

SAFETY

- for patients and staff

SPECIAL: PSYCHIATRIC CARE TODAY



PLUS

- The importance of social interaction for nursing staff
- Hospital-acquired infections
- Focus: Portugal

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THE CHALLENGE OF CHANGE

With the evolution of the European Union, we are witnessing a parallel, multidimensional process of structural change which has impeded the creation of a shared Europe. The failure of efforts to establish a European constitution and mounting scepticism among citizens about the direction in which the Union is moving are symptomatic of this trend. Structural changes stemming from globalisation and the enlargement of the EU to the east are the underlying reason for public dissatisfaction. Workers and skilled employees are being displaced across the Union as a result of the different economic fortunes of Member States and the ageing of the workforce.

It is appropriate, therefore, in this era of structural adjustment to review the workings of the European Union, while safeguarding the necessary advances proposed in the Constitution. It must be possible to streamline the text and facilitate more effective decision-making in the EU. Europe's external political profile must also be significantly enhanced, albeit in a manner that does not compromise the identity of the Member States.

The process of change poses a major challenge for the European Union and its Member States. While we should not dismiss the risks involved, where there are risks there are also opportunities. We must accept change and take a proactive role in

creating a viable Europe, one which responds to changing circumstances.

The process of change is closely linked to the delivery of health services in European countries. Demographic developments place considerable pressure on solidarity-based social insurance systems, while offering medicine an opportunity to overcome the challenges of ageing. As people grow older, maintaining good health and mobility becomes increasingly important. For this reason, it is vital that the focus of medicine shifts towards preventive and curative measures to treat citizens and chronic diseases. The expansion of healthcare and growing innovation in the sector will also stimulate economic growth in Europe and its constituent parts.

Hospitals will have a special role to play in these developments, given their role, in partnership with industry, in fostering medical innovation. Moreover, they will be a crucial element in achieving progress towards integrated healthcare and the provision of services across the healthcare spectrum. Hospital managers have confronted this challenge by helping to shape change in hospitals and elsewhere. They work in their national associations to create the conditions that will ensure success in the future. The European dimension is also crucial. Most national associations of hospital managers (currently 26) have banded together in the EAHM to

meet the challenges confronting them and to develop and implement common strategies at European level.

(E-)Hospital, too, must adapt. The decision has been taken to cease publishing three distinct language versions. The

decision was taken for economic reasons and will deliver greater efficiency and afford the *(E-)Hospital* team an opportunity to streamline our work on behalf of the EAHM. The EAHM (the Board, Executive Committee and Editorial Board) has agreed a new direction with the publisher and editorial staff.

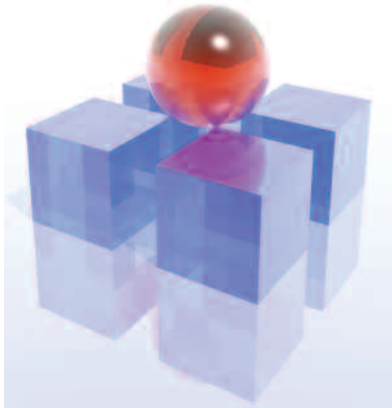
The printed edition of *(E-)Hospital* will appear primarily in English, although abstracts of specialist articles, the editorial column and the EAHM news will continue to be published in English, German and French. Published articles will be made available as PDF files online in the original language of the author. The EAHM and *(E-)Hospital* ask readers for their understanding and call on national associations to support our new policy. ■

Heinz Kølking
Vice-President EAHM

Willy Heuschen



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



SAFETY

Safety of patients and staff is a constant pre-occupation of all hospital managers. Our focus approaches this theme from several angles: from a systemic approach, with an overview of an anonymous error-notification system; then logistical, with an analysis of needlestick injuries, and models which help avoid these injuries and the ensuing costs. Safety is also becoming an issue at the European level, with the attempted harmonisation of medical device reprocessing. Finally, Dr. Anjali, of the Center for Health Design, examines the concept of architecture which enhances patient safety by reducing hospital-acquired infections.

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MENTAL HEALTH

Psychiatric hospitals and mental health organisations have specific requirements, which make them difficult to compare with acute hospitals. Yet the challenges they face are sometimes similar, as revealed in the special focus in this issue. We wanted to highlight these circumstances: firstly with an article from Norway which envisages integrated care from the point of view of mental health, and underlines the importance of prevention and informing the public. Next, from an architectural approach, with the Queen Mary Hospital of Roehampton (United Kingdom), where the interior and exterior were conceived with the well-being and safety of the patient in mind.

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FOCUS: PORTUGAL

The Portuguese health system faces the structural problems common to numerous member states: coordination between primary and secondary care; a critical lack of nurses; management of waiting lists; and implementation of real equality of care when faced with astronomical private healthcare spending. The Portuguese government has adopted a creative approach to these problems and has developed new forms of management and partnership, for example by the concept of hospitals S.A., envisaged as public corporations.

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MEETING OF THE BOARD OF THE EAHM IN KRAKOW (POLAND)

The first meeting of the year of the EAHM Board took place at the beginning of June in Krakow, in Poland.

The delegates were happy, not only to be able to admire this magnificent town in fine weather, but also to participate in the festivities of its 750th anniversary. On 5 June 1257, Krakow's Act of Location was declared. The foundation of the town took place in 1257, after it was destroyed by a Mongol invasion in 1241. The festivities consisted of many free open-air and indoor shows.

The Polish member of the Board, Professor Mieczyslaw Pasowicz, also celebrated an anniversary: his hospital, the John Paul II Hospital celebrated 90 years of existence and the 10-year anniversary of the visit of Pope John Paul II.

On this occasion, Asger Hansen, a Board member and former President of the EAHM, as well as Willy Heuschen, the Secretary General, who were closely associated with the founding and integration of the Polish Association of Hospital Managers, were honoured.

Numerous members of the Board took part in these colourful events after the end of the meeting.

During the Board meeting, the President Paul Castel, as he announced after his election in August 2006, presented his work programme and the activities accomplished. He also outlined the future of the EAHM.

The organisation of a seminar in 2007 (see announcement on page 5), the establishment of an official position at the beginning of the year in relation to the plan of action of the Commission on healthcare, and an eventual project of collaboration with hospital IT managers in Europe which is currently being studied was also communicated to the Board members.

Furthermore, Paul Castel announced, following the official position and in connection with other responses to the consultation and to the activities of the European Parliament, that he will prepare another communication, in which the EAHM underlined once more the reasons for the necessity for European standards for quality in healthcare, and will plead for a European model of accreditation for healthcare establishments.

Following this new communication and the November seminar, Paul Castel made contact with the French health ministry, as France will take over the presidency of the Council of Europe in July 2008. The aim of the EAHM is to promote the theme of quality management and methods for evaluating quality, and to make it part of the programme of the French presidency.

Mr. Castel then announced the "Hospital IT Managers Work Group".

At the beginning of the year, the Board took part in a meeting with the *Groupement pour la Modernisation du Système d'Information Hospitalier* ('Group for the Modernisation of Hospital Infor-

mation Systems'), GMSIH.

The GMSIH is a French public-interest group, which is a legal entity and is linked to the hospital association. The aim is to encourage hospitals to cooperate in the IT domain. Its sixteen collaborators support the hospitals of the GMSIH and their IT projects by managing projects, making written recommendations on IT management, performance, etc. The management of change of IT administrators, aimed at improving their activities, is another one of their priorities.

Since the hospital IT suppliers have already established structures on a European level, and since European standardisation is in progress, this French group is of the opinion that a real need exists to unite users in order to define the specific interests of hospital IT managers throughout Europe. They therefore proposed to the EAHM to establish a working group, which, though regular trimestrial meetings, will define the common interests, exchange experience and give input to hospital managers. The members of the Board are requested at this moment to share their views on this project by means of a brief questionnaire.

CONFIRMATION OF WILLY HEUSCHEN AS SECRETARY GENERAL OF THE EAHM

The Board had to decide in Krakow on naming a Secretary General for 2008. Willy Heuschen (Belgium) was confirmed in his post, and his candidacy accepted unanimously. Willy Heuschen has occupied this post since 1997. His background: since



ASSOCIATION EUROPÉENNE DES DIRECTEURS D'HÔPITAUX
EUROPAISCHE VEREINIGUNG DER KRANKENHAUSDIREKTOREN
EUROPEAN ASSOCIATION OF HOSPITAL MANAGERS

First Seminar Announcement

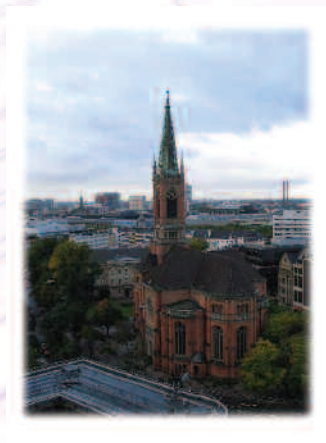
The European Association of Hospital Managers (EAHM) invites you to a seminar entitled:

“Quality Assessment Tools in Hospitals – Towards a European Accreditation System?”

The seminar will be held in conjunction with the EAHM General Assembly 2007 and German Hospital Day, both of which are taking place during the world’s largest medical trade fair, MEDICA.

16 November 2007
Messe Düsseldorf

The seminar is **FREE OF CHARGE** and will be held in German and English.



Seminar details:

The first keynote speaker will provide an overview of existing quality assessment methods and models used in European Member States and will highlight advantages and disadvantages.

Users of the various assessment systems will give clear insights into their experiences when implementing quality assessment tools in their health-care institutions.

Also invited is a speaker from the European Commission to talk about planned community action in the field healthcare services and especially EU plans in terms of quality assurance.

Finally, representatives from various existing assessment systems will have a round table debate and will be answering questions from the public.

Join us in Düsseldorf!

To register: please email josvanlanduyt@eahm.eu.org or call at +32 2 733 69 01 for more details.
Pre-registration is required, limited space available.

1979, Willy Heuschen is the manager of Eupen Hospital, in the German-speaking region of Belgium. He participates in several Belgian consultative committees, e.g. the National Committee of Hospitals (“Comité national des hôpitaux”), and the Joint Committee of Doctors and Hospitals (“Commission paritaire des médecins et hôpitaux”).

THEME OF THE EAHM CONGRESS 2008

The theme of the next EAHM Congress 2008 will be: “New Leadership for New Challenges”. The Board and the Austrian delegation agreed on this central theme.

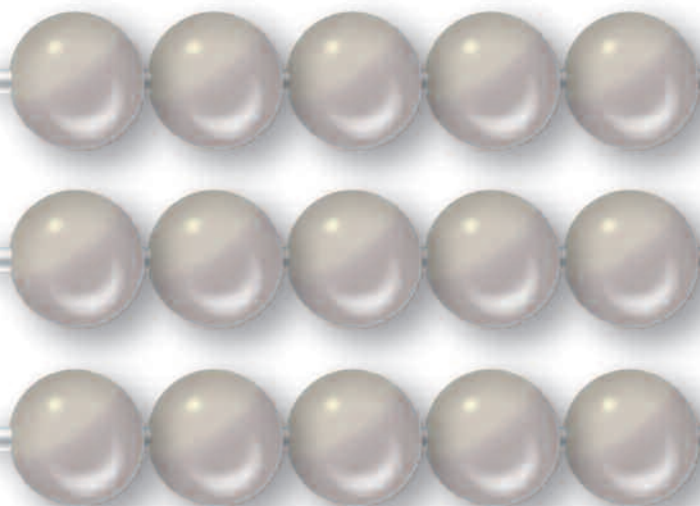
The subtitle is: “Hospital Management Meets Leadership”. For more information, consult the adjoining invitation to the Congress. The scientific programme summary will be communicated shortly on the website of the Congress: www.aedh-congrès2008.eu

PRESENCE OF THE EAHM AT INTERNATIONAL CONFERENCES

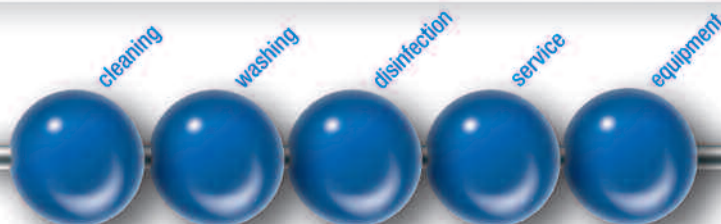
The EAHM was once again highly visible on the international scene in 2006 and 2007. The Secretary General, Willy Heuschen, represented the EAHM at the 9th European Health Forum in Bad Gastein, Austria, and delivered a presentation

on the theme of quality management and accreditation of healthcare establishments in Europe.

Willy Heuschen and Asger Hansen were both invited to the International Symposium for Prevention of Cardiovascular Diseases entitled “Imaging, Management & Clinical Research”, during which they both spoke of a European accreditation model, and the safety and mobility of the patient. The Vice-President, Heinz Kölking, represented the EAHM in March 2007 at the World Health Congress and spoke on the theme of the spirit of enterprise in hospitals. ■



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22 CONGRESS

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BOOK REVIEW: “TRENDS IN EU HEALTHCARE SYSTEMS”

Interview with the author Prof. Win De Gooijer

(E-)Hospital interviewed Prof. de Gooijer on the main findings of his book:

What are the implications of the changing social context for healthcare systems in the EU?

The neo-liberal course that the international political economy has taken since the beginning of the 1980s has negatively influenced social cohesion in the countries of the European Union. Governments withdrawing from the economic process, leaving social developments increasingly to the market, have created a society with a growing gap between “haves” and “have nots”. This development has also affected the healthcare systems of the countries of the EU. Although these systems are based on the idea of solidarity among all citizens, the neo-liberal course of the international political economy is slowly creating a “two classes medicine”.

Based on your findings, who do you believe decides on the production and consumption of healthcare goods and services?

In a democratic society where the production and consumption of goods and services are mainly a matter of private enterprise, governments have to tolerate, in principle, the produce of private initiatives. That also applies for the production and consumption of healthcare goods and services. However, governments can and do condition and correct, in this respect. As for



Win De Gooijer is a professor in the Department of Public Policy at Leiden University, the Netherlands, where he teaches a course on ‘Healthcare Systems in an International Perspective’. He has spent over 25 years in the healthcare industry, as General Manager of a psychiatric hospital, and as CEO of a foundation for care of the elderly. During his career in healthcare, he served on several governing and advisory boards in the Netherlands and the European Union.

Professor De Gooijer is the author of ‘Trends in EU Healthcare Systems’, a scholarly publication in which he likens the healthcare system to a pendulum that can be positioned and repositioned along a spectrum represented by a social solidarity model on the far left, and a market model on the far right. He advances compelling evidence that the pendulum has been moving further right since about 1980 and he views this trend as a cause for concern by all who believe that social solidarity should underpin entitlement to healthcare.

healthcare, one can think of quality regulations, capacity limitations, educational conditions, and licensing. It is important to know however, that governments can never be



completely absent in the process of the production and consumption of healthcare goods and services, because of constitutional obligations.

Do you believe there will one day be a universal EU healthcare system?

Healthcare systems of the EU countries are subject to the subsidiarity principle, which means that each member state is free to make its own arrangements. However, directives from Brussels have a spill-over effect as regards healthcare, which causes the subsidiarity principle to slowly erode. That, surely, will not lead to a universal EU healthcare system, because cultural differences

continued on page 15



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COMPARE YOUR ESTABLISHMENT WITH THE EUROPEAN COMPETITION!

Dear Hospital Managers,

Would you like to compare your establishment with others, in your country or elsewhere in Europe? Would you like to know what decision-making structures are like in neighbouring hospitals, how the purchasing procedure is organised, what information systems are already in place, in which area investment is taking place and what percentage of the budget is spent on average on medical technology equipment in European hospitals?

In other words:

Are you of the opinion that the existence of your establishment depends on the evolution of the market and that it can be useful to have an in-depth view right now?

If you share this conviction, we invite you to take part in a study on the mutual relations between hospital management and medical technology!

CONTEXT

The pressure which is being exerted throughout Europe on hospitals to transform themselves results firstly from the demographic evolution as well as the increasing demands linked to new medical technology. The question is therefore to know how hospitals can reach a high quality of service and constant improvement while maintaining increasing efficiency. In this context, the relation between the two essential players is all-important:

- hospitals and their management as service providers.
- the medical technology sector as initiator and sponsor of innovation.

In order to respond to the questions which emerge from this situation, Emergent Actio KG, in collaboration with *(E-)Hospital* are carrying out a survey on the theme of "The Interaction Between Hospital Management and Medical Technology".

MAIN POINTS OF THE STUDY

The study will examine two important points, in order to shed light on the interaction between hospital management and medical technology and to determine future reciprocal requirements.

1. On one hand, it involves discovering the evolution and trends in hospitals and hospital management in Europe.
2. On the other hand, it involves the question of the contribution to the hospital sector made by the medical technology sector, and the future demands which will follow from the evolution of healthcare and hospital management.

OBJECTIVES

The objective is to show the principle trends in hospital management in Europe in different areas:

- Orientation and strategic

adaption of hospitals of the principal European countries.

- Influence of European regulations on hospital management.
- Effects of the organisational structure of hospitals and the structural decisions on the structures themselves (who decides what?)
- Decision-making procedures (who decides on every purchase of medical technology and on what basis?)
- IT solutions for hospitals: the local value of IT, demands, technical and/or financial motivation for the acquisition of IT solutions, etc.

CONDITIONS OF PARTICIPATION, THANK-YOU PRESENT AND A PRIZE

The survey will start in this edition of *(E-)Hospital* and continues until 15 October.

The participation is done electronically and is rapid, simple and non-bureaucratic. Just a series of multiple-choice questions which are short and easy to complete.

Please find your password in the adjoining envelope and fill in the questionnaire on-line on: www.ea-survey.com/hospital in one of three available languages (French, German or English).

The on-line questionnaire will take approximately 15 minutes of your

time. The evaluation of this survey will take place anonymously and the results will be used exclusively for scientific purposes.

And don't forget: the participants in this survey will receive a thank-you present which will be sent to them by post, at the end of the survey.

The evaluation of the results and the summary of the findings of the survey will continue until Medica 2007, where the results will be presented in detail. Furthermore, a surprise is awaiting one of the participants, in the form of a prize. We will be delighted to meet you during the presentation of results and at the reception which will follow, in order

to discuss further and perhaps to congratulate you on your winning ticket!

**SOME ESSENTIAL POINTS
ON THE ADVANTAGES FOR YOU:**

The study will be beneficial for your day-to-day work, but also in view of the evolution of a lasting vision of the future of your establishment. Every participant will receive a summary of the results and the possibility to measure themselves against a European benchmark. Not only the individual results can serve as a basis for discussion in relation to governing bodies or other institutions, but they can also generate new ideas and impetus for the future direction of your establishment! The possibility is

there for you to keep a step ahead of the competition. Information is power!■

If you have questions, or require additional information, please contact:

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URL: www.emergent-actio.de

- ➔ Would you like to compare your establishment with others, in your country or elsewhere in Europe?
- ➔ Are you of the opinion that the existence of your establishment depends on the evolution of the market?

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PUBLIC HEALTH THREATS TODAY

From Rory Watson

The first epidemiological report from the European Centre for Disease Prevention and Control (ECDC) identifies antimicrobial resistance as the most serious public health threat facing Europe.

The Stockholm-based agency warns that “if the present rapid negative development is not halted, mankind will soon lose one of its most important weapons against infectious diseases”. It points out that every year, some three million people in the EU catch a healthcare-associated infection (HCAI), of whom 50,000 die, and that one patient in ten treated in EU hospitals acquires such an infection.

The report is based on national data from the 25 countries that were members of the EU in 2005 and from Norway, Iceland and Liechtenstein. Zsuzsanna Jakab, ECDC’s director, said that it would “give a major input to policy makers on where they need to invest in public health” particularly on diseases that easily cross borders and cannot be treated in one country alone.

In second place, after healthcare-associated infections, comes HIV infection. In 2005, just over 28,000 new cases were reported in the EU. Throughout the Union, there are now some 700,000 HIV-infected people – almost a third of whom are unaware they have the disease.

Other major threats are pneumococcal infections, especially among the young and the elderly; influenza – of both pandemic and seasonal varieties; tuberculosis, which was responsible for nearly 60,000 new cases in the EU in 2005; and Chlamydia infection and campylobacteriosis where

some 200,000 cases are reported annually.

However, given the challenges associated with antimicrobial resistance (AMR), the ECDC makes a special plea for more accurate reporting in a bid to establish a clearer picture of the phenomenon. The data that exist, it points out, suggest that the problem is less acute in northern Europe, notably Scandinavia and the Netherlands, and that only two countries – France and Slovenia – have been successful in significantly reducing the proportion of methicillin-resistant *Staphylococcus aureus* (MRSA).

The agency notes that the present EU surveillance networks are focused on a few key pathogens in a system that relies on voluntary reporting from a limited number of laboratories. Not only can this be incomplete, but it can fail to shed light on the big regional differences which may exist within countries.

It would like to see existing EU and national surveillance covering trends of resistance in major important pathogens extended into two other areas. The first would involve detection of outbreaks and the spread of different problem bacteria; the second would identify novel superstrains where each isolate requires immediate and forceful action.

The ECDC study also draws attention to a relatively recent development: the way in which a large number of diseases is being detected and monitored is changing. No longer do they emerge from a doctor’s diagnosis of a patient. Instead, they tend to be discovered, often by chance, as an unexpected finding in a medical

investigation or as part of a screening programme.

This shift leads the agency to offer more public policy advice. It is urging health authorities to raise the capabilities of their national laboratories to the same uniform level so that it becomes possible to draw an accurate epidemiological picture for the entire European Union.

The report also draws attention to the significant costs to health services of treating communicable diseases. In England, the process from consultation with a general practitioner to hospital admission for all communicable diseases can total £6 billion a year. In the Netherlands, the direct health service and wider indirect costs due to norovirus alone was estimated at 25 million in 2004.

In his foreword to the report, Markos Kyprianou, the EU Health Commissioner, acknowledges that for many of the 49 diseases examined by the ECDC, the 10-year trend in the EU is either stable or declining. But, he too defines the emergence of new microbes as “perhaps the biggest challenge” health authorities now face, especially as “our defences are weak, or even non-existent”.

He contrasts the high-profile attention which has been given to the threat of an influenza pandemic with the observation that “deadly new microbes can also emerge in less spectacular ways”. The European Commission, he pledged, will make support for measures to address healthcare-associated infections one of its priorities in the coming months. ■

EUROPEAN HEALTHCARE SERVICES PRESENT AT THE EUROPEAN PARLIAMENT AND COUNCIL

During an informal meeting in Aix-la-Chapelle in April, the Ministers of Health of the 27 member states reached an understanding with the Commission to regulate the healthcare services market in the European Union according to different measures. These will consist of regulations and other measures, for example guidelines.

The need for clarification concerns especially the question of reimbursement, as well as the responsibility for and the right to good quality healthcare, according to ministers. Moreover, it is essential to put in place the full conditions for patient information on the service offering and the quality of care.

In May, the European Parliament announced itself in favour of better information on patients and specialists, and for more legal security, as well as clear rules on responsibility. The bureaucratic obstacles must disappear, thanks to, for example, the promotion of electronic systems of identification of the patient, on-line healthcare and telemedicine. The members of the European Parliament want to guarantee patients access to the largest possible healthcare services in Europe.

The European deputies think that the safety and rights of patients are not guaranteed for the moment for cross-border healthcare. They asked for a precise definition of healthcare services, in order to clarify future legal rulings in the sector and to define unequivocally their domain of application. Furthermore, a European charter of patient rights must be adopted on the basis of the existing charter.

The members of the EU Parliament concluded by saying that close cooperation on all levels in the member states and in the EU could improve

healthcare systems considerably and make them more efficient.

The Commissioner for Health, Markos Kyprianou promised to put forward a proposition on regulation before the end of the year, which will take account of the national jurisdiction in matters of organisation and funding of healthcare systems, but also the rights of insurers and suppliers in relation to cross-border freedom of movement.

REIMBURSEMENT OF SERVICES OF PRIVATE, FOREIGN, HEALTHCARE PROVIDERS AND NON-NATIONALS

In the ruling of 19 April 2007 (C-444/05), the European Court of Justice in Luxembourg decided that the absolute exclusion of reimbursement for a hospital treatment received in a foreign country violated the rights of the community. A system of prior approval, with the adoption of a table of reimbursement, would allow better adherence to the fundamental rights of the community, according to the judges. The case concerned a Greek patient who went to the United Kingdom for two hospital treatments. Reimbursement for the costs of these treatments was refused on the grounds that, according to Greek law, the cost of hospital treatments in a private, foreign clinic is not reimbursable, unless it concerns a child of under 14 years old.

For the Court, it was clear that such a rule discouraged the patient from enquiring about hospital service providers in other Member States other than that of which he/she is a member and that therefore represents a restriction of free circulation of services. There was no objection to this.

ECJ DEFINES EMPLOYER OBLIGATIONS FOR THE PROTECTION OF EMPLOYEES

In a ruling of 14 June 2007 (C-127/05), the European Court of Justice decided that the regulations in

place in Great Britain for the protection of workers (Health and Safety at Work Act 1974) are legal. The law included a clause according to which every employer must care about the safety, health and well-being of workers at work, "in as much as that is possible in practice".

The directive 89/391/EEC on safety and health of workers obliges the employer to ensure the safety and health of the worker in all areas of work.

According to the European Commission, the British exception rule was too lax. The British legal conditions offer the possibility to employers to liberate themselves of their responsibilities if they can prove that the measures to guarantee the safety and health protection, compared to the cost, time and other difficulties, are completely disproportionate in relation to the risk incurred.

The decision of the judges did however follow the British explanations, according to which the Commission did not indicate in a strictly judicial fashion that this clause limited the responsibility of the employer in ignoring the provisions of the directive.

The Commission explained in this regard that the directive established the responsibility of the employer independently of any fault. According to the judges, such an interpretation of the directive is not sustained either by its wording, the preparatory work, or its classification. (HH) ¹⁰

GERMANY

Hospitals compare therapeutic results

The latest edition of the report on the quality of German hospitals reveals profound changes: the latest edition shows for the first time the data resulting from the guarantee of external quality for every hospital. In future, hospitals will present the quality of specific treatments in relation to other establishments and will deliver important information to patients and referring doctors.

Furthermore, the hospitals will use more than 200 quality indicators and will display their status in relation to the federal level. It will be obligatory to publish 27 quality indicators. The publication of supplementary indicators will be left to the discretion of the hospital.

With the appearance of reports, the patients can look on the internet sites of insurers or hospitals, and compare their local healthcare establishment to other hospitals in the country in the areas of:

- gall-bladder removal
- obstetrics
- pacemaker implantation
- hip or knee replacement (primary-implantation)
- coronary or thoracic surgery.

It is however necessary to carefully discuss this information with the referring doctor in order to put it in context.

SPAIN

Translation services

The Andalusian health service has launched a new distance translation service to help foreign patients.

The Spanish health services have many enquiries from foreign patients: the town of Alicante, for example, just revealed that 17,345 foreigners were hospitalised in the province in 2006, mostly for surgical interventions. Apart from emergen-

cies such as falls or appendicitis, most foreign patients, mainly British, German, Danish and Dutch, were operated on for the heart or hips.

The new method of translation consists of a telephone service where doctors and patients can talk in real time via a translator. The service is offered in English, French, Arab, German and Romanian, and is available every day of the year, 24 hours a day. This idea is the result of a shortage of translators, who often served as volunteers in the hospitals of the region.

FRANCE

New Minister of Health

Roselyne Bachelot was named Minister of Health by the new French president, Nicolas Sarkozy. She was already Minister for the Environment in the previous government.

Since taking her place, Madame Bachelot has announced that she wants to 'push forward' in the restructuring of certain activities, in particular surgery and obstetrics in public hospitals. She wants to regroup these practices in order to guarantee "excellence and quality". The minister also defined an objective of 15,000 home medical care places to be attained by 2010 compared to 8,000 now.

UK

HealthExecTV

HealthExecTV is the on-line television channel for managers and professionals across the National Health Service.

The channel and its programmes are designed for all those responsible for the management and delivery of all aspects of healthcare services. HealthExecTV is produced by GBTV in association with the Institute of Healthcare Management and other leading representative bod-

ies of healthcare professionals. These bodies provide editorial direction ensuring that the channel covers the issues and subject matter critical to IHM (Institute of Healthcare Management) members, managers and professionals across the health services community.

The channel assists health managers in keeping abreast of the rapidly changing health services environment and the increasing breadth of demands placed upon them as individuals.

For more information, refer to: www.healthexec.tv

IRELAND

HMI Responds to MRSA Challenge

The HMI (Health Management Institute of Ireland) fully accepts that the task of minimising the incidence of MRSA, in hospitals and other residential care settings, is a shared responsibility of all staff. It is true that staff who deal directly with sick patients can, by adopting safe practices, make a greater contribution than those who are less directly involved in patient care. Safe practice is more likely to occur where safe systems are in place and it is in relation to safe systems that managers can contribute most.

The report of the first National Hygiene Audit set out in paragraph 11.2 the role of managers in implementing and monitoring national policies, procedures and standards. In response to that report the institute commissioned an e-learning resource, entitled 'Challenging MRSA', which has been providing staff with an understanding of the MRSA 'superbug' and enabling them to follow the hygiene procedures required to minimise transmission of the infection.

Details of the e-learning resource are available at www.hmi.ie/elearningresources.htm. ■



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continued from page 8

between member states are far too large. Nevertheless, there are several aspects of healthcare, which do not affect the subsidiarity principle. Here, one can think of matters like technology assessment, clinical guidelines, and quality regulations. They could easily be transferred to Brussels. I believe this will happen.

Do you feel that EU countries have succeeded in achieving the threefold objectives of their reform methods, i.e., improving quality, containing costs, and maintaining equal access?

The answer is unrestrictedly negative. We don't know if all the money which has been spent on quality improvement has led to better outcomes. Furthermore, we don't live up to our promise of equal access, and cost containment measures have had an only temporary subduing effect. Healthcare has its own dynamics, which are very difficult to control in democracies.

In your opinion, how can hospital management contribute to the positive development of healthcare?

The primary objective for hospital managers always has been and should be to convince doctors that it is of utmost importance to pursue efficiency and effectiveness in healthcare delivery. After all, the bulk of healthcare is financed with public money. It is a moral and ethical obligation to spend that money responsibly.

In the short term, what will be the major changes in healthcare in the future?

In the framework of the present-day international political economy, one may expect a growing importance of the market for healthcare. Those who cannot play that market game will depend on an increasingly limited healthcare safety net provided by the government. Personally, I would favour a more social international political economy. There are some signs which point in such a direction. It is too early however to say that these are a prelude to major changes in the international political economy. ■

Win de Gooijer: Trends in EU Health Care Systems, Springer, New York, 2007

REPORTING – THE FIRST STEP TOWARDS IMPROVEMENT

The St. Gallen CIRS in the Meldeportal®: A successful error-reporting system in healthcare

By Dr. Norbert Rose

SWISS CHEESE MODEL OF SYSTEM FAILURE

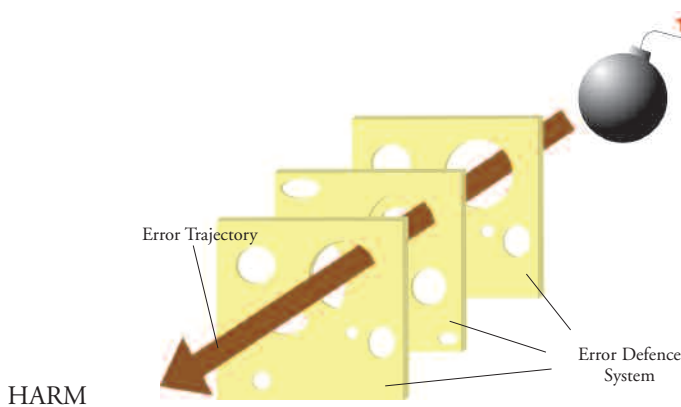


Figure 1.

Critical incidents and adverse patient episodes caused by avoidable and deficient processes or decisions are a daily occurrence in hospitals and other health-care institutions. Doctors, nurses and other health professionals agree that everyone must learn from dangerous events to enable them to prevent their reoccurrence in the future. The question, however, is how this can be done.

ERROR THEORY

The overriding objective must be to continuously reduce the number of catalysts and preconditions for errors or accidents, thereby precluding them from triggering an unsafe act. Studies in error theory show that the majority of accidents or errors occur when a series of failures take place in sequence (see Figure 1). As the possibility of an unsafe episode increases, so too does the likelihood of a manifest critical incident. By continuously assessing errors, it becomes possible to reduce the number of catalysts for errors and accidents and the frequency of critical incidents.

CIRS SINCE 2002, CANTONAL HOSPITAL ST. GALLEN, SWITZERLAND

Reporting systems such as the CIRS in St. Gallen Hospital provide an effective and appropriate tool for systematically developing improvement measures drawing on the information gleaned from events which had the potential to harm patients. Using a snowball system, the Cantonal Hospital St. Gallen has, since 2002, introduced 24 reporting groups throughout the hospital group (St. Gallen Cantonal Hospital, Rorschach Hospital and Flawil Hospital).

Since the introduction of the system, the number of reported CIRS events has doubled from 596 to 1,200 per annum. Increased reporting is not due to greater risk-taking in the hospital. On the contrary, as analyses have shown, growing confidence in the reporting mechanism has resulted in more staff using the system. The new culture of safety in the hospital is underpinned by a multi-professional and interdisciplinary conceptual approach, which is conspicuous in the manner in which CIRS reports are jointly discussed and reviewed by nursing and medical practitioners in all three hospitals using the St. Gallen CIRS (Figure 2).

FOUR CORE FEATURES OF THE ST. GALLEN CIRS

The introduction of a reporting system causes concerns among staff – some of which are tacit while others are explicit – that it will result in the imposition of legal or internal sanctions. These reservations, which were expressed in equal measure by medical and nursing staff, can be address-

FOUR CORE CHARACTERISTICS OF THE ST. GALLEN CIRS

- Guarantee of complete anonymity.
- Episodes resulting in harm to patients are not reported in the CIRS.
- The “three-minute” form.
- A culture of safety based on promoting a multi-professional, interdisciplinary approach.

CRITICAL SUCCESS FACTORS OF A CIRS

DEFICIT	SUCCESS FACTOR
Null Statement	➔ Make management decisions
Interdisciplinary apportioning of blame	➔ Build a safety culture (management)
All types of reports	➔ Don't report episodes of patient harm
Fear of legal repercussions	➔ Inform, develop a data protection policy
Reporting group too small/large	➔ 40 – 250 participants is adequate
Administrative expense	➔ The “3 minute form”
Anonymity not guaranteed	➔ Create confidence in CIRS officers and system
Lack of staff participation	➔ Carry out institutionalised CIRS discussions

Figure 3: N. Rose, 2005

sed by giving a guarantee that reports will be made in confidence and that incidents of harm to patients are not reported on the CIRS.

The hospital must minimise the technical and formal obstacles facing those who wish to file a report. Difficulty accessing report forms will deter staff who will most probably forget the matter and return to their core activity. The St.Gallen “three-minute form” can be easily downloaded from the Intranet in just two clicks of the mouse. The volume of information required on a form impacts on the user-friendliness of a reporting system. Forms requiring more than 100 separate fields to be filled in have a deterrent effect which results in low reporting levels. The three-minute form used in St. Gallen is successful precisely because it requires only a small number of key fields to be filled.

The use of a CIRS allows some of those working in the hospital to realise that errors are caused by everyone involved in the investigation, treatment and care processes. Errors are pervasive in all parts of the organisational hierarchy and in all professions and disciplines and no one is better or worse than others in terms of making errors. Medical and care staff from all disciplines examine reported incidents with a view to finding solutions. Grounded in multi-professional, interdisciplinary approaches, this safety culture is an indispensable feature of the modern CIRS.

CIRS IN HOSPITAL

The experience of St.Gallen demonstrates the benefits of establishing a reporting system in a hospital or hospital group. The vast majority of reports

relate to investigation, treatment and care processes in the hospital, clinic or discipline in question. Detailed knowledge of local conditions is, therefore, required to evaluate improvement measures.

As a reporting system underpinned by a functioning error culture becomes more established, the willingness to report serious incidents grows. Confidence in the system is also influenced by the profile of those responsible for the CIRS. The number of reports will increase if the person or persons receiving the reports on the CIRS system show sensitivity and social skills when performing the evaluation of the reports (Figure 3).

MELDEPORTAL®, A TOOL TO SAVE RESOURCES

Some of the reporting mechanisms in place in the German, Austrian and Swiss health systems are statutory systems (for instance, in the area of hae-

Name of Reporting System	Type of Reports
St. Gallen CIRS	Anonymous reporting system for critical incidents.
Haemovigilance	Reporting system for adverse effects before, during and after the administration of blood products (Swissmedic).
Material Vigilance	Reporting system for incidents with medical devices (Swissmedic).
Pharmacovigilance	Reporting system for adverse drug reactions.
Reporting Falls	Reporting system for all types of fall.
Personal Injury and Damage to Property	Reporting system for personal injuries and damage to property.
Notifiable Communicable Diseases	Reports to the Cantonal Chief Medical Officer and/or Federal Office of Public Health.

Figure 4: Reporting Systems in the Meldeportal®
Table by Dr. N. Rose, St. Gallen; CIRS



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CORE Captured the UK



As the pace of technology increases in all areas of society, surgeons face challenges common to all medical professions: how can we ensure we are offering the best possible technology and the best possible care to our patients, when we simply cannot afford to constantly upgrade our equipment? And how can we ensure that we are continuously educating ourselves, so we know what technology works best? Equipment has to move forward, while remaining highly functional and simple to operate.

The **CORE** Complete Operating Room Endoscopy system offered by Richard Wolf GmbH was created to help tackle these important issues. **CORE** is designed to provide a simple solution for surgeons and increase efficiency amongst the surgical staff, by offering an all-in-one operating system for laparoscopic surgery.



Dr. Bruce Jaffray

Mr. Bruce Jaffray is a Senior Surgeon at The Royal Victoria Infirmary in Newcastle, UK. Although Mr. Jaffray originally started

as a general surgeon, he switched to pediatric surgery because he finds long-term outcomes for children in pediatrics more positive: *"In general, I prefer children as patients because their recovery times are quicker and prospects for their long-term health after surgery are more optimistic"*. He has a unique expertise in pediatric laparoscopic surgery, and introduced it to his hospital.

Laparoscopic surgery was developed solely for adults and Mr. Jaffray believes that explains the initial resistance to using minimally invasive surgical procedures on children. However, clinical trials

revealed impressive results: children got the same benefits from minimally invasive surgery vs. traditional open operations as adults did. They went home more quickly, less morphine was required after surgery, and fewer complications arose.

Because of these positive results, Mr. Jaffray predicts a leap in demand for laparoscopy applications in children. Surgeons are also experiencing increasing parental pressure for the technology: using laparoscopy means shorter hospital stays and increased efficiency amongst the surgical staff. Surgeons are becoming more experienced at performing single-stage operations on children, instead of staged operations - which require longer stays and have potential for more complications.

In 2006, Mr. Jaffray's hospital was donated a substantial grant by the hospital charity to buy a minimally invasive unit. The staff determined essential selection criteria and set image quality as the number one priority. A public tender was then called, and all major manufacturers were assessed. **CORE** was finally selected, since it clearly offers the best image quality.

Bespoke Operating Solution

Furthermore, the Richard Wolf team was able to integrate the hospital's existing equipment into the new system, which offered the staff a bespoke solution. The system was specifically tailored to their needs and precisely matched their requirements. After the equipment was installed, the after-service care provided by Richard Wolf quickly managed to iron out all snags.

Ergonomics and Safety Using Satellite LCD technology

According to Mr Jaffray, **CORE**'s biggest advantage

is that it makes complex procedures easier to perform. The screens are placed at a 360° angle from the operating table, so there is no need to move any equipment around. Everything is suspended from the ceiling, and there are no cables on the floor, which makes the operating room safer for the patient and staff. The equipment can also be moved for traditional open surgery when necessary, so the space is used as efficiently as possible. The system is ergonomically designed for the comfort of the surgical staff, so they can concentrate on the patient.

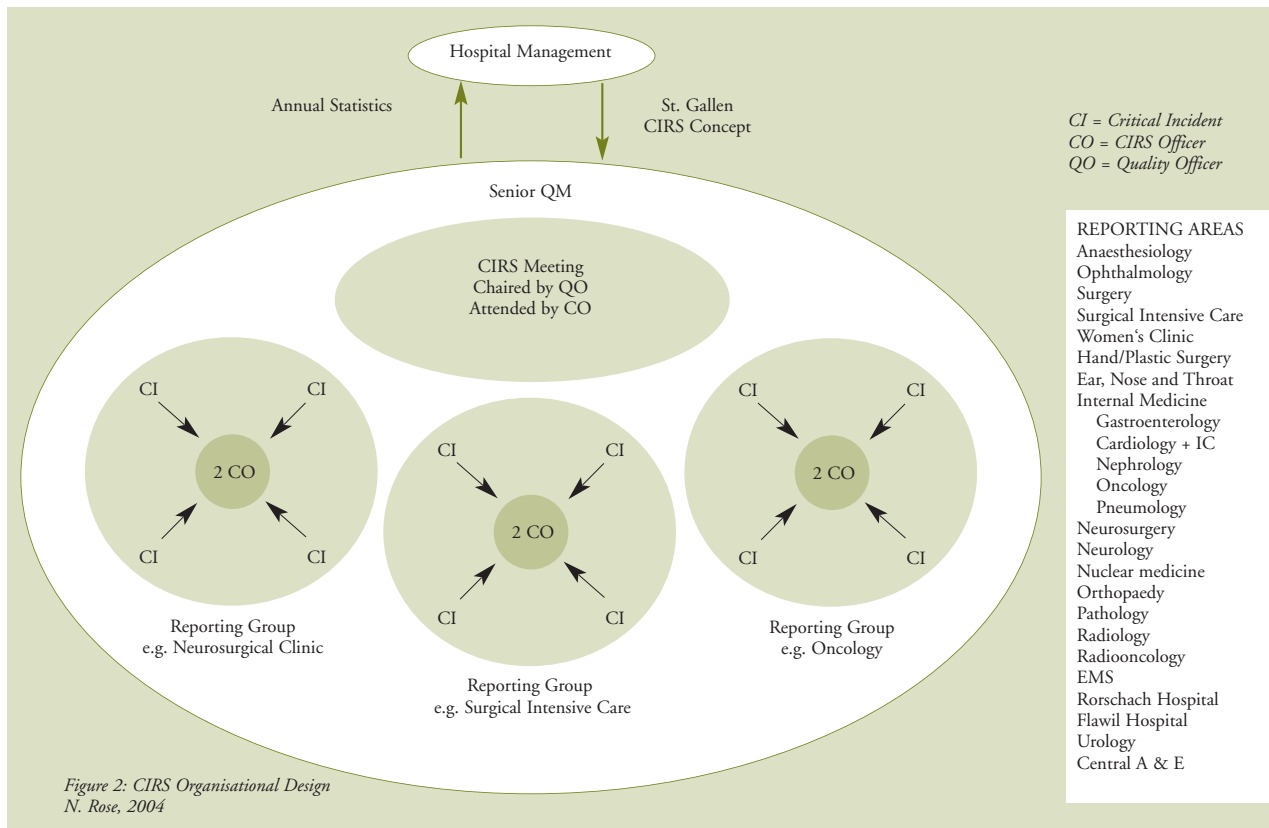
Tele-surgery

CORE also has a managerial dimension, by associating clinical governance to complex procedures. Surgeons have indeed a new way to share data and disseminate information. Traditionally, they were kept up-to-date via medical and surgical journals, but today can watch a new procedure in real-time, or watch a recognized expert perform an operation to help further increase their proficiency. Since **CORE** allows for video transmission in real-time via the hospital's intranet, and all procedures are automatically archived on a secure central server.

Overall, **CORE** has made Dr Jaffray's surgical life easier. It gives him excellent image quality, fits his needs perfectly and makes it more comfortable for him to perform complex operations. With **CORE**, Dr Jaffray actively contributes to twenty-first century pediatric surgery.



CANTONAL HOSPITAL ST. GALLEN 24 CIRS REPORTING GROUPS



movigilance), while others have different origins (for example, the reporting of falls). Reporting an incident must be simple and unproblematic for the person reporting. For instance, a person who wishes to make a report is unlikely to search for very long for a form on the Intranet or Internet. For this reason, the St. Gallen Cantonal Hospital decided to develop a single reporting portal known as Meldeportal® to provide all reporting systems, statutory and otherwise. The Meldeportal® is easy to find on the Intranet and directs those who want to make a report to the appropriate reporting system.

The Meldeportal® (see www.meldeportal.ch) contains a number of reporting systems:

1. St. Gallen CIRS, the only anonymous reporting system for critical incidents.
2. Haemovigilance, a reporting system on risks before, during and after the administration of blood products (Swissmedic).
3. Material vigilance, a reporting system for incidents connected to medical devices (Swissmedic).
4. Pharmacovigilance, a reporting system for adverse drug reactions (Swissmedic).
5. Reporting Falls, a reporting system for all types of falls, whether by patients, relatives or staff.

6. Personal injury and damage to property, a reporting system for personal injuries and material damage.
7. Notifiable communicable diseases, reports to the Cantonal Chief Medical Officer or the Federal Office of Public Health concerning notifiable diseases (see Figure 4.)

CIRS IN OTHER HEALTHCARE INSTITUTIONS

Experience shows that the St. Gallen CIRS concept can be uniformly implemented across the healthcare spectrum - from acute, psychiatric and geriatric hospitals to rehabilitation clinics to care homes for the elderly. The four core characteristics of the St. Gallen CIRS (see box, page 17) apply to all types of healthcare institution. ■

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THE COST-EFFECTIVENESS OF PROTECTION SYSTEMS FOR SHARPS

Prevention of Needlestick Injuries

by *Andreas Wittmann*

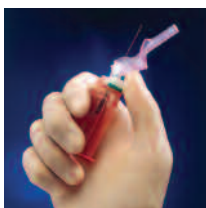


Figure 1: Blood collection system with a retractable needle guard (Becton Dickinson)

Uniform European rules are in place to regulate the key elements of occupational health and safety, with Article 118a of the European Treaty underpinning European minimum standards for health and safety in the workplace. The Federal Republic of Germany transposed European law in this area by means of the Occupational Safety Law, which has since been amended and complemented by a series of further regulations. It also introduced a Biological Agents Regulation to implement the requirements set down in EU Directive 2000/54/EC for the protection of employees from biological agents. This regulation explicitly refers to the danger posed by biological agents in human samples and the risk of injury arising from procedures of this nature.

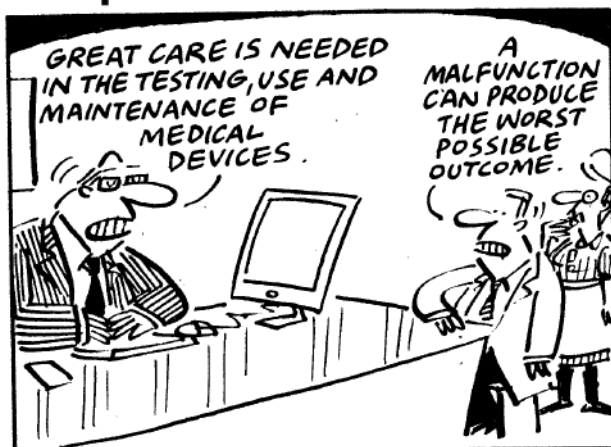
The medical device industry now offers an array of products for percutaneous interventions which

significantly reduce the risk of needlestick injury. Known as safety engineered devices, these products offer a range of safety features for sharps, including simple needle guards (Figure 1), sophisticated retraction systems in which used needles are pulled into a sheath using a spring mechanism and assistive devices that render sharps harmless immediately after use.

In 2003, the European Agency for Safety and Health at Work formally called for these types of safety systems to be introduced in the healthcare sector. Partly as a result of this statement, the European Parliament adopted a resolution in June 2006 calling on the Commission to make the use of safety engineered instruments mandatory at the earliest possible date. One of the reasons for the parliamentary resolution was the consistently positive results to have emerged from the United States since a law was introduced in 2000 obliging healthcare providers to use safety engineered sharp systems.

In Germany, paragraph 4.2.4 of Technical Rule 250 - Biological Agents in Healthcare and Welfare Facilities - requires that safety devices be used where the risk of infection or accidents is high (prisons, accident and emergency departments, the ambulance service and in the treatment of

Hospital Directors



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patients with life-threatening infectious diseases or at risk of causing harm to others). They are also prescribed where procedures are likely to result in the transmission of a quantity of blood or other bodily fluid sufficient to cause infection. The paragraph specifically refers to drawing blood and all percutaneous procedures for the collection of bodily fluids.

ADDITIONAL COSTS ARISING FROM THE USE OF SAFETY DESIGNED DEVICES

It subsequently transpired that the principal obstacle to the introduction of these modern safety products was their significantly higher cost when compared to conventional devices.

We calculated these costs by posing a set of questions to ten manufacturers using a hypothetical maximum care hospital with 1,000 beds. It was estimated that for 2003 the additional cost of switching to safety products would be €156,000. The corresponding figure for the same hospital for 2006 was €116,000 or €116 per bed. Using these figures, the anticipated additional cost of introducing safety devices across Germany, where the hospital sector has 530,000 beds, would be roughly €61 million.

THE COSTS OF NEEDLESTICK INJURIES

There is a tendency to overlook the high costs associated with needlestick injuries, contingent on the prevalence of key infectious agents, hepatitis B immunisation rates among staff and the possibili-

ty of testing the source patients. Our working group at the Bergische University of Wuppertal in Germany calculated the individual cost of a needlestick injury to be €487 per reported incident, of which the hospital must bear a cost of €147. When the administrative costs incurred as a result of a reported NSI are taken into account, the costs to the hospital are significantly higher. A recent German study identified the cost to one hospital per reported NSI to be €1,601, of which €754 was recouped from the accident insurance company.

International studies cite broadly comparable figures. For example, a Swiss author has produced figures in the range of €356 to €3,465, while an American research team put the cost of each reported NSI at between €630 and €785 (figures are based on prevailing exchange rates at the time of publication). Using a mathematical model developed at the University of Wuppertal and the Niederrhein University of Applied Sciences, it is possible, for the first time, to calculate the estimated costs of unreported needlestick injuries. The economically relevant costs of an unreported NSI are €79 (undiscounted) and around €52 when discounted over 30 years. These can largely be attributed to the high treatment costs associated with long-term illnesses.

COST-EFFECTIVENESS OF SAFETY DEVICES

Recent studies demonstrate that the use of safety engineered devices reduces needlestick injuries by around 85%. The costs of a NSI are closely correlated with immunisation rates among staff, where-

Number of Reported NSI	Number of NSI after Introduction of Safety Devices	Hospital Savings	Insurance Company Savings	Savings Hospital + Insurance Company	Savings Insurance Co. Additional Costs for Hospital
400	60	50.000 €	166.000 €	216.000 €	166.000 € 66.000 €
300	45	38.000 €	124.000 €	162.000 €	124.000 € 78.000 €
200	30	25.000 €	83.000 €	108.000 €	83.000 € 91.000 €
166	25	21.000 €	69.000 €	90.000 €	69.000 € 95.000 €
100	15	13.000 €	42.000 €	54.000 €	42.000 € 103.000 €

Table 1: Economic cost-benefit analysis for the introduction of safety devices in a 100-bed hospital with 166 reported needlestick injuries per annum; costs per NSI of €487, of which €147 are direct costs for the hospital. The additional costs for safety products of approx. €116,000 will only be recouped if all savings arising from a reduction in the number of needlestick injuries (i.e. savings for both the hospital and the insurance provider) are treated in combination.

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as to the prevalence of dangerous pathogens among patients is less significant. Cost benefit calculations were carried out for the hospital in question based on the known figures on the prevalence of dangerous pathogens and staff immunisation rates.

The figures show that the introduction of safety engineered devices would not be cost-effective in the hospital. Even if the level of needlestick injury reporting were to increase significantly, the hospital's accident insurance provider would stand to benefit from any savings accruing (Table 1).

Only about one tenth of the estimated 500,000 needlestick injuries in Germany are reported each year. The total cost of NSI to the country is approximately 47 million per annum (23 million in unreported NSI and 24 million in reported injuries).

DISCUSSION

Safety products designed to prevent needlestick injuries reduce the number of expensive injuries. The costs of NSI are largely borne by the statutory health insurance providers, although it should be noted that their expenditure and income are financed by employers. When further potential savings associated with the use of safety products are taken into account, for example, the option of allowing pregnant women to perform tasks from which they have generally been precluded due to the high risks of infection (taking blood and giving injections), the change-over to safety products could, in some cases, already make economic sense.

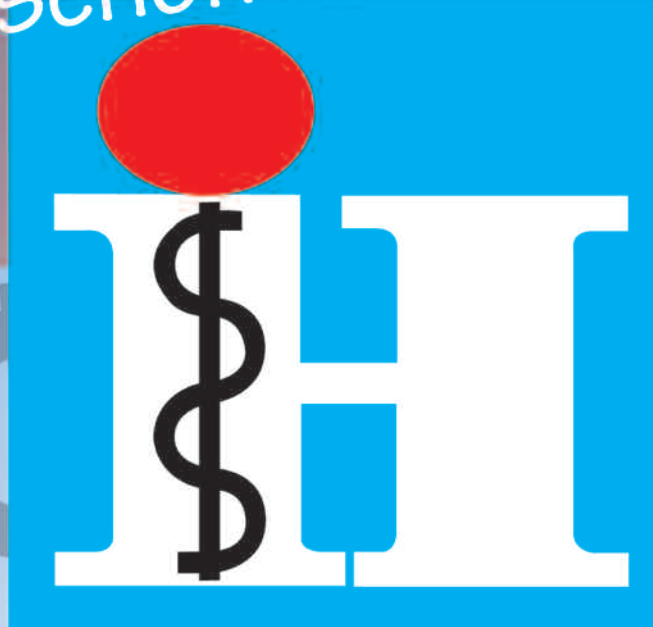
The economic cost of NSI in Germany only slightly outweighs the anticipated additional cost of introducing safety devices nationwide. Moreover, given that the price of these products has already fallen by more than 25% over the past three years, rising demand will probably mean that the introduction of safety engineered devices will be cost neutral in the foreseeable future. ■

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HEUTE SCHON VORMERKEN!!!



30. Deutscher Krankenhaustag

Düsseldorf 14. - 17.11.2007

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REPROCESSING MEDICAL DEVICES IN EUROPE

Reform of the EU Medical Devices Directive

By Dr. Thomas Ulmer

In 2005 the European Commission introduced a proposal to amend the medical devices directive and thereby signalled its intention to boost competitiveness in the European medical devices sector. The purpose of the proposed changes was to simplify and clarify the existing legal framework. The amendments included provisions to enhance patient safety and establish a single legal framework to foster competitiveness.

The European Parliament voted to endorse the Commission's revised legislation without significant reservations, marking a further important achievement for the German Presidency. The proposals were then adopted by EU Health Ministers in late May. Achieving consensus on the first reading of legislation is highly unusual in Brussels and it was not expected in this case due to the significant differences in the positions of the various protagonists.

RECONCILING COMPETING INTERESTS

The proposals sought to update three directives, which collectively set down the basic requirements for securing market approval of medical devices. Product classification, i.e. risk assessment, risk management and risk-benefit analysis, are addressed first. However, a procedure for risk-based conformity assessment to be carried out by independent agencies (so-called notified bodies) is also envisaged. The three relevant directives are the medical devices Directive 93/42/EEC, the active implantable medical devices Directive 90/385/EEC and Directive 98/8/EC on biocides.

The term "medical device" encompasses a wide range of products. Around 400,000 different medical devices, ranging from simple syringes and spectacles to diagnostic and imaging equipment to highly sophisticated implantable devices, are currently available on the market.

With a workforce of approximately 350,000 employed in around 7,000 companies, the medical device industry has recorded significant growth in recent years. The challenge facing legislators is to strike a balance between the legitimate interests

of patients and the competitiveness of industry. This will require providing additional safeguards to enhance patient protection while, at the same time, securing jobs in the sector.

SUBSIDIARY PRINCIPLE APPLIES TO REPROCESSING

The reprocessing of medical devices emerged as the most controversial issue because it is here that the interests of patients, hospitals, industry and the various actors in the healthcare sector collide. The rules on reprocessing vary among Member States. For example, reprocessing is banned in Spain and the United Kingdom, although the practice continues illegally. In Germany, on the other hand, legislation on reprocessing is unambiguous and is based on guidelines drawn up by the Robert Koch Institute. The Scandinavian countries intend to introduce similar rules.

The following cases, both of which are theoretically possible, give an insight into the legal complexities surrounding reprocessing:

1. In countries where a strict reprocessing ban applies, it is still possible to reprocess single use products legally, provided the reprocessor is willing to assume the third party liabilities of a manufacturer and, in so doing, operate as a manufacturer on the market.
2. It is also possible for a reprocessor to act on behalf of a hospital. As the reprocessor does not operate on the market, the hospital must assume full legal liability for the reprocessed products.

The understandable reluctance of manufacturers, hospitals and other users of medical devices to assume such a substantial risk led to calls for the introduction of European legislation to regulate reprocessing, using the German legislation as a template. This proposal was put by the Committee on the Environment, Public Health and Food Safety but failed to secure majority support in a plenary sitting of Parliament. The introduction of such a legislative framework would

implicitly answer the following questions: “Should the reprocessing of medical devices be permitted? Are the risks not too high?”

A report by a German academic was unambiguous. Professor Haindl from Hanover stated that it is simply not possible to safely reprocess many of the single-use medical devices currently being reprocessed. This raises a fundamental ethical consideration and poses the question: Can the reprocessing of medical devices be ethically justified?

At this point, it should be noted that the EU is not, and never has been, the appropriate authority for addressing ethical questions. For example, an accommodation has been found to address differences between Member States on funding research on human embryos. In light of the fact that the EU may not circumvent national views on questions of life, the only option available to it was to leave the crucial decision on reprocessing to Member States. In other words, the subsidiarity principle applies. In the event that a Member State chooses to allow reprocessing, EU-wide standards will apply and these will be set out in a forthcoming directive.

The Commission will carry out further studies to determine whether additional measures would ensure a high level of protection for patients. Within three years of the revised directive entering into force, the Commission must present Parliament and the Council with a report on the reprocessing of medical devices. This document may form the basis for additional regulations in this area.

DANGEROUS CHEMICALS: AN ISSUE FOR DEBATE

Debate also focused on the so-called CMRs, dangerous substances used in the manufacture of medical devices. While it is essential that the use of such chemicals in medical devices must cease in the medium term, unfortunately this will not be possible in the short term because an outright ban would jeopardise production of certain products which are indispensable to the protection of human health. Parliament, therefore, approved a compromise proposal under which:

- Manufacturers should avoid or minimise the use of dangerous substances in the production of medical devices.
- Devices containing dangerous chemicals must be labelled accordingly.
- Where such a device is used in the treatment of children or pregnant women, the manufacturer must set out reasons for using the substances in question.

- All CMRs must be phased out within five years of the directive entering into force.

LESS BUREAUCRACY

The adoption of the directive has helped cut EU bureaucracy. Contrary to the wishes of the Commission, an agreement was reached to streamline the work of EUDAMED (the European database of medical devices). It will no longer be necessary to register all custom-made devices on the database because, as MEPs noted, it is pointless to record such information if each device is unique.

Parliament also rejected a Commission proposal to require all medical devices to be labelled with a GMDN (‘Global Medical Device Nomenclature’) code. Rejection of the recommendation will save the industry hundreds of thousands of euro. Until now, companies have been forced to pay high charges to a valorisation agency to secure the rights for each individual code, resulting in many products not being placed on the market. Unlike the case of medicines, the GMDN code has no role in the registration procedure for medical devices and cannot, therefore, be compared to a pharmaceutical registration number.

CONCLUSION

On balance, all the relevant stakeholders are satisfied that the new rules create much greater clarity and legal certainty in the medical devices market. In particular, clear demarcation between the three directives - which rules apply to which products - will eliminate confusion. This will deliver time and cost savings to industry, and incentivise companies to prioritise innovation and job creation. By significantly strengthening the rights of patients, the new measures will improve safety and transparency and create long-term confidence in European medical devices. They also offer additional benefits to manufacturers who choose Europe as a location for doing business.

I believe our collective endeavours on this issue have contributed towards achieving the Lisbon goals, under which the European Union will strive to ensure Europe becomes the most successful, knowledge-based economic region in the world. ■

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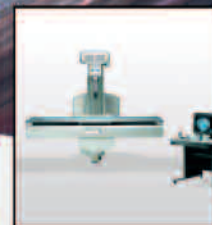
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DESIGN STRATEGIES TO REDUCE HOSPITAL-ACQUIRED INFECTIONS

By Anjali Joseph, Ph.D.

A visit to a hospital can be risky, even dangerous for your health. Hospital-acquired infections or nosocomial infections affect 1 in 10 patients admitted to UK hospitals. Every year this results in more than 5,000 deaths in the country and costs the National Health Services £1billion (Inweregbu, Dave, & Pittard, 2005). According to Inweregbu et al. (2005), on average, a patient with hospital-acquired infection spent 2.5-times longer in hospital, incurring additional costs of £3,000 more than an uninfected patient. Nosocomial infections typically affect patients whose immune systems have become weak because of age, underlying diseases, or medical or surgical treatments.

Some of the key factors that have led to increasing nosocomial infection rates in hospitals include:

- low handwashing rates by staff between patient contacts,
- sicker and more immuno-compromised patients in hospitals,
- infrastructure repairs and renovations to ageing hospitals and new construction on existing campuses creating risk of airborne fungal diseases caused by dust and spores released during demolition and construction, and
- increasing antimicrobial use in hospital and long-term care facilities creating a large reservoir of resistant microbial strains (Weinstein, 1998).

At least one third of these nosocomial infections are preventable (Weinstein, 1998). A strong body of research shows that the built environment in particular influences the incidence of infection in hospitals and that, by careful consideration of environmental transmission routes - air, surface and water - in the design and operation of healthcare facilities, hospital-acquired infections can be reduced dramatically.

This paper presents three key environmental design strategies that have been successful in reducing the incidence and spread of nosocomial infection in hospitals. This excerpt is taken from a recent review of the literature conducted by The Center for Health Design in the United States, linking physical environmental design factors with

hospital-acquired infections in acute care settings. The complete paper titled, 'The Impact of the Environment on Infections in Healthcare Facilities' can be accessed at the Center's website at www.healthdesign.org/research/reports. The paper was funded by a grant from the Robert Wood Johnson Foundation.

INCREASE HANDWASHING COMPLIANCE THROUGH ENVIRONMENTAL DESIGN

Most infections are now acquired in the hospital via the contact pathway (Bauer, Ofner, Just, Just, & Daschner, 1990). Microbiologically contaminated surfaces can be reservoirs of pathogens. However, these surfaces are generally not associated with the direct transmission of infection to patients or staff (Schulster & Chinn, 2003). It is the hands of healthcare staff that is the principal cause of contact transmission from patient to patient (Larson, 1988). Poor handwashing compliance by healthcare staff (rates in the range of 15%–35% are typical) pose a serious problem in this regard. Education programmes to improve handwashing compliance among staff have not been successful.

Ulrich and colleagues (2004) cite studies that show that providing environmental support for handwashing through visual cues (such as posters reminding staff to wash their hands) and the presence of numerous, conveniently-located sinks, and handwashing dispensers and alcohol rubs may result in an increase in handwashing rates. For example, in one study, a combination of bedside, antiseptic hand-rub dispensers, and posters to remind staff to clean their hands was effective in increasing compliance (Pittet et al., 2000). Also, when the ratio of the number of sinks to the number of patient beds is higher, the observed frequency of handwashing increases (Kaplan & McGuckin, 1986).

In addition, regular cleaning and disinfection of environmental surfaces as appropriate is critical to controlling surface contact transmission of infections. High-contact surfaces (i.e. those with fre-

* este osso está ligado a um servidor.

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quent hand contact (such as surfaces of medical equipment and high-touch housekeeping surfaces such as doorknobs, bedrails, light switches, wall areas about the toilet in the patient room, and edges of privacy curtains) in patient-care areas need to be cleaned and disinfected more frequently than minimal contact surfaces (e.g. walls and ceilings).

PROVIDE SINGLE ROOMS TO REDUCE NOSOCOMIAL INFECTIONS

The evidence from many different studies suggests that providing single rooms might be a critical strategy for reducing nosocomial infection in hospitals. Ulrich and colleagues (2004) identified three studies that suggest that providing single-patient rooms with a conveniently located sink in each room reduces nosocomial infection rates in ICUs, such as neonatal intensive care or burn units, compared to when the same staff and comparable patients are in multi-bed open units with few sinks. Further, single-bed rooms are clearly superior to multi-bed rooms in preventing the transmission of airborne pathogens from one patient to others because of the ease of isolating a patient. Providing high-quality HEPA filters, and negative room pressure prevents a patient with an aerial-spread infection from infecting others, or maintaining positive pressure protects an immunocompromised patient from airborne pathogens in nearby rooms. Compared to single-bed rooms, multi-bed rooms are far more difficult to decontaminate thoroughly after a patient is discharged, and, therefore, worsen the problem of multiple surfaces acting as pathogen reservoirs. Because different staff members who enter a room can touch the same contaminated surfaces, the risk of a nurse unknowingly becoming contaminated should be greater in multi-occupancy rooms (Ulrich, et al, 2004).

REDUCE AIRBORNE INFECTIONS THROUGH HEPA FILTRATION

Airborne infections are transmitted from person to person as droplets and when environmental reservoirs of a pathogen (e.g. soil, water, dust, etc.) are disturbed such as during renovation and construction activities. The importance of good air quality in controlling and preventing airborne infections in healthcare facilities cannot be overemphasized. Providing clean, filtered air and effectively controlling indoor air pollution through ventilation are two key aspects of maintaining good air quality. In this context, High Efficiency Particulate Air filters (HEPA) that are at least 99.97% efficient for removing particles $\geq 0.3 \mu\text{m}$ have proven effective in preventing the incidence of infection among immunocompromised and high acuity patients

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HOSPITAL GOVERNANCE: EXPLORING THE EUROPEAN SCENE - PART II

By Kristof Eeckloo, LL.M., Luc Delesie, CE, MS, PhD and Arthur Vleugels, MD, PhD

This second part of the results of the study (see (E-)Hospital 2/2007) deals with Hospital Boards and general conclusions.

HOSPITAL BOARD

The survey included a large set of questions on specific governing bodies. One of these bodies is the Hospital Board. The composition, role and functioning of this Board has been the focus within most traditional studies on hospital governance. Within this study the aim was to compare the main characteristics of these Hospital Boards and link them with elements of the larger governance configurations in which they are embedded.

Substantial differences between the various countries were found. One aspect, 'Board Size', is shown in Figure 4. As the figure shows, a middle-sized Board in Ireland counts 14 members, whereas in Portugal and Greece, a middle-sized Board counts only 5 members. Other countries with relatively large boards are Spain, Belgium and the United Kingdom. These differences in board size can be a first indication of differences in the tasks of the boards. One might expect that large boards are dealing more with long-term policy, whereas small boards have more operational tasks. The results of the survey confirm this only in part. In the Netherlands for instance, hospital boards are relatively small (median value 7), but answers to several questions of the survey tell us that these Boards have predominantly a supervisory and long-term policy function. In Belgium, on the other hand, boards are relatively large (median value 12), but many hospital boards in Belgium are also actively involved in operational decision-making.

The results in Table 2 give a further picture of the profile of the different boards. The table includes the expertise or backgrounds that are represented

at board level. Those individuals who have an executive function inside the hospital (e.g. Chief Executive Officer) are listed in the top part of the table. Individuals with an "external background" are listed in the bottom part of the table. The table reveals a clear "insider dominance" in Greece and Portugal, and an "outsider dominance" in The Netherlands and Switzerland. In Ireland, Belgium and France hospital boards typically include both insiders and outsiders.

One side remark: in times where "health service integration" is an often-acclaimed policy objective, it is notable that this is hardly reflected in the composition of the Hospital Board. Board members with a background in community healthcare are only common in Ireland, and to a certain extent in France and The Netherlands.

Figure 5, finally, is rather surprising. It shows the CEO's assessment of the impact of the hospital board on the overall performance of the hospital. As the graph shows, about half of the CEOs of France, Switzerland, Spain, The Netherlands and Portugal state that the board of their hospitals has



Figure 4: Number of Board members

BACKGROUND/EXPERTISE ■ More than 25% of hospitals ■ More than 50% of hospitals

n=363	%	EI	ES	BE	UK	DE	FR	CH	NL	GR	PT
CEO (65%)		30%	83%	73%	90%	41%	54%	29%	20%	78%	90%
CMO (48%)				46%	90%	22%	37%	6%	5%	76%	85%
CNO (42%)				23%	90%	22%	40%			73%	85%
Medical, non top manag. (29%)		50%		13%	13%	9%	59%	6%		41%	10%
Liberal profession (33%)		80%		51%	7%	38%	19%	59%	70%	17%	10%
Local government (32%)		30%	50%	24%	10%	22%	7%	29%	20%	6%	
Nat. or reg. government (24%)		30%	67%	6%	10%	9%	51%	18%	5%		5%
Community health care (16%)		40%		11%	7%	16%	34%	24%	25%		
Religious(14%)		70%		40%	3%	19%	4%				
Other hospital (12%)		30%		27%	3%	6%	8%	18%	5%		5%
For profit company (12%)		30%		15%	3%	9%	1%	47%	40%	3%	

Table 2: Background/expertise represented at Board level

only a poor or fair impact on the performance of the hospital. High impact boards can be found especially in Greece, but also in the U.K. and Ireland.

CHECKS AND BALANCES

The concept of “Checks and Balances” takes a prominent place within the governance literature. It refers to all kinds of relationships, functions and procedures that are built into the decision-making process. These should allow the managers of an organisation to take balanced decisions, which are based on a proper consideration of the interests of the different internal and external stakeholders. Or negatively phrased: they aim at reducing the likelihood of “inappropriate” or “opportunistic” behaviour of executive managers.

The previous paragraphs gave already some examples of such Checks and Balances. A functional hospital board for instance, with a balanced representation of backgrounds, which can monitor and guide the executive management, is a classic example of checks and balances. Openness to the public is another example; as the decision-making process becomes more transparent, more external parties become empowered to assess, influence and sanction or support the decisions as well as the decision-makers themselves.

The autonomy profile of a hospital is also a determining factor of Checks and Balances, since low autonomy rates imply that the decision-making process within the hospital will be highly influenced by decisions of the government or other third parties. This too diminishes the discretionary power of the executive management.

One of the purposes of the study was to analyse and synthesize these Checks and Balances across the different countries. The hypothesis was that within each of the participating countries, certain types of Checks and Balances would be more important than others. In other words: the research question was whether any “effect of substitution” could be found between the different Checks and Balances. For instance: is a higher

‘IS A HIGHER DEGREE OF AUTONOMY-COMPENSATED ... BY MORE OPENNESS TO THE PUBLIC?’

degree of autonomy compensated or “substituted” by more openness to the public?

To test this research question, we identified 14 aspects of Checks and Balances within the survey (see Table 3). Some of them are quite complex aggregate variables (e.g. distribution of tasks over different governing bodies); others are simple yes-no variables (e.g. whether or not an audit committee has been installed). However, all of the variables have in common that they measure the degree of delineation of the discretionary power of the executive management.

Overall, we found many complementary associations between the different variables of Checks and Balances, which means that when a hospital scores high for a certain variable, the odds are high that it scores high for the other as well. An example of two variables that are complementary can already be deduced from Figure 3 (see *Hospital 2/2007*):

TABLE 3: ASPECTS OF CHECKS AND BALANCES

1. Distribution of tasks/activities over different governing bodies
2. Information sources open to the public (meeting reports, budget specifications, financial statements, activity data, external assessment reports)
3. Information sources open to hospital MD's
4. Hospital autonomy, in the field of management
5. Formal role hospital employees in decision-making process of governing bodies (e.g. advisory procedures, specific committees)
6. Formal role citizens/community representatives in decision-making process of governing bodies
7. Formal role physicians in decision-making process of governing bodies
8. Audit committee
9. Remuneration committee
10. Nomination committee
11. Physicians of hospital assembled in one or more formal collective bodies
12. Range of different 'outsider' backgrounds/expertise represented in the governing bodies of the hospital
13. Range of different 'insider' backgrounds/expertise represented in the governing bodies of the hospital
14. Systematic use of integrated organisational policy instrument (e.g. Balanced Scorecard, EFQM)

the extent to which information sources are open to hospital MD's is positively associated with the extent to which information sources are open to the public (Kendall +0.34083, $p < 0.001$).

Another important complementary association was found between the extent to which information sources are open to hospital physicians and the extent to which hospital physicians have a formal role in the decision-making process of the hospital (Kendall +0.15790, $p < 0.001$). This confirms the general rule that information is indispensable for an effective management participation of physicians.

Yet, we also found some indications of substitution. An important finding for instance is that a high degree of hospital autonomy (i.e. low "external Checks and Balances") is positively associated with a large distribution of tasks/activities over different internal governing bodies (Kendall +0.15832, $p < 0.001$).

In addition, a high degree of hospital autonomy was also positively associated with the use of integrated policy instruments, such as the Balanced Scorecard or the EFQM-model (Kendall +0.11117, $p < 0.05$). Both findings seem to indicate that in hospitals with high autonomy, there is a stronger need for internal techniques to guide and balance the decision-making process of the hospital management.

FURTHER ANALYSIS

In-depth analyses on the data are currently taking place. Rather than making general observations and identifying general trends, the analyses aim to reveal and explain specific patterns of hospital governance and to offer the tools to translate them into practical knowledge. To make this possible, new methods of data-mining and knowledge discovery (including Multi-Dimensional Scaling) are applied, which are designed specifically to discover and display patterns and relationships within large databases. The methods are all based on computer algorithms calculating iteratively (step by step, data per data) the "best" visualisation for the selected variables in one single visualisation or virtual reality model.

CONCLUSION

The preliminary results confirm that governance practices in hospitals, based on the descriptions of the generic structures, processes and relations, maintain a direct correlation with the larger characteristics of the healthcare systems to which they belong. Despite the different levels of freedom for hospitals, certain systematics emerge even between different health systems. Comparing these to the Checks and Balances reveals the options available to European hospitals. ■

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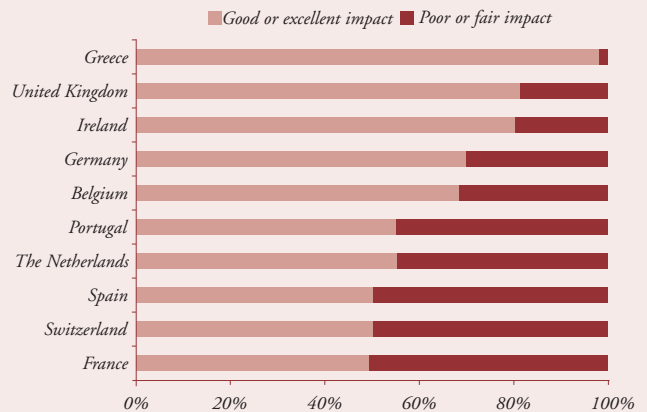


Figure 5: Overall positive impact Hospital Board on hospital's performance

THE IMPORTANCE OF SOCIAL CLIMATE FOR HOSPITAL NURSES

Results of the European NEXT Study

By H.-M. Hasselhorn, P. Tackenberg

The work carried out in hospitals is characterised by a considerable amount of social interaction. Contact with colleagues, supervisors, other staff and clients can be a positive resource that is perceived as enriching. Permanent contact can, however, cause considerable psychological stress. Nurses cannot cope with stress during working hours by choosing not to perform a task. Research on stress has produced mounting evidence that the prevailing workplace social climate is a leading cause of burnout among employees. Using the findings of the European NEXT Study, a research team investigated the role of social relationships, and its impact on the intention to leave the nursing profession.

The European NEXT Study (www.next-study.net) investigated the working conditions and career prospects of nursing staff in ten European countries. Conducted between 2002 and 2006 and financed by the European Commission (QLK6-CT-2001-00475), the study attracted more than 56,000 responses over four surveys. The questionnaires circulated in 2002-2003 asked the following question about the quality of social relationships:

“How would you describe the relationship between nursing staff and:

- nursing management,
- superiors,
- colleagues,
- physicians, and
- hospital management?”

Respondents were offered five options from a spectrum ranging from “friendly and relaxed” to “hostile and tense”. To enhance data comparability the analyses were restricted to registered nursing staff in hospitals (N=23,223, Table 1).

RESULTS

Table 1 shows that nurses rarely reported negative relationships with other members of the profession (reported by 3.8% of respondents). Tensions with superiors and physicians were more com-

mon (reported by 13.5% and 12.7% of respondents, respectively). On average, 27% of respondents reported that relations with hospital management were poor, while 30.4% gave a negative rating to relationships with nursing management. Substantial differences emerged between countries. In Italy, for example, relationships with all groups were characterised as negative. In this case, restructuring processes underway in the Italian health service and nursing profession are most probably to blame. Similarly, French nurses frequently reported negative relationships with nursing and hospital management. Negative relationships with physicians were reported relatively frequently in France, Belgium, Slovakia, Poland and Italy (ranging from 12.2% to 22.4% of respondents). However, contrary to expectations, poor relationships with doctors were reported infrequently in other countries. The results from Finland were conspicuous in that relationships with nursing management were rated negatively while those with colleagues and physicians were not particularly poor.

Differences in perception between age groups were identified in the study, with younger staff more likely to take a critical view than older colleagues of relations with nursing and hospital management and a more positive view of relations with other nurses.

The quality of the relationship between nursing staff and

	No. of Respondents	Percentage of respondents with strained to hostile relationships with relevant professional groups				
		Colleagues	Superiors	Physicians	Nursing Management	Hospital Management
BE	1959	3,1	11,2	13,1	24,3	17,2
DE	2523	2,7	10,8	9,9	25,8	19,2
FIN	1825	1,2	14,7	4,8	28,1	41,3
FR	2724	3,0	15,8	12,2	40,3	39,2
GB*	1845	1,4	8,4	4,2	20,5	13,8
IT	4525	7,3	15,6	17,7	41,9	45,0
NL	2455	0,8	9,7	6,7	21,5	7,0
PL	3207	5,3	16,1	22,4	33,8	27,4
SLK	2160	4,8	15,7	13,1	20,6	14,2
Total	23223	3,8	13,5	12,7	30,4	27,0

*(England)

Table 1: Figures by country and percentage of respondents with a “negative to hostile” relationship with nursing managers, superiors, colleagues, physicians and hospital management (respondents confined to registered nursing staff working in hospitals)

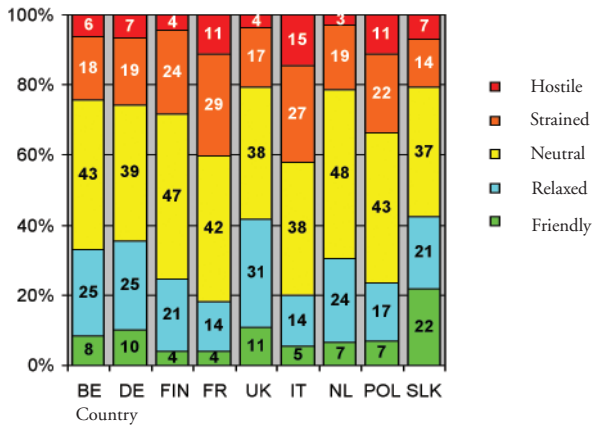


Figure 1: Distribution of replies according to reported quality of nurses' relationship with nursing management by country (TN = 22,634)

nursing management is shown in a more differentiated light in Figure 1. Around a quarter of respondents in Belgium, Germany, Finland, Britain, The Netherlands and Slovakia, and approximately one third of respondents in France, Italy and Poland reported a strained to hostile relationship.

The quality of social relationships has a significant impact on nurses' intent to leave the profession. Figure 2 shows that the relationship with nursing management plays an important role (solid black line). Where the relationship is considered "friendly and relaxed", only 10% of all nurses frequently (at least once per month) consider leaving the profession. This figure rises to roughly 30% when the relationship is perceived to be "hostile and

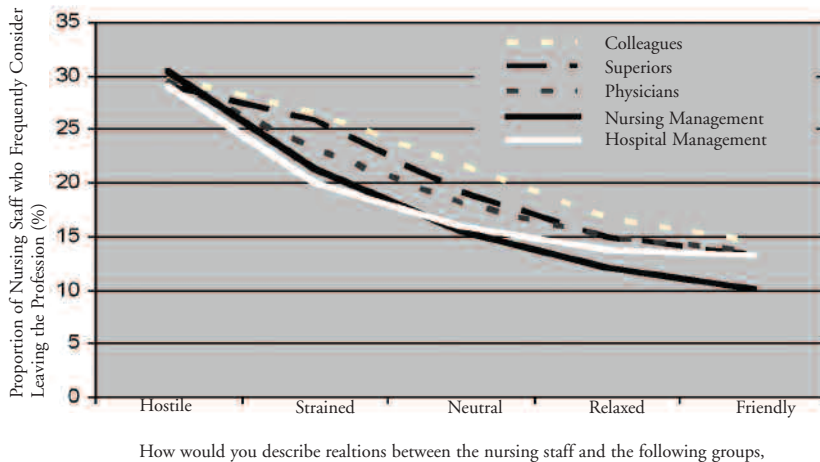


Figure 2: Relationship between a) the quality of relations between nursing staff and various organisational groups and b) intent to leave the nursing profession. (Proportion of respondents who consider leaving nursing at least once a month.)

tense". If, instead of "negative or hostile" the relationship with nursing management were perceived as "neutral", the proportion of nurses intending to leave the profession would fall from 17.2% (3,506 persons) to 15.6% (absolute number = -564 persons). This effect is most pronounced in Italy (where the reduction in those intending to leave would decline from 20.7% to 16.7%,

n = -163), France (16.3% to 13.4%, n = -73) and Germany (19.2% to 16.5%, n = -60). It is less pronounced in countries where low rates of intent to leave are reported, namely, Slovakia (12.4% to 10.7%, n = -29), The Netherlands (10.6% to 9.2%, n = -32) and the United Kingdom, where relations between nursing staff and nursing management were found to be best (36.8% to 34.2%, n = -44). If relations were "friendly and relaxed", the percentage of the overall group intending to leave nursing would fall to 10.1% (n = -1,485). The impact on intent to leave is halved when the same calculations are applied to relations with hospital management.

A similar picture emerges in relation to burnout among nurses. If the relationship with nursing management were perceived as "neutral" as opposed to "negative or hostile", burnout among nurses would fall by 12%. This figure would rise to 25% if relations were "friendly and relaxed".

SUMMARY AND DISCUSSION

We have shown the scale of the impact of the hierarchical relationship between nursing staff and nursing management. Intent to leave nursing increases where this relationship is poor. A new finding to emerge from our investigations is that nursing managers have the potential to shape the social setting in a way that actively promotes staff retention, particularly when those involved are qualified employees. It is clear that nursing managers are involved in a balancing act as they try to reconcile the conflict between implementing the restructuring measures required for commercial success and the need to maintain a positive work climate that supports staff in meeting the growing demands presented by increased workload, shorter patient stays and new treatments while avoiding the phenomenon of burnout. Nursing managers must, therefore, utilise their expertise in operational processes to ensure internal procedures adapt and innovate in a manner that maintains high quality care. However, this goal cannot be achieved without motivated and committed nurses. ■

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SHOULD MENTAL HEALTH SERVICES BE INTEGRATED INTO GENERAL HOSPITALS?

By George Witte and Alan Yates

In its recent consultation the European Union stated in its Green Paper on Mental Health that a model of service which integrates mental health services into a general hospital is preferable.

ISSUES

There is very good evidence¹ that psychiatry services when provided within somatic care can make an impact on both survival and length of stay. This paper identified 576 studies of potential interest, of which 97 met pre-defined quality criteria and were examined in detail.

The study found that mental illness was much more common in general hospitals than in the general community with the prevalence of patients with mental health symptoms making up between 60% and 70% of the total. To illustrate this another way the report says “To put these findings into context we return to our typical general hospital. We already know that of its 500 beds, 330 are occupied by older people at any one time. Two hundred and twenty of these older people will have a mental disorder. 96 will have depression, 102 dementia, 66 delirium, 10 alcohol misuse and two schizophrenia. Such a general hospital will have at least four times as many older people with mental disorders on its wards than the local mental health services have on theirs.”

THE REPORT NOTES THAT LENGTH OF STAY IS LONGER AND MORTALITY IS WORSE FOR PATIENTS WITH MENTAL HEALTH PROBLEMS THAN THOSE WITHOUT.

This evidence supports strongly the hypothesis that a high proportion of patients in district general hospitals will benefit from psychiatric interventions. It does not demonstrate the case for integration, because that service can be provided by liaison psychiatry either within the same organisation or outside the organisation.



DO PSYCHIATRY SERVICES BENEFIT FROM BEING WITHIN THE SAME ORGANISATION AS SOMATIC SERVICES?

The authors' experience is that psychiatric services provided for severely mentally ill patients have not benefited from integration. In England money set aside for a liaison psychiatrist was used instead for an A&E consultant in an integrated organisation because government targets gave greater priority to A&E waiting times than psychiatry. Similarly, medium-secure mental health services in an integrated organisation had 20% of their income diverted to support somatic services in the general hospital. As the effect of mental health services is less determinate than somatic services, there is a view that reducing financing has less consequences.

This view is not supported by the World Health Organisation's understanding that depression causes the second-highest burden of disease, and bi-polar disorder is the sixth most disabling disease. If we go back to the pro-

portion of in-patients in somatic care with intercurrent mental health problems, diverting funds from mental health services may be a false economy and may in fact be the origin of some of the inefficiencies in somatic care, causing longer lengths of stay and higher mortality.

SO FROM WHICH ORGANISATIONAL MODEL DO PATIENTS BENEFIT MOST?

It is useful to make a distinction between patients with common mental disorders like anxiety and mood disorders, and the Severely Mentally Ill (SMI). The common

‘...IN THE AVERAGE GENERAL HOSPITAL ... NEARLY HALF OF PATIENTS PRESENTING WITH PHYSICAL HEALTH PROBLEMS (HAVE) INTERCURRENT MENTAL HEALTH PROBLEMS.’

mental disorders typically do not need in-patient care, are less debilitating and, by definition, are more common. Typically 15-18% of the population will have a common mental health problem at any moment in time. These patients often present with physical symptoms and can be actively investigated in somatic care departments of a hospital. They are also often treated in their local community-based services or in general practice.

For patients with common mental disorders the concept of offering an integrated care model in a general hospital is self-apparent. Patients with mood disorders and anxiety report that they do not wish to be treated in a way that separates them from “normal” healthcare. They feel stigmatised by the psychiatric label and feel associated with those with more severe mental illnesses. As shown in the English study of liaison services, there is very significant co-morbidity in the average general hospital with nearly half of those patients presenting with physical

‘THE CASE IS MADE, WE BELIEVE, FOR THOSE WITH COMMON DISORDERS WHO NEED SECONDARY CARE TO RECEIVE THAT IN A GENERAL HOSPITAL SETTING.’

health problems having intercurrent mental health problems. Meanwhile those presenting with a common mental health problem very often have intercurrent physical health problems. This very common inter-relationship between physical health problems and common mental health problems indicates a preference for the care to be inter-related.

By severe mental disorder we mean schizophrenia, manic-depressive illness, severe personality disorders and

brain damage. For this group, very different considerations apply. People with severe mental illness often lead more chaotic lives and have important non-health service needs whose consideration is essential if the patient is to be able to achieve the most satisfactory mental health state possible. A high proportion of those patients with severe mental illness are regarded as chronic patients; not necessarily that they need constant care but that from time to time they will need an intensity of service that people with common mental health disorders will not. The central needs of patients with chronic psychiatric illnesses are often connected with housing, money, activities, social company, social support as well as psychological and psychiatric treatment. Sometimes it is necessary to intensify the treatment a patient with severe mental illness receives either by making treatment compulsory or by placing the patient in a secure setting when necessary. It is accepted that when the social elements such as housing, social interaction and so on are not available, psychiatric support and treatment are not as effective.

The group who have been diagnosed as having a severe mental illness need different settings, different values, different treatment modalities than other patient groups, from those with common mental health problems right through to patients with a single, straightforward physical condition. A service to people with severe mental health problems needs to take these factors into account. In a general hospital, long-term accommodation, a therapeutic milieu, social contact, compulsory treatment, and homely and inclusive buildings are secondary considerations when compared with the technical quality of a procedure. For the patient group with severe mental illness those issues are an integral part of the care. The combination of social, psychological and medical needs is not part of the core business of general hospitals. This makes it unlikely that general hospitals will provide the best care.

WOULD MENTAL HEALTH SERVICES BENEFIT FROM INCREASED SOMATIC INVOLVEMENT?

People labelled “mental health” experience inferior access to somatic services than the general population. People with mental health problems have increased incidence of disease such as coronary disease, diabetes and pulmonary deficiency. They are more inclined to smoke, abuse alcohol and use recreational drugs. People with mental health symptoms should get increased access to somatic services but in most European countries that is not true.² Having patients with common mental health disorders in general hospital settings would overcome some of this stigma and help good mental health to be seen as a normal thing.

SO WHAT ABOUT INTEGRATION?

There is little doubt that integrating mental health services into a general hospital has benefits for that hospital.



We have seen that a somatic hospital's workload is compounded by the very significant levels of mental health co-morbidity. The case is made we believe, for those with common disorders who need secondary care to receive that in a general hospital setting. They will be less stigmatised, probably more receptive to treatment, and healthier as a result of a short intervention in their local hospital.

**‘THE MORE SEVERE THE NEED,
THE MORE CARE NEEDS TO BE
SPECIALISED AND ORIENTED AROUND
THE WIDER AND MORE COMPLEX
NEEDS OF THE INDIVIDUAL’**

For patients with severe and enduring psychiatric symptoms, their needs are not best served by the general hospitals except for their separable somatic care needs. Patients in this group have a much bigger spectrum of needs from housing and social interaction to systems of work and modalities of treatment which are not the staple fare of general hospitals. General hospitals try to treat psychiatry patients in the way they treat all other

patients. „Standardisation is a worthy managerial approach to service quality. However when patients sit so far outside the standard that standardised treatment can be counterproductive, we need to think again.

The question is defined by the patient and quite rightly so. The answer must reflect that too. The guiding rule should be that the less severe the need, the more a patient should receive their care at a general hospital, and the more severe the need, the more care needs to be specialised and orientated around the wider and more complex needs of the individual concerned.■

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A HOSPITAL PROMOTING MENTAL HEALTH

Early help: little extra cost, great results

By Inger Kari Nerheim

- 'Are you feeling sad?' – 'Do you know anybody who has these symptoms: withdraws from friends and family, is turning careless about personal appearance, lies awake at night, or stays in bed all day.' - 'Are you worried about a friend?' - 'Is anyone you know hearing voices?'

Stavanger University hospital runs ads like this in the regional newspaper of Stavanger in the Rogaland region of Norway several times a week, amid announcements, car sales, movies and shows, grocery and clothes bargains. The message is loud and clear: seek help early at signs of mental distress or illness. The TIPS (early detection and intervention) team is there to help you. Mental illnesses are like any other illnesses: they get better if you get help at the first symptom – and they are harder to treat if you wait until you are really sick.

EARLY INTERVENTION IN MENTAL HEALTH

The aim in 1996 was to set up a study on the effectiveness of early intervention in the most severe psychiatric illness, schizophrenia. Was it possible to use modern mass media to create greater awareness about mental illnesses, to change help-seeking behaviour, and to actually get young people with psychosis to get treatment earlier? The average time gap, the duration of untreated psychosis, between the first symptoms – retrospectively – and first treatment for the disease, was in 1996, 118 weeks, i.e. more than two years. Two years with increasing bewilderment, alienation from family and friends, gradually losing touch with reality for many young people. Possibly, the researchers setting up the study thought, one could

even show that starting treatment early would make the course of the illness less severe? It was worth an effort.

Three sites were set up, in Oslo and Rogaland county, Norway, and in Roskilde, Denmark. Rogaland was the



Newspaper ad: "Not feeling so well after all? Call TIPS if you have questions about mental illness"

Information material "The results are better when the family takes part in the treatment."

Information booklets were spread to all homes in the county.

experimental site, trying to establish early detection, while Oslo and Roskilde provided detection as usual. All three sites gave a 'state of the art' treatment programme with individual talking therapies, medication and family group therapy, over a period of a minimum of two years. The inclusion to the study was rigorous, and the highest scientific standards set up. The research programme around the project involved three universities: Oslo; Roskilde; and Yale.



In Rogaland, two detection teams were established, with a 'within 24 hours' response time. Patients, parents, friends, teachers; anybody with a concern for a young person with symptoms of mental distress could call in and ask for an assessment.

The team would come to the home or the school and speak with the young person, using a systematic approach. A comprehensive information campaign rolled over the county's towns and countryside.

All secondary schools – teachers and student advisors – were educated in early symptoms and told about the new early treatment service. The movie theatres ran ads before the main picture, showing ordinary girls and boys with problems, and where to get help. Every household in the county got a booklet informing them about the project, the symptoms, and where to get help.

Teachers, community and school nurses, and doctors were given courses and lectures, and were later targeted in ads in the local newspapers. They were sent pens, mugs and brochures with the detection teams' telephone numbers on them, to ensure that the message was not forgotten.

The full-page ads started in 1996 were used in several series, and a marketing survey was carried out on a yearly basis. During the project, the knowledge of psychiatric symptoms rose to the same level as the knowledge about cardiac arrest and infarctia. In 2006, the newspapers remind the locals every week - along with "remember the birds in the winter" - to be alert to symptoms of severe mental distress; it is just as necessary to seek help early for mental problems, as for heart symptoms or diabetes.

Ten years later, the TIPS project is no longer a project, but a part of Stavanger University Hospital's everyday programme for reducing stigma and educating the public about treating mental illness. The main results are scientifically weighed and found sound:

- Suicidal ideas, attempts and plans among young people with newly diagnosed psychosis are significantly lower in the site with early detection programmes, up to 50% compared with the two other sites.
- Use of modern mass communications methods significantly alters a population's help-seeking practice around severe mental illness, and also "catches" a lot of less severe mental distress among the young; the

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118 weeks of untreated schizophrenia is now reduced to an average of 16 weeks, with a median time lapse of two weeks (half of the help seekers get help before two weeks have passed from their first symptom).

- The health services are not flooded by help seekers, even with a low threshold for contact.
- The patients detected early are less ill at their first appointment, and at the one- and two-years' follow-up.

The general consensus among user-groups is that the programme has reduced the stigma of mental illness in Rogaland county.

THE COST OF HEALTH PROMOTION

Stavanger University Hospital has annually for the last six years had a budget of approximately 120,000 euros for information-work and ads like these.

The results for the young, at-risk population is that they all know that there is help for mental illness, where to find the information should they need it, and that there is hope for a good life and even a cure for severe mental problems. The one year that we did not keep up the massive focus on information, and saved money, the negative results came fast. The length of time between the early symptoms and when help was given again rose. The hospital found this impossible to ignore, and redistributed means back to the information budget in the mental health clinic.

One of the buses driving along the freeway between Stavanger and Sandnes, two, medium-sized Norwegian towns, will for the next four years look like this. "Rapid help for young people with serious mental illness: 51515959". The cost: a mere 3,500 euros, for four years, all day, all week. Worth it? Without a doubt!

Do doctors need pens and coffee mugs to remember the early intervention team? The pharmaceutical firms evidently think it works. Do young people react to the soft drinks ads or to clothes ads with cigarette names? The programme does not only rely on the baser marketing schemes, but has a wide array of films, brochures, courses for teachers, health personnel and families, that together build up a steadily renewed knowledge basis about mental illness and mental health in the local area.

THE NEED FOR A COMPREHENSIVE OUTREACH SYSTEM: INFORMATION CANNOT BE GIVEN WITHOUT EARLY DETECTION TEAMS AND A TREATMENT PROGRAM

The TIPS programme rests on the experience of others, and collaborates with many other groups. The EPPIC programme in Melbourne has inspired many of these ini-

tiatives. PEPP in Canada, "Detect" in Ireland, the UK early intervention teams, and other projects in Europe and elsewhere are giving important results, and not to be forgotten, the ongoing joint European prediction of psychosis study, EPOS.

The TIPS programme has shown that information work and early detection both are important. There are no rea-

One of the buses driving along the freeway between Stavanger and Sandnes, two, medium-sized Norwegian towns, will for the next four years look like this. "Rapid help for young people with serious mental illness - 51515959". The cost: a mere 3.500 Euros, for 4 years, all day, all week. Worth it? Without a doubt!



sons that this should not be an integrated part of every community's health service. There must be firm, yearly funding, and a standard treatment protocol must be agreed on and financed, building on international research results, and incorporating on a yearly basis changes in the international consensus on effective treatment for this unnecessarily debilitating disease. And, in the course of the detection work, we also can find the young people with depressions and anxiety, behavioural disorders etc, and give them as scientifically-based comprehensive treatment programmes as the ones for the psychoses.

The EU Green Paper, which is now being turned into a new framework for mental health in Europe, gives hope for the future. The ethics of this are unquestionable, and so are the economics; the saving of numerous life-years for Europe's young people is a good investment from any angle. ■

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QUEEN MARY'S HOSPITAL, ROEHAMPTON

Award-winning general hospital with integrated mental health facilities

By R.C.Jenssen

The award-winning Queen Mary's Hospital at Roehampton breaks new ground in the design of adult, mental health, in-patient facilities in the UK. Uniquely, it provides mental health facilities that are integrated within a community hospital setting. A decision based initially on economics has come to signify a step change in attitudes to mental health, no longer the poor relation within the health sector.

The new hospital opened in March 2006, with the external works and parking completed in September 2006. The mental health facilities within the community hospital include an Addiction Treatment Centre, three 23-bed adult mental health wards, and Community Mental Health Team facilities.

Designed by Devereux Architects Ltd, under a PFI ('Private Finance Initiative') procurement route with consortia lead Catalyst, and main contractor Bovis Lend Lease, the new community hospital marks the regeneration of healthcare facilities on this historic and nationally-renowned site. Queen Mary's Hospital is one of the largest community hospital facilities in the country, and meets the requirements of the Government white paper on community hospitals.

OBJECTIVES OF THE DESIGN

The objective of the design was to build a hospital that was not just a community hospital but part of the community. The requirement was to create lots of light and access to the outside world. The use of colour, light and open spaces give real hope that this hospital is a healing environment."

The new community hospital at Roehampton has been applauded for serving to de-stigmatise mental health services, by providing them as part of an integrated community hospital.

The design places the patient, staff and visitor experience as the main focus, with an internal environment that provides high-quality therapeutic care as well as maximising views, natural light and access to outside space.

The mental health wards have been located on the first floor, with bedroom areas set back from the main



façade wherever possible, to provide maximum privacy along with enhanced outlook.

Each ward has its own garden terrace immediately accessible from the ward's day areas. The terraced gardens for the mental health wards at first floor level, provide a therapeutic environment whilst addressing the significant concerns of safety and security. The design of these areas was subject to lengthy consultation and full-scale mock-up testing with the mental health Trust, during the design development stage. These gardens are viewed as an extension to the internal space, and have been designed to facilitate easy access. They have been commended as providing some of the most accessible mental health garden facilities, with safety and security built in as part of the design of the garden. Indeed, nursing staff are entirely content to allow patients access to the gardens without supervision, such is the reduction in risk that has been achieved.

Throughout the unit, importance has been given in the design to creating the most appropriate internal environment, which provides interest and variety for patients. The use of interior and exterior spatial concepts, colour, texture, natural and artificial lighting and art have been combined to create variety, as well as providing stimulation and calmness.

The top floor of the three-part, four-storey community hospital accommodates the new mental health in-patient facility, enjoying spectacular views over the London skyline.

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Country General Manager
Baxter Médico Farmacêutica. Lda

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IMAGE

The new hospital needed to portray the appropriate image to reflect the Trust's healthcare philosophy: how it values its patients and staff. It was also viewed as a Catalyst/BLL flagship facility and needed to reflect the ethos of Catalyst Healthcare consortia.

Key words reflecting the Trust's image included:-

- Quality
- Care
- Efficiency
- Friendly
- Welcoming
- Confidence
- Professionalism

The design acknowledges that the buildings we inhabit affect the way we feel, with the aim of achieving the correct ambience for all areas.

The key points considered in delivering the appropriate internal environment were:

- Maximising natural light
- Providing suitable ventilation, maximising natural ventilation
- Good aspects with views to external spaces
- Spatial concepts that are varied in height, shape and plan form
- Use of colour
- Use of texture
- Use of natural materials
- Carefully designed artificial lighting in association with services consultants
- Carefully selected artwork, sourced and installed by the Trust, sited to act as landmarks to help with finding the way
- Co-ordinated selection of furniture and furnishings, in association with equipping specialist
- Easily understood and co-ordinated signage
- Integration of notice-boards and places for temporary signs/notices

MENTAL HEALTH WARDS

All three wards are located at the first-floor level, with dedicated external spaces provided in the form of terraced gardens. The upper floor location provided some problems as well as some unique opportunities. Safety and security concerns lead to detailed testing of all perceived weak points, such as windows, anti-climb eaves and the garden perimeter walls.

Natural light has been maximised throughout, utilising side-lighting to corridors and roof lights wherever possible. This assists in ensuring that circulation spaces are well lit, feel homely and provide views out. The upper floor location minimises any potential issues of overlooking, and provides an unparalleled sense of privacy whilst maintaining outlook.

Each ward layout follows similar principles of grouping rooms by activity. The ward entrance areas include a lobby with a generous open-plan waiting area and two interview rooms. On entering the ward, the staff base is immediately visible, providing a sense of arrival and reassurance. Observation within a ward can be as much about staff being visible, as providing observation of in-patients. The staff base provides a central focus to the ward during the daytime. The main day facilities are arranged around this base, including an open-plan dining area and two sitting-rooms opening out onto the private garden areas. It has been a high priority that the patients need for personal space, and meaningful activity is catered for within the building.

The bed areas are arranged together, in three distinct groupings, including a male bed area, a female bed area and five 'swing' beds arranged around the night-time staff base to accommodate patient's of either gender. All bedrooms are in the form of single bedrooms with ensuite facilities. The bedrooms have been carefully designed to maximise observation from the door for staff, whilst maintaining privacy for patients. The bedrooms were designed above the current, recommended, single bedroom size, to ensure adequate space for daily activities including study and future flexibility.

Within the mental health wards, colours and materials have been selected to achieve a more homely environment balanced with the needs of addressing safety and security concerns.

Each ward has its own landscaped garden/courtyard terrace immediately accessible from the ward's day areas. These gardens were viewed as an extension to the internal space, and have proved to be very popular amongst the in-patients. They provide an open aspect with views into the landscape and surrounding area outside the unit's confines. All of the gardens are open to the sky, with a variety of perimeter wall screening including clear fixed panels, glass blocks, cedar boarding and facing bricks. The overhanging eaves serve to provide security and prevent climbing, as well as providing shelter and accommodating the main garden lighting. The gardens have been designed so that they can be used throughout the year.

Alan Hargreaves from Catalyst commented, "The hospital was handed over exactly one year ago on 3 March. It is an excellent building and the customers are, overwhelmingly, happy with it. It is operating well and obviously benefiting from the quality input."

All in all, the project is a great success! 

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MANAGING HEALTHCARE WASTE TOGETHER

Involving staff in the solution

By Karl Dalton

Waste management is one of the biggest challenges for our society now and in the future. Since one of the main factors in economic growth is consumption it follows that waste volumes generally increase along with this growth.

The healthcare sector in Ireland has increased its business activity just like any other industrial sector. The growing population and its expectancies has fuelled this activity. Connolly Hospital Blanchardstown (CHB) in Dublin has expanded and cares for more patients every year. As a result its waste volumes have continuously increased.

We took a decision in 2004 to address our waste management by introducing a 2-Phase plan. Phase 1 addresses the demand side i.e. on-site in CHB and Phase 2 would address the supply side, i.e. our supplier of products and services including waste services. Neither phases will ever reach completion, they are work-in-progress since the hospital environment is forever changing and there is always more that can be done to improve performance. This article focuses on Phase 1.

AIMS

The aims of Phase 1 were simple and logical to establish:

- reduce hospital waste costs.
- improve the waste management service and environmental performance.
- contribute to improving hospital hygiene standards.

METHODOLOGY

Many management systems propose the reliable method of Plan-Do-Check-Act (ISO Technical Committee 2004). When applied to CHB waste it entails the following:

- Analyze the existing waste management service.
- Examine the nature and composition of the waste.
- Develop a relationship with the staff so that they can identify a person with Environmental Management.
- Devise and propose solutions with the staff as a team while acting as guide and mentor.
- Implement and communicate solutions to all staff.
- Monitor the solutions by dialogue with staff and key performance indicators.

In addition:

- Educate staff in the broader environmental impacts of waste management so that they want to participate and not just have to participate.
- Create a common mentality of environmental awareness through frequent staff newsletters, occasional competitions and do not forget to thank staff for their efforts.

RESULTS

Before we view the results, it is important to consider certain aspects of the hospital's growth. Figure 1 shows the range of activities that are typical indicators of our activity. The average increase of each of these five indicators gives us a growth in hospital activity of 20% from 2004 to 2006. This explains how the volume of total waste has increased by 8% in the same time period, as shown in the light blue trend in Figure 2. (Note: In Ireland, clinical waste is referred to as Healthcare Risk Waste)

The first result, as seen from Figure 2, is that there has been an improvement in waste segregation. Healthcare Risk Waste (HCRW) stream has diverted a sizeable fraction to the Non-Risk stream.

The second result of Phase 1, as seen from Figure 3, is that the total waste costs have been driven down by 16% over the period since 2004. In monetary terms, this is providing an average saving of 4,363 per month. This has been achieved by changes in staff practices and without capital expenditure.

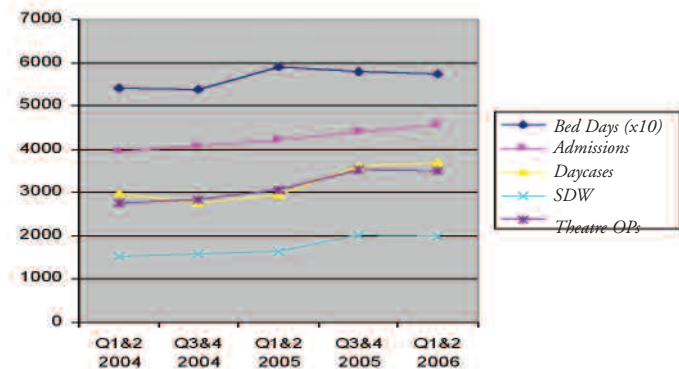
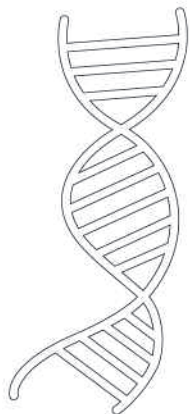


Figure 1. Hospital activity, using average increases of above data trends, from January 2004 to June 2006 has increased by approximately 20%.

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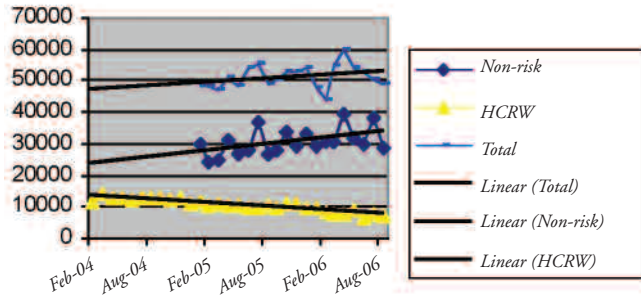


Figure 2. Hospital waste by volume since January 2004, using backward projections, has increased by approximately 8%.

The third result is that these efficiencies have been achieved without compromising hospital hygiene standards. Connolly Hospital moved from a score of 76% to 89% in the National Hygiene Audits.

CONCLUSION

Based upon the aims of Phase 1 of the plan and the results obtained, it is clear that a modern hospital can benefit in practice and financially by the implementation of an organised waste management plan.

Due to improved segregation of the waste, the impact on the environment may have been reduced.

Although waste is a source of infection, the improved control and education regarding waste has contributed to improved hospital hygiene.

The most important element in the success of this project has been involving the staff in formulating the solutions and providing them with adequate environmental education.

TO THE FUTURE

Phase 1 will continue developing with the life of the hospital. For example, Environmental Representatives are being established on a voluntary basis at a department level. They will further help to create a “green” mentality with their colleagues in the organisation.

The strategy of Phase 2 is being prepared at the moment with implementation beginning this year. This is where we begin to bring about change external to CHB:

- We will work with suppliers with a view to improving the composition and volume of their packaging.
- Work with stakeholders to examine how we can improve the actual products used in patient care. For example in the Vienna Hospital Association,

Glanzing Paediatric and Preyer Paediatric Hospitals are eliminating PVC and DEHP in medical practice because of the associated health risks of these products. (HCWH Europe/EPHA Environment Network/EEN 2005)

- Waste contractors will be given a defined time period to engage in best environmental and social responsibility regarding all stages of the cradle-to-grave path of our waste.
- Educate the centralised off-site procurement department in the principles and benefits of green procurement.

The need for healthcare organisations to focus on waste and environmental management is imperative from both monetary and environmental perspectives. The ultimate negative impact of poor waste management is on human health through the various pathways that pollution takes to the person both locally and abroad. The World Health Organisation has estimated that more than 3 million children under five die annually from environmental-related causes and conditions (WHO 2005). In Europe, air pollution is the greatest environmental factor that impacts on human health yet so much of our healthcare waste is treated by incineration (EEA 2005).

Is it not ironic that an industry which sets out to improve human health has such a propensity to impair it? ■

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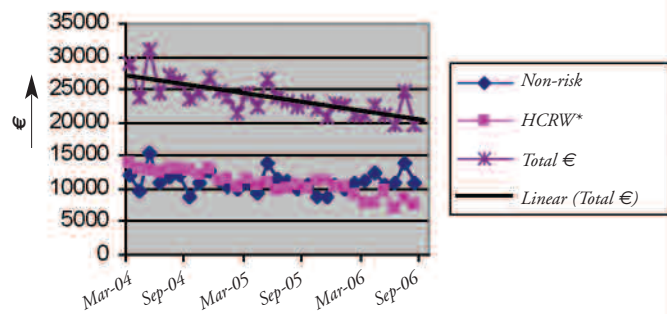


Fig3. Hospital waste by cost, using annual monthly average, has decreased by approximately 16%.



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THE PORTUGUESE HEALTHCARE SYSTEM

The state of Portuguese hospitals at the beginning of the decade made significant gaps apparent: quality control was absent, and there was no standardised information system to facilitate the control of the performance of managers and healthcare establishments. These managers did not have any effective incentives, or the autonomy necessary, especially in the area of managing human resources, to improve the performance of the hospital. In addition, the hospitals suffered from important personnel problems: while the number of doctors per hospital bed was greater than the OECD average, the number of nurses was only half of the OECD average, which effected the efficiency and quality of care.

The Portuguese healthcare system is composed of three co-existing systems: the national health service (Serviço Nacional de Saúde, SNS), the special social programmes of health insurance for certain professions (subsystems of the state), and private, voluntary health insurance. The national health service offers universal coverage. Furthermore, approximately 25% of the population is covered by the healthcare subsystems, 10% by private health insurance and 7% by mutual funds.

The Ministry of Health is responsible for developing health policy as well as managing the SNS. Five regional health administrations are responsible for implementing the national health policy objectives, developing directives and protocols, and supervising healthcare services. Decentralisation efforts have aimed at shifting financial and management responsibility to the regional level. In practice, the autonomy of regional health administrations over budget setting has been limited to primary care.

Funding

The national health service is predominantly funded through general

taxation. The contributions of employers (including the state) and of employees represent the principal source of finance of health subsystems. Furthermore, direct payments by patients and voluntary health insurance premiums represent a large part of the financing. Private healthcare spending amounts to approximately 30% of total spending, reflecting a large share of out-of-pocket payments (including co-payments) which, combined with a strong dependence on indirect taxes, results in a funding system which is slightly regressive.

The Ministry of Finance fixes the annual budget of the national health service based on historical spending and plans laid down by the Ministry of Health, who allocates a budget to each regional administration so that they can provide care to a geographically defined population. The public hospitals are financed by case-mix adjusted global budgets and fixed by the Ministry of Health. Since 1997, an increasing portion of the budget is based on Diagnostic Related Grouping as well as unadjusted outpatient activity. Primary healthcare facilities are financed by the regional health administrations and have no financial or administrative autonomy.

The primary health services in the public sector are principally carried out by general practitioners and family doctors who work in the primary healthcare centres. There is no direct access to secondary health services, with general practitioners acting as gatekeepers.

Secondary and tertiary care are ensured by the hospitals, even if certain health centres offer specialist ambulatory care.

Principles of the Portuguese healthcare system

Current political agenda in Portuguese healthcare combine the expansion and re-orientation of the policies launched by preceding governments (hospitals considered as public enterprises, PPPs, the promotion of generic medicines) with a new approach in terms of the role of the public, as well as the private and social sectors. The Portuguese health system is now viewed as a network of healthcare services between different sectors. The citizens must choose between different options according to their needs and their preferences. Certain reforms which affect secondary care and hospitals in particular (management of waiting lists, public-

PORTUGAL	
Total population:	10,495,000
GNP per capita (2004):	19,475 USdols
Life expectancy mlf (years):	74/81
Infant mortality mlf (per 1,000):	6/5
Birth rate:	11 per 1,000
Fatality rate:	10,3 per 1,000
GDP per capita:	12,500 euros
Total health expenditure per capita (2005):	1,791 USdols
Total health expenditure as a % of GDP:	9,6
Share of public financing of health system	71%
Doctors (2003):	34,440
Doctors per 1,000 inhabitants:	3,42
Nurses:	43,860
Nurses per 1,000 inhabitants:	4,36
Midwives:	824
Dentists:	5,510
Pharmacists:	9,543



private partnerships, incorporated hospitals) are described in the following article, which tackles the Portuguese hospital sector.

The present government programme focuses equally on the reorganisation of medical emergency services, the development of long-term care, a pricing system for publicly financed healthcare delivery, financial incentives to encourage productivity in the public sector, informing the public about public hospital and health centre performance, and finally, fiscal incentives for the development of private health insurance.

Challenges to face

Despite the enormous progress realised in the last few years in the matter of health policy, the health system will always and forever face a number of challenges. Compared to other European countries, the Portuguese health sector spending is characterised by an elevated level of resources compared to its GDP, a low level of spending per capita, significant spending on medicines, and very high spending compared to other countries possessing a similar national health system structure. It has also been shown that the system is performing low in terms of equity, efficiency, accountability, and responsiveness objectives. Numerous health reforms have been legislated, but never completely implemented.

In the near future, it will be essential for Portugal to improve its access to health services, to reduce the inequal-

ities and to guarantee better coordination between primary and secondary care levels. A tendency towards the diversification of healthcare organisms is in view in Portugal, as in most EU countries. Emerging new forms of public management and public-private partnerships aim at improving accountability and cost containment in the health sector.

ICT

In relation to ICT (Information and Communication Technology), the Ministry of Health, via the national health plan, defined the guiding principles by which health establishments can contribute to the realisation of advances in healthcare between 2004 and 2010. The priorities are: technical assistance, hospital access network, use of information technologies and communication, quality certification, the creation and upgrading of health centres, and the modernisation of hospital services.

e-Health is also a national priority in the National Action Plan for an Information Society. The main objective is to utilise ICT to place the citizen at the centre of the health system, while increasing the quality of services provided, increasing the efficiency of the system and reducing costs. The e-Health policy has three lines of action with the following objectives:

- Health information networks: Improve the backbone communication infrastructure of the health sector. Encourage use of this backbone to introduce added-


value services and improve information exchange between health service providers.

- Online health services: Improve communication between doctors and patients. For example, use new applications based on Internet and mobile services to assist continuous monitoring of some chronic illnesses (diabetes, high blood pressure, obesity, drug-dependency), support medication and treatment follow-up, and support the patient's family.
- User cards for patients: Introduce patient cards to provide more efficient and effective personalised patient care.

Besides the national personal data protection law, the clinician practice guidelines, and the publicity and medicines marketing guidelines, there is no separate legal framework for e-Health or telemedicine practice.

Conclusion

Financing and investment are undoubtedly two critical themes for Portuguese healthcare. The limited and unbalanced human resource structure, reflecting poor long-term resource policy and planning capacities in the past, might represent one of the strongest challenges the Portuguese health sector may have to face in the years ahead.

A comprehensive health strategy is now in place in Portugal. This is expected to bring together health promotion and protection issues with health service concerns. (CH) 

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THE PORTUGUESE HOSPITAL SYSTEM

The structure of public hospitals

After significant reform carried out in 2002, public hospitals are divided into three categories:

- Hospitals S.A.: public corporations with the state as the exclusive shareholder (under corporate law). They were created through the transformation of 34 public hospitals, chosen as medium-sized ones with a debt below 35% of total expenditure and having previously demonstrated some management ability. These public corporations received their own capital (the hospitals were recapitalised before being transformed into corporations so as to cover

Portugal has 3,3 acute beds per 1,000 inhabitants, or a total of 33,000 beds (77% public and 23% private). It has 205 hospitals, of which 180 are for acute care. The hospitals are divided into 110 public, 11 semi-public, 40 'private for profit' and 44 'not for profit'. The hospitals are not distributed equally across the country, and the hospitals situated in the rural and central areas have recently benefited from a programme of supplementary investment. There are 24,400 hospital doctors, which represents 73% of all Portuguese doctors. The doctors working in hospitals are employed and paid by the national health system. Doctors who provide services privately at hospitals are paid on a 'fee for service' basis.

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existing obligations and ensure that the hospitals had enough working capital to effectively manage their balance sheets) and took over all assets and liabilities of the former public units. They have financial and administrative autonomy. Hospital boards are independent and accountable for operational and financial results. The new regulation sets an upper limit on corporate hospitals indebtedness at 30 per cent of the social capital (board approval is required when new borrowing raises the debt above 10 per cent of the social capital). The hospitals S.A. started to operate in January 2003 with new management teams appointed by the Ministry of Health. While the hospitals S.A. remain under the supervision of the Regional Health Authorities, their development and performance have been closely monitored by a special task force (Unidade de

Missão Hospitais SA), directly attached to the Ministry of Health. Benchmarking of hospitals is made on a monthly basis, with a focus on productivity and efficacy of resource management. There are plans to add quality indicators in the future and launch patient satisfaction surveys. In 2005, these establishments became trusts of the state. They represent a new model of management integrating private mechanisms, notably for personnel contracts (who are now salaried employees of a private society as opposed to civil servants).

- Public hospitals (SPA): These are public institutions with administrative and financial autonomy, but under public management (under the public sector administrative law). They concern the 51 remaining public hospitals. The modernisation of



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Bisolvon and Mucosolvan Mucolytic therapy in acute and chronic bronchopulmonary diseases associated with abnormal mucus secretion and impaired mucus transport.
Combivent Treatment of bronchospasms associated with reversible obstructive airway diseases in patients requiring more than one bronchodilator.
Silomat Symptomatic treatment of irritable, non-productive cough.
Spiriva (in co-promotion with Pfizer) Tiotropium is indicated as a maintenance bronchodilator treatment to relieve symptoms of patients with chronic obstructive pulmonary disease (COPD).

CARDIOLOGY

Actilyse Fibrinolytic treatment of acute myocardial infarction, acute massive pulmonary embolism and ischaemic stroke.
Metalyse Metalyse is indicated for the thrombolytic treatment of suspected myocardial infarction with persistent ST elevation or recent left Bundle Branch Block within 6 hours after the onset of acute myocardial infarction (AMI) symptoms.
Micardis and Micardis Plus Treatment of essential hypertension.

CENTRAL NERVOUS SYSTEM

Cymbalta (in co-promotion with Lilly) Major depressive disorder (MDD), diabetic peripheral neuropathic pain (DPNP).
Lendormin Insomnia requiring pharmacological intervention.

IMONOLOGY – HIV / AIDS

Aptivus Used co-administered with 200 mg of ritonavir, is indicated for combination antiretroviral treatment of HIV-1 infected adult patients with evidence of viral replication, who are highly treatment-experienced or have HIV-1 strains resistant to multiple protease inhibitors.
Viramune Is indicated as part of combination therapy for the antiviral treatment of HIV-1 infected patients with advanced or progressive immunodeficiency.

UROLOGY

Pradif Lower urinary tract symptoms (LUTS) associated with benign prostatic hyperplasia (BPH).

OTHER PRODUCTS

Buscopan Gastrointestinal tract spasm, spasm and dyskinesia of the biliary system, genito-urinary tract spasm.
Buscopan Compositum Paroxysmal pain in diseases of the stomach or intestine spastic pain and functional disorders in the biliary and urinary tracts and female genital organs (e.g. dysmenorrhoea).
Dulcolax Laxative for use in patients suffering from constipation. In preparation for diagnostic procedures, in pre-and postoperative treatment and in conditions, which require defecation to be facilitated.
Movalis Short-term symptomatic treatment of exacerbations of osteoarthritis;
Long-term symptomatic treatment of rheumatoid arthritis or ankylosing spondylitis.
Pharmaton To improve physical and mental performance and well-being.

the management is essential to avoid creating a two-speed system. It started in August 2003 with the adoption of new regulations that try to replicate as much as possible the hospital S.A. experience within the public sector. New management teams were appointed at end-2003. Contract programmes will be established with each hospital, setting objectives and quantitative targets, priorities and modalities for the provision of services, quality standards, and monitoring and evaluation systems.

- Public-Private Partnership (PPP) hospitals: public institutions with administrative, financial and asset management autonomy under contracted private management (under the public sector administrative law). Ten PPP hospitals (including eight substitutions to existing old facilities and two additional units) are planned to

be built by 2010. The first one should be inaugurated in 2008 in Loures. Ten-year contracts for the operations and thirty-year contracts for the infrastructure will be granted after competitive bidding, with technical competence and economic terms offered being the most relevant criteria. Most hospitals under PPP will be linked with one university, so as to increase the number of doctors in the future. The lesson, which Portugal learned about PPPs with the Amadora Sintra pilot experience, was the need to put in place a very strong legislation as regards supervision of these PPPs, and to ensure close monitoring of the performance of these PPPs.

Waiting lists

One of the most important problems which affected the hospital sector at the beginning of the decade was the very long waiting lists for non-urgent

surgery. 1% of the population was on the waiting list in 2002, and it had reached six years. According to experts, these long waiting lists were due to the low productivity of public hospitals, limited doctor availability because of time spent in private practice, and lack of nurses. The strategy of the authorities to win quick visible results also includes a special programme to eliminate, within two years, the waiting lists for surgery (Programa Especial de Combate às Listas de Espera Cirúrgicas, PECLEC). The programme relies on contracting some private (profit and non-profit, if necessary foreign) hospitals, which are being paid on a DRG basis, as well as a more productive use of resources in the public sector resulting from the changes in management, and extra financial resources provided to public services and staff engaged in the programme. (CH) ■

continued from page 29

and are recommended for special care areas of the hospital such as surgical areas, burn ICU units, and protective environments for such patients. In one study, bone-marrow transplant recipients were found to have a tenfold greater incidence of nosocomial *Aspergillus* infection, compared to other immunocompromised patient populations, when assigned beds outside of a HEPA-filtered environment (Sherertz et al., 1987).

Other than providing good quality air and ensuring adequate ventilation in patient-care areas, instituting effective prevention and control measures during construction and renovation is critical. Effective measures include using portable HEPA filters, installing barriers between the patient-care and construction areas, using negative air pressure in construction/renovation areas relative to patient-care spaces, and sealing patient windows.

In addition to these key strategies, the regular cleaning and maintenance of Heating, Ventilation and Air Conditioning (HVAC) systems as well as

the water supply systems and point-of-use fixtures (such as showers, faucets, respiratory therapy equipment and room-air humidifiers) is critical to prevent the growth of infectious pathogens that may cause airborne and waterborne diseases among patients and staff in the hospital.

To summarize, three key environmental design strategies that may be effective in reducing nosocomial infections in hospitals include:

- Provide numerous, conveniently located alcohol-rub dispensers or washing sinks at the point of care to increase handwashing compliance.
- Provide HEPA-filtered single-bed rooms for immunocompromised patients and other high-acuity patient groups. Also, HEPA filters are strongly recommended in all construction and renovation areas.
- Provide single patient rooms to reduce nosocomial infections. ■

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