenda européen, considéré de près par le sous-comité de l'AEDH aux affaires européennes.

L'EAHM était également le fier co-organisateur des IT@Awards 2009. M. Castel a souligné la diversité des projets et des solutions informatiques des soins de santé européens et combien l'analyse comparative de l'informatique des soins de santé pourrait être très utile à l'échelle européenne. Cet événement a incité l'AEDH à encourager le groupe de travail sur l'informatique.

Vers 2010

La 23ème édition du congrès de l'AEDH aura lieu à Zurich, en Suisse, sous le thème : « Une feuille de route pour la qualité ». M. Castel a également appelé à une période de réflexion et le conseil d'administration a décidé de mettre en place un groupe de travail. L'année à venir est l'occasion de créer une nouvelle dynamique dans l'organisation et de développer des groupes d'associations à un niveau national. L'assemblée générale de septembre 2010 élira de nouveaux président et vice-président et renouvellera le conseil d'administration.

Conclusion

En conclusion, M. Castel a appelé tous les membres à adhérer et à s'impliquer dans les projets de l'AEDH. L'association a besoin de l'aide de toutes les associations nationales pour atteindre le but qu'elle s'est fixé : faire profiter l'Europe de ses compétences. La création d'un groupe de jeunes gestionnaires pourrait constituer ce laboratoire d'idées dont l'AEDH a besoin, profitant de leur enthousiasme et de leur expertise pour acquérir plus de propositions qu'elle n'en a pour le moment.

Comptes et plan économique

Les comptes pour 2008 ont été présentés par le secrétaire général, suivis par le rapport des vérificateurs. Ces comptes ont été approuvés et la décharge a été accordée au conseil d'administration et au secrétaire général. Le plan économique 2010 et les frais d'adhésion des membres actifs et des membres associés ont tous deux été proposés et acceptés.

Nouveaux membres

L'association italienne ANMDO, une association de médecins également directeurs, a été acceptée comme nouveau membre à part entière de l'AEDH. Le groupe Ecclesia (assurance et gestion des risques) a également été accepté à l'unanimité en tant que membre associé de l'AEDH.

Congrès en 2010

Le comité d'organisation suisse s'est montré ravi du prochain congrès de l'AEDH à Zurich les 9 et 10 Septembre 2010. Un aperçu en a déjà été imprimé et des copies sont disponibles en anglais, en allemand et en français. Le site web *www.zurich2010-AEDH.ch* est opérationnel et contient une mine de renseignements sur le congrès.

Le programme a été préparé conjointement par le sous-comité scientifique de l'AEDH et le comité d'organisation suisse et sera défini avec les conférenciers après la visite à Zurich du conseil d'administration.

Il a été convenu que la prochaine assemblée générale ordinaire aurait lieu le 9 septembre 2010 à 9 heures à Zurich.

Une formation médiatique efficace pour les directeurs d'hôpitaux

Par John Illman

Effectuer une communication médiatique efficace, c'est tourner le dos à ce que vous faites habituellement et oublier les structures classiques « début, milieu et fin ». Les programmes de formation en communication et médias sont conçus pour identifier les connaissances dont a besoin un public spécifique. Les patients ne sont pas intéressés par les dossiers qui forment le quotidien de la vie professionnelle des directeurs d'hôpitaux, leur préoccupation est le service aux patients et la sécurité. Ceci devrait être reflété dans votre communication avec les médias.

Les déclarations inexactes et les contraintes de travail avec les médias découragent les porte-paroles disposant pourtant d'un bon potentiel. Dans ce cas, il est bon de penser au rapport bénéfice-risque. Globalement, la publicité fonctionne et génère des bénéfices significatifs, c'est pourquoi les gouvernements et l'industrie partout dans le monde y investissent autant de temps et d'argent. En outre, les gestionnaires et les cadres hospitaliers qui tournent le dos aux médias risquent de voir leur opinion mal interprétée.

Le marketing et le leadership clinique

Par Stephen Willcocks

L'utilisation du marketing n'a pas toujours été considérée comme pertinente ou appropriée dans le secteur public des soins de santé, notamment par les professionnels de la santé. Toutefois, la politique des réformes dans le secteur public a introduit la concurrence et le choix des clients en tant que dispositif permettant d'améliorer les services, et cela a provoqué un regain d'intérêt pour le marketing.

Il existe deux types de marketing: le « marketing mix » (axé sur les produits, les prix, la distribution et la communication) et le marketing relationnel (l'accent est mis ici sur le processus d'établissement d'une « relation » avec ses clients avérés ou potentiels). Les objectifs de base du leadership sont compatibles avec l'approche marketing.

« Concept Mapping » pour les organisations de soins de santé du 21ème siècle

Par Michael Hall

La commercialisation et l'impact des organisations de soins de santé au 21ème siècle devra faire face aux défis rencontrés par les spécialistes du marketing des services et produits commerciaux. Peu importe si le support est un bandeau publicitaire de Google, un lien de réseau social, une vidéo YouTube ou tout ce qui précède, le message doit être suffisamment convaincant pour pousser à l'action l'utilisateur final potentiel. Le contenu doit être informatif et donner envie d'agir sur le message, d'utiliser le service ou de pousser l'utilisateur à la consommation.

Une approche prometteuse pour la réalisation de tous les éléments nécessaires au marketing et à la construction théorique est la construction d'un schéma conceptuel ou « Concept Mapping » combiné avec l'estimation de l'impact direct. Cela s'applique aussi bien aux groupes cibles qu'à la mesure d'analyse de données et permet de créer une représentation schématique des concepts recueillis auprès des consommateurs par le biais d'interviews ouvertes. Après l'analyse, un questionnaire de mesure de la perception est établi sur la base des réponses données lors des interviews. La suite de cet article paraîtra dans le prochain numéro. Elle présentera un exemple de travail de schéma conceptuel.

Pratique de la gestion de la relation fournisseur

Par Tobias Mettler et Peter Rohner

Les organisations de santé sont sous pression croissante pour réduire leurs coûts tout en améliorant la prestation des services. Il y a un potentiel économique important dans l'amélioration des dépenses sur les produits et services. La gestion de la relation fournisseur comprise comme une approche de gestion systématique des intéractions d'une organisation avec les sociétés qui lui fournissent des produits et des services peut aider à réduire les coûts et améliorer la qualité des prestations de services.

La gestion de la relation fournisseur étant pour nous constituée de composants à la fois techniques et sociaux, une approche holistique est nécessaire. D'une part, notre cadre de processus de gestion de la relation fournisseur comporte la gestion des affaires courantes et des processus en relation avec le fournisseur : la gouvernance, l'approvisionnement stratégique et les marchés opérationnels. D'autre part, le cadre comprend des processus de soutien cruciaux pour les réseaux sociaux et techniques : les ressources humaines, les infrastructures et les services informatiques.

La réforme des soins de santé en France

(E)Hospital a demandé à Paul Castel, directeur général des Hospices Civils de Lyon et président de l'AEDH, de nous parler de la loi HPST (Hôpital, Patient, Santé et Territoires) et de

ses implications pour la gouvernance des hôpitaux publics. C'est une loi controversée et sa préparation a provoqué de grands débats dans la classe politique et parmi la population. M. Castel estime que même si elle ne résoud certainement pas tous les problèmes des hôpitaux publics français, les principes sur lesquels elle se base et les solutions qu'elle introduit dans le secteur de la santé peuvent répondre aux attentes des gestionnaires d'hôpitaux en ce qui concerne une plus grande souplesse de fonctionnement et une réactivité et une efficacité accrues.

La loi allège les contraintes pesant sur les établissements de santé, et simplifie leur fonctionnement interne et externe. Elle resserre la composition des organes de décision (conseil de surveillance et conseil d'administration) en clarifiant les responsabilités internes, mais aussi en limitant la médicalisation croissante de la gestion hospitalière.

Le « National Paediatric Toolkit »

Par Ian Robertson

Le « National Paediatric Toolkit, (NPT) » est une innovation unique qui utilise une méthodologie d'animation pour connaitre l'opinion et l'expérience des enfants et des jeunes dans les milieux de la santé, de l'éducation et des services sociaux. Conçu par des enfants pour les enfants, le NPT a été développé au « Alder Hey Children's NHS Foundation Trust » à Liverpool. Il permet aux jeunes patients de transmettre leurs propres priorités au sujet des soins d'une manière qui leur semble simple et leur permet de fournir beaucoup plus de détails.

Le NPT permet de définir les priorités du patient pouvant induire des changements dans les services de soins, et donc les stratégies et les futurs plans de dépenses. Il peut également être utilisé pour définir un plan de soins de longue durée d'un patient en particulier, et ainsi alimenter le projet de soin individualisé du jeune patient.

Le programme national de PACS en Angleterre

Par Mary Barber

Les systèmes d'archivage d'images (Picture and Archiving Communication Systems, PACS) sont maintenant intégrés dans le travail quotidien du NHS en Angleterre. L'implémentation du PACS a contribué à soutenir d'importantes améliorations en ce qui concerne la rapidité et la qualité du diagnostic et du traitement des patients, le traitement est devenu plus sûr et plus rapide. L'approche collaborative du programme national a vu gagner sa reconnaissance au niveau national et international.

Maintenant que sa couverture a atteint la totalité du pays, le programme national PACS a travaillé au partage sécurisé des images et des rapports diagnostiques entre hôpitaux afin de soutenir les cheminements cliniques des patients. Les solutions actuellement disponibles permettent de réduire le temps, le coût et les efforts consacrés au déplacement des images, en protégeant les informations concernant les patients et en libérant le personnel pour exercer d'autres activités.

Country Focus : l'Allemagne

Le ministre fédéral actuel de la santé allemand est un médecin. C'est une bonne condition préalable pour une compréhension de la complexité du système de santé et une prise de décisions adéquate. Il partage son influence sur le développement du système de santé avec de multiples groupes d'intérêts et d'importantes modifications démographiques, médicales et économiques.

Le secteur hospitalier est une force économique puissante. On compte 1 million de personnes employées dans les 2 000 hôpitaux que compte le pays, 17 millions d'hospitalisations et 18 millions de patients soignés en ambulatoire. Le chiffre d'affaires est d'environ 65 milliards d'euros, soit près de 3 % du PIB. Les patients hospitalisés sont rémunérés selon le Diagnosis Related Groups allemand (G-DRG), un système comprenant environ 1 200 catégories, réajusté sur une base annuelle. L'idée principale est que l'argent suit le service.

Le « plan de 10 points » pour renforcer les alliances pour le progrès et la qualité médicale

Par Manfred Beeres

BVMed a publié un « plan de 10 points » concernant les soins de santé et la technologie médicale, sujet de discussion pour les négociations sur la politique de santé du nouveau gouvernement. Le plan inclut la garantie du niveau de qualité des dispositifs médicaux qui est établi par une marque de qualité CE-Med, un accès flexible et non bureaucratique à des innovations techniques médicales et leur introduction non restrictive dans les hôpitaux. BVMed souligne également l'importance de la télémédecine, la création d'un pool d'innovations et la sensibilisation à des innovations fiscalement avantageuses permettant d'effectuer des économies. L'accent devrait être mis sur la recherche, la coopération et la qualité.

Willy Heuschen

NEUORIENTIERUNG DER EVKD

Das Jahr 2010 wird ein bedeutsames für die EVKD. Zunächst steht der 23. Kongress der EVKD mit dem Thema ‚Wegekarte zur Qualität' in Zürich an. Somit führen wir unsere Arbeit zu diesem Thema fort. Beim EVKD Seminar in Düsseldorf im Jahr 2007 hatten wir es ja zu einem Schwerpunkte unserer Arbeit gemacht. Es war der Start zur Erarbeitung von europäischen Qualitätsstandards für Krankenhäuser. Der nächste Kongress ist ein wichtiger Beitrag hierzu. Mit unserer Teilnahme an einer Arbeitsgruppe mit anderen europäischen Schwesterorganisationen setzen wir diese Arbeit fort.

Mit den anstehenden Neuwahlen beim Kongress 2010 endet auch die Mandatszeit des jetzigen Präsidiums und des Vorstandes. Es ist also Zeit, Bilanz zu ziehen und die Perspektiven der nächsten vierjährigen Mandatszeit aufzuzeigen. Bei der Bilanz gilt es die 3 Schwerpunktthemen zu nennen. Neben dem schon genannten Thema der Qualität widmeten wir uns der Problematik der Führung eines Krankenhauses oder wie es in der Fachsprache heißt, der ‚corporate governance'. Nach der erfolgten Umfrage und der wegzeigenden theoretischen Bearbeitung durch Prof. K. Eeklo (KUL-Leuven-Belgien) steht diese Problematik weiter auf der Agenda unseres Wissenschaftlichen Beirates.

Beim letzten EVKD-Seminar voriges Jahr in Düsseldorf erklärten die ausgesuchten Referenten (siehe auch Berichterstattung in dieser Ausgabe) die verschiedenen Aspekte und Standpunkte bezüglich der sich vortuenden Privatisierung von Krankenhäusern. Nicht von ungefähr hatten wir dieses Thema ausgesucht. Zunächst galt es den Begriff ‚Privatisierung' zu entmystifizieren. Dazu dokumentierte Prof. Maarse die vielfältigen und unterschiedlichen Inhalte und Formen, die dieser Begriff abdeckt. Diese wurden auch in den Erfahrungsberichten der anderen Redner deutlich. Auch wurden die Risiken beleuchtet, die ausschließlich auf gewinnbringende Leistungen ausgerichtete Krankenhausbetriebe in der gesundheitlichen Versorgung der Patienten, besonders der sozial schwachen und beim flächendeckenden Leistungsangebot nach sich ziehen könnte. Folgt man der ‚corporate governance', müsste eine solche gewinnorientierte Strategie im Leitbild des Krankenhauses festgehalten sein.

Denn wie in anderen Unternehmen sollten Strategien und die davon abgeleitete Geschäftsführung sich am Leitbild und an den Werten des Krankenhauses inspirieren.

Neben dem Aufsichtsrat, der das Leitbild bestimmt, den Geschäftsrahmen und die Mittel absteckt, obliegt es dem Krankenhausmanager und seinem Team die tägliche Geschäftsführung wahrzunehmen. Dabei spielt der Krankenhausdirektor eine besonders gewichtige Rolle. Angesichts des raschen Wandels sowohl von der Erwartungshaltung der Patienten als auch von dem immer mehr abnehmenden Finanzmittel stehen der Direktor und sein Führungsteam vor Entscheidungen, die auch sozialethische Aspekte tangieren. Eine Auswahl von ausschließlich gewinnbringenden medizinischen Leistungen könnte eine solche Entscheidung sein. Diese zeigt, wie auch in vielen anderen Sach- und Personenfragen welcher Balanceakt der Krankenhausmanager zu vollziehen hat. Die Aufgabenstellung des Krankenhausdirektors hat sich schon geändert du ist im stetigen Wandel begriffen.

Diese Überlegung führt uns zum Aktionsprogramm der EVKD in den nächsten 4 Jahren. Bei der Mitgliederversammlung erklärte unser Präsident, Paul Castel die Vorstandsentscheidung eine Reflexionsgruppe einzusetzen. Sie soll Vorschläge erarbeiten, wie die Zielsetzung der EVKD entsprechend des Wandels und der neuen Bedürfnisse umzusetzen ist, die sich den Krankenhäusern und speziell deren Führungskräfte stellen. Dazu gibt es bereits im Vorfeld der Einsetzung dieser Reflexionsgruppe wichtige Ansätze. Einer ist die Ausrichtung der EVKD als Berufsverband, der sein Angebot an den Erwartungen der Mitglieder hinsichtlich der Information, des Wissenstandes und des Erfahrungsaustausches zu orientieren hat.

Eine erfolgreiche Umorientierung erfolgt am besten von unten nach oben, von den Mitgliedern der Nationalverbände hin zu den Führungsgremien. Das Augenmerk müsste sich dabei besonders auf die jungen und zukünftigen Kollegen richten. Sie müssen für die jetzigen und künftigen beruflichen Herausforderungen das Rüstzeug erhalten, damit unsere Krankenhäuser auch Morgen noch die optimale Behandlung der Patienten anbieten können. Dazu wird die Reflexionsgruppe Vorschläge erarbeiten. Nach Abstimmung mit den Nationalverbänden werden diese Inhalte als Schwerpunkt in unser Arbeitsprogramms einfließen. Dazu sind jetzt schon Anregungen und Vorschläge willkommen.

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.

Freitag, 20. November 2009

39. ORDENTLICHE HAUPTVERSAMMLUNG

Bei der 39. Ordentlichen Hauptversammlung der EAHM, die nach dem diesjährigen erfolgreichen Seminar „In Richtung einer ausgewogenen Kooperation privater und öffentlicher Akteure" in Düsseldorf stattfand, standen zwei Bereiche im Mittelpunkt: der Tätigkeitsbericht und das anstehende EAHM Seminar 2010 in Zürich.

Tätigkeitsbericht

Nach der Danksagung an Hrn. Kolking und sein Team für die Organisation des diesjährigen Seminars gab Hr. Paul Castel, Präsident der EAHM, einen Überblick über die Aktivitäten der Jahre 2008-2009 ab. Er zollte zunächst dem Erfolg des EAHM Kongresses 2008 Beifall, der unter dem Motto „Neue Führung für Neue Herausforderungen" in Graz stattgefunden hatte und mit seiner Auswahl an ausgezeichneten Vortragenden eine Lernerfahrung für alle Teilnehmer darstellte.

Finanzielle Krise

Hr. Castel hob den Einfluss der finanziellen Krise auf den Krankenhausbereich hervor. Viele Spitäler und Gesundheitsträger wurden in Mitleidenschaft gezogen und gezwungen, Kosten zu senken und generelle Umstrukturierungen durchzuführen. Dasselbe gilt für einige unserer nationalen Vereinigungen, die sich nicht in der Lage sahen, ihre Beiträge zu zahlen. Die EAHM muss ihrerseits Vorsicht walten lassen, um die finanzielle Stabilität zu sichern. In diesem Sinne wurden strengere Statuten in Bezug auf die Mitgliedschaft implementiert.

Auf Europäischer Ebene

Eine weitere Herausforderung der Jahre 2008-2009 stellte zweifelsohne der Vertrag von Lissabon dar. Kontroversiell diskutiert und wegen der Europäischen Wahlen und dem Irischen Referendum hinausgezögert, wurde der Vertrag schließlich von allen Mitgliedsstaaten ratifiziert. Nun darf darauf gehofft werden, dass sich die Europäische Union wieder der Fortführung ihrer Arbeit widmen kann. In diesem Jahr wurde außerdem die Europäische Arbeitszeitdirektive implementiert. Auch dies eine kontroversielle Angelegenheit der EU, und sicher auch des Krankenhaussektors: Die Arbeitszeit wurde ab 31. Juli 2009 auf 48 Wochenstunden herabgesetzt. Diese Direktive stellt in Bezug auf die Arbeitszeit von Ärzten in Ausbildung eine besondere Schwierigkeit dar. Ungarn, die Niederlande und Großbritannien können diese Zielvorgabe schlicht und einfach nicht einhalten und haben eine Ausweitung bis 2011 erhalten, doch darf in der Zwischenzeit ein Maximum von 52 Stunden nicht überschritten werden. Grenzüberschreitende Gesundheitsversorgung und Patientenrechte standen ebenfalls auf der Europäischen Agenda, und werden vom EAHM Subkomittee für EU Angelegenheiten genau überwacht.

Die EAHM war außerdem stolze Mitorganisatorin der IT @ Networking Awards 2009. Hr. Castel unterstrich die Vielfalt Europäischer Gesundheits-IT Lösungen und Projekte und wies darauf hin, dass das Benchmarken von Gesundheits-IT auf Europäischer Ebene sehr nützlich sein könnte. Dieser Event animierte die EAHM dazu, mit der „Working Party on IT" fortzufahren.

Ausblicke auf das nächste Jahr

2010 wird die 23. Ausführung des EAHM Kongresses ‚Wegekarte zur Qualität' in Zürich stattfinden. Hr. Castel rief außerdem zu einer Phase der Besinnung auf, und der Vorstand beschloss, eine entsprechende Gruppe aufzusetzen. Das nächste Jahr bietet die Gelegenheit, neue Dynamiken innerhalb der Organisation zu entwickeln und nationale Vereinigungen zu fördern. Die im September 2010 stattfindende Generalversammlung wird einen neuen Vorstand und einen neuen Präsidenten und Vizepräsidenten wählen.

Zusammenfassung

Zusammenfassend rief Hr. Castel alle Mitglieder dazu auf, bei EAHM Projekten mitzumachen und sich zu beteiligen. Die Vereinigung benötigt die ganze Hilfe aller nationaler Organisationen, um das letztendliche Ziel zu erreichen, Europa mit seiner Fachkompetenz zu versorgen. Er schlug vor, eher in Richtung eines Think Tanks zu gehen und Gruppen jüngerer Manager aufzustellen, um von deren Enthusiasmus und Wissen zu profitieren, und hob nochmals hervor, dass die EAHM mehr Vorschläge benötigt, als derzeit vorhanden.

Geschäfts- und Wirtschaftsplan

Die Geschäftsunterlagen 2008 wurden vom Generalsekretär vorgestellt, gefolgt vom Bericht der Auditoren. Diese Unterlagen wurden bestätigt, und der Vorstand und Generalsekretär wurden entlassen. Der Wirtschaftsplan 2010 und die Mitgliedsbeiträge für sowohl Vollmitglieder als auch außerordentliche Mitglieder wurden vorgeschlagen und angenommen.

Neue Mitglieder

Die Italienische Vereinigung ANMDO, ein Zusammenschluss von Ärzten, die gleichzeitig Generaldirektoren sind, wurde als Vollmitglied der EAHM angenommen. Die Ecclesia Gruppe (Versicherung und Risikomanagement) wurde ebenfalls einstimmig als außerordentliches Mitglied der EAHM angenommen.

Kongress 2010

Mit Begeisterung arbeitet das Schweizer Organisationskomitee am anstehenden EAHM Kongress, der vom 9.-10. September 2010 in Zürich stattfindet. Die erste Ankündigung wurde bereits gedruckt, und Kopien stehen auf Englisch, Deutsch und Französisch zur Verfügung. Die Webseite www.zurich2010-EAHM.ch ist aufgestellt und in Betrieb und enthält eine Fülle von Informationen über den Kongress.

Das Programm wurde gemeinsam vom Wissenschaftlichen Subkomitee der EAHM und dem Schweizer Organisationskomitee vorbereitet; die Liste der Vortragenden wird nach dem Zürichbesuch des Vorstands finalisiert. Laut Übereinkunft wird die nächste Ordentliche Hauptversammlung am 9. September 2010 um 9 Uhr in Zürich stattfinden.

Effektives Medientraining für Krankenhausmanager

Von John Illman

Eine effektive Medienkommunikation bedeutet, alles auf den Kopf zu stellen, was man üblicherweise getan hat – und die konventionelle Struktur des "Anfang, Mittelteil, Ende" zu vergessen. Kommunikation und Medien-Trainingsprogramme sind aufgebaut, um bestimmen zu können, welche Informationen für spezifische Zielgruppen nötig sind. Patienten interessieren sich nicht für die Bestandteile, die das tägliche Arbeitsleben von Krankenhausmanagern ausmachen – ihr Interesse gilt der Patientenversorgung und -sicherheit. Dies sollte in Ihrer Kommunikation mit den Medien zum Ausdruck kommen.

Unverantwortliche Berichterstattung und die Beschränkungen der Zusammenarbeit mit den Medien schrecken viele gute potentielle Sprecher ab, aber bedenken Sie das Nutzen-Risiko Verhältnis. Im Allgemeinen funktioniert Öffentlichkeitsarbeit, und sie kann einen signifikanten Vorteil erwirtschaften. Deshalb investieren Regierungen und Industriezweige weltweit soviel Zeit und Geld in diesen Bereich. Außerdem: Wenn Krankenhausmanager und Führungskräfte den Medien ihren Rücken zuwenden, würde ihre Positionen falsch repräsentiert werden.

Marketing und Führungsverhalten in der Klinik

Von Stephen Willcocks

Marketing wurde nicht immer als relevant oder auch angemessen für das öffentliche Gesundheitswesen angesehen, nicht zuletzt von medizinischem Fachpersonal. Doch mittlerweile haben Gesetzesreformen im Gesundheitssektor das Prinzip des Wettbewerbs und der Konsumentenwahl als Mechanismen für die Verbesserung des Angebots eingeführt, was wiederum ein verstärktes Interesse an Marketing zur Folge hatte.

Es gibt zwei Arten von Marketing: Der Marketing-Mix (Betonung auf den 4 P: Produkt, Preis, Ort (place) und Promotion), und Beziehungsmarketing (Betonung auf das Aufbauen einer Beziehung, den Einfluss auf die „Erhaltung des Kunden" und das Erwerben neuer Kunden). Die wichtigsten Ziele des Führungsverhaltens sind kompatibel mit und Teil des Marketingansatzes.

Konzepte für Gesundheitsorganisationen im 21. Jahrhundert

Von Michael Hall

Marketing und Öffentlichkeitsarbeit von Gesundheitsorganisationen werden sich denselben Herausforderungen stellen müssen, denen sich auch Marketingfachleute kommerzieller Anbieter und Produkte gegenüber sehen. Unabhängig davon, ob es sich beim Medium um eine Google-Werbebanner, ein soziales Netzwerk, ein YouTube Video oder um alles zusammen handelt, die Botschaft muss überzeugend genug wirken, um den potentiellen Endverbraucher zur Handlung zu motivieren. Der Inhalt muss informativ sein, eine starke Absicht auslösen, auf die Nachricht zu reagieren oder das Angebot zu nutzen, oder den Endverbraucher dahingehend motivieren, eine Empfehlung vom Provider zu suchen.

Ein vielversprechender Ansatz, um alle nötigen Elemente des Marketings und der Theorieaufbaus zu erreichen, ist ‚Konzept Mapping', kombiniert mit ‚Direct Magnitude Estimation'. Diese wendet die Datenanalyse von sowohl der Zielgruppe als auch von Messdaten an, um eine diagrammatische Repräsentation der Konzepte von Konsumenten durch offene Interviewfragen zu erhalten, und folgt der Analyse dieser Fragen mit einem Messfragebogen der Wahrnehmung, basierend auf den im Interview gegebenen Antworten. Der zweite Teil dieser Serie enthält ein praktisches Beispiel des Konzept-Mapping.

Management der Lieferantenbeziehung in der Praxis

Von Tobias Mettler und Peter Rohner

Gesundheitsorganisationen sind unter zunehmendem Druck, ihre Kosten zu vermindern und gleichzeitig die angebotenen Leistungen zu verbessern. In der Verminderung von Ausgaben für Produkte und Leistungen liegt ein hohes wirtschaftliches Potential. ‚Supplier Relationship Management' (SRM) ist ein Ansatz, um die Interaktionen einer Organisation mit den Zulieferer-Firmen zu managen. Er kann dabei helfen, Kosten zu reduzieren und die Qualität der gelieferten Leistung zu verbessern. Da wir davon ausgehen, dass SRM sowohl technische als auch soziale Komponenten enthalten sollte, wird ein holistischer Ansatz benötigt. Einerseits enthält unser Rahmenwerk für SRM die vorliegenden Geschäfts- und Managementprozesse, um Beziehungen zu Lieferanten zu handhaben: Überwachung, strategisches Belegen, und operationelles Beschaffungswesen. Andrerseits beinhaltet das Rahmenwerk auch Unterstützungsprozesse, die Schlüsselfaktoren für das soziale technische Netzwerken sind: Human Ressources, Infrastruktur und IT-Leistungen.

Die französische Gesundheitsreform

(E)Hospital sprach mit Paul Castel (Generaldirektor der Hospices Civils de Lyon und Präsident der EAHM) über die HPST Gesetzgebung (Hospital, Patienten, Gesundheit und Regionen) und deren Implikationen für die Leitung öffentlicher Krankenhäuser. Als umstrittenes

Gesetz führte die Vorbereitung des HPST Gesetzes zu hitzigen Debatten, sowohl in politischen Kreisen als auch in der Allgemeinbevölkerung. Hr. Castel geht davon aus, dass obwohl das Gesetz sicherlich nicht alle Probleme öffentlicher Krankenhäuser in Frankreich lösen wird, die Prinzipien, auf denen es ruht, und die Lösungen, die es für den öffentlichen Gesundheitsbereich einführt, die Erwartungen von Krankenhausmanagern anspricht, sowohl in Bezug auf größere Flexibilität beim Führen des Krankenhauses, als auch bezüglich einer besseren Reaktionsfähigkeit und einer verbesserten Effektivität.

Das Gesetz schwächt Einschränkungen ab, welche das Führen von Gesundheitseinrichtungen erschwert, und vereinfacht deren interne und externe Arbeitsweisen. Es geht dabei um eine Straffung der Zusammenstellung der entscheidungsfähigen Körperschaften (Aufsichtsrat und Vorstand), eine Klärung interner Verantwortlichkeiten, aber auch um die stetig ansteigende Medikalisierung des Krankenhausmanagements.

Der ‚National Paediatric Toolkit'

Von Ian Roberton

Der ‚National Paediatric Toolkit' (NPT) ist eine einzigartige Innovation, die Zeichentrickfiguren einsetzt, um die Meinungen und Erfahrungen von Kindern und Jugendlichen in Strukturen wie Gesundheitssorge, Bildung und Sozialeinrichtungen einzufangen. Von Kindern für Kinder aufgebaut, wurde das NPT am Alder Hey Children's NHS Foundation Trust entwickelt. Es erlaubt jungen Patienten, ihre individuellen Prioritäten für Gesundheitssorge in einer einfachen Art und Weise zu kommunizieren, und bietet dennoch viel mehr Detailinformationen, als sie sonst geben könnten. Das NPT erlaubt Usern, die Prioritäten des Patienten für Veränderungen von Leistungen zu definieren, was zukünftige Strategien und Ausgabepläne definieren kann. Es kann außerdem dazu eingesetzt werden, den langfristigen Pflegeplan eines Patienten zu definieren, und kann damit in den Individuellen Patienten-Plan (IPP) eingespeist werden.

Das Englische PACS Programm

Von Mary Barber

‚Picture and archiving communication systems' (PACS) ist mittlerweile in das tägliche Leben der National Health Services NHS in England eingebettet. PACS hat dabei geholfen, wesentliche Verbesserungen für sowohl die Geschwindigkeit als auch die Qualität von Diagnose und Therapie durchzuführen, und als Folge davon erhalten Patienten eine schnellere, sicherere Behandlung. Der kollaborative Ansatz dieses nationalen Programms hat nationale und internationale Anerkennung geerntet.

Nun, da englandweit die PACS-Abdeckung erreicht wurde, arbeitet das nationale PACS Programm daran, die „einzelnen Punkte" zu verbinden, indem der Fokus zunehmend darauf gelegt wird, wie die einzelnen Träger auf gesicherte Art und Weise diagnostische Bildaufnahmen und Berichte besser gemeinsam nutzen können, um die ‚klinischen Pfade' der Patienten zu unterstützen. Die derzeit zur Verfügung stehenden Lösungen helfen Krankenhausträgern dabei, Zeit, Kosten und Anstrengungen beim Weiterleiten von Bildern zu vermindern, die Patienteninformation zu schützen und es Arbeitnehmern zu ermöglichen, sich vermehrt anderen Aktivitäten zu widmen.

Länderfokus: Deutschland

Der derzeitige deutsche Gesundheitsminister ist Arzt – eine gute Voraussetzung für das Verständnis der Komplexitäten des Gesundheitssystems und für eine angemessene Entscheidungsfindung. Allerdings ist es nicht nur der Bundesminister, der die Entwicklung des Gesundheitssystems beeinflusst, sondern auch die unterschiedlichsten Interessensgruppen und wichtige demographische, medizinische und wirtschaftliche Veränderungen. Der Krankenhaussektor ist eine enorme wirtschaftliche Kraft. Eine Million Menschen in 2.000 Krankenhäusern kümmern sich um 17 Millionen stationäre und 18 Millionen ambulante Patientenfälle. Der Umsatz beträgt etwa 65 Milliarden Euro, beinahe 3 Prozent des Bruttoinlandsprodukts. Stationäre Fälle werden von der ‚German Diagnosis Related Groups' (G-DRG) vergütet, ein System, das auf jährlicher Basis angepasst wird. Die grundsätzliche Idee lautet: Geld nach Leistung.

10-Punkte-Plan für die Stärkung der Allianzen für Medizinischen Fortschritt und medizinische Qualität

Von Manfred Beeres

Die BVMed hat einen ‚10-Punkte-Plan' für die Versorgung von Patienten mit modernster Medizintechnologie veröffentlicht, als Diskussionsgrundlage für die gesundheitspolitischen Verhandlungen der neuen Regierung. Der Plan beinhaltet unter anderem, dass die Qualität medizinischer Apparate mittels CE-Med Qualitätssiegel sichergestellt ist, und dass es unbürokratischen und flexiblen Zugang zu medizinisch-technischen Innovationen und deren uneingeschränkte Einführung in Krankenhäuser gibt. Die BVMed unterstreicht außerdem die Bedeutung der Telemedizin und des Schaffens eines innovativen Pools und des Engagements für ein steuerbegünstigte Innovations-Sparschema. Der Fokus sollte auf Forschung, Kooperation und Qualität liegen.

AGENDA 2010

March 2010

ECR 2010 5-9
Vienna, Austria
www.myesr.org

ISICEM 2010 9-12
Brussels, Belgium
www.intensive.org

World of Health IT Conference and Exhibition 15-18
Barcelona, Spain
www.worldofhealthit.org

April 2010

ECCMID 2010 10-13
Vienna, Austria
www.congrex.ch/ECCMID2010

Med-e-Tel 14-16
Luxembourg, Luxembourg
www.medetel.lu

International Forum on Quality and Safety in Health Care 2010 20-23
Nice, France
www.internationalforum.bmj.com

May 2010

Central and Eastern Europe Medical Tourism and Healthcare Summit 17-18
Zagreb, Croatia
www.globalengage.co.uk/central_eastern_european_medical_tourism_summit.html

HOPITAL EXPO-Intermedica/ Hit Paris 2010 18-21
Paris, France
www.hopitalexpo.com

World Health Care Congress - Europe 19-20
Brussels, Belgium
www.worldcongress.com/events/HR10015

June 2010

Hospital Build Middle East 1-3
Dubai, UAE
www.hospitalbuild-me.com

September 2010

23rd Congress of the European Association of Hospital Managers 9-10
Zurich, Switzerland
www.zurich2010-eahm.ch

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- Waste Management
- Hospital Acquired Infections
- Focus: Ireland

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