

# Hospital

**EAHM**  
ASSOCIATION EUROPÉENNE DES DIRECTEURS D'HÔPITALS  
EUROPAISCHE VEREINIGUNG DER KRANKENHAUSDIREKTOREN  
EUROPEAN ASSOCIATION OF HOSPITAL MANAGERS

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## ROADMAP TO TOP QUALITY

23<sup>rd</sup> EAHM CONGRESS

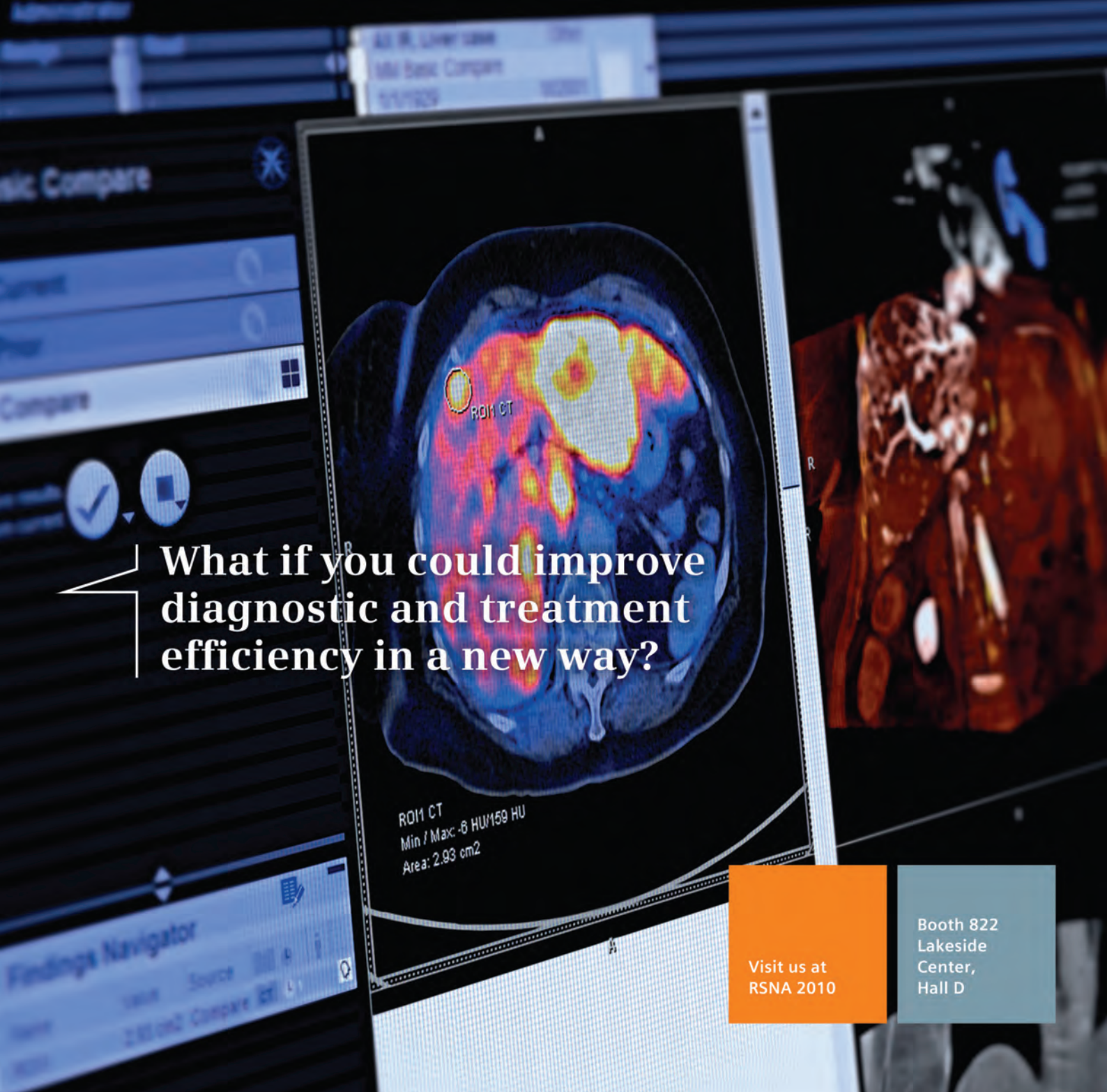
### Plus

- > A Healthy Workforce  
for a Healthy Economy
- > The Integrated OR
- > Focus: Luxembourg

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Heinz Kölking

# A NEW CHAPTER FOR EAHM

September 9-10 the 23rd congress of the European Association of Hospital Directors took place in Zurich. Many thanks to everyone who attended! We would particularly like to thank our colleagues from Switzerland for the organisation of the congress. It was a highlight in our programme of European cooperation.

The Executive Committee, Board and General Assembly of the EAHM also met in Zurich. The General Assembly voted for the new Board for the next 4 years. The result stands both for continuity and for new directions. The Executive Committee and the Board had already decided in the summer to reflect and restructure the strategy of the EAHM. This seems absolutely necessary due to the situation in our societies and also in the provision of health supply against the background of various structural changes taking place in Europe. On this basis, a working group was set up to engage specifically with this issue. The working group reflected upon the present situation of the EAHM and developed suggestions on aims and strategies in a closed meeting in Brussels in May.

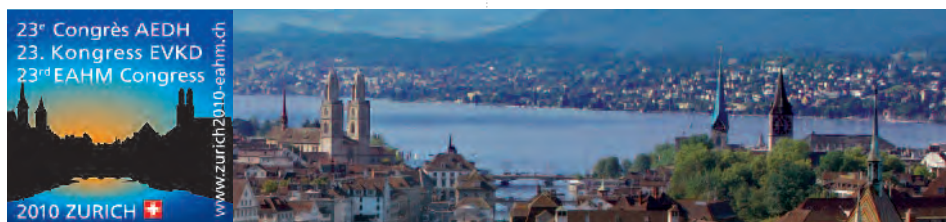
Our new strategy concerns particularly our common identity as hospital managers in Europe. A close coordination between national associations and the EAHM and the further development of partnerships are prerequisites

for our progression. The following aims have been formulated:

1. To create an identity of the European hospital director;
2. To ensure an active exchange of management experiences and the comparison of success models;
3. To formulate new strategies and instruments to improve the management in hospitals; and
4. To develop, together with partners, management training programmes and share this with younger hospital managers.

For these aims, corresponding working agendas have been developed. This is undoubtedly a very ambitious programme but the congress in Zurich has shown us the advantages of exchanging experiences at the European level and the importance of developing common ideas about a future-oriented health supply in our own countries and in Europe. Good management is an essential prerequisite for the success of our hospitals and our health systems. This is our contribution to a safe and social Europe. I am honoured to play a part in it as President of EAHM with the Board and Executive Committee.

Heinz Kölking  
President EAHM



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.



## Roadmap to Top Quality

This issue is a review of the 23rd EAHM Congress, "Roadmap to Top Quality". The congress was a resounding success with hospital managers from across Europe congregating in the beautiful city of Zurich to attend high-level presentations and learn how they can increase quality in their hospitals.

Our dossier summarises each presentation, including the American perspective on quality in the keynote speech by Charles Denham; managers' and patients' points of views; specific examples of quality improvement from Portugal and Austria; and even how we as hospital directors can learn from the automobile industry and their lean processes.

## Integrated Operating Rooms

The integrated Operating Room (OR), otherwise referred to as "digital OR" or "interventional suite" is a technical solution mainly dedicated to minimally invasive surgery where environment (lights, climate, etc.), medical devices and video distribution are controlled via one or more PCs and activated via a single graphic interface. In such an OR each and every control is in the surgeon's reach, allowing him to interact and control the system using a boom-mounted, sterile touch screen that can be placed right on the operating field.

In this issue, Umberto Nocco and Silvia del Torchio examine whether these expensive installations are worth the investment by surveying the surgeons and scrub nurses who use them.

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Luxembourg, with a population of 502,000 (Eurostat, 2010 estimate) has one of the best state-funded healthcare systems in Europe. The system is based on three fundamental principles: compulsory health insurance, free choice of provider for patients and compulsory provider compliance with the fixed set of fees for services.



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The European Association of Hospital Managers is proud to invite you to the *IT @ Networking Awards 2011*, a global healthcare IT and medical technology competition.

*IT @ 2011* will recognise and promote outstanding healthcare IT and medical technology projects. 25 nominees from across Europe and beyond will compete in the *IT @ Networking Awards 2011* on January 19- 20 2011. This high-level competition will see candidates go through two rounds of presentations in an effort to convince the expert audience and panel of judges why their solution deserves to win. If last year is anything to go by, attendees will not hold back in cross-examination of each presenter during the Q&A sessions before placing their vote for their favourite solutions.

## WHY ATTEND THE *IT @ NETWORKING AWARDS 2011*?

This event will give you the possibility to expand your general and in-depth knowledge on IT solutions. Every presentation is strictly structured according to our presentation cri-

# GENERATION



19 – 20  
JANUARY 2011  
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BRUSSELS

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A € 5,000 CASH PRIZE AND MEDIA  
PROMOTION WORTH € 50,000

teria (box). Such criteria allows for a cross-departmental understanding of each solution.

Uniquely, *IT @ 2011* requires all presenters to talk about the key problems they have encountered in creation or implementation. By highlighting honestly the problems and obstacles encountered, they provide the audience with an excellent tool for advancing similar issues in their own institutions.

IT and medical technology is of key importance to hospital management, especially considering the current financial constraints and increasing pressure our healthcare systems are faced with. Intelligent IT solutions increase cost-effectiveness, productivity and safety.

## HOW IT WORKS

*IT @ 2011* is a two-day event comprising two rounds of presentations. During the first day, 25 projects will be showcased in a Mindbyte presentation. Mindbytes are short and straight to the point. In just five minutes, each presenter will highlight the main advantages of their project and convince the audience they want to know more. After each presentation you, the expert

audience, and our panel of judges will place their votes. The top nine presentations make it through to the second day of competition where they are given the opportunity to present their projects in detail. This Workbench presentation has an allocated time of 30 minutes followed by 15 minutes of cross-examination.

## WHAT SETS US APART

What differentiates *IT @ 2011* from other congresses? The main difference lies in the element of competition. Yes, *IT @ 2011* features presentations from across the world. But these are presentations with a difference, competitors are presenting to win; they have a completely different mindset. Each presenter will do the best to secure the top prize, to persuade the audience and judges that their solution deserves to win. The Q&A sessions also take on a new dimension with presenters having the opportunity to cross-examine their competitors.

## HOW TO REGISTER

EAHM members are eligible for a reduced rate of only 300 EUR. For this fee you can enjoy two

days of informative presentations of fully implemented and running IT and medical technology projects. Moreover, you will have a say in who will win the trophy. Refreshments, lunch and evening entertainment are also included, giving ample opportunity for networking.

To register, please visit:

<https://www.conftool.net/itawards2011/>

## LOCATION

*IT @ 2011* will take place in the famous Théâtre du Vaudeville, a most stimulating environment in the Galerie de la Reine, the centre of Brussels.

Hotel reservations can be obtained through [www.booking.com](http://www.booking.com).

For more information please visit our website [www.itandnetworking.org](http://www.itandnetworking.org) or contact us on +32/2/2868501 or send an email to [office@hitm.eu](mailto:office@hitm.eu)

**We look forward to seeing you in Brussels in January!**

# 40<sup>TH</sup> ORDINARY GENERAL ASSEMBLY

9 September, 2010 9.00- 10.00 / Kongresshaus Zurich

The 40th Ordinary General Assembly of EAHM took place in Zurich before the official opening ceremony of the 23rd EAHM Congress: Roadmap to Top Quality. The General Assembly focused mainly on two topics: The President's activity report for 2009-2010, including the results of the reflection group on the future and evolution of EAHM, and the election of the President, Vice-President and the Executive Committee for the next four years (2010-2014).

Mr. Castel declared the General Assembly officially open and thanked the Swiss organising committee for their hard work in the run up to the congress. Before giving his activity report for the past year, the agenda for the General Assembly was approved as were the minutes of the previous assembly.

## The Activity Report

Speaking about his four years as President of EAHM, Mr. Castel highlighted the creation of the statutes of the organisation as one of his key achievements. This was a considerable amount of work but a lot of progress has been made in how the association is organised and run. EAHM must now define a clear service policy and become more visible, improving communication within the association but also with other actors in the European hospital sector. Efficiency and productivity must also improve, especially considering the current economic situation.

Firstly, the report reiterated the importance and success of the 2009 seminar "Towards a balanced cooperation of public and private actors". Mr. Castel noted that as hospital directors we are facing more and more competition between hospitals and that management now has an increased economic context. Although there are differences between public and private hospitals there are also many similarities including political choices and the need for ethical management.

## Reflection Group

His second point concerned the profession of hospital director. This was one of the main goals of his presidency: the examination of this dimension for the association. Although still in its early stages, a reflection group was set up a few months ago examining the role of EAHM. Determining that it must be a utility for hospital managers and younger managers of the future. EAHM is also asking its national associations to be vigilant and to focus on younger managers in their associations. EAHM recognises the need to prepare and educate the hospital managers of the future.

The Executive Committee validated a plan of action the day before the congress. This plan includes defining the modern hospital, improving communication between directors, and training and education. Mr Castel stated that the next EAHM congress in Greece in two years from now will be an opportunity to work on this.

Mr. Castel finished his activity report by thanking the Board Members, Executive Committee, Secretary General, his office and everyone who helped him during the four years. The report was accepted unanimously.

## Tendering of Accounts and Budget

EAHM was affected by the financial crisis, as were the national associations.

Revenue from membership fees was lower as some countries experienced financial and structural difficulties. The official journal *(E)Hospital* also faced difficulties. Consequently their contribution was lower than expected. The quality has nonetheless been upheld and the board thank the editor and team.

Concerning expenditures, EAHM tried to cut costs without having to reduce activities. There was a 3.44 percent saving. The accounts were approved by an external auditor. The internal auditors, Ms. Pellerin (Luxembourg) and Mr. Timmermans (the Netherlands) gave their report and the 2009 accounts were unanimously approved. Both reports are available on the website.

The financial needs of EAHM are increasing. Cost of personnel (travel and accommodation) is increasing and the office of the General Secretariat is in need of restructurisation. Therefore the Board proposes an increase in personnel costs, this includes an extra 2,000 euro in the budget for travel expenses. Moreover, new programmes and the need for more subcommittee and board meetings will also increase costs.

Mr. Heuschen stressed that although more needs to be financed, EAHM will not take financial risks. The association will only spend what it receives and does not want to raise membership fees. This new method of financing will be through a forum, a partner's forum with the in-



# New, non-surgical treatment for uterine fibroids

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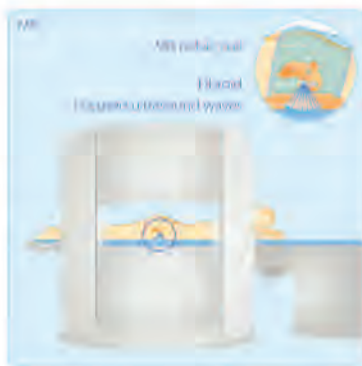
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### Ablation of uterine fibroids

Uterine fibroids are the most common benign tumors in pre-menopausal women. Fibroids occur in 20 to 50% of women of child-bearing age, and with increasing size produce pain, excessive menstrual bleeding,

pressure, bloating and urinary and bowel compression symptoms. Fibroids may also cause infertility. Many women suffer from uterine fibroids but don't want to undergo surgery and continue to endure the condition in silence. Philips' new Sonalleve MR-HIFU system now offers a non-invasive treatment of uterine fibroids. The technique is much more convenient and comfortable than other therapeutic procedures such as hysterectomy, myomectomy or uterine artery embolization. These require hospital admission as an in-patient and sometimes weeks of recovery. In contrast, with Sonalleve fibroid therapy, patients can be treated as an out-patient, be out of the hospital the same day and almost fully recovered within a few days.



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dustry. Companies have approached the association and requested an exchange. Therefore a forum will be set up and the industry will pay for this privilege. This will offset the expenses. The national associations have agreed to help with this.

Questions were then opened to the floor. Jean Luc Chassaniol (France) expressed his concern about the increase in personnel fees and asked why it was so high and was also concerned about spon-

sorship making up a third of the budget. Mr Castel responded that increased personnel expenditure has only arisen due to the increase in activities. Regarding sponsoring, the Executive Committee has agreed that only money already received will be spent. The Budget and Membership fees were then approved unanimously. The auditors for 2010 were proposed and elected and it was decided that there would be no admission or exclusion of members this year.

**Election**

After the activity report attendees of the General Assembly were invited to place their votes for the new President, Vice-President and Executive Committee. Mr. Heuschen explained that names had been nominated by each national association and also the Executive Committee. A ballot was then collected and taken to be counted and verified by two members of the Executive Committee, Asger Hansen and Manuel Delgado.



From left to right: Manuel Delgado, Pedro Lopes, Juraj Gemes, Asger Hansen, Freddy Iemants, Luigi D'Elia, Gerry O'Dwyer, Heinz Kölking, Jos Vanlandyut, Marc Hastert, Stasys Gendvilis, Nikolaus Koller

**The New EAHM Board and Executive Committee**

**Board:**

- Heinz Kölking, President (DE)
- Gerry O'Dwyer, Vice-President (IE)
- Paul Castel (FR)
- Mieczyslaw Pasowicz (PL)
- Pedro Lopes (PT)

**Executive Committee:**

- Nikolaus Koller (AT)
- Freddy Iemants (BE)
- Nikolina Muskurova (BG)
- Christoph Pachlatko (CH)
- Joern Koch (DK)

- Rauno Ihalainen (FI)
- Jean-Luc Chassaniol (FR)
- Paul Castel (FR)
- Gregory Roumeliotis (GR)
- Kresimir Rotim (HR)
- Ari Lajos (HU)

- Luigi D'Elia (IT)
- Stasys Gendvilis (LT)
- Marc Hastert (LU)
- Mieczyslaw Pasowicz (PL)
- Juraj Gemes (SK)



The Swiss Organising Committee



Paul Castel, EAHM President 2006-2010



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## INTERVIEW: HEINZ KÖLKING

Mr. Heinz Kölking, the new President of EAHM took some time to speak to *(E)Hospital* during the congress in Zurich. He talked about his objectives for the four upcoming years, highlighting that the association must work together to overcome the challenges facing our hospitals today.

**(E)Hospital:** First of all, congratulations, you have been Vice-President for 4 years and now you are President of EAHM. What can we expect from the next 4 years?

**Kölking:** First of all, I have to say that because of the regular change of Vice Presidents and Presidents we are constantly evolving as an association, which is very important. Every new President elected gets the chance to set new directions and create new initiatives, and this is what I want to do.

**(E)Hospital:** The former President Paul Castel focused on the internal reorganisation of the association (such as the creation of the statutes), and on modernisation. What are your key objectives?

**Kölking:** Within the last few years, we have tried to regenerate the basic organisation and objectives of the association. This was necessary, from a juristic and formal perspective. An essential task, this was very hard and time consuming. As decided by the Board and the Executive committee, my focal point will be with regard to structure, which is essential as we are affected by an enormous change of structures in European hospitals. So I want to involve and realign the work of the association in this environment. Due to my own experiences I know that there is a lot of work to be done to ensure successful association activities. Not only because of our colleagues but also because of the basic conditions in which we are working.

**(E)Hospital:** So the focus for EAHM will be on the one hand the integration of

the national associations and on the other hand the support of the work of Hospital Directors?

**Kölking:** Yes, exactly. We will also do some structural work on the basic conditions in cooperation with the national associations of hospital directors. However, the focus has to be on the level of the management and due to structural change there is a lot to do. We have to better organise the running of our hospitals so that we can cope with current challenges. Demographic change is putting pressure patient care and aging healthcare workforce is also of great concern. In addition to this, there is an economic pressure not only to ensure the quality, but also to improve it. Good management is required here, i.e. hospital directors who can form and develop new structures. This is the mission we have in Europe. Therefore we have to form a common commitment of hospital managers in Europe, i.e. a common idea of what hospital management should be. However, this is not just about technology but also about human resources management, and human resources management requires an idea of the targets of our social commitment.

**(E)Hospital:** Many people are saying that hospital directors are being overtaken by health managers as the most effective form of hospital management. What do you think about this idea?

**Kölking:** First of all I have to say that it is not possible for one person to take care of all management responsibilities. However, the top management, no

matter if it consists of one, two or three people, has to have a comprehensive knowledge of the hospital system and the ability to organise the management successfully. The question if the manager should be an economist or a person in the medical profession is secondary; a manager should understand the way a hospital works and should be able to have empathy for employees and patients. If this is true, they can be a successful manager. There are many tools and training programmes for managers that we must standardise and pass on to colleagues. This is very important for the next generations of hospital managers.

**(E)Hospital:** How do you rate this year's congress, "Roadmap to Top Quality" in comparison to previous congresses?

**Kölking:** I don't think that it is necessary to compare congresses. The congress was, just like Graz, a highlight for our association and our work. I think that the colleagues in attendance will gain from the congress through the high quality presentations and exchange of experiences. The presentations have shown us the newest trends in quality management, highlighted the common problems we all have and indicated where we can find proper solutions.

This year, the focus was rightly on quality. However, you can't see quality as a isolated factor but in connection with financial conditions. It is our challenge to find the perfect balance between quality and financial conditions to ensure the best healthcare for patients. All in all, the congress was excellent.



## EAHM AWARDS THREE NEW HONORARY MEMBERS: ASGER HANSEN, ERVIN KÖVESI AND MANUEL DELGADO



Introduced by Heinz Kölking, Ervin Kövesi was unable to accept his Honorary Membership in person. Kovesi completed his education as an economist and has worked in healthcare ever since. Roles have included Administration Director and later President of the Medical University Debrecen/Hungary. Mr. Kövesi was also acting Director of the Institute of the Hungarian Depart-

ment of Health. He has also been editor-in-chief of the Hungarian hospital journal since 1984.

Paul Castel presented the impressive CV of Manuel Delgado to the General Assembly and awarded him an Honorary Membership. Manuel Delgado has been extremely active in EAHM. A member of the Executive Committee as the representative of the Portuguese Association

of Hospital Managers from 1994-2010, Mr. Delgado has also been a Board member from 1998-2010. President of the Portuguese Association of Hospital Managers from 1992-2008, Mr. Delgado was also bestowed the honour of EAHM President for the period of 2002-2006.

Willy Heuschen presented Asger Hansen with his award, describing him as a well-known personality within the organisation. For 25 years he has represented the Danish Association of Hospital Managers in the Executive Committee. Member of the Board, he has been first Vice-President and then from 1998-2002 the President of EAHM. During his presidential mandate the General Secretariat in Brussels and the subcommittees were created. Since its creation he has been the President of the Scientific Subcommittee.



All pictures available online  
[www.myhospital.eu](http://www.myhospital.eu)



# TACKLING CLIMATE CHANGE FOR HEALTH

By Rory Watson

**Europe's public health services would reap major benefits from an ambitious policy to tackle climate change, according to a new report by two health and environmental non-governmental organisations.**

As European governments prepare to draw up their negotiating stance for the next round of global climate change talks in Cancun in December, the Health and Environment Alliance (HEAL) and Health Care Without Harm Europe (HCWH Europe) argue that the European Union should aim to reduce greenhouse gas emissions by 30% instead of the 20% now on the table.

Génon Jensen, HEAL's executive director, says: "This study provides conclusive evidence that cleaner energy and cleaner air, associated with an immediate move to 30% domestic cuts in greenhouse gases by 2020, would go a long way to paying for itself in better health in Europe."

By increasing its overall target, the Union would make annual health savings of up to 30.5 billion euro by 2020, they forecast, in addition to the 52 billion euro health gains anticipated from the existing 20% target.

The calculation of health benefits from cleaner air takes account of anticipated improvements in life expectancy, respiratory and cardiac health, reductions in hospital admissions and fewer days of restricted activity due to respiratory health problems.

More specifically, the report (Acting now for better health: a 30% target for EU climate policy) points to 140,000 additional years of life, three million fewer lost working days per year, 1.2 million fewer days of respiratory medication use by adults and children, 142,000 fewer consultations for upper respiratory symptoms and asthma each year and 3,776 fewer hospital admissions for respiratory and cardiac conditions.

Germany, for instance, would have 1,010 fewer hospital admissions per year. There would be similar reductions in other countries: Belgium (114), France (432), Italy (420), Netherlands (136), Poland (501), Spain (108) and the UK (113).

The research provides for the first time a breakdown of projected health savings by country if EU governments commit themselves to the 30% target. The biggest beneficiary would be Germany (up to 8.1 billion euro a year). Poland, France and Italy would be the next highest beneficiaries and Belgium, Spain and the UK would make health savings of up to 900 million euro annually.

The authors note that their analysis, by covering the cost of both deaths and ill-health, which include hospital, consultation and medication expenditure and restricted activity due to heart and lung conditions, goes further than recent findings from the European Commission. The EU executive's calculations had fo-

cused on the health benefits on the basis of increased mortality from exposure to air pollution alone.

Indeed, the two NGOs suggest that the real health benefits could be even higher than they predict since as greenhouse gas emissions fall, so too do other air pollutants. These co-benefits, would be in addition to the obvious health advantages to be gained by reducing the phenomena associated with climate change such as heat waves, flooding and the spread of infectious diseases.

## Cross-Border Reimbursement Clarifications

Meanwhile, pan-European legislation clarifying the conditions under which patients may be reimbursed for healthcare they receive in another EU country has moved a significant step closer to its final adoption. In mid-September, EU governments formally set out their proposals which are roadmap to top quality to strike a balance between an individual's right to cross-border healthcare and the ability of national authorities to organise their own healthcare systems.

As a general principle, patients may be treated abroad and reimbursed up to the level they would have received for the same or similar treatment in their national health system. However, a government may limit application of the reimbursement rules if it believes overriding interests of general interest exist, such as the danger of seriously undermining the balance of its social security system.

National authorities would also be able to manage the outward flow of patients by requiring prior authorisation for healthcare which involves overnight hospital accommodation, or highly specialised and cost-intensive medical procedures or gives rise to concerns over the quality and safety of the care.

Similarly, countries receiving incoming patients would be able to take measures to ensure that their health facilities are not overwhelmed by the extra demand to the detriment of their own nationals. At the same time, they would be responsible for establishing national contact points to provide patients from other countries with the necessary information on safety and quality standards to enable them to make an informed choice.

The draft legislation now passes to the European Parliament which is likely to introduce further amendments this autumn.

# OPENING CEREMONY

The 23rd EAHM Congress in Zurich was officially opened by Mr. Rolf Gilgen, President of the Swiss Association of Hospital Managers. Artemis Trio, a three-piece band played the Swiss national anthem as a procession of two men and two women made their way through the convention hall symbolically carrying the Swiss and EAHM flags.



Rolf Gilgen,  
President of the Swiss Association  
of Hospital Managers



Paul Castel,  
President of the EAHM 2006-2010

Mr. Gilgen welcomed participants to the first EAHM congress to be held in Switzerland. With the slogan of "Roadmap to Top Quality" Mr. Gilgen stressed the pressure hospital managers are under to ensure excellence within their organisations under increasing financial constraints. He explained that the presenters would present innovative and pragmatic solutions and called for participation and discussion among delegates; to be inspired and learn from each other. With this he called the host of congress Nicole Westenfelder, editor and host of Swiss healthcare programme Pulse, to the stage to start the proceedings.

Ms. Westenfelder was appreciative of her position of host and declared that she would lead participants through the programme but that she would not be the centre-piece. With this she welcomed Paul Castel, President of EAHM 2006-2010 to the stage.

Mr. Castel expressed what a great pleasure it was to take the floor and thanked the Organising Committee for their hard work. As President of the EAHM for a few more hours, Castel emphasised the important role of the association, creating a "social Europe" to share ideas and reflect on issues at a time when healthcare systems are experiencing difficulties. Financial circumstances and strong competition from the private sector make it essential for hospital managers to come together.

Managers share the same values of public service for the benefit of the patient. There are common concerns that require a common approach and common solutions. That is why EAHM set up a reflection group to focus on this common identity, the identity of the association as a stakeholder and a key player in Europe. The reflection group also calls for more attention on young managers and the establishment of partnerships with other industries.

For Mr. Castel, the theme of quality is at the heart of the profession of hospital manager. Quality of management staff is of prime importance. We will see new ways of measuring quality during the congress. We will set a new course and weather the storm.

After another musical interlude, City Councillor Claudia Nielsen, Head of the City of Zurich's Department of Health and the Environment was introduced to the stage. Nielsen emphasised that Zurich does not just stand for chocolate cows and punctuality- it is also famous for healthcare!

In Switzerland healthcare is available to all regardless of economic status- this is how

it is written in the by-laws. She spoke of an initiative called Health Network 2025. This initiative is jointly committed with other organisations in Switzerland for an integrated healthcare network. Quality should improve and if possible, reduce costs.

State Councillor Dr. Thomas Heiniger, Head of the Department of Health of the Canton of Zurich, was next to address the crowd. Focusing on the topic "Roadmap to Top Quality", he declared he was happy that this road to top quality has led EAHM to Zurich. Heiniger stressed that it is difficult to define quality but we need fixed requirements to ensure quality. There are clues to these requirements in the congress agenda. The city of Zurich has its own roadmap. There are 17 topics and objectives with an exact plan to achieve them. Two objectives concern healthcare, one of them being high tech medicine.

Dr. Pascal Strupler from the Federal Department of Health was the last to speak during this informative Opening Ceremony. He is the senior guardian of the health of all of Switzerland. Although reiterating the fact that the Swiss healthcare system is well-regarded internationally, Strupler admitted that improvements can be made regarding safety. Hospitals are complex institutions and therefore prone to error and high risk. Risks, however are not always checked. We need to find ways to reduce risks.

In Switzerland one in ten patients suffer damage in the healthcare setting, half of these could have been avoided. To prevent this, quality indicators should be published and next year data of all hospitals will be published to increase transparency, hopefully facilitating improvements for hospitals and patients.

The Opening Ceremony came to an end with a final song from the Artemis Trio.



## Keynote Speech

# REAL HEALTHCARE REFORM:

## Safety First- The Intrinsic Property of Financial, Operational and Clinical Success



Charles Denham,  
MD, Chairman, TMIT; Co-Chairman, National Quality Forum  
Safe Practices, Consensus Standards Maintenance Committee

Mr. Denham began by addressing what was on everyone's mind- why is an American delivering the keynote speech at a European congress!? Moreover, what can we learn from the US- a country with possibly the lowest quality of care and the most expensive of the industrialised nations? Mr. Denham believes that healthcare reform and quality are not only national, but global perspectives.

His objective was to share some of the very harsh business lessons that they are learning through healthcare reform in the US in the hope that Europe does not have to go through the same pain.

### Quality Through Leadership

The focus was on the opportunity that leaders have to make a significant impact on healthcare reform. "It is my belief that the next generation of breakthroughs in healthcare quality will not be software; it won't be hardware; it won't be a new pharmaceutical agent; it won't be a new breakthrough in understanding the genome. It will be you. It will be leaders."

Mr. Denham stressed that research in the US suggests one in ten patients has harm from the care that we as healthcare providers deliver and that we have an excellent opportunity to reduce that harm. To illustrate the problems with healthcare in the US, Mr. Denham used the example of a news mag-

azine. The cover story highlighted the best hospitals in America while another article described the problem of over-prescription of medications and another the dangers of medical insurance fraud. Also included was a patient survival guide for going into hospital. Clearly quality of care is a preoccupation of the general public as well as healthcare providers.

### Story Power

Stories are a key tool for leadership. There are many stories that can provoke improvements in processes and quality. Dennis Quaid joined Safety Leaders because of his particular story. His ten-day old twins experienced a catastrophic medication error. They were admitted to the hospital for an infection and were given 1000 times the dose of blood thinner herapin, twice. By joining the organisation and sharing his story he is helping to build awareness.

For Mr. Denham, leaders can use stories to bring the heart and the head together. That means bringing together facts and numbers with emotion and love. The greatest leaders are those that can communicate and empower their staff by telling stories.

### Failure of Support Systems

Why are there so many quality issues? Denham believes that these problems are due

to the failure of support systems: leadership support systems, practice support systems and technology support systems. These three systems can deliver high quality care but this is not happening in practice; information is not managed correctly nor are medications and pathology reports. System failures have a direct impact on quality.

Taking nurses as an example, Denham claims that, "We are asking our staff to do more and more without teaching them how to work smarter with leadership." Nurses go to the nursing station on average 200 times a shift, and to the medication cabinet 100 times meaning they are travelling three to five miles in a typical shift. They RFID tagged the nurses to calculate how they were using their time but the technology failed as the nurses moved too fast to be recorded. This illustrates the pressures put on healthcare staff.

### The Four A's

For Mr. Denham, the four A's: Awareness, Accountability, Ability and Action are key to quality in the adoption of technologies and practices. "Awareness of performance gaps, accountability of those who must close the gaps, the ability or know-how of those who are accountable (you can be aware and accountable but not be able to close them), and then the direct actions that need to take place."

To illustrate the importance of the four A's, Mr. Denham looked to the CT scan radiology accident issue, something prevalent in both the US and Europe. He showed a photograph of a patient with a Saturn ring area of alopecia on his head due to radiation. Basically the patient was given too high a dose. In the US 70 million CT scans are performed per year but there is a 30% overutilisation rate and 40% of studies are inappropriate.

Mistakes like these are system failures, the leadership are more often than not unaware, there is a lack of accountability, and no investment in knowing when accidents might occur and the risks and actions. The four A's prevent problems like this from occurring.

## QUALITY AND IMPROVING QUALITY: Concept, Implementation and Communication



Anthony Staines,  
PHD, Associated Professor at IFROSS,  
Project Manager "Patient Security" Switzerland

Anthony Staines focused on three aspects of quality: concept, implementation and communication. He stressed that there is a discrepancy between the quality demonstrated by research to be achievable and the quality actually attained.

Starting with the history of the concept of quality, Staines explained how the concept evolved. Before the industrial revolution products were made by hand, by an individual, meaning therefore quality was ensured. After the industrial revolution, production became mechanical and organisation reached a new level. Quality was no longer determined by an individual but part

of the system. Moreover quality is not just a result of the correct materials and individual expertise, it must be managed and co-ordinated.

Staines informed the audience of some of the key players in the history of the quality movement. Walther A. Stewart of General Electric created a concept to reduce the need for physical inspection using statistical analysis of processes. This led to the cycle of continuous improvement: ACT-PLAN-DO-STUDY-ACT.

Within the healthcare sector specifically, Ignace Phillippe Semmelweis and Florence Nightingale

discovered the causes of reduced quality; finding the origin of puerperal fever came from contamination during dissection by surgeons and that hygiene affected the mortality rates of soldiers during the Crimean war. Ernest Armorey Codman is recognised as the founder of "outcomes management", the impact of the relationship between the result and the process of medical treatment. He founded the American College of surgeons and the "Hospital Standardization Program" which later became "Joint Commission International".

After this, the healthcare sector was equipped with articles, books on quality of care, its definition and evaluation. Quality analysis models were created and Archibald L Cochrane developed Evidence-Based Medicine. International societies dedicated to ensuring quality soon followed.

However, the challenge for health services is the gap between the potential revealed by scientific research (best practices) and clinical practices. Staines used the example the insertion of a central line to illustrate the difference

between recommendations and what is done in practice. Recommended are checklists, hand washing, use of antiseptic etc when in reality things are very different (no checklist are used, 45% conformity with hand hygiene...).

So how do we ensure best practices? Staines believes that the system is key: if a system is good enough, individuals will adopt them.

He cites 10 key points essential for clinical quality and patient safety:

- ▶ Understanding
- ▶ Leadership Vision
- ▶ Organisation
- ▶ Measure and information system
- ▶ Culture
- ▶ Teamwork
- ▶ Best Practices
- ▶ Objectives, Evaluation and Feedback
- ▶ Inclusion of the Patient
- ▶ Cost/Value

For five of these points communication is key: leadership vision, culture, inclusion of the patient, objectives evaluation and feedback and teamwork.

## LACK OF TRANSPARENCY WITH REGARD TO QUALITY IS UNSETTLING PATIENTS



Erika Ziltener,  
President of the DVSO,  
Swiss Patient Centres,  
Switzerland

Patients hear little about the quality of services in hospitals. Their opinions and expectations are formed through discussions in social settings or their GP or healthcare provider act as a guide. The media also plays a role in forming opinions, often raising fears. But patients' expectations can be met by providing transparency with regard to quality in hospitals.

Ms. Ziltener explained that she is here to provide an external view on hospitals and quality. Her presentation was based on the point of view of patients, the response of hospital managers to her organisation's work, the press and different working groups.

According to Ms. Ziltener we subscribe to too high expecta-

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and devices from other manufacturers, such as endoscopy equipment can be integrated without any difficulties. For the equipment pool that is found in most operating theatres, this compatibility is particularly significant when it comes to choosing the right system for coordinating workflows.



*By centralizing video management, documentation, device control and room control on an intuitive user interface, AV CONFERENCE reduces the complexity in the OR.*



tions of medicine. When a patient is admitted they have the expectation to undergo an extensive programme of care and to be cured. The problem arises when patients are not cured, when expectations conflict with reality. We need to help patients cope with this as they are not familiar with quality assessment.

Patients and their families interpret risks and complications as lack of quality, which leads to lawsuits. This is, in turn, worsened

by the media. We do not learn of measures of consequences independent of guilt. Yes, this information is available in trade journals but the public does not access this information.

Patients are left alone for important decisions. When choosing a hospital, patients do not look to quality indicators/publications but to their friends, relatives; they ask about their experiences. They do not ask about quality as-

surance and just have to trust hospital personnel.

Ms. Ziltner believes that trust is key for quality and patient satisfaction. Independent of the reputation, in case of lack of transparency there is a lack of trust. Hospital managers must create this trust, including efforts for transparency. After all, wherever humans work mistakes are made. Transparency is the best pre-requisite for trust.

Publication of quality indicators is essential. It is clear that there is a lack of data, but what is available should be published, even if the numbers are low or hard to understand. The public also needs feedback on how hospitals deal with error. In this way we can learn what they do to prevent mistakes in the future. There needs to be a change in the error processing culture within our institutions, with feed-

back on consequences and measures taken. This will ensure that patients know the same mistake won't be made again.

Ziltner stressed that although transparency is not equal to quality, it often triggers more measures and acts as the first step to improving quality. As we all know, pressure can lead to improvements. Patients have the right to know what quality to expect during treatment. This in turn fosters compliance among patients.

To conclude, hospitals must promote standards, error reporting systems and quality competition instead of cost. Results must be published; there must be transparency of medical indicators and comparable performances. We need a knowledge-based medical system encouraging quality competition and collaboration between patient centres and hospitals.

## THE COMMUNICATION OF RISKS— THE RISKS OF COMMUNICATION



Prof. Dieter Conen,  
President of the Patient Safety Foundation

It is widely accepted that 30–50% of medical errors could be avoided. Conen believes that risk in our hospitals is poorly defined; it is uncertainly expressed in empirical fact in numbers. Patients need to weigh the benefits with the risk of harm; those who understand this situation have a better forecast.

Conen took the example of a patient whose potassium levels

were at the upper limit. The doctor informed the patient of this fact, who in turn asked what it meant exactly. The doctor replied that it did not matter, it is not serious but that he wanted to keep the patient informed. As long as you can make decisions for your patients you do not need to explain. There is however a need for figures and knowing how to handle them.

The presentation emphasised that communicating risks with patients depends on their level of literacy. Surveys have found that only 15% of patients are competent in reading, writing and critical thinking. OECD launched an initiative called “Are you a prepared patient?” illustrating the need to move from a patronised patient to a competent patient. For this we must look to the doctor, they have a responsibility, as do patients. Communication is key.

So how do we do this? Doctors must assess what patients already know, what they would like to know and then describe the risks, implications, processes according to their level of literacy. This should be done with empathy and sincerity. Communicating the risks like this can build trust.

Patients must be faced with clear and easy decisions. Qualitative statements should be

used (whether something is positive, likely, common, unlikely or rare). Conen believes that we need a standardised method of risk communication with less numerical answers; people think in categories rather than percentages. This is also important in the media, as they use only percentages, which scares the public.

Also important is telling patients where they can get more information from. For example, risks and damages from medication. Indeed, it is very hard to distinguish between the benefit and damage of medication. We only hear about the approval of new medication, not the associated risks. Moreover, cash interests often taint drug advice.

For Conen the key importance is telling the truth and in doing so, conveying hope. Facts must be provided along with a message of hope, which is not possible using technical jargon.

## QUALITY: THE MANAGER’S POINT OF VIEW



Prof. H.J.J.M. Berden,  
CEO St. Elisabeth Hospital, Tilburg, The Netherlands

Quality of care remains the most important aspect for every patient as well as the first selling proposition of every hospital. A great principle, but

extremely difficult in practice. Of great help is the fact that there is a strong correlation between the quality of care and safety, cost-effectiveness and

the satisfaction of both consumers/patients and workers.

Mr. Berden examined the question of how quality can be improved and stressed that this should be sustainable. As well as the well-known and useful instruments such as standards, protocols and checklists, the decision-making process at a professional level also plays an important role.

In the Netherlands there are around four serious incidents per year discussed heavily in the press and parliament. 25% of cases are over-treated and 35% under-treated. There are large differences in professional compliance and also between institutions. From the US experience

we have learnt that poor quality is expensive.

So what improves quality and what does not?

*Transparency* can be effective if the source is reliable, if we are shown how it can be done better and if it is repeated on a regular basis.

*Involvement of the Patient*: considering the dreams, expectations of the patient. Berden believes the Boivin level of involvement is of help when exploring the needs and experiences of the patient through consultation, when informing the patient about the quality and involving the patient. *A better organised system* is also very important. Quality of care is

managing complexity so the organisation of the care process, including coordination, using protocols, guidelines and checklists and also improving the effectiveness of the team, is important. Changing the system is the best way of changing individuals but this is something yet to be imple-

mented in many hospitals.

*Commitment of professionals:* healthcare workers make the system and make the mistakes (clinical and managerial). Yes, commitment is effective but it is not natural. According to Berden we need a new professional mindset of being accountable,

being a team member and accepting the context. This mindset is created through education and socialisation.

*Leadership* is a critical success factor that we must be aware of and use to improve quality and safety:

*A conditio sine qua non!*

*Noblesse oblige!*  
*Including our leadership!*

To conclude, Berden reiterated that these five points are vital elements for further developments in quality. No single element is the Holy Grail; it is the combination of all five that will bring success.

## QUALITY OF HEALTHCARE: HEALTH ECONOMICS VERSUS HEALTH POLITICS



Dr. Gediminas Cerniauskas,  
PHD Health Care Reform Expert, Lithuania

Dr. Cerniauskas' presentation focused on how both economics and politics are important in regards to quality of healthcare. Although healthcare professionals, politicians and economists may not see eye-to-eye they are all implicated in the quality of care.

While quality of healthcare and quality related issues have, for a long time, been almost exclu-

sively in the domain of medical professionals, politicians and economists also have important roles to play. Starting from the fall of the nineteenth century politicians stepped in for reasons of social stability (Bismarck), grip on power (Semasho), equity and solidarity (Beveridge). In parallel to the health sector becoming the major sector of the economy, economist fol-

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lowed politicians bringing their concepts of marginal costs and utility as well as the principles such as Pareto optimality.

For economists, although healthcare is one of the largest sectors in the EU, the healthcare market is not perfect. Consumers are not rational (risky lifestyles etc), there is an induced demand, some goods and services are public and there are many monopolies such as global patented drugs, regional natural monopolies in healthcare services etc. In turn, public politics have to correct these market failures. Risky lifestyles are combated by legal prohibition of certain behaviour and induced demand can be corrected through limited marketing, making GPs gatekeepers and the health education of the general public.

For Dr. Cerniauskas quality of care has multiple dimensions in-

cluding access, safety, equity, appropriateness and health improvement. Optimal quality in healthcare is different for all three groups. For economists optimal quality is about achieving highest possible utility, but politics is a show. Politicians have tools to cope with long term problems by using recourses pooled by tax offices to support fundamental science, medical universities, help the poor and the elderly. But they also have to face the political cycle; to withstand pressures put forth by the medical profession, the industry, and patients on the topic of temptation to use public recourses above the sustainable levels and to resolve "emergencies" created by mass media.

Medical professionals are against this show (at least because of the principal "you

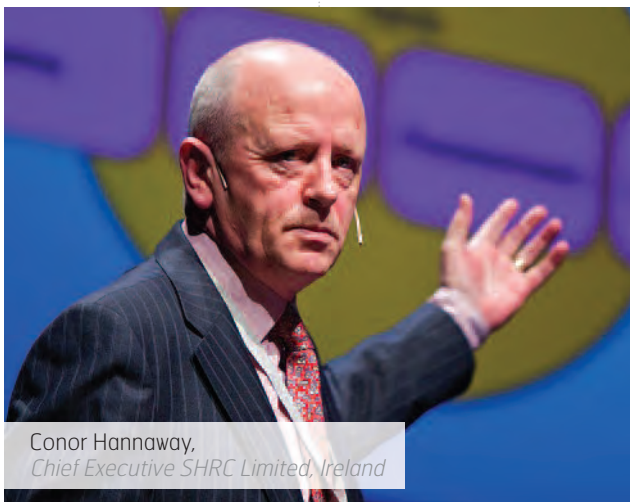
should not harm the patient"). Economists are also against such short-term policies (they prefer "boring" equilibrium and incremental changes to "bright" new ideas about radical reforms or "miracles" created by the welfare state) and both groups of professionals are critical about politicians and this sceptical approach creates a rational framework for political show.

Doctors and economists, while usually suspicions of each other, sometimes (e.g. medical technology assessment or evidence based medicine) need mutual exchange of professional expertise.

To illustrate the interaction of these three professional groups Dr. Cerniauskas used a Lithuanian public health example concerning road deaths. The country had a very high rate of road deaths and casu-

alties so the government invested in highways and speed controls. This however resulted in no change. The trigger for decisive action came when a drunk police officer killed three children. The public demanded action and this incident ensured that it happened. Now future drivers receive more training and following passing their test they have two years probation. There are also intensive public awareness campaigns. Now we can see a huge decline in road deaths dropping from 899 deaths in 2006 to 452 in 2009. A similar decrease can be seen with injuries. The outcome: positive health results, positive political results (more public trust of government) and positive economic results (one life year saved 5000 euro).

## THE ROLE OF THE TOP MANAGEMENT TEAM IN ENHANCING QUALITY OF CARE THROUGH INTEGRATED CARE PATHWAYS (BETWEEN A LEADING HOSPITAL IN IRELAND AND THE COMMUNITY IT SERVES)



Conor Hannaway,  
Chief Executive SHRC Limited, Ireland

Conor Hannaway believes that integrated health services are an efficient, effective, patient-centred strategy best suited to the challenges hospitals are facing in Ireland. Integrated healthcare systems can improve hospital

systems and also quality of care for patients.

In Ireland, the idea is to develop integrated care services across all stages of the care journey. Hannaway described a care pathway as a complex interven-

tion for the mutual decision making and organisation of care processes for a well-defined group of patients during a well-defined period. The aim of this pathway is to enhance the quality of care across the continuum by improving risk-adjusted patient outcomes, promoting patient safety, increasing patient satisfaction, and optimising the use of resources.

Integrated care should be person-centred and offer a readily accessible and seamless service based on the needs and preference of people who use the service. Both patient experience and quality of care can be enhanced through integrated services. The focus is on values, equity and easy access but also on appropriateness, quality, efficiency, responsiveness and accountability.

Through integrated care pathways, the Irish Health Service has improved health outcomes, ensured the efficient use of resources, improved accountability, streamlined management and moved towards prevention and community care.

Hannaway stressed that implementing integrated care pathways can be a challenging process. There are strategic/structural questions to be asked: What is a hospital? What is the future of hospitals? There is also a leadership challenge. The hospital management must be ready and equipped with all the competencies required. Lastly, there is the knowing-doing gap. We can read about best practices, new methods but can we actually put them in practice? This is another challenge.

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## THE PITFALLS AND USE OF OUTCOME INDICATORS, TAKING POST-SURGICAL INFECTIONS AS AN EXAMPLE



Prof. Nicolas Troillet,  
Central Institute Health Network Sion, Switzerland

Various partners in the health system are increasingly turning to indicators to reveal the quality of the care given. The path of 'outcome measurement' is however, strewn with pitfalls, and it is essential to be aware of these in order to interpret and use such data. Prof. Troillet illustrated this through the example of a Swiss multi-centric programme for monitoring surgical site infections.

Prof. Troillet stressed that the programme concerns outcome indicators and not process indicators. The focus is on figures for mortality, patient satisfaction, infection rates, SSIs.

Surgical site infections (SSIs) are infections occurring within 30 days (12 months in case of foreign bodies) at the level of the surgical incision or involving the organs or spaces that were opened or manipulated during the intervention. SSIs are the most frequent nosocomial infection in Switzerland.

SSIs are too common a complication, the rate in Switzerland is 5.6% equating to 33,500 patients per year. The surveillance of SSI provides data that can both inform and influence practice to minimise the risk of SSI. Data collection results should

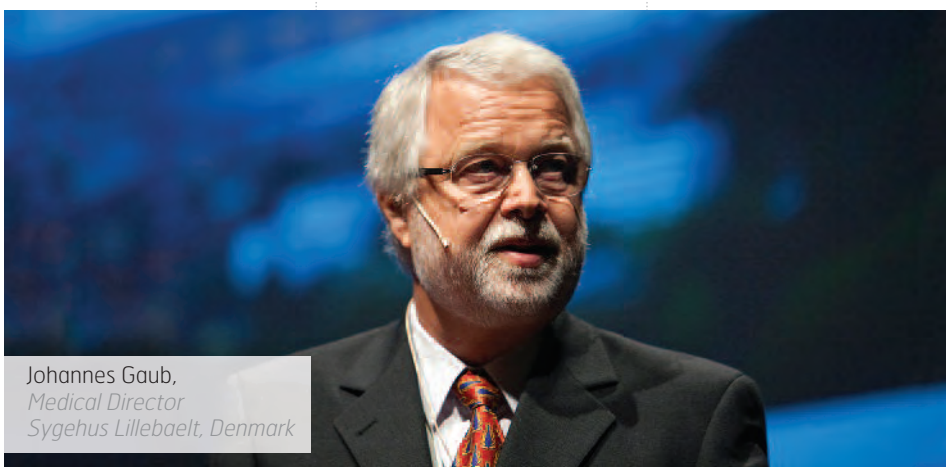
be followed by analysis and interpretation and then a feedback and discussion session. This in turn should result in corrective measures. We must strive to bridge the gap between what we know and what we do.

Data must be broken down in order to make comparisons. Prof. Troillet cited several rules for surveillance and comparison of results. The first rule to remember is that there are rates of infection by type of intervention; there are different risks categories for SSIs among the same interventions, not linked to quality of care (case-mix). Secondly, data should be broken down into rates by intervention and by risk category and thirdly not all surgical site infections are identical. A lot of SSIs occur after the patients have left the hospital and this should be taken into account. The fourth and fifth rules ask the questions, is there post-discharge follow-up? And is there a validation system in place? It is hard to decipher whether rates within hospitals and countries are so different or whether some countries are doing a better job of finding them.

According to Troillet, one major pitfall lies in the comparison and interpretation of such data. There are many reasons for observed differences and these differences can be artificial and true differences. Artificial differences are case definitions, case detection (during hospital stay, post discharge) and the aggregation of small samples. True differences are quality of care and risk factors (procedures and patients case-mix).

Prof. Troillet concluded his informative presentation by discussing the challenging questions that lie ahead. The first question is what to do with the results? They should be given to surgeons and management should make sure they are used. The second question is whether inter-hospital comparisons are meaningful or not? Troillet believes that under several conditions and with caution they can be useful. The third and final question concerns public reporting- is it a good idea? Although it might induce gaming and be counterproductive it is nonetheless important to get prepared!

## PLANNED PATHWAYS IN THE MANAGEMENT OF CANCER



Johannes Gaub,  
Medical Director  
Sygehus Lillebaelt, Denmark

In the last three decades the incidence of cancer in Denmark has been among the highest in the OECD countries. At the same time the outcomes of cancer treatment rank among the poorest. Since the turn of the century, this picture has changed completely as a result of the national Cancer Plan I and Cancer Plan II, adopted in 2001 and 2006 respectively. One important tool in this process is the universal use of planned patient pathways, in which the neces-



sary diagnostic and surgical capacities are pre-booked and the services delivered according to national guidelines.

Mr. Gaub stressed that packaged pathways can be extremely helpful for cancer care but that they are also challenging for both management and clinicians. Indeed, packaged pathways will be neither implemented nor a success unless managers play an active role.

High cancer incidence in Denmark is often related to lifestyle choices but outcomes are always determined by the health-care system. The system in Denmark is often marred with delays; long waiting lists and delays cost lives. There are waiting lists for each step in the care process, from diagnosis to treatment. At Sygehus Lillebaelt they found a solution to this problem: compressing waiting times into

packages (packaged pathways). For example, there is a lung package, with a lung team. The diagnostic work-up for suspected lung cancer is then done within 10 days.

Gaub defines a packaged pathway as a standardised part of clinical pathway, diagnostic or therapeutic, consisting of pre-reserved elements, in predetermined sequences and according to national consensus guidelines.

To facilitate packaged pathways there should be electronic communications everywhere with universal access to lab-data and imaging and easy access to initial examination, e.g. thoracic x-ray. There must also be teams of specialists, a contact physician and contact nurse and a team boss. Jobs must be easily swapped if it allows smoother operation and a weekly team conference is the essential cornerstone.

The advantages of packaged pathways include that results from diagnostic tests are always available at an agreed time, since capacity is pre-reserved and there is also a high rate of productivity and high training efficiency. Unused pre-reserved slots are rarely wasted, if released 72 hours before occurrence and any team member can answer questions from the patient. Losing patients between departments is rare thanks to contact nurse and physical handing-over procedures.

But if packaged pathways are such a good idea, why didn't everybody do it a long time ago? Gaub explained that success depends on rigid planning to make it work 52 weeks per year and that consultants must accept to be booked by their colleagues. Other factors producing resistance to packaged pathways in-

clude misconceptions about the need for excess capacity, misconceptions about "industrialised" pathways, the tendency to view a long waiting list as an asset (a well padded order book) and surprisingly the failure to realise that delayed diagnosis costs lives.

Packaged pathways are not always the best choice, they will not work if the weekly volume is below two to four patients as pre-reservation becomes meaningless. This is also true if bottlenecks are not removed immediately and if failure to deliver results occurs frequently, and there is a lack of cooperation and commitment.

To conclude, Mr. Gaub stressed that the role of the management is key. They must provide the hardware, break down old habits and keep an eye on the results - all the time.



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## CLINICAL RISK MANAGEMENT- A MANAGEMENT TOOL FOR HOSPITALS



Peter Gausmann,  
Head of Risikoberatung GmbH, Germany

According to Mr. Gausmann clinical risk management has been around since the 1990s. For around five years, the clinical risk management system has been receiving a stimulus from patients themselves, which is having a long-term effect. Preventative measures in particular are aimed at increasing patient safety.

Indeed, there are many global processes and programmes for recommendations for patient safety. Such programmes

include 'Clean Care is Safe Care' which focused on hand disinfection projects, 'Safe Surgery Saves Lives' promoting the surgical safety checklist, 'Patients for Patient Safety' for patient information, and reporting and learning systems (local, national and international).

Meanwhile a whole series of tools and procedures are available for improving patient safety, which interlink to allow a risk management system to be built up. Knowledge about prevention

can be generated through retrospective examination of adverse outcomes and complications. Measures supporting this perspective include the morbidity and mortality conference, the retrospective adverse event analysis or an event and risk communication analysis. Seen from this perspective, risks can be identified, weighed and altered in risk audits. The external risk audit has proven to be the tool offering the highest gain in knowledge and the widest potential for the implementation of preventative measures.

So what effect has clinical risk management as a control tool? Gausmann argues that it can improve patient safety and also be used as an economic control tool. Analysing risk can also have a positive effect on public relations and organisational development.

To illustrate the positive effects on patient safety, Gausmann used the example of the surgical safety checklist. The checklist must be completed before,

during and after each surgical procedure. He stressed that these checklists must be filled in completely and if done so they decrease the margin for error and confusion.

Mr. Gausmann also mentioned the importance of simulation centres. Here doctors train with animation dolls. This interactive learning experience is extremely beneficial for clinicians. The parameters change during the course of the treatment and it is the instructor who is behind these changes. A highly efficient method of learning, simulation centre experiences also include the analysis of each clinician's performance afterwards.

The presentation was concluded with a quotation from Robert Wachter, from *Understanding Patient Safety*, published in 2008. The quotation emphasised that we still have a long way to go concerning patient safety, stressing that we must not rest until patients can go away without the fear and anxiety over treatment and care.

## VALUE CREATION BY SERVICE OUTSOURCING IN HEALTHCARE



Jeff Gravenhorst,  
Group CEO ISS Global, Denmark

Mr. Gravenhorst highlighted the current challenges in the health-

care industry: economic and political climate; increased public

sector focus; and demographic development. These challenges have led to certain macro economic developments. Financial constraints include declining reimbursements, increased costs and a change of workforce and demand. Service levels have been impacted due to rising demands, capacity constraints, pressure to cut costs and specialised treatments. Patient behaviour has also changed due to more transparent information, greater variety of choice and litigation. There are also new market drivers: competition is

emerging, there is a need for productivity efficiencies and a new trend from institution to brand.

Gravenhorst emphasised that these trends are driving a change process in the healthcare sector where providers are being forced to re-evaluate their business models, to become more innovative. The development consequences for hospitals mean managers must focus on the key market drivers like the private sector. Managers must determine what are the key competencies and what makes

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you successful. They must also determine what is core to quality medical services; what is a prerequisite for healthy patients and then liberate medical resources by outsourcing of “non-core” services.

There are three key questions to ask when you are considering outsourcing:

- ▶ If starting from scratch today would we really build the capability inside?
- ▶ Are we so good at this that others would hire us to do it for them?
- ▶ Is this an area of our business from which our future leaders will come?

If not YES to all three, then outsourcing should be examined.

To solve these problems:

- ▶ Find partners who can support you in achieving your goals and reaching your success criteria;

- ▶ Transfer financial and operational risks;
- ▶ Strive for management and operational excellence by outsourcing processes and not tasks; and
- ▶ Performance based on balancing quality and cost.

Gravenhorst believes that a transparent and streamlined value chain makes management more efficient and creates value:

- ▶ Drive for efficiency – price,

cost, performance and service level dynamics;

- ▶ Doubled-up functions are easily eliminated;
- ▶ A single point of contact shortens and optimises lines of communication; and
- ▶ Risks are eliminated by transferring them to a (reliable and sound) partner
  - Someone who mitigates these risks
  - Someone who protects the brand you are building

## CREDO-DRIVEN QUALITY: WHAT IS THE PRODUCT?



Peter Steinmann,  
Regional Vice President, Austria, Germany,  
Switzerland, Johnson & Johnson

“Caring for the world, one person at a time” is how Steinmann described Johnson & Johnson. In today’s healthcare environment, the focus on quality, trust and safety has never been greater and more important. Steinmann believes that it is this focus and the commitment to the medical community and patients, which ignites new innovation, continuing education and better approaches to delivering products to customers.

Steinmann cited the three main challenges in hospital management today as: comprehensive care for patients, managing patient safety/quality management, and operational efficiency. Comprehensive care for patients means we

must focus on innovation and customer solutions; looking at healthcare from a patient-centric perspective. This comprehensive care also depends on continuing professional educa-

tion (product training, surgeon-to-surgeon training, etc.) Steinmann used the European Surgical Institute as an example. This institute is a modern and innovative centre for surgical training with lessons in the latest minimally invasive surgery skills, expert teachers and state of the art simulation technology.

To illustrate the second challenge, managing patient safety/quality management, Steinmann turned to single-use devices. Johnson & Johnson medical device companies provide high quality, cost-effective single-use devices that are designed and manufactured to be used on a single patient for one diagnostic or surgical procedure, and then discarded. Quality can be enhanced by design controls and risk

management tools, benchmarking and the utilisation of the latest (cutting edge) technologies.

Operational efficiency, the third and final challenge was illustrated through suture inventory management. The key advantages of such a system include minimal time invested by hospital in managing their inventories; less likelihood to run into a back order situation as during regular stock takes; continuous and speedy replenishment of used inventory, and less capital intensive.

Steinmann concluded his presentation by reiterating his company’s commitment, “a true collaboration of all involved in the health of patients based on trust, responsibility and guiding principles.”



## USING EUROPEAN UNION STRUCTURAL FUNDS FOR TOP QUALITY OF HEALTHCARE



Dominika Gryszowka,  
Head of Bureau for International Projects,  
John Paul II Hospital, Krakow.

Ms. Gryszowka, from John Paul II Hospital in Krakow, spoke from the fundraiser's point of view. The hospital admits over 22,000 patients annually, performs about 87,000 imaging examinations, functional tests and endoscopies annually using digital technology, and performs about 1,000,000 laboratory tests annually. But how is all this financed?

Well, John Paul II Hospital in Krakow is a leader in Malopolska Region in using Structural Funds of the European Union and other external financial sources. The Hospital has realised 11 projects. The total sum of the projects is 43 million euro and the total sum of the co-financing is 35 million euro.

For Ms. Gryszowka, top quality is ensured through infrastructure, research and development, technology transfer, telemedicine and international cooperation. For each of these categories Ms. Gryszowka explained how her hospital used funds from the European Union to improve quality.

An example of improving infrastructure was the construction of a specialist emergency ward with diagnostic and logistic infrastructure and a helipad on the roof. The hospital re-

ceived funds from the EU and the project, which started in 2007, will be fully operational in 2012.

Regarding research and development, the hospital also secured European funding for the development of the Krakow Center for Medical Research and Technology. The primary goal of the project is to establish innovative infrastructure to facilitate a comprehensive delivery of healthcare services and conduction of research using novel technology, knowledge transfer, IT-aided construction of medical databases. In the new setting it will be possible to expand diagnostics, treatment, prevention, telemedicine, health promotion and lifestyle changes, and implementation of information society solutions, education, exchange of specialist knowledge and experience.

John Paul II Hospital has also benefited from structural funds for research and development projects. For example, the project named "innovation transfer in the medical sector from clinics", which was part of the INTERREG IV C programme. The aims of the project are to compare the situation between clinics and SMEs in each participating country in line with their

specific healthcare environment and reimbursement system, the development of tools for access of SMEs to the innovation capability in clinics and the implementation of a European wide tool for innovation transfer from clinics to companies.

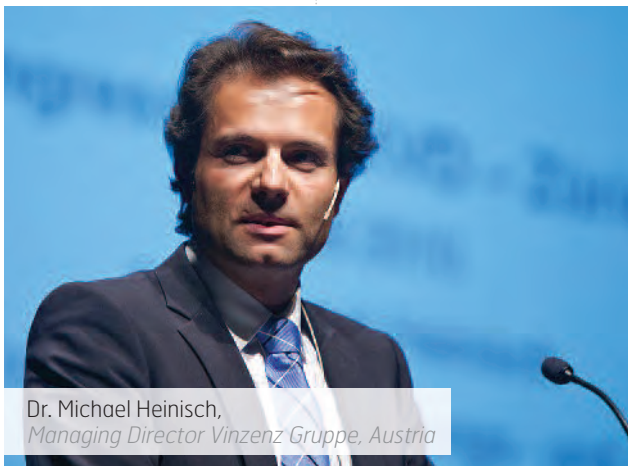
A telemedicine project is also underway: TCares - Technology Care. An INTERREG IV C (PEOPLE) project, it aims to create better understanding of the needs of system users and purchasers in private and public healthcare sector. To create basic training packages in the field of telemedical technology for the staff, to test telecare systems in private and public healthcare sector and to conduct pilot studies "Action Research" in order to define the needs of system users and pur-

chasers. The goal is then to disseminate best practices to all participating regions.

Gryszowka's last example of EU funded projects was an international project: NETC@RDS service for electronification of the European Health Insurance Card, Phase B Initial Deployment. The goal of the project is to start an electronic version of the European Health Insurance Card which successfully completed Phase A3 of the NETC@RDS project funded by the European Commission and eTen. The initial deployment project phase (Phase B) is extending implementations to enable healthcare access for European citizens providing evidence of entitlement in 305 service units and 566 service points across the participating countries.



## PRACTICAL EXAMPLES AND EXPERIENCES FROM AUSTRIA



Dr. Michael Heinisch,  
Managing Director Vinzenz Gruppe, Austria

The focus of Dr. Heinisch's presentation was on how investments in quality can also lead to improvements in efficiency. During his presentation he used the example of the hospital partnership between the Hospital of the Sisters of Mercy and the Hospital of the Brothers of Mercy in Linz, through which quality and efficiency improved.

Heinisch believes that there are two aspects of quality in Austrian healthcare reform: quality of information that patients are given and quality of our decisions as healthcare providers. The Vinzenz Gruppe is an umbrella

organisation for seven Order hospitals. Each hospital is of long-standing tradition. There is a public mandate and they work just like other hospitals.

Today in Austria the quality debate is cost-driven. This is not unexpected as healthcare expenses amount to 30 billion euro, 75 percent being public expenses; this amounts to 10 percent of GDP. Consequently, there is a huge pressure on public budgets. More and more people are discussing quality of care; better performances and services are increasingly important but so is economic per-

formance and value creation. Heinisch stressed that hospitals are there to heal patients but also that economic benefits are a good sideline. Economic performance is there and it needs to be discussed.

There is no binding quality reporting in Austria, it is optional to inform on quality. Patients do not learn about quality or performance in hospitals, even though the hospitals have this data. While private health insurers produce national patient surveys, public insurers do not; there is a lack of comparable patient experience data. For these reasons Heinisch believes that we need to focus on the quality of our discussions and that improving quality is an investment not only to improve quality but to improve efficiency and also our values and humanness. All decisions must be made using these criteria.

Using the example of the new-found partnership of two hospitals in Linz, the Sisters of Mercy (<100 beds) and the Brothers of Mercy (<400 beds). Lots of departments are the same in both hospitals so in order to create a

successful partnership the hospital needed to be restructured to become state-of-the-art. Departments had to be closed, staff were transferred to other institutions. This process took 10 years but eventually it was completed successfully. The saving potential is five million euro per annum and quality has also improved. Patient information is now shared and there is a new investment in humanness.

This investment in humanness is about improving the patient experience. Think about when a patient will be most afraid during their hospital stay. This is probably right before surgery, on their way to the OR. To counteract fear at this moment they have included a new group-people who push the bed to the OR. Before this was a man who has had no previous contact with the patient, now certified nurses, who know the patients and their families, do this job. This adds value for the patient. While medical results are questionable and costs are increased, a human touch is added, which you cannot pay for.

## LEAN PROCESSES IN HOSPITALS



Dirk Pfitzer,  
Division Manager for Healthcare,  
Pharmaceuticals Porsche Consulting

A hall of hospital managers taking advice from Porsche- seems a little hard to believe but Dirk Pfitzer had some interesting comparisons and lessons to

transmit. Indeed, many managers are discussing ways in which lean processes can be implemented and sustained in the long-term, taking the automo-

bile industry as a model. Lean processes mean avoiding waste and increasing efficiency for the benefit of the patient.

To illustrate the current waste in hospitals today Pfitzer used four images: one nurse surrounded by six physicians, a busy waiting room, a pile of paper files not in order and a copy of a confusing hand-written schedule. He cites silo thinking, lack of systemised interfaces and a lack of transparency as the main reasons for waste in hospitals. His solution: lean processes.

It has been frequently said that if only there was an IT tool to solve the problem... But most

hospitals have state-of-the-art IT solutions which can help but do not solve all the problems. There are several core philosophies from the automobile industry that can be applied to healthcare. There must be simultaneous adaptation to quality, enhancement, and adherence to the schedule.

Hospitals are not hotels but while patients cannot assess medical quality, they can assess comfort (bed, food, TV, etc). The patient must be at the centre of value creation. All things that heal the patient must be central, "anything that does not heal the patient is

waste". This is a shocking statement but Pfitzer said it to try to open our eyes to the waste in our hospitals.

According to Pfitzer there are two types of waste: obvious waste such as waiting and looking for files, and concealed/necessary waste (documentation, coding, writing up). We cannot get rid of this waste but we can

systemise it and make it more efficient. Waste reduction is not the consolidation of performance. It is not necessarily about working more but working differently, improving patterns and working habits.

To compare the two industries, Pfitzer used two videos: a pit stop and the operating theatre. It was evident that the pit stop

is synchronised, very fast and the team works together to help each other in the fastest and safest possible way. In the operating theatre the same structures are there but there is also a lot of waiting. The patient was not punctual or adequately prepared by staff, meaning that the physician was left to wait. This would be fine if the physi-

cian was waiting in his office, relaxing, but he was just sitting there with nothing to do. Pfitzer compared this situation to being in a traffic jam.

To conclude, he stressed that quality is not a matter of ratios and questionnaires it is about the patient. To ensure quality we must imagine ourselves as patients in our hospitals.

## THE PORTUGUESE EXPERIENCE OF QUALITY IMPROVEMENT IN HEALTH



Dr. Margarida Franca,  
*Hospital de Magalhaes Lemos, E.P.E, Porto, Portugal*

Dr. Franca explained that the Portuguese National Health Plan (2004-2010) was criticised by WHO in an evaluation in February 2010. They concluded that, "The Plan does not focus sufficiently on the quality and safety of health care services. The monitoring of health care outcomes, medical processes, medical errors and safety in health care services, as well as safety at the workplace, has not been a particular focus of the Plan."

The strategy for 2011-2016 is in the discussion phase and Dr. Franca defines its mission as "to maximise the health gains for population through the alignment and integration of sustainable efforts of all sectors of society, focusing on access, quality, healthy policies and citizenship."

In a first step to dedicated quality improvement, a new department, Quality in Health, was created in 2009 within the Gen-

eral Directorate of Health, Ministry of Health. This was closely followed by a National Strategy for Quality in Health, published June 2009, with seven priority areas: Clinical and organisational quality; transparent information to patients; patient safety; qualification and national certification of health units; integrated disease management and innovation; international patient mobility management; and NHS users satisfaction evaluation and management.

Methods to enhance organisational and clinical quality include a new accreditation system in partnership with the Quality Agency from Andalusia, Spain and the development of national quality indicators. Patients and professionals satisfaction assessment is also to be launched. Regarding patient safety, Portugal is collaborating with various European Associations to control HAIs.

So what are the key weaknesses in quality improvement? Franca believes that Portugal shares the same weaknesses as other countries including the general difficulty to compare QI experiences and lack of benchmarking at national and international level. There is also a lack of support from top-level leaders and a lack of evidence about effectiveness and adequacy of QI methods and tools. Other difficulties include sustaining and financing quality systems and programmes and the inconsistency of strategies and leadership of programmes and of methodologies.

The main achievements in quality improvement can be defined as:

- ▶ Quality culture spread in NHS
- ▶ Experience on QI techniques and methods;
- ▶ Risk management and adverse events registries on

- ▶ hospitals as good practices;
- ▶ 24 hospitals achieving the goal of accreditation;
- ▶ Local services projects with a pool of trained professionals in QI methodologies;
- ▶ Interest from professionals on QI and in self-development; and
- ▶ Adhesion to projects from care units and professionals.

Franca believes we can learn from the Portuguese experience and put QI on the top of the Ministry agenda and develop explicit interest and support. Integrate QI programmes with contracting and financing of care and pay for performance initiatives; publicise results on performance and quality of care, and empower patients and their families, with specific focus on chronic diseases. QI should be integrated in undergraduate courses and into strategy design and actions on a national level.

# MAKING A HEALTHY WORKFORCE FOR A HEALTHY ECONOMY

By Lee Campbell

**The European Union has a working age population in excess of 170 million. Almost one in six people have a long-standing health problem that affects their daily lives – their ability to take part in the labour market. Musculoskeletal disorders (MSDs) account for a large proportion of the working days lost each year.**

The UK-based Work Foundation published in Brussels exactly a year ago the Fit for Work Europe report showing that musculoskeletal disorders (MSDs) account for nearly half (49 percent) of all absences from work and a shocking 60 percent of permanent work incapacity in the European Union. These and other socio-economic consequences of suffering from poor health due to muscle and joint pain represent an estimated cost to society in Europe of up to 240 billion euro.

MSDs are an enormous burden to the European workforce, and it is essential that this burden be addressed and patients given the opportunities to carry on their lives as best as is possible.

## A Healthy Workforce Means a Healthy Economy

On the one-year anniversary of the Fit for Work Europe initiative, at the annual conference “Reducing the burden of MSDs: a human and economic imperative for Europe” work and health experts convened in Brussels to launch the Fit for Work Coalition, calling for action in making MSDs a priority in public health policy.

Spanning over 200 conditions of the bones, joints and connective tissue, MSDs affect a vast number of European workers, bringing them chronic pain, fatigue, disabling inflammation of joints, severely reduced functioning, temporary but disabling incapacity and, on occasions, permanent and irreversible bone and joint damage.

MSDs manifest themselves in disparate ways and may cause periods of intense discomfort and incapacity, which may affect the ability of the individual worker to carry out their work. They may also abate for long periods.

The impact of MSDs on the individual and their ability to work varies significantly from person to person. It is the role of all stake-

holders within the healthcare system, including GPs, nurses and caring physicians to assess the ability of a patient to return to work, and work with their patient to identify the limits of their abilities.

## The Role of Hospitals

As healthcare centres, hospitals are a vital part of healthcare systems’ drive to keep patients in their daily jobs. For the care of MSD patients, hospitals must be constructed not only to take care of disabilities, but also to provide services to allow patients to stay in work.

The Fit for Work Coalition has called for action from all stakeholders and, based on the Fit for Work research, identified numerous interventions, which could help to prevent joint damage, strain and disease progression:

- ▶ Training on ergonomics at the workplace;
- ▶ Rehabilitation programmes, including intense physiotherapy;
- ▶ Guidance services on suitable working hours and job designs;
- ▶ Early referral to physical therapy – health professionals must aim to provide prompt access to psychotherapy;
- ▶ Early access to effective drug therapies for workers with inflammatory conditions;
- ▶ Early access to cognitive behavioural therapy for selected back pain patients; and
- ▶ Provide access to condition management and rehabilitation practices.

The impact of healthcare and hospital services is potentially huge, and must be taken fully into account. Early intervention and the investment in skills, technology and innovation to strengthen the European workforce must be considered by all managers of healthcare services.

## Early Interventions Make a Difference

Hospitals play an all-important role in early intervention, through occupational therapy, rheumatology clinics, specialist treatment and the full range of secondary care provision. Early intervention can reduce the severity, impact or progression of the condition in patients. Long periods away from work have been demonstrated to be generally detrimental for MSD patients; the longer the sick leave, the more difficult it is to get the employee to return to work and the higher the economic cost.

If the negative effects of MSDs on both quality of life and work disability are to be minimised then early diagnosis and treatment can often be critical. The Fit for Work research, upon which the recent coalition was built, clearly demonstrates that early interventions can make the most difference to both health and labour market participation. In the healthcare system domain, we might even begin to speak of an ‘early intervention premium’ of savings, certainly in terms of wider society costs, but specifically even in long-term hospital expenditure.

## Conclusion

Successful early interventions require clinicians, employers and the healthcare and social welfare systems to work together. The Fit for Work Europe Coalition urges hospital managers to recognise the urgent need to adapt services to focus on a patient’s ability, rather than disability, and allocate resources to innovative treatment and administration of such treatment. Providing the right services to patients can help retain a healthy workforce, and therefore a healthy economy.

References are available on request, [lee@myhospital.eu](mailto:lee@myhospital.eu)



# THE INTEGRATED OR

## An "In-House" Customer Satisfaction Survey

By Umberto Nocco and Silvia del Torchio

Technology evaluation is considered a must in today's healthcare systems, especially when a significant monetary investment is required. Such evaluations must be multi-dimensional in their approach and can take place before installation or be used as a follow-up verification. Managers can verify if statements, data and stakeholders introduced during the acquisition process are real or need to be redefined. Varese Town and University Hospital in Italy performed such an evaluation of their integrated operating rooms.

The integrated Operating Room (OR), otherwise referred to as "digital OR" or "interventional suite" is a technical solution mainly dedicated to minimally invasive surgery where environment (lights, climate, etc.), medical devices and video distribution are controlled via one or more PCs and activated via a single graphic interface. In such an OR each and every control is in the surgeon's reach, allowing him to interact and control the system using a boom-mounted, sterile touch screen that can be placed right on the operating field. A computerised video matrix controlled by the same touch screen distributes images to boom mounted monitors thus allowing the best viewing angle to each operator. Only solutions granting video distribution and medical device control should be categorised as an "integrated OR".

Vendors state that boom mounted devices, with the possibility to view images on many displays that can be best fitted for the surgeon and surgeon's direct device control connote the digital/integrated OR as a very efficient and effective environment, providing enhancement in flexibility and integration of information. This aspect is to be investigated and verified.

At the time being, there are many installations worldwide of such integrated ORs which differ by vendor, degree of integration available, surgical specialty they are destined to, etc. Nevertheless, it is not clear whether this technological solution is useful, effective and worth the economic and organisational effort needed to implement it in a new or existing hospital.

In Varese Town and University Hospital 20 digital ORs have been recently built to fulfill the needs of 10 Surgical Specialties. The imaging distribution control can be performed using a multiple choice of monitors available as destination, i.e. one or more boom mounted dis-

plays, a 40" plasma monitor on wall, a video-conference system, a DVD recorder or a centralised storage. If the OR is fully integrated, a medical device control is also present.

### Objectives

Two years after installation, the hospital management and Clinical Engineering Depart-

ment wanted to evaluate the surgeons' and staff nurses' satisfaction and comments on the ORs. Such evaluation is considered an assessment of the acquisition process; assessing whether expectations had been fulfilled or how they had been missed or over-considered. A qualitative study based on clinical staff opinion was conducted and was considered a valuable judgment of the so-

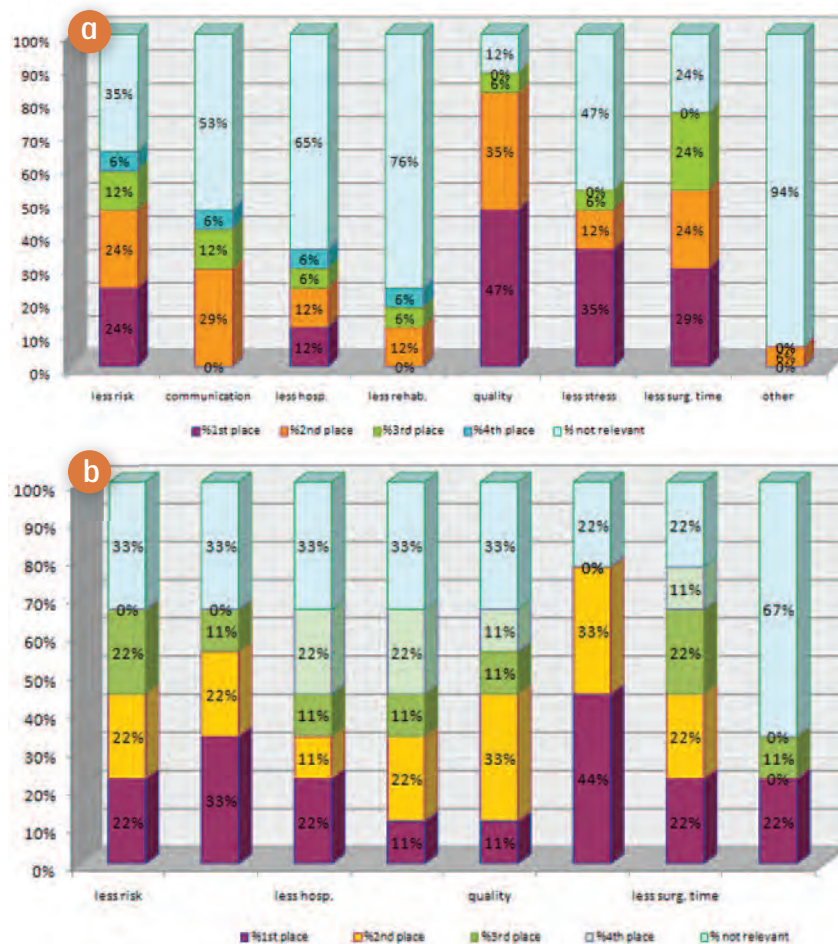


Figure 1. Answer distribution to first item (performance improvement) a) surgeons b) scrub nurses

lution implemented. Moreover, the evaluation is by all means needed by the entire scientific community due to the lack of literature on the subject. Although the data is limited in its scope, referring to a local situation only, it still represents a valuable set of data for hospital management.

**Methods**

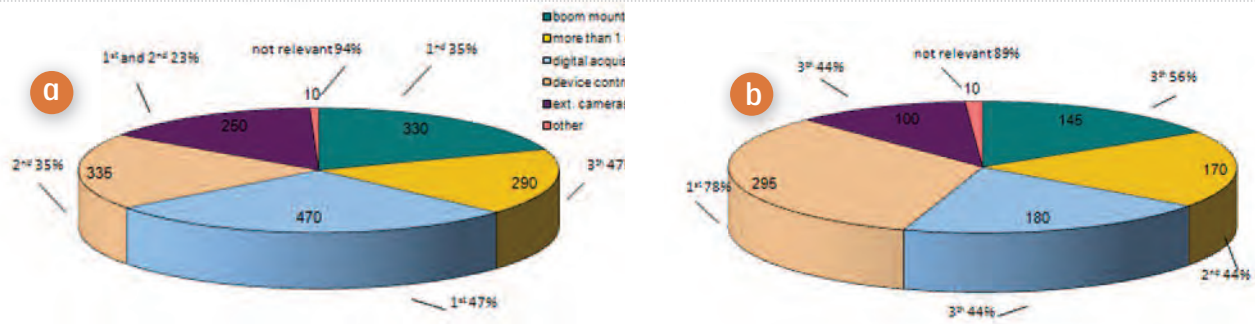
A multiple answer questionnaire was handed to surgeons and scrub nurses. 17 surgeons and nine scrub nurses were interviewed. Interviewees were all fully integrated OR users in order to allow a complete evaluation, especially on the device control integration. Only surgeons and scrub nurses were interviewed as they represent the real direct users of the OR. The interviewees belong to different affiliations (mainly General Surgery) and

the integrated OR. Answers available ranged from the reduction of patient risk to hospitalisation time, rehabilitation, quality of surgery, surgical stress, and surgery time. Surgeons classified enhanced quality of the surgical act as the best option (520 points total) while the second choice was stress reduction (475 points total), followed by reduction in surgical time (375 points total) (Figure 1). It's interesting to read the same data in terms of classification: quality of surgery has been chosen as best option by 47% of surgeons vs only 11% of scrub nurses, while 35% of surgeons rank it as 2nd option, resulting in an overall 82% of surgeons stating that the integrated OR augments quality. Both surgeons and scrub nurses agree that the integrated OR can reduce stress related to intervention (35% of surgeons and 44% of scrub nurses chose this as the best

anesthesia preparation procedure became shorter due to the integrated OR facilities.

Automatic presetting functions (a tool that allows to store in the system functional parameters which have to be set on each device for a defined user) can help staff reduce theatre preparation time (53% of surgeons and 67% of scrub nurses).

OR layout was then analysed to evaluate available functions such as the usefulness of the computerised video matrix for images acquisition and distribution, the control system use, the utility of mounting devices (endoscopic camera, light source, CO<sub>2</sub> insufflator, electrosurgical unit) on a single boom and the possibility to orient more than one display on independent boom arms. 47% of surgeons rank video acquisition and distribution most important (1st place, and a total score



**Figure 2.** Answer distribution to classification of each technology employed in integrated OR. (a) Surgeons (b) Scrub nurses. Next to each value indicating the total score obtained by each option the highest ranking expressed in percentage has been annotated.

Figure 2a Surgeons' answer distribution for 1st question: which performances are improved by integrated OR? Graphic a) represents the absolute scores for each choice divided in colored blocks representing points distribution. Inside the block the number of subjects that assigned that single value of points is reported. Graphic b) shows the distribution of surgeons' percentage for each choice in terms of place classification.

have different experiences; they also use different products since three different solutions are in use. There are some common questions asked to both surgeons and scrub nurses. These common questions made it possible for us to evaluate the different professions' approach to the digital OR.

"Multiple guided answer" questions were proposed; the interviewee had to define a level of importance by distributing 100 points among the available options. Questionnaires were answered with the interviewer present; this encouraged detailed comprehension and more reliable answers.

**Results**

Six subjects are considered in this article. The first one aims to test the usefulness of

option) and reduce surgery time (29% of surgeons rank it as 1st, 24% as 2nd and 24% as 3rd, 22% of scrub nurses rank it as 1st, 2nd and 3rd).

The fact that the integrated OR can reduce risk related to surgery has been voted with 315 points, and obtained a total (1st and 2nd place considered together) percentage equal to 48% and 44% of surgeons and scrub nurses respectively.

In order to acquire more details on the subject, a specific question was proposed about surgical time reduction. Surgeons think that time reduction can be achieved in surgery scheduling phase while staff has the impression that surgical act duration and devices set up phase has been reduced. Scrub nurses in particular stressed the point that also

equal to 470 points) (Figure 2) while on the contrary, 78% of scrub nurses rank device control in first place with a total assigned score of 295 points. A different judgment regarding the need for boom mounted devices can be seen too: it has been voted with 330 points by surgeons (35% of surgeons rank it in 1st place and 29% in 2nd) and with 145 points by scrub nurses (mainly ranked as 3rd place). The judgment on the availability of more than one display is comparable.

Options regarding medical device control were: increased reactivity to events, reduced setting errors, reduced confusion and reduced displacements of devices and monitors. Both surgeons and scrub nurses stated firstly that direct control can grant better reactivity to events that occur during surgery (this point



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**Figure 3.** Answer distribution for “unsolved issues” related with integrated OR. **a)** surgeons **b)** scrub nurses

was particularly emphasised by scrub nurses). On the other hand, both surgeons and scrub nurses observed that such a system can reduce device setting errors. It has been additionally noticed that device control implemented inside integrated ORs can reduce mess and racket and the number of displacements of devices, monitors etc.

Teaching capabilities of the integrated OR were considered. The majority of the interviewed surgeons (76%) think primarily that a better “point of view” on the surgical field can be achieved and therefore that a higher amount of surgeries can be viewed. Scrub nurses also indicated the chance to have more interventions available for learners.

Evidently there is still more work to be done; surgeons and scrub nurses agree that there

is first of all a need for education (i.e. knowledge of how to operate the integrated OR) and how a correct operation can affect organisation. Moreover, Nurses evaluated the lack of integration of specific medical devices as a relevant problem (i.e. ultrasonic scalpels, electrosurgical units) and think that there is a significant cultural problem when approaching such technology (Figure 3).

### Conclusions and Discussion

The results of the questionnaire show a substantial satisfaction by both surgeons and scrub nurses, given that the installed technology grants multiple advantages to workers and patients. Among such advantages we can enumerate increased quality of patient treatment and reduced stress during surgical act (Figure 2), reduced time for de-

vice setup and surgical act, increased reactivity for urgent decisions and reduced setting errors and racket. These advantages are mainly obtained using features of the integrated OR such as video acquisition and distribution and medical device control. The use of medical device control and availability of different types of information can improve security and efficiency of the surgical act, as stated by other authors.

In fact, the main conclusion derived from results, while considering the data as a post installation impact, is that a relevant improvement in quality has been introduced with the integrated OR and a less stressful and shorter surgical procedure has been achieved.

The results presented above show a different approach to technology between surgeons and scrub nurses, the latter being more concerned about workflow and surgical process in general. This is confirmed by answers given to the question concerning layout (where little interest was reserved to video acquisition) and to utility of medical device control and presetting. Surgeons appear to be more concentrated on the surgical act itself; such conclusion is endorsed by the ranking given to availability of images from surgery, reduced surgery time and increased quality (Figure 3) rather than device control, setting errors or process standardisation. The results shown outline that it is clear that the integrated OR can help overcome the usual problems of modern ORs, i.e. a conspicuous presence of high tech devices with little care to ergonomics of the OR itself.

The data presented illustrate that the integrated OR is a technical solution that should be evaluated by each institution wanting to enhance its healing capabilities and its organisational structure. The great need for education, a modification of cultural approach and coordination between surgeons and scrub nurses (Figure 3), with related costs, can be used as other drivers to define if the solution is to be acquired or not.

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# OVERVIEW OF THE HEALTH- CARE SYSTEM IN LUXEMBOURG

By Natalia Marczewska

**Luxembourg, with a population of 502, 000 (Eurostat, 2010 estimate) has one of the best state-funded health-care systems in Europe. The system is based on three fundamental principles: compulsory health insurance, free choice of provider for patients and compulsory provider compliance with the fixed set of fees for services.**

The health service, overseen by Luxembourg's Union of Sickness Funds, ensures high quality, free and subsidised health-care is available to all citizens and registered long-term residents. The state system covers the majority of treatments provided by GPs and specialists as well as laboratory tests, pregnancy, childbirth, rehabilitation, prescriptions and hospitalisation. The patient initially has to pay for the medical fees, which are decided on and revised annually by the Caisse de Maladie, and then submit the receipts for a reimbursement, which varies from 80 to 100 percent. Vulnerable groups are not obliged to pay any charges and students, unemployed and children are covered up until the age of 27. Dental and optical treatment also qualify for reimbursement, but some services must be pre-approved.

## Financing the System

Luxembourg's healthcare system is mainly publicly financed through social health insurance. All employees contribute on average 5.44 percent of gross income (with a maximum contribution of 6,225 euro) to the Caisse de Maladie, which is deducted directly from their salaries and half of which, is paid by the employer. In 2002, total healthcare expenditure was estimated to amount to 6.2 percent of GDP, representing one of the lowest shares in Europe with 86 percent of the total health expenditure estimated to come from public sources.

As Luxembourg is small, few resource allocation decisions, except for hospital bud-

gets, are delegated to local authorities. The individual hospital budgets are negotiated between the hospital administrative boards and the Union of Sickness Funds, whilst payments to health professionals are based on a fixed statutory fee level, also set by the Union of Sickness Funds. The Division of Pharmacy of the Directorate of Health maintains a comprehensive list of pharmaceuticals, which is approved for use as a national guide for reimbursement.

## Private Healthcare

Although 99 percent of the population is covered by the state healthcare system private healthcare is also available and about 75 percent of the population purchases additional health insurance coverage, which is mostly used to pay for services categorised as nonessential under the compulsory schemes and provided by non-profit agencies or mutual associations called *mutuelles*, which are also allied to the Ministry of Social Security.

However, there are no private hospitals in Luxembourg as all hospitals are state run by the Caisse de Maladie and you must have a referral from your doctor for an admission to hospital, unless it is an emergency. All emergency care is provided at large hospitals and is free, even if you have no insurance. Long-term care is financed through separate insurance called *assurance dépendence*.

Luxembourg also has specialist hospitals and specialist doctors available for consultation but an appointment is necessary.

As of 1 January 2004, Luxembourg had 14 acute-care hospitals, only one of which, specialising in maternity services, is run for profit. There are three groups of hospital service available (first class, second class, third class), which depend on your insurance contributions or the private health cover you have.

Prescription drugs can only be prescribed by doctors and consultants and the costs are also reimbursed by the Caisse de Maladie. Non-prescription drugs are priced much higher and are generally not reimbursed. Pharmacies are usually open during normal working hours and there is always a duty chemist available for out-of-hours service.

## Main Healthcare Challenges

In 2002, noncommunicable diseases accounted for 78 percent of all deaths in Luxembourg (mainly cardiovascular diseases - about one third of deaths), external causes for about nine percent and communicable diseases for 1.5 percent.

Cancer accounts for almost 26 percent of deaths in Luxembourg, whereas the combination of death and illness due to cancer, represented as DALYs (Disability Adjusted Life Year), accounts for 14 percent of disease burden among men and women equally. Preventive care, delivered through the country's primary care system, aims to improve all-cause mortality and premature mortality.

Injuries are also a public health problem in Luxembourg, causing nine percent of

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deaths with mortality 52 percent higher than in other European countries, mainly due to suicide and motor vehicle traffic injuries. Luxembourg, like many other European countries, also has an increasingly aging population with the number of people aged 65 and over expected to grow from 14 percent of the population in 2003 (Council of Europe, 2003) to an estimated 18 percent in 2030.

### Vulnerable Populations

People who are socioeconomically disadvantaged bear the greatest burden of disease, which includes the elderly, immigrants, refugees and prison inmates. Furthermore, as populations migrate and become more urban, there are increases in the number of urban poor whose housing, employment conditions and diet expose them to greater risk of illness and disease.

This article was adapted from the following sources:

- ▶ Highlights on Health in Luxembourg, 2004: [www.euro.who.int/\\_data/assets/pdf\\_file/0016/103561/E88551.pdf](http://www.euro.who.int/_data/assets/pdf_file/0016/103561/E88551.pdf)
- ▶ [www.europe-cities.com/en/633/luxembourg/health/](http://www.europe-cities.com/en/633/luxembourg/health/)
- ▶ [www.who.int/gho/countries/lux.pdf](http://www.who.int/gho/countries/lux.pdf)

# L'ENTENTE DES HÔPITAUX LUXEMBOURGEOIS

By Marc Hastert

L'Entente des Hôpitaux Luxembourgeois (EHL) groups together the hospital institutions of the Grand-Duché of Luxembourg. According to the clauses of article two of the statutes, the association has the objective of grouping together the hospital institutions of Luxembourg, the defence of their professional interests and the realisation of all forms of progress within the hospital sector, especially those concerning the well-being of the patient. These roles are performed in a spirit of political and denominational independence, the association equipping itself with the necessary structures to fulfil its missions. EHL has been a non-profit organisation for 45 years but has existed as an association since 1948.

EHL has been a member of EAHM since 2001. As hospital management is one of our priorities we wish to actively participate in initiatives within this context at a European level.

EHL is made up of 16 members including four regional hospitals, three national centres (radiotherapy, cardiac surgery and interventional cardiology, rehabilitation) and four specialist institutions (gynaecology and obstetrics, psychiatry, medium stay). This is a total of 2621 critical care and medium stay beds for a country of 2.586 km<sup>2</sup> with a population of around 500,000 inhabitants with

another 150,000 travelling across the border to work.

The current President of EHL is Mr. Paul Junck. Educated in law, Mr. Junck has a sound knowledge of the hospital and healthcare sector through his previous experience as a member of the Board of Directors of the health insurance fund and numerous hospitals. The current Vice-President is Dr. Raymond Lies, Director General of Kirchberg Hospital in Luxembourg.

The different services of EHL are arranged around the General Secretariat, which benefits from a central position around which are arranged different departments and services: legal, economic, quality, statistics, IT, medical physics and SIST-EHL.

### The Role of EHL

EHL represents the interests of Luxembourg hospitals at their respective managerial levels. We are to some extent, the Luxembourg hospital federation, that is to say the association whose mission is realise the common objectives of hospitals.

In this sense, our actions are two-fold. We act first and foremost as an employer's association. For example through the negotiation of the collective work agreement of 8,000 salaried hospital employees, or more

generally, to make our point of view heard each time it is needed. We maintain good relations with other political and financial associations (notably the Minister for Health, Minister for Social Security, National Health Fund) and we equally wish to develop our lobbying activity. We must also inform all relevant actors in the healthcare sector and the general public of our actions. We want to achieve a political communication that illustrates, in an appropriate and efficient way, our objectives and strong points.

### Main Activities

We want to work on the continuity of quality hospital services in the interest of patients and all other actors involved. We need to collaborate on joint projects which allow us to remain efficient and competitive. We need to manage this approach daily. The General Secretariat and the permanent office are in daily contact with actors from different sectors, notably in the form of numerous meetings on themes which vary from benchmarking quality management, security, financing, investment, standardisation, human resources, purchasing, continuous education, IT, new technologies, etc.

It is unfortunately not possible to list all the activities of EHL over the years but there



is no doubt that this activity is increasing and will continue with new projects in the future. Joined together by a solid pact, hospitals possess, through EHL, an indispensable instrument to make their views heard and to define new joint projects.

In order to realise all of these objectives, EHL is financed by membership fees, that is to say hospitals. Hospitals are in turn financed by the National Health Fund (Caisse Nationale de Sante, CNS). EHL is therefore indirectly dependent on the CNS as its budget is negotiated directly with them. This is why we have created, together with the CNS, a collective approach to manage a certain number of essential activities regarding projects on quality, regulations, investments or statistics. Similar collaborations exist with the Ministry of Health and Social Security. Our means therefore depend directly on the good nature of our members and our financial partners. We must demonstrate the efficacy of our actions, on an association as well as member level. All of these issues are implicit in the decisions we make.

We must also act responsibly with our actors in face of the rising costs of health services. We must be able to make the right choices, even with more restrictive budgets. Decisions are to be made with a spirit of solidarity and of confidence as in this situation of budget constraints the importance of optimal management in all institutions is indispensable. The healthcare sector must combine an economic and technological approach with an ethical and social component, which is easier said than done. As financial resources are limited it is necessary to define a framework for managing health costs and services deemed acceptable in the national sociopolitical environment.

## Recent Developments

The crisis affected the entire economy and our activities were not spared. The hospital sector is confronted with a question for the public health sector on an international level: how to optimise the functioning and quality of the management of a healthcare institution within the context of financial deficit?

Throughout the years of EHL's existence, it has lived through numerous transformations in the hospital and healthcare landscape. Strategies have been elaborated and readapted. With the health insurance bud-

get in deficit, hospitals are called to contribute to a national effort and EHL must also react with its own propositions. It is in favour of reaching a national strategy to re-stabilise the financial situation of the hospital sector in general.

EHL will continue its efforts and create new projects to optimise hospital services. Particular attention will be placed on using existing resources to make the hospital sector as efficient as possible and prepared for the future. All actors in the hospital sector, on every level, will be implicated in achieving our number one priority: quality care in the interest of the patient.

Some recent developments include central purchasing for goods and services in hospitals, standardisation of IT, new legal framework. EHL wants to introduce codification systems, which will allow, in the future, the generation of qualitative data of hospital activity. This will in turn allow increased transparency of quality of care and the better internal management of the hospital. EHL is also focused on implementing quality indicators, which would allow the comparison of Luxembourg data to other countries.

EHL needs to refocus its activities in light of recent developments and rethink its governance together with the representatives of its member establishments. Statutory changes are very probable in order to facilitate these actions and to guarantee we make the right decisions on a national level.

## Training

For several years now EHL has provided several specific training programmes for hospital management. These programmes are provided together with IUIL (L'Institut Universitaire International Luxembourg).

The management training programme is designed to help managers achieve their objectives. It provides:

- ▶ Information on management, legislation, financing; and
- ▶ Introduction into applied research.

Through the course hospital managers can benefit from new competences and feel ready to face the problems of the future. The programme will have a positive impact on the professionalisation of the role of the manager in the hospital sector and a better management of services at the heart of health institutions.

## Communication and Trade Journal, EHL-Info

EHL-Info is the association's trade journal in circulation for several years now. Since 2009, it is published three times per year. We decided to produce the journal because Luxembourg did not have such a journal, unlike its bordering countries. We wanted an appealing communication tool allowing us to consolidate important information and reach more people in our sector, other sectors and the general public.

So far the journal has been a great success and we receive requests to publish articles. EHL-Info has become the association's business card, an important marketing tool for our activities. Thanks to the journal we can make people aware of our activities and the quality of hospital services in Luxembourg, increase transparency, reinforce inter-hospital collaboration, federalise certain hospital activities, create competence centres and improve relations with patients.

We also wanted to create a website to reflect our activities. Unfortunately we have neglected this tool. This however will change, a new site will be up and running in the next few months. The site will play an integral role in the changes within our organisation. Members will have the opportunity to access information and new services.

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Heinz Kölking

## UNE PAGE SE TOURNE POUR L'AEDH

Le 23<sup>ème</sup> congrès de l'Association Européenne des Directeurs d'Hôpitaux s'est tenu à Zurich du 9 au 10 septembre 2010. D'abord un grand merci à tous ceux qui y ont participé ! Nous tenons particulièrement à remercier nos collègues suisses pour l'organisation de ce congrès qui fut un événement marquant dans notre programme de coopération européenne.

Les membres du conseil d'administration, du bureau et l'assemblée générale de l'AEDH se sont également rencontrés à Zurich. L'Assemblée générale a élu le nouveau conseil pour les quatre prochaines années. Le résultat tient à la fois du choix de la continuité et de la décision de nouvelles orientations. Les membres du conseil d'administration et du bureau avaient déjà décidé pendant l'été de réfléchir et de restructurer la stratégie de l'AEDH. Cela leur semblait une absolue nécessité si l'on tient compte de la situation dans nos sociétés et de l'offre des prestations de santé dans le contexte des divers changements structurels qui se produisent actuellement en Europe. Sur cette base, un groupe de travail a été mis en place pour prendre en compte cette question spécifique. Il a réfléchi à la situation actuelle de l'AEDH et a émis des suggestions sur les objectifs et les stratégies dans une réunion à huis clos qui s'est tenue en mai à Bruxelles.

Notre nouvelle stratégie concerne particulièrement notre identité commune en tant que directeurs d'hôpitaux en Europe. Une étroite coordination entre les associations nationales et l'AEDH ainsi que

le développement de partenariats sont indispensables à notre progression. Nos objectifs formulés sont les suivants :

1. créer une identité pour les directeurs d'hôpitaux européens ;
2. assurer un échange actif d'expériences de gestion et la comparaison des modèles de réussite ;
3. élaborer de nouvelles stratégies et de nouveaux instruments pour améliorer la gestion des hôpitaux ;
4. développer, en collaboration avec des partenaires, des programmes de formation à la gestion et les partager avec les jeunes gestionnaires hospitaliers.

Pour satisfaire ces objectifs, des agendas de travail ont été développés. Le programme est sans doute très ambitieux, mais le congrès de Zurich nous a montré les avantages d'un échange d'expériences au niveau européen et l'importance de développer des idées communes concernant la prestation de soins de santé orientés vers l'avenir dans nos propres pays et en Europe. Une bonne gestion est une condition préalable essentielle au succès de nos hôpitaux et de nos systèmes de santé. C'est notre contribution à une Europe sociale et sûre. Je suis honoré d'y prendre part en tant que président de l'AEDH, auprès des membres du Bureau et du Conseil d'administration.

**Heinz Kölking**  
Président de l'AEDH



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

## 40ème assemblée générale ordinaire / Jeudi 9 Septembre 2010, de 9 à 10 h

La 40ème assemblée générale ordinaire de l'AEDH s'est tenue à Zurich avant la cérémonie officielle d'ouverture du 23ème Congrès de l'AEDH intitulé « Roadmap to Top Quality ». L'Assemblée générale a principalement porté sur deux sujets : le rapport d'activité du président pour la période 2009-2010 et l'élection du président, du vice-président et du conseil d'administration pour les quatre prochaines années.

### Rapport d'activité

Parlant de ces quatre années en qualité de président de l'AEDH, M. Castel a désigné la création des statuts de l'organisation comme l'une de ses principales réalisations. L'AEDH doit maintenant définir une politique de service claire, et devenir plus visible et améliorer la communication autant au sein de l'association qu'avec d'autres acteurs appartenant au secteur hospitalier européen. L'efficacité et la productivité doivent aussi être améliorées, en particulier dans le contexte économique actuel.

Le rapport a rappelé l'importance et le succès du séminaire 2009 « Vers une coopération équilibrée des acteurs publics et privés ». M. Castel a noté que les directeurs d'hôpitaux doivent affronter une concurrence croissante entre les hôpitaux et qu'ils doivent maintenant prendre davantage en compte le contexte économique.

### Groupe de réflexion

Le second point qu'il a développé concernait la profession de directeur d'hôpital. L'un des principaux objectifs de sa présidence a été l'étude de cette dimension pour l'association. Bien qu'encore à ses débuts, un groupe de réflexion a été mis en place il y a quelques mois qui se concentre sur les responsabilités des directeurs d'hôpitaux. Constatant que ce sujet est d'une grande importance pour

les gestionnaires d'hôpitaux et les futurs dirigeants, l'AEDH demande à ses associations nationales d'être vigilantes et de porter leur attention sur les jeunes responsables membres de leurs associations.

La veille du congrès, le conseil d'administration a validé un plan d'action comprenant la définition de l'hôpital moderne, l'amélioration de la communication entre les administrateurs, la formation et l'éducation.

M. Castel a terminé son rapport d'activité en remerciant le Bureau, le Conseil d'administration, le Secrétaire général, et tous ceux qui l'ont aidé pendant ces quatre années.

### Présentation des comptes et budget

L'AEDH, tout autant que les associations nationales, a été affectée par la crise financière. Les recettes provenant des frais d'adhésion ont été d'autant plus faibles que certains pays ont connu des difficultés financières et structurelles. Le magazine (E)Hospital a également rencontré des difficultés avec des recettes publicitaires plus basses par rapport à celles de l'année précédente.

En ce qui concerne les dépenses, l'AEDH a essayé de réduire ses coûts sans devoir diminuer ses activités, et cela a généré une économie de 3,44 %. Les comptes ont été approuvés par un vérificateur externe. Mme Pellerin (Luxembourg) et M. Timmermans (Hollande), vérificateurs internes, ont ensuite présenté leur rapport et les comptes 2009 ont été approuvés à l'unanimité. Les deux rapports sont disponibles sur le site web.

Les besoins financiers de l'AEDH sont en augmentation. Les frais de personnel (voyage et hébergement) sont de plus en plus importants et le bureau du Secrétariat général a besoin d'une rénovation. Par conséquent, le Bureau propose une augmentation des frais de personnel qui comprend un supplément de 2000 euros versé au budget des dépenses pour les voyages. En outre, les nouveaux pro-

grammes et la nécessité de plus de réunions des sous-comités et du Bureau occasionneront également plus de coûts.

M. Heuschen a souligné que, même si ses besoins sont devenus plus importants, l'AEDH ne prendra aucun risque financier. L'association ne dépensera que ce qu'elle reçoit et n'a pas le désir d'augmenter les frais d'adhésion. Ce nouveau mode de financement se fera à travers un forum, c'est à dire un partenariat avec l'industrie. Des entreprises ayant sollicité un échange avec l'association, nous allons mettre en place un forum de partenariat avec l'industrie dont les revenus compenseront nos frais.

Les vérificateurs ont été proposés et élus pour l'année 2010 et il a été décidé qu'il n'y aurait ni admission ni exclusion de membre cette année.

Pendant l'assemblée générale, les participants ont été invités à déposer leur vote pour les nouveaux président, vice-président et conseil d'administration. Les bulletins de vote ont ensuite été recueillis, comptés et vérifiés par deux membres du conseil d'administration, Asger Hansen et Manuel Delgado. Les résultats sont les suivants :

#### Bureau :

Heinz Kölking, Président (Allemagne)  
Gerry O'Dwyer, Vice Président (Irlande)  
Paul Castel (France)  
Mieczyslaw Pasowicz (Pologne)  
Pedro Lopes (Portugal)

#### Conseil d'administration :

Nikolaus Koller (Autriche)  
Freddy Lemants (Belgique)  
Nikolina Muskurova (Bulgarie)  
Christoph Pachlatko (Suisse)  
Joern Koch (Danemark)  
Rauno Ihalainen (Finlande)  
Jean-Luc Chassaniol (France)  
Paul Castel (France)  
Gregory Roumeliotis (Grèce)  
Kresimir Rotim (Croatie)  
Ari Lajos (Hongrie)  
Luigi D'Elia (Italie)  
Stasys Gendvilis (Lituanie)  
Marc Hastert (Luxembourg)  
Mieczyslaw Pasowicz (Pologne)  
Juraj Gemes (Slovaquie)

### ▶ **La vérité sur la réforme des soins de santé : la sécurité d'abord – le caractère intrinsèque du succès financier, opérationnel et clinique**

*Par Charles Denham*

M. Denham a porté notre attention sur la possibilité qu'ont les dirigeants d'avoir un impact significatif sur la réforme des soins de santé. Il estime que la prochaine avancée pour les soins de santé ne sera ni informatique, ni matérielle, mais portée par le leadership. Les plus grands dirigeants sont ceux qui peuvent communiquer et donner les moyens à leurs employés de bien effectuer leur travail.

Pour M. Denham, les quatre A (de l'anglais « Awareness, Accountability, Ability and Action » que l'on pourrait traduire par conscience, responsabilité, capacité et action) sont la clé de la qualité dans l'adoption de technologies et de pratiques. Son dernier conseil a été que les gestionnaires d'hôpitaux devraient essayer de devancer la détérioration passive des systèmes de soutien des technologies et de s'assurer que les importantes réductions des coûts ne leur sont pas défavorables.

### ▶ **Séance 1 : Qualité : amélioration et transparence**

Anthony Staines a souligné trois aspects de la qualité : le concept, la mise en œuvre et la communication. Il a insisté sur le fait qu'il existe un écart entre la qualité démontrée par la recherche comme réalisable et la qualité effectivement obtenue. Il croit qu'il y a dix points clés pour la qualité clinique et la sécurité des patients. Il s'agit de la compréhension, de la sagacité des dirigeants, de l'organisation, du système de mesure et d'informatique, de la culture, du travail d'équipe, des meilleures pratiques, des objectifs incluant évaluation et feedback, de la participation du patient, et du rapport coût-efficacité.

Mme Ziltener croit que les attentes des patients vis à vis de la médecine sont trop élevées. Un patient, une fois qu'il est admis, a l'espoir de se soumettre à un vaste programme de soins et d'être guéri. Le problème se pose lorsque les attentes sont en conflit avec la réalité. Elle conseille aux hôpitaux de promouvoir des normes, des systèmes de rapports d'erreurs et de se rendre compétitifs au niveau qualitatif plutôt que de mettre en avant les coûts. Les résultats doivent être publiés, et les indicateurs médicaux et les comparatifs de performances doivent être transparents. Nous avons besoin d'un système médical basé sur la connaissance qui encourage la concurrence pour la qualité et la collaboration entre les associations de patients et les hôpitaux.

### ▶ **Séance 2 : Qualité : communication, gestion, politique et économie**

Le Professeur Conen nous a parlé de la communication des risques et des risques de la communication. Il est largement

admis que 30 à 50 % des erreurs médicales pourraient être évitées. Le Professeur Conen estime que, dans nos hôpitaux, le risque est exprimé en chiffres sans autre détail ou explication. Les patients ont besoin d'estimer les avantages d'une intervention en les comparant avec le risque de préjudice. Ceux qui comprennent la situation ont un meilleur pronostic, mais la communication des risques avec les patients se fait en fonction de leur niveau d'instruction.

Le Professeur Berden a souligné que la qualité des soins reste l'aspect le plus important aux yeux du patient ainsi que la meilleure publicité pour un hôpital. L'amélioration de la qualité doit être durable. Comme les dispositifs connus et utiles tels que les normes, les protocoles et les listes de contrôle, le processus de décision au niveau personnel joue également un rôle important.

La présentation du Dr Cerniauskas a porté sur la façon dont économie et politique sont importantes en ce qui concerne la qualité des soins de santé. À partir de la fin du XIXe siècle, les politiciens sont intervenus pour des raisons de stabilité sociale. Quand le secteur de la santé est devenu un des principaux secteurs de l'économie, les économistes ont suivi, apportant leurs concepts de coût marginal et d'utilité. En utilisant une initiative de santé publique lituanienne concernant la mortalité sur la route, il a démontré les résultats positifs de l'interaction de ces trois groupes.

### ▶ **Séance 3 : Qualité : services intégrés, indicateurs de résultats et « Planned Pathways »**

Conor Hannaway a expliqué que les services de soins intégrés représentent un immense potentiel pour influencer positivement les systèmes hospitaliers et la qualité des soins dispensés aux patients. Il croit que l'intégration sur la base des dossiers médicaux est préférable à l'intégration basée sur des structures.

Les divers partenaires du système de santé se tournent de plus en plus vers des indicateurs pour témoigner de la qualité des soins donnés. Le Professeur Troillet a pris l'exemple des infections post chirurgicales pour illustrer que ces données peuvent à la fois informer et influencer les résultats pratiques, la collecte des données devant être suivie par leur analyse et leur interprétation, puis d'une séance de feedback et de discussion. Nous devons nous efforcer de combler le fossé entre ce que nous savons et ce que nous faisons.

Le traitement du cancer au Danemark n'était pas des meilleurs. Johannes Gaub a expliqué comment cela a changé grâce aux « Planned Pathways » dans lesquels les examens diagnostiques requis et les capacités chirurgicales sont réservés par avance et les soins effectués conformément aux directives nationales. Les avantages comprennent la disponibilité des résultats des examens diagnostiques, un taux de productivité élevé et une très grande efficacité. Mais le succès est le corollaire d'une planification et d'une gestion strictes.

#### ▶ Séance 4 : Qualité : gestion des risques cliniques, délocalisation des services, produits

Peter Gausmann a présenté des informations sur les systèmes cliniques de gestion des risques et a relevé leur popularité auprès des patients, notamment celle des mesures préventives visant à accroître leur sécurité. Toute une série d'instruments et de procédés sont disponibles pour améliorer la sécurité des patients. Ils permettent, une fois reliés, l'élaboration d'un système de gestion des risques. La liste de contrôle pour la sécurité chirurgicale en est un parfait exemple.

Pour Jeff Gravenhost, si l'on envisage de recourir à la sous-traitance dans un domaine d'activité, trois questions clés doivent être posées : si l'on repartait de zéro, voudrions-nous construire aujourd'hui cette compétence à l'intérieur de notre service ou hôpital ? Sommes-nous réellement si performants que les autres pourraient vouloir nous proposer de le réaliser pour eux ? Est-ce un domaine de notre activité dans lequel se trouvent nos futurs dirigeants ?

Si la réponse n'est pas OUI à tous les trois, l'externalisation doit être envisagée. Elle peut permettre d'accroître l'efficacité, d'optimiser la communication et d'éliminer les risques.

Peter Steinmann a cité les trois principaux défis qui se présentent aujourd'hui aux gestionnaires d'hôpitaux : procurer aux patients des soins de santé globaux, gérer la sécurité des patients et la qualité ainsi que l'efficacité opérationnelle. La prise en charge globale des patients nous demande de mettre l'accent sur l'innovation et d'examiner les soins de santé dans une perspective centrée sur le patient.

#### ▶ Séance 5 : Qualité : l'utilisation du financement de l'Union européenne et les expériences en Autriche

L'hôpital Jean-Paul II de Cracovie représente le meilleur exemple de l'emploi des fonds structurels de l'Union européenne et d'autres sources financières externes dans la région de Malopolska.

L'Hôpital a réalisé 11 projets. La somme totale des projets s'élève à 43 millions d'euros et la somme totale du cofinancement est de 35 millions d'euros. Pour Mme Gryzowka, la meilleure qualité s'obtient grâce à l'infrastructure, la recherche, le transfert de technologies, la télémédecine et la coopération internationale.

L'objectif de l'exposé de M. Heinisch était de savoir comment les investissements dans la qualité peuvent également conduire à des améliorations en matière d'efficacité. Au cours de son exposé, il a utilisé l'exemple du partenariat entre l'Hôpital des sœurs compatissantes et l'Hôpital des frères compatissants à Linz. Malgré une longue période de restructuration, la qualité et l'efficacité ont été améliorées. L'économie potentielle est de 5 millions d'euros par an.

#### ▶ Séance 6 : Qualité : des processus allégés et l'expérience portugaise

Dirk Pfitzer a parlé des façons dont on pourrait implémenter une division du travail et la soutenir à long terme, en prenant l'industrie automobile comme modèle. L'introduction de telles mesures permettrait d'éviter le gaspillage et d'accroître l'efficacité au profit du patient. Il existe plusieurs théories de base venant de l'industrie automobile qui pourraient être appliquées aux soins de santé. Elle prônent simultanément adaptation pour la qualité, amélioration et respect du calendrier.



Après les critiques de l'OMS concernant la qualité et la sécurité des patients dans son dernier plan de santé, le Portugal a défini la qualité comme l'une de ses principales priorités. Un nouveau département ministériel a été créé en 2009, suivi par une stratégie nationale pour la qualité des soins de santé, avec sept domaines prioritaires : la qualité clinique et organisationnelle, la transparence de l'information aux patients, la sécurité des patients, la qualification et la certification nationale des centres de santé, la gestion globale de la maladie et l'innovation, la gestion de la mobilité des patients au niveau international, et l'évaluation et la gestion de la satisfaction des usagers.

#### ▶ Le système de santé luxembourgeois

*Par Natalia Marczevska*

Le grand Duché de Luxembourg, avec une population de 502000 habitants (selon l'estimation 2010 d'Eurostat), a l'un des meilleurs systèmes publics de santé en Europe. Le système est basé sur trois principes fondamentaux : l'assurance maladie obligatoire, pour les patients le libre choix du médecin et pour les prestataires le respect obligatoire des rétributions qui leur sont allouées.

L'Entente des Hôpitaux Luxembourgeois (EHL) regroupe les établissements hospitaliers du Grand-Duché de Luxembourg. Les objectifs de l'association sont le regroupement des établissements hospitaliers luxembourgeois, la défense de leurs intérêts professionnels et la réalisation de toutes les formes d'amélioration au sein du secteur hospitalier, en particulier celles qui concernent le bien-être du patient.



Heinz Kölking

## EINE NEUES KAPITEL FÜR DIE EVKD

Vom 9. bis zum 11. September hat der diesjährige Kongress der Krankenhausdirektoren in Zürich stattgefunden. Teilnehmer, Organisatoren und Verantwortliche schauen auf einen exzellenten und erfolgreichen Kongress zurück. Allen die daran mitgewirkt haben sei auf das Herzlichste gedankt. Insbesondere unseren Kolleginnen und Kollegen aus der Schweiz danken wir für den Kongress. Es war ein Highlight in unserer europäischen Zusammenarbeit.

Ebenfalls in Zürich haben sich Präsidium, Vorstand und Mitgliederversammlung der EVKD getroffen. Die Mitgliederversammlung hat turnusmäßig das neue Präsidium für die nächsten 4 Jahre gewählt. Das Ergebnis steht sowohl für Kontinuität als auch für neue Akzente. Vorstand und Präsidium hatten bereits im Sommer beschlossen, die Strategie der EVKD neu auszurichten. Dies erscheint uns vor dem Hintergrund des vielfältigen Strukturwandels in unseren Gesellschaften und insbesondere auch in der Gesundheitsversorgung absolut notwendig. Grundlage dafür ist ein Bericht einer eigens beauftragten Arbeitsgruppe. Die Arbeitsgruppe hatte in einer Klausurtagung in Brüssel im Mai die derzeitige Situation der EVKD reflektiert und Vorschläge für Ziele und Strategien erarbeitet.

Es geht dabei insbesondere um unsere gemeinsame Identität als Krankenhausmanager in Europa. Voraussetzung dafür ist eine möglichst enge Abstimmung zwischen den Nationalverbänden und dem

EVKD und die Weiterentwicklung von Partnerschaften. Folgende Ziele sind dabei formuliert worden:

1. Wir schaffen eine Identität der europäischen Krankenhausdirektoren.
2. Wir sichern einen regen Erfahrungsaustausch des Managements und vergleichen Erfolgsmodelle.
3. Wir beschreiben perfekte Strategien und Instrumente für das Management in Hospitälern.
4. Gemeinsam mit Partnern entwickeln wir Trainingsprogramme für das Management und sichern darüber den beruflichen Nachwuchs.

Für diese Ziele sind entsprechende Arbeitsprogramme entwickelt worden, die nunmehr angegangen werden. Dies ist sicher ein sehr ambitioniertes Programm. Aber gerade der Kongress in Zürich hat uns gezeigt, dass es sich lohnt, auf der europäischen Ebene Erfahrungen auszutauschen und gemeinsame Vorstellungen über eine zukunftsorientierte Gesundheitsversorgung in unseren europäischen Ländern, und damit in Europa, zu entwickeln. Gutes Management ist eine wesentliche Voraussetzung für den Erfolg der Krankenhäuser wie auch der Gesundheitssysteme. Ein Beitrag für ein sicheres und soziales Europa. Ich bin sehr dankbar dafür, dass ich mit Präsidium und Vorstand daran mitwirken darf.

Ihr  
**Heinz Kölking**  
 Präsident EVKD



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

## 40. Ordentliche Mitgliederversammlung / 9. September 2010, 9.00- 10.00

Die 40. Ordentliche Mitgliederversammlung fand vor der offiziellen Eröffnungszeremonie des 23. EVKD Kongresses ‚Roadmap to Top Quality‘ in Zürich statt. Die Versammlung konzentrierte sich im Wesentlichen auf zwei Punkte: den Tätigkeitsbericht des Präsidenten 2009-2010 und die Wahl des Präsidenten, des Vizepräsidenten und des Exekutivausschusses für die nächsten vier Jahre.

### Tätigkeitsbericht

Hr. Castel äußerte sich auch über die vier Jahre, in denen er als Präsident aktiv war. Als einer seiner wichtigsten Errungenschaften nannte er die Statutenerstellung der Vereinigung. Die EVKD muss nun eine eindeutige Politik der Dienstleistungen definieren und sichtbar werden, wozu auch die Verbesserung der Kommunikation innerhalb der Vereinigung, auch aber mit anderen Akteuren im Europäischen Krankenhaussektor zählt. Effektivität und Produktivität sollten ebenfalls gesteigert werden, vor allem angesichts der derzeitigen Wirtschaftslage.

Der Tätigkeitsbericht unterstrich zum wiederholten Male die Wichtigkeit und den Erfolg des 2009 stattgefundenen Seminars ‚In Richtung einer ausgewogenen Kooperation öffentlicher und privater Akteure‘. Hr. Castel merkte an, dass wir als Krankenhausdirektoren vermehrt dem Wettkampf zwischen Spitalanstalten gegenüber stehen, und dass das Management dieser Häuser zunehmend in einem wirtschaftlichen Kontext gesehen wird.

### Reflection Group

Sein zweites Anliegen betraf den Beruf des Krankenhausdirektors. Dies war eines der Hauptziele seiner Zeit als Präsident – die Untersuchung dieser Dimension für die Vereinigung. Obwohl noch in der Anfangsphase, wurde vor wenigen Monaten eine Arbeitsgruppe gegründet, die sich schwerpunktmäßig um die Verantwort-

lichkeiten der Krankenhausmanager dreht. Dies ist nicht nur nützlich für die momentanen Führungskräfte, sondern vor allem für die zukünftigen, jungen Manager.

Am Tag vor dem Kongress bestätigte der Exekutivausschuss einen Aktionsplan. Im Plan enthalten sind unter anderem eine Definition der modernen Krankenanstalt, die Verbesserung der Kommunikation zwischen Direktoren, und Aus- und Weiterbildung.

Hr. Castel beendete seinen Tätigkeitsbericht mit der Danksagung an den Generalsekretär, die anderen Mitglieder des Exekutivausschusses und des Präsidiums, seines Büros, und jedem, der ihm in den vergangenen vier Jahren tatkräftig zur Seite gestanden ist.

### Rechnungslegung 2009

Ebenso wie die nationalen Vereinigungen blieb die EVKD von der wirtschaftlichen Krise nicht unbetroffen. Einkünfte aus Mitgliedsbeiträgen sanken, da sich etliche Länder in finanziellen und strukturellen Schwierigkeiten befanden. Das Krankenhaus Magazin sah sich ebenfalls Schwierigkeiten gegenüber – die Anzeigeneinnahmen waren im Vergleich zum Vorjahr geringer ausgefallen.

Hinsichtlich Ausgaben versuchte die EVKD, Kosten zu reduzieren, ohne Aktivitäten einzuschränken. Die Sparrate betrug 3,44 Prozent. Die Abrechnungen wurden von einem außerbetrieblichen Rechnungsprüfer bestätigt. Die internen Rechnungsprüfer, Frau Pellerin (Luxemburg) und Herr Timmermans (Niederlande), gaben nachfolgend ihren Bericht ab, und die Geschäftsbücher 2009 wurden einstimmig bestätigt. Beide Berichte sind auf der Webseite abrufbar.

Die finanziellen Bedürfnisse der EVKD sind im Ansteigen begriffen. Die Personalkosten (Reisen und Unterkünfte) steigen und das Büro des Generalsekretariats bedarf einer Umstrukturierung. Der Vorstand schlägt daher eine Anhebung der Personalkosten vor, einschließlich eines zusätzlichen Budgets von 2.000

Euro für Reisekosten. Zusätzlich werden neue Programme und die Notwendigkeit vermehrter Meetings der Unterausschüsse und des Vorstandes die Kosten ebenfalls wachsen lassen.

Hr. Heuschen betont, dass die EVKD trotz der notwendigen steigenden Finanzierungskosten keinerlei finanzielle Risiken eingehen wird. Die Vereinigung wird nur die Beträge ausgeben, die sie auch einnimmt; eine Anhebung der Mitgliedsgebühren ist nicht angedacht. Die neue Finanzierungsmethode sieht ein Forum vor, ein Partnerforum mit der Industrie. Unternehmen sind an die Vereinigung herangetreten und haben um einen Gedankenaustausch gebeten. Ein Forum wird daher gegründet werden, die Industrie wird für dieses Privileg bezahlen und somit die Kosten ausgleichen.

Die Rechnungsprüfer 2010 wurden vorgeschlagen und gewählt, und es wurde bestimmt, dass es dieses Jahr keine Annahme und keinen Ausschluss von Mitgliedern geben würde.

Die Teilnehmer der Mitgliederversammlung wurden danach eingeladen, ihre Stimmen für den neuen Präsidenten, Vizepräsidenten und die Vorstandsmitglieder abzugeben. Die Ergebnisse lauten wie folgt:

#### Präsidiummitglieder:

Heinz Kölking, Präsident (DE)  
Gerry O'Dwyer, Vize-Präsident (IE)  
Paul Castel (FR)  
Mieczyslaw Pasowicz (PL)  
Pedro Lopes (PT)

#### Vorstandsmitglieder:

Nikolaus Koller (AT)  
Rauno Ihalainen (FI)  
Freddy Lemants (BE)  
Nikolina Muskurova (BG)  
Christoph Pachlatko (CH)  
Joern Koch (DK)  
Jean-Luc Chassaniol (FR)  
Paul Castel (FR)  
Gregory (Roumeliotis) (GR)  
Kresimir Rotim (HR)  
Ari Lajos (HU)  
Luigi D'Elia (IT)  
Stasys Gendvilis (LT)  
Marc Hastert (LU)  
Mieczyslaw Pasowicz (PL)  
Juraj Gemes (SK)

### Die ECHTE Gesundheitsreform: Sicherheit an erster Stelle – der Schlüssel zu finanziellem, operativem und klinischem Erfolg

Von Charles Denham

Laut Meinung von Hrn. Denham haben Führungskräfte die Möglichkeit, einen signifikanten Einfluss auf die Gesundheitsreform zu nehmen – seiner Ansicht nach wird sich der nächste Durchbruch im Gesundheitsbereich nicht auf Software oder Hardware beziehen, sondern auf Führungsstärke. Die bedeutendsten Führungskräfte sind diejenigen, die über das Erzählen von Geschichten mit ihren Mitarbeitern kommunizieren und deren Fähigkeiten steigern. Für Hrn. Denham sind Bewusstsein, Verantwortung, Fähigkeit und Tätigkeit die Schlüsselwörter bei der Einführung von Technologien und Methoden. Sein abschließender Ratschlag: Krankenhausmanager sollten versuchen, die passive Verschlechterung von Unterstützungssystemen zu verhindern, und sicherstellen, dass aktive Kostensenkungen diese Systeme nicht schädigen.

### 1. Session Qualität: Verbesserungen und Transparenz

Anthony Staines konzentrierte seinen Vortrag auf drei Qualitätsmerkmale: Konzept, Implementierung und Kommunikation. Er betonte, dass es Diskrepanzen gäbe zwischen der Qualität, die laut Forschung erreichbar wäre, und der Qualität, die dann tatsächlich erreicht wird. Seiner Ansicht nach müssen zehn Schlüsselfaktoren für die klinische Qualität und Patientensicherheit gewährleistet werden: Verständnis; die Vision der Führung; Organisation; Mess- und Informationssystem; Kultur; Teamwork; beste Praktiken; Ziele, Evaluierung und Feedback; Einbeziehung des Patienten, und Kosten/Wert.

Frau Ziltener geht davon aus, dass an die Medizin zu hohe Erwartungen gestellt werden. Wird ein Patient aufgenommen, hat er die Erwartung, sich einem ausgedehnten Betreuungsprogramm zu unterziehen und geheilt zu werden. Das Problem beginnt dann, wenn Erwartungen nicht mit der Realität übereinstimmen. Krankenhäuser müssen Normen, Fehlermeldesysteme und den Qualitätswettbewerb fördern, und nicht Kosten. Ergebnisse müssen veröffentlicht werden; es muss eine Transparenz medizinischer Indikatoren und vergleichbarer Leistungen geben. Wir brauchen ein auf Wissen basierendes medizinisches System, welches den Qualitätswettbewerb und die Zusammenarbeit zwischen Patientenzentren und Krankenhäusern fördert.

### 2. Session Qualität: Kommunikation, Management, Politik und Wirtschaft

Prof. Conen besprach die Kommunikation von Risiken und die Risiken der Kommunikation. Es gilt heute als weitgehend ge-

sichert, dass 30-50% der medizinischen Fehler verhindert werden könnten. Conen glaubt, dass das Risiko in unseren Krankenanstalten nur schlecht definiert ist, es wird als empirische Zahl nur unzuverlässig ausgedrückt. Patienten müssen die Vorteile gegen das Risiko eines Schadens abwägen; jene, die diese Situation verstehen, haben eine bessere Prognose. Wie gut dem Patienten das Risiko erklärt werden kann, hängt allerdings vom Bildungsstand des Patienten ab.

Prof. Berden betonte, dass die Qualität der Betreuung für Patienten nach wie vor den wichtigsten Aspekt darstellt – ebenso wie es für Krankenhäuser an erster Stelle der Wettbewerbsvorteile steht. Die Qualitätsverbesserung sollte anhaltend sein. Zusätzlich zu den gut bekannten und nützlichen Instrumenten wie etwa Normen, Protokolle und Checklisten spielt auch der Entscheidungsprozess auf fachlicher Ebene eine entscheidende Rolle.

Die Präsentation von Dr. Cerniauskas lenkte den Fokus auf die Wichtigkeit, welche die Wirtschaft und auch die Politik hinsichtlich der Qualität der Gesundheitsversorgung haben. Schon seit Ende des 19. Jahrhunderts haben Politiker aus Gründen der gesellschaftlichen Stabilität eingegriffen. Im selben Ausmaß, wie der Gesundheitssektor zu einem wesentlicher Pfeiler der Wirtschaft wurde, folgten Wirtschaftler den Politikern, und brachten ihre Konzepte von Grenzkosten und Grenznutzen mit. Am Beispiel einer Gesundheitsinitiative aus Litauen, die sich gegen tödliche Straßenverkehrsunfälle richtete, zeigte der Experte die positiven Resultate auf, die sich bei Interaktion der drei Gruppen einstellen.

### 3. Session Qualität: Integrierte Betreuung, Outcome Indicators und geplante Abläufe

Conor Hannaway erklärte, dass integrierte Gesundheitssysteme ein immenses Potential haben, sowohl Gesundheitssysteme als auch die dem Patienten zugeteilte Qualität der Pflege günstig zu beeinflussen. Er glaubt, dass Integration auf Basis von Pflegeabläufen der geeignete Weg ist, statt Integration auf Basis von Strukturen.

Verschiedene Partner des Gesundheitssystems setzen zunehmend Indikatoren ein, um die Qualität der Pflege bewerten zu können. Prof. Troillet benutzte ‚surgical site infections‘ (SSI), um aufzuzeigen, dass Daten sowohl informieren als auch die Praxis beeinflussen können – doch muss dem Datensammeln zunächst die Analyse und Interpretation und später auch eine Feedback- und Diskussionsrunde folgen. Wir müssen danach streben, die Lücke zwischen dem, was wir wissen und dem, was wir tun zu überbrücken.

Die Behandlung Krebskranker in Dänemark war alles andere als ideal. Johannes Gaub gab einen Überblick, wie sich die Situation dank geplanter Patienten-Abläufe verändert hat. In diesen werden die notwendigen diagnostischen und chirurgischen Kapazitäten vorausgebucht und die Dienstleis-



tungen entsprechend den nationalen Richtlinien geliefert. Die Vorteile sind die schnelle Verfügbarkeit diagnostischer Testergebnisse, eine hohe Produktivitätsrate und eine hohe Ausbildungseffizienz. Um erfolgreich zu sein, bedarf es allerdings eines strikten Plans und Managements.

#### ▶ 4. Session Qualität: Klinisches Risikomanagement, Auslagerung von Dienstleistungen, Produkte

Peter Gausmann stellte Informationen über klinische Risikomanagement-Systeme vor, und erklärte, dass diese bei Patienten sehr populär seien. Vor allem präventive Maßnahmen zielen darauf ab, die Sicherheit der Patienten zu erhöhen. Eine ganze Reihe von Tools und Vorgängen stehen für die Verbesserung der Patientensicherheit zu Verfügung, die nach Verknüpfung den Aufbau eines Risikomanagement-Systems erlauben. Die Sicherheitscheckliste im OP ist dafür ein perfektes Beispiel.

Für Hr. Gravenhost müssen bei Erwägung von Auslagerungen die folgenden drei Fragen gestellt werden: Falls wir heute von Grund auf beginnen würden, würden wir diese Leistungsfähigkeit wirklich intern einbauen? Sind wir darin so gut, dass uns andere dafür bezahlen würden, diese Arbeit auch für sie zu übernehmen? Ist das einer unser Geschäftsbereiche, aus dem unsere zukünftigen Führungskräfte kommen werden? Wird eine dieser Fragen nicht mit JA beantwortet, dann sollte die Auslagerung als Möglichkeit in Betracht gezogen werden. Auslagern kann die Effizienz antreiben, die Kommunikation optimieren und Risiken ausschalten.

Laut Steinmann sind die folgenden Faktoren derzeit die drei wesentlichen Herausforderungen im Bereich des Krankenhausmanagements: umfassende Patientenbetreuung, Management der Patientensicherheit/ Qualitätsmanagement, und operative Effektivität. Die umfassende Patientenbetreuung bedeutet, dass wir uns auf Innovation und kundenorientierte Lösungen konzentrieren müssen; der Blick auf die Gesundheitsversorgung aus Sicht des Patienten.

#### ▶ 5. Session Qualität: EU-Förderungen einsetzen und Erfahrungen aus Österreich

Das Johannes Paul II Krankenhaus in Krakau ist in der Małopolska Region führend beim Einsatz struktureller Förderungen der Europäischen Union und anderer externer Finanzquellen. Das Krankenhaus hat 11 Projekte durchgeführt. Die Gesamtsumme der Projekte beträgt 43 Millionen Euro, die Gesamtsumme der Co-Finanzierung 35 Millionen Euro. Für Frau Gryszowka wird die Topqualität durch Infrastruktur, Forschung und Entwicklung, Technologietransfer, Telemedizin und internationale Kooperation gewährleistet.

Dr. Heinisch lenkte in seiner Präsentation den Fokus auf die Frage, wie Investitionen im Bereich der Qualität auch zu verbesserter Effizienz führen können. In seinem Vortrag führte er dies am Beispiel der Kooperation zwischen dem Krankenhaus der Barmherzigen Schwestern und dem Krankenhaus der Barmherzigen Brüder in Linz aus. Obwohl die Phase der Restrukturierung lang war, konnten Qualität und Effizienz verbessert werden. Das Einsparpotential beträgt 5 Millionen euro pro Jahr.

#### ▶ 6. Session Qualität: Lernprozesse und das Portugiesische Modell

Dirk Pfitzer stellte Möglichkeiten vor, wie Lernprozesse implementiert und langfristig erhalten werden können; die Automobilindustrie diente hierzu als Modell. Schlanke Prozesse bedeuten das Vermeiden von Verschwendung und eine erhöhte Effizienz zum Vorteil des Patienten. Es gibt mehrere zentrale Philosophien aus der Automobilindustrie, die in der Gesundheitsversorgung angewandt werden können. Es muss eine gleichzeitige Anpassung an Qualität, Ausdehnung und Festhalten am Zeitplan geben.

Nach Kritik der WHO hinsichtlich Qualität und Patientensicherheit im Gesundheitsplan Portugals machte das Land die Qualität auf diesem Gebiet zu einer seiner Prioritäten. Eine neue Abteilung, Qualität der Gesundheitsversorgung, wurde 2009 gegründet. Nachfolgend wurde eine Nationale Strategie für Qualität in der Gesundheitsversorgung implementiert, mit sieben Schwerpunktbereichen: Klinische und organisatorische Qualität; transparente Information für die Patienten; Patientensicherheit; Qualifikation und nationale Zertifizierung von Abteilungen; integriertes Krankheitsmanagement und Innovation; internationales Patientenmobilitäts-Management; und Evaluierung und Management der Zufriedenheit der Benutzer des staatlichen Gesundheitsdienstes.

#### ▶ Das Gesundheitssystem in Luxemburg

Von Natalia Marczewska

Luxemburg, mit einer Einwohnerzahl von 502.000 Personen (Eurostat, Schätzung 2010), hat eines der besten, staatlich geförderten Gesundheitssysteme in Europa. Das System beruht auf drei Prinzipien: zwingende Gesundheitsversicherung, freie Wahl des Anbieters für Patienten und verpflichtende Einwilligung des Anbieters, mit einem festgelegten Gebührensatz.

Die L'Entente des Hôpitaux Luxembourgeois (EHL) fasst die Krankenanstalten des Großherzogtums Luxemburgs zusammen. Die Ziele der Vereinigung sind der Zusammenhalt der Krankenhäuser Luxemburgs, die Verteidigung der beruflichen Interessen und die Realisierung aller Formen des Fortschritts innerhalb des Krankensektors, vor allem solche, die mit dem Wohlbefinden des Patienten assoziiert sind.

**November**

**ESICM - 23<sup>rd</sup> Annual Congress of the European Society of Intensive Care Medicine ..... 10-13**

Barcelona, Spain  
www.esicm.org

**Medica 2010 ..... 17-20**

Dusseldorf, Germany  
www.medica.de

**RSNA 2010 ..... 28-03**

Chicago, USA  
www.rsna.org

**January**

**IT @ Networking Awards ..... 19-20**

Brussels, Belgium  
www.itandnetworking.org

**February**

**International Meeting on Emerging Diseases and Surveillance ..... 4-7**

Vienna, Austria  
www.isid.org

**March**

**ECR ..... 3-7**

Vienna, Austria  
www.myesr.org

**ISICEM ..... 22-25**

Brussels, Belgium  
www.intensive.org

**April**

**Hospital Build Europe 2011 ..... 4-6**

Nürnberg, Germany  
www.hospitalbuildeurope.com

**Med-e-Tel ..... 6-8**

Luxembourg, Luxembourg  
www.medetel.eu

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- ▶ Crisis Management
- ▶ Financing in Crisis
- ▶ Complaint Management
- ▶ Focus: Spain

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