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PRIVATISATION

ETHICAL MANAGEMENT

OFFICIAL JOURNAL OF THE EUROPEAN ASSOCIATION OF HOSPITAL MANAGERS

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Heinz Kölking

IMPROVING EFFECTIVENESS

The fundamental transformation under way in our societies continues apace. While change impinges on all aspects of life, its impact is particularly acute in the area of healthcare.

The causes and characteristics of these changes are multidimensional. On the one hand, the range of medical services is expanding in response to demographics, advances in medicine and rising consumer expectations, while on the other, the capacity of governments and health insurance systems is constrained by limited resources and the growing problem of manpower shortages.

Safeguarding the future of healthcare in the context of these competing forces is a major challenge for all economies and, as such, for Europe in general.

If we are to prevent rationing and guarantee universal access to health services, we must attain high levels of effectiveness and efficiency while maintaining high quality structures, processes and outcomes.

The privatisation of hospitals is regarded in some quarters as a panacea. The argument goes that shareholder expectations of a return on investment increase pressure to reduce costs and maximise profits – this must, therefore, improve effectiveness and efficiency.

This argument is assessed in this issue of HOSPITAL, which also highlights the unique nature of the healthcare market as well as the factors which distinguish it from other markets for goods and services.

We also examine the proposition that mechanisms other than the profit motive can deliver increases in efficiency and effectiveness. Good examples of such mechanisms can be found in both voluntary and public hospitals. The EAHM will devote greater attention to this issue in the coming months.

The aforementioned areas of conflict give rise to complex ethical questions which have implications for both the individual citizen and society as a whole. These questions are becoming increasingly relevant for hospital managers who must continually strive to strike a balance between ethical principles and economic needs.

Although these two sets of priorities are often regarded as mutually exclusive, this is not necessarily the case. The economy must be treated not as an end in itself but as a means by which to realise an objective (quantity and quality) using the minimum amount of resources (without waste!).

This and many other questions will be discussed at this year's EAHM Congress in Graz. These are vital issues to be addressed in managing our hospitals and securing efficient, effective and high quality patient care. We look forward to Graz!

Heinz Kölking ,
EAHM Vice-President

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

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PRIVATISATION

This concept summarises one of the main evolutions of European hospitals in the last decade. Willy Heuschen, EAHM's Secretary General, first conveys the position of the association on this fundamental phenomenon and how it should be properly regulated by European authorities. The position of, successively, France, Germany and the Netherlands is then articulated, as they each represent a different strategy towards that issue. Professor Grimaldi emphasises the flaws of T2A, Mr Schulten analyses the growing privatization of German hospitals while Professor Maarse outlines Dutch reforms trying to balance competition and quality of care.

ETHICS

How to allocate hospital resources in a time of shrinking budgets? How to maintain the quality of care in spite of financial cuts? How to support hospital staff who have to make difficult ethical decisions on a daily basis? A well-organised and structured mediation service could be one of the answers, according to Mr Vanormelingen. By facilitating communication between patients and hospital professionals, it reduces complaints and contributes to the quality and safety of care. Professor Reiter-Theil cites two typical cases faced by doctors and nurses and explains how an ethical project developed by the Basel university hospital can help them deal with sensitive decisions.

FRANCE

In the United Kingdom, all British subjects are entitled to access healthcare free at the point of delivery from the National Health Service (NHS). The NHS is the largest employer in Europe with just over 1.3 million staff. As it approaches its 60th anniversary, the NHS is planning to devolve all healthcare provision responsibilities away from Primary Care Trusts (PCTs) and to encourage competition and pluralism in terms of providers. It is worth pointing out that the NHS ended 2007 in financial surplus.

Susan Hodgetts, the chief executive of the Institute of Healthcare Management, describes her EAHM member association's objectives and main activities.

Dr Bullivant and Professor Deighan analyses hospital governance in the UK, its flaws and its various options for evolution.

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MOVING HEALTH AND HOSPITAL CARE **FORWARD WITHIN EUROPE**

On the occasion of the French Presidency of the European Union, EAHM calls for moving health and hospital care forward in Europe:

Towards evaluation of quality and safety

Hospitals in Europe face challenges like increasing patient mobility and the free movement of trained staff, crossborder purchasing of healthcare services triggering increased competition, the protection of public safety and patients' rights....

Despite the current efforts, services offered around Europe vary widely in terms of quality and safety, which leaves a lot of room for further improvement. Further liberalisation of the healthcare market may increase the variability in quality of offered services.

There exist many ways of promoting high quality and safety practices targeting the many actors active and responsible in healthcare.

In order to follow up on the state of quality care in Europe, it is important to be able to measure it in a reliable way. This demands a consistent set of standards leaving a small variation of interpretation.

Many standards exist around Europe, making it more difficult to compare results between the different initiatives. Furthermore, most sets of standards pay little attention to outcomes or the broader context of healthcare delivery (e.g. primary care).

Existing information sources on quality and safety should be reviewed and compared. They should be tested by its application in the field. This exercise should include local, national and international programs like ISQua. It should bring the actual systems from living apart to a state of mutual understanding or even comparability, which may eventually lead to a growing together of existing systems.

The existing richness of standards becoming comparable will also help to avoid the use of minimum standards leaving little motivation for improvement.

Special attention need also be given to the use of the standards in the assessment of health services. Although external assessments are more likely to satisfy the improvement of quality and safety, internal assessment should be promoted as a first step towards external assessment.

Comparable to the quality and safety standards, there exist a variety of external evaluation mechanisms. A coherence of evaluation mechanisms may not be feasible in the short term, it is nevertheless important to make them more transparent.

The current status leaves a lot of potential for European action in this field. In order to support patient and professional mobility within the European Union in terms of quality and safety, it is crucial to monitor the evolutions in the different member states in a consistent way.

Ensuring common core standards as well as coherent evaluation mechanisms will also motivate hospitals to focus more on quality and safety as it will lower the administrative, financial and practical barriers to introduce them in their daily care and management process.

Towards a governed and managed healthcare

Since patient empowerment, budgetary constraints and increased competition set the tone at the European hospital scene, the issue of hospital governance is subject to increasing public interest.

In many European countries, local public and private hospital boards and managers have been urged to be more effective and efficient in governing the hospital's performance. Therefore they are currently challenged to find the right "fit" between the changing context of healthcare and the key configurations of the governing structures and processes within their hospitals.

Hospital governance deserves special attention as it differs from corporate governance in several aspects. A majority of hospitals are public or non-profit private institutions and have no shareholders as in private companies. A large diversity of stakeholders (tax payers, patients, G.P.'s, government authorities, health insurers,..) can be identified as de facto owners, although not always represented in a body of the hospital.

As a consequence of this, the principle of profit maximisation (as a clear-cut touchstone for evaluating decisions in private companies) is missing. Also the outcome of hospitals being complex

organizations is less transparent and more difficult to assess.

Hospital governance refers to the combination of checks and balances that determine how decisions are made within the top structures of hospitals. It deals with the configuration (bodies and its composition...) and functioning of the governing bodies of hospitals (control function, strategic development, quality assurance...).

Several evolutions are taking place in the European countries that influence the governance of hospitals (clinical pathways, health service integration, DRG financing, patient empowerment...).

Although the European Union has limited competence in the field of healthcare, it has already had an indirect impact on organisation of the hospital care, for example the EU working time directory pushed France to review the organisation and (internal) functioning of French healthcare and especially hospitals.

Reviewing hospital governance around Europe indicates that it is important to find the right "fit" between the changing context of healthcare and the key configurations of the governing structures and processes within hospitals.

On the one hand, hospitals should remain more or less autonomous business entities and therefore require a well-adjusted, efficient and effective internal framework.

But at the same time, they need to be deeply embedded in, and influenced by, the healthcare system of which they form part. The resulting duality of 'object of entrepreneurial autonomy' and 'instrument of public health policy' is crucial for hospitals in the delivery of care to the citizens.

It is important for the European Union to create a framework (e.g. through its healthcare service directive) which embeds this duality. Becoming an integrated and accountable actor in the healthcare system is a major challenge for the hospital in the future and the governance of the hospital has a huge impact on this.

It does not depend only on the actors within the governance configurations, the structure and the composition of the governing bodies and the competencies required (the who-question) or the roles and the tasks of the different actors and their mutual adjustment (the what-question).

It depends also on the non-structural checks and balances as well as the techniques used: internal control procedures, reporting systems, risk management... (the how-question). The European Union can stimulate its member states to share experiences or can help finding the appropriate techniques given the different governance configurations.

Restricted budgets are pushing governments and health authorities to identify new resources by attracting private providers or insurances. While this potential is generally welcome, some reflection is needed. Mr. Heuschen, our Secretary General, is expanding on the issue on p.16. The European Affairs subcommittee is following up on this evolution and will report its findings in the near future.

The full text of the paper presented to the French Presidency can be consulted on EAHM's website: www.eahm.eu.org

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EHealth: Commission launches two initiatives

The European Commission has launched two initiatives to improve the safety and quality of care to people who require medical assistance while traveling or living abroad: a recommendation on crossborder interoperability of electronic health records (EHR) and the Smart Open Services (SOS) project.

The recommendation aims to provide member states with basic principles and guidelines for ensuring that doctors can gain access to vital information on patients that they are trying to treat, wherever such information may be located in Europe. A key objective of the recommendation, according to the Commission, is "to allow patients to choose to access his/her important information stored in electronic health record systems anywhere at any time." It invites member states to take action at:

- the overall political level to set up the necessary regulatory and financial environment to make eHealth infrastructure and services interoperable;
- the organisational level to create, for example, a common domain accompanied by the necessary interfaces that enable the national domains to interact;
- the technical level to promote use of technical standards and to establish common interoperability platforms;
- the semantic level to agree on common priorities and specific applications, and
- the level of education and awareness raising to monitor and consider all intended and related developments.

The recommendation will be implemented by The SOS project, co-funded by the European Commission. The three-year 22 million euros joint initiative is supported by 12 member states and their industry players, to demonstrate the benefits of such interoperability. It will enable health professionals to access specific medical data such as current medications of patients from other EU countries. In an emergency, sharing of medical information could save many patients'lives.

Annual work plan priorities

DG Sanco is seeking views on priorities for the annual work plan 2009. The Health Programme 2008-2013 entered into force on 1 January 2008. It is intended to complement, support and add value to the policies of the member states and contribute to increased solidarity and prosperity in the European Union by protecting and promoting human health and safety and by improving public health.

The Programme is implemented by means of an annual work plan which sets out the areas that will be funded and gives an indicative budget for each financing mechanism. To ensure that European citizens can give their input into the programme, the Directorate General for Health and Consumers is seeking views on which priorities should be included in the work plan for 2009.

Views on priority areas to be included in 2009 can be sent by 30 September 2008 to:
sanco-workplan2009@ec.europa.eu

EUPHIX knowledge system launched

The EUPHIX knowledge system was recently launched in Leiden, The Netherlands. EUPHIX (www.euphix.org) is a web-based knowledge system for health professionals, policy makers and others. It presents structured European public health information, giving a special insight into similarities and differences between EU member states.

In this website, EUPHIX presents information on topics related to health status, determinants of health, health interventions and systems, health policies, demography and broader public health themes.

Medical devices directive

The European Medical Device Industry associations (representing 95% of the medical device industry) resist the European Commission's proposal to build up a centralised European Agency for Medical Devices. The new authority is planned to regulate medical devices affairs, such as classification and pre-market approval of "highest risk" devices. According to the industry, the concerns of the EU Commission can be addressed through improved implementation of existing measures.

Pharma package could relax drug advertising rules

The proposed new directive on information to patients is expected to be one of the most controversial initiatives in the Commission's pharmaceuticals package. Current EU legislation allows advertising of non-prescription medicines that are not reimbursed, but bans direct-to-consumer advertising of prescription drugs.

The new rules would maintain the ban on direct advertising of prescription medicines, but would create an opportunity for the industry to provide "additional information" to the public via the media. The pharma package, which is expected to be released in October or November, contains the following three initiatives:

- a directive on information to patients concerning pharmaceuticals;
- a regulation amending an existing one of the authorisation and supervision of medicinal products for human and veterinary use and a directive modernising pharmacovigilance, and
- a legislative proposal to combat counterfeit medicines for human use.

THE FUTURE OF THE WORKING TIME AND THE CROSSBORDER **HEALTHCARE DIRECTIVES**

By Rory Watson

European Union governments may have reached a political agreement on the implications of future working time rules on hospital employees, but the draft legislation still faces a bumpy ride before reaching the statute book.

Alejandro Cercas, the Spanish Socialist MEP, who will act as draughtsman for the proposal when it goes through the European Parliament, has already made clear that he is opposed to three key elements of the current text.

In addition to his overall opposition to the continued existence of the possibility for employees to opt out of the maximum 48 hour week, he is looking to overturn two specific features of the ministers' agreement in June.

The first is their decision to create a category of "inactive" on-call time, whereby medical staff would not be paid if they are required to be on hospital premises, but are not working. "This is scandalous. Ministers talk of a social Europe and then decide this. It goes against rulings of the European Court of Justice (ECJ). Governments have a hidden agenda. They do not want to pay the costs and want to make Europe responsible. All on-call time should count as working time," he explains.

He is also critical of the current wording of the compensatory rest periods that employees must be given after working long hours. This states that the rest should be granted "within a reasonable period". Arguing that this is a regression from the existing situation, he maintains: "Health staff are extremely tired after working long hours and so should have their rest straightaway."

Cercas will start tabling amendments to the ministers' text in September and is already canvassing support for the changes he has in mind. Initial soundings suggest he has the backing of most left of centre European MPs, and also a number of centre right, including members from France, Germany and Italy.

He is hoping that the Parliament will give its final opinion on the draft legislation in November or December at the latest. If he succeeds in pushing through the changes he has in mind, then the Parliament and EU governments, led by the French European presidency, will face tense negotiations if they are to bridge their differences before the end of the year.

Most governments are waiting for a political decision on the draft legislation to clarify the confused situation. But some, partly under pressure from national courts to implement the European Court judgements stating that all on-call time counts towards the working week, have begun to do so.

That is notably the case of Germany, Poland, the Netherlands and Hungary. Given the non-regression principle, it is unlikely they could deviate from that, even if the draft legislation as approved by employment ministers in June remains in its present form.

France has adopted a different approach. It announced immediately after the June ministerial meeting that it would treat all on-call time as work, using the provision in the draft legislation that this is possible if set out in national legislation or in collective agreements.

Legislation on the maximum working week is not the only issue on which politicians will try to agree European measures affecting the health sector this autumn in response to earlier far reaching judgements from the Luxembourg-based European judges. They also have on their agenda a proposal tabled by the Commission in early July that would set out the parameters allowing patients to receive medical treatment in another EU country and be reimbursed by their own national health authority.

This right has been confirmed by the ECJ, but uncertainty exists on how it may be exercised and the impact any sudden increase in demand may have on health services.

The Commission stresses that the draft legislation, which must be approved by EU governments and the European Parliament, is not designed to harmonise health systems. They remain a national responsibility.

The proposal would allow patients to receive reimbursable non-hospital care in another EU country without requiring prior authorisation from their own authorities.

However, mainly because of the potential costs involved, governments could insist on that authorisation for any hospital treatment whether this involves an overnight stay or not. In either case, patients would have to pay the costs themselves and be refunded the amount the operation would have cost in their own country.

It is unclear how much use the public will make of this right. Only 4% of Europeans say they have received medical care in another country, and the Commission estimates that crossborder patient mobility accounts for only 1% of total health expenditure in the 27-member EU.

UNITED KINGDOM

NHS booking system failing patients

The new NHS computerized booking system is failing to provide the promised level of choice of appointment times, dates and locations, according to a study. The first ever survey of patients who had used the Choose and Book system found that 66% of those asked were not given a choice of date for their outpatient appointment and the same number were not given a choice of appointment time.

The first NHS Online Maternity Guide

The first NHS online maternity guide, offering a wealth of information on pregnancy and birth, at just the click of a mouse, was launched in August. The new Pregnancy Care Planner gives the latest and most comprehensive advice on all aspects of pregnancy, from getting pregnant, early pregnancy, the scans, to the birth, and the most up to date comparative guides to what is on offer at local maternity units.

Health is the most researched subject on the internet, and pregnancy is the most researched health subject. This new service is available on the national NHS website, NHS Choices and the link to the planner is: http://www.nhs.uk/pregnancy.

Scottish hospital admissions

Hospital admissions for heart attacks and chest pains fell by 17% in Scotland after a 2006 ban on smoking in enclosed public spaces. There were 2,684 emergency hospital stays for chest pains in the 10 months after the ban, compared with 3,235 in the same period before the law, they study said. England, which didn't have similar legislation until July 2007, had a 4% decline

ROMANIA

Healthcare staff migration

According to a recent poll, 45% of doctors and medical assistants surveyed in Romania wish to leave the country. According to Dimitrie Onciul, director of the Filantropia hospital, "it has become very easy to migrate to the European Union, and it is particularly tempting given the difference in salary." After six years in medical school, a doctor who wishes to specialize receives a monthly salary of 220 euros, less than the 350 euro average salary, according to official statistics.

SPAIN

European medical bills

Europe is to pay 25 million euros to the Andalucian Health Service, SAS, for the medical bills of tourists who have been treated in the region. This summer the SAS has taken on 233 extra professionals, including 99 doctors, to meet the demand from tourists in coastal hospitals, and the money comes via the Health Cohesion Fund of the EU. On the Costa del Sol most European tourists to use the health facilities are from Britain (27%), followed by Germany (5%).

GERMANY

Gay and lesbian nursing home

The Asta Nielsen Haus in Berlin's Pankow district is the first gay-only old people's home in Europe. The new facility is part of a 78-bed nursing home, with 28 beds reserved exclusively for gay and lesbian residents. The project is the result of a collaboration between a gay rights association and an aged care agency.

The home will allow residents to speak freely of their past and their relationships without encountering negative reactions or prejudices. Special training is given to care assistants, 50% of whom are themselves homosexual.

DENMARK

Copenhagen cuts back on ambulances

Regional authorities have recently announced a major cutback in the number of ambulances serving the Greater Copenhagen area as of 2009. Under the change, large areas of the Danish capital will be covered by just one ambulance at night while the number of ambulances available 24 hours a day in the Greater Copenhagen region will be cut from 38 to 28. However, a new centralised control system will maintain current levels of ambulance service and be more cost-efficient according to the head of the emergency medicine unit for the region.

CENTRAL AND EASTERN EUROPE

Surgical disposables boom

The surgical disposables market generated revenues of 35.1 million euros in 2007 and estimates this to nearly triple by 2014 to reach 101.5 million euros. As emerging markets look to raise the quality of their healthcare services, there has been a significant uptake of surgical disposables such as drapes, gowns, gloves and masks in Central and Eastern Europe. Ongoing education drives to spread awareness about hospital-related diseases have supported this trend. This market does however face the challenge of adhering to, and maintaining, EU standards of healthcare. As new Eastern European member states join the EU, they are compelled to raise their healthcare standards to meet EU-mandated standards.

MÖLNLYCKE HEALTH CARE

Analyzing The Cleanliness of Surgical Gowns with Scanning Electron Microscopy

By Catarina Alenius Jensen, B.Sc.[1] and Kristina Blom, M.Sc. Ph.D.

Surgical gowns are available as both single-use, made of non-woven materials and reusable, made of cotton or synthetic based materials. As their main purpose is to prevent the transmission of infectious agents between the clinical staff and the patient, surgical gowns are classed as medical devices.

An essential requirement for all medical devices is that they should be clean from microbial contamination[1]. In addition, to avoid foreign body reactions, medical devices should be clean from foreign bodies or particulate matters[2]. Although, it is possible to see objects as small as 50 µm, with the naked eye, a microscope is required to detect anything smaller. In this study, surgical gowns, single use of standard performance (SP) and high performance (HP) material and reusables made of cotton and synthetic material, were evaluated to explore their cleanliness at a microscopic level using scanning electron microscopy (SEM).

Results

A wide variety of particulates could be seen on all the surgical gowns with SEM. The particulate matter on the single use gowns were confirmed to be integrated in the material. All SEM analyses of the non-woven gowns of both SP and HP materials were consistent and showed that the non-woven material looked clean (Figure 1 A and B).

In contrast, all samples of the reusable gowns revealed a wide variety of unidentified structures. Figure 1C indicates that synthetic reusable gowns' materials may be coated and that could potentially come off. It was also observed that reusable synthetic and cotton gowns harbored particulate matters that appeared foreign, i.e. not part of the gown material, and some of them resembled microbial structures (Figure 2 A and B).

Discussion

For reusable surgical gowns to be fit for purpose, they must be processed involving cleaning, disinfection and sterilisation to secure that the gown is clean from foreign materials such as soil and contaminating microbes that could come loose during a procedure [2]. However, the product will not be fit for use unless it has been effectively processed. Multiple factors such as the level of soiling, organic contamination (e.g. microbes, body fluids and tissue), the hardness and temperature of water, and type and amount of detergent and disinfectant affect the efficacy of each process. If contaminants on reusables are not properly washed away, these will remain and could go unnoticed, especially if they are of microscopic size.

Particulate matters

While some of foreign materials detected on the reusable gowns could be contaminants, they could possibly also be residue from disinfectants or other impregnating chemicals. These particulate matters may not be a problem while adhered to the material. However, if they become detached, they could cause an inflammatory reaction in the surgical wound causing foreign body reaction and formation of granulomas

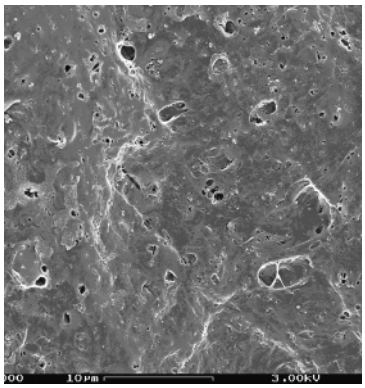

Figure 1.A

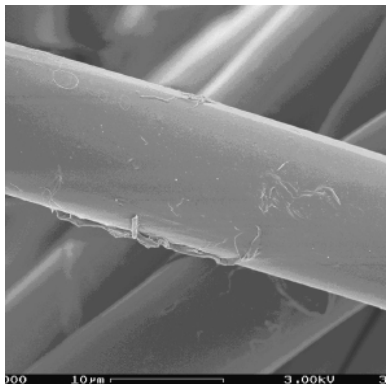

Figure 1.B

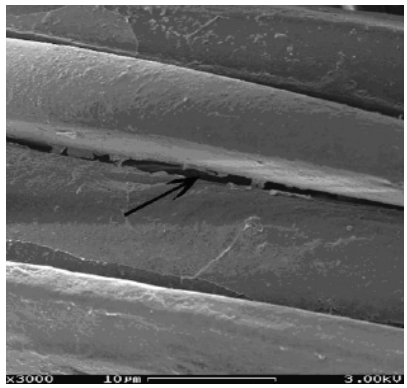

Figure 1.C

Figure 1. SEM analysis of single use gown of HP (A), SP (B) and synthetic reusable gown (C). Arrow (C) is indicating a particulate matter about 5 µm in size that seems to be loosely adhered to the surface of the material.

and adhesion[3] or accidentally be contaminating catheter lines and cause emboli[4].

Microbial like particulate matters

It is intriguing to speculate that reusable surgical gowns ready to be worn could harbor microbes. Recently, Kramer et al. summarized reports, where inanimate surfaces have been incriminated as the source for outbreaks of nosocomial infections[5]. Both gram-negative and gram-positive bacteria, fungi and viruses were found to survive on different surfaces at hospitals for an extensive length of time. In an experimental study, it was also shown that bacteria can survive for months on hospital fabrics and plastics[6]. In yet another experimental study, confined to surfaces in the operating room, gloves and surgical gowns were studied to see if they could be a source of many biomaterials related infections[7]. It was shown that bacteria can adhere to and be transferred between different surfaces in varying degrees, depending on the bacterial species, the presence of moisture and the friction and characteristics of both the donating and receiving surfaces. As microbes can survive on inanimate surfaces and be transferred, it is clear that these surfaces must be properly disinfected before a subsequent use.

Numerous studies have reported on bacterial survival after the laundry process[8]. There have been reports where linen has been the incriminating source of surgical site infections, even though the products have been washed and disinfected[9].The incidence was due to the linen harboring Bacillus spores that were not efficiently washed away. The ordinary washing temperature and disinfectants did not have any effects on the spores.

There is therefore a potential risk that reusable surgical gowns will harbor microbes that are not efficiently removed and killed between uses[10]. Furthermore, in a drive to reduce energy consumption, the use of lower washing temperatures, may diminish laundry efficacy[11]. Lower temperatures are also used because mixed materials in synthetic reusable gowns cannot withstand high washing temperatures[10].

Conclusion

This study revealed that single use surgical gowns appeared to be clean at a microscopic level. In contrast, reusable surgical gowns, both synthetic and cotton, did not look clean, and seemed to harbor foreign particulate matter. These resembled microbial structures and/or possibly chemicals applied to recondition the gowns. These foreign particulate matters could potentially have a negative clinical impact, which has been highlighted by others.[3, 4, 10]

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References:

1. EU (1993). Medical Device Directive 93/42/EEC.
2. Barrie, D. (1994). How hospital linen and laundry services are provided. J Hosp Infect 27, 219-235.
3. Duron, J.J., and Olivier, L. (1997). Foreign bodies and intraperitoneal post-operative adhesions. J Long Term Eff Med Implants 7, 235-242.
4. Konwaler, B.E. (1950). Pulmonary emboli of cotton fibers. Am J Clin Pathol 20, 385-389.
5. Kramer, A., Schwebke, I., and Kampf, G. (2006). How long do nosocomial pathogens persist on inanimate surfaces? A systematic review. BMC Infect Dis 6, 130.
6. Neely, A.N., and Maley, M.P. (2000). Survival of enterococci and staphylococci on hospital fabrics and plastic. J Clin Microbiol 38, 724-726.
7. Knobben, B.A., van der Mei, H.C., van Horn, J.R., and Busscher, H.J. (2007). Transfer of bacteria between biomaterials surfaces in the operating room-an experimental study. J Biomed Mater Res A 80, 790-799.
8. Jaska, J.M., and Fredell, D.L. (1980). Impact of detergent systems on bacterial survival on laundered fabrics. Appl Environ Microbiol 39, 743-748.
9. Barrie, D., Hoffman, P.N., Wilson, J.A., and Kramer, J.M. (1994). Contamination of hospital linen by Bacillus cereus. Epidemiol Infect 113, 297-306.
10. Fijan, S., Koren, S., Cencic, A., and Sostar-Turk, S. (2007). Antimicrobial disinfection effect of a laundering procedure for hospital textiles against various indicator bacteria and fungi using different substrates for simulating human excrements. Diagn Microbiol Infect Dis 57, 251-257.
11. Christian, R.R., Manchester, J.T., and Mellor, M.T. (1983). Bacteriological quality of fabrics washed at lower-than-standard temperatures in a hospital laundry facility. Appl Environ Microbiol 45, 591-597.

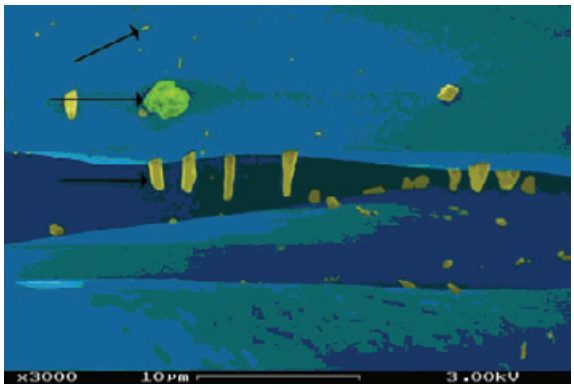

Figure 2.A

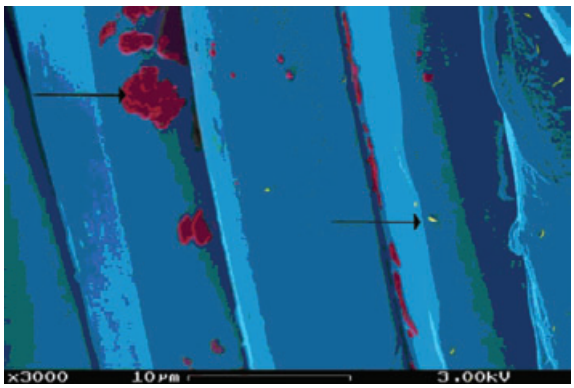

Figure 2.B

Figure 2. SEM analysis of surgical gown made of cotton (A) and of synthetic (B). Arrows point to structures that could be foreign particulates and the upper (A) and right (B) arrows point to microbial like structures.

HEALTHCARE AND COMPETITION **BETWEEN HOSPITALS IN EUROPE**

Is privatisation the answer?

An interview with EAHM Secretary General Willy Heuschen

Mr. Heuschen, why is it timely to reflect on the developments on the healthcare market?

WH: Rulings of the European Court of Justice in these last years have served to underline the point that member states health systems, and in particular the delivery of healthcare, do not lie outside the jurisdiction of Community law. Health systems therefore are subject to Treaty provisions governing the free movement of goods and services. Internal market regulations are generally aimed at freeing up markets to obtain the economic benefits associated with free competition.

However, health is not a typical market. The importance of health to the individual, and the need for member states to ensure equitable access to healthcare across their populations, give rise to a form of market, which is not easily subjected to the competitive model.

Market competition hence cannot be accepted without regulations by state authority, and market chances need to be the same for all providers, which is not presently the case.

Moreover, developments in this field in EAHM member countries are following different patterns.The experience of Sweden, for example, demonstrates that when a nation adopts market-oriented reforms for its healthcare system, those reforms will fail if the market is not allowed to function naturally, On the other hand in the UK it has been observed that market competition within the public sector is not impossible.

Measuring the performance or quality of a hospital can be seen as a way to evaluate healthcare, and it can contribute to increased patient safety. Although many countries set up national strategies to improve quality in hospital care, this has not led to the development of internationally comparable quality standards, even though they are a "must" in an internal healthcare market. Problems in this process are due to a lack of definitions and a lack of international agreements between European countries in the area of external assessment of quality in healthcare.
Therefore, our first EAHM Seminar held in November 2007 opened the floor to health policy makers and hospital managers around this question. The final purpose is to launch the development of a voluntary European accreditation model.

> The importance of health to the individual, and the need for member states to ensure equitable access to healthcare across their populations, give rise to a form of market, which is not easily subjected to the competitive model

What does this mean for hospitals in Europe?

WH: New (private) providers are assumed to increase productivity, to enhance patient choice, to adopt more efficient work practices. But the question is: are existing public and voluntary hospitals unable to do the same? Competition can and should motivate them to do so. This, however, implies that generating profits must also be a tool for public and voluntary hospitals towards achieving required investments.

The goal should be that if public and voluntary hospitals perform as efficiently as private providers, any ideological debate about the privatisation of healthcare automatically becomes obsolete.

What are, according to you, likely future developments?

WH: The patient as final consumer must be enabled to choose the best provider, otherwise one cannot consider healthcare as a market. Currently patients are not involved to the necessary extent .

In the future, systems will change and become more patient-centered. It will be even more important for not-for-profit hospitals to be able to generate profits. In our current system, all healthcare stakeholders generate profit, except for hospitals, which is ridiculous. However it should be kept in mind that values that have been established and adhered to in the past must not be lost in the search for more efficiency and effectiveness. Basic principles must be identified and kept as well as respected by all healthcare providers.

What action is EAHM planning to undertake?

WH: Public arrangements will remain the essential tool of healthcare financing because of Europe's history. However, further privatisation in provision and management of healthcare is to be expected, and PPPs are likely to increase.

This is a favourable evolution. There needs to be a mix of healthcare providers on the market, all benefiting from each other and creating synergies. But it needs to be a controlled development, not only underlying market forces.

To date, our association, and especially its European affairs subcommittee, has debated the issues intensively and has elaborated preliminary opinions and main points of interest. These have been presented to the EAHM Executive Committee and an official position of the EAHM is to be issued before the end of the year. This is meant to create awareness of current processes for all stakeholders involved.

> The goal should be that if public and voluntary hospitals perform as efficiently as private providers, any ideological debate about the privatisation of healthcare automatically becomes obsolete

Next, in 2009, EAHM is to organise a seminar around that theme. And finally, our European association will continue to monitor developments on the European market. The starting point of EAHM's position is the acknowledgement that regulations are needed to ensure the free provision of healthcare. It is essential for all actors to look at privatisation in healthcare from a strategic, financial and operational point of view.

The main focus should be equal accessibility of a high-quality healthcare system for all citizens in a sustainable environment.

LETHAL TREATMENT **FOR PUBLIC HOSPITALS**

The shock of T2A

By André Grimaldi

Funding healthcare by T2A (activity-based fees) has replaced the funding of hospitals via the general budget established in 1983. The goal of the general budget was to limit expenses by restricting activity. The main criticisms of the general budget were its injustice vis-à-vis private clinics, which were not subject to the general budget, and its unsuitability for the activity since it offered a "peculiar advantage" to well-funded hospitals and penalised less well-funded hospitals experiencing growth in their activity. The result has therefore been a transition from a deflationary system to a potentially inflationary system by "activity-based" payment.

The end goal of the system, as well as its ultimate corruption, is revealed by the assertion of a total convergence of public and private care by 2012, even though, as recognised by the director of the Minister's office and health advisor to the President of France, the structure of healthcare for public hospitals and private clinics is fundamentally different. This difference extends to the medical salaries included in hospital costs, even though medical fees and social security subsidies for medical insurance are not included in the costs of private clinics.

In practice, as confirmed by expected losses at 29 of the 31 CHUs (university hospitals), the T2A financing system was developed in favour of private clinics, to the detriment of public hospitals. Thanks to T2A, the turnover of private clinics has risen by 9%. The Générale de Santé, which owns 180 clinics, has paid EUR 420 million to its shareholders while the deficit of public hospitals exceeded EUR 350 million and next year is expected to exceed EUR 400 million.

French private clinics are currently undergoing in-depth restructuring, a trend that has resulted in interest from international investment funds such as Blackstone that seek returns of 15-20%. In certain regions, private clinics already have a monopoly. At the same time, charging healthcare fees in excess of what social security will reimburse is becoming increasingly common, paving the way for supplementary insurance.

Functioning of T2A

To succeed in organising a system characterised by activity-based payment, it was necessary to quantify this activity, which led to the adoption of a reductionist approach involving the use of codes. Some 10,000 different pathologies were classified into 750 "homogenous" hospital stay codes, which are therefore very heterogeneous. Average benchmark measures were chosen based on a very opaque, highly criticised methodology, in particular as regards pathologies that are highly specialised or that are almost exclusively treated in hospitals, such as leukaemia or very intensive care. Very benign pathologies mainly treated in private clinics were placed in the same homogeneous groups as serious pathologies that are mostly treated in hospitals. T2A does not take into account emergencies or highly specific activities in specialised centres.

Impact of T2A

T2A is going to force hospitals to change the way they are organised, i.e. to "increase their productivity", by reducing their headcounts. According to the French Hospital Federation, the only way for the system to break even will be to find 20,000 redundancies, even though no one dares to talk about this! Hospitals are also going to have to change the way they are structured by adopting financial profitability criteria corresponding to the activity of private clinics, i.e. surgery and simple treatment acts (surgery for varicose veins, cataracts, hip replacements, pacemaker, etc.), to the detriment of activities deemed unprofitable (therapeutic prevention and education, chronic illnesses, multiple pathologies and dependencies). This means that complementarity will be replaced by competition. Dialysis machines are already working at their full capacity and Paris hospitals are attempting to win "market shares" in orthopaedic surgery and cataract surgery. Hospitals will lose their unique characteristics and, in so doing, their appeal.

Hospitals must be in a position to provide care 24 hours a day. This means that there must always be free beds to satisfy an acute need (epidemic of bronchiolitis, heat wave, etc.). Unlike a clinic, a hospital cannot aim for a 100% occupancy rate. A failure to finance 15–20% of empty places would be like paying firemen only when there is a fire! For the same reason, a certain percentage of hospitalisations cannot be anticipated. Yet, for the exact same pathology, an unscheduled admission costs roughly 60% more than a scheduled admission.

Thus, in order to cope with this situation, it will be necessary to pay hospital surgeons the same way as their private clinic peers are paid: by medical act, at the risk of destabilising teamwork. This restructuring will be managed by directors who will have become businessmen. They may come from the private sector, be hired on private contracts at non-public hospital salaries, and return to the private sector after a few years, if they so wish. Moreover, both doctors and administrative staff will likely be entitled to a share in profits, thereby creating a conflict of interests inconsistent with medical ethics and the spirit of public service.

Reform principles

There are two dominant thoughts behind this reform of public hospitals:

as is the case in most countries, this involves the calling into question of the supposedly inefficient public services. The government's aim is to achieve at least partial privatisation, introduce competition and "make work more flexible", in order to reduce costs. This market-based approach is tantamount to merchandising medicine. It reflects a misunderstanding of the evolution of medicine, an approach that only looks at things in terms of technical progress and acute illnesses (according to Claude Le Pen, a healthcare economist, "caring for a sick person and fixing a car is the same thing").

The other characteristics of the evolution of the healthcare system, i.e. the increase in chronic illnesses requiring comprehensive, multi-professional, multidisciplinary care and therapeutic education, are excluded from the analysis or marginalised with the illusion of a transfer of coverage to non-hospital or non-medical "community" resources (patient associations, NGOs, call centres, etc.). The US system based on private insurance, despite its numerous failings, has become a reference for decision makers' analysis of the situation.

Conclusion

The organisation and funding of the healthcare system should be analysed in these two ways: acute disease and treatment acts on the one hand and comprehensive care for persons with chronic illnesses, on the other.

There is an urgent need to limit T2A to what it is suitable for and to rethink hospital financing before T2A has turned the entire system's structure upside down by transforming hospitals into private clinics (for profit or not-for-profit) on the one hand and into modern homes for the disabled, on the other.

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THE PRIVATISATION OF HOSPITALS IN GERMANY

Lowering confidence of Germans in their hospitals?

By Nils Böhlke and Thorsten Schulten

There is no other country in Europe that has seen such an enormous wave of hospital privatisations over the last years of Germany. Traditionally the German hospital market was dominated by public clinics but has always included a significant proportion of private not for-profit hospitals that are mainly owned by the two big Christian churches and other welfare organisations. However, since the early 1990s, the number of private for-profit hospitals has increased continuously and has led to the emergence of a few leading private hospital corporations such as Rhön-Klinikum, Helios and Asklepios.

While in 1991 46% of the hospitals were public, in 2006 this proportion was reduced to 34.1%. On the other hand the share of hospitals with a private for-profit owner increased from 14.8% to 27.8% over the same time period. The percentage of private not-for-profit hospitals remained relatively stable (Figure 1). Most studies expect a continuation of this trend so that eventually up to 40 % of the hospitals will be run by private for profit hospital chains. Already more than half of the remaining public hospitals have modified their legal status to private law institution.

This is often the first step towards the sale of the entire hospital to a private company. Additionally many public hospitals outsource services such as cleaning, laundry, catering or lab research to private companies or subsidiaries .

Until the late 1990s private hospital companies primarily bought small hospitals. Still almost half of the beds and almost 58% of the employees can be found in public hospitals and just 12% in private for-profit hospitals (Figure 2).

However, since 2000 privatisations have affected an increasing number of larger hospitals. The largest privatisations so far were the purchase of the State enterprise Hospitals Hamburg (LBK Hamburg) in 2005 and the privatisation of the university clinic in Marburg-Giessen in 2006. Regarding the latter, it was the first time that a university hospital was privatised making Germany a privatisation forerunner in Europe. This has increased the share of bad capacity of private for-profit hospitals almost to U.S. levels.

In most other countries privatisation trends are limited to the outsourcing of certain services or the development of Public-Private-Partnerships (PPP) while the purchase of entire hospitals is still an exception. In Sweden, the former social-democratic led government even prohibited further privatisations of hospitals in 2004. Only France traditionally has an even larger for-profit hospital sector.

Motivations of hospital privatisations

The reasons for the wave of hospital privatisations in Germany are manifold. The most important issue behind this development is some fundamental changes in the hospital funding system. Since the early 1970s the hospitals have been funded by the so called dual financing system (duale Finanzierungssystem). While operational costs are funded by health insurance contributions, investments are supposed to be covered by the German Federal States. In order to keep health insurance contribution rates stable, far reaching reforms of the funding system have been decided since the 1990s. This primarily comprises the introduction of budgets on running costs as well as the implementation of a system of case-based lump sums. This so called DRG System (Diagnosis Related Grouping) shifted the financing from daily rates to lump sums for certain diagnoses. The reorganisation of the funding system has led to tremendous financial pressure on hospitals. According to the hospital rating report 2008 of the RWI Economic Institute, more than one third of the hospitals will experience budget deficits in 2008. The overall deficit will amount to a sum between 1.3 and 2.2 billion euros. For many municipalities, hospital privatisations seem to be the only way out of this financial quagmire.

The strongest boost for privatisation comes from the lack of investment by the Federal States, though. According to the German Hospital Association (Deutsche Krankenhausgesellschaft) this has piled up to 50 billion euros. Health economist Michael Simon estimates that it might even be twice as high. While in 1984 2.6% of the GDP was invested in hospitals, in 2004 it was just 1.3%. Hospital investments were among the lowest in Europe. Therefore it is hoped that privatisations will help to overcome this large investment gap.

Consequences of privatisation

The general trend towards a contractualisation of hospital services has far reaching consequences on employees and patients. This impact is exacerbated by the increased importance of private for-profit hospitals. Since about 60% of the operational costs of a hospital are labour costs, it makes economic sense to rationalise and reduce personnel costs. Since the beginning of the 1990s the number of employees (measured in full-time equivalents) in the hospital sector has decreased by nine per cent. As the number of cases has risen sig-

nificantly over this time period, work is a lot more intense nowadays.

In private for-profit hospitals the workload is exceptionally high (Figure 3). In 2006 a nurse in a private for-profit house had to care for 515 occupied beds in days, 65 more than her colleague in a public clinic. The difference is even bigger for physicians: in private for-profit clinics doctors have to treat 30 % more patients than in public hospitals. A similar ratio can be observed for the medical-technical staff that includes physiotherapists, psychologists, pharmacists and social workers. Furthermore, according to a patient survey by a leading health insurance this has significantly deteriorated patient satisfaction levels.

The privatisation of hospitals also has severe consequences on relations within hospitals. Usually private for-profit hospitals dismiss general collective agreements for the public sector and conclude collective agreements at company level. Studies suggest that these agreements usually implement much broader wage dispersion. Thus physicians earn the same or even more in private for-profit hospitals while nurses earn significantly less. The overall problem for employers and unions in private as well as public establishments is the capping of the budget system by the government, though. This leads to very little financial leeway for wage increases. Therefore unions and employers collectively demand the abolition of capped budgets.

Conclusion

Due to bad experiences by employees and patients, hospital privatisations in Germany become more and more contested. In recent years almost all larger hospital privatisations have faced local anti-privatisation initiatives supported by trade unions and other social organisations. In many cases these initiatives have tried to organise a referendum to prevent hospital privatisations. The best known example has been the initiative against the majority privatisation of the LBK Hamburg in 2004, after which the hospitals were finally sold despite the fact 76.8% of the voters voted against it. In some cases, as, for example, Dresden (2008), Meissen (2006), Zwickau (2003) and Northern Friesland (2002) these initiatives were able to successfully prevent the privatisation.

Even though only a few studies have been released so far on the impact of hospital privatisations on the quality of care in Germany, the resistance against privatisations indicates that patients view it as controversial and expect for-profit hospitals to favor their earnings over the quality of care. Hence the status of Germany as a hospital privatisation forerunner has probably lowered Germans' confidence in their hospitals.

So far, it is rather uncertain if the protests by patients and staff will be able to reverse the trend towards hospital privatisations. The future developments will depend very much on whether or not German politics will find a way to reduce the huge investment gap in public hospitals. However, the readiness to allocate more money to the hospital system is still rather limited, so that privatisation will continue to bee seen as a possible solution to funding problems. Therefore, the protests are no longer only against privatisation but more and more also against capped hospital budgets and in favour of spending more money for German hospitals.

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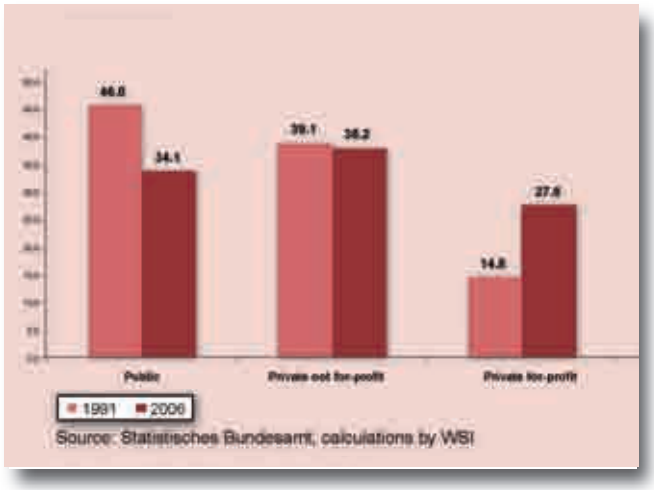

Fig 1: Ownership of hospitals in Germany 1991 and 2006 (in %)

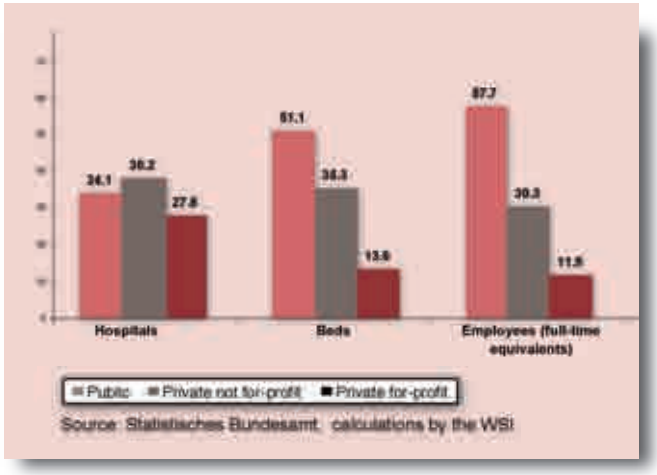

Fig 2: Proportion of hospitals, beds and employees according to ownership 2006 (in %)

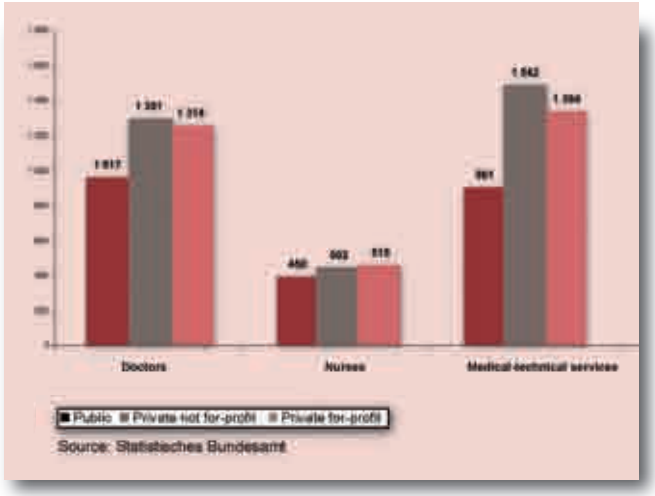

Fig 3: Number of occupied beds in days to be carried by a full-time hospital employee (2006)

HOSPITAL MARKET COMPETITION IN THE NETHERLANDS

By Hans Maarse

A cornerstone of the ongoing reform process in the Netherlands is to introduce market competition in health insurance and health care provision to make healthcare more efficient, innovative and client-driven. To avoid adverse consequences of competition for the quality, accessibility and afforda-bility of health care, the new regulatory framework contains many legal provisions – sometimes denoted as 'public constraints' to competition – regulating the market behaviour of health insurers, providers of care and 'consumers' (Bartholomée & Maarse, 2005).

The general trend in Dutch hospital care over the last decades has been one of uninterrupted consolidation. Over the period 1981-2001 the number of general hospital organisations almost halved from 172 to 96 (the number of hospitals fell significantly less because many consolidated hospitals were multi-location hospitals).

Consolidations must be approved by the Dutch Competition Authority (Nederlandse Mededingingsautoriteit). Regulations are now stricter than in the past to avoid that market concentration will erode competition.
As yet, no hospital chains have been formed in the Netherlands. Hospitals prefer to operate as independent organisational entities. Nevertheless, they gradually begin to realise that the current competition wave will require them to set up effective collaborative arrangements to reinforce their market position.

The most important objective of collaboration is to counteract the ongoing consolidation on the health insurance market where in 2008 the 'big four' had almost 90% of the market.

Independent treatment centres

A remarkable development since 2000 concerns the rapid increase of a new type of provider organisation which, unlike general hospitals, concentrate upon a limited range of medical services such as orthopaedic surgery, cataract surgery, diagnostic services or maternity care. The number of specialised centres or 'independent treatment centres' (ITCs) rose spectacularly from 31 in 2001 to approximately 160 by the end of 2006 (NZa, 2007). The waiting list crisis at the end of the 1990s and the competition vogue in the 2000s created a more favourable environment for ITCs and eventually led to new regulatory arrangements that now give them an almost fully-fledged position in health care delivery. The current legislation allows ITCs to provide care with overnight stay for certain categories of treatments.

The rise of the number of ITCs is somewhat misleading because so far, ITCs account for a very small part (about 1%) of total expenditures for hospital care. The real impact of ITCs on hospital care may be more in their influence on the performance (e.g. productivity and quality of care) of general hospitals rather than in the market share they gained. A strategy various hospitals have adopted is to set up ITCs themselves or to actively give support to entrepreneurial specialists in their hospitals.

For-profit hospital care

Healthcare legislation traditionally contained a formal ban on for-profit hospitals and, as a consequence, all hospitals in the Netherlands have a not-for-profit status. However, the previous government announced it would lift the ban as part of its market reform in 2012. An important reason for this cautious strategy was that it did not consider the new hospital payment system by means of case-based payments (see next section) to be stable enough to permit for-profit hospital medicine at short notice.

The new government that took office in 2007 has come up with a revised proposal. For-profit hospital care will be permitted by 2010 in order to make it easier

for hospitals to attract capital resources for investments. However, there will be restrictions to the extent hospitals can pay their shareholders a return on investment. Profits must be reinvested in hospital care. Furthermore, it is forbidden that financial reserves of hospitals, particularly in real estate, that were built up in the past in a 'protected financial environment' of full cost reimbursement, leak away to the commercial sector after hospitals have gone for-profit.

If the new regulatory framework for for-profit hospital care will indeed be based upon the social enterprise concept, it will obviously restrict the potential of the hospital sector for investors. This illustrates the dependence of hospital market reforms on political conditions.

Presently, various hospitals are reconsidering their legal status of private foundation to effectively operate as an 'entrepreneur in hospital care'. One can already observe an unprecedented proliferation of so-called private limited companies (PLCs), operating under a holding structure governed by the chief executive board.

Pay for performance and price competition

A very important element of the ongoing market reform in the Netherlands is that it allows for some price competition in hospital care. For that purpose, the financial revenues of each hospital are split into two segments. In the A-segment, the tariff of each DTC (Diagnosis Treatment Combination) is still centrally regulated by the Netherlands Healthcare Authority (Nederlandse Zorgautoriteit) by means of maximum tariffs. Price competition between hospitals is absent here, though ITCs may offer lower prices. Another key characteristic of the A-segment is that the NZa sets an annual budget limit for each hospital. If the revenues of a hospital exceed its budget limit, the cost overrun will be set off retrospectively. Due to this arrangement in which DTCs are only used as an administrative tool to pay for hospital care, hospitals have no incentive to 'overproduce' in the A-segment. In the B-segment, however, hospitals and insurers are free to negotiate on the prices of DTCs. Contrary to the A-segment, there is also no budget limit in the B-segment.

The fraction of revenues for which price competition is higher for general hospitals than for academic centres. The fraction also differs by type of medical specialty. Information of the NZa indicates that negotiated prices are much more relevant for orthopaedics and ophthalmology than for neurology (NZa, 2007). There are various policy issues in price competition yet to be resolved: which part of hospital care will be open to competition? Will it be 70% as envisaged in earlier government statements or will it be a significantly lower percentage? The government has repeatedly argued that price competition is inappropriate for several forms of hospital care including emergency care and top-clinical care. A second problem concerns cost control. Will competition and the concurrent lifting of the budget ceiling elicit an uncontrollable growth of expenditures for hospital care?

As yet, there are a few signs that price competition may work. Nominal price increases in the B-segment were less than in the A-segment: 0% versus 1,5% in 2006 and 2,1% versus 2,5% in 2007 (the prices of ITCs are not included in these percentages). Another interesting finding was that price increases tend to be lowest in those specialty areas where ITCs have entered the market (examples are ophthalmology, urology and gastroenterology). However, the question is of course whether these effects are only temporary.

Furthermore, they may lead to cost shifting to other sectors of healthcare that are not in the equation. Interestingly, the NZa (2007) also found that insurers with a big market share were able to negotiate lower prices than small insurers. This result suggests that hospitals consider it very important to contract with the market leader in their region. As far as the growth of volume of hospital care is concerned, the NZa signalled a stronger growth of the volume in the B-segment than in the A-segment over the period 2005-2007. In its view this may only be a temporary registration effect of the new funding model. Nevertheless, it does not exclude the possibility of a supply-induced demand effect (NZa, 2008).

Capital investments

The market reform also includes a major revision of the arrangement for the financing of capital investments. Under the previous arrangement, the costs of rent and depreciation were covered by a mark-up to the inpatient per diem rate over a 40-year period after the government had given its ap-proval to these investments. As a consequence, neither hospitals nor financial agents providing long-term loans to finance hospital investments did incur a financial risk. This arrangement is considered to be incompatible with competition.
Competition not only requires hospitals to make their own investment decisions, but also to make them self-responsible for financing these investments. For that purpose they will be paid a centrally-regulated 'investment' mark-up on the DTC-rate. In this new model, the hospital's room for capital investments is contingent on hospital revenues.

Policymakers expect that the new model will make all stakeholders more critical about capital investments and financing arrangements. Hospital investments are no longer a risk-free activity for hospitals and financing agencies.

Conclusion

If we put all the pieces of this article together, we can draw the general conclusion that hospital care in the Netherlands finds itself in a period of transition. The introduction of market competition can be regarded as an important driving force of the ongoing alterations in the 'hospital landscape'. The mid-term consequences of the market reform can hardly be overseen yet, the more so because various market-making decisions have still to be taken (e.g. as regards the scope of price competition and the introduction of for-profit hospital care) or still have to become effective (in particular, the introduction of a new regulatory framework for capital investments). Though competition in hospital care is not new, it is fair to say that both the intensity and type of competition is rapidly changing. Many begin to see hospital care is as 'business'. Patients also tend to become more critical on hospital performance. It is an interesting time for hospitals indeed!

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THE MEDIATION FUNCTION
ON THE BELGIAN HOSPITAL SCENE
A contribution to the quality of care

By Piet Vanormelingen and Emmanuel Legrand

The Belgian law concerning patients' rights gave individuals the right to submit a complaint to the relevant mediator. The Royal Decree of 8 July 2003 set out the terms for carrying out the function and in particular its obligation to draw up a report containing various elements such as the number of complaints, their subject and, when applicable, any recommendations that were issued.

In light of this, several distinct tasks have been attributed to the function, among which, in addition to mediating complaints, drafting recommendations to avoiding shortcomings likely to give rise to complaints. Consequently, we can clearly see the link between the function of complaint mediation and the role that the mediator is able to play in the context of the transformations affecting the hospital sector.

Appealing to the mediator

In general, the number of complaints has not considerably increased over the years, contrary to the fears often expressed by health professionals. Quite the opposite, actually, since the complaints index went from 0.17% in 2004 to 0.11% in 2007 .

A number of mediators who had come together in the context of their professional association have been comparing their detailed figures since 2001 based on a table for recording identical complaints. In 2007, 49 hospitals in Belgium participated in this benchmarking. This comparative analysis represents 11,004 complaints, of which 7,350 concerned patients' rights; 3,654 cases of the benchmark involved a problem resulting from the relationship between the patient and the institution (organisational, administrative, technical, etc.)

The mediator's tasks

Only the obligation to provide access to the mediator is legally defined. Although it is in the process of being standardised, the complaint management process is still individually assessed by hospitals which are free to address it through their own internal rules. To date, while some mediators are identified as the complainant's only contact, others only act in a second phase, thereby first resorting to communication between the patient and the professional in question. The mediator will then only play a role if patients are not satisfied with their first approach or no longer wish to have contact with this health professional.

Note that the law only makes provision for individuals to appeal to the mediator for complaints concerning the legal relationship between the patient and professional practitioner (right to quality care, information, free consent, etc.). However, in practice, a large majority of mediators are also called upon by patients for problems arising from the relationship between the patient and the hospital (organisational and administrative issues, etc.).

Issues brought up

The vast majority of complaints concern the right to quality care (56% of cases). Complaints of this kind concern issues involving technical acts (expertise) about as often as behaviour (interpersonal skills). This observation was also included in the 2005 annual report of the "patients' rights" federal mediation service, which backs up the recommendation of providing professional practitioners with communication training .

A second issue that is regularly cited by patients is the right to access medical or administrative information. This weakness may result in patients who are not informed of potential complications of a type of medical treatment and who invoke professional negligence or fault.

The lack of financial and/or administrative information regarding the costs of care to be borne by the patient is also often cited by patients (32% of cases). Nevertheless, the lack of information that is so often criticised also brings up the issue of the patient's responsibility in the matter: did the patient even consider the issue before the problem arose? Did he try to find out more? Did he want to hear what

the health professional told him? It is certainly a matter of encouraging one-on-one dialogue between the patient and the professional as much as making health professionals aware of their duty to inform patients.

The main motivation behind complainants' will to resort to a mediator is to have a place where they will be heard out, where they are guaranteed that their case will be dealt with and where they can be certain that they will be able to send a message to the institution so that other patients will not experience the same inconvenience (41% of cases).

Financial considerations rank only second as a reason for patients to contact the mediator (40% of complainants) and they will ask for the bill for care to be corrected or voided; only 10% of patients demand compensation for their complaint. Patients rarely inform mediators of their satisfaction with regard to the outcome of the mediation process.

This aspect was not analysed in 2007, but in 2006 the fact emerged that the outcome of the mediation was only known in 62% of cases. Among these, in 51% of cases the patient was satisfied with the mediation process, even though in 10% of these cases the outcome obtained did not meet their expectations. In 46% of cases, patients clearly demonstrated their lack of satisfaction both with regard to the mediation process and the outcome obtained. In the event that mediation fails, the mediator is legally required to inform the patient of possible alternatives to settle the complaint.

We do not have data regarding the number of complainants who, after attempting mediation, decide to settle their conflict by other means (mutual insurance company legal department, medical association, legal proceedings, etc.).

The mediator's challenges

Most mediators in the hospital sector are employees of the hospitals for which they carry out this role. The "patients' rights" federal mediator indicated in her 2005 annual report that patients sometimes question the neutrality or impartiality of mediators because mediators are paid by the institution for which they are supposed to mediate. This issue of the independence of mediators was also stated in the 2006 annual report , noting however some interesting progress in this domain, such as the Royal Decree of 19 March 2007 which sets out incompatibilities between the function of mediator and other types of functions carried out within the same institution.

Naturally, the inception of this function has altered the traditional procedure of complaint management: the addition of a new level of power leads to legitimate questioning and reactions from the teams already in place. While no studies have been carried out on the professional integration of mediators, our numerous encounters have enabled us to make two highly relevant observations.

The first combines institutional efficiency, the role in supporting hospital transformations and the place given to them in the institution. Mediators must succeed in combining strict neutrality in managing patients' complaints on the one hand, and productive enthusiasm in making recommendations on the other: how can this be accomplished without a clearly defined position in the institution?

The second observation concerns the perception of mediators by their peers, a relationship built around complaint management: is it perceived as causing guilt or, on the other hand, totally lax? Is it constructive, consistent with improving the quality of care, or simply authoritarian and punitive?

Here we must reiterate that the mediator's role is not to judge the grounds of a complaint but rather to attempt to re-establish communication between the complainant and the professional practitioner.

This connection to the institution is more of a guarantee for success thanks to the fast and efficient contacts that the mediator will be able to obtain internally. The challenge for mediators is thus to succeed in gaining the trust of the parties present through attitudes, behaviour or a writing style that is suitable and impartial.

Lastly, issuing annual recommendations brings up the issue of their legitimacy. How does one justify recommendations based on such a limited number of complaints? We believe that through recommendations aiming mainly to modify the hospital scene, mediators must be able to apply the uniqueness of the complaint to the general points observed, thereby bringing about a level of reflection in relation to the standards in force with regard to interactions between the hospital and its patients.

Mediator training

In order to provide the various mediators with the basic tools to succeed in this effective communication, thanks to the support of the King Baudouin Foundation, since 2007 the AMIS (Belgian Association of Healthcare Mediators) has offered training aimed at all hospital mediators centred on four modules: management of complaints, management of emotions, management of aggressiveness and the art of mediation.

This training will soon extend to relevant legal and organisational concepts. The decision to offer this training was also motivated by the observation that hospital mediators have very different backgrounds (social sciences, psychology, nursing, law, communications, etc.).

Conclusion

In Belgium, the mediation function, which is still relatively new, has become a prerequisite for hospital licensing. It is the result of transformations in current society that are trying to re-establish the legitimacy of citizens' voices with regard to institutions.

Hospital mediators are trying to clarify the perception of their role, which is a link between citizens, health professionals and the relevant institutions. In addition, mediation is part of the process for managing the quality and safety of healthcare institutions. Lastly, hospital mediation must contribute to the assessment and improvement of complaint management in individual institutions.

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THE RESPONSIBLE USE OF LIMITED RESOURCES IN HOSPITALS

The METAP ethical project

By Stella Reiter-Theil and Barbara Meyer-Zehnder

Having to deal with limited resources is an unavoidable part of day-to-day hospital work. What measures are appropriate in each case and what criteria apply?

A **A 21-year-old man has a motorcycle accident, suffering a severe cranio-cerebral trauma, a pulmonary contusion with multiple rib fractures and an open fracture of the femur. He undergoes an operation and has to receive further treatment in an intensive care unit; because of the cranio-cerebral trauma he is intubated and given mechanical ventilation. The local (mixed) ICU cannot accept any more mechanically ventilated patients; it has 8 beds and 8 patients:**

- two newly operated-on cardiac patients
- two newly operated-on patients after a major brain operation
- an 85-year-old patient after a major abdominal operation who is receiving circulatory back-up medication and is only passing small quantities of urine
- a 35-year-old pregnant patient with severe pre-eclampsia
- a 45-year-old father with sepsis following chemotherapy
- a 65-year-old female patient with fresh myocardial infarction

Question: Do you turn the new patient down or move one of the 8 others, and if so: which one?

B **An 85-year-old female patient (widowed, 2 sons) is suffering from a myocardial infarction with a ventricular septal rupture. In the end she was mentally active, but no longer fully mobile due to a peripheral arterial occlusive disease. Because cardiac insufficiency with deterioration of renal function develops, she undergoes an emergency operation. The operation is difficult, and lasts 5 hours. The defect in the ventricular septum proves extremely difficult to close. Cardiac function is reduced to such an extent that she has to be supported with high doses of circulatory back-up medication. An intra-aortal balloon pump is also fitted.**

After the operation the patient is treated in the ICU for 3 days (medicinal back-up of circulation, balloon pump). She develops a high fever and does not wake up, despite all sedative medication being stopped; nor does she move the left side of her body. Renal output is minimal.

The ICU team doubts very much that the patient will recover and seeks to speak with the surgeons. The surgeons reproach the team for having stopped treatment too quickly.

Question: Is it defensible to consider restricting treatment in this case?

Ethical focal points at the sick bed – and support

Current studies show that most doctors experience ethical difficulties at the sick bed. Studies which we carried out with different methods and in different countries [1,2,5,7,8,9,10,11,14,15] point to the following focal points:

- Therapy decisions with patients whose decision-making ability is temporarily or permanently impaired: if no clear patient will can be established
- Decision as to whether a vital measure such as cardiovascular resuscitation is appropriate or should not be performed
- Lack of agreement among the various persons involved as to therapy decisions.

Having to work with limited resources at the sick bed represents a major problem area:

- There are reports both of inadequate provision (e.g. waiting lists) and of unequal treatment (discrimination against certain groups), and also of overtreatment (so-called futility).

If we add further attendant findings from these studies to the effect that the quality of decision-making is not infrequently inadequately structured and explicit, we can assume a considerable need for offers for ethical assistance in everyday clinical activities.

Clinical ethical advice or ethical counselling (clinical ethics consultation) is – alongside rather informal internal case discussions, qualification measures or orientation assistance such as directives and guidelines – one of these possibilities[12,3].

In Europe it is in the grip of a highly dynamic development and expansion, which has also encompassed the German-speaking area. We take as our starting point the prerequisite that different forms of ethical support are meaningful and – depending on institutional framework conditions – possible[13].

A further source of ethical support that has received little sys-

ADVERTORIAL

The Outsourcing of Clinical Engineering Services

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by Angelo Gaiani
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The necessity to contain management costs and to focus organisational attention on activities of a purely healthcare nature have led hospitals to increase the outsourcing of "non–core" services. At the outset, outsourcing was introduced for labour-intensive services such as cleaning, laundry and canteen. Subsequently it included services of higher added value such as the management of all technological equipment (central heating plants, medical gases, distribution networks, etc.) as well as the ICT services.

Midway through the '90s, the first attempts at the outsourced maintenance of biomedical equipment were made which, in the following decade, became the Clinical Engineering Services (CES) contracts which are now very widespread.

The principal reasons for the outsourcing of CES are the following:

• **Financial saving;** between 5% and 25% as opposed to previous expenditure thanks to process optimistion and economies of scale;

• **Sharing of management respons bility** with a qualified supplier to whom all legal obligations are tran ferred;

• **Fixed expenditure;**
with the "full-risk" contractual formula, the overall maintenance costs of technological equipment are predetermined thereby preventing any economic risk during the year;

• **Bureaucratic simplification;**
with a single contract, the internal administrative workload required for the management of thousands of maintenance activities is reduced and problems related to the selection, training and management of technical personnel are avoided;

• **Significant reduction of machine downtimes;** chine 70% of equipment is repaired within 48 hours of the call as against 32% with traditional management.

Currently the outsourcing of CES is not homogeneous throughout the European countries: in Italy and Spain 50% of hospitals have outsourced the service. Germany has lower but still significant percentages. In France, Portugal and the United Kingdom, this choice is prevalent in the private hospital sector but is also starting to become more widespread in the public sector. In Northern European countries their diffusion is very low but on the increase.

The introduction of DRG (Diagnosis Related Groups) or other service payment systems in all European countries, together with the necessity to curb the overall costs of national healthcare systems, is imposing a detailed reassessment of hospital organisational models. The economies of scale obtainable with the outsourcing of CES represent a further possible option for healthcare managers.

The issue of control and accurate checking of the services provided by the supplier is still relevant but extensive experience, in some cases of twenty years, indicate that the way forward is both viable and secure.

Throughout Europe the trend is shifting from in-house maintenance (corrective and preventive) to the outsourcing of CES, structured according to a management model which covers all problems relating to electromedical equipment.

The appropriate and safe management of biomedical technologies requires dedicated and highly specialised professionals (clinical engineers and biomedical technicians) and a series of management processes (assessment, acceptance checking, safety checks, functional controls, clinical effectiveness evaluation, adjustments etc.) which are no longer limited simply to repair, as in the past.

If the first CES in outsourcing responded to the need to curb maintenance costs, today's CES are also expected to guarantee quality, decisional support in relation to technological development plans, cost analysis even before purchase of new technologies, above all for those hospitals which have undertaken ISO 9000 certification of their health services or JCI accreditation.

tematic investigation is the set of directives or guidelines with the emphasis on Clinical Ethics[4]; pioneering work remains to be carried out here to provide a stronger scientific background for such rules and to make them more readily applicable.

The METAP project at the University Hospital Basel

To help clinical staff and those involved in such difficulties through structural and scientifically well-founded measures and to promote ethically appropriate therapy decisions, we created the clinical-ethical cooperation project METAP (Modular Ethical Treatment Allocation Process), in which clinical areas such as intensive care, geriatrics and palliative care cooperate.

The evidence for the (sometimes simultaneous) occurrence of inadequate provision, overtreatment and unequal treatment and therefore also the everyday experience of clinical staff is based on the fact that patient care is occasionally experienced as unfair.

Over time, this experience can cause moral distress among staff and lead to burnout. Interestingly, the experience of not handling ethical questions such as the sense and usefulness of measures competently can also contribute to this: if ethical decisions are experienced as simply arbitrary (e.g. as dependent on who happens to be on duty), motivation and work satisfaction are adversely affected - not to mention the consequences for the patients themselves.

We have developed a set of instruments which provides the cooperating departments with bases founded on research and literature, as well as "tools" for a structured decision-making, precisely for difficult ethical questions, e.g. if patient will is unclear or if there are differences of opinion as to the correct level of treatment:

- What medical measures are appropriate in each individual case, in what intensity and duration, and what criteria are to be taken into account during re-evaluation?
- When is it defensible to restrict treatment, and when not? How is a patient's risk profile assessed so that he or she receives too much or too little treatment, i.e. is not cared for "appropriately"?
- How is the procedure for taking difficult decisions to be formulated: when is an internal ethical case discussion appropriate, and when should use be made of extra specialist help such as a clinical ethics consultation?

Outlook

The METAP set of instruments, which includes a full and abridged version, recommendations or guidelines, manuals and other tools, is currently in the pilot implementation phase. After an initial evaluation and corresponding modification, implementation will take place in various departments.

There are also plans to expand the clinical spectrum, which currently covers operative intensive care, acute geriatrics and palliative care.

Problem cases such as those formulated above can be tackled in various ways with the help of METAP.

Specifically prepared (empirical and ethical) bases pertaining to various relevant questions are available which contain criteria and recommendations.

Insofar as the treating staff who are seeking guidance cannot yet reach a workable decision and agreement in the specific situation by consulting this material, further steps and procedures are indicated: the use of methodical "tools", an ethical case discussion with internal moderation or - as further support - a clinical ethics consultation with appropriate independent experts.

The use of METAP is systematically assessed and modified. Beyond individual case analyses, insights from this are also assessed for the institutional development of the cooperating departments.

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GENETIC VARIATION
IN THE CRITICAL CARE SETTING

Pharmacogenetics has made significant progress in recent years. Advances in pharmacogenetics and information technology will benefit critical care patients most of all.

By Bonny Lewis Bukaveckas

An intersection of the disciplines pharmacology and genetics produces "pharmacogenetics." The term is not a new one. Pharmacogenetics first appeared in the medical literature in the early 1950s.

But the ability to apply knowledge of the role of individual genetic variation into the treatment of disease with medications is new. This new diagnostic ability comes from three major technological advances: advanced genomic analytics, the world HIV epidemic and the digitizing of health records.

The Human Genome Project was the late 20th century's equivalent to the space race of the mid-20th century, in that a focused scientific effort towards a single goal drove the development of more and more advanced technology.

Prior to the Human Genome Project, clinical genetic testing was slow, labor intensive and, as a result, expensive. Even though there is an extensive body of literature on the role of genetic variation in the pharmacokinetics and pharmacodynamics of xenobiotic compounds, applying that knowledge in the clinic wasn't previously, for the most part, practical. But we have now realized clinical genetic testing at speeds and costs that make this sort of testing comparable to other one-time diagnostics tests, generally in the $100-$800 range, with prices dropping as testing becomes more common.

The HIV/AIDS epidemic resulted in enormous advances in the way genetic testing results are reported. With the realisation that viral genetics could be used to rescue patients from failed highly active anti-retroviral therapy (HAART) regimens, viral genetics became an important laboratory test. But expecting physicians, even infectious disease specialists, to be able to derive a therapy choice from a viral genetic sequence was unrealistic. Therefore, over a 10-year period, we progressed from a written genotyping report with a collection of nucleotides on it, to the current red, yellow, green reports that are generated electronically.

Concurrently, there was a movement to provide the best possible interpretation of the test results through consensus and phenotyping. The lessons learned from these experiences in HIV/AIDS reporting are being directly applied to pharmacogenetics.

Although we can now test and report a useful result, given complete information, applying the test result to a single patient is a complicated process, in many cases. Truly personalised medicine requires the use of many different kinds of information, including age, gender, height, weight and concomitant conditions and medications. Also, liver and kidney function must be considered for many dosing decisions. While the patient's genomic sequence is invariant, the interpretation of that genotype may be of little or of great importance at any given time. But as with HIV, expecting physicians to be able to make the leap from a genetic sequence to a therapy choice is unrealistic in many cases.

Fortunately, many of the variables needed for dosing algorithms are available in an electronic medical record. Therefore, with some fairly basic programming, that information can be put together to provide a test result reflecting the current status of the patient.

Now that the information is available, there is an urgent need to adapt this new technology to improve care and reduce healthcare costs.

This is driving another merger of fields, similar to the merger of pharmacology and genetics: this merger is of bio- and medical

Clinical Condition	Genes of Interest
Asthma	Type 2 beta adrenergic receptor (ADRB2)
Sepsis	Tumor necrosis factor alpha (TNFa)
Infectious Disease	Organism genotyping
Coagulation	Cytochrome P450 2 family C9 (CYP2C9), Prothrombin (F2), Factor 5 Leiden variation (F5L), 5,10-methylenetetrahy drofolate reductase (MTHFR)
Glycemic Control	Peroxisome proliferator-activated receptors (PPAR)
Seizure Control	CYP2C9, UDP glucuronosyltransferase 1 family, Polypeptide A4(UGT1A4)
Inflammation	C-reactive protein (CRP), Tumor necrosis factor receptor (TNFR)

Table 1: Most Useful Genes for Critical Care

informatics into biomedical informatics, or smart clinical tools. One example that my own group is developing is called SmartWarf™, used to incorporate genetic testing along with other clinical modifying factors to provide dose-finding guidance for the most widely used anticoagulant medication, warfarin.

SmartWarf™ is currently for use in hand-held computing devices, but similar tools are being incorporated into health information systems, using other genes and other medications.

Example applications for intensive care

To the author's knowledge, there are no point of care pharmacogenetic tests currently on the market. This reduces the ability to use a new genetic test order to make immediate dosing decisions in the emergent setting. Probably of more use at this time in the critical care setting is the ability to provide dose guidance based on past test results.

This is really only practical with a "smart" electronic health record. Such systems are emerging in the in-patient care setting in the United States, as well as in organisations such as the U.S. Veteran's Administration medical system.

There is also a movement, with the advent of Medicare Part D, to build a U.S. national electronic medical record system. This would be an enormous advantage for pharmacogenetics. Human genomic DNA, practically speaking, will not change over a person's lifetime. This provides opportunities to use previous test results in new settings, as well as to use archived DNA specimens to run new tests, thereby reducing turnaround time. The genes most useful in the critical care environment at this time are given in Table 1.

Health-Point Cards coming to a physician's office near you?

The invariable nature of genetic information lends itself to being tested once, and simply queried at the appropriate time, when needed. Now that whole genome sequencing is a reality and is economically feasible, there will be a need to store this information in a secure, universally acceptable way. Healthcare providers could use electronic data card technology to access genetic code information or, in fact, the patient's entire medical record, using the appropriate access code.

The groups that would stand to benefit the most from such a system, in the form of cost savings from reduced duplicate diagnostic testing alone, should be of enormous interest to healthcare benefits managers, be they private or governmental organisations.

The patients that will benefit the most from readily accessible to genetic and other medical information are undoubtedly those in critical care.

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UK HEALTH
AND HOSPITAL SYSTEM

By Andrew Corbett-Nolan

The United Kingdom (UK) is comprised of England, Scotland, Wales and Northern Ireland and is situated within the British Isles. A constitutional monarchy governed from Parliaments in London and Edinburgh, and Assemblies in Cardiff and Belfast, the UK is a stable and mature democracy. Indeed, the current constitutional monarch Queen Elizabeth II, traces her direct descent from the last successful invasion of England in 1066.

The national Parliament at Westminster has been controlled since 1997 by a Labour Party administration, and the Prime Minister changed to Gordon Brown in 2006. A sign of the political stability is that Mr. Brown is just the fourth Premier since 1979.

The Labour administration has sought to increase funding from taxation for the welfare state, and in particular has funded significant increases in healthcare to bring the UK healthcare spend to the European national average by 2010.

Healthcare in England reports to the national Parliament at Westminster via the Secretary of State for Health (currently the Rt. Hon Alan Johnson MP), while for Scotland it reports to the local Parliament and in Wales to the Assembly. Social care is funded and managed through the local authority system of Councils.

Population, demography and languages

In 2006 the total UK population topped 60 million, with 50.7 m living in England, 5.1 m in Scotland, 2.9 m in Wales and 1.7 m in Northern Ireland. The average age was 39.0 years, having risen from 34.1 in 1971. Today, one in five in the UK is aged under 16, and one in six is over the age of 65. The population has grown 8% in the last 35 years.

Death rates have continuously fallen in the UK, and in 2006 502,599 deaths were registered with rates per million of the population being 7,123 for men and 4,989 for women. In 1900 around half of all deaths were for people aged 45 or under, and by 2006 this had been reduced to 4%. Life expectancy at birth is now 81 for women and 76 for men. At age 65 male life expectancy is now 81, and female life expectancy 84.

English is the main native language, with Welsh being a second official language in Wales. However, the UK is a highly cosmopolitan country. In London, some 300 languages are spoken and there are some 50 non-indigenous communities with a population exceeding 10,000. Around 40% of London's population are from an ethnic minority group, and nearly 30% was born outside the UK.

The economy

The economy is strong, with a gross domestic product of £1.209 billion (1.522 billion euros) in 2005 and an annual GDP growth in 2007 of 3.1%. This makes the UK the fifth largest economy in the world on the basis of market exchange rates.

In 2006 average income in England was £34,197 or 43,064 euros (within a range from London at £46,228 to £27,405 in the North East). However, first home prices start from 2.8 times average income in the North East but 4.8 times average income in London.

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The employment rate in 2006 was 74.9%, and the unemployment rate 5.3%. 819,300 unemployment benefit claimants were chasing 678,600 vacancies in May 2008. Inflation for consumer prices currently stands at 3.3%.

Public health

In 2005 239,000 new cases of malignant cancer were diagnosed in England, more than half of which were breast, lung, colorectal and prostate. One in three of the UK population will develop cancer during their lives, and one in four will die from it. In 2005 126,600 people died from cancer in England. Five year survival rates range from 3-16% for cancers of the pancreas, lung, oesophagus and brain, 50% for colon cancer and 81% for breast cancer. Survival rates for most cancers improved during the 1990s.

Regarding health risk factors, 24% of adults in the UK smoked cigarettes in the UK, this having declined from 45% in 1974. The Government aims to reduce this to 21% by 2010. 35% of adults exceed the Government safe drinking guidelines, with 72% of men and 57% of women having consumed an alcoholic drink within the past week in 2005. Drinking is higher in younger adults, with 42% of men aged 16-24 having exceeded the safe drinking limited on at least one day during the previous week. Just 14% of men and 27% of women consume the recommended five portions of fruit of vegetables a day, and 67% of men and 58% of women are overweight.

Sexually transmitted diseases have significantly increased, with there being a 5% rise of Chlamydia diagnoses at sexual health clinics between 2004 and 2005. Some 63,500 people in the UK live with HIV infection with 2005 showing a record increase of 7,450 new cases.

The National Health Service (NHS)

In the United Kingdom, all British subjects are entitled to access healthcare free at the point of delivery from the National Health Service (NHS). Founded in 1948 and this year celebrating its 60th anniversary, the NHS is a unique national institution. The NHS is the largest employer in Europe with just over 1.3 million staff. There were in 2005 679,157 professionally qualified clinical staff in the NHS, including 122,345 doctors, 404,161 nurses and midwives and 18,117 ambulance support staff. There were 39,391 managers and senior managers. Pay accounts for around 65% of the NHS budget.

Focussing on England, healthcare is funded by taxation at £92.2 billion (116.1 billion euros) for 2007. Some 83% of this is controlled by the 152 Primary Care Trusts (PCTs). PCTs are responsible for managing through contracts with general practitioners and secondary care organisations the healthcare needs of their local resident populations. Currently, PCTs also have some directly managed community services.

General practitioners are self-employed, working under national or local contractual arrangements to provide primary care to local patients registered with them. Other primary care providers, in part funded by the NHS through contracts, include community pharmacists, opticians and dentists. Patients of working age generally make co-payments to access these non-medical clinical professionals. In 2003 there were 10,683 general practices in the UK with 39,920 individual general practitioners. The average list size per practice was 5,891 in England, 5,885 in Wales and 5,095 in Scotland. In 2005 87% of general practictioner consultations took place in the surgery, 9% over the telephone and 4% in the patient's home.

Though there is a small private healthcare insurance and provision sector in the UK, the majority of all secondary care is provided by NHS organisations. In England these are termed NHS Trusts or NHS Foundation Trusts, the latter having increasing earned independence from central control, this being achieved on the basis of sustained good financial management and good quality ratings from the regulator.

The 570 Trusts tend to divide into those specialising in acute secondary care and others for mental health services. The intent is that over the coming few years all NHS Trusts migrate to becoming NHS Foundation Trusts. The NHS runs a number of central programmes to support local delivery. These include NHS Direct, a unique national telephone helpline open 24 hours a day which can offer immediate nurse-led advice to callers, or arrange for a doctor to call the patient.

This helpline provides detailed information and advice to callers, including details of local service access arrangements, advice on self care and on those cases where the patient needs to access more immediate care. The NHS has invested heavily in quality in the last decade, and in

England all healthcare services are regulated by the Healthcare Commission. This institution rates NHS organisations on an annual basis, registers private healthcare establishments and conducts investigations into service failures. It is planned that in 2009 this organisation will merge with the comparative social care inspectorate and form the Care Quality Commission.

from general management or finance backgrounds. CEO pay for local healthcare organisations has increased 70% in the past decade.

The average pay for acute hospitals was £112,500 (141,670 euros) with the top paid hospital CEO earning £215,000 (270,000 euros). PCT CEOs average around £92,500 (116,000 euros).

> ...all British subjects are entitled to access healthcare free at the point of delivery from the National Health Service (NHS).

Other central quality initiatives include the National Patient Safety Agency (NPSA), which aims to support the NHS reduce the number and significance of clinical errors.

The National Institute for Health and Clinical Excellence (NICE) provides advice on good health and the prevention and treatment of ill health. Taking a thorough and robust evidence-based approach, NICE provides guidance on health technologies and clinical practice, taking into account both proven benefits to patients and cost effectiveness.

Managing the healthcare system

In the UK, healthcare managers come from a variety of professional backgrounds. As far as NHS chief executives (CEOs) are concerned, a minority will have clinical backgrounds (mostly nursing) while most will be

With managers coming from a variety of professional backgrounds there are different professional development and career options open to aspiring healthcare leaders.

The uni-professional healthcare management organisation is the Institute of Healthcare Management (IHM), which was founded in 1902. With around 6,000 members IHM works to develop healthcare managers in the UK through training, accreditation schemes and a code of managerial ethics (see article on p.).

Plans for the future

As it approaches its 60th anniversary, the NHS reform agenda continues. In response to international trends in healthcare inflation, an ageing population, increased public expectation and continually improving healthcare interventions, the NHS has in place significant plans for change. In England, these include devolving all healthcare provision responsibilities away from PCTs in order that they can become local healthcare benefit organisations which hold the public funds for health and healthcare for the local population.

PCTs are increasingly being asked to consider the healthcare risk held within their local population and to craft both healthcare services to meet current needs and wellness programmes to reduce the burden of ill-health over time.

The NHS has a policy of encouraging competition and pluralism in terms of providers, and is charged with both modernising current NHS providers through the NHS Foundation Trust programme and by bringing in new private and independent sector care providers. The aim is to both sharpen performance and increase patient choice.

Ending 2007 in financial surplus, the NHS continues to drive through efficiencies and improvements. Year on year the productivity and outcome targets are revised upwards for the NHS, increasingly linking to other metrics intended to improve public services overall.

Current development themes include closer working with social care, consideration of new ways of caring for patients outside hospitals and the steady decrease of health inequalities within the different communities in the UK.

Nationally, the NHS continues to promote best practice through unique agencies charged with system development, quality, safety, the increased use of information technology and public health. Working as partners with professional and special interest groups the NHS is set to ensure that it remains a unique national asset to the people of the UK by the time of its 100 anniversary in 2048 and beyond.

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THE INSTITUTE OF HEALTHCARE MANAGEMENT

By Susan Hodgetts

During 1902, a number of senior hospital officers felt there was a need for an institution to meet the support needs for hospital administrators. In March of that year, The Hospital Officers Association was founded to:

"...promote the social and professional wellbeing of hospital officers...Membership of the association conferred the direct advantage of an education character by enabling each worker to associate with his fellows in the consideration of hospital questions..."
Thomas Ryan, President 1907.

The Diploma in Hospital administration was launched in 1925 – an essential qualification for career development in the health community.

In 1944 the organisation evolved into The Institute of Hospital Administrators.

It was in 1999, when the organisation joined with the Association of Managers in General Practice (AMGP) that the institute came to be known as the Institute of Healthcare Management (IHM)

The IHM has been a member of the EAHM for 10 years. This has brought benefits to the organisation including a sharing of knowledge and best practice as well as opportunities for members to visit and learn from other European countries.

IHM Objectives

- To enhance and promote high standards of professional healthcare management in order to improve health and healthcare for the benefit of the public;
- To create, sustain and represent a professional community of healthcare managers;
- To provide an independent voice for healthcare managers, and to protect and promote the status, interests and welfare of the members of the institute, including by ensuring their contribution to good health and healthcare is recognised;
- To influence policy, operations and culture in healthcare.
- To provide local networks for members of the institute and support for members of the institute, especially in times of professional difficulty;
- To promote professional standard setting in healthcare management;
- To promote good practice and professional development in healthcare management;
- To advance the study of and in healthcare management, and
- To provide or support the education and training of healthcare managers.

MAIN ACHIEVEMENTS AND RECENT ACTIVITIES:

- Recovering from a financial challenge;
- Developing and delivering a revised and new set of learning packages relevant today's manager;
- Taking on the development of "oral histories" to capture the history of the lives and works of healthcare managers;
- Modernising the organisation through the use of IT (websites, e-learning);
- Regaining networks and contacts to influence policy, operations and culture in the healthcare world;
- Extending the membership of the healthcare community into the armed forces;
- Developing educational tools for special interest groups (estates and facilities);
- Maintaining good management networks across the countries, and
- Starting to develop access to an accredited healthcare manager process for all managers across health and social care.

The IHM awarded Fellowships to members who had demonstrated outstanding service, significant work or a valued contribution to the healthcare community.

This was and is a prestigious award. England Scotland and Wales (1960) were the three countries at that time involved in the award.

Today Fellowship is an award achieved thorough an alignment of evidence to senior level competencies and the fellowship award has been superseded by Companionship.
The IHM is the only professional body to represent healthcare managers. It recognises their unique position as managers in healthcare, dealing with individual patients, working alongside clinicians and being prey to the ever changing political climate.

The institute is funded by membership and the expectations are high in a diverse landscape where different members want different things.

At times the work of members is surrounded by controversy and contradiction as the managers navigate their way through the constant change of healthcare services.

We are currently ensuring sustainability of the organisation; promoting membership, offering opportunities for stimulating debate on important issues, finding ways to represent members views and share good management practice across the world.

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GOVERNANCE IN THE UK **HEALTH SYSTEM**

By John Bullivant and Michael Deighan

Governance is important. It is how we hold ourselves to account and give confidence to the public, staff and partners that we have an organisation that is fit for purpose.

It is a tricky business though and a common question from non executive directors is 'how do I know what I don't know?'

UK board system

In the UK hospitals are run with a unitary board system. This is a single board made up of executive directors who also manage departments, and non executives who are part time independent members recruited from the community, but usually nowadays with business acumen and experience.

All board members have the same responsibility to debate and to decide the strategic issues and risks facing the organisation, though executive directors often find it easier to remain in their departmental role.

The unitary board approach is not universal. In continental Europe and New Zealand for example, it is more common to find the dual board system with a board of part-time independent directors supported by the CEO and a separate management board, the model also used by charitable trusts in the UK.

Again in England, Foundation Trusts are experimenting with an additional board of governors, the mutual model seeking to ensure stakeholder interests are well represented. Recent reports suggest this new model is getting a mixed response and more work is needed to develop its maturity.

Problems include the large size of these boards of governors (often with more than forty members), governors with single-issue interests and the failure of some appointed members to attend meetings.

The approach is not the same in the four UK devolved nations. Whereas in England the main focus recently has been on developing an NHS Constitution and the capacity and focus of Primary Care Trusts (PCTs) to commission healthcare; in Wales there has been a rejection of the internal market of commissioning and providing and new structures are being debated in an attempt to reduce the burden of governance.

Acute trusts across Wales have lately been merged into much larger and fewer Trusts and the likely model for Wales is the whole area board adopted in Scotland. Northern Ireland, which already has integrated health and social care providers, has recently (2007) merged the number of Trusts from 18 to just 5.

The role of the Health and Social Services Authority (HSSA), the single health authority which replaced the previous four boards, is being reconsidered.

In Scotland, the services are brigaded into one tier health boards which have responsibility for all non primary service planning, enabling and delivery. In spite of this variation and experimentation there have been a number of consistent themes running through governance.

The UK governance system

The UK system has been criticized for the following reasons:

- Boards are independent and should seek their own determination. Slavish response to central direction and targets is not good enough. The smarter organisations see compliance with central requirements as a first step to freedom to focus more locally
- Governance has become too divided with clinical, research, corporate, information governance operating in silos. New variants of partnership, quality or security governance are unhelpful in ensuring joined up working and accountability. The response in the UK over the last few years has been a programme of integrating governance, with a common approach to risks and incidents that are persistent, strategic and reputational. These are addressed by the board whilst most other issues are recorded and analysed but managed as close as possible to the patient or service user.
- There is still some confusion between governance and management, and too many toolkits and guides really only address the management issues, the controls rather than the assurance that these controls are in place and working.
- There are a tricky set of issues which arise between organisations, We are seeing a consistent set of failures at the boundaries between teams and between organizations (ref 'Learning from investigations', Healthcare Commission 2008). These issues are: continuity of patient care, partnerships and mutual aid in event of pandemics, extremes of climate and terrorism. The debate on the simple rules and etiquette of governance between organisations (GBO) is in its infancy but the road maps to maturity are being developed (see GBO debate paper, IHM 2008)

Governance recommendations

The 10 key points for integrated good governance are:

1. Clarity of purpose aligned to objectives and intent - the work of the board must be in tune with the strategy of the organization;

2. Strategic annual agenda cycle of business with all agendas integrated encompassing activity, resources and quality – the board's work programme is planned, and properly addresses the broad range of governance issues;
3. Integrated assurance system in place –the various assurance mechanisms, such as the board assurance framework, the risk register and adherence to external compliances are seen as a single, coherent framework;
4. Decision taking supported by intelligent information –board deliberations are based on robust and timely analysis and trends;
5. Streamlined committee structure; clear terms of reference and delegation; time limited – a cull of committees to focus NHS organizations along commercial lines with three principle committees (audit, remuneration and appointments) supported as and when needed by task and finish groups;
6. Audit committee strengthened to cover all governance issues – audit committees in the NHS are now required to move beyond finance and incorporate clinical and developmental issues into their work programmes. They are to scrutinise the governance systems: process rather than content;
7. Appoint board supports, e.g. company secretary AND senior independent director (SID) to support board, committees–the means by which an NHS board can be put on the same footing as commercial boards;
8. Selection, development and review of board members – proper appointment, induction and review for all board members with the Chair reviewing the contribution of executives as well as non execs to add value to the Board
9. Board etiquette agreed –the board agrees on the manner in which it will work, so that all members of the board can constructively participate in the work of the board, and
10. Development of individual executive directors and non-executives by the Trust/Board to ensure board corporacy – with the aim of achieving a unitary board with equal and empowered contribution form both executives and non-executives.

Best practice suggests that ongoing personal development plans are in place for all directors.

Conclusion

Governance in the UK is topical and evolving. The trick will be to demonstrate that whatever systems and behaviours we adopt will add value and confidence and begin to answer that tricky challenge of anticipating and reacting to what I do not yet know. As Lord Darzi makes clear in 'High Quality Care for All' (DH 2008) 'What matters is that there should always be clarity and transparency about who takes what decisions on our behalf'. That is the assurance that the new NHS Constitution will seek to provide.

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Heinz Kölking

OPTIMISATION DE L'EFFICACITÉ

La mutation de nos sociétés se poursuit inexorablement. Tous les domaines de la vie en sont affectés. Ceci est particulièrement vrai pour le secteur des soins de santé. Les origines de ces changements, tout comme ses caractéristiques, sont multiples et variées.

D'un côté, les spécificités démographiques, le progrès médical et les attentes et exigences des citoyens encouragent une augmentation du volume de prestations.

A cela s'opposent des ressources limitées au niveau des assurances solidaires et du budget de l'état ainsi qu'une main d'œuvre qualifiée en quantités toujours plus limitées.

Assurer l'avenir des soins de santé dans ce contexte tendu est un énorme défi pour toute économie nationale et donc pour l'Europe entière. Si nous voulons éviter le rationnement et donc offrir un accès libre aux services de santé à tous les citoyens, nous sommes tous appelés à garantir une efficacité et une efficience maximales, mais aussi une qualité irréprochable de nos structures, procédures et résultats.

La privatisation des hôpitaux est considérée comme un point d'attaque de cette stratégie. Elle sous-entend que les attentes des investisseurs en termes de taux de rendement maximalisent et stimulent les réductions de coûts et l'augmentation des revenus, ce qui doit entraîner un regain d'efficacité et d'efficience.

Cette édition d'*Hospital* se focalise sur ce thème vu de différents angles et éclaire les spécificités du marché de la santé, qui se différencie clairement des autres marchés de services et de biens. Il faut également faire de la place à la thèse selon laquelle il y a d'autres mécanismes que le taux de rendement pour arriver à augmenter l'efficience et améliorer l'efficacité. Il y en a de parfaits exemples aussi bien dans les hôpitaux privés à but non lucratif que dans les hôpitaux publics. Notre association européenne va se consacrer de façon intensive à ce thème dans les mois qui viennent.

En rapport direct avec le contexte de tension qui vient d'être décrit se posent de nombreuses questions éthiques. Cette constatation vaut autant pour sa dimension sociétale qu'individuelle. Elle affecte également et de façon grandissante la gestion hospitalière, qui doit continuellement maintenir un équilibre entre les principes éthiques et les exigences économiques. On voit souvent dans cet équilibre une contradiction, même si ce n'est pas nécessairement le cas. L'économie ne doit pas être une fin en soi, ses outils doivent plutôt permettre d'atteindre un objectif (la quantité et la qualité) avec le moins de dépenses possible (sans gaspillage!).

Ces questions et beaucoup d'autres seront abordées lors de notre prochain congrès européen de l'AEDH à Graz. Ce sont des questions essentielles pour la gestion des hôpitaux et donc une base solide pour des soins de santé efficaces, efficients et d'une qualité supérieure. Nous avons hâte d'être à Graz et de vous y voir!

Heinz Kölking
Vice-Président de l'AEDH

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

POUR FAIRE AVANCER LES SOINS SANITAIRES ET HOSPITALIERS EN EUROPE

A l'occasion de la présidence française de l'Union européenne, l'AEDH entend faire avancer les soins sanitaires et hospitaliers en Europe:

Vers une évaluation de la qualité et de la sécurité

Les hôpitaux européens font face à des défis comme l'intensification de la mobilité du patient, la libre circulation du personnel spécialisé, l'offre transfrontalière de services de soins de santé débouchant sur une concurrence accrue, la protection de la santé publique et des droits du patient....

Malgré des efforts constants, les services prestés à travers toute l'Europe présentent de larges variations en termes de qualité et de sécurité et doivent être améliorés. Une libéralisation plus large du marché des soins de santé pourrait augmenter la variabilité de qualité des services offerts.

Il existe heureusement de nombreux moyens de promouvoir le niveau de qualité et les pratiques sécuritaires ciblant les nombreux professionnels de santé.

Afin d'assurer un suivi des soins de qualité en Europe, il est important de pouvoir la mesurer de façon fiable. Ceci exige un ensemble cohérent de normes à faible variation d'interprétation.

Trop de normes existent actuellement en Europe, ce qui rend difficile la comparaison entre les différentes initiatives. De plus, ces normes n'accordent souvent que peu d'attention aux résultats ou au contexte général de la prestation des soins de santé (les soins primaires, par exemple).

Les sources d'information existantes sur la qualité et la sécurité devraient être analysées et comparées. Elles devraient être testées au moyen d'une application sur le terrain. Cet exercice devrait inclure des programmes locaux, nationaux et internationaux, comme ISQua.

Ceci permettrait d'amener les systèmes actuels co-existants à une compréhension mutuelle et même à une comparabilité, ce qui pourrait mener à terme à un rapprochement des différents systèmes.

La richesse réelle des normes comparables contribuera à éviter le recours à des standards minimaux qui n'offrent que peu de motivation à l'amélioration.

Il faut également accorder une attention spéciale à l'utilisation de normes dans l'évaluation des services de santé.

Bien que les évaluations externes soient plus à même d'améliorer la qualité et la sécurité, l'évaluation interne devrait être encouragée en tant qu'étape préliminaire à l'évaluation externe. De façon comparable à la qualité et aux normes de sécurité, il existe un éventail de mécanismes d'évaluation externe. Une cohérence de ces procédures n'est sans doute pas envisageable à court terme, mais il est indispensable de les rendre plus transparentes.

La situation actuelle offre un gros potentiel d'action à l'Union européenne dans ce domaine. Afin de soutenir la mobilité des patients et des professionnels au sein de l'Union en termes de qualité et de sécurité, il est essentiel de contrôler de manière soutenue l'évolution des différents états-membres.

La garantie de normes de base communes ainsi que de mécanismes d'évaluation cohérents motivera également les hôpitaux à se focaliser sur la qualité et la sécurité, puisque elle lèvera les barrières administratives, financières et pratiques à leur introduction dans les soins quotidiens et les procédures gestionnaires.

Vers des soins de santé dirigés et gérés

Puisque la responsabilisation du patient, les contraintes budgétaires et l'intensification de la concurrence dominent le paysage hospitalier eu-

ropéen, la question de la gouvernance hospitalière va susciter un intérêt croissant.

Dans de nombreux pays européens, les conseils d'administration et les dirigeants d'hôpitaux locaux publics et privés on été poussés à une efficacité et une efficience accrue dans la gestion de la performance de leur établissement. Ils doivent donc trouver le juste milieu entre le contexte changeant des soins de santé et les configurations principales des instances et procédures gouvernantes de leur hôpital.

La gouvernance hospitalière mérite une attention spéciale, vu ses différences par rapport à la gouvernance d'une entreprise. Une majorité d'hôpitaux sont publics ou privés à but non lucratif et n'ont pas d'actionnaires comme dans les sociétés privées.

Une large part des intervenants (contribuables, patients, généralistes, autorités gouvernementales, assureurs de santé,...) peuvent être identifiés comme propriétaires effectifs, même s'ils ne sont pas représentés dans les instances de l'hôpital.

En conséquence, le principe de maximisation du profit (en tant que pierre de touche évidente de la prise de décision dans les sociétés privées) est absent. Le résultat de l'hôpital en tant qu'organisme complexe est également moins transparent et plus difficile à évaluer.

La gouvernance hospitalière se réfère à la combinaison des freins et contrepoids qui déterminent la prise de décision au sein des instances gouvernantes de l'hôpital. Elle traite de la configuration (organismes et leur composition,...) et du fonctionnement de ces instances (fonction de contrôle, développement stratégique, assurance qualité...).

Certaines évolutions prennent corps dans les pays européens avec un impact certain sur la gouvernance hospitalière (chemins cliniques, intégration du service de santé, financement par DRG, responsabilisation du patient,...).

Bien que l'Union européenne ne dispose que de compétences limitées dans le domaine des soins de santé, elle a une influence indirecte sur l'organisation des soins hospitaliers (par exemple, la directive européenne sur le temps de travail a poussé la France à revoir l'organisation et le fonctionnement interne de ses soins de santé, et particulièrement de ses hôpitaux).

Une étude de la gouvernance hospitalière à travers l'Europe révèle qu'il est important de trouver le bon équilibre entre le contexte fluctuant des soins de santé et les configurations-clés des structures et procédures gouvernantes au sein de l'hôpital.

D'un côté les hôpitaux devraient rester des entités fonctionnelles plus ou moins indépendantes et donc fixer un cadre interne approprié, efficace et efficient. Mais en même temps, ils doivent s'intégrer parfaitement et être en interaction avec le système de soins de santé dont ils font partie.

La dualité qui en résulte entre «objet d'autonomie entrepreneuriale» et «instrument de politique de santé publique» est essentielle aux hôpitaux pour la prestation de soins aux citoyens. Il est important que l'Union européenne établisse un cadre (par exemple grâce à la directive de soins de santé) qui ancre cette dualité.

Devenir un acteur intégré et réponsable au sein du système de santé est un défi majeur pour l'hôpital du futur, et la gouvernance y contribue grandement.

Ceci ne dépend pas seulement des acteurs des différentes configurations de gouvernance, de la structure et de la composition des instances gouvernantes et des compétences requises (la question du qui) ou des rôles et missions des différentes acteurs ainsi que de leur ajustement mutuel (la question du quoi).

Cela dépend aussi du système non structurel de freins et contrepoids et des techniques utilisées: procédures de contrôle internes, systèmes de notification (la question du comment).

L'Union européenne peut encourager ses états-membres à partager leurs expérences ou aider à identifier les techniques appropriées selon les différentes configurations de gouvernance.

Les restrictions budgétaires poussent les gouvernements et les autorités de santé à explorer de nouvelles ressources en attirant les prestataires privés ou les assureurs. Bien que ceux-ci présentent un potentiel intéressant, une certaine réflexion est indispensable.

Mr Heuschen, notre Secrétaire Général développe ce sujet en p. 16. Le sous-comité Affaires Européennes suit également le dossier et fera part de ses constatations très bientôt.

La position de l'Association présentée à la présidence française peut être consultée sur le site de l'AEDH: www.eahm.eu.org

Soins de santé et concurrence entre hôpitaux en Europe: une interview avec le Secrétaire Général de l'AEDH, *Willy Heuschen*

Selon Willy Heuschen, un développement du phénomène de privatisation dans la prestation et la gestion de soins de santé est probable et les PPPs sont amenés à se multiplier. Il voit cela comme une évolution favorable, car le marché des soins de santé requiert un éventail diversifié de prestataires. D'ailleurs, l'AEDH va organiser un séminaire autour de ce thème.

L'association veut que les institutions européennes reconnaissent qu'une réglementation est nécessaire pour garantir la liberté de prestation des soins de santé. Le point principal devrait être une accessibilité équitable à un système de soins de santé de grande qualité pour tous les citoyens au sein d'un environnement durable.

Cependant, il sera important de soulever également la question suivante: les nouveaux prestataires privés sont supposés augmenter la productivité, améliorer le choix du patient et adopter des méthodes de travail plus efficaces, mais les hôpitaux publics actuels sont-ils incapables d'en faire autant?
Ceci impliquerait néanmoins que le fait de générer des profits doit aussi être un moyen pour les hôpitaux publics de réaliser des investissements nécessaires.

Traitement mortel pour l'hôpital public

Par André Grimaldi

Le financement à l'activité par la T2A a remplacé le financement des hôpitaux par le budget global mis en place en 1983. Le but du budget global était de limiter les dépenses en contraignant l'activité.

Les critiques principales faites au budget global ont été celles de son iniquité vis-à-vis des cliniques privées qui n'y étaient pas soumises et son inadaptation à l'activité en offrant une «rente de situation» aux hôpitaux bien dotés et en pénalisant les hôpitaux mal dotés connaissant un développement de leur activité.

On est donc passé d'un système déflationniste à un système potentiellement inflationniste par paiement dit «à l'activité». Il est urgent de limiter la T2A à ce à quoi elle peut être adaptée et de repenser le financement des hôpitaux de façon diverse, avant que la T2A n'ait déstructuré l'ensemble du système en transformant les hôpitaux en cliniques privées (à but lucratif ou non lucratif) d'une part, et en hospices modernisés d'autre part.

La privatisation des hôpitaux en Allemagne

Par Nils Böhlke et Thorsten Schulten

Traditionnellement, le marché hospitalier allemand est dominé par les hôpitaux publics, mais il a toujours inclus une proportion significative d'hôpitaux privés sans but lucratif, qui sont principalement la propriété des deux grandes églises chrétiennes et d'autres organismes de bienfaisance.

Pourtant, depuis le début des années 90, le nombre de cliniques privées à but lucratif a connu une augmentation constante, ce qui a débouché sur l'émergence de quelques grandes chaînes hospitalières comme Rhön-Klinikum, Helios and Asklepios.

Les patients et le personnel ont connu des expériences malheureuses suite à la privatisation des hôpitaux allemands et la contestation est montée de plus en plus. Même si seules quelques études ont été réalisées sur l'impact de la privatisation hospitalière sur la qualité des soins en Allemagne, cette résistance au phénomène indique que les patients le considèrent comme sujet à controverse. Ils partent du principe que les hôpitaux à but lucratif privilégient leurs bénéfices par rapport à la qualité des soins.

En conséquence, le statut de pionnier de l'Allemagne sur le terrain de la privatisation a probablement diminué la confiance des Allemands dans leurs hôpitaux.

Concurrence sur le marché hospitaliers aux Pays-Bas

Par Hans Maarse

La tendance dans les soins hospitaliers néerlandais de ces dernières décennies est allée vers une consolidation continue. Celles-ci doivent être approuvée par l'Autorité néerlandaise sur la Concurrence, dont la réglementation est devenue plus stricte que par le passé afin d'éviter que la concentration du marché ne vienne éroder la concurrence.

Un autre élément principal de la réforme du marché aux Pays-Bas est qu'il autorise un certain élément de concurrence des prix dans les soins hospitaliers. A cette fin, les revenus financiers de chaque hôpital sont divisés en deux segments: l'un doit se soumettre à des tarifs réglementés au niveau central, et l'autre est ouvert à une négociation libre entre les assureurs et les hôpitaux. Jusqu'à présent, il semble que cette forme de concurrence marche: les augmentations de prix nominales ont été moindres dans le segment libre que dans le segment réglementé. La réforme du marché comprend également une refonte majeure du système de financement des investissements: le nouveau modèle lie la marge de manœuvre des hôpitaux en matière de mises de fonds à leurs revenus financiers.

La fonction de médiation dans le paysage hospitalier belge

Par Piet Vanormelingen et Emmanuel Legrand

En Belgique, la fonction de médiation, encore relativement jeune, est devenue une condition d'agrément des hôpitaux. Elle est le produit des mutations de la société actuelle, qui cherche à réinscrire la légitimité de la parole des citoyens vis-à-vis des institutions.

Les médiateurs hospitaliers cherchent à clarifier la perception de leur rôle, trait d'union entre les citoyens, les praticiens professionnels et les institutions concernées.

En outre, la médiation participe au processus de management de la qualité et de la sécurité des institutions de soins. Enfin, la médiation hospitalière doit contribuer à l'évaluation et à l'amélioration de la gestion des plaintes de son institution. La grande majorité des plaintes concerne le droit aux soins de qualité (56% des dossiers). D'autres problèmes régulièrement cités par les patients sont le droit à l'information médicale ou administrative et le manque d'information sur le coût des soins.

Une utilisation responsable des ressources limitées à l'hôpital

Par Stella Reiter-Theil et Barbara Meyer-Zehnder

La qualité de la prise de décision est souvent implicite et structurée de façon inadéquate. Un modèle de conseils en éthique clinique ou de guidance éthique est indispensable.

Afin de soutenir le personnel clinique et les professionnels impliqués dans ce genre de problématique grâce à des mesures structurelles et fondées sur des principes scientifiques et afin de promouvoir des décisions thérapeutiques éthiquement justifiées, l'hôpital universitaire de Bâle a mis sur pied un projet de coopération clinico-éthique appelé METAP (Processus Modulaire d'Allocation Thérapeutique Ethique). Des départements cliniques comme les soins intensifs, la gériatrie et les soins palliatifs coopèrent à ce projet.

Un ensemble d'instruments à été développé, qui fournit aux départements associés des bases fondées sur la recherche et la littérature publiée, ainsi que des outils pour une prise de décision structurée et ciblée sur des questions éthiques sensibles, par exemple si la volonté du patient n'est pas claire ou en cas d'opinions divergentes sur le niveau de traitement.

Focus: Royaume-Uni

Au Royaume-Uni, tous les sujets britanniques ont accès à des soins de santé gratuits au point de soins par l'intermédiaire du Service national de Soins (Natonal Health Service ou NHS).

Le NHS est le principal employeur d'Europe, avec plus d'1,3 million d'employés. Les soins de santé sont financés par la taxation. 83% de ces revenus sont contrôlés par les 152 Trusts de Soins Primaires (Primary Care Trusts ou PCTs). Les PCTs gèrent ces revenus en concluant des contrats avec les généralistes et les organismes de soins secondaires afin de pourvoir aux besoins sanitaires des populations de leur circonscription.

Bien qu'il existe un secteur réduit de prestation et d'assurance de soins privé au Royaume-Uni, la majorité des soins secondaires est assurée par les établissements du NHS, à savoir les Trusts ou Foundation Trusts. Ces derniers ont acquis une indépendance plus grande par rapport au pouvoir central, grâce à une gestion financière saine et soutenue, et à une évaluation favorable du régulateur en ce qui concerne la qualité des soins. Les 570 Trusts se divisent principalement en établissements de soins aigus et établissements de santé m entale.

Il est prévu que dans les prochaines années tous les Trusts obtiennent le status de Foundation Trusts.

Au Royaume-Uni, les gestionnaires de santé ont une multitude de profils professionnels. Pour les directeurs généraux du NHS (CEOs), une minorité provient du secteur médical (sourtout infirmier) tandis que la plupart ont une formation en gestion générale ou en finance. Vu la diversité des profils de ces gestionnaires hospitaliers, les possibilités de carrière et de développement de carrières sont multiples.

L'association professionnelle représentant la gestion de santé est l'Institute of Healthcare Management (IHM), qui a été créée en 1902. Comptant environ 6000 membres, l'IHM travaille à faire évoluer les gestionnaires de santé britanniques par le biais de formations, de programmes d'accréditation et d'un code d'éthique de gestion.

En ce qui concerne la gouvernance hospitalière, le Royaume-Uni a opté pour un système unitaire de conseil d'administration. Il se compose de directeurs exécutifs qui gèrent différents départements, et de membres non exécutifs et indépendants qui sont recrutés dans la société civile et jouissent d'une expérience des affaires. Cependant ce type de gouvernance présente des lacunes, comme un manque d'indépendance, une division excessive entre les domaines clinique, administratif et de recherche, et une délimitation floue des limites entre les équipes et les organisations.

Heinz Kölking

EFFEKTIVITÄTSVERBESSERUNG

Der Wandel in unseren Gesellschaften setzt sich unaufhaltsam fort. Alle Lebensbereiche sind davon betroffen. Dies gilt besonders für den Bereich der Gesundheitsversorgung. Die Ursachen für die Veränderungen wie auch die Merkmale des Wandels sind vieldimensional. Demografie, Medizinischer Fortschritt, und die Erwartungshaltung der Menschen auf der einen Seite führen zu einer zunehmenden Leistungsmenge. Dem stehen knappe Ressourcen der solidarischen Versicherungen und der Staatshaushalte sowie zunehmend auch knappe qualifizierte Arbeitskräfte gegenüber. In diesem Spannungsfeld die Zukunft in der Gesundheitsversorgung zu sichern ist eine große Herausforderung für jede Volkswirtschaft und somit auch für Europa. Um Rationierung zu vermeiden und damit den Zugang aller Menschen zu den Gesundheitssystemen zu sichern, sind wir alle aufgerufen, hohe Effektivität und Effizienz bei gleichzeitiger Qualität in den Strukturen, Prozessen und Ergebnissen zu sichern.

Ein Ansatzpunkt wird in der Privatisierung von Krankenhäusern gesehen. Dabei wird unterstellt, dass die Renditeerwartung der Investoren den Druck zur Kostensenkung und Erlössteigerung maximiert und darüber zu Effektivität und Effizienz führen muss. Diese Ausgabe von HOSPITAL befasst sich an mehren Stellen mit diesem Thema und beleuchtet die Besonderheit des Gesundheitsmarktes, der sich von anderen Märkten von Dienstleistungen und Gütern unterscheidet. Es wird auch die These aufgestellt, dass es neben der Rendite auch andere Mechanismen zur Effizienzsteigerung und Effektivitätsverbesserung gibt. Es gibt gute Beispiele dafür sowohl in freigemeinnützigen Hospitälern wie auch in öffentlichen Krankenhäusern. Unsere Europäische Vereinigung wird sich diesem Thema in der nächsten Zeit verstärkt widmen.

Im Zusammenhang mit den beschrieben Spannungsfeldern ergeben sich vielfältige ethische Fragestellungen. Dies gilt für die gesamtgesellschaftliche wie auch für die individuelle Dimension. Davon ist auch das Management eines Krankenhauses im zunehmenden Maße betroffen, ist doch ständig die Balance zwischen ethischen Grundsätzen und ökonomischen Anforderungen zu finden. Häufig wird hierin ein Widerspruch gesehen, was gar nicht so sein muss. Die Ökonomie darf nicht nur Selbstzweck sein, vielmehr muss sie mit ihren Instrumenten dafür sorgen, dass ein Ziel (Quantität und Qualität) mit möglichst wenig Aufwand (ohne Verschwendung!) erreicht wird.

Diese und viele andere Fragen werden zu unserem diesjährigen Europäischen Kongress der EVKD in Graz thematisiert. Essentielle Fragen für die Führung von Krankenhäusern und damit für die Grundlage einer effizienten, effektiven und qualitativ hervorragenden Krankenversorgung. Wir freuen uns auf Graz!

Ihr Heinz Kölking
Vizepräsident der EVKD

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

DAS GESUNDHEITS- UND KRANKENHAUSWESEN IN EUROPA VORANBRINGEN

Aus Anlass der französischen EU-Präsidentschaft appelliert die EVKD, das Gesundheits- und Krankenhauswesen in Europa weiterzuentwickeln.

Evaluierung von Qualität und Sicherheit

Krankenhäuser in Europa sehen sich mit Herausforderungen wie der steigenden Mobilität von Patienten und des ausgebildeten Personals, mit grenzüberschreitenden Gesundheits-Dienstleistungen, die den Wettbewerb ankurbeln, der Absicherung öffentlicher Notfallversorgung und mit Patientenrechten... konfrontiert.

Abgesehen von den derzeitigen Anstrengungen unterscheiden sich die in Europa angebotenen Dienstleistungen jedoch sehr stark was die Qualität und Sicherheit betrifft. Das lässt natürlich weiteren Verbesserungen großen Raum. Eine weitere Liberalisierung des Gesundheitsdienstleistungs-Marktes könnte auch die Veränderlichkeit der Qualität der angebotenen Dienste erhöhen.

Es gibt auch viele Möglichkeiten, um hohe Qualität und Sicherheitspraktiken zu fördern, die auf die vielen aktiven Akteure und Verantwortlichen im Gesundheitswesen abzielen.

Um den Status der Qualität der Pflege in Europa nachvollziehen zu können, ist es wichtig, dass man in der Lage ist, dies zuverlässig durchführen zu können. Dies verlangt ein kohärentes Set von Standards, das nur wenige Interpretationen zulässt. In Europa gibt es zu viele Standards, wodurch die Resultate der verschiedenen Initiativen sehr schwer miteinander verglichen werden können. Darüber hinaus beachten die meisten Standard-Sets die Ergebnisse oder den weiteren Kontext der Bereitstellung des Gesundheitswesens (z.B. Erstversorgung) wenig.

Bestehende Informationsquellen über Qualität und Sicherheit sollten überprüft und verglichen werden. Sie sollten durch ihre Anwendung auf dem Gebiet getestet werden. Diese Übung sollte lokale, nationale und internationale Programme wie ISQua beinhalten.

Es sollten die aktuellen Systeme von ihrer „Abgeschiedenheit" zu einem Status des gegenseitigen Verstehens oder sogar der gegenseitigen Vergleichbarkeit bringen – was vielleicht zu einer wachsenden Gemeinsamkeit der bestehenden Systeme führen könnte.

Die Vergleichbarkeit der bestehenden Standards könnte auch den Gebrauch von Minimumstandards, die wenig Motivation für Verbesserungen lassen, verhindern.

Spezielle Aufmerksamkeit sollte auch der Anwendung von Standards bei der Bewertung von Gesundheitsdiensten gewidmet werden.

Obwohl externe Bewertungen mehr dazu dienen, die Qualität und Sicherheit zu verbessern, sollten interne Bewertungen als erster Schritt zu externen Bewertungen beworben werden.

Vergleichbar zu den Qualitäts- und Sicherheitsstandards gibt es eine Vielzahl von externen Evaluierungsmechanismen.

Eine Kohärenz der Evaluierungsmechanismen ist vielleicht in kurzer Zeit nicht durchführbar, dennoch ist es wichtig, diese Mechanismen transparenter zu machen.

Die derzeitige Situation lässt auf diesem Gebiet viel Spielraum für eine Europäische Aktion. Um die Patienten- und Professionistenmobilität innerhalb der Europäischen Union hinsichtlich Qualität und Sicherheit zu unterstützen, ist es zwingend, dass die Entwicklungen in den verschiedenen Mitgliedstaaten konsequent kontrolliert werden.

Die Sicherung allgemeiner, zentraler Standards wie auch die kohärente Evaluierungsmechanismen werden die Krankenhäuser motivieren, ihren Fokus mehr auf Qualität und Sicherheit zu legen, da diese die administrativen, finanziellen und praktischen Hürden herabsetzen und Qualität und Sicherheit in ihren täglichen Pflege- und Managementprozess eingeführt wird.

Zu einem gelenkten und gemanagten Gesundheitswesen

Seit im Europäischen Krankenhaussektor zunehmend Patientenrechte, budgetäre

Engpässe und stärker werdender Wettbewerb den Ton angeben, ist auch das Krankenhausmanagement zunehmend von öffentlichem Interesse.
In vielen europäischen Ländern wurden die lokalen öffentlichen und privaten Krankenhaus-Leitungen aufgefordert, effektiver und effizienter das Krankenhausmanagement zu führen. Daher besteht derzeit die Herausforderung den richtigen Mix zwischen den sich verändernden Kontext der Gesundheitsversorgung und den Schlüssel-Konfigurationen der leitenden Strukturen und Prozesse innerhalb der Krankenhäuser zu finden.

Die Leitung eines Krankenhauses erfordert besondere Aufmerksamkeit, da sie sich von der Unternehmens-Leitung in mehreren Aspekten unterscheidet. Der Großteil der Krankenhäuser ist eine öffentliche oder nicht auf Gewinn ausgerichtete Institution und hat keine Stakeholders wie private Unternehmen.

Eine große Gruppe unterschiedlicher Akteure (Steuerzahler, Patienten, Arztpraxen, Behörden, Krankenkassen, ...) kann als De-facto-Eigentümer identifiziert werden, obwohl diese nicht immer innerhalb des Krankenhaus-Apparates vertreten sind. Eine Folge daraus ist das fehlende Prinzip der Gewinn-Maximierung (als klarer Maßstab für die Bewertung von Entscheidungen in privaten Unternehmen). Auch das Ergebnis von Krankenhäusern, als komplexe Organisationen, ist weniger transparent und schwieriger zu beurteilen.

Die Krankenhaus-Leitung bezieht sich auf eine Kombination von „Kontrollen und Gleichgewichten", die festlegen, wie Entscheidungen innerhalb der Top-Strukturen von Krankenhäusern getroffen werden. Sie befasst sich mit der Zusammensetzung (Gremien und deren Aufbau...) und der Arbeitsweise der Organe der Krankenhäuser (Kontroll-Funktion, strategische Entwicklung, Qualitätssicherung...).

In den europäischen Ländern gibt es mehrere Entwicklungen, die auf die Leitung von Krankenhäusern (klinische Wege, Gesundheitsservice-Integration, DRG-Finanzierung, Patienten-Ermächtigungen...) Einfluss haben.

Obwohl die Europäische Union nur über eine begrenzte Zuständigkeit im Bereich der Gesundheitsversorgung verfügt, hat sie bereits ein indirekten Einfluss auf die Organisation der Krankenhausversorgung, z.B. durch die EU-Arbeitszeitrichtlinie, die Frankreich zur Überprüfung der Organisation, der (internen) Funktionsweise des Gesundheitswesen und insbesondere zur Überprüfung der Krankenhäuser gedrängt hat.

Bei einer Untersuchung von Krankenhaus-Leitungen in Europa deutete vieles darauf hin, dass es wichtig ist, den richtigen „Mix" zwischen den sich verändernden Rahmenbedingungen der Gesundheitsversorgung und der Schlüssel-Konfigurationen der herrschenden Strukturen und Prozesse bei Krankenhäusern zu beachten.

Auf der einen Seite sollten Krankenhäuser mehr oder weniger autonome Organisationen bleiben und benötigen daher einen gut angepassten, effizienten und wirksamen internen Rahmen.

Aber gleichzeitig müssen sie gut eingebettet und Teil des Gesundheitssystems sein, zu dem sie gehören. Die daraus entstehende Dualität „unternehmerischer Selbständigkeit" und „Instrument der öffentlichen Gesundheitspolitik" ist von entscheidender Bedeutung für Krankenhäuser bei der Bereitstellung von Gesundheitsdienstleistungen für die Bürger.

Es ist wichtig, dass die Europäische Union Rahmenbedingungen schafft (z. B. durch ein Gesundheitsdienstleistungs-Richtlinie), die diese Dualität berücksichtigt.

Es ist eine große Herausforderung für das Krankenhaus der Zukunft, ein integrierter und verantwortlicher Akteur im Gesundheitssystem zu werden - und die Leitung eines Krankenhauses hat einen gewaltigen Einfluss darauf.

Es hängt nicht nur von den Akteuren innerhalb der Führungs-Konfigurationen, von der Struktur und der Zusammensetzung der Organe und den erforderlichen Kompetenzen (Wer-Frage) oder der Rolle und die Aufgaben der verschiedenen Akteure und deren gegenseitiger Abstimmung (Was-Frage) ab.

Es hängt auch von einer nicht-strukturellen Kontrollen und Gleichgewichten, sowie von den verwendeten Techniken (Verfahren der internen Kontrolle, Bericht-Systeme, Risikomanagement...) (Wie-Frage) ab.

Die Europäische Union kann ihre Mitgliedstaaten zum Austausch von Erfahrungen anregen oder helfen, bei der Suche nach geeigneten Techniken angesichts der unterschiedlichen Leitungs-Konfigurationen helfen.

Budgetbeschränkungen drängen Regierungen und Gesundheitsbehörden neue Ressourcen durch die Gewinnung von privaten Anbietern und Versicherungen zu gewinnen. Während diese Möglichkeit generell zu begrüßen ist, sind doch einige Überlegungen erforderlich.

Herr Heuschen, unser Generalsekretär, erläutert dieses Problem auf S.6. Der Unterausschuss des Komitee für Europäische Angelegenheiten verfolgt diese Entwicklung und wird über seine Erkenntnisse in der nahen Zukunft berichten.

Der gesamte Text des Diskussionspapiers der französischen EU-Präsidentschaft kann auf der Webseite der EVKD abgerufen werden: www.evkd.eu.org

Gesundheitswesen und Wettbewerb bei Krankenhäusern in Europa: Ein Interview mit EVKD Generalsekretär *Willy Heuschen*

Laut Willy Heuschen sind weitere Privatisierungen bei Bereitstellung und Verwaltung von Gesundheitsdienstleistungen zu erwarten. Die Anzahl von öffentlich-privaten Partnerschaften wird sich wahrscheinlich erhöhen. Er glaubt, dass dies eine positive Entwicklung ist, da es ein gemischtes Angebot von Akteuren bei Gesundheitsdienstleistung auf dem Markt geben soll. Dazu sei angemerkt, dass die EVKD ein Seminar rund um das Thema Privatisierung von Gesundheitsdienstleistungen veranstalten wird. Die EVKD wird die EU-Institutionen davon zu überzeugen suchen, dass Rahmenbedingungen auf EU-Ebene festzulegen sind, um sicherzustellen, dass Gesundheitsdienstleistungen unbehindert angeboten werden können. Das Ziel sollte der gleiche Zugang aller Bürger zu einer hochwertigen Gesundheitsversorgung in einer nachhaltigen Umwelt sein. Man sollte jedoch auch die folgende Frage stellen: Von privaten Anbietern wird eine Steigerung der Produktivität erwartet, eine Verbesserung der Wahlmöglichkeiten für Patienten oder etwa effizientere Arbeitsverfahren - aber sind bestehende öffentliche Krankenhäuser nicht auch in der Lage, das Gleiche zu erreichen? Dies jedoch bedeutet, dass Gewinne auch den öffentliche Krankenhäusern als Werkzeug zur Erreichung dieser Ziele zur Verfügung stehen müssen.

Letale Behandlung der öffentlichen Krankenhäuser

Von André Grimaldi

Die Finanzierung des Gesundheitssektors durch T2A (leistungsabhängige Beiträge) hat die seit 1983 für den Krankhaussektor bestehende Finanzierung über den Gesamthaushalt ersetzt. Das Ziel des Gesamthaushaltes bestand in der Begrenzung der Ausgaben durch Beschränkung von Aktivitäten. Als Hauptkritikpunkt dieser Finanzierung wurde die Ungleichbehandlung gegenüber Privatkliniken gesehen, die keinen Zugang zum Gesamthaushalt hatten, und der damit verbundenen Unangemessenheit gegenüber Krankenhausaktivitäten, da dies einen Vorteil für gut dotierte Krankenhäusern darstellte, aber weniger gut dotierte Krankenhäuser in deren wachsenden Aktivitäten bestrafte. Das Ergebnis war daher ein Übergang von einem deflationären System zu einem potenziell inflationären System aufgrund der Finanzierung leistungsabhängiger Aktivitäten. Es besteht ein dringender Bedarf zur Einschränkung T2A auf dem Bereich, wofür es geeignet ist. Es ist daher die Krankenhausfinanzierung nochmals zu überdenken bevor sich das gesamte System durch die T2A Finanzierung auf den Kopf stellt und eine Umwandlung des Krankenhaussektors in private Krankenhäuser oder Kliniken mit modernen Wohnungen für Menschen mit Behinderungen.

Die Privatisierung der Krankenhäuser in Deutschland

Von Nils Böhlke und Thorsten Schulten

Traditionell ist der deutsche Krankenhaussektor von öffentlichen Kliniken dominiert. Es gab aber auch immer einen erheblichen Anteil privater und nicht auf Gewinn ausgelegter Krankenhäuser, die hauptsächlich im Besitz von den beiden großen christlichen Kirchen und anderer sozialer Organisationen waren. Doch seit den frühen 90er Jahren ist die Zahl privater Krankenhäuser mit Gewinnabsichten stetig angestiegen. Dies hat zur Entstehung von ein paar führenden privaten Krankenhäus-Konzerne wie Rhön-Klinikum, Helios und Asklepios geführt.

Aufgrund von schlechten Erfahrungen von Mitarbeitern und Patienten, kam die Krankenhaus-Privatisierung in Deutschland immer stärker in Kritik. Auch wenn nur wenige Studien über Auswirkungen von Krankenhaus Privatisierungen auf die Qualität der Versorgung in Deutschland bis dato veröffentlicht wurden, deutet der Widerstand gegen die Privatisierungen darauf hin, dass Patienten, sie als diskussionswürdig ansehen.

Von einem auf Gewinn ausgerichteten Krankenhaus wird die Maximierung seines Gewinnes zulasten der Qualität erwartet. Daher hat der Status Deutschlands als „Frontrunner" im Bereich der Krankenhausprivatisierung wahrscheinlich das Vertrauen der Deutschen in den Krankenhaussektor gesenkt.

Wettbewerb im Krankenhaussektor in den Niederlanden

Von Hans Maarse

Der allgemeine Trend im niederländischen Krankenhaussektor in den letzten Jahrzehnten bestand in einer laufenden Konsolidierung. Diese musste von der niederländischen Wettbewerbsbehörde genehmigt werden, deren Regelungen waren, um eine Marktkonzentration mit reduziertem Wettbewerb zu vermeiden, strenger geworden. Ein weiteres sehr wichtiges Element der laufenden Strukturreform in den Niederlanden ist die Tatsache, dass diese zu einem Preiswettbewerb in dem Krankenhaussektor geführt hat.

Zu diesem Zweck wurden die finanziellen Einnahmen jedes Krankenhaus in zwei Segmente geteilt: ein Segment mit zentral geregelten Tarifen und ein anderes Segement über die die Krankenhäuser und Versicherer frei verhandeln können. Bisher gibt es nur wenig Anzeichen, dass der Preiswettbewerb funktioniert. Nominale Preiserhöhungen im freien Preissegment waren kleiner, als im reglementierten Segment. Die Marktreform beinhaltet auch eine umfassende Revision der Regelung für Finanzierungen von Investitionen. Im neuen Modell, ist der Spielraum eines Krankenhauses für Kapitalanlagen von seinen Einnahmen abhängig.

Das Mediationsverfahren im belgischen Krankenhaussektor

Von Piet Vanormelingen und Emmanuel Legrand

In Belgien ist die relativ neue Mediation eine Voraussetzung für eine Genehmigung eines Krankenhauses. Es ist das Ergebnis eines gesellschaftlichen Transformationsprozesses, der versucht, die Legitimität von Institutionen durch stärkeres Mitspracherecht der Bürger zu legitimieren. Krankenhaus-Mediatoren erklären ihre Aufgabe als eine Mittlerrolle zwischen den Bürgern, Fachleuten im Gesundheitswesen und den verschiedenen Institutionen. Darüber hinaus ist die Mediation ein Teil eines Prozesses für ein gutes Qualitätsmanagement im Gesundheitswesen. Schließlich muss eine Krankenhaus-Mediation einen Beitrag zur Bewertung und zur Verbesserung des Beschwerde-Management der einzelnen Institutionen liefern. Die meisten Beschwerden betreffen das Recht auf qualitativ hochwertigen Gesundheitsversorgung (56% der Fälle). Als weitere Themen werden das Recht auf Zugang zu medizinischen oder administrativen Informationen angeführt, sowie fehlende Informationen über die Kosten einer Pflege.

Die verantwortliche Verwendung knapper Ressourcen in Krankenhäusern

Von Stella Reiter-Theil und Barbara Meyer-Zehnder

Die Qualität von Entscheidungen ist häufig unzureichend strukturiert und oft unvorbereitet. Klinische ethische Anweisungen oder ethische Ratschläge sind oftmals erforderlich. Zur Unterstützung des klinischen Personals und des betroffenen Umfeldes in schwierigen Entscheidungssituationen durch strukturell und wissenschaftlich gut fundierte Leitlinien ethisch richtige und vertretbare Therapien zu entwickeln, erstellte die Universitätsklinik Basel das klinisch-ethische Kooperationsprojekt METAP (Modular Ethical Treatment Allocation-Prozess). Darin sind klinische Bereichen wie Intensivpflege, Geriatrie und Palliativmedizin zusammengefasst.

Eine Reihe von Instrumente wurde entwickelt, die die kooperierenden Abteilungen mit Grundlagen von Forschung über Literatur bis zu "Werkzeuge" für strukturierte Entscheidungsfindung versorgt.

Diese Instrumente sollen gerade bei schwierigen ethischen Fragen helfen, z.B. falls der Patientenwille nicht eindeutig ist, oder wenn es unterschiedliche Auffassungen für die richtige Intensität von Behandlungen gibt.

Country Focus: UK

Im Vereinigten Königreich haben alle Bürger das Recht auf kostenlosen Zugang zu den Einrichtungen des National Health Service (NHS). Der NHS ist der größte Arbeitgeber Europas mit knapp über 1,3 Millionen Mitarbeiter. Das Gesundheitswesen wird durch Steuern finanziert. Rund 83 % des Budgets gehen in die 152 Einrichtungen der Erstversorgung (Primary Care Trusts - PCT). PCT sind für die Verwaltung der Verträge der Allgemeinmediziner und der sekundären Organisationen des Gesundheitswesens verantwortlich, die den Bedarf im lokalen Bereich abdecken. Obwohl es auch eine kleine private Versicherungsanstalt und einen kleinen privaten Gesundheitssektor im Vereinigten Königreich gibt, wird die Mehrzahl der weiterführenden Betreuungen durch NHS - Organisationen, nämlich NHS-Stiftung oder NHS-Gründungsstiftung, abgedeckt. Bei den Gründungsstiftung haben die zunehmende Einnahmen zu mehr Freiheiten gegenüber den Kontrollstellen geführt, was aufgrund laufend guter Haushaltsführung und guter Beurteilungs-Einstufung durch die Regulierungsbehörde möglich wurde. 570 Stiftungen spezialisieren sich in einer Gruppe für akute sekundäre und eine Gruppe für psychische Gesundheitsversorgung. Für die kommenden Jahre ist die Umwandlung aller NHS Stiftungen in NHS Gründungsstiftungen geplant.

Im Vereinigten Königreich haben Gesundheits-Manager verschiedene berufliche Hintergründe. Bei NHS Chief Executives (BSB) hat nur eine Minderheit einen klinischen Hintergrund (meist Krankenpflege), während die meisten entweder aus der allgemeinen Verwaltung sind oder einen kaufmännischen Hintergrund haben. Für Führungskräfte mit verschiedenen beruflichen Hintergründen gibt es unterschiedliche berufliche Weiterbildungsmöglichkeiten und Karriere-Optionen. Als eine allgemeine Gesundheitsdienst-Managementorganisation gilt das Institut für Healthcare Management (IHM), das 1902 gegründet wurde. Mit rund 6000 Mitgliedern arbeitet IHM an der Entwicklung der Führungskräfte im Gesundheitswesen im Vereinigten Königreich mit. Angeboten werden Ausbildung, Akkreditierungssysteme und Ethik Code für Führungskräfte.

Soweit die Krankenhausleitung betroffen ist, hat man sich im Vereinigten Königreich für ein einheitliches Leitungssystem entschieden. Dieses Single-Board setzt sich - sowohl aus geschäftsführenden Direktoren, die Abteilungen verwalten, als auch aus „Nicht-Führungskräften", die für bestimmte Zeit als unabhängige Mitglieder der Leitung rekrutiert werden und in der Regel über Wirtschaftsverständnis, Erfahrung im Management oder über Spezialwissen verfügen – zusammen. Allerdings hat diese Art der Leitung auch seine Schwächen, wie Mangel an Unabhängigkeit, Trennung zwischen Klinikum, Forschung und Unternehmensleitung. Es kann auch zu Kommunikationsschwierigkeiten zwischen den Teams und den verschiedenen Organisationen führen.

October

8th International Symposium: Qualität im Gesundheitswesen "PatientInnensicherheit im Spiegel" 13-14
Vienna, Austria
www.qualitaetssymposium08.wienkav.at

Healthcare Estates Conference and Exhibition 14-15
Harrogate, UK
www.healthcare-estates.com

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

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

Patient admission, flow and discharge 21
Birmingham, UK
www.sbk-healthcare.com

Journées Françaises de Radiologie 24-28
Paris, France
http://www.sfrnet.org/

Priorities 2008, Managing scarcity in healthcare : theory-to-practice and practice-to-theory 28-31
Newcastle, UK
www.healthcarepriorities.co.uk

November

7th Wiener Forbildungstage für Krankenhausmanagement 4-5
Vienna, Austria
www.argev-wien.at

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

Transforming healthcare through research, education and technology 5-7
Dublin, Ireland
www.tcd.ie

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

EUPHA 2008, Ihealth: health innovation in Europe, ... 6-8
Lisbon, Portugal
www.healthinnovation2008.com.pt

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

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

Dec RSNA Annual meeting of the Radiological Society of North America, ... 30–5
Chicago, USA
http://rsna2008.rsna.org/

December

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

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

February

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

March

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

April

Medetel, ... 1-3
Luxembourg
www.medetel.lu

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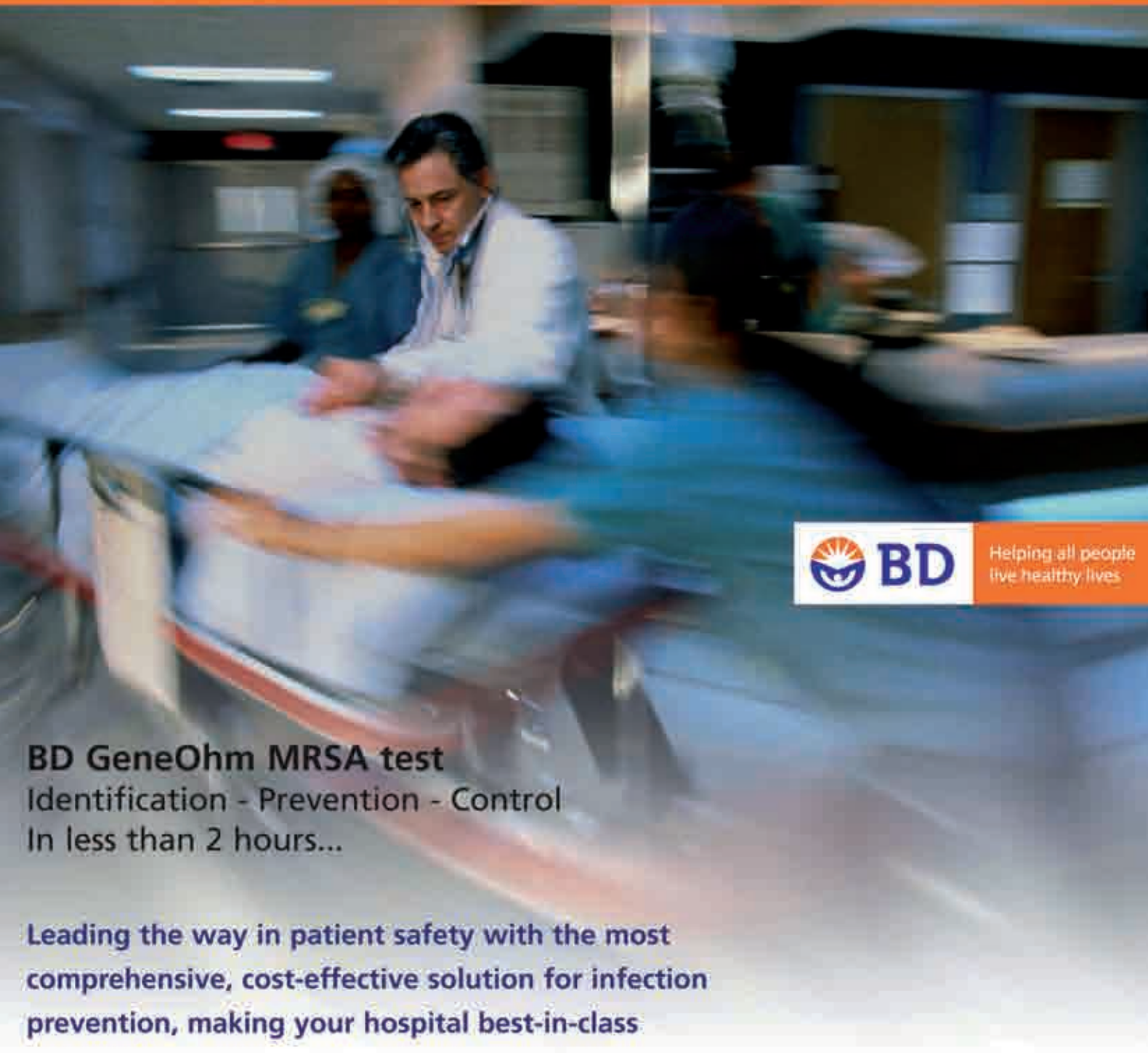

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