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Paul Castel

FRENCH HEALTH SYSTEM
UNDERGOES A TRANSFORMATION

As with our European neighbours, the French health system has been facing serious challenges for several years. Naturally, these have taken a variety of forms, but they all have the same origins: the increasing scarcity of medical human resources, a very high increase in health expenditure coupled with large budgetary constraints, and the difficulty of reconciling the necessary proximity of health establishments with the demands for care safety, which requires a concentration of care teams and technical support centres.

Since being elected as President of France, Nicolas Sarkozy has expressed his will to propose a reorganisation of the French health system. Thus, as the result of extensive dialogue, the HPST bill (Hospital - Patient - Health - Territory) was presented to hospitals.

Inspired by conclusive experiments carried out across Europe in recent years, this bill will be examined throughout the course of the first half of 2009 by the Parliament of France and should introduce some major changes:

- In the first instance, the bill aims to redefine the notion of public services in hospitals by specifying that all health establishments, be they public or private, can assure these operations. The government's goal is to make everyone bear the responsibility and limitations of these public service operations, and thus to grant the system better efficiency.

- The other main motivation is in introducing the idea of a "health territory" and in creating territorial hospital communities, a formal structure for cooperation between public establishments within the same territory. While retaining their legal autonomy, several establishments in the same zone will thereby be incited to define a joint strategy, share their human resources, concentrate their technical support centres in the same place and so on.

- Alongside this increased territorialisation, regional health agencies (ARS) will be set up as of January 2010. Given tasks and powers greater than those of the current Agences Régionales de l'Hospitalisation, the regional health agencies will be required to define and implement a regional health policy, be it hospital policy, public health policy, outpatient care, or medico-social policy. Announced several years ago, these new agencies should allow the hospital and non-hospital sector to better complement one another.

- Finally, the new law should generate innovations in the internal management of health establishments: the in-depth development of decision-making bodies within hospitals, reinforcement of the powers of the managers of the establishments, a strengthening of the role of medical activity clusters and their competences, as well as the creation of new types of work contracts aimed at improving hospital careers, notably by making it possible to link remuneration to the individual performance of actors in the health system.

In this climate of profound change, it is more crucial than ever that every hospital decision-maker is inspired by the measures taken in other states to face similar problems. This is why, in 2009, the EAHM intends to invest a great deal of energy into this mission to bring actors in the field of European hospitals together; it is only in doing so that we can work, step by step, towards a Europe of robust and coherent health services.

Wishing you all a superb 2009!

Paul Castel,
President of the EAHM

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.

E-Health

Hospital managers sometimes get the feeling that they have seen it all, read it all about e-health. That's why this issue focuses on seldom considered aspects of e-health: the financial one, with an article dealing with investment rationale behind e-health projects, but also the legal one, with Professor Herveg reviewing all the different legal questions revolving around ICT applications within a hospital. Susan Burnett gives us some vivid, and probably familiar, examples of the tight relationship between e-health and patient safety. Our dossier ends with a very innovative Spanish e-health project, which highlights the need for preventive healthcare and the essential interaction with chronic patients.

Human Resources

Our human resources dossier revolves around attraction and retention of staff and contains two theoretical articles, along with two more practical implementations. Dr Marchal reminds us that money is not the only incentive at our disposal to enhance motivation and commitment of our staff, as illustrated by magnet hospitals. Mr Ullrich analyses the impact of hospital outsourcing on labour regulations. On the other hand, a Paris hospital unit has decided to modify nurses' working shifts from 8 to 12 hours, to the great satisfaction of both staff and patients. And an often very troublesome relationship between two hospital professional groups, i.e. doctors and nurses, is being worked out in Vienna hospitals towards a balanced dual management of the department.

Focus: Lithuania

During the last five years Lithuania has had one of the highest economic growth rates among EU candidate and member countries, reaching 10.2% in 2003 and 8.9% in 2007.

Starting from 1 January 2009 special health contributions at the level of 6% will replace allocations from general income tax. The change will mean that about 75% of statutory health insurance revenues will be generated by health insurance contributions (HIC) and 25% by contributions from the state budget and other sources of marginal importance. The relative increase of importance of HIC means that the system is moving closer to the Bismarck model but certain differences remain.

In 2003 the government of Lithuania adopted a resolution on the restructuring strategy of healthcare facilities. Two phases were provided for the restructuring of healthcare establishments, the first period in 2003-2005, and second in 2006-2008.

During the restructuring process, specialised units were closed in many municipal and regional hospitals, and theses services were transferred to the specialist sections of district and university hospitals. The number of inpatient institutions fell by as much as 44.4%. There are now plans to facilitate the infrastructure of consultative outpatient facilities and emergency departments, and to develop outpatient rehabilitation services, day hospital and day surgery.

The Association of Hospital Managers Physicians of Lithuania was founded in 1991. In 1996 during the EAHM Congress in Tampere (Finland), our association was accepted as a member.

Editor's note

This article was written before the recent economic problems in Lithuania.

DANISH DELEGATION **VISITS BRUSSELS**

Last year, our Danish sister organisation, the Dansk Selskab For Ledelse I Sundhedsvæsenet, decided to create an international subcommittee. The aim was to promote the exchange of knowledge and experiences with the international community; to follow international developments in healthcare management and bring Danish experiences to the international context (see *(E)Hospital* 2008/5).

As a starting point, last December, a Danish delegation of 14 people travelled to Brussels combining several visits. On the agenda was a visit to the European Parliament with the Danish MEP Karin Riis-Jorgensen and a meeting with the European Commission. There was also a meeting with the Danish representation in Brussels and in particular with the Danish regional representatives.

Combined with a visit to the Clinique Saint-Jean/Kliniek Sint-Jan, the EAHM welcomed the delegation to its office. The group was introduced to the activities of our associations as well as the policy issues currently high on the European agenda.

The draft Directive on patients' rights and cross-border care offered the opportunity to discuss quality of care. The contribution that an accreditation model can make to quality was also dealt with, in line with the 2007 EAHM seminar on the subject. The theme of privatisation, and the co-existence of public and private stakeholders on the European hospital scene is high on the healthcare agenda as well and will be the main topic of this year's EAHM seminar (see agenda). Danish and European visions on hospital governance were shared during this meeting, in the light of the recent banking crisis and the stormy relationship between hospital management and providers.

Novel Technology May Help to Fight Catheter-Related Bloodstream Infections

Tra-Mi Phan, MD, Medical Director, Baxter Healthcare SA

Vascular catheter-related bloodstream infections (CR-BSI) are a leading cause of health-care-associated bloodstream infections and are associated with substantial morbidity and mortality as well as increased cost of care.[1-2] Nearly one third of these infections are related to central venous access devices.[3]

What Is a Catheter-Related Bloodstream Infection?

CR-BSI is defined as the presence of systemic infection and evidence implicating the catheter as its source, i.e., the isolation of the same microorganism from blood cultures as that shown to be significantly colonising the catheter of a patient with clinical features of bacteraemia.[4-5]

Microorganisms gain access to an implanted catheter by these two main pathways: extraluminal, at the time of catheter insertion or in the days following insertion; intraluminal, by contamination of the catheter hub (Figure 1). Intraluminal contamination is the principal source of CR-BSI with long-term catheters, but also with short-term catheters after proper skin antisepsis.[6]

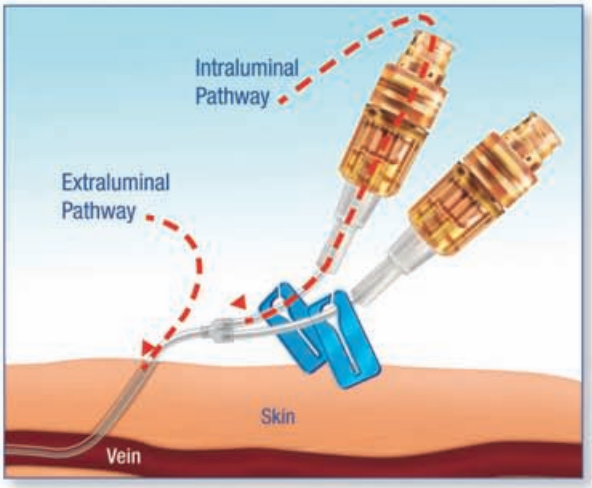

Figure 1: Microorganisms gain access to catheters by extraluminal and intraluminal pathway

Coagulase-negative staphylococci, particularly Staphylococcus epidermidis, are the most frequently implicated microorganisms associated with CR-BSI. Other microorganisms commonly involved include Staphylococcus aureus, Pseudomonas aeruginosa and enterococci.[7]

Once a typical device is contaminated, pathogens can attach to the surface, colonise and multiply. Once these colonies are established, they can continue to grow and form a biofilm. The biofilm matures, and when overcrowded large sections can break off, releasing pathogens into the bloodstream. Killing pathogens before they have a chance to form a biofilm may be critical to reducing CR-BSI risk.[8-9]

A novel technology has been recently introduced to protect the intraluminal fluid path. The V-Link Luer-activated device (LAD) with VitalShield protective coating is the first needle-free IV connector containing an antimicrobial coating.

Persistent and Durable Antimicrobial Efficacy

The VitalShield coating is intended to help prevent microbial contamination and growth of pathogens in the fluid path of the device. The interior and exterior surfaces of the V-link device are coated through a process that deposits silver nanoparticles. They serve as reservoirs of bactericidal silver ions that are control-released when in contact with solution.

The low level of silver ions released from the device is biocompatible, well tolerated and effective. However the V-Link device is contra-indicated for individuals with hypersensitivity to silver or silver components.

The persistence and durability of the antimicrobial performance of V-Link have been tested in vitro over 7-day use (Table 1). V-Link reduced microbial contamination by at least 99.99% of the six most common pathogens known to cause CR-BSI.[10] *

Pathogen	Average % Reduction	Average Log Reduction
Staphylococcus aureus (MRSA)	99.99	4.2
Escherichia coli	99.99	4.7
Pseudomonas aeruginosa	99.99	4.1
Enterococcus faecalis (VRE)	99.99	4.6
Enterobacter cloacae	99.99	4.3
Staphylococcus epidermidis (coagulase negative)	99.99	4.5

*Table 1: Antimicrobial Performance Summary – 7-Day Use**

* *The antimicrobial agent should not be used as a treatment for existing infections. Reduction in colonization or microbial growth has not been shown to correlate with a reduction in infections. Clinical studies to evaluate reduction in infection have not been performed.*

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POPULATION GROWTH – **A CHALLENGE**

Latest News From the Association of Hospital Managers of Vienna

Population growth and the consequent challenges for the healthcare sector was the aptly chosen theme of the Seventh Training Conference for Hospital Managers held in Vienna in November 2008.

The proportion of the population aged 65 years and over is increasing worldwide. Accounting for only 5% of the population in 1950 and 7% in 2000, the number of people in this age group is expected to rise to 1.5 billion or 17% of the global population by 2050, with Europe and Japan expected to be disproportionately affected. While this trend is ostensibly positive, the ageing of the population raises questions for society in general, for instance, in employment, and health systems in particular. Another issue arising from demographic change is the increasing proportion of migrants in the population, some of whom come from alien cultures. While the phenomenon is common to all European countries, in Austria it is most marked in Vienna.

The Congress Organiser

The Association of Hospital Managers of Vienna, also known by its old-fashioned title, the Working Group of Administrators of Health and Welfare Institutions of Vienna, was founded in 1956 (1). It is a member of the Federal Conference of Austrian Hospital Managers or BUKO as it is commonly known (2). The Vienna Hospital Management Congress has been held biennially since 1996 when it was first organised to mark the 40th anniversary of the founding of BUKO (3). The 2008 Congress took an in-depth look at population growth in a series of presentations and workshops.

The Future of Healthcare in the "Silver" Society

This was the title of a powerful opening address given by Jeanette Huber of the Future Institute (Zukunftsinstitut GmbH in Germany). Ms Huber mapped out several so-called megatrends of the future, including the healthcare revolution and the "silver" revolution. As people live longer and more active lives than their forefathers, the number of older people in the workplace increases. Although this group takes personal responsibility for its health and well-being and values individuality much more than earlier generations, it is important to acknowledge the drawbacks of an ageing population. For example, the incidence of degenerative neurological diseases such as Alzheimer's is on the increase. In light of rising public and private pro capita expenditure on health in virtually every country in the world, the ageing of the population clearly poses a major challenge for all healthcare systems.

The second presentation was given by Kurt Wagner from Vienna City Council. Mr. Wagner tackled the challenge of demographic change head on and highlighted many of the specific problems facing the Austrian capital. Securing sufficient funds to provide health services, a problem familiar to hospital managers, was another key part of his contribution.

Other presentations addressed a range of issues, including cooperation between providers of nursing home care and the hospital sector, in other words, the transition from illness to needing care. One contribution focused on how we should define optimum patient care. Does it mean providing all possible aspects of care or only those which are needed? The medical challenges arising from increased life expectancy were also discussed.

Another presentation - Older Staff: Headache or Treasure Trove? – dealt with an important topic which is often overlooked in debates on demographic trends. The issue of diversity was scrutinised in a presentation which used as an example the migrant community in Vienna, its health needs and the demands it places on the health service. Unfortunately, for reasons of space, it is not possible to do justice to the various contributions by discussing them in detail.

Workshops and Summary

Several workshops were arranged to allow participants to respond to what they had heard at the congress. Delegates were encouraged to express their opinions, offer ideas and make recommendations. One workshop focused on Economics in Healthcare, while a second took as its theme the issue of Care for the Elderly. Reports on the conclusions reached at the workshops were delivered in the plenary session and revealed a wealth of creative and innovative proposals. While the congress may not have found a panacea for all healthcare ills, it produced many useful ideas. The collective knowledge of the health professionals in attendance demonstrated that there is no shortage of good ideas in the health and hospital sectors. The problem in many cases, one which is not confined to Austria, is the inability of policymakers and healthcare providers to translate ideas into action.

(1) "50 Jahre Arbeitsgemeinschaft" is available in German only at www.argev-wien.at/show_2308.aspx
(2) See Hospital 1/2008, pages 35 and 36: Hradsky, J. "The Austrian Association of Hospital Managers"
(3) An overview of the Congresses is available in German only at www.argev-wien.at/show_2278.aspx

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Green Paper on the European Workforce for Health

Last December, the European Commission adopted a green paper on the EU workforce for health. This marks the beginning of a consultation period which aims to identify common responses to the many challenges facing the health workforce in Europe. A high quality health workforce is crucial for successful health systems. The health workforce plays an important role in the EU economy, accounting for about 10% of all jobs. In addition, 70% of EU healthcare budgets are allocated to salaries and employment related issues.

The aim of the green paper is to increase the visibility of these issues, to generate a clearer picture of the extent to which local and/or national health managers face the same challenges and to engage stakeholders in the debate so as to help those responsible across Europe to address these problems effectively.

The results of the consultation will feed in to what the EU can do to support member states in tackling these challenges.
http://ec.europa.eu/health/ph_systems/docs/workforce_gp_en.pdf

First EU Health Prize for Journalists

The European Commission has launched the first EU health prize for journalists as part of the Europe for Patients campaign. The prize has a dual purpose: the recognition and promotion of high quality health journalism across Europe. It is hoped that the prize will stimulate and contribute to the debate on EU health issues, specifically those initiatives related to the Europe for Patients campaign.

The Europe for Patients campaign was launched in September 2008 by EU Health Commissioner Androulla Vassiliou to provide a single entry-point to the often complex world of EU healthcare policies and actions. The Commissioner has emphasised the responsibility journalists have in communicating EU health policies to European citizens, especially concerning the Europe for Patients campaign which focuses on issues that affect us all such as cross border healthcare, patient safety and organ donation. She hopes that this prize will have the desired effect and stimulate debate on a local, national and international level.

Articles published in print or on-line publications between 2 July 2008, when the first Europe for Patients initiative was adopted, and the closing date of 15 June 2009 will be considered. Journalists are invited to submit their articles using the on-line entry form on the Europe for Patients website.

http://ec.europa.eu/health-eu/europe_for_patients/index_en.htm

European Commission's Communication and Recommendation on Patient Safety

Each year in the EU between 8% and 12% of patients admitted to hospitals suffer harm from the healthcare they receive, including from healthcare associated infections. Much of that harm is preventable. Therefore, last December the European Commission adopted a communication and a proposal for a Council recommendation with specific actions that member states can take, either individually, collectively or with the Commission, to improve the safety of patients.

The Commission held a public consultation earlier last year, the results of which have informed the current proposal. This follows an earlier consultation on the specific threat to patient safety posed by healthcare associated infections. Working groups representing member states and key stakeholder groups, including health professionals and patients, have also contributed to discussions.

The Commission has already taken individual initiatives in the past, such as addressing certain aspects of patient safety in community legislation, or fostering research and collaboration on patient safety by community co-funded projects. With this communication and the accompanying proposal for a Council recommendation, the Commission aims to put in place an integrated approach to patient safety.
http://ec.europa.eu/health/ph_systems/patient_safety_en.htm

EU Crossborder Health Directive

During the month of December, EU health ministers met in Brussels in order to discuss the crossborder health directive. They focused their discussion on the first three chapters of the draft directive. While some progress has been made since the tabling of the draft directive, some health ministers have shown restraint and have proven divided on its support. They reaffirmed their fears about a loss of national sovereignty over healthcare, while others expressed a wide range of views on the scope and implementation of the directive. They reached general consensus on improving legal recourse for crossborder patients, as well as expressing their preference for a provision allowing "informed choices" and enhanced cooperation between countries.

The ministers at the Employment, Social Affairs, Health and Consumer Affairs Council will discuss this revised draft, after the Parliament has issued its opinion, in June of this year.

Work Programme of the Czech Presidency
(1 January – 30 June 2009)

As of 1 January the Czech Republic has taken over the Presidency of the EU and has announced their "work-plan" for the upcoming months.

In the sphere of employment, the Czech Republic has announced that "worker mobility within the EU" is one of their top priorities. They believe "restrictions on the free movement of workers constitute a major barrier to the development of the internal market, hampering full use of the real potential of the EU member states and the EU as a whole", thus promoting the "full liberalisation of the movement of workers within the EU and the simplification and increase of professional and geographic mobility of workers in the labour market." Along the same lines, the Presidency believes that a "practical implementation of the Integrated Guidelines for Growth and Jobs and of the general principles of flexicurity" are needed to improve conditions within the EU in general.

Regarding the health sector, the Presidency has announced its support for the current EU initiatives in crossborder healthcare, quality and safety of organ donations and transplantations, rare diseases, as well as patient safety and the control of nosocomial infections, with a focus on antimicrobial resistance. It also articulated great interest in the development of "the definition of financial sustainability and its objectives, and on the analysis of the resources available for healthcare funding", in an effort to be better prepared for the May 2009 high level conference. This conference is the perfect forum in which "to share experience and exchange information and best practices concerning healthcare systems and their financial sustainability."

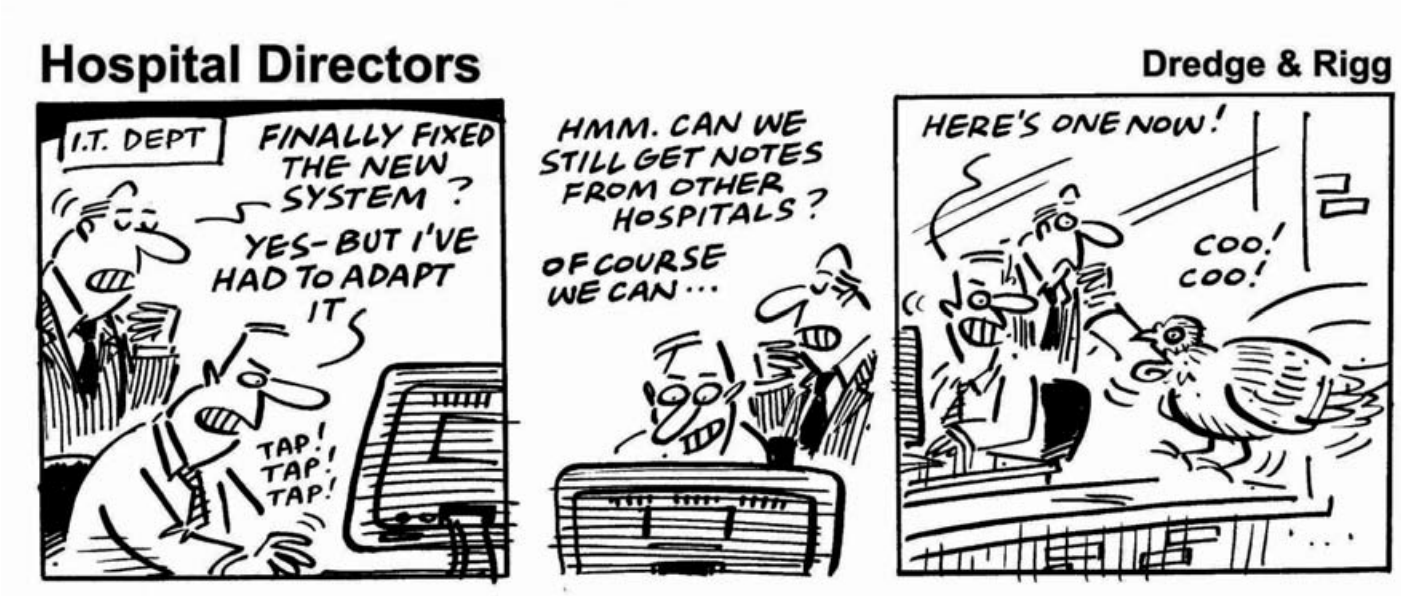
The Presidency has also expressed a great interest in e-health and telemedicine. It has asserted its disposition to increase the quality of healthcare through the aid of telemedicine and strengthening the interoperability of information systems in the healthcare sector. It has also proclaimed that "in February 2009, the topic of e-health will be discussed at a ministerial conference organised in cooperation with the Commission," with the aim of improving cooperation between EU member states in this sphere.

EHCI Rates the Netherlands as "Best Healthcare System in Europe"

In November, the 2008 edition of the annual Euro Health Consumer Index came out with its facts and figures for the year. This publication, which comprises 34 indicators of quality, ranked the Dutch healthcare system as "the best" in Europe.

The overall ranking was divided into six categories: e-health, patient rights, patient information, waiting time for treatment, waiting time for pharmaceuticals, and the speed at which new drugs are deployed.

The report went on to single out Denmark, Ireland, Czech Republic and Hungary for praise due to their noteworthy improvement ratings. Not all in the report was positive however. It also gave a damning warning that standards may be falling, particularly in terms of patient waiting times in many member states.



CZECH **EU PRESIDENCY**

By Rory Watson

The biggest challenge facing the Czech government during its European presidency over the next six months will be to secure agreement on new legislation to update existing European working time rules. Prague, with the help of the European Commission, has just three months to end the stand off between national governments and the European Parliament which emerged shortly before Christmas over the terms and conditions of the new rules.

If it succeeds, the new legislation could be implemented within two to three years. If it fails, the existing legislation will remain in place. This would allow national authorities, 15 of whom already do so, to continue using the opt out from the 48 hour maximum working week if they wish, but would cause almost every country problems with on call time for medical and emergency staff at their place of work.

The European Court of Justice (ECJ) has repeatedly ruled that on call time should be counted as working time – an interpretation that would cause huge costs for health services. Some have even predicted this could mean hospitals in some countries being closed between midnight and 6am.

The Commission has investigated existing practices throughout Europe and concluded that all 27 EU members are breaking the existing rules, as interpreted by the ECJ, in one way or other. A raft of embarrassing court cases against national capitals is not expected immediately, but their prospect is definitely in the wings.

The Czechs have wasted no time in trying to find a way through the current deadlock. They organised a meeting of senior national officials in Prague in mid-January and followed this up a week later with further informal ministerial discussions. The stance being taken by most governments was clear, according to officials close to the issue.

There is strong support among many governments to give health and emergency services flexibility by retaining the opt out indefinitely – a stance that sets member states against the European Parliament which voted in December to phase it out.

However, there are suggestions that a compromise might be possible over the definition of on call time at the place of work. If so, this would need to bridge the government view that inactive time does not count towards the working week and the parliamentary position that all such time should be considered as work.

As if reconciling these different views was not enough, any agreement must be reached and approved by EU governments and MEPs by the time of the last European Parliament plenary session at the beginning of May, before the European elections in June. If that deadline is missed, the proposal for reforming the existing legislation falls and the existing measures remain in place.

Despite this high profile legislative challenge they face, the Czechs are looking to move the public health agenda forward on many fronts in the coming months. In line with one of the wider political objectives of its presidency – advancing a Europe without borders – they will address some of the obstacles in the way of cross-border medical care.

Despite this high profile legislative challenge they face, the Czechs are looking to move the public health agenda forward on many fronts in the coming months.

They will also be taking up the Commission's proposal to improve the quality and safety of organ donations by setting Europe-wide standards and encouraging greater cooperation between national health services so that supply and demand are more aligned.

Currently, some 56,000 people in the 27 EU countries are waiting for an organ transplant and a dozen are expected to die every day because of an absence of suitable donors. While donor numbers and transplants are increasing across Europe, rates vary considerably from 34.6 donors per million people in Spain, to 13.8 in the UK and just 0.5 in Romania.

Another issue that the Czechs will be focusing on will be moves to tackle antibiotic resistance. As Dr Panova Stanislova, a director in the country's health ministry, told a Brussels conference last November, the country has a long tradition of work in this area and the subject will be examined at a conference on antimicrobial resistance and patient safety.

The digitalisation of healthcare services and the development of e-health will also be on the agenda with a two-day conference in mid-February, as will the financial sustainability of healthcare systems, which will be the subject of a two-day conference in early May.

Finally, the Czech Presidency will be organising early national reaction to the Commission's proposal towards the end of last year to update pharmaceutical legislation. This is designed to boost innovation and research and to make the industry more competitive, but at the same time contains the controversial suggestion that drug companies should be able to give information on certain medicines direct to patients.

E-HEALTH **INVESTMENT**

High Potential Opportunity and Managerial Challenge

By Alexander Dobrev, Tom Jones and Karl A. Stroetmann

The increase in demand for health services tends more and more often to outstrip the increase in supply. Ageing populations, increasing incidence of chronic diseases, and improvements in medical knowledge and technological equipment are the main demand drivers across the EU. The financial and real resources available for meeting this increase in demand are limited. As a result of this worsening mismatch, the generic investment challenge is to improve the performance and capacity of the supply side in order to meet some of the growth in demand. The European eHealth IMPACT (2006, www.ehealth-impact.eu) and EHR IMPACT studies (2008 www.ehr-impact.eu) showed that effective e-health solutions can substantially contribute to improvements in quality, access and efficiency of healthcare, thus increasing the capacity of the supply side.

How to Invest in E-Health?

The recently completed Financing e-Health Study (2008, www.financing-ehealth.eu) provided a generic guide for potential e-health investors to support them in the decision making process. The guide, addressing decision makers and managers, sheds light on, and draws the connection to, the overall decision taking and change management processes that are part of e-health investment.

The main lesson regarding the models to adopt is to integrate the e-health investment decisions into the healthcare strategy of the organisation. E-health can deliver, but it has to become part of the general resource mix considered in addressing healthcare needs. Then, e-health investments are considered alongside more conventional investments and the ones with the best value for money can be selected. The financing model for the investment should only be considered after the economic analysis is being performed. The approach is illustrated in the figure below. Too often, investments are driven by affordability considerations and not by a comparison between investment and the economic value of its impact.

The Process of Economic and Financing Decisions

Common difficulties in e-health investments reflect the differences between e-health and conventional ICT investment. E-health focuses on changes in the way healthcare is delivered, which is a demanding endeavour. In e-health investment, ICT serves only as an enabler, not as an end. In this context, the main obstacles to success include:

- unrealistic timescales;
- underestimated risks;
- inherent procurement difficulties, and,
- a common misperception of the nature of most valuable benefits from e-health.

Timescales for E-Health

Project management for some e-health projects focuses mainly on deploying and managing the resources during the design, development and implementation stages, and possibly the initial stages of operation. This timescale can be too short for sustainable e-health investment. It may fit an ICT project, but seldom provides the time required for the activities needed to realise net benefits: typically, about four years on average and at least eight years for EHRs. The appropriate timescales extend well beyond the business and financial planning of most healthcare provider organisations and can present financing challenges for e-health.

Instead, the e-health investment lifecycle should be set by the time needed to realise the required net benefit, the ultimate objective. This will enable the management and productive utilisation of all the reallocated resources, as part of change lifecycle.

Risks

Like all investments, as complexity and scale increase, so do the scope, probabilities and costs of risk. Plans for e-health investment seldom evaluate the potential of risk realistically. The result is no recognition of risks as costs, no mitigation and no respective financial provision. This in turn leads to understated costs and overstated benefits, which is not a good foundation for e-health investment.

For example, engagement with users and other stakeholders is a high risk activity. Where it is not successful, the effect can inhibit e-health activities for many years. Where it is successful, e-health investors tend to apologise for the extended timescales, understating the significant reduction in risk by pursuing effective collaboration and engagement, especially with healthcare professionals.

Procurement

Another concern is that there is still a mismatch between supply and demand for e-health systems and tools. Experts consulted in the Financing eHealth Study reported of repeated occasions in which ICT suppliers were not in the position to supply the solutions needed for benefit realisation, leaving investors with the task to develop rather than procure. At the same time, requirements are not always set effectively by procurers, making the lives of ICT vendors more difficult.

The Value of Non-Financial Benefits From E-Health

The challenge is to ensure that the total investment matches an appropriate total economic benefit. It is important to treat e-health investment in the same way as other new investments in healthcare, such as new drugs and surgical techniques. It should not be a means of saving money and improving overall cash flow, but an investment in better healthcare.

Large proportions of economic benefits from e-health are from quality, including patient safety, and time improvements. E-health is usually a net investment, with a negative financial return, so financial benefits must be realistic in their value and their timing. Sustainable e-health investment requires that all decision takers and financial stakeholders are clear about the distinction between economic benefits and financial savings.

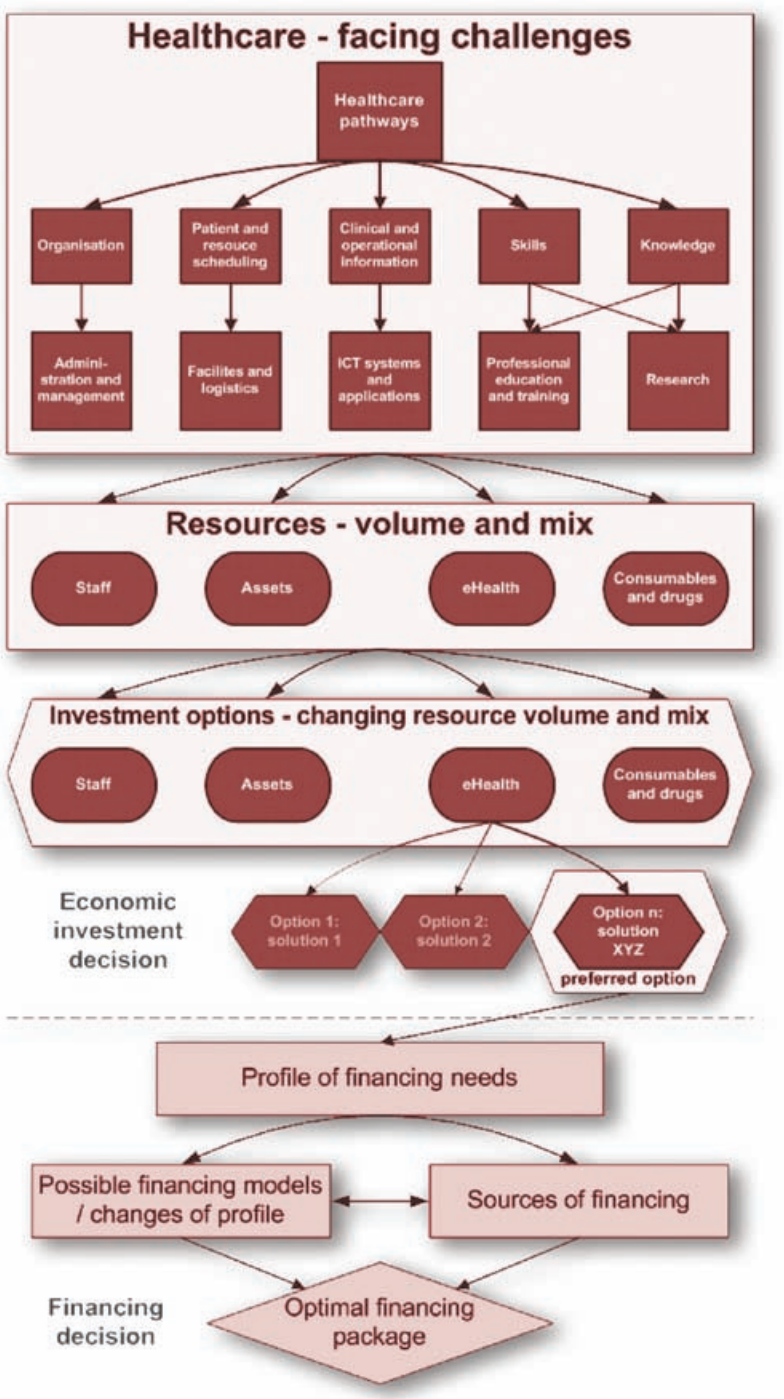
The task is to identify, define and describe all the benefits needed from better information for each strategic initiative. There are several examples, such as inform patients better, improve patient safety, improve timeliness, streamline healthcare, improve clinical effectiveness by sharing patient information with other healthcare professionals that form the multidisciplinary team providing patient care, and modernise healthcare: all quality goals. Some citizens, such as those in remote locations, may need improved access to hospital and other specialist health services. Improving efficiency by saving time and cutting waste may be a priority.

The Impact of E-Health on Hospital Management

The critical requirement for leaders, executives and e-health stakeholders is to be able to deal with e-health investment as an integrated part of all healthcare investment. Finance executives and managers have a more specific role. First, they need to understand the value and impact of e-health, so they can extend and develop financial planning to deal with e-health investment timescales. Second, they need to extend their financial management skills to be able to develop ways to invest in better value.

This expands the principle of organisational change from healthcare professionals who use the e-health investment directly, to the whole organisation. It is just as uncomfortable for executives as it is for healthcare professionals. As healthcare professionals use new information to improve quality, access and efficiency, executives are confronted with new clinical, working, and information exchange practices: they have a different organisation to run.

Source: © TanJent/empirica 2006



Conclusion

E-health is slowly becoming a must have in modern healthcare. Expectations and resource constraints call for a high potential response, and e-health seems to be part of it. This seems to be common wisdom, but begs the question why e-health investments are not always successful in proving their potential. The answer is to some extent conveyed in this article, which is based on extensive research for the European Commission in the Financing eHealth Study. More needs to be invested in acquiring appropriate knowledge and experience with e-health in order to master the managerial challenges associated with realising its potential.

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ICT USAGE IN THE HOSPITAL ENVIRONMENT

Laws and Regulations: Ensuring the Safe and Successful Implementation of e-Health

By Jean Herveg

E-health refers to the application of information and communication technologies to the healthcare sector. From the management of the electronic patient or staff data, to the use of telesurveillance, telesurgery, teleexpertise, teleconsultations, to long distance learning by personnel members, e-health manifests itself through a wide range of products and services within the hospital context. But what about the legal implications of such applications?

e-Health applications are often governed by regulations on the right to respect for private life and on the processing of personal data. But in order to ensure the sound management of a hospital there are many other conditions and regulations to be adhered to, depending on the angle and approach of analysis.

Information Management

Information management is key when it comes to the use of ICT. In this regard, it is necessary to highlight that regulations concerning processing of personal data are largely harmonised within the EU. To summarise, these regulations require to identify the purposes pursued by the data controller - in this case, the hospital (medical or nursing management, scientific research, healthcare quality control, reimbursement of healthcare costs, etc.), the different actors involved in the collection/management of the data (the data controller and the processor, the data subject, the personal data protection official, etc.), as well as the rights and responsibilities - awarded by law - in terms of general conditions of lawfulness, the data subject's rights (i.e. the patient or staff members), of notification, security, and confidentiality.

As well as the processing of personal data, intellectual rights (rights of the author, copyrights, and trademarks) must not be forgotten. An example of this would be the creation and use of software and databases.

Equipment Management

Whether they are designed as "autonomous" (meaning through a wireless network of telecommunications allowing easy communication among practitioners) or in interaction with other pre-existing hospital equipment (such as a connection through a wireless system to a EEG device), e-health products must comply with general regulations for products and equipment as well as specific regulations for medical devices.

Healthcare Management and the Free Delivery of Services Within the EU

The use of ICT is likely to influence the conditions in which hospital activities are exerted. When the hospital offers remote services, questions are raised concerning conditions for the promotion and delivery of these services. Most notably in terms of information society services, of quality criteria for healthcare websites, of professional qualifications for health practitioners, of unfair trade practices, of misleading publicity, of online contracts, of electronic signatures, and of the online promotion and selling of drugs. This also raises questions regarding conditions for creating electronic communication networks in healthcare. In this respect, discussions remain underway on the usage of bandwidth for telemedicine applications within the framework of universal service.

Similarly, if the hospital uses services offered by external providers, a set of conditions must be developed in order to appeal to these providers. This is particularly relevant concerning the recognition of their professional qualification if they do not fall within the same jurisdiction. In this regard, it is necessary to remember that, as a rule, within the European Union, online medical services can be offered from any member state and these services are subject to the law of the state of origin, except when receiving states perceive them to be duly justified special cases (such as cases that affect public health).

Hospital Liability

The question of liability for damages caused by the use of ICT is a recurrent one, even if some underestimate it. Any hospital intending to use ICT in its day-to-day performances cannot disregard this

question. At European level, there are two legal instruments that partially address this issue. Firstly, there is legislation on the processing of personal data, which sanctions the right of the data subject to hold the data controller liable for any illicit processing or of any action incompatible with the applicable national law. Secondly, there is the legislation on the liability for defective products.

As for the rest, it is necessary to interpret the law as it applies to each individual case, if need be according to private international law for international cases. What must be remembered is that there is a series of legal instruments in place at European level that can prove to be useful in matters of jurisdiction, of applicable law (be they of contractual or non-contractual obligations), of serving, of recognition and execution of judicial decisions.

Competition

The relationship between a hospital's activities and competition law gives rise to questions of particular sensitivity. Among these the primary concern is the very idea of applying competition rules to the healthcare sector. If competition laws are found to be applicable, it is then necessary to look into questions relating to inter-hospital agreements, concerted practices and abuses of dominant positions, without forgetting those related to state aid and inter-hospital mergers.

Conclusion

The legal aspects of e-health in hospitals are not limited to matters of right to respect for private life or to regulations on the processing of personal data. They are also pertaining to equipment laws, laws regarding services, as well to hospital liability laws and competition rules. A great portion of these rules and regulations are not specific to the hospital sector or to healthcare. It is not however, always possible to avoid the examination of their value when using ICT in a hospital concerned with the sound management of its activities.

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FORUMCLINIC

An Interactive Programme for Patients with Chronic Illnesses

By I. Grau, J. Gene-Badia, E. Sanchez Freire, M. Bernardo and M. DeSemir

forumclinic is a set of audiovisual material (DVDs and Website) in both Spanish and Catalan launched in January 2007. Its purpose: improving the quality of life of chronically ill patients. Based on the premise that by having a better understanding of their disease patients can become more autonomous, the project aims to encourage patient involvement in the clinical decision making process hand in hand with the healthcare team.

Health requirements and the demand for services have seen substantial changes in recent years. Increased life expectancy has resulted in a greater prevalence of chronic pathologies. The WHO has classified this situation as priority even in developing countries. Current models of patient care need to be revised, with a greater emphasis on patients taking a more active role in diagnostic and therapeutic processes. Patients will need to make substantial changes to their lifestyle, but these behavioural changes can only be achieved when the patient has the necessary information, acquires new skills and adopts a more positive attitude to the problem.

Today we are faced with a growing need for more health information from the population in general whilst witnessing an expanding capacity of accessibility to information thanks to new forms of communication and information technologies. This massive expansion has resulted in a proliferation of content that at times can be of dubious quality, which is not in the patient's best interest.

Determining the Forum Content

Content had to be selected and prioritised. This was achieved using the following criteria:

- The degree of prevalence of the illness;
- The existence and size of an existing network of patients that can guarantee the spread and impact of new and customised material;
- Degree of relevance and current interest of the material produced, both for specialists in the field and affected patients as well as originality of the material;
- Quality and experience of the specialist medical team that will prepare the material;
- How chronic the disease is;
- Level of interest in the chosen subject by health administration bodies, and
- Effectiveness of therapeutic education in improving patient's quality of life.

Following this criteria, we completed monographs on ischemic cardiopathy, diabetes, chronic obstructive lung illness, schizophrenia, breast cancer, depression and factors of cardiovascular risk. Arthritis and arthrosis, obesity and bipolarity are also in production.

Authors are professionals from hospitals, clinics and associated health centres. The project has been financed by the Fundación BBVA, a non-profit organisation. Information combines the best scientific evidence available, professionals' experience and individual patients' perspectives. It is available in DVD format and can also be accessed via a web site (http://www.forumclinic.org) containing information as well as videos.

The Portal

The portal (www.forumclinic.org) combines content of general interest in text and multimedia format. The blog provides direct two-way interaction with the public.

Each illness section includes four distinct types of information:

- Text that summarises basic data on each illness;
- Recent news items related to the illness;
- Videos and 3D animations that explain biological mechanisms, among other aspects, and
- Professionally moderated discussion forums that form virtual communities. Forums

facilitate dynamic group interaction between professionals and patients via direct intervention, via moderation following topics raised by patients, and via the 'suggest a topic' suggestion box.

Quality Criteria

We are enrolled as members and have received the seal of approval of the Health On the Net Foundation (http//www.hon.ch), and have been recognised by the Barcelona Institute of Doctors official web site. These accreditations require adherence to the following standards:

- Transparency and honesty (site provider, aim and objective of the site, site's source of financing);
- Authority: sources of all information provided as well as dates of publication;
- Privacy and data protection;
- Updated status of information;
- Responsibility, and
- Accessibility.

Some Statistics

Even without promotion, the audience of the website has grown. Currently we receive an average of more than 2,000 different visitors every day, half of whom are from South America (breast cancer is the most visited site). The forums represent around 24% of web visits.

Forum visitors have a participation rate ranging from 1.15% to 5.5%. 195,000 DVDs have been distributed through Spanish Health Centres and patient associations.

Conclusion

The growth rate of visits to the website, as well as posts to the forums together with the high degree of penetration that the DVD has achieved confirm the appropriateness of the material.

forumclinic has proved to be a useful electronic tool for bidirectional communication between healthcare professionals and patients, as well as for disseminating scientific knowledge to the public in general, dealing with both scientific findings and the emotional aspects of healthcare.

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PATIENT SAFETY AND E-HEALTH

By Susan Burnett

Since the publication in 1999 of arguably the most important call to action for patient safety, the Institute of Medicine's report 'To Err is Human', we have learnt a lot about how to reduce risk in healthcare and how to improve patient safety. Technology clearly has an important role to play but we know that it can also bring increased risks which every hospital board member should be aware of.

Research has shown that the context in which we work affects our behaviour and our chance of making mistakes. For example long hours and tiredness increases our chances of slips and lapses; insufficient staff or poorly designed equipment increases the likelihood of us taking short cuts and committing violations; a lack of communication and teamwork amongst colleagues and poor training increases the likelihood of knowledge based errors. Many of these latent, error producing conditions are organisational factors, often the result of management decisions taken to satisfy other priorities and needs, such as meeting externally imposed targets or balancing the finances.

Using Technology to Reduce Risks in Healtcare

Computerised decision support systems (CDSS) have grown in use in the last ten years, driven by clinicians suffering from information overload whilst being pressurised to make accurate, cost effective, evidence based clinical decisions. These systems provide access to a wealth of accessible information removing over reliance on memory; they use the power of the technology to analyse tests and compare the results to millions of stored images and evidence; and they accurately perform complex calculations taking into consideration multiple patient factors.

Once a clinical decision is made CDSS's can help with ongoing treatment. For example, electronic prescribing systems take the vagaries of the pen out of prescribing. They can ensure that blood tests are ordered when required for certain high risk drugs. Alerts are built in to laboratory systems highlighting abnormal values of test results. Reminders can pop up to prompt a review, for example a re-assessment of a patients risk factors for venous thrombo-embolism (VTE).

Electronic patient records enable fast access to important information at the point of clinical decisions being made, wherever the patient is.

Technology, People and Patient Safety

When considering e-health applications and patient safety it is important to recognise that we have mixed relationships with technology. Some of us feel at ease using the latest gadget, others haven't mastered the mobile phone and feel very uncomfortable anywhere near a computer. The way we see, feel, understand and trust technology affects how we use it and this in turn affects patient safety.

The rapid development of technology makes it hard to keep up. The latest version always seems better than the one you bought last week and there are constant temptations to upgrade and improve. But this means multiple systems can be in use in one hospital, all of different ages and potentially not able to communicate with each other very easily. This increases the risk of staff not being familiar with the technology and not trained in its use. It also increases the risk of software related problems and the associated costs to sort them out. For managers it brings problems of not knowing who is most up to date and best able to advise the organisation on new technology.

Reporting and Learning About Adverse Events

It is vital in any organisation wishing to improve patient safety that staff report when things go wrong, or when there is a near miss. In any complex software there can be a hundred million lines of code and inevitably this will contain errors, making it difficult to find the source of a problem. Automatic error reporting systems are built in to some software, but not all, so other ways of capturing this information becomes essential.

Even if problems are reported, if it relates to the software it is often very difficult to repeat what happened and find the root cause. The vendors of e-health applications often can't find the root cause of a problem because they have assembled the system from components manufactured by different companies – so even they are uncertain about how the system works as a whole .

Design of the Processes to Use E-health Applications

In improving patient safety it is important to recognise that human behaviour is a function of the system in which people work. For example emailing pathology test results to doctors may appear on the surface to be very efficient but if they are too busy to look at their emails more than once a day then this new system will guarantee that a patient's abnormal test results will not be acted upon immediately. If there is only one computer on each ward and doctors are queuing up to use it, then computerised decision support systems will not be used. There are many techniques to help

those implementing new technology to consider the processes and the potential risks that may arise. Failure modes and effects analysis is one such technique that is increasingly being used in healthcare. For example in one unit they had overlooked the need to ensure that the computer in the cardiac unit was always plugged into a socket powered by the hospital's generator in case of a power failure. If the computer screen showing where the probe was inside the patient's artery had gone blank in the middle of a procedure the outcome doesn't bear thinking about.

It is often faults in the design of the processes that create the conditions for staff to violate the rules and take short cuts. Leaving a computer logged in on a ward for all to use because it takes too long to keep logging off and on, sets up security problems and the possibility of one doctor reading records for the wrong patient. In one unit the staff took to carrying high risk drugs around in their pockets because of problems with the computerised pharmacy system. This highlights the importance of carefully designing and thinking through the process for using technology in healthcare, not only during installation but on a regular basis thereafter as other parts of the system change and develop.

Design of the Technology

With the increasing movement of professionals between hospitals and between countries the issue of familiarity with the technology in use in healthcare becomes important.

Hardware

We know that not being familiar with the technology can cause errors yet we still do not have standardisation of even the basic equipment. In one study by the National Patient Safety Agency in the UK over 60 different types of infusion device were found to be in use in one hospital. Starting in the top left, some of the keypads counted down from '9', others counted up from '0' with the potential for patients to be given massive overdoses. In a truly safe hospital system, all technology would have a common user interface allowing staff to walk in to any ward or clinic and be able to safely use any device or technology.

Software

Even if the technology is well designed, the software can let the operator down. For example drop-down boxes in electronic prescribing systems having drugs in alphabetic order putting highly toxic drugs with similar names next to the most commonly prescribed antibiotics, with inevitable consequences. Electronic prescribing systems have alerts built in to them to notify a doctor of a potentially toxic drug or combination of drugs but these systems often have ways of turning the alerts off or ignoring them by quickly pressing the return button. If alerts regularly appear they can become irritating and over time their impact lessens to the point where they are completely ignored.

Technology and the Operator

Skills and knowledge can be acquired in using the technology but the human condition brings other factors into play that need considering in the context of patient safety.

Trusting the technology

In two tragic cases in the UK patients were overdosed when receiving radiotherapy treatment. Despite the procedures for checking doses, the staff had begun to trust each other and the machine and their levels of vigilance had reduced. Lisanne Bainbridge (1987) set out some of the principle 'ironies of automation' and here we find one: the fact that vigilance and monitoring, checking the performance of a machine over long periods of time is notoriously difficult for humans to perform but we often rely on it.

Applying what we know from other systems

When the computer at home freezes, after we have made our usual attempts to sort out the problem, we press the re-boot button, never quite understanding why it froze in the first place. Applying this approach to e-health applications can have much more serious consequences, losing valuable patient data or at worst re-setting carefully calibrated patient monitoring systems.

Readily available and non-judgemental support for people using complex technology is costly but vital with all applications in the hospital. Here we find another of Lisanne Bainbridge's (1987) 'ironies of automation': we

leave the operator to carry out the tasks that the designer couldn't find a way to automate – such as the operator being left to recover a system breakdown. If the new technology has been introduced with the requirement to save money then often there is a downgrading of the skills of the people operating the system and with fewer clinical staff operating e-health technologies, risks will inevitably increase.

Mental workload of the operator

Physician job satisfaction was measured in one study of telemedicine assessing in particular mental workload. The research into the telemedicine system found that the mental workload scores were high for the doctors and commensurate with those of air traffic controllers. This area requires much more attention as the technology becomes more complex.

Security and Backup

The loss of identifiable data held on computers is not uncommon. In November 2007 the government lost 25 million records giving details of names, addresses and bank accounts for people claiming child benefit . Despite systems and procedures and policies to prevent such loss, the rules are violated to save time and to help doctors with patient care – in one hospital I worked in, a doctor regularly saved on a USB key the records of the patients he was due to see the next day in outpatients, reading them at home in the evening. I found out when a member of his son's computer hacking 'club' rang anonymously to say he had gained access to the records!

E-health applications are now being designed to allow remote access by healthcare staff and also by patients via the internet, making the systems increasingly at risk from viruses and illegal access . Good practice in IT dictates that hospitals have systems in place for regular security testing, reporting vulnerabilities; that vendors should take steps to 'harden' their systems when implemented, for example ensuring that applications that might increase vulnerability are switched off and services on the internet are disabled, pop-ups and cookies blocked for example, but even these can be violated, especially if it means time consuming log-on procedures or slow functionality.

What About the Patient?

Studies of patient satisfaction with telemedicine are revealing – some patients are concerned about telemedicine meaning reduced social interaction with the doctor, feeling 'distanced' from the hospital; some are unhappy about having photographs taken and transmitted electronically (just look at what appears on YouTube!). Yet other studies have found patients prefer to communicate over the internet, avoiding travel to hospital and avoiding face to face contact.

What we don't know is how all this affects patient safety – does the feeling of being distant from the doctor mean that patients are more or less likely to comply with their treatment? Are patients more or less likely to reveal personal details required for a diagnosis over a telemedicine link if they are not sure who is watching? What about cultural differences? What about language? More research is needed here.

What we do know is that patients and their families will interact with health technology in hospitals and at home. For example they will turn off irritating alarms; change dosages; and interpret and act on warnings. Family members will be asked to help or may play with the machine to see how it works. Again this is an unexplored area in terms of patient safety.

Quality Assurance – is the Technology an Improvement?

How accurate are the decisions being taken using the CDSS? Are the prompts and reminders being acted upon? Are appropriate tests and drugs being ordered? If the CDSS relies on information from other systems within the hospital, such as the laboratories and pharmacy, what reliability checks are performed to ensure these systems always communicate? What systems are in place to ensure that over time the knowledge base is kept up to date and that any new knowledge is checked and verified and agrees with local and national guidelines? And of most importance, how is patient morbidity and mortality affected by the CDSS – has the change been an improvement for patient care?

Management, Governance and Accountability

In the book 'Management Mistakes in Healthcare' a case study is presented relating to the purchase and installation of a new computer system in Heartland Healthcare System. The study sets out the management failures that can occur with the introduction of new technology ranging from recruiting people without the requisite IT skills and knowledge; ill-defined roles of IT contractors; an absence of goals and measures of success; the absence of accountability; non-adherence to purchasing protocols; and a failure to prevent the 'intra-staff' warfare that subsequently developed. Any one of the failures listed would cause problems with the introduction of new technology and could introduce the potential for systems not to be set up safely.

Patient safety needs to be writ large throughout the information technology strategy of any healthcare organisation and needs to be central to the running of all systems that interact with the technology and with patient care. For example in the human resource department issues arise such as staffing levels and skills mix required to use the new systems; policies about the use of temporary staff, who may not be suitably trained to use the applications; also the ongoing training and accreditation for both new and existing staff in the use of the technology. Many organisations have introduced new clauses in staff contracts concerning the misuse of IT for example.

E-health has the potential to enable significant improvements in patient safety, it also brings with it new risks. Hospital boards need to have an understanding of these risks, an understanding of the theory of human error and systems thinking and ensure they have the requisite management systems in place to deal with them.

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FALLING NUMBERS OF HEALTH WORKERS: FACING THE CRISIS

What Can We Learn From Magnet Hospitals?

By Bruno Marchal

In many European countries, health service managers are facing increasing problems of staff attraction and retention. Especially in the nursing health workforce, turnover rates are high, vacancies remain open and the resulting staff deficits lead to increased workload, burnout and reduce staff commitment.

During the last decade, several European countries took policy measures to increase the inflow in the paramedical professions and the retention of existing cadres, including the creation of new cadres of health workers, the recruitment of nurses from other countries, better remuneration schemes, and the introduction of more flexible working conditions. Far less has been written on how health service managers can develop practices to attract and retain health workers that go beyond offering better financial incentive packages or recruiting health workers from the South.

Several interesting alternatives to deal with staff shortages have been developed elsewhere. First, when major shortages of nurses occurred at hospital level all over the US during the 1980s, some hospitals were found to attract and retain professional nurses [1]. Second, high commitment management is a promising stream in the human resource management literature.

This paper describes the key principles of magnet hospitals and draws lessons from high commitment management that could be useful in the current hospital staff crisis. In essence, we'll argue that investment in relations and in effective support to health workers may pay off sooner than later.

Principles of Magnet Hospitals

During the 1980s crisis, magnet hospitals stood out in the US hospital landscape because they had a low staff turnover and low vacancy rates despite their location in areas with high competition for staff.

Nurses working within them considered magnet hospitals as good places to practise nursing according to their professional norms. Magnet hospitals were found to share leadership, professional and organisational attributes. In other words, top management created space and opportunities for mid-level (nursing) managers to develop responsive management practices that were appreciated by nurses.

Table 1 summarises these attributes:

Magnet hospital nurse leaders (leadership attributes)
• visionary leaders, planning for the future • creating an organisational culture that enhances staff satisfaction and fosters professional growth • maintaining a high visibility: open communication, responsive to staff concerns and interests • supportive towards their own staff: (1) supporting staff involvement in decision making and control of patient care issues; (2) supporting staff development & Continued Medical Education
Clinical nursing practice (professional attributes)
• adequate autonomy within clinical practice, allowing nurses to establish and maintain therapeutic nurse-patient relationships • collaborative nurse-physician relationships • team autonomy: control over work
Organisational/management attributes
• participative management style including nurse managers in hospital-wide decision making

Table 1

Underlying Mechanisms of the Magnet Hospital Approach

The key principles underlying magnet hospital management include:

(1) facilitating professional autonomy for nurses,
(2) participation in decision-making, and
(3) systematic communication [2].

Through such management practices, the professional nursing practice is explicitly or implicitly valued and respected, and nurses are being empowered.

Magnet hospital management can, indeed, be considered as empowering nurses [3]. Managers give the nursing staff the means, information and support to optimally carry out their professional duties. Further studies linked empowerment to increased trust in management and to commitment to the organisation and its mission of care [4].

Lessons From High Commitment Management

Management practices that are leading to high commitment of employees have been receiving quite some attention in HRM literature for a few years. Such practices have been shown to lead to better organisational performance, reduced stress and higher productivity [5].

In essence, high commitment management consists of applying complementary bundles of HRM practices. Pfeffer identified 7 key elements:

- Selective hiring,
- Employment security,
- Comparatively high compensation contingent on organisational performance,
- Instituting training and development,
- Self-managed teams and decentralisation,
- Reduction of status differences, and
- Information sharing [6].

The main message from the current literature, however, seems to be that the exact composition of the bundles is less important than its internal coherence and external fit. Effective bundles include practices that are congruent (i.e. not cancelling out each other) and fitting well with the tasks the organisation is carrying out.

In American magnet hospitals, the hospital management teams were able to find such bundles.

> Involving staff nurses on crosscutting task forces, delegation of responsibilities and providing opportunities for professional development are strategies that create responsibility and challenge.

Involving staff nurses on hospital-wide crosscutting task forces and committees, delegation of responsibilities and providing opportunities for further professional development are all strategies that create responsibility and challenge. These in turn increase feelings of respect and recognition among nurses, which contributes to their positive commitment towards the hospital and its mission. This ultimately contributed to increased attraction and retention in such hospitals.

Conclusion

The principles underlying magnet hospital management can be assumed to be important for any professional nurse, and as such, this approach seems promising. In practice, however, management approaches that focus on human relationships on the work floor can be expensive in terms of time and management capacity. Support to mid-level nursing managers is of key importance, and they should be given the opportunity to invest heavily in open communication, meetings and on-the-floor presence.

Second, the issue of staff commitment needs to be better understood. What would staff expect from management in return for their commitment to the organisation? Salary buys indeed time of employees, but other practices ensure their motivation and commitment. Hospital managers will need to find out what their nurses appreciate most and consequently adapt their management practices. Facing shortages and limited possibilities to further increase remuneration, managers need to tap other sources of motivation and commitment. Both magnet hospitals and the high commitment management literature offer interesting options.

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What is Magnet status?

Magnet status is an award given by the American Nurses' Credentialing Center (ANCC), an affiliate of the American Nurses Association, to hospitals that satisfy a set of criteria designed to measure the strength and quality of their nursing. A Magnet hospital is stated to be one where nursing delivers excellent patient outcomes, where nurses have a high level of job satisfaction, and where there is a low staff nurse turnover rate and appropriate grievance resolution. Magnet status is also said to indicate nursing involvement in data collection and decision-making in patient care delivery.

The original Magnet™ research study from 1983 first identified 14 characteristics that differentiated organisations that were best able to recruit and retain nurses during the nursing shortages of the 1970s and 1980s. These characteristics became the ANCC Forces of Magnetism that provide the conceptual framework for the Magnet appraisal process.

The 14 Forces of Magnetism are Quality of Nursing Leadership, Organisational Structure, Management Style, Personnel Policies and Programmes, Quality of Care, Quality Improvement, Consultation and Resources, Autonomy, Community and the Healthcare Organisation, Nurses as Teachers, Image of Nursing, Interdisciplinary Relationships and Professional Development.

The idea is that Magnet nursing leaders value staff nurses, involve them in shaping research-based nursing practice, and encourage and reward them for advancing in nursing practice. Magnet hospitals are supposed to have open communication between nurses and other members of the healthcare team, and an appropriate personnel mix to attain the best patient outcomes and staff work environment.

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OUTSOURCING IN HOSPITALS

Impact of Employment and Labour Law

By Thilo Ullrich

For many reasons, it often makes greater sense to have certain hospital functions performed externally rather than leaving these tasks to the hospital itself. Such reasons include greater flexibility, the ability to draw upon professional know-how, the effects of synergies or cooperations, or the adoption of different compensation systems. Furthermore, departments requiring expensive machinery, such as laboratories or radiology, are only able to function cost-effectively if a partial ambulatory utilisation is also possible. Moreover, outsourcing plans are also driven by a trend towards small entities that focus on their core activities. Supplementary activities are merely binding resources that are desperately needed for the hospital's core business: medical care and treatment.

General Remarks

No standard solution exists under German employment and labour law with respect to the outsourcing of measures. The specific circumstances of the hospital, the goal of outsourcing services or certain parts of the business, as well as the type of the division affected, all lead to a broad range of possibilities for the appropriate course of action, e.g. the outsourcing of such services to an external service provider, to a newly founded company owned by the hospital, or to a joint venture between the external service provider and the hospital.

Regardless of the chosen method, the outsourcing of services or parts of a business will in any case raise several employment and labour law related questions, including matters concerning the transfer of business and participation rights of employee representative bodies, i.e. the Works Council (Betriebsrat) or Staff Council (Personalrat).

Transfer of Business

The mere outsourcing of functions will not necessarily lead to what is legally known as a transfer of business (Betriebsübergang). However, in many cases the hospital will also transfer material assets, such as buildings or machinery, and parts of the work force.

1. Definition

A transfer of business requires the transfer of a (complete) business unit to a new owner. The new owner must acquire an economic business unit that maintains its identity after the transfer. The workforce and the assets of a business unit, which share the common purpose of performing an economic activity, determine the identity of a business unit. The German Federal Labour Court (Bundesarbeitsgericht) considers several aspects to be relevant in determining whether a complete business unit has been transferred, and whether such a unit has maintained its identity. These factors include a transfer of the most material assets (both tangible and intangible); the continuation of the work organisation; the similarity of work performed at the business before and after the transfer; a transfer of the main workforce; the type of industry concerned; and the period of time for which the operation of the business has ceased (if applicable).

Whether outsourcing services or parts of a business constitutes a transfer of business can only be determined by a comprehensive evaluation of the deal and the state of the target's business. This was confirmed in a ruling by the European Court of Justice. The Court lately held that taking over a hospital cafeteria without taking over any personnel nevertheless led to a transfer of business, since the company acquiring the cafeteria also acquired the right to work with the heavy and expensive kitchen equipment.

Hence, under certain circumstances, even mere successions in function may result in a transfer of business. Furthermore, supplementary activities of hospitals (such as laundry services or security operations) depend heavily on the personnel and less so on the assets. Consequently, the taking over of activities and parts of the workforce may also lead to a transfer of business.

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2. Legal Consequences

If a transfer of business has occurred, the employment contracts of all employees connected to the business unit will be transferred to the new owner by operation of law. Provisions of collective bargaining agreements with works councils and unions may be incorporated into individual employment contracts. Furthermore, the employment contracts may not be terminated for reasons of the transfer within one year of it taking place.

Moreover, all employees affected must be informed about the transfer of business in writing. Each employee can object to the transfer of the employment contract in writing within one month of receiving the notification letter. The employees' right to object will expire after one month only if the information provided was complete and accurate. If, however, the letter contained incomplete or inaccurate information, the employees' right to object would not lapse. The German Federal Labour Court has recently tightened the requirements for such notification letters.

Participation Rights of Works Council/ Staff Council

Outsourcing may also trigger participation rights of the works council or staff council, ranging from information rights through to co-determination rights. Whether a staff council or a works council exists depends on the form of organisation. Staff councils are established in hospitals belonging to the public (i.e. state) administration, whereas works councils are formed in hospitals that are organised in a private legal entity, e.g. a company with limited liability (GmbH). While such employee representative bodies may not prevent an outsourcing measure, they may delay it considerably.

1. Staff Council

The participation rights of staff councils differ considerably from federal state to federal state, and may range from extensive co-determination rights to the mere hearing of the staff council's opinion. Where a co-determination right does exist, the administrative body may only initiate outsourcing measures if the staff council has agreed to the outsourcing proposal. In case the staff council does not agree, an arbitration committee is formed with a view to negotiating the outsourcing measure.

But even in federal states that grant such co-determination rights, it is the highest administrative body that has the final say on the outsourcing proposal, since the decision of the arbitration committee is not binding. However, the co-determination procedure may be both time-consuming and costly.

In certain federal states, the staff council merely has to be informed (albeit thoroughly and in good time) about the outsourcing plans and is entitled to be heard by the administrative body, including for negotiations regarding the proposed measures. If no agreement can be reached, the decision on the proposed measure is taken by the administrative body next up in the hierarchy.

In addition, the staff council may also have co-determination rights where the outsourcing plan requires the transfer or delegation of employees within the hospital or to the external service provider (or joint venture).

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2. Works Council

In private legal entities, the hospital may have to negotiate a conciliation of interests (Interessenausgleich) and a social compensation plan (Sozialplan) in the event that the outsourcing leads to a change of business (Betriebsänderung) in accordance with Section 111 of the German Works Constitution Act (Betriebsverfassungsgesetz). As a general rule, it is unlikely that the outsourcing of mere supplementary activities, such as laundry services, will lead to a change of business, since the external procurement of minor services has no general impact on the business as a whole.

By contrast, the outsourcing of primary functions, such as laboratory, radiology or nursing services, is highly likely to result in a change of business, thereby establishing co-determination rights in favour of the works council. In such case, if the hospital attempts to outsource measures without first negotiating with the works council, the latter may be entitled to seek an interim injunction against the measures, and affected employees may have compensation claims.

In case the hospital management is unable to reach an agreement with the works council, an arbitration board will issue a binding decision on the social compensation plan. The board may not, however, decide on the outsourcing itself, but may only determine whether the management has taken all necessary steps to find an amicable solution. Thus, while the works council may delay the process, ultimately it will not be able to prevent an outsourcing measure.

Conclusion

Outsourcing may lead to a multitude of employment and labour law related problems. In order to establish what rights will be afforded to the individual employee, it is essential to determine whether the proposal will result in a transfer of business.

Furthermore, consideration must also be given to the rights of a works council or staff council, so as to prevent time-consuming delays as well as cost-intensive claims. The careful and thorough legal preparation of outsourcing plans can therefore prevent many problems and, ultimately, save both time and money.

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MODIFICATION OF WORKING HOURS OF NURSING STAFF IN ONCOLOGICAL SURGERY

Patient and Staff Satisfaction

By Anne-Marie Teller and Pascale Witz

The Gustav Roussy Institute, the first European centre of cancerology, is situated in the south of Paris, in the Villejuif district. Its four hundred beds are divided between different sectors of medicine: paediatrics, general and cervico facial surgery. The "Tarn" unit, affected by the timetable change, is situated in general surgery. This sector of twenty-six beds caters for the "difficult" patients in gynaecology and sarcoma.

The care of severe patients has important physical and psychological implications for nursing staff. Also, the institute's location in the inner-ring suburbs of Paris, its Ile de France environment and its access difficulties have made us consider the improvement of working conditions for several years now.

The care management, in agreement with the general management and the department of human resources, offered staff the possibility to switch from working 8 hour shifts to 12 hour shifts. Being aware of the derogatory nature of this timetable, the switch over to 12h was done on a voluntary basis, with an evaluation after 3 and 6 months in order to find a win-win solution. The renewal process in the unit's workforce with a decrease in the average age also favoured this request of the unit staff. Our wish to modify the working hours had to take into consideration the economic situation and could not envisage an increase in workforce.

Methodology

The implementation of this new timetabling model was achieved in several stages:

- An analysis of the Ile de France and institutional context by nursing staff, medical staff and human resources. The assured commitment of these groups to the project was also important;
- Collaboration and proposition of the feasibility study concerning the switch to 12 hours with the nursing staff of the unit;
- The analysis of the organisation of care and the handling of patients with the staff, the unit's doctor, the nursing manager and the manager in charge,
- The analysis of the roles of registered nurses and auxiliary nurses by an ergonomist bringing to light organisational problems. This was then shared with the team and organisational targets set for the new context;
- The development of an acceptable scenario for each type of patient treated in the unit and the calculation of direct care workload with the head nurse. The goal of this was to reassure staff of the feasibility of the switch to 12 hours in terms of care time as compared with the current workforce;
- The adaptation of premises and material for the new organisation;
- The development of the framework for the schedule;
- Development of a complete dossier of opportunities and organisation and presentation of this dossier to the administrative and union (works council) authorities;
- Development of criteria for the evaluation of the operation's success;
- Implementation and follow up by the manager in charge, and Evaluation after 3 and 6 months of implementation.

Conclusions

We now have 6 months hindsight since the switch to 12 hour shifts for the registered nurses of the Tarn unit. The long process (around one year) that we took to implement the modification of hours has permitted a better understanding of the issues at stake and a newfound respect for the different professions contributing to care. We had a very positive response from patients who knew "their" nurse for the day (sector of care) and at the most for the 2 following days.

The working atmosphere in the unit changed: different specialities realised their organisational impact on each other and their interdependence. Six months into the switch to 12 hours, we observed a 40% decrease in absenteeism due to ill health. We also reclaimed hours dedicated to permanent training. Transfer requests have also stabilised.

Our demand for replacements for 12 hour shifts (when necessary) are easier filled by temporary replacement registered nurses. Finally, the unit staff have expressed a real satisfaction concerning the improvement of their working environment.

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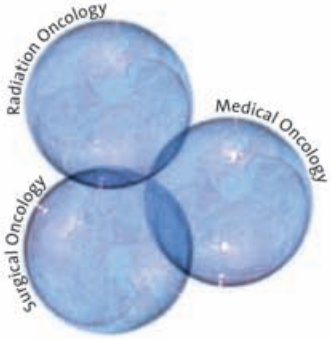
Comprehensive workflow and information management.



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DUAL MANAGEMENT AT THE DEPARTMENT LEVEL

Developing Process Structures and Framework Guidelines in Vienna's Hospitals

By Josef Smolen, Gerda Sailer and Wilhelm Strmsek

Those responsible for running a department repeatedly come up against the limits of practicability on many levels. Fixed-term projects can often be very helpful here – they allow people to familiarise themselves with a new situation and examine to what extent things have improved (or not). In this sense not only should strengths be reinforced, but above all, weaknesses should be given all the support they need to become strengths.

Also, the fact should not be overlooked that a department, as "part" of a whole, must act in the spirit of the whole and also receive instructions in this spirit. The balance between this "recipient situation" and independence in organising and implementing the tasks on behalf of the people entrusted to us is one of the key elements of department management.

Current developments in the health sector show a trend towards:

- Shorter stays in acute hospitals;
- An increase in age-specific illnesses (dementia etc.);
- More multimorbid patients in acute hospitals;
- An increase in chronic diseases and the need for care, and
- A demographic shift in our society.

These changes can also be felt in the departments. The potentials of the organisation department therefore need to be utilised and developed. However, effective management and a "learning" organisation are also required.

Nurse and Doctor Cooperation

In the field of dual management at department level (doctor and nurse), the significance of the profitability dimension in management is on the rise, as are "soft skills" such as social competence and conflict resolution. Nothing new there, but the optimal cooperation of medical professional groups, especially between nurses and doctors, is indispensable. Working processes must be coordinated and evaluated on a regular basis. At the same time there should be no "taboo subjects", potential sources of danger or actual mistakes, and the "courage to admit when you don't know something", must be highlighted as central themes.

Guidelines

In Vienna's hospitals, process, structures and framework guidelines have been recently implemented to effectively carry out shared activities between medicine and nursing. These guidelines are based on the results of the project "Improving the quality of training of trainee doctors". The medicine and nursing framework aims to further develop and redefine the quality of medical and nursing services, as well as the form of cooperation between professional groups.

Mistakes and minimising risk by applying the 4-eyes "hands" principle

The aim of the "morning work" guideline is to improve patient safety in the field of medical "morning work". The period from 7.00 to 9.00 a.m. has been defined as a potentially dangerous time. It was therefore decided that doctors and nurses should carry out their routine morning work together.

However, this 4-eyes principle is also applied as a quality assurance measure following on from morning work in potentially dangerous situations such as administering stored blood, chemotherapy and the like. These dangerous situations are determined by each department, including all relevant professional groups. This department-specific regulation is on display on the ward and should be brought to the attention of everyone. It is checked to ensure it is up to date as part of an annual multi-professional department discussion.

The 4-eyes principle makes patient safety during potentially dangerous activities the focus of attention.

Admission and discharge management

The admissions discussions of nurses and doctors have been coordinated. Duplications of work are thus avoided. Patients have to be informed of the importance of their attendance at the scheduled visiting and treatment times at the informed consent discussion, provided this is not prohibited for medical organisational reasons. Each department must define the admission and discharge process in writing. Admis-

sions planning and discharge management are organised on a multi-professional basis. In the case of discharge management, particular attention is also paid to the social needs of patients following their in-patient treatment. To that effect, cooperation is sought out and upheld within the established area, home-helps, rehabilitation centres and individually with family members. A gradual transition from the residential care of hospitals to the extramural supply chain is essential; to offer patients the highest possible quality of care and to make the best possible use of all associated resources.

In Vienna's hospitals process, structures and framework guidelines have been recently implemented to effectively carry out shared activities between medicine and nursing. The 4-eyes principle makes patient safety during potentially dangerous activities the focus of attention.

Improving cooperation between professional groups

Planned minimum presences of employees of all professional groups should be laid down in writing and adhered to for each operational unit. In addition, multi-professional workflows are coordinated and established in a spirit of process optimisation. Team development processes are promoted (e.g. joint team meetings, joint supervision, multi-professional further training).

Target agreements

Each year target agreement talks are held between the dual management of the departments and their colleagues in hospital management. Department and investment budgets with regard to the hospital's predefined economic plan, targets in relation to bed and staff management, possibilities for optimising methods of billing medical services, and various content-based objectives (relating to complaints management, risk management, and quality management) are discussed and agreed.

Department budgets

The operating expenses budget for drugs and medical treatment requirements is broken down on the basis of figures and performance plans at department level. Monthly controlling overviews and close doctor, nurse and administration cooperation, allow anomalies to be identified promptly and countermeasures introduced. On top of this it is vital that innovations in treatment are planned in advance and implemented accordingly.

Internal hospital committees (e.g. committee for new medical consumables) or standardisation groups for various areas maintain close contact with the departments' dual managements. Improvements can easily be achieved here through feedback mechanisms.

Monthly controlling information and associated controlling talks with the department management are necessary to identify and fathom anomalies and jointly take appropriate control measures. Savings in the department budget are available to the department for other purposes (investments, further training, etc.). The budgetary funds saved must also be distributed and prioritised consensually per department.

Investment plans are prioritised and applied for jointly with consideration for reinvestments and new purchases in the medico-technical sphere, amortisation projects and facilities (with regard to the "hotel components" and nursing requirements).This planned "bottom–up" budgeting is checked for plausibility internally and discussed and negotiated with the owner each year.

Bed and staff management

Staff deployment planning in the medical and nursing services must be planned, coordinated, and organised jointly. This is increasingly important because flexible working hour models are being pushed through, and at the same time over-long daily and weekly working hours are to be reduced. Because of the increasing flexibility, also with regard to the utilisation of operational spaces, functional bed and staff management in situ is essential.

With the support of the administration, various working hours models are being adapted to the requirements of each department and implemented accordingly. Here too it is increasingly worthwhile first planning such models as pilot projects, analysing the results and then implementing them in, where necessary, improved form.

To organise patient care as efficiently as possible, an ever-growing number of services are being offered at daily clinics (daily admissions for suitable operative or non-operative services) or at weekly clinics (service spectrum of smaller plannable treatments with no more than five-day stays in a continuous operation early Monday to Friday evening). Naturally, achieving this optimal patient mix to maximise utilisation (day patients, week patients, normal ward operation) requires a professional department and admission/discharge management coordinated across all professional groups.

Conclusion

The many examples cited show that managing the core tasks of hospitals' individual departments is becoming increasingly important. A harmonic and coordinated dual management scheme in collaboration with other operational centres appears essential for the benefit of patient care, patient safety and satisfaction, as well as for economic success.

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SHOULD WE BUY AN ONCOLOGY MANAGEMENT SYSTEM?

A Mini HIS for Oncology

By Andrew Hoole and Edwin Claridge

The selection and integration of appropriate information systems is one of the challenges facing hospital managers in their quest to achieve organisations offering a high level of clinical care, coupled with efficiency, and good financial and clinical governance. The issues become particularly difficult when 'top down' systems, such as EHR, HIS and PACS come into contention with established departmental systems. This article considers Oncology Management Systems (OMS), where issues of integration between departmental systems and corporate systems currently engender debate.

OMS offerings have developed from the real-time computer systems used in radiotherapy (RT) departments, mainly with linear accelerators, to control treatment delivery. Complex daily treatment fractionation is tracked through Record and Verify (R&V) modules that maintain a complete record of each radiation beam's contribution to the overall dose.

OMS Components

R&V modules and the machine verification aspects are specialist and unique RT features, now incorporated into OMS systems. These encompass other modules covering from medical history, to record tumour diagnosis and staging, scheduling, not only for patient preparation and therapy attendances, but also for activities in treatment preparation that do not involve patient attendance. Additionally, with modules for the organisation and delivery of Chemotherapy (Chemo) regimes and RT protocols, concurrent treatments can be tracked. Clearly this OMS functionality now overlaps with some features found in 'top-down' Hospital Information Systems (HIS).

OMS Structural Options

OMS suppliers serve the international market and can offer independent systems or can create hybrid systems by linking OMS with DICOM to related RT systems and to PACS, and with HL7 to HIS systems dealing with demographics and more. One can also envisage systems in which almost all oncology records are maintained on the main HIS system. The departmental system would then receive treatment machines requests for worklists and treatment parameters from the HIS and in turn submit treatment delivery records back to the HIS. The growing maturity of the RT extensions to the DICOM standards and their adoption across the community makes moves towards this model potentially possible, although the many unresolved integration issues suggest that the hybrid system model is the pragmatic choice for now. Whatever model is adopted, within the sphere of oncology the appropriate use of OMS technology can considerably aid the process of achieving the necessary clinical, efficiency, financial and governance objectives.

Benefits to RT Processes

Patient pathways through oncology are complex, involving input from various professionals. Developments within OMS introduce the possibility of actively tracking 'back-office' tasks such as tumour delineation on planning images and the subsequent RT planning processes. Careful mapping of preparation processes and available staff skills makes it possible to devise ways in which the scheduling ca-

> An OMS is now a critical component in the day-to-day operation of Oncology facilities and a potentially rich data resource for management to meet larger goals.

pabilities of an OMS can be used to more clearly define and allocate the associated tasks within the processes. This precise definition and allocation of tasks can also improve the sense of ownership, accountability and control that staff feels. Such techniques also enable the audit of pathways. This kind of audit highlights areas of resource bottlenecks, enabling managers at all levels to address such issues by training or physical resource provision. The need to meet stringent waiting time targets requires the overall process to be intelligently controlled.

Over the past decade or so the technology behind RT and chemo has increased in complexity. The ability to safely utilize new technologies has been due largely to the parallel development of OMS, handling information on patient configurations, image guided RT, or the complex regimes associated with chemo. As treatment complexity increases, it is important that treatment management does not become fragmented across too many information systems. This would increase the difficulty of maintaining an overall picture of a patient's treatment. Potential conflicts arise in that context, such as whether it is best to have a chemo prescribing system that serves clinics distant from a cancer centre and is part of an OMS, or whether it is better to prescribe chemo from individual hospital pharmacy systems?

Other Advantages

Integration: To achieve good integration, OMS providers should be encouraged to provide solutions that both embrace the newly developing technologies and that integrate with HIS and other corporate systems. This is most likely to be achieved by ensuring that systems support developing standards, for example, HL7 for general message passing, and the maturing RT components of the DICOM standard, for PACS integration, both encouraged by the Integrating the Healthcare Enterprise (IHE) initiatives for exchanging data between systems using agreed definitions.

Patient pathways through oncology are complex, involving input from various professionals. Developments within OMS introduce the possibility of actively tracking 'back-office' tasks such as tumour delineation on planning images and the subsequent RT planning processes.

Time and space management: Oncology management falls at the complex end of the spectrum of hospital activities. Work is largely out-patient oriented and both RT and chemo are likely to involve many treatment sessions. The scheduling is complex because slots in treatment bays and rooms are used so intensively. The treatment pathways are many; their modification as treatments regimes and protocols progress is quite common. When using an OMS database a distinction between activities concerned with the provision of patient treatment and those intended to provide management statistics needs to be appreciated. For costing/billing and process/revenue allocation managers must choose between collecting large volumes of daily data from incomplete prescriptions, or lower volumes of summary data, which has been through more quality screening and deals with finished prescriptions. For monitoring the use of treatment rooms, the various waiting times and the techniques in use, the OMS is also a rich resource.

Dissemination of information: A challenge for the oncology community is to make local data appropriately available across a broader spectrum in a manner that is not open to misinterpretation; uses could include audit and resource planning. Unfortunately the terminology used in oncology and OMS is not standardised and comparisons between centres are therefore difficult. The wide availability of PACS systems, themselves based on the DICOM standard and in some countries becoming integrated across the nation, make them a potential platform for achieving this wider dissemination of information. The operational differences between radiology and oncology departments make it difficult to envisage a real-time integration with OMS, but the retrospective uploading of a completed RT episode summary DICOM data object into PACS is a potential way in which this data may be "protected" for the benefit of the patient across a broader geographical spectrum.

Data security: Data protection is often viewed as ensuring that data does not fall into the wrong hands. Another important aspect is to ensure that the data held remains available for continued use, in the context of both current and future treatments. The centralised storage of data in local OMS facilitates this process. Note that statutory Oncology data storage periods are usually greater than many OMS software life cycles, implying that evolutionary planning must include archive data.

Conclusion

In conclusion an OMS is now a critical component in the day-to-day operation of Oncology facilities and a potentially rich data resource for management to meet larger goals. Currently the level of integration, for example for the assimilation of OMS elements beyond R&V into HIS and/or PACS, is not completely developed. The standards for the definitions required for national and international data exchange have also not yet been agreed. It is necessary to consider these issues when purchasing an OMS solution and essential to engage in an active debate about future relationships between OMS, HIS and PACS.

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THE LITHUANIAN HEALTH SYSTEM

By Gediminas Černiauskas and Janina Asadauskien

Lithuania, officially the Republic of Lithuania, is one of the three Baltic States. Situated along the southeastern shore of the Baltic Sea, it shares borders with Latvia to the north, Belarus to the southeast, Poland, and the Russian enclave of the Kaliningrad Oblast to the southwest. Lithuania is a member of NATO. Its population is 3.4 million, declining during the last decade because of demographic factors and negative migration. Its capital and largest city is Vilnius.

History

During the 14th century, Lithuania was one of the largest countries in Europe: Belarus, Ukraine, and parts of Poland and Russia used to be territories of the Grand Duchy of Lithuania. With the Lublin Union of 1569 Poland and Lithuania formed a new state, the Polish–Lithuanian Commonwealth. The Commonwealth lasted more than two centuries, until neighbouring countries systematically dismantled it from 1772 to 1795, with the Russian Empire annexing most of Lithuania's territory. In the wake of the First World War the sovereign state had been reestablished but in 1940, Lithuania was occupied first by the Soviet Union then Nazi Germany. As World War II neared its end in 1944 and the Nazis retreated, the Soviet Union reoccupied Lithuania. On March 11, 1990, Lithuania became the first Soviet republic to declare its renewed independence.

Institutions

The Lithuanian head of state is the President, elected directly for a five-year term, serving a maximum of two consecutive terms. The post of President is largely ceremonial; main policy functions however include foreign affairs and national security policy. The President, with the approval of the parliamentary body also appoints the prime minister and on the latter's nomination, appoints the rest of the cabinet, as well as a number of other top civil servants and the judges for all courts. The unicameral Lithuanian parliament, the Seimas, has 141 members who are elected for four-year terms. 71 of the members of this legislative body are elected in single constituencies, and the other 70 are elected in a nationwide vote by proportional representation.

The litas, the national currency, has been pegged to the euro since February 2, 2002 at the rate of EUR 1.00 = LTL 3.4528, and Lithuania is expecting to switch to the euro on January 1, 2011.

Lithuania is a member of the World Trade Organisation, and the European Union (Since May 2004). Lithuania became a full member of the Schengen Agreement on 21 December 2007.

Economy

During the last five years Lithuania has had one of the highest economic growth rates among EU candidate and member countries, reaching 10.2% in 2003 and 8.9% in 2007. Fast growth has radically changed the country's relative figures. In 2001 the GDP per capita in Lithuania was 41% of EU27 level, reaching 61% in 2007.

Fast economic growth has also contributed to improvements in social indicators with unem-

ployment rate decreasing from 16.5% in 2001 to just 4.3% in 2007, but provoked growth of inflation from 1.6% in 2001 to 5.8% in 2007 and up to 10% in 2008 and unsustainable levels of current account deficits.

Mounting internal pressures in combination with the gloomy international environment is slowing economic growth in 2008 to 3-4% and there is a risk of falling in to recession in the first quarter of 2009. The slowdown will hit the healthcare sector, which was growing during the last years in line with the general economic growth. At least in 2009 positive trends in long-term social stability will not be affected, i.e. the number of births was 30.5 per thousand in 2005, 32.3 per thousand in 2007 and will reach about 35 per thousand in 2008.

Health System

The healthcare system in Lithuania is designed according to the basic principles common to European cultures. Universal access to basic medical services is granted to the whole population. Basic medical services are mainly free of charge for the consumer and mostly financed according to a solidarity-based scheme of statutory health insurance operational since 1997. From the start funding was raised according to a mixed model: about 50% of health insurance funds came from general income tax (30% of the tax was allocated to health insurance); 3% of payroll tax and contributions from the state budget for pensioners, unemployed and children, contributed for the residual part.

As of 1 January 2009 this model has been modified: special health insurance contributions at the level of 6% of payroll will replace allocations from general income tax. The change will mean that about 75% of statutory health insurance revenues will be generated by health insurance contributions (HIC) and 25% by contributions from the state budget and other sources of marginal importance.

The relative increase of importance of HIC means that the system is moving closer to the Bismarck model but certain differences between the two will remain:

- The statutory health insurance fund in Lithuania is a semi autonomous state monopoly under the Ministry of Health (MOH) referred to as the State Patient Fund (SPF);
- Contributions, benefit packages, price providers are fixed by law or state authorities, and
- Formulas to assure regional equity in funds distribution to regional branches of SPF are in place.

So far the statutory health insurance scheme has been in balance, whether they are going to be as successful during the period of incoming hard times remains to be seen.

Coverage

Most dental and spa services are not covered by the public scheme and almost no copayments are applied to general health services. There have been some suggestions to introduce marginal copayments for certain hospital services and certain types of modern technologies but until recently there was no political will to introduce those measures. Even taking into account the fact that copayments based on reference pricing are common for medicines and other medical goods, the limited scope of copayments results in the virtual absence of supplementary forms of health insurance. In the fall of 2008 the government opted for a national implementation of medical savings accounts supported by tax subsidies, but this decision is still just a political statement.

Hospitals

The provision of healthcare is shaped in a pyramid form with university hospitals at the top, a few regional hospitals with a majority of services except organ transplants and sophisticated testing procedures provided on the high end, municipal hospitals providing ordinary therapeutic and surgical services as well as nursing in the middle and primary healthcare institutions at the bottom. Special units of most hospitals provide specialised outpatient health services.

Polyclinics that at the beginning of market reforms were considered as rudiments of a Semasho system and had to be closed are flourishing in some private clinics and big cities today. Private practices are mainly concentrated in dental care with no public coverage and in family care with public funding based on an age adjusted capitation model and some incentives for screening and other services considered national priority. Roughly 80% of the labour force of about 80,000 in the healthcare sector are public employees with very slow dynamics towards becoming employed by private entities or self-employed.

National Health Council

The Lithuanian Health Programme was prepared and approved by the Seimas in 1998 in line with the implementation of the European health policy "Health for everyone in the twenty-first century" and the provisions of the Law on Health System passed in 1994, legitimating an active healthcare policy.

The common objectives of this programme are:

- Reduction of mortality rates and increase of life expectancy;
- Equity of access to healthcare, and
- Improvement of quality of life.

The specific indicator levels to reach were determined according to specific objectives concerning cardiovascular diseases, cancers, accidents and injuries, mental illnesses, infectious diseases, oral health and diabetes mellitus.

The National Health Council was established to create an independent institution accountable to the parliament, consisting of leading figures among public health professionals, researchers and community activists, local governments and non-governmental organisations representing the interests of public health. The council is composed of 15 members representing these groups with the mission of contributing to the formulation of a modern public health concept and implementation of health policies. Its role:

- To analyse health promotion processes;
- To assess the practical implementation of health policies, and
- To provide conclusions, suggestions and recommendations around the improvement of performance of lifestyle, environment and healthcare services.

The Council has the authority, while considering problems, to include all strata and socio-economic sectors of society, which, as referred to in the Maastricht Treaty approved in 1992, must assume the responsibility for the health of its people. The legal basis of the Council's activities is established in the Law on Health System of the Republic of Lithuania, and regulations are approved by resolutions of the Lithuanian Parliament.

The National Health Council assesses population health trends, their relationship to the social and economic policy decided by the state, provides information to the Seimas, government and society, prepares and submits an annual report to the Seimas on the population's health conditions and health policy formulation, and at their discretion provides suggestions to the government and Seimas on draft laws and other legislation.

Conclusion

Assessing key population health indicators in Lithuania, one may conclude that measures towards changing health markers are still needed. There have been significant positive developments only in the area of infant mortality reduction. In 2004, the infant mortality rate in Lithuania was better than the European average. However, it is disappointing that the former significantly positive trends of health indicators (in particular, mortality) from 2000 tend to be negative. Morbidity and mortality rates of the country's population from cancer, cardiovascular disease, spreading of HIV/AIDS and drug problems, smoking and alcohol consumption among children and adolescents are all increasingly growing.

One should note that without investing in the public health sector, without attracting other country's sectors of the social economic framework into the processes of the health sector, the possibilities of the health sector itself will gradually decline. If governmental strategy for dealing with health problems does not change, it will be virtually impossible to achieve the accelerated improvement of health indicators.

In order to implement the set objectives one needs a balance and sufficient funding for all areas affecting health:

- Competent and methodical process control;
- Definition of responsibilities and accountability for the obligations imposed;
- Division and reorganisation of functions among public health institutions;
- Identification and education of health sector entrepreneurs, and
- Maturation of society, politicians, and media.

It is expected that the successful implementation of the Lithuanian Health Programme provisions will help to achieve substantial changes in creating a healthy and happy society. Health policy must be comprehended by everyone as an investment in the future, rather than as cost.

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RECENT CHANGES IN LITHUANIAN **HOSPITAL ACTIVITIES**

By Edmundas Baltakis

Since restoration of Lithuania's independence in 1990, the most significant changes in the country's health system have taken place in the area of inpatient treatment. Lithuania inherited an expensive model from the Soviet Semashko system; a system in need of refocusing on the market model by a gradual reduction of inpatient beds and hospital network. This process was carried out in several stages.

Facts and figures

In 1990 there were 198 inpatient treatment institutions in the country: 8 state and university hospitals, 7 republican rehabilitation hospitals, 3 scientific research institutes, centres and clinics, 20 city hospitals, 1 children's hospital, 4 maternities, 78 district hospitals, 31 small neighbourhood hospitals, 7 nursing and 24 specialised hospitals (3 hospitals of infectious diseases, 10 of tuberculosis, and 2 of skin, venereal diseases, 8 psychiatric hospitals). In addition to these, there were 15 facilities with stationary departments (tuberculosis, skin - venereal diseases, oncology, psycho neurological, rehab centres).

Thus, in total there were 46,175 hospital beds in the country, and 124.73 beds per 10,000 inhabitants, 2.5 times above the EU average.

Number of beds

During the period of 1990-2000 (in 1997, hospitals became public institutions) the number of inpatient hospitals established in the country experienced little change and at the end of 2000 there were 187 establishments. However, during the current decade, the number of beds has decreased by 26 percent (12,000). The most significant decrease was noted in the therapeutic, obstetrics-gynaecology and surgery type of beds. Many small hospitals have been converted to nursing and supportive treatment units. In 2000, nursing and support treatment hospitals had 3,233 beds (9.2 beds per 10,000 inhabitants), but their territorial distribution was uneven.

Until 2000, there were no private hospitals in Lithuania.

Hospitalisations

In 1990 hospitalisation rates were 18.68 cases per 100 inhabitants, and it grew until 1999, when it reached 25.69 cases. There are two main reasons for this increase: a difficult economic situation after the restoration of independence with high inflation, increased morbidity and repercussions of the Russian crisis, but also the transition to a new funding system in 1997; after the introduction of medical insurance

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and without any quota for inpatient services, many patients were hospitalised because it was financially beneficial to hospitals.

Restructuring

In 2003 the government of Lithuania adopted a resolution on the restructuring strategy of healthcare facilities. Healthcare establishments were to be restructured in two phases - the first period in 2003-2005, and second in 2006-2008.

Among many problems the most important was to restructure the network of healthcare institutions, by improving the efficiency of healthcare facilities, reducing inpatient services and accelerating the expansion of a wider range of ambulatory healthcare services.

While the country's inpatient institutions were being restructured, day care, day surgery and outpatient rehabilitation services were significantly developed. During the restructuring process, specialised tuberculosis, infectious, gerontology, psychosomatic, eyes, ENT and other specialised units were closed in many municipal and regional hospitals, and these services were transferred to the multiprofile, specialised sections of district and university hospitals.

In the country's largest cities Vilnius, Kaunas (and others), hospitals were merged and grouped together. Thus, by the end of 2006 the country already counted only 104 hospitals with a legal status.

Compared with 2000, the number of inpatient institutions fell by as much as 44.4%, and accordingly, the number of hospital beds declined by 41.3 percent, whereas the number of beds per 10,000 of population was 80.1.

Consequences of Restructuring

The hospitalisation rate from 2000 until 2007 gradually declined and reached 20.3 cases per 100 inhabitants, i.e. fell by more than 10 percent.

The results of the first restructuring phase of healthcare institutions indicated that specific changes have taken place regarding the basic indicators of the country's healthcare system: a significant decrease of inpatient beds in the country's institutions and a hospital admission rate per 100 inhabitants that fell from 23.2 to 20.9 of patients. The average length of stay was 2.2 days less, going from 10.2 to 8 days, and the occupancy of beds increased from 284 to 308 days.

In 2007, compared with 2006, healthcare institutions provided 675,000, i.e. 10% more priority services (outpatient specialist, acceptance and emergency assistance, day care, day surgery, observation, short-term treatment). During that period, the number of inpatient hospital services was reduced by 11%.

Within the framework of goals and tasks required in the second phase of restructuring in the inpatient area, there are plans to facilitate the infrastructure of consultative outpatient facilities and emergency (reception) departments, and to develop outpatient rehabilitation services, day hospital and day surgery.

In addition, the optimisation of hospital activities requires municipal hospitals to enhance the infrastructure of departments for treatment of the most common and easy to treat diseases and to concentrate the diagnosis and treatment of complex diseases in university hospitals and hospitals in large cities, by providing them with sufficient modern equipment and latest technologies.

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THE ASSOCIATION OF **HOSPITAL MANAGERS PHYSICIANS OF LITHUANIA**

Our History, Our Activities and Our Priorities

By Stasys Gendvilis

Founded in 1991, the Association of Hospital Managers Physicians of Lithuania grew significantly during its first decade of existence: its membership extended not only to the managers of healthcare facilities, but also to other people working in the field of healthcare establishments. In 2004 the Association evolved: it updated its charter, structured itself as an association as far as legal entities, and their managers (true members), other senior health staff (associate members), and honorary members are concerned. The growth in the number of members of the association indicates that the activities and efficiency of the association have an operational significance. Over the last five years, the number of members of the association increased from 50 to 114. It involves another 80 associate members in its activities.

The EU Dimension

Our association was accepted as a member of the European Association of Hospital Managers during the EAHM Congress in the city of Tampere (Finland) in 1996. This membership opened up new opportunities for our association: we were offered the opportunity to participate in congresses and other events, to communicate directly with our European colleagues and to familiarise ourselves with the health systems of the old and new EU member states. We learned of

The constant focus of our association activities is the question of maintaining the quality of health services. Quality and safety can be ensured by a system of institution accreditation.

their experiences and the effectiveness of already accomplished reforms and issues through a variety of channels, including Hospital magazine.

Our Mission

The association's mission is to unite the members of the association for joint actions, gather them around issues ranging from rearranging and improving the performance of healthcare institutions, to upgrading the quality of healthcare services, improving their organisation, shaping health policy in cooperation with official bodies, and participating in the activities of international institutions and organisations.

Recently, the association has decided to focus mainly on:

- Training programmes for our members;
- Organising and coordinating the management of staff skills development;
- Researching new funding sources for healthcare facilities, and
- Disseminating information among the association members about the new innovative health service delivery methods and forms of work organisation.

Training Programme

As managers of Lithuanian healthcare facilities are generally medical doctors, our association deems it essential to improve their managerial, legal and economic knowledge and skills. We have thus decided to organise the Lithuanian Health System Development, which consists of professional development training courses for all healthcare managers. Pursuing this work, we are currently organising a joint project of all association member institutions, partly funded from the EU structural funds, in order to continue the training and knowledge improvement of our association leaders and their staff - doctors, nurses and other specialists in the managerial and professional fields.

Cooperation with Governmental Bodies and Activities

Economic recession and financial hardship are prevailing right now in Lithuania, as in many other countries. The country's parliamentary elections took place at the end of 2008, with a subsequent change of government. The new government is preparing a stabilisation plan of the country's financial and economic system.

Our association is working hard to propose the changes that will significantly and positively affect the financing of our country's health system management, as well as the principles of transformation and strategic trends for 2008-2012. Our association is also involved in medical community building activities.

After Lithuania's accession to the EU and the establishment of the free movement of citizens, goods and services, a large number of highly trained doctors from our country left to work abroad. For this reason we are now facing a shortage of doctors, particularly in remote parts of the country. The association has repeatedly proposed solutions to this human resources problem to the government, ministry of health and medical universities.

Recently the association participated, along with the Ministry of Health and State Patient Fund, in the European Union's new initiative on patients' rights and ensuring the freedom of movement and the right to the necessary assistance for the insured in EU member states. It analyses the cooperation and the implementation of the European Parliament and Council Directive on patients' rights to healthcare services in other member states. The country has few private healthcare institutions (with the exception of family clinics, and dental care). Consequently the association often addresses the issue of rational approaches to public-private partnership, and promotes cooperation between public and private sectors.

Quality and E-Health

The constant focus of our association activities is the question of maintaining the quality of health services. Quality and safety can be ensured by a system of institution accreditation. We learned about the accreditation systems most often applied in European hospitals, and a large number of our institutions have already implemented quality management systems and European certificates of management.

Managers of healthcare facilities are also greatly interested in e-health issues. The association is involved in the development of e-health strategies in the country. It aims to create and develop e-health services in institutions, and encourages patients to use them.

In many institutions, an electronic advance patient registration system is being implemented; separate elements of the hospital information system in medical institutions, and a unified national electronic health system are being developed.

Conclusion

In recent years, especially after Lithuania's accession to the EU, big changes have taken place in the country's healthcare system: our legislation was adapted according to European standards. All healthcare institutions are now subject to the same modern diagnostic and treatment technologies; hospitals and clinics are managed and renovated. We are pleased to note that the managers of healthcare institutions, who are members of our association, take the most active part in these processes.

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Paul Castel

LE SYSTÈME DE SANTÉ FRANÇAIS EN PLEINE MUTATION

A l'instar de ses voisins européens, le système de santé français est confronté depuis plusieurs années à des problématiques lourdes. Celles-ci se manifestent certes selon des formes différentes, mais ont toutes les mêmes origines: raréfaction des ressources humaines médicales, augmentation très forte des dépenses de santé couplée à d'importantes tensions budgétaires, difficulté à concilier la nécessaire proximité des établissements de santé avec l'exigence de sécurité des soins qui impose une concentration des équipes soignantes et des plateaux techniques...

Dès après son élection à la Présidence de la République, Nicolas Sarkozy a fait part de sa volonté de proposer une nouvelle organisation du système de santé français. C'est ainsi qu'à l'issue d'une large concertation, le projet de loi Hôpital – Patient - Santé - Territoire a été présenté aux hospitaliers.

Inspiré d'expériences concluantes mises en œuvre en Europe ces dernières années, ce projet de loi sera examiné au cours du premier semestre 2009 par le Parlement français et devrait apporter des évolutions majeures:

▸ En premier lieu, le projet de loi s'attache à redéfinir la notion de service public hospitalier en précisant que ces missions peuvent être assurées par tout établissement de santé, qu'il soit public ou privé. L'ambition du gouvernement est de faire porter sur tous la charge et les contraintes de ces missions de service public et de permettre ainsi une meilleure efficience du système.

▸ L'autre innovation majeure réside dans l'introduction de la notion de « territoire de santé » et dans la création de communautés hospitalières de territoire, structure formalisée de coopération entre établissements publics d'un même territoire. Tout en conservant leur autonomie juridique, plusieurs établissements d'une même zone seront ainsi incités à définir une stratégie commune, à partager leurs ressources humaines, à concentrer leurs plateaux techniques en un seul lieu...

▸ Parallèlement à cette territorialisation accrue, des Agences Régionales de Santé vont être mises en place dès janvier 2010. Dotées de missions et de pouvoirs plus larges que les actuelles Agences Régionales de l'Hospitalisation, les Agences Régionales de Santé seront chargées de définir et mettre en oeuvre une politique régionale de santé, qu'il s'agisse de la politique hospitalière, de la politique de santé publique, des soins ambulatoires, ou encore de la politique médico-sociale. Annoncées depuis de nombreuses années, ces Agences devraient permettre au secteur hospitalier et non hospitalier de développer leur complémentarité.

▸ Enfin, la nouvelle loi devrait apporter des innovations dans le management interne des établissements de santé: évolution profonde des organes décisionnels des hôpitaux, renforcement des pouvoirs du directeur d'établissement, renforcement du rôle des pôles d'activité médicale et de leurs compétences, mais aussi création de nouvelles formes de contrats de travail destinées à améliorer l'attractivité des carrières hospitalières en permettant notamment de lier la rémunération à la performance individuelle des acteurs du système de santé.

Dans un contexte en profonde mutation, il est plus que jamais indispensable pour chaque décideur hospitalier de s'inspirer des actions déployées dans les autres Etats pour faire face aux mêmes types de problèmes. C'est pour cela qu'en 2009, l'AEDH inscrira fortement son action dans cette recherche de convergences entre les acteurs hospitaliers européens qui seule permettra de construire, pas à pas, une Europe de la santé forte et cohérente.

Excellente année 2009 à tous !

Paul Castel
Président de l'AEDH

UNE DÉLÉGATION DANOISE EN VISITE À BRUXELLES

L'année dernière, notre organisation sœur, la Dansk Selskab For Ledelse I Sundhedsvæsenet a décidé de créer un sous-comité international. L'objectif était de promouvoir l'échange de connaissances et d'expériences avec la communauté internationale; de suivre les développements mondiaux de la gestion des soins et de porter les expériences danoises au niveau international (voir *(E)Hospital* 5/2008).

En tant que point de départ à cette démarche, une délégation danoise de 14 personnes est venue à Bruxelles en décembre dernier et y a combiné plusieurs rencontres. Le programme comprenait une visite au Parlement européen avec l'europarlementaire danois Karin Riis-Jorgensen et une réunion à la Commission européenne. La délégation s'est également rendue à la Représentation danoise à Bruxelles et a discuté avec les représentants régionaux danois.

L'AEDH a accueilli la délégation dans ses bureaux, en combinaison avec une visite de la Clinique Saint-Jean. Le groupe a été informé des activités de notre association ainsi que des questions d'actualité figurant à l'ordre du jour au niveau européen. La proposition de directive sur les droits du patient et les soins transfrontaliers a ouvert une discussion autour de la qualité des soins. La contribution qu'un modèle d'accréditation pourrait apporter à la qualité a également été abordée, dans le droit fil du séminaire que l'AEDH a organisé en 2007 autour du même sujet. Le thème de la privatisation et la coexistence d'acteurs publics et privés sur la scène hospitalière européenne est une question tout aussi actuelle et sera le point central du séminaire mis sur pied par l'AEDH cette année (voir agenda). Les visions danoises et européennes à propos de la gouvernance hospitalières ont été échangées durant cette entrevue, à la lumière de la récente crise bancaire et de la relation tumultueuse entre gestion hospitalière et financeurs.

Investissement en e-santé

Par Alexander Dobrev, Tom Jones et Karl A. Stroetmann

L'étude récente, intitulée Financing eHealth, fournit une guidance générale aux investisseurs potentiels en e-santé afin de les soutenir dans leur processus décisionnel. La leçon principale en ce qui concerne les modèles à adopter est d'intégrer les décisions d'investissement en e-santé à la stratégie de soins de l'établissement. L'e-santé peut s'atteler à la tâche mais il faut qu'elle fasse partie intégrante du panel général de ressources mises en œuvre pour répondre aux besoins de soins de santé. Le modèle de financement de l'investissement ne devrait être envisagé qu'après que l'analyse économique ait été effectuée.

L'exigence essentielle pour les dirigeants, cadres et acteurs de santé est d'être capable de traiter l'investissement d'e-santé comme une composante de l'investissement général de santé. Les gestionnaires financiers ont un rôle plus spécifique. D'abord, ils doivent comprendre la valeur et l'impact de l'e-santé, afin de pouvoir développer un planning financier en concordance avec les perspectives d'investissement de l'e-santé. Ensuite, ils doivent utiliser pleinement leur compétences managériales pour pouvoir trouver les moyens d'investir dans la valeur ajoutée.

Questions légales autour des TICs à l'hôpital

Par Jean Herveg

L'e-santé renvoie à l'application des technologies de l'information et de la communication au secteur des soins de santé. Elle se retrouve dans une large gamme de produits et de services dans le contexte hospitalier. Depuis la gestion électronique des données du patient ou du personnel, l'utilisation de la télésurveillance, de la téléchirurgie ou même la formation du personnel à distance. D'un point de vue juridique, ces applications sont souvent réglementées par la législation sur le droit à la vie privée et le traitement des données personnelles. Cependant, d'autres réglementations doivent aussi être prises en considération selon l'approche et l'angle d'analyse. Elles concernent les lois sur l'équipement, les services ainsi que la responsabilité de l'hôpital et la concurrence. Une grande majorité de ces règles n'est pas propre au secteur sanitaire ou hospitalier.

Sécurité du patient et e-santé

Par Susan Burnett

Si on veut améliorer la sécurité du patient, il est important d'apprécier la valeur d'une approche systémique dans la prévention et l'analyse des erreurs, en reconnaissant que le comportement humain est fonction du système dans lequel les gens travaillent. La sécurité du patient doit être mentionnée en toutes lettres dans la stratégie de technologie de l'information de tout établissement de santé et doit être au centre de tous les systèmes en interface avec la technologie et le soin au patient. Par exemple pour le département des ressources humaines, les questions concernent les besoins en personnel et les compétences requises par rapport aux nouveaux systèmes, l'utilisation de personnel temporaire qui ne sait éventuellement pas utiliser les applications, ainsi que la formation continue et la certification du personnel ancien et nouveau pour l'utilisation de la technologie. De nombreux établissements ont introduit de nouvelles clauses dans les contrats de travail à propos de l'usage abusif de l'IT par exemple.

L'e-santé peut améliorer considérablement la sécurité du patient, mais elle entraîne aussi des risques nouveaux. La direction hospitalière doit comprendre la théorie de l'erreur humaine et la pensée systémique, et s'assurer que les systèmes managériaux appropriés sont en place pour les traiter.

Forumclinic

Par I. Grau, J. Gene-Badia, E. Sanchez Freire, M. Bernardo et M. DeSemir

Forumclinic est un ensemble d'outils audiovisuels (DVDs et site web) en espagnol et catalan lancé en janvier 2007 afin d'améliorer la qualité de vie des patients chroniques. Basé sur le principe qu'en comprenant mieux leur maladie les patients deviennent plus autonomes, le projet vise à encourager l'implication du patient dans le processus décisionnel clinique en collaboration avec l'équipe de santé.

C'est pourquoi des monographies ont été rédigées sur la cardiopathie ischémique, le diabète, les maladies pulmonaires chroniques obstructives, la schizophrénie, le cancer du sein, la dépression et les facteurs de risque cardiovasculaire. Le portail combine un contenu d'intérêt général en format texte et multimédia. Le blog permet une interaction avec le public. Quatre types d'information sont fournis : des données de base sur chaque maladie, des nouvelles récentes les concernant, des vidéos et animations 3D et des forums de discussions gérés par des professionnels.

Face à une baisse du nombre de travailleurs de santé

Par Bruno Marchal

Durant la dernière décennie, plusieurs pays européens ont pris des mesures pour accélérer l'afflux dans les professions paramédicales et la rétention des cadres existants, y compris par la création de nouveaux cadres de professionnels de santé, le recrutement d'infirmières à l'étranger, de meilleures rémunérations et l'introduction de conditions de travail plus souples. On a beaucoup moins parlé de la façon dont les gestionnaires de santé peuvent développer des mesures pour attirer et retenir leur personnel au-delà des incitants financiers ou des tentatives de recrutement dans le Sud. En fait, un management centré sur l'engagement consiste à appliquer un ensemble cohérent de pratiques identifiées par Pfeffer:

- une embauche sélective,
- la sécurité de l'emploi,
- une rémunération comparativement élevée en fonction de la prestation organisationnelle,
- une formation et développement institutionnalisés,
- des équipes auto-gérées, une décentralisation,
- une réduction des différences de statuts, et
- une dissémination de l'information.

Impact de l'externalisation sur l'emploi hospitalier

Par Thilo Ullrich

Pour de nombreuses raisons, il est souvent plus sensé d'externaliser certaines fonctions hospitalières plutôt que de confier ces tâches à l'hôpital. Ces raisons vont d'une plus grande flexibilité à la possibilité de faire appel à une expertise professionnelle, un effet de synergie ou l'adoption de différents systèmes compensatoires. Quelle que soit la méthode choisie, l'externalisation de services ou de parties de l'activité soulèvera différentes questions liées à l'emploi et au droit du travail, y compris le transfert de fonctions et les droits de participation aux organismes de représentation, comité d'entreprise ou assemblée du personnel.

Afin d'établir quels droits seront octroyés à chaque employé, il est important de déterminer si la proposition d'externalisation aboutira à un transfert d'opérations. De plus, il faut également prendre en compte les droits du comité d'entreprise ou de l'assemblée du personnel, afin de prévenir des retards qui font perdre du temps et provoquent des plaintes dispendieuses. Une bonne préparation juridique des plans d'externalisation peut donc éviter de nombreux problèmes et, à terme, faire gagner du temps et de l'argent.

Modification des heures de travail en chirurgie oncologique

Par Anne-Marie Teller et Pascale Witz

Les soins aux patients lourds ont d'importantes implications physiques et psychologiques pour le personnel infirmier. La gestion des soins, en collaboration avec la direction générale et le département des ressources humaines, a offert au personnel la possibilité de passer de périodes de travail de 8 à 12 heures. Vu la nature dérogatoire du changement, il a été fait sur base volontaire avec une évaluation après 3 et 6 mois.

La réaction a été très positive du côté des patients qui connaissaient «leur» infirmière pour la journée et au mieux les 2 jours suivants. L'atmosphère de travail a changé: les différentes spécialités ont pris conscience de l'impact organisationnel qu'elles avaient l'une sur l'autre et de leur interdépendance.

Six mois plus tard, on observe une baisse de 40% de l'absentéisme. On a aussi récupéré des heures de formation. Les demandes de remplacement pour des périodes de 12 heures sont plus facilement satisfaites par du personnel temporaire. Enfin, le personnel de l'unité a exprimé une réelle satisfaction à propos de l'amélioration de son environnement de travail.

Gestion double au niveau du département

Par Josef Smolen, Gerda Sailer et Wilhelm Strmsek

Un schéma de gestion bicéphale, harmonieux et coordonné avec d'autres centres opérationnels apparaît essentiel pour le bien du soin au patient, la satisfaction et la sécurité du patient ainsi que pour la réussite économique.

Dans le domaine de la gestion double (médecin et infirmière) au niveau du département, l'importance de la dimension rentabilité en gestion est en augmentation, ainsi que les «soft skills», comme la compétence sociale et la résolution de conflits. Rien de très nouveau, encore qu'une coopération optimale des groupes professionnels médicaux, particulièrement des médecins et des infirmières, soit indispensable.

Dans le secteur hospitalier viennois, des structures et guidances générales ont été récemment mises en place pour effectuer de façon efficace des activités partagées entre la médecine et les soins infirmiers. Ce cadre vise à développer et redéfinir la qualité des services médicaux et infirmiers, ainsi que les formes de coopération entre groupes professionnels.

Devrions-nous acheter un système de gestion oncologique?

Par Andrew Hoole et Edwin Claridge

La sélection et l'intégration de systèmes d'information appropriés est un des défis qui attendent les gestionnaires hospitaliers dans leur quête d'établissements offrant un niveau élevé de soins cliniques, combiné à une efficience et une bonne gouvernance financière et clinique. Ces questions se compliquent particulièrement quand des systèmes directifs (top down), comme les SIH et les PACS sont en conflit avec des systèmes départementaux établis.

Un OMS (Oncology Management System) est devenu un élément essentiel du fonctionnement journalier des départements oncologiques et une source de données potentiellement riche pour la gestion d'objectifs plus larges. Actuellement, par exemple, le niveau d'intégration pour l'assimilation d'éléments de l'OMS dans le SIH ou le PACS n'est pas complètement développé. Les normes de définitions nécessaires à l'échange de données nationales et internationales n'ont pas encore été approuvées. Il est nécessaire d'envisager ces questions lors de l'achat d'une solution OMS et d'engager une discussion active autour des relations futures entre OMS, SIH et PACS.

Focus: Lituanie

Ces cinq dernières années, la Lituanie a connu une des croissances économiques les plus fortes des états membres de l'UE, avec 10,2% en 2003 et 8,9% en 2007.

Le système de soins de santé lituanien est conçu selon les principes de base communs à toutes les cultures européennes. L'accès universel aux services médicaux de base est fourni à toute la population. Ces services sont le plus souvent gratuits pour le consommateur et financés selon un modèle d'assurance-santé obligatoire basé sur la solidarité et opérationnel depuis 1997.

Depuis le 1er janvier de cette année des contributions spéciales de santé à hauteur de 6% remplacent les allocations prélevées sur les impôts. Ces changements signifient qu'environ 75% de l'assurance-santé obligatoire seront générés par les contributions d'assurance-santé (HIC) et 25% par le budget de l'état et d'autres sources d'importance marginale.

L'augmentation relative de l'importance du HIC signifie que le système se rapproche du modèle Bismarck, même si certaines différences demeurent.

Même si on prend en compte que le tiers payant basé sur le tarif de référence est courant pour les médicaments et autres produits médicaux, la limitation de ce tiers payant débouche sur une absence virtuelle de formes complémentaires d'assurance-santé. A l'automne 2008 le gouvernement a opté pour l'adoption nationale de comptes d'épargne médicaux (medical savings accounts) soutenus par des avantages fiscaux, mais pour l'instant cette décision n'est encore qu'une déclaration politique.

En 2003 le gouvernement lituanien a adopté une résolution sur la stratégie de restructuration des établissements de santé. Deux phases ont été prévues à cet effet, la première de 2003 à 2005, et la seconde de 2006 à 2008.

Pendant le processus de restructuration, des unités spécialisées ont été fermées dans de nombreux hôpitaux municipaux et locaux et transférées dans des hôpitaux régionaux et universitaires.

En conséquence, le pays comptait 104 hôpitaux (à statut légal) fin 2006. Comparé à 2000, le nombre d'établissements a été réduit de 44%. Le taux d'hospitalisation a baissé progressivement entre 2000 et 2007 pour atteindre 20,2 lits pour 100 habitants, une réduction de plus de 10%.

Durant la même période, la durée moyenne de séjour a été réduite de 2,2 jours.

Dans le cadre des objectifs et tâches requis pour la seconde phase de la restructuration du secteur hospitaler résidentiel, des plans sont conçus pour faciliter l'infrastructure de consultation externe et de départements d'urgence et pour développer les services de revalidation externes, d'hôpital de jour et de chirurgie ambulatoire.

L'association des directeurs d'hôpitaux lituaniens a été créée en 1991. En 2004 l'association a évolué : elle a actualisé sa charte, s'est structurée en association en tant qu'entité juridique en ce qui concerne les directeurs, cadres supérieurs et membres honoraires. En 1996, pendant le congrès de l'AEDH à Tampere (Finlande), notre association a été acceptée en tant que membre de l'Association européenne des Directeurs d'Hôpitaux. L'association a pour mission d'unir ses membres pour des actions communes, de les rassembler autour de questions allant de l'amélioration de la performance des établissements de santé et de la qualité des services de santé, à l'amélioration de leur organisation et à la conception de la politique de santé en collaboration avec les instances officielles, ainsi qu'à la participation à des activités organisées par des institutions internationales.

Paul Castel

DER WANDEL IM GESUNDHEITSSYSTEM IN FRANKREICH

Das Gesundheitswesen in Frankreich ist, wie bei den europäischen Nachbarn, seit mehreren Jahren mit erheblichen Probleme konfrontiert. Diese äußern sich zwar in verschiedenen Formen, haben aber alle dieselben Ursprünge: Verknappung medizinischer Humanressourcen, starker Anstieg der Gesundheitskosten - gepaart mit erheblicher Haushaltsmittelverknappung, Schwierigkeiten, die notwendige Bürgernähe von Einrichtungen des Gesundheitswesens mit der Versorgungssicherheit in Einklang zu bringen. Das alles führte zu einer Konzentration von Behandlungszentren und zu Technologiezentrum. Nach seiner Wahl zum Präsidenten der Republik, kündigte Nicolas Sarkozy eine Neuorganisation für das französische Gesundheitswesen an. Parallel mit einer umfassenden Konsultation wurde den Krankenhäusern der Gesetzesentwurf Krankenhaus-Patienten-Gesundheit-Region vorgelegt.

Inspiriert durch Erfahrungen, welche in Europa in den letzten Jahren umgesetzt wurden, wird der Gesetzesentwurf im ersten Halbjahr 2009 vom französischen Parlament geprüft und sollte folgende Entwicklungen enthalten:

▸ In erster Linie bemüht sich der Gesetzesentwurf um eine Neudefinition des Begriffes des öffentlichen Dienstes in Krankenhäusern. Es sollen jene Aufgaben präzisiert werden, die von den Gesundheitseinrichtungen wahrgenommen werden – unabhängig, ob sie öffentlich oder privat sind. Das Ziel der Regierung ist es, sich allen Belastungen und Grenzen dieser Aufgaben des öffentlichen Dienstes anzunehmen, um damit eine höhere Effizienz des Systems zu gewährleisten.

▸ Die anderen Innovationen sind die Einführung des Begriffs "Gesundheitsgebiet" und die Schaffung von Gebietsverwaltungen von Krankenhäusern, mit fester Struktur für die Zusammenarbeit zwischen öffentlichen Einrichtungen im selben Gebiet. Jedoch behalten alle gleichzeitig ihre rechtliche Unabhängigkeit. Den Betrieben der selben Zone werden Anreize zur Schaffung gemeinsamer Strategien geliefert, um Humanressourcen zu teilen, ihre technischen Einrichtungen an einem Ort zu konzentrieren...

▸ Parallel zu dieser territorialen Ausrichtung werden ab Januar 2010 regionale Gesundheitsagenturen in Kraft treten. Diese werden mit mehr Aufgaben und Befugnissen ausgestattet als die bestehenden regionalen Krankenhausagenturen. Die Agenturen sind für die Festlegung und Umsetzung der Gesundheitspolitik einer Region zuständig, welche die Krankenhaus- und Gesundheitspolitik, die ambulanten Versorgung oder die medizinisch-soziale Politik umfasst. Seit vielen Jahren entwickeln diese Agenturen im Bereich des Krankenhauswesens und auch außerhalb ihre Zusammenarbeit weiter.

▸ Schließlich wird das neue Gesetz zu Innovationen beim internen Management von Gesundheitseinrichtungen führen: tiefgreifender Wandel der Entscheidungsträger in den Krankenhäusern, Stärkung der Befugnisse des Direktors, Stärkung der Rolle der medizinischen Geschäftsbereiche und ihrer Zuständigkeiten, aber auch neue Formen von Arbeitsverträgen zur Verbesserung der Attraktivität beruflicher Laufbahnen in Krankenhäusern und insbesondere die Verknüpfung der Vergütung mit der Leistung einzelner Akteure.

In diesem Kontext des Umbruchs ist es für die einzelnen Entscheidungsträger mehr als wichtig, zu beobachten, welche Maßnahmen Krankenhäuser in anderen Staaten zur Bewältigung der gleichen Problemen entwickeln. Das ist der Grund, weshalb die EVKD 2009 ihr Engagement auf der Suche nach Konvergenz zwischen den Akteuren im Krankenhauswesen in Europa verstärken wird. Schritt für Schritt soll so ein Europa mit einem starken und kohärenten Gesundheitssystem aufgebaut werden.

Gutes Neues Jahr 2009!

Paul Castel
EVKD-Präsident

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.

DÄNISCHE DELEGATION BESUCHT BRÜSSEL

Vergangenes Jahr beschloss unsere dänische Schwester-Organisation, das dänische „Selskab For Ledelse I Sundhedsvæsenet", ein internationales Sub-Komitee zu gründen. Das Ziel ist ein Erfahrungs- und Wissensaustausch mit der internationalen Gemeinschaft, das Verfolgen von internationalen Entwicklungen im Managementbereich des Gesundheitswesens und das Einbringen dänischer Erfahrungen im internationalen Kontext (siehe dazu *(E)Hospital* 2008/5).

Als Startsignal dazu reiste eine dänische Delegation mit 14 Teilnehmern vergangenen Dezember nach Brüssel, um verschiedene Besuche zu absolvieren. Auf dem Programm stand unter anderem ein Besuch im EU-Parlament bei der dänischen Europaabgeordneten Karin Rii-Jorgensen und ein Treffen mit der Europäischen Kommission. Und es gab auch ein Treffen mit der Ständigen Vertretung Dänemarks in Brüssel und vor allem mit den dänischen Regionalbüros.

Die EVKD begrüßte die Delegation - verbunden mit einem Besuch in der Klinik Saint-Jean – in ihren Büroräumlichkeiten im genannten Krankenhaus. Der Gruppe wurden nicht nur die Aktivitäten der Organisation nähergebracht, sondern auch die derzeit wichtigsten Politiken auf der europäischen Agenda. Der Entwurf der Richtlinie über Patientenrechte und grenzüberschreitende Pflegeversorgung bot die Möglichkeit über die Pflegequalität zu diskutieren. In diesem Zusammenhang wurde, wie beim EVKD-Seminar 2007, auch diskutiert, dass ein Akkreditierungsmodell zu mehr Qualität führen kann. Das Thema der Privatisierung und der Koexistenz von öffentlichen und privaten Stakeholdern in der europäischen Krankenhausszene stand auf der Agenda des Gesundheitswesens ganz oben. Dies wird auch beim das Hauptthema des EVKD-Seminars in diesem Jahr sein (siehe Tagesordnung). Dänische und europäische Visionen über Krankenhausführung wurden, im Licht der letzten Bankenkrise und stürmischen Beziehung zwischen Krankenhausmanagement und Bereitstellern, während des Treffens ausgetauscht.

Ehealth investment

Von Alexander Dobrev, Tom Jones und Karl A. Stroetmann

Die kürzlich fertiggestellte eHealth-Finanzierungsstudie stellt einen allgemeinen Leitfaden für künftige Investoren im eHealth-Bereich dar und liefert eine Unterstützung bei Entscheidungen über Finanzierungen. Der wichtigste Punkt der angebotenen Modelle ist die Integrierung der Investitionsentscheidungen im eHealth-Bereich in die Gesundheitswesenstrategie der Organisation.

EHealth kann Ergebnisse liefern, aber es muss auch als Bestandteil des allgemeinen Ressourcen betrachtet werden, die zur Bewältigung der Aufgaben bei der Gesundheitsfürsorge zur Verfügung stehen. Das Finanzierungsmodell für die Investition sollte nur nach einer wirtschaftlichen Analyse ausgeführt wird.

Die wichtigste Anforderung an die Direktoren, Führungskräfte und eHealth-Interessengruppen ist es, eHealth-Investitionen als einen integrierten Teil aller Investitionen zu behandeln. Vor allem Finanzführungskräfte und Manager haben hier eine spezifische Rolle.

Erstens sollte der Wert und die Auswirkungen von eHealth erkannt werden, sodass die Finanzplanung erweitert und entwickelt werden kann, um mit eHealth-Investitionen innerhalb übersehbarer Fristen arbeiten zu können. Zweitens müssen finanzielle Managementfähigkeiten entwickelt werden, um Investitionen mit einem besseren Kosten-Nutzen Verhältnis zu bekommen.

Rechtsaspekte von ICT in einem Krankenhaus

Von Jean Herveg

EHealth bezieht sich auf die Anwendung von Informations- und Kommunikationstechnologien im Gesundheitswesen. Es manifestiert sich durch eine breite Palette von Produkten und Dienstleistungen für den Krankenhausbereich:

Von der Verwaltung elektronischer Patientenakte oder Mitarbeiterdaten über den Einsatz von Video bzw. Behandlung mittels Video und bis hin zum Fernunterricht für Teile des Personals. Aus rechtlicher Sicht sind diese Anwendungen häufig durch Verordnungen hinsichtlich des Rechtes auf Achtung des Privatlebens und dem Umgang mit personenbezogenen Daten geregelt.

Aber auch andere Regelungen mussen betrachtet werden, je nach Betrachtungswinkel und Ansatz der Analyse. Diese beziehen sich auch auf Geräte, Gesetze betreffend Dienstleistungen, dem Krankenhaus-Haftungsrecht und Wettbewerbsregeln. Ein Großteil dieser Regeln und Vorschriften ist nicht spezifisch für den Krankenhausbereich oder für das Gesundheitswesen.

Patientensicherheit und eHealth

Von Susan Burnett

Bei der Verbesserung der Patientensicherheit ist es wichtig, sich ein Bild vom Wert der Systeme zu machen - hinsichtlich Prävention, Analyse und der Fähigkeit aus Fehlern zu lernen sowie dem Verständnis, dass menschliches Verhalten ein Teil des Systems ist, in dem Leute arbeiten.

In jeder Gesundheitsorganisation sollte bei Strategien bezüglich Informationstechnologien großer Wert auf Patientensicherheit gelegt werden. Und diese sollte bei den Systemen, die mit Technologie und Patientenversorgung verknüpft sind, von zentraler Bedeutung zu sein.

Zum Beispiel tauchen in der Personalabteilung diverse Fragen auf - bezüglich Personalausstattung und Zusammensetzung der Fähigkeiten zur Nutzung der neuen Systeme, Strategien über den Einsatz von Bediensteten auf Zeit, die möglicherweise nicht ausreichend ausgebildet sind, um die Anwendungen zu nutzen; aber auch die Weiterbildung und Befähigung für sowohl neue, als auch vorhandene Mitarbeiter bei der Nutzung der Technologie.

Viele Organisationen haben beispielsweise neue Klauseln in Arbeitsverträgen gegen den Missbrauch von IT eingeführt.

EHealth hat das Potenzial zu signifikanten Verbesserungen der Patientensicherheit, aber bringt auch neue Risiken mit sich. Krankenhausleitungen müssen ein Verständnis für die Theorie der menschlichen Fehler und Systemen haben und sicherstellen, dass sie über die erforderlichen Management-Systeme verfügen, damit umzugehen.

Forumclinic

Von I. Grau, J. Gene-Badia, E. Sanchez Freire, M. Bernardo und M. DeSemir

Forumclinic besteht aus einer Reihe von audiovisuellen Materialien (DVDs und Website) in Spanisch und Katalanisch, dass im Januar 2007 mit dem Ziel der Verbesserung der Lebensqualität von chronisch kranken Patienten gestartet wurde.

Basierend auf der Annahme, dass Patienten durch ein besseres Verständnis ihrer Krankheit autonomer werden, bezieht das Projekt die Patienten in die klinische Entscheidungsfindung mit ein. Daher wurden Monographien zu ischemischen Kardiografie, Diabetes, chronische obstruktive Lungen-Krankheit, Schizophrenie, Brustkrebs, Depression und Faktoren von Herz-Kreislauf-Risiko verfolgständigt.

Das Portal verbindet Inhalte von allgemeinen Interesse in einem Text- und Multimedia-Format. Der Herausgeber-Blog bietet eine unmittelbare Zwei-Wege-Interaktion mit der Öffentlichkeit. Vier Arten von Informationen werden bereitgestellt: Basisdaten zu jeder einzelnen Krankheit, jüngste Nachrichten im Zusammenhang mit der Krankheit, Videos und 3D-Animationen und professionell moderierte Diskussionsforen.

Konfrontiert mit immer weniger Personal im Gesundheitswesen

Von Bruno Marchal

In den vergangenen zehn Jahren haben mehrere europäische Länder politische Maßnahmen getroffen – das Ziel: Die Erhöhung des Zustroms in paramedizinische Berufe und die Erhaltung bestehender Kader, die Aquirierung von Krankenschwestern aus anderen Ländern, bessere Vergütungssysteme und die Einführung von flexibleren Arbeitsbedingungen.

Weit weniger wurde darüber geschrieben, wie Manager im Gesundheitswesen Praktiken zur Gewinnung und Erhaltung von Personal entwickeln können – die über bessere finanzielle Anreize und das Rekrutieren von Krankenhauspersonal aus dem Süden hinausgeht.

Im Wesentlichen besteht ein wirkungsvolles Management aus einem sich ergänzendenden Bündel von HRM-Praktiken. Pfeffer identifiziert sieben wesentliche Elemente:

- selektive Einstellung,
- Sicherheit der Beschäftigung,
- vergleichsweise hohe Entschädigung abhängig von der organisatorischen Leistung
- Aus-und Weiterbildung-smöglichkeiten
- selbstgeleitete Teams und Dezentralisierung,
- Verringerung der Status-Unterschiede, und
- Austausch von Informationen.

Die Auswirkungen von Auslagerungen auf das Krankenhauspersonal

Von Thilo Ullrich

Aus verschiedenen Gründen macht es oft mehr Sinn, bestimmte Krankenhaus-Funktionen nach außen zu verlagern, als diese Aufgaben durch das Krankenhaus auszuüben.

Solche Gründe sind: eine größere Flexibilität; die Fähigkeit professionelles Know-how hinzuzuziehen, die Wirkung von Synergien und Kooperationen oder die Annahme anderer Ausgleichssysteme.

Unabhängig der gewählten Methode, wird die Auslagerung von Dienstleistungen bzw. Teilen davon, Unternehmen in jedem Fall eine höhere Reihe von Beschäftigungs- und Arbeitsrechtsfragen bringen, einschließlich Bereiche der Übertragung von Geschäfts- und Mitbestimmungsrechte der Arbeitnehmer in Vertretungsorganisationen, d.h. Betriebsrat oder Personalrat.

Um festzustellen, welche Rechte den einzelnen Arbeitnehmer gewährt werden, ist es wichtig zu entscheiden, ob ein Auslagerungs-Vorschlag zu einer Übertragung von Unternehmensrechten führt.

Darüber hinaus müssen auch die Rechte des Betriebs- oder Personalrates mitbetrachtet werden, um zu verhindern, dass zeitliche Verzögerungen oder kostenintensive Ansprüche entstehen.

Änderung der Arbeitszeit des Pflegepersonals in der onkologischen Chirurgie

Von Anne-Marie Teller und Pascale Witz

Die Betreuung schwerer Fälle hat auch für das Personal schwere körperliche und psychische Folgen.

Das Pflegmanagement hat - im Einvernehmen mit der Geschäftsführung und der Abteilung für Humanressourcen - den Mitarbeiter die Möglichkeit angeboten, anstelle einer 8-Stunden-Schichten in einer 12-Stunden-Schichten zu arbeiten.

Im Bewusstsein der Besonderheiten, die sich aus der Änderung des Zeitplans ergeben, wurde der Wechsel auf freiwilliger Basis, mit einer Evaluierung nach drei und nach sechs Monaten, durchgeführt, um die beste Lösung zu finden. Eine sehr positive Resonanz kam von Patienten, die "ihre" Krankenschwester am ersten Tag bzw. innerhalb der ersten beiden Tage kennenlernten.

Die Arbeitsatmosphäre änderte sich: verschiedene Vorkommnisse machten die organisatorischen Auswirkungen untereinander und deren Zusammenhänge bewusst.

Sechs Monate nach dem Wechsel, erfolgte eine 40prozentiger Rückgang der Fehlzeiten aufgrund von Erkrankungen. Stunden, die für die Aus- und Weiterbildung zur Verfügung standen, wurden wieder zurückgefordert.

Anfragen für Transfers auf andere Abteilungen haben sich stabilisiert. Und Forderungen nach Ersatz für die 12-Stunden-Schichten wurden, wenn notwendig, von registrierten Krankenschwestern leichter ersetzt.

Und vor allem haben die Mitarbeiter selbst ihre Zufriedenheit über die Verbesserung ihrer Arbeitsumgebung zum Ausdruck gebracht.

Dual-Management auf Abteilungsebene

Von Josef Smolen, Gerda Sailer und Wilhelm Strmsek

Ein harmonisches und koordiniertes Dual-Managementsystem in Zusammenwirken mit anderen operativen Zentren erscheint für den Vorteil der Patientenpflege, -sicherheit und –zufriedenheit, sowie für den wirtschaftlichen Erfolg von größter Bedeutung.

Im Bereich des Dual-Management auf Abteilungsebene (Arzt und Krankenschwester) ist die Bedeutung der Rentabilität auf dem Vormarsch, ebenso wie die "soft skills" wie soziale Kompetenz und Konfliktlösung.

Hier gibt es nichts Neues, jedoch ist die optimale Zusammenarbeit zwischen den medizinischen Berufsgruppen, vor allem zwischen Krankenschwestern und Ärzten, unverzichtbar.

Im Wiener Krankenhausbetrieb wurden kürzlich Strukturen, Rahmenbedingungen und Leitlinien eingeführt, um gemeinsame Aktivitäten zwischen medizinischen Personal und Pflegebereich wirksam umzusetzen.

Der Rahmen für den Medizin- und Pflegebereich zielt auf die weitere Entwicklung und die Neudefinition der Qualität der medizinischen Dienste und Pflegedienste ab, sowie auf die Form der Zusammenarbeit zwischen den Berufsgruppen.

Sollten wir ein Onkologie-Management-System kaufen? Von Andrew Hoole und Edwin Claridge

Die Auswahl und die Integration der entsprechenden IT-Systeme ist eine der Herausforderungen für Krankenhaus-Manager in ihrem Streben nach einer Organisationen auf hohem Niveau der klinischen Versorgung, in Verbindung mit Effizienz und guter finanzieller und klinischer Governance .

Die Fragen werden vor allem dann schwierig, wenn "Top-down" Systeme, wie z.B. HER, HIS und PACS mit etablierten Systemen in Dienststellen in Berührung kommen.

Ein OMS (Onkologie-Management-System) ist zur Zeit eine kritische Komponente im täglichen Betrieb der Onkologie und eine potentiell reiche Datenressource für die Verwaltung, um größere Ziele zu erreichen.

Derzeit ist der Integrationslevel für z.B. die Anpassung von OMS-Elementen über R€V in HIS und/oder PACS noch nicht gänzlich entwickelt. Die erforderlichen Standards für die Definitionen des nationalen und internationalen Datenaustausch wurden bis jetzt noch nicht abgestimmt. Bei Ankauf einer OMS-Lösung sollten diese Punkte beachtet werden. Es ist auch wesentlich, sich aktiv in die Debatte über die zukünftige Beziehungen zwischen OMS, HIS und PACS einzubringen.

Fokus: Litauen

Während der letzten fünf Jahre hatte Litauen innerhalb der EU-Kandidaten- und Mitgliedsländer die höchste wirtschaftliche Wachstumsrate, die 2003 10,3 Prozent und 2007 8,9 Prozent erreichte.

Das Gesundheitswesen in Litauen ist nach den allgemeinen Basis-Prinzipien der europäischen Kulturen aufgebaut. Der allgemeine Zugang zur medizinsichen Grundversorgung ist für die gesamte Bevölkerung garantiert. Diese Dienste sind für die Konsumenten meist kostenfrei und hauptsächlich durch eine seit 1997 bestehende gesetzliche Krankenversicherung finanziert. Ab dem 1. Januar 2009 wird ein besonderer medizinischer Beitrag in Höhe einer Zuweisung von 6 % aus der allgemeinen Einkommensteuer ersetzen. Die Änderung bedeutet, dass etwa 75% der Einnahmen der gesetzlichen Krankenversicherung durch Beiträge der Krankenversicherung (HIC) und 25% durch Beiträge aus dem Staatshaushalt und aus anderen Quellen von untergeordneter Bedeutung finanziert werden.

Die relative Zunahme der Bedeutung der HIC bedeutet, dass das System sich dem Bismarck Modell annähert, aber gewisse Unterschiede bestehen bleiben.

Trotz der Tatsache, dass auf Grundlage von Referenzbeträgen Beiträge für Arzneimittel und andere medizinische Produkte zu leisten sind, liefern die Beiträge keine praktischen Ergebnisse für die Krankenversicherung.

Im Herbst 2008 wird die Regierung die nationale Umsetzung von medizinischen Sparkonten mit steuerlichen Subventionen vorschlagen, aber diese Entscheidung ist nach wie vor nur eine politische Erklärung.

2003 hat die Regierung von Litauen eine Resolution über die Strategie der Umstrukturierung von Einrichtungen des Gesundheitswesens angenommen. Zwei Zeitphasen waren für die Umstrukturierung der medizinischen Einrichtungen vorgesehen: der erste Zeitraum von 2003-2005 und der zweite von 2006-2008.

Während der Umstrukturierung wurden spezialisierte Einheiten in vielen kommunalen und regionalen Krankenhäusern geschlossen und Spezialaufgaben auf spezialisierte Abschnitte der Bezirks - und Universitätskliniken verlagert.

So zählte das Land bis zum Ende des Jahres 2006 nur 104 Krankenhäuser mit einem rechtlichen Status. Verglichen mit 2000 fiel die Zahl der stationären Einrichtungen um 44,4%.

Die Aufnahmen in den Krankenhäusern gingen von 2000 bis 2007 schrittweise zurück und erreichte 20,3 Betten pro 100 Einwohner, eine Senkung von mehr als 10%.

Im Rahmen der Ziele und Aufgaben, die in der zweiten Phase der Umstrukturierung des stationären Bereichs erforderlich waren, gab es Pläne zur Förderung der Infrastruktur der beratenden ambulanten Einrichtungen und

Der Verband der Krankenhaus-Manager Litauens wurde 1991 gegründet. Im Jahr 2004 entwickelte sich der Verein: seine Charta wurde geändert und ein Verband als juristische Person gegründet, deren Manager leitende Mitarbeiter im Gesundheitswesen und Ehrenmitglieder sind.

1996, während des EVKD-Kongresses in Tampere (Finnland), wurde der Verein als Mitglied der Europäischen Vereinigung der Krankenhaus-Manager anerkannt.

Der Verein hat die Aufgabe, die Mitglieder für die gemeinsamen Maßnahmen zu vereinen und in bestimmten Fragen zu koordinieren: der Neuordnung und Verbesserung der Leistungsfähigkeit der Einrichtungen des Gesundheitswesens, der Verbesserung der Qualität der medizinischen Versorgung, der Verbesserung ihrer Organisation, der Gestaltung der Gesundheitspolitik in Zusammenarbeit mit amtlichen Stellen oder der Teilnahme an Aktivitäten der internationalen Institutionen und Organisationen.

March

ECR 2009 European Congress of Radiology, 6–10
Villach, Austria
www.myesr.org/cms/website.php

International Forum on Quality and Safety in Healthcare, 17–20
Berlin, Germany
www.internationalforum.bmj.com

April

Improving Care Through Patient Centered Environments, 1–2
Dublin, Ireland
www.healthcare-ireland.com

Medetel, 1–3
Luxembourg
www.medetel.lu

HIMSS Healthcare Information & Management Systems Society Annual Conference and Exhibition, 4–8
Chicago, USA
www.himssconference.org

6th Annual World Health Care Congress, 14–16
Washington, USA
www.worldcongress.com/events/HR09000

12th World Congress on Public Health, 27–1
Istanbul, Turkey
www.worldpublichealth2009.org

May

52th Hospital Management Congress of the Upper Austrian Association of Hospital Managers, 4–6
Linz, Austria
www.ovkd.at/ooe/kongress.htm

17th International Conference on Health Promoting Hospitals and Health Services (HPH) Hersonissos, 6–8
Creta, Greece
www.univie.ac.at/hph/crete2009

5th Annual World Health Care Congress Europe 13–14
Brussels, Belgium
www.worldcongress.com/events/HR09015/index.cfm?confCode=HR09015

IHM Annual Conference 14–15
Management for Quality Improvement
London, UK
www.healthcare-events.co.uk

ECCMID, 19th European Congress of Clinical Microbiology and Infection Diseases, 16–19
Helsinki, Finland
www.congrex.ch/eccmid2009

European Congress on Health Information Systems, 26–28
Paris, France
www.health-it.fr

June

16 Congreso Nacional de Hospitales Extremadura 2009, 2–5
Caceres, Spain
www.16congresohospitales.org

EAES 17th Congress of the European Association for Endoscopic Surgery, 17–20
Prague, Czech Republic
www.congresses.eaes-eur.org

MCC Health World 2009, 22–24
Aachen, Germany
www.health-world.info

Top Clinica, 24–26
Stuttgart, Germany
cms.messe-stuttgart.de/cms/index.php?id=35437

NI2009 10th International Congress on Nursing Informatics, 28–1
Helsinki, Finland
www.ni2009.org

September

34th Multidisciplinary Congress of ESMO, the European Society for Medical Oncology, 20–24
Berlin, Germany
www.esmo.org/events/berlin-2009-congress.html

October

11th European Health Forum «Creating a better future for health in Europe», 1–4
Gastein, Austria
www.ehfg.org

November

Medica 2009, 18–21
Düsseldorf, Germany
www.medica.de

EAHM Seminar «Towards a balanced cooperation of public and private actors», 19
Düsseldorf, Germany
www.eahm.eu.org

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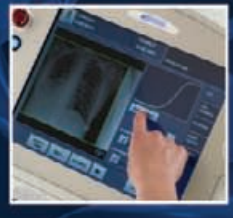

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