Hospital

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EUROPÄISCHE VEREINIGUNG DER KRANKENHAUSDIREKTOREN
EUROPEAN ASSOCIATION OF HOSPITAL MANAGERS

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ACCREDITATION

CAPACITY PLANNING

PLUS

- European Health Consumer Index
- Focus: Belgium

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Healthcare managers and development tools for organisations

It would be an understatement to say that European hospitals are currently facing a number of challenges. Beyond the particularities and specific characteristics of each EU member state, questions are arising everywhere regarding the exact role of hospitals, their ability to meet patient expectations, their appeal in a highly competitive environment, changing financing structures, etc. Despite the apparent dissimilarity of these issues, they all have one thing in common: they call into question the establishments' organisation and their ability to continue moving forward.

More than any other institution, hospitals are perpetually evolving entities that must constantly adapt to their environment, improve their efficiency and review their organisation in order to provide care that is most suited to the needs of their patients.

This task is, of course, at the heart of the job of hospital managers, who have many tools available to aid them in accomplishing this mission of optimising hospital organisation.

These tools and methods have taken many shapes and sizes and differing outcomes depending on the time period and the country. However, accreditation, and more generally, quality assessment, has become a critical and central approach in all member states. In this context, the articles included in this new issue of *(E)-Hospital* will enable every reader to take notice of the groundbreaking nature of today's approaches to external quality assessment and evaluation in Europe, which have demonstrated their power, positive character and ability to make organisations more efficient everywhere.

In keeping with its mission of contributing to health in Europe, EAHM chose to go even further in addressing accreditation systems and it has drawn up the framework of what could become a European accreditation model.

The association's next seminar, which will take place on 16 November in Düsseldorf, will thus provide hospital managers with the opportunity to discuss accreditation and quality assessment systems and, ultimately, consider the conditions for a harmonised European approach on the subject. Without replacing of existing systems or negating the particularities of each member state, such an approach would make it possible to define a qualitative European standard accepted by all and visible to patients.

Of course, the move towards accreditation is not the only tool available to healthcare managers to help improve their organisation, and in that sense new technology offers innovative possibilities and endless opportunities for development. This is the case in particular for the capacity planning method, which will undoubtedly have promising uses for hospitals and which *(E)-Hospital* is promoting today.

Paul Castel

Clearly, the challenges that hospitals face are expansive, but so are the solutions, and hospital managers will undoubtedly demonstrate their ability to move forward and work together. In that regard, EAHM is fulfilling its role now more than ever as an influential think tank. It will continue its efforts to develop new European visions in the field of healthcare.

Paul Castel
EAHM President

ACCREDITATION

is a pivotal issue for all European hospitals, and the theme of the upcoming EAHM seminar. An introduction and concise overview of main accreditation models and national schemes contextualizes the topic. Two articles definitely broaden our readers'views on the issue: Jeffrey Braithwaite tells us about accreditation in Australia, and more specifically about the process reliability and interaction with hospital culture, while Karen Timmons updates us on the latest JCI accreditation standards, focusing on a patient-centered approach.

In addition, Maximilian von Eiff reports on a practical experience with Six Sigma.

PAGE 14-24

CAPACITY PLANNING

Same capacity planning problem, different solution: Professor Kuntz analyzes the German situation and favours alliances, while Knut Bergsland demonstrates that expansion is not the only answer. Sometimes, a restructuring of the workflow is more efficient than a few extra rooms.

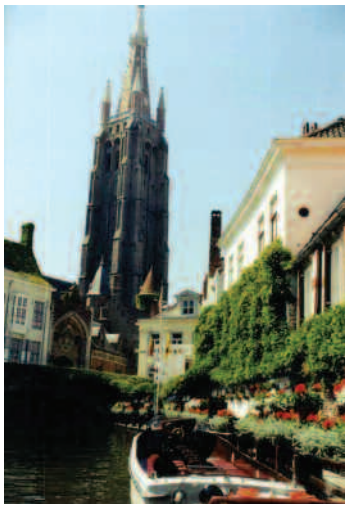
Periodically, technology offers an alternative to capacity planning issues as well: a Swiss hospital fitted all the beds with an RFID chip and acquired the corresponding bed management system, resulting in an availability to function at the same level with 20% less beds.

PAGE 25-30

VOLUME 9 - ISSUE 5/2007 - DECEMBER/JANUARY

(E-)Hospital

FOCUS: BELGIUM



The Belgian health system is characterized by its intricate structures, and its responsibilities split between the federal and regional system.

This results in high costs to the taxpayer. However, the accessibility of the system to citizens is one of its major benefits.

The Belgian association of hospital managers helps local hospital managers get proper training and exchange experiences with colleagues, either nationally, during frequent seminars, or internationally, on the occasion of regular study trips. The Belgian association also actively supports the European association of hospital managers.

PAGE 31-36

FOCUS: BELGIUM

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EAHM ACTS ON MOBILITY OF HEALTH WORKFORCE

After concluding its short survey in September 2007, the EAHM Subcommittee "European Affairs" has decided to further push ahead on the issue of mobility of health workforce.

The EAHM survey, *Mobility of Healthcare Professionals* answered pertinent questions concerning migration of staff within countries and hospitals. Highlighted were inquires into whether staff migration was viewed in general, beneficial or a detrimental; specifics concerning the percentage of hired foreign staff within country/hospital; as well as a focus on main problems and what in the view of hospital management, should be done about them.

Answers showed the following general results:

Benefits

Notable differences appeared between western and eastern European Countries: While western European countries largely reported benefiting from mobility, (i.e. Austria, France, Luxembourg, Netherlands) eastern European countries did not report any benefit, and some stated present problems and/or expected issues to arise in future.

In Bulgaria for example, directors of several hospitals noted that there are doctors working abroad, but most of them specialise in different areas and are expected to return in a year or two. Fluctuation of nurses, midwives, X-ray, and clinical laboratory assistants is more alarming however. There was not a single health institution in the country, which did not lose at least five nurses during the past month. Mobility is a troubling concept for Bulgaria because for the last 16 years the number of doctors decreased by one fifth, which means that within a few short years it will suffer from severe deficit of highly specialized medical personnel. In Croatia, it is expected that after entering the EU, the problem (or benefit) of mobility of healthcare professionals will mimic that of other countries in transition. Lithuania already is suffering from the growing mobility of healthcare professionals, especially in regards to doctors. In Poland, research conducted last year in Ma_opolska Region showed that at the moment, there is no threat for the healthcare delivery system due to growing mobility. There is, though, a threat in the longer term, since most professionals leaving the country are relatively young—meaning that within the next couple of years, Ma_opolska will likely suffer due to a generation gap. Reports from other Polish regions seem to echo this trend, leading to the conclusion that professional mobility is or shortly will be a problem for the Polish healthcare system.

Interestingly, in the UK, the situation can judged as two-fold: Receiving foreign staff means less stability and less relationship building, but also and more positively, "new blood" injects energy and new ideas into the hospital environment.

Figures

In response to the question regarding the percentage of hired foreign staff in hospitals, figures for doctors in western European countries lie between 3.56% and 7%; for healthcare staff in general—figures are between 3-30% with an average of 5% in Germany and 10% in the Netherlands.
In the Netherlands, the highest percentages of foreign staff are nurses and medical technicians (up to 30%!). Regarding non-medical professionals in France and Germany, the percentage of staff from abroad is lower than for doctors (in France less than 1 %, in Germany, 4%).

Noteworthy is that in Lithuania, it is not possible to hire foreign staff due to lack of a juridical basis (as well as a distinct difference in payment).

Problems

Language barriers were cited as the main problem with mobility of healthcare professionals (Austria, France, Luxembourg, Germany, Netherlands). The second most underlined difficulty concerns bureaucracy (work licence, diploma homologation, registration in appropriate registrar) and was reported in Austria, France, Ireland, and Germany. These issues created time complications and left no possibility for flexibility. Cultural integration problems were cited by the Netherlands and the UK, but were overshadowed by the other factors. The Netherlands also cited fiscal problems.

Interestingly, Luxembourg stated that education standards are higher abroad, and as a result, staff being trained in Luxembourg is requesting a revaluation of the country's education. Hospitals are also being criticised for hiring foreign doctors, who are often highly specialized. The fear

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is that it creates a "demand" for specialists, which could influence health insurance budgets.

Regulation

In terms of possible means of solving problems or regulating existing gaps, answers could be classified in two categories: Creating standards for common education/practice; and creating central points of information.

Some countries pleaded for common training standards (France, Ireland, Luxembourg, Germany), whilst others pleaded for common practice standards (Bulgaria, Ireland, UK, Germany), while some pleaded for both.Luxembourg also proposed continued training to acquire necessary knowledge of work practices, including language courses (also the main proposal from Germany).

France also proposed the creation of a "Board" – as the go-between for hospitals and professionals. The Netherlands and Bulgaria appealed for the construction of an information point where migrating professionals can inform themselves on necessary education standards, procedures to follow, etc.
The Netherlands also pointed to the necessity of mutual acceptance of educational and training paths (if training hospitals want to accept residents from abroad). A framework of professional standards is an important basis for this, and should be regulated on a European or at least bilateral level.

After considering these results, the EAHM Subcommittee "European Affairs" decided at its' meeting on 19 October 2007, to suggest to the EAHM Board and Executive Committee to further act on the issue. With the support of several cross-border regions, initial exploratory meetings with involved hospitals (i.e. in the Region Rhine-Maas with the University hospitals of Maastricht and Aachen) and university representatives have been proposed. These proposed meetings will be an opportunity for all involved to further discuss how existing problems and shortfalls for hospitals can be overcome.

First programme announcement of the 2008 EAHM Congress in Graz, Austria

The Scientific Subcommittee at its meeting on 12 October 2007, has elaborated on the scientific programme of the forthcoming EAHM Congress in Graz (Austria) on 25-26 September 2008. (Also see announcement on p.41)

The following programme titles have been defined:

New Leadership for new challenges

- Hospital Management meets Leadership -

Thursday September 25th 2008

14:00 – 15:30 Leadership meets Politics
16:00 – 17:30 Leadership meets Economy

Friday September 26th 2008

09:00 – 10:30 Leadership meets Ethics
11:00 – 12:30 Leadership meets Patients
14:00 – 15:30 Leadership meets Healthcare professionals
- Mobility
- Ageing workforce

16:00 – 17:30 Leadership meets Leaders
- Accreditation
- Hospital governance

Numerous EAHM member states had responded to the call for papers and had suggested many high-level speakers and moderators. Members of the Scientific Subcommittee were happy to review very interesting presentation titles and abstracts, rendering the selection however difficult. Following lengthy and in-depth discussions, the selected speakers from all over Europe now promise to turn the event into a successful Congress! For further details and developments please regularly check the Congress website: www.evkd-kongress2008.eu

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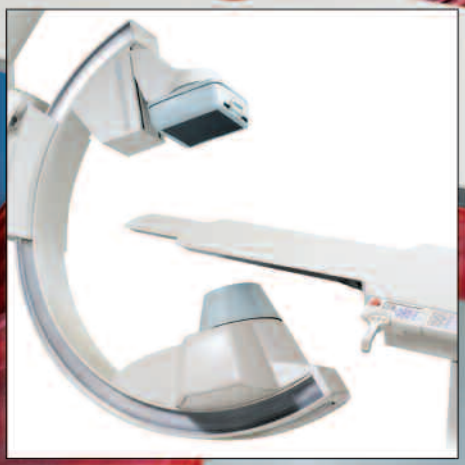

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Initial information on planned EU action on healthcare services

Following consultations, the Commission is preparing its action on healthcare services and cross-border healthcare. These issues have been discussed widely at the European level and the Commission has recognized the need to address current uncertainties about the application of community law to health services, and to provide support for efforts to improve effectiveness, efficiency, quality and safety of national health systems. Health ministers have welcomed the Commission's initiative and endorsed the need for action. The planned EU action, which is to be tabled shortly is likely to be a package of legislative and non-legislative measures, including a directive and a communication.

The Commission, together with representatives from member states is drawing up a list of highly specialised and expensive services. For those services, in the case of cross-border performance in a hospital, a prior authorisation from the payment provider would be needed. For non-hospital care, no such authorisation would be required.

Also planned are extensive information rights for patients as well as the duty to inform for service providers and member states. The latter would have to set up "patient information centres" to support patients from abroad in finding the right service providers and in cases of potential damage claims.

At the European Health Forum in Bad Hofgastein (see further), Markos Kyprianou highlighted some goals: "We should aim to reduce inequalities and disparities between regions by enabling interaction and cooperation between different health systems. Health technology assessment is a good example, where it is more efficient for everyone to collaborate on assessing new health technologies rather than duplicating assessments across member states. A clear framework at the EU level would also provide clarity for healthcare purchasers and health insurers to take full advantage of expertise in other member states, such as through European networks of centres of reference."

The Commission is planning two further specific initiatives in 2008 – one on patient safety and another on a health workforce in Europe, the Commissioner said.

In all cases, the benchmark should remain what works in practice for patients,physicians, hospitals and for health systems as a whole, he finished.

Second programme of community action in the field of health

On 9 October, the Council adopted a decision establishing a second programme of action in the field of health. Ministers approved all amendments from the European Parliament in second reading.

The programme is established for the period from 1 January 2008 to 31 December 2013 on the basis of a budget of 321,5 million euros. The objectives are: improvement of citizens' health security; promotion of health, including the reduction of health inequalities; and generation and dissemination health information and knowledge.

To ensure full participation in the programme by organisations that promote a health agenda in line with the programme objectives, a wider variety of financing mechanisms are offered. These include:

- cofinancing of projects intended to achieve a programme objective,
- tendering actions to achieve a programme objective;
- cofinancing of the operating costs of a non-governmental organisation or a specialised network;
- joint financing of a public body or NGO by the Community and one or more member state;
- joint actions with other Community programmes, which will generate coherence between this instrument and other Community programmes.

The Health Programme 2008-2013 is intended to complement, support and add value to the policies of the member states and contribute to increased solidarity and prosperity in the European Union by protecting and promoting human health and safety and by improving public health on the whole.

10 Years Gastein - Shaping the future of health

At its 10th anniversary, the European Health Forum Gastein has been established more than ever as an international health policy platform, which plays a key role in the preparation and presentation of new activities. The event, which took place this year in Bad Hofgastein from 3 to 6 October, was the most important health policy event in the EU. More than 600 high profile experts took part in nearly 30 individual events.
One of the key events was the session on planned EU actions in healthcare. Leading EU experts and member states involved in drawing up these measures had the opportunity to meet at Gastein in order to discuss the Commission's recommendations immediately prior to the expected closure of proceedings.

A second key topic was to support innovation and to stabilise key areas. The continuously increasing numbers of patients and rising costs demand new medical and organisational approaches to the treatment of chronic diseases, in particular diabetes. New technological innovations, as well as new forms of care will be necessary to stabilise these key areas of European health services for the future. New care models outdated structures and permanently change the care of the chronically ill. Experts hence presented numerous successful examples of innovative solutions in a push to implement them across Europe.

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Health Consumer Index and MRI legislation

By Rory Watson

Austria runs a healthcare system that is consumer friendly and provides excellent results, according to the Euro Health Consumer Index, which nominates the country as the winner in its latest annual survey. It is placed narrowly ahead of the Netherlands, France, Switzerland, Germany and Sweden. At the other end of the table are several "new" European Union countries: Latvia, Bulgaria and Poland with Lithuania, Romania and Hungary only narrowly ahead.

Now in their third year, the rankings were produced by the Brussels-based analysis and information organisation, Health Consumer Powerhouse. Placement is determined by 27 indicators grouped into five categories: patients' rights and information, waiting times, outcomes, the generosity of public healthcare systems and access to medication. Indicators are selected to evaluate the extent national healthcare systems are user-friendly. They do not take into account whether the system is publicly or privately funded.

The findings, according to the authors, suggest that the Bismarck healthcare system, widely used on the continent, based on social insurance with many insurance institutions, delivers better customer value than the Beveridge model where, as in the UK, financing and provision are handled within one organisational system.

The commentary accompanying the index notes: "It is very hard to avoid noticing that the top five countries, which fall within 36 points on a 1,000 point scale, all have dedicated Bismarckian healthcare systems. There is a gap of 30 points to the first Beveridge country in sixth place."

The survey reveals major differences in waiting times for medical treatment. For major non-acute operations within 90 days, Belgium, Germany and Switzerland all fare well. The Czech Republic, Estonia, Hungary Ireland, Italy, Latvia, Luxembourg, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden and the UK do not.

When it comes to more serious treatment, cancer therapy can be provided within 21 days in only Austria, Belgium, Cyprus, the Czech Republic, Finland, France, Germany, Luxembourg, Malta, Norway and Switzerland. The divide is even greater for MRI scans. Only Austria and Belgium can offer them within seven days, while the situation is considered "poor" in 15 of the countries surveyed. These include many of the new EU members, but also Denmark, Finland, Greece, Italy, Spain, Sweden and the UK.

The authors note that, in some respects, progress is not only slow but lacking. They conclude that "MRSA infections in hospitals seem to spread and are now a significant health threat in one out of two measured countries". The only countries to be given a "good" rating in this regard are Denmark, Estonia, Finland, the Netherlands, Norway and Sweden.

The survey acknowledges that the countries covered have very different levels of health expenditure, ranging from around $600 per capita in Bulgaria and Romania to between $4,000 and $5,000 in Norway, Switzerland and Luxembourg with most European countries averaging around $2,500 to $3,000.

To take this financial factor into account, they have worked out a general value for money table. While well-established healthcare systems in countries such as Austria, the Netherlands, Finland, France and Germany perform strongly, Estonia comes out on top. In contrast, the UK emerges fourth from bottom.

Meanwhile, the European Commission is recommending that EU health and safety legislation which should take effect next April, and would have unintentionally restricted the use of Magnetic Resonance Imaging (MRI) in patient care and scientific research, should be postponed for four years.

The proposal, which will be formally approved by EU governments and the European Parliament in the coming weeks, follows a determined campaign by the Alliance for MRI – a coalition of Euro MPs, patient groups, scientists and medical professionals. It had pointed out that the legislation would have unnecessarily limited the amount of time operators could spend near MRI machines to the detriment of patient care and research.

The four-year delay will be used to carry out further research in this area and to draft entirely new legislation.

Instructions:
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INTERNET

Internet users can now have access to their own medical file on the Internet. Thanks to the HealthVault site, proposed by Microsoft, patients can manage and store their own medical records. Financed by targeted ads, the site contains a search engine and specialised tools with which patients can, for instance, control their weight or the evolution of their condition. Microsoft officials claim that the confidentiality of sensitive data will be strictly guaranteed.

This new service puts Microsoft in the lead, before Google, which will soon launch a similar application called Google Health. The software will provide the user with alert messages for prescription renewal or medical appointments, as well as information on local doctors.

More than half of American adults regularly search the Internet for health information.

FRANCE

The French Senate recently released a report aimed at reducing the number of doctors where they are overrepresented and developing telemedicine in order to enhance access to healthcare in areas lacking doctors.

To this end, the report proposes not only to improve information on aid provided to doctors who practice in remote areas, but also to impose financial penalties, such as reduced consultation fees, for doctors opening a practice in an area where health professionals are already overrepresented. This latter measure is fiercely criticised by medical trainees, who are organizing demonstrations throughout France to protest it.

SPAIN

The new health minister, Bernat Soria, has given details of his plans for the next six months, which include a joint conference with the ministry of education to match jobs in the health sector to the needs of the Spanish public. He announced a human resources study for the nursing sector, together with more opportunities for resident doctors, and medical students in Spanish universities.
He also mentioned increasing possibilities in Spain for doctors from other countries, but only when they meet the requirements of the Spanish health service.

BELGIUM

The largest Belgian consumers association has proposed the formulation of precise guidelines about patient information in hospitals, after establishing that most hospitals do not systematically provide written and exhaustive information about potential risks, existing options and expected outcomes of tests or operations. For instance, in the case of hip prosthesis, details about pros and cons according to the type of prosthesis, side effects, posssible complications, success rates, durability of prostheses, alternatives... are often missing or incomplete. One fourth of Belgian hospitals volunteered to participate to this study.

To fill the information void, Belgian hospitals are encouraged to put together brochures on as many surgical procedures as possible, review them annually, appoint in each hospital a patient information coordinator, submit new brochures to a patients panel, and promote cooperation between hospitals around basic and common documents, according to the association.

UNITED KINGDOM

NHS trusts hygiene

More than a quarter of NHS trusts in England failed to comply with the hygiene code brought in by the government to combat superbugs in hospitals and doctors' surgeries. 70% of primary care trusts failed to ensure patients got a choice of four NHS or private hospitals for surgery or treatment. Most trusts admitted the failings, but inspectors identified 12 where senior managers signed a declaration saying they were complying with national standards on infection control. They were later discovered to have breached the rules.

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QUALITY ASSESSMENT SYSTEMS IN HEALTHCARE

A European perspective

By Ewa Gojniczek

Europe faces an incredible diversity of national healthcare systems. The extent of this problem is intensified by the fact that the European Community's competence in this field is marginal. Article 152 of the Treaty establishing the European Community states that the EU must fully respect members' responsibilities for the "organisation and delivery of health service and medical care". In this case, the limits of this subsidiarity principle should be emphasised. It only applies once the member states fulfil their basic obligation, namely ensuring the delivery of high quality healthcare service. Judgments of the European Court of Justice have shown that member states do not fully comply with this requirement. The Watts-case (Case C-372/04) points out that a state can refuse authorization for treatment abroad, if it is not assured that the patient in question receives "high quality treatment".

This creates important challenges for European hospitals in terms of quality requirements and progress measurement. Problems, such as reducing the number of errors in healthcare, still represent a major hurdle for hospital management.

Quality management in healthcare may be defined as a system that defines the quality policy, objectives and responsibilities and puts into place the structures (quality planning, quality control, quality assurance and quality improvement) to ensure it. The organisation of such systems differs from country to country due to

COUNTRY	PROGRAMME / RESPONSIBLE BODY	VOLUNTARY/ OBLIGATORY	NATIONAL/ REGIONAL
Denmark (DK)	National Institute for Quality and Accreditation, IKAS (in future - control of hospitals), programme in development	Obligatory (from the 2008)	National
Finland (FIN)	The Social and Health Quality Service (SHQS), body - SHQuality Ltd	Voluntary	National
France (F)	Haute Autorité de Santé (HAS) - Non - governmental but independent public body with financial autonomy	Obligatory for all healthcare organisations (private and public)	National
Germany (D)	1. KTQ - Kooperation fuer Qualität und Transparenz GmbH. (approx. 600 hospitals have this certificate) 2. JCI-A Joint Commission international (7 hospitals) 3. ISO 9001:2000 (unknown number of hospitals, only a few hold a certificate for the whole hospital)	All Voluntary	All national
Ireland (IRL)	Major Academic Teaching Hospitals (MATHs) Accreditation Project - Private hospitals	Voluntary	No information
Italy (I)	Regional systems monitored by the National Agency for Regional Health Service in Rome, examples: 1. Accreditamento Instituzionale Regione Emilia-Romagna 2. Region Marche	1. No information 2. No information	Regional (national law to establish regional models and standards based on national guidelines) 1. No information 2. Managed by the government
Lithuania (LT)	Accreditation of Health Care Organisations (programme for 2008-2010, is not yet approved by the Ministry of Health) managed by the State Health Care Accreditation Agency under the Ministry of Health	Voluntary	National
Netherlands (NL)	Nederlands Institute voor Accreditatie van Ziekenhuizen (The Netherlands Institute for Accreditation of Hospitals)	Voluntary	National
Poland (PL)	Program Akredytacji Szpitali (National Centre for Quality Assessment in Health Care)	Voluntary	National
Portugal (P)	Health Quality Service (HQS) Instituto da Qualidade em Saude (IQS)	Voluntary	A pilot national accreditation programme began in 1998 with funding from the Ministry of Health
Slovakia (SK)	Slovak National Accreditation Service, Centrum pre kvalitu a akreditaciu v zdravotnictve (Centre Quality and Accreditation in Health care)	Voluntary	National

the absence of comprehensive and common standards. The most effective and internationally accepted methods for external quality assurance are those resulting from assessment and audits.

Models

There are four basic external peer review models (approaches) intended to measure the quality of service management:

1. Industrial certification- International Organisation for Standards (ISO 9000 series) (Switzerland, the Kings Fund Institute)
2. European Foundation for Quality Management – EFQM (Scandinavia)
3. Speciality driven visitation such as Visitatie (Dutch version of scheme based on the peer review)
4. Accreditation in healthcare (UK, Mediterranean countries)

This list is far from an exhaustive one. It includes examples of several attempts at assessing quality in European hospitals; those that possess an established position of experience in the European market. There are of course other programmes and methods in use. As mentioned earlier, the European systems differ greatly and it is no straightforward procedure to summarise the diversity of this field in a simple table. However, it is hoped that the table will serve as an explanatory tool for the reader to understand and assess the models and the issues these models face.
The programmes are listed by nation. The first column contains names of the programmes and main managing body or organisation. Secondly, we have two columns describing the range and status of the programmes. A fourth category explains the scope of the programme, namely what kinds of institutions can be part of the scheme. Fifthly, we describe either the model that was used to develop the system or the model that is currently in use. This categorisation is dependent on available information, which is not always complete. Where national legislation requires quality assessment, the last column attempts to identify the legal act in question.

Let us consider one example more closely, the Netherlands accreditation model. Here it is important to mention that there are other systems used in the Netherlands, such as visitatie, which is not included in the table. The system covers approximately 50% of acute hospitals. The whole process comprises four phases and takes around four years. It starts with a voluntary application and ends with a contract signed with NIAZ. After submitting the application, the organisation undergoes a self-assessment process according the NIAZ standards and prepares a report. On the basis of this report, NIAZ decides if the organisation can undergo a survey. If this is the case, the second stage begins. This survey is prepared by an audit team (trained by NIAZ), who prepare a report. This report is then a base for an "action plan". This plan contains specific actions on how to improve the quality in a particular organisation. NIAZ subsequently decides to grant or reject the application for accreditation. The final phase of the process begins after the institution has been granted the accreditation. After one year, another survey is made, especially to check the implementation of the "action plan". If this proves to be positive, the accreditation is then extended to a period of four years and is published on the NIAZ website. This model is entirely voluntary (where in France, for example it is enforced by law) but covers already around 50% of the total number of hospitals in the Netherlands. The system is private but publicly regulated. A very important characteristic is that it not only helps to assess the quality in healthcare, it also requires constant improvement and development of standards. This scheme serves as a simple example of one of the systems aiming to measure quality in healthcare, namely the accreditation.

SCOPE	MODEL	LEGISLATION
Both public and private hospitals	Model developed in Denmark	No information
All health and social service (public and private hospitals, primary healthcare, health centres, rehabilitation centres, nursing homes, etc.)	The King's Fund (also elements of ISO 9000)	No legal requirement (Ministry of Social Service recommends adopting Quality Managementsystems in all health and social service organisations)
All private and public healthcare organisations	Accreditation (mixed model - Canadian/ Catalon	Parliamentary Law April 24, 1996
Hospitals, doctors surgeries, dental surgeries, psychotherapy centres, rehabilitation centres and in-patient health care facilities, ambulatory care services, hospices and alternative residential arrangements	Certification KTQ has some characteristics of JCI-A	No legal requirement
Acute care, palliative care	Based on Canadian programme	Irish Health Services Accreditation Board Establishment) Order, 2002
1. No information 2. No information	1. No information 2. Canada, Australia	National Government D.L. 14.1.1997 and D.L.229, 1999; 3. Regional Authorisation and Accreditation Act, 1. No information 2. Marche Regional Council no 20.2000
Hospitals and general practitioners, both public and private	Has to be decided/ approved by the Ministry of Health	"The Law on Health Care Organisation" and "The Law on Health Care"
Public facilities	Based on Canadian model (currently main standard EFQM)	1996, Kwaliteisswet zorginstellingen
Hospitals, both private and public, especially acute, and also psychiatric units	Joint Commission	Health Organisation Act 1997 (art. 18c - accreditation as an external method for assessment in health care)
No information	Parent programme HQS (UK)	SNS 21, 1998
All resorts and health service laboratories (ISO standards)	ISO standards (Poland, USA)	(In 2003 no legislation)

International Organisation for Standards

This model has its roots in standards designed for defence engineering and manufacturing industries in the United Kingdom in 1947. Currently there are 11,000 international standards in use. In the field of healthcare, there were 230,000 ISO 9000 certificates awarded. The process consists of certifying organisations, which mostly operate on a for-profit basis and are recognized by national accreditation bodies, which carry out audits.

These organisations focus on quality systems and process control. This approach is not peer-reviewed since experts using ISO norms, not a sector-specific organisation, perform it. The specific norms/standards may be applied in all types of organisations. Thus, this method stresses system quality and not actual work content. When this model is used in quality management, it may contribute to a description of the process itself but not the appropriateness of a specific treatment. The ISO method is mostly applied in technical departments (such as laboratories, transport) and describes the management and decision making process in hospitals. This frequently updated model is often seen as one that can easily merge with others.

European Foundation for Quality Management

14 large European companies with the support of the European Commission originally introduced this model. At present, it comprises some 600-member organisations. This model is the only one to originate exclusively in Europe. It serves as a base for some national quality awards. EFQM focuses on the quality management development perspective.

This model may be used as a self-assessment tool or by organisations applying for external review in order to achieve the European Quality Award (or national awards). The basic idea behind this project is to motivate and support development and improvement in activities leading to quality in areas such as customer satisfaction as well as business results. This model supports the implementation of so-called Total Quality Management. There is a noticeable difference with ISO, as the EFQM does not standardise systems, but promotes quality management. This is achieved through award schemes and self-assessment, wherein a special published model is used. The EFQM appears to be the most complete model, as it focuses on Total Quality Management and defines the necessary quality areas that require management.

Visitatie

Medical associations originally implemented this model as a peer review for re-registration of members in the Netherlands in 1992. Currently, this method is commonly used in the Netherlands, but also serves as reference in other countries. The method was developed by professionals and is carried out by them.

It focuses on clinical performance, with a special emphasis on knowledge and skills. In the visitatie scheme, the emphasis is placed on the functioning of specific groups of specialists more than on the whole organisation, and it provides no award or certification at the end of the process.

The Healthcare Accreditation

Origins of this model go back to 1917, when the American College of Surgeons set up a Hospital Standardization Program. It was later introduced in Australia in 1926, then in Canada in 1953 and only in the 1980s in Europe (in the Catalan region of Spain). It is now used internationally (for example, more then 80% of nations participating in the ExPeRT project used this model). Professionals created it with a focus on the organisational process. This model puts emphasis on specific departments, only recently extending it to the whole organisation. It seeks to grasp all the activities in healthcare organisation, not only the management process, but also important issues such as infection contamination in hospitals.

Legislation

In some countries, such as Greece, Portugal, Ireland and the United Kingdom, little governmental action is taken in the field of health service standards. Outcomes vary according to the use of quality assessment systems or the lack thereof. In Portugal, there is an ongoing debate going on about issues concerning quality in healthcare, no implementation planned. In contrast, the United Kingdom has a series of successful programmes (such as the Hospital Accreditation Programme) without national regulation.

Short comparison

According to the ExPeRT project, ISO is the most commonly used method, followed by accreditation, then EFQM and visitatie. The popularity of the ISO 9000 may be explained by the fact that it is internationally recognised and may be applied only to particular departments. Accreditation, on the other hand, is designed to be applied to the whole organisation. All methods have interesting

and valuable elements, but accreditation and visitatie seem to be the most adequate to healthcare professionals. Both EFQM and ISO deal primarily with the organisational side of the process.

Summary

Although there is no unique European system for external quality assessment in hospitals, some convergence may be observed between national situations. Responsible bodies in different European countries recognise positive elements in all models and try to implement them into their national systems. In some countries, such as Sweden and the United Kingdom, all of the models are used simultaneously. A trend towards creating international standards is also developing (for example ALPHA standards of the International Society for Quality in Healthcare). Seminars, such the one organised by the European Association of Hospital Managers, create great opportunities for discussion in this field. Hopefully, in the near future, a single European model for external quality assessment will emerge in all hospitals.

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RESEARCHING ACCREDITATION

By Dr David Greenfield and Professor Jeffrey Braithwaite

There are now over 70 national accreditation agencies and an international body, the International Society for Quality in Health Care (ISQua). While there have been many calls for research into accreditation, the evidence base to support the claims of many programmes remains insufficient (Greenfield 2007; Greenfield et al. 2007; Shaw 2003). In 2004, the Centre for Clinical Governance Research (CCGR) at the University of New South Wales, Australia, in conjunction with industry partners the Australian Council on Healthcare Standards (ACHS), an industry body responsible for standards and accreditation, and Ramsay Health Care, a private health care provider, commenced a multi-faceted project to research accreditation.

An overview of health service accreditation by ACHS

The ACHS has over 1000 member organisations, making it the major health service accreditation agency in Australia. The ACHS, in consultation with representatives from the health industry, has developed a continuous quality improvement programme called the Evaluation and Quality Improvement Programme (EQuIP). The programme has been revised regularly and is now in its fourth edition. During the period 2003-2006, using the third edition of EQuIP, ACHS conducted 1233 accreditation surveys (AHCS 2007). The programme contains a set of standards that cover infrastructure or organisational issues as well as a continuum of patient care issues. Infrastructure standards, for example, include human resource management in addition to leadership and management functions, while continuum of care standards include consumer participation in the care process itself and care planning processes (ACHS 2002).

ACHS assesses health organisations against EQuIP standards, and when considered appropriate, participating organisations are granted accreditation status. The assessment process involves a number of activities, many of which are common to other accreditation programmes around the world. Firstly, a health organisation completes a pre-survey, self-assessment report where evidence is provided to demonstrate how standards have been achieved. Secondly, ACHS sends a team of surveyors – professionals drawn from medicine, nursing, allied health and administration who are specifically selected and trained for the task – to assess the health organisation against the standards. The visit involves interviews, document analysis and observations of the health organisation. At the conclusion of the survey, the team provides verbal feedback to the organisation and a written report to ACHS. When assessed positively, an organisation receives accreditation for a defined period, usually four years. If problems are identified, there are mechanisms in place as well as an opportunity for re-assessment.

The CCGR accreditation research project

The CCGR is conducting research into accreditation, using EQuIP as an exemplar of accreditation. The CCGR accreditation research programme has two aims with four studies. The research aims are: to examine the relationships between accreditation and organisational performance (clinical performance and organisational culture) and to examine the influence of surveyors on reliability and the organisations in which they work. The research protocol is outlined in Braithwaite et al. (2006).

Studies 1 and 2 used the same methods. This has involved researchers visiting health organisations and undertaking organisational (culture and climate) assessments. In addition, data about clinical indicator performance have been collected. This information is to be related to each organisation's accreditation performance, to determine whether there is any correlation between these variables. Interim results indicate a positive correlation between accreditation outcome and organisational culture and climate, as well as leadership and clinical indicator performance. There does not appear to be any relationship between accreditation and consumer participation. A paper outlining the final results is to be released later this year.

Intra- and inter-rater reliability is being explored in study 3. There are several parts to this study. There is an investigation of the views of accreditation stakeholders about reliability of surveyors and survey teams; an examination of inter-rater reliability of survey teams using scenarios; an examination of intra-reliability of surveyors using scenarios; and a case study of two teams in one organisation. Initial assessments indicate that surveyors and sur-

vey teams are reliable. The accreditation programme, surveyor selection and surveyor management in particular, are recognised as factors standardising the conduct of individuals and teams. Papers describing the findings are currently being developed for publication.

Study 4 focuses upon the influence of surveyors in the organisations in which they work. Two studies are being conducted. One is using network analysis to map the connections and influence surveyors have on quality and safety issues, including accreditation activities. The other is inquiring into how surveyors enact leadership in relation to accreditation and safety and quality activities. Results from this study are expected in the next year.

Motivation for, benefits from, and challenges associated with accreditation

Research interviews with over 1,000 health professionals reveal interesting findings about the motivation for, benefits from, and challenges associated with accreditation. Health organisations seek accreditation for a host of reasons. Two of the most commonly expressed are: a desire from health professionals to improve their services and the care provided; and the requirement from governments and health funds to demonstrate attention to, and outcomes from, their quality and safety activities. Participation in an accreditation programme is considered one important way to achieve these goals. Similarly, health professionals discussed a range of benefits emerging from participating in an accreditation programme. Several of the more common ones are: improved communication, improved care, better use of resources and greater understanding of other services and professional roles.

In contrast to these positive views, health professionals also held strong views about the challenges an accreditation programme presents. In particular, undertaking and maintaining quality activities in busy clinical services and meeting documentation requirements were highlighted as most difficult. In addition, preparing for a survey visit was identified as being demanding and stressful for some participants. Nevertheless, a majority of people in our study perceived the benefits of accreditation outweigh the costs. Many professionals explained that accreditation stimulated them, and their organisations, to deal with issues that, in their hectic environments, were sometimes put to one side.

Conclusion

Accreditation is a major strategy by which quality and safety are being addressed. Accreditation offers benefits to providers delivering patient care and works to improve organisational processes. Research underway is illuminating the benefits and challenges associated with accreditation. The findings of these studies offer important insights for policymakers, hospital directors in addition to other healthcare managers and clinical professionals.

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NEW JCI STANDARDS

Emerging Challenges to Providing Safe, Quality Care

By Karen Timmons

The new Joint Commission International (JCI) accreditation standards to take effect on January 1, 2008, are quite different from previous standards in that they focus even more on the top priority of JCI: Patient safety. Since we last updated our standards in 2003, we have learned additional lessons and best practices from the many hospitals we accredit around the world -there are currently about 140 hospitals in 26 countries accredited by JCI – and we have incorporated those lessons into 323 standards, that hospitals must meet to receive accreditation. JCI accreditation is for a period of three years.

JCI is the international arm of the Joint Commission. The Joint Commission accredits more than 90% of hospitals in the United States. JCI accreditation standards are comparable to Joint Commission accreditation standards, but they are different.
The difference is that the JCI standards and survey process were created for the international community and designed to be culturally applicable and in compliance with country-specific laws and regulations. Our standards allow for cultural differences while still requiring hospitals to standardize and provide patient care that promotes safety and quality.

Unlike some high reliability industries, such as air traffic control, healthcare has lacked standardization across the globe. JCI is working to change that by helping hospitals around the world learn a common healthcare language that promotes safety and consistency in the delivery of care.

One example of a change to our standards that better protects patients is our more stringent requirements for how hospitals verify credentials of healthcare providers. It is no longer sufficient for a hospital to simply gather diplomas and certificates. Moving forward, JCI accredited hospitals must validate these credentials with the institutions that were supposed to have granted them. We also have new standards addressing what health professionals in training programs in JCI accredited hospitals may do with or without supervision.

Because our research shows medication errors are the most common errors threatening patient safety, JCI has made medication use standards a chapter by itself, which brings added scrutiny to how healthcare providers store, prescribe, dispense, and administer medications. Our new standards have us examining the many areas where errors can occur that lead to patients receiving the wrong medicine or wrong dosage.

Our standards aim to ensure patient's rights are protected. We require that every patient and their family be educated about their care in a language that he/she understands. With so many international travelers now seeking healthcare in other countries, this requirement is taking on added importance. We also believe all patients need to be involved in their care decisions, so we have requirements regarding consent as well as confidentiality issues. Finally, we also require that doctors transfer information to the patient upon dismissal so that recommendations for follow-up care, wherever it may be, are communicated. This transfer of information makes it less likely there will be the need for emergency care or readmission to the hospital in the coming weeks.

Another major change in our new standards is our emphasis on ensuring healthcare organizations provide uniform care 7 days a week, 24 hours a day. We want to be sure that care provided on weekends and in the middle of the night meet our standards as well. We are also requiring that patient care be planned out and written down within 24 hours of admission. Physicians must conduct exams and run tests within that time frame.

A final area, which has evolved with the growing concern about potentially fatal infectious diseases such as avian flu and SARS, is standards for mana-

ging and preventing infectious disease outbreaks. For example, we expect hospitals to have rooms with negative pressure that vent outside, which is critical when a patient needs to be isolated.

To determine if a hospital is meeting our 323 standards, with their 1193 measurable elements, we conduct an on-site survey with a team of three professionals, typically a doctor, nurse, and administrator. Although JCI visits are currently announced, our organization will be moving to unannounced surveys at some point in the near future. The Joint Commission moved to unannounced surveys for all U.S. hospitals this year. To begin the on-site evaluation process, our surveyors use a tracer methodology where they select as many as eight patients and examine their healthcare services from the time they enter the hospital until they are discharged. We believe it is vitally important to examine how hospital departments work together to create positive outcomes for patients rather than survey each department separately as distinct units within the organization. This process takes between three and five days. Before leaving the organization, our survey team has a conference with hospital administrators and provides a preliminary report on how the organization fared in the survey.

JCI has also been actively involved in helping countries around the world develop their own accreditation programs. Through partnerships with ministries of health, we are fulfilling our mission by working with our partners on how they can best evaluate the quality of care in their countries and thus enhance patient safety. Many of these countries are adopting the JCI standards while others have used our accreditation format as template for their own accreditation programs.

Although our reports are all confidential, we list hospitals receiving accreditation on our website. For more information on JCI, its new standards, and our accredited hospitals, please visit our website at www.jointcommissioninternational.com.

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Karen Timmons is President and CEO of Joint Commission International (JCI), which is part of Joint Commission Resources (JCR), an affiliate of the Joint Commission. Through international consultation, accreditation, publication, and education, JCI helps to improve the quality of patient care around the world.
www.jointcommissioninternational.com

PATIENT RISKS AND AVOIDABLE COSTS

Six Sigma reduces variation in medicine

By Maximilian C. von Eiff

In all health service systems that have introduced a DRG system for billing in-patient medical services (e.g. Italy, Germany, Australia, USA) a few target costing situations have occurred. Hospitals get a specific amount for a defined treatment, yet this amount needs to support operational costs as well as income to be invested further.

Since, at the same time, competition between hospitals is intensifying, more private hospital chains are entering the market through M & A, and financial institutions have discovered healthcare to be worth investing in, hospitals find themselves in an unusual situation. They must increase medical quality step-by-step, improve patient care (service, comfort and fear management), while reducing avoidable costs, optimising the use of resources and shortening patient stays.

Such goals can only be realised by following an efficient performance process, the outcome of which fulfills patient expectations and uses resources in an optimised way, which means that no amount of time, capital or materials can be wasted.

The phenomenon of variation

Disruptions in quality and efficiency of the medical treatment process can usually be traced to the phenomenon of variation, which can be found in all parts of living and working processes.

For example, after a long flight, the amount of time it takes to claim your luggage could be anywhere between five and 50 minutes. By the same token, a hip replacement operation can take 85 or 130 minutes, depending on a number of variables.

The phenomenon of variation of the service process has been named the most important cause for errors, unnecessary costs, and client satisfaction. Variation is a sign of not properly controlling services. Once time pressure is added to this lack of service control, the risk of error rises exponentially. Variation needs to be in balance with the quality demand of the client who is paying for the service (e.g. an airline traveler) or the ethical demand of a qualified result (e.g. an operated patient).

- In air travel, a delay of 15 minutes is "on time according to flight schedule"
- In emergency care, for a heart attack patient, the "First-Contact-To-Balloon-Time" of 90 min. max. is considered the benchmark standard.

The knowledge of variation is a much more meaningful indicator for productivity in terms of client orientation, fair prices and quality than the use of averages such as average waiting time of a patient for an x-ray diagnosis, average costs of a surgical procedure, etc. An average recovery time of 20 days for a patient until s/he can go back to work following a certain procedure (e.g. hemorrhoidecotomy) does not say very much about the quality of the entire care process. This value can only be achieved by adding some patients' 28-day recovery times and others' 12-day recovery time. According to ethical and economic reasons, it is best to keep variance as low as possible and declare a cumulative goal of 14 days instead of the average 20 days.

Six Sigma makes variation transparent

To make the phenomenon of variation transparent, the Six Sigma concept has proven itself in the industry as well as in American and Singaporean hospitals.

99 % perfection = 2.8 Sigma	99.9997% perfection = 6 Sigma
5.000 not correctly performed surgical procedures per week	1.7 not correctly performed surgical procedures per week
200.000 wrong prescriptions a year	68 wrong prescriptions a year
48.000 to 98.000 avoidable deaths in hospitals a year	17 to 34 avoidable deaths in hospitals a year

Figure 1: 99 % perfection is not enough for the health care system. Source: Creative Healthcare (2004)

Six Sigma defines quality as a measure of variance from a given performance standard or promise of quality.

Six Sigma was derived from a measuring index that is used in quality management: defects per million opportunities (DPMO) = actually occurred defects in 1 million error possibilities.

Every DPMO value corresponds to a Sigma value. A DPMO shows the frequency in which the error will possibly occur.
An error possibility (opportunity) is every chance that a given request (promise of quality) or not correctly exercised.

Especially in healthcare, even a 99 % degree of perfection is ethically and economically unacceptable: patients and hospital workers are highly endangered in this scenario, and the misuse of resources also leads to prevention of future investments.

Every process, every error phenomenon and every variance of a determined quality standard in a hospital could generally be improved with the help of Six Sigma. Examples include: Reduction of patient falls/injuries, less medication errors, shorter circulation time for pharmaceutical goods, shortening of billing cycles for private patients as well as those with health insurance, shorter waiting periods for heart attack patients at the heart catheter lab, etc.

Detecting the Six Sigma value of a performance process

For the first step in detecting the Six Sigma value, following definitions need to be established:
- "Unit" of performance (object/product/service) to be delivered to the patient
- "Requirements" or the main parts that make up the performance that will satisfy or anger the patient.
- Number of "requirements" for every performance category ("unit") in which the number of "requirements" equals the number of error possibilities.

Example: Cardiologic outpatient clinic
The most important demands to the outpatient clinic from the patient's point of view are:
- Maximum amount of time spent waiting is 15 minutes
- Satisfaction with the kind of care provided by the treating physician or nurse (friendliness, communication)
- Clean toilets

These 3 demands are equal to 3 error possibilities

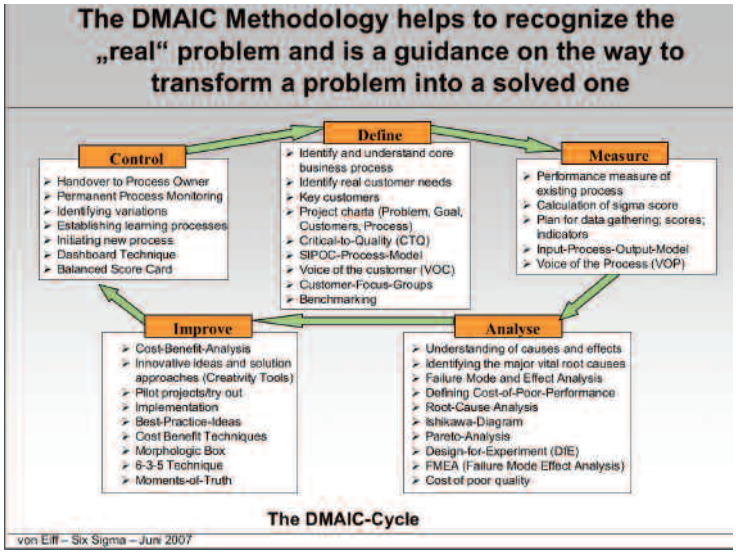

Figure 2: Six Sigma types of measuring

for every outpatient visit. If data of 500 patients' data have been collected, you will get the following picture (as an example): 83 patients had to wait more than 15 minutes, 25 patients felt they were not treated in a friendly manner and 54 thought the toilets were not clean.

Thus, the Six Sigma value computes:

$$\frac{(83 + 25 + 54)}{500 \times 3} = \frac{162}{1.500} = 0.108 = \text{Defects per opportunity}$$

With a (generally assumed) base of 1 million error possibilities, this means 108.000 mistakes in a million (=DPMO). This corresponds to a Sigma value of about 2.75—hardly a satisfactory situation.

The Six Sigma Method

In accordance to the kind of project, Six Sigma provides two approaches to solve a problem:

a) The DMAIC-Cycle method is used if an existing service process with regards to client orientation, higher quality and lower costs (elimination of existing wastefulness in the "hidden factory") need to be optimised or reorganised.

b) The DFSS-Method (Design for Six Sigma) is used if a completely new concept is to be established and realized. For instance, the construction of a new hospital, functionally designed, will comply with the demands of patient care and patient triage with regard to innovative care methods and financial restrictions of the DRG system (i.e. shorter stays, tendency towards outpatient or pre-inpatient care).

Six Sigma is process oriented, thus four categories of measurements are generally taken:

- Output (= direct process results)
- Outcome (= the process results as felt by the patient with long-term effect)
- Process variables (process efficiency, use of resources, complications)
- Input (factors or pieces that are needed to create output and outcome in order to meet process goals and patient expectations)

Typical input for medical service processes are, e.g. quality of pre-diagnosis, quality of pre-treatment, health status of the patient (multi-morbidity) etc.

Summary and Evaluation

The phenomenon of variation is the pivotal cause of patient risks, quality deficiencies and avoidable costs of medical service processes. Variation is the typical feature of an improperly controlled care process. Six Sigma supports the detection of the variation phenomenon and offers tools to overcome it.

Six Sigma is an attuned system of thoughts, methods and techniques for the achievement and advancement of superior business success.

Six Sigma is characterized by:

- An understanding of true client needs,
- a disciplined use of data and facts on the basis of statistically secured methods, and
- a focus on business process as well as its permanent improvement and client-oriented reorganization.

The consistent use of the Six Sigma tools is implied, whether it concerns the expertise of all taking part in the project, or the design of the product. In these times of flexible and/or closed budgets, the necessary capital for all this is fairly easy to mobilise.

In many cases, the easier method (e.g. the PDCA-cycle) is appropriate and leads to quick results.

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CAPACITY PLANNING IN GERMAN HOSPITALS

Excessive capacities as result of inadequate incentives

By Dr. Boris Augurzky, Prof. Dr. Ludwig Kuntz and Roman Mennicken

Capacity in hospitals is determined by production facilities and production factors (Sibbel 2004). Facilities like beds or departments, needed for the provision of services are predetermined on the federal level by hospital plans. Hence, for hospitals, efficient management of production factors—like physicians and nurses, play the most important part in capacity management and planning.

In Germany, hospitals are facing excess capacities of beds, which are the result of faulty regulatory incentives by hospital plans and the financing system. Since the introduction of DRGs in 2004, hospitals are confronted with a more competitive environment increasing the need for efficient capacity planning and management.

Regulatory environment

Officially, hospital investments in Germany are financed by federal states, while patients reimburse operating costs, usually by their health insurances (dual financing, KHG 1972). Since hospitals have to apply for investment funding, this system leads to additional administrative costs. It also does not afford the possibility to optimise investment decisions with respect to operational costs. Additionally, hospitals receive a fixed rate of funding per bed (DKG 2006), creating incentives to keep beds. With the introduction of DRGs in 2004, hospitals find themselves in a more competitive environment than before. Investments become crucial for hospitals that want to improve their competitiveness. This increases the need to establish a monistic financing with investments and operational costs stemming from one source and, thus, giving hospitals full responsibility over their investments (SVR 2007). It is noteworthy that due to restrictions of public budgets in recent years, dual financing is not working well either. About 20% of all hospital investments are already financed by hospitals themselves (DKI 2005) – virtually in contradiction to the law.

The federal states plan supply of hospital capacities. Until recently, capacity has been defined by the number of beds. Most federal states forecast future demand for bed capacity with a target level (TL) for occupancy rates, an estimate of demographic changes, hospital length of stay (LOS), and frequency of hospitalisation (FH) using the so called Hill-Burton formula (Kuntz, Scholtes & Vera 2007):

Bed capacity =
(LOS x FH x population)/ TL x 365 days.

Some federal states use additional information such as hospital diagnoses with the Hill-Burton formula or other methods. Hence, hospital plans differ by method, depth, and planning horizon (Kortevoß 2005). The observed excess capacities in Germany seem to be the result of erroneous incentives by dual financing and federal hospital plans (SVR 2007).

Capacity planning and management
With increasing cases, decreasing LOS and a shift towards outpatient treatment, hospitals have to focus on efficient process management while continuing to reduce excess beds (Sibbel 2004). Shifting planned beds or departments between hospitals of the same regional hospital operator is one option in reaction to market changes within rigid hospital plans. Regardless of local boundaries, hospitals can cooperate to optimise procurement and utilisation of service facilities.
However, given existing tensions between hospital planning and a competitive hospital sector, the expectation is that federal states will reduce the depth of their hospital plans (Busse, Schreyögg & Gericke 2006). With fewer regulations, strategic capacity planning will become more and more important. Indeed, the federal state of North-Rhine-Westphalia aims at reducing the depth of regulation in hospital planning in 2007.

Forecasting hospital demand

Hospitals have to take into account several external developments when planning their supply (e.g. beds, personnel, operating rooms). The most

important ones are
- local demographic change,
- technical progress, and
- regulatory changes.

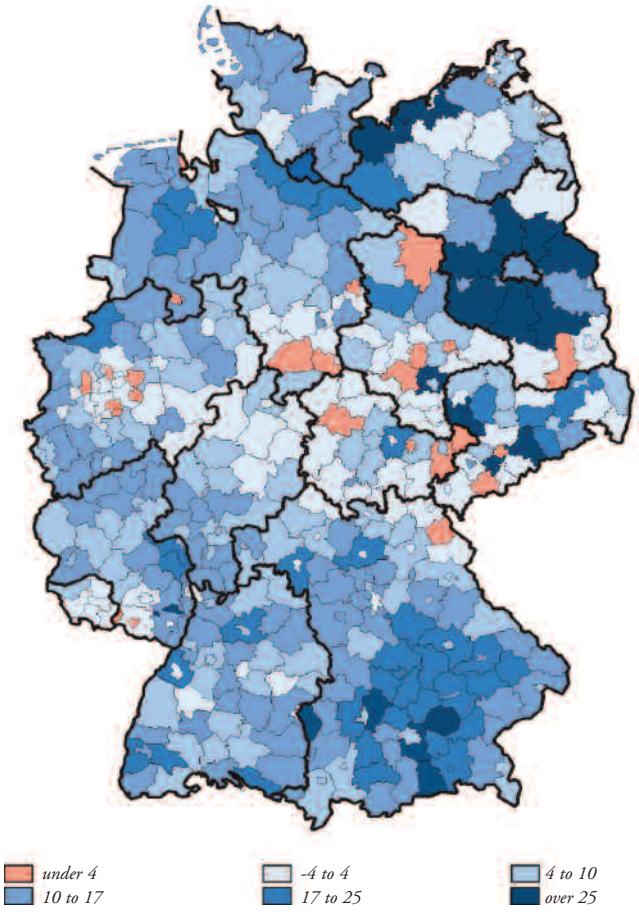
Since hospital business is primarily a local, demand for hospital services is strongly determined by the local demographic structure. Management has to forecast demand – sometimes even for each DRG. If possible, expected regulatory changes have to be taken into consideration. In Germany, the legislator encourages a shift towards outpatient treatment. This means that, for some DRGS, the number of inpatient cases might decrease, even though the total number of cases will increase. Inpatient and outpatient capacities have to be planned accordingly. The following figure shows a forecast of the growth in the number of cases by 2020 taking into account local demographic changes, a shift towards outpatient treatment, and steady technical progress (Augurzky et al. 2007).

In addition, – but with more difficulty – hospital management has to take into account the business strategies of their competitors and hospital admissions based on referrals by local practitioners. In Germany, patients with a mandatory health insurance (90% of the population) are not allowed to use hospital services without referral from a practitioner – except for emergencies. Therefore, general practitioners' decisions on patient admissions have a substantial impact on hospital performance.

Planning and management options

An analysis of the current product portfolio comprising data on diagnoses, procedures, and resulting DRGs is essential to the optimisation of recent capacities. Together with forecasts in demand, they are the necessary basis for capacity planning. Methods for strategic capacity planning range from models of investment theory over efficiency analyses (Kuntz, Scholtes & Vera 2007) to methods derived from operations research (Preater 2002). Sibbel (2004) provides an excellent overview of these more theoretical methods for capacity planning in hospitals.

Expected number of residential cases (upon use of ambulatory potential) 2004 to 1010; change in %



When it comes to optimising capacity, usage cooperations prove to be successful. Horizontal and vertical alliances show an improving effect on capacity utilisation (Vera 2006). Horizontal alliances with other hospitals show economies of scale with service facilities and improve leverage in negotiations with suppliers. They can be used to channel patient flows and hence increase occupancy rates. Resulting efficient capacity utilisation primarily and significantly contributes to cost containment. However, capacity utilisation also seems to influence quality of care in hospitals (Mennicken 2007). Vertical alliances with practitioners lead to improved referral behaviour and increasing market shares. Vertical alliances at the other end of the healthcare supply chain, e.g. with rehabilitation centres or nursing homes, improve treatment processes and quality of care.

Conclusion

Capacity planning plays an important role for hospital management. So far, great emphasis in Germany is put on the efficient utilisation of capacities, since beds and departments are mostly predetermined. However, it is quite likely that in the near future regulations in many federal states will be reduced. Hospitals will then have more managerial freedom to plan their capacities according to their product portfolio.

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HOSPITAL CAPACITY PLANNING – WITH SPACE IN MIND.

By Knut H. Bergsland

Most European hospitals will have to expand their examination and treatment capacity in the future, as well as rearrange and restructure core functions. Whether to remain competitive or for other reasons, it will be essential to maximise short and long-term performance. It is seldom economically viable to build oneself out of capacity problems—regardless of how healthcare investments are financed.

SINTEF Health research has been doing capacity planning projects on national, regional and hospital trust levels for specialist somatic and psychiatric healthcare services. This article will focus on the role of capacity in relation to buildings and space in strategic hospital planning. We will use a typical planning process to highlight the levels of capacity planning that need to be addressed, and conclude with some implications for hospital management.

Hospital expansion plans are usually a product of institutional dissatisfaction with working conditions that have built up over a number of years. Often this is a result of ongoing changes in medical technology, models of care, demographics and epidemiology, and emerges from a lack of proactive planning from hospital administration. Investment projects for solving problems with cramped space, poor capacity and functionality, however, often derive from a process based upon clinicians' judgments of their own treatment capacity. Gradually, these judgments are adopted by hospital administration, and culminate in a definitive need for expanded capacity, which is undisputed. Too often, this leads to plans for building additions to hospitals,

without a thorough examination of how existing buildings may be utilised to increase the existing treatment capacity and in turn, relieve the pressure for investing in infrastructure to simply solve structural problems. Such projects may not always match paramount objectives.

A teaching hospital in northern Norway recently asked us to examine their plans for a 7000m² expansion, which was supposed to solve the hospital's need for more beds. The activity analysis showed that the hospital had a lower utilisation of beds, a higher amount of personnel per patient and per bed day, and a lower outpatient production than comparable hospitals. The combined capacity/space analysis of the project showed that the hospital had a lower and unevenly distributed use of their beds and available space between clinical (sub)specialties. Some departments had low space standards per bed, while others had very high standards. This led to a sub-optimal use of hospital space. After an examination of possibilities for reshuffling the functional elements of the hospital, our study concluded that at present, there was no need for the 7000 m² building project. From the onset, our study generated some resentment from local stakeholders, but in the end, the hospital was content with our critical examination of their plans. The final result remains to be seen, but continuing pressure from medical professions and plans for an extension still persist.

This Norwegian hospital project demonstrates several beneficial points on coping with lack of hospital capacity:

- Hospital administration should have both the determination and the ability to explore all possibilities for maximising activity within the existing hospital, not relying exclusively on clinicians' judgments. Hospital management should conduct critical studies concerning treatment capacity utilisation, length of stay, and other determinants.
- Collaboration with other providers in the treatment chain, outside the hospital should be developed, in order to expand the hospital capacity itself as well as utilise the capacity of others.
- Hospital administration should attempt to reduce internal pressure for unnecessary expansion as much as possible. In this context, hospital leaders' need to prioritise activity within limited capacity is imperative.
- Priorities should be based upon quantified arguments, and should at all times be as definite as possible.
- Hospital managers should always have indicators and access to detailed, quantitative data that makes internal capacity assessment and decisions possible. This data may differ from those used to report indicators at that regional and national levels.
- Long term forecasting models should be employed, refined and upgraded in line with the extended knowledge of system development.
- Hospital strategy should include the vision of making the institution as small as possible in terms of the number of inpatients.

As capacity of any given function is closely related to efficiency, organising workflow is the key to expanding capacity. On a hospital level, this may lead to extensive rearranging of work. The ability of hospital administration to encourage better utilisation of the existing rooms may lead to improving results up to a given point. After that threshold is reached, creative rearranging of work may be the only answer to the internal problems. Existing ways of organising work should be challenged. The planning on hospital / trust level will always have to take the existing facility into account, in terms of activity, capacity and space. Positive results may not be reached immediately, but every hospital should be capable of monitoring activity, capacity and space use.

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RFID BED MANAGEMENT

Experience of the Insel Hospital Bern

By André Calame and Gregor Hotz

Like other large university hospitals, the Insel Hospital must face up to the twin phenomena of an inexorable rise in patient numbers and ongoing reductions in the length of the average patient stay. Not only does this trend create additional logistical requirements but it also results in increased bed turnover in the hospital's bed centres.

This development prompted the hospital to carry out a detailed analysis of bed management processes, including an evaluation of optimisation potential in this area. Our investigations found that bed management is a highly interdisciplinary and information intensive process that requires input from the bed centres, the hospital transport service, its workshops, and nurses on the wards.

The analysis found that information processing is the key to resolving the problem of continuous growth. Better dissemination of information has delivered improvements in bed planning with the result that the hospital has been able to maintain existing capacity, using fewer beds. Armed with this finding, we decided to seek a solution which offered improved information flow but did not add to the administrative burden of staff engaged in the bed management process.

Working closely with our external consultants and the Swiss Federal Institute of Technology Zurich, the hospital tested the viability of using RFID technology in bed management as part of a KTI project. In autumn 2005, we introduced a pilot

project in cooperation with the urology clinic. Prior to commencing the project, the hospital's medical technicians performed a number of tests to exclude the possibility of RFID technology adversely impacting on medical-technical equipment and implants.

The pilot demonstrated the feasibility of generating the required information automatically. The match between the automatically generated information and the data produced in parallel on paper was found to be 99.9%. The new system functioned perfectly and no special measures were needed to achieve correct data transmission. A point of contact established to deal with faults or other adverse incidents has so far received just one incident report and this fault was later shown to have no direct link with the RFID technology.

Following the completion of the pilot project, the hospital issued an invitation to tender for the implementation of an RFID bed management system using a solution based on the same know-how and technology as was used in the pilot. This solution has been successfully commissioned and implemented.

The tender process revealed that the necessary know-how is provided by niche suppliers who have specialised in a number of key applications. Specialisation is confined in each case to a small number of fields, for which the supplier designs customised software solutions. The technical infrastructure itself will be marketed internationally.

During the implementation phase, it was decided for economic reasons to adapt the potential roll-out of the system as compared to the pilot phase. A number of modifications were made in the context of information concerning the latest position vis-à-vis beds. For this reason, we opted to fit antennae in bed centres and the storage facility but did not equip the wards.

The destination wards are recorded on a touchscreen unit when the beds are being prepared. The new system was designed to be able to adapt to emerging requirements and can, if necessary, be extended and upgraded.

1,600 beds, 1,000 mattresses and three bed management stations are now equipped with the RFID system. Every bed and/or mattress is fitted with a RFID chip (EN60601) approved for hospitals. RFID readers are set up in cleaning stations, stockrooms and upon bed delivery. The system infrastructure is linked to the hospital information system. Touchscreens and standard computers are used to visualise and capture data.The whole process is managed electronically and provides information in real time. This facilitates ISO audits and reduces legal problems in case of malfunctioning beds and errors.

The automatic capture of data also relieves of routine tasks hospital staff in charge of management, transportation, maintenance, accountancy and cleaning.We expect the RFID bed management system to meet the challenges arising from increasing bed turnover for several years, without increasing staff levels or adding to their workload. This has become feasible because the system has released staff from performing administrative tasks.

As the hospital is constantly aware of the location of all its beds, it should be possible to meet current bed capacity needs using 20% fewer beds. This should deliver substantial cost savings during the current phase of bed replacement.

Finally, the hospital will reduce labour costs and expenditure on cleaning materials because cleaning and disinfection procedures for beds and mattresses will differ depending on the length of occupancy.

These savings should cover the system's investment costs within two and a half to three years, a reasonable expectation when introducing new technologies.

According to Bernhard Leu, management director at the Insel Hospital, the efficiency improvement potential represents approximately 200,000 euros over 2 years. This basic figure relies on a reduction of beds in stock (50 beds x 3,000 euros), the saving of one employee salary (50,000 euros), automatic invoicing, which results in saved working hours (12x10x100 euros) as well as other benefits to the amount of 10,000 euros.

Staff members in the bed centres identify strongly with the project and are impressed with the solution. In fact, they see the new system as enhancing the status of the work they do. Transport, repair and nursing staff understood and accepted the solution quickly and training requirements were minimal owing to the simplicity and user-friendliness of the system. The system has been in operation since May 2007 and a product costing analysis will be carried out in November 2007. The results of this review will be published at a later date.

The new system was designed to be able to adapt to emerging requirements and can, if necessary, be extended and upgraded.

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THE BELGIAN HEALTHCARE SYSTEM

By Kristof Eeckloo

FACTS & FIGURES	
Total population	10,419,000
GNP per capita (2004)	32,640 USdols
Life expectancy (m/f)	76 /82 years
Infant mortality (m/f)	5 per 1,000
Birth rate	11 per 1,000
Fatality rate	8 per 1,000
Total health expenditure per capita (2004)	3,133 USdols
Total health expenditure as a % of GDP	9,7
Share of public financing of health system	71%
Doctors	46,000
Hospital doctors	18,400 (40% of total doctors)
Doctors per 1,000 inhabitants	4,48
Nurses per 1,000 inhabitants (1996)	10,75

Belgium is a federal state. There are three levels of government: federal, regional (three regions and three communities) and local (provinces and municipalities).

The Belgian healthcare system is mainly organised on the federal and regional level. The federal government is responsible for regulating the compulsory health insurance, determining licensing criteria for healthcare facilities, financing the operations of healthcare facilities, regulating qualifications of healthcare professionals and registration and price control of pharmaceuticals. The regional governments are responsible for preventive care and health promotion, maternity and child health services, different aspects of elderly care, implementation of licensing criteria of healthcare facilities and financing of infrastructure (within basic rules enacted at federal level).

In 2005, total health expenditure as a percentage of gross domestic product (GDP) was 9.7%. Public sector funding as a percentage of total expenditure on healthcare fluctuates around 70%. (Source: WHO)

Key features of the Belgian healthcare system are: 1) Compulsory health insurance, managed jointly by the major stakeholders of the sector (insurers, healthcare providers and public authorities), 2) Liberal ideas of medicine (majority of providers are self-employed, with predominantly fee-for-service payment) and 3) Freedom of patients to choose both their healthcare provider and their hospital.

Healthcare financing and expenditure

Compulsory health insurance is financed through employer and employee income contributions as well as through taxation. It covers the whole population and has a broad benefits package.

A public body endowed with legal personality, the National Institute for Sickness and Disability Insurance (RIZIV/INAMI), is charged with the implementation and control of the compulsory insurance scheme.

All individuals entitled to health insurance must join or register with a health insurance fund: either one of the six not-for-profit and privately managed funds or a regional service of the public Auxiliary Fund for Sickness and Disability Insurance. Since 1995, Belgian health insurance funds are held financially accountable for a small proportion of any discrepancy between their actual spending and their so-called normative,

i.e. risk-adjusted, healthcare expenditures.

Patients participate in healthcare financing via co-payments (fixed amounts) and co-insurance (percentage of the overall charge). For ambulatory care, patients pay the full costs of services to service providers and afterwards receive a refund from the health insurance fund.

For inpatient care and pharmaceuticals there is a third-party payer system, which means that the health insurance fund directly pays the provider, leaving the patient only to pay the co-payment or co-insurance.

Healthcare provision

In the mid-1990s a supply planning system was established for healthcare providers. A quota mechanism is applied immediately after basic training, at the moment of application for recognition as a dentist or physiotherapist and at the application for specialisation for a physician (GP or specialist). In order to achieve these objectives, the communities, which are responsible for education policy, were requested to limit the number of medical and dental students.

In 1997, the Flemish community introduced entrance examinations to limit the number of students entering medical schools. The French community has chosen to limit the number of medical students after their third year of medical education on the basis of the first three years' results.

Delivery of ambulatory care in Belgium is mainly private. The vast majority of physicians work as independent self-employed health professionals. Medical specialists can work in institutions (mostly hospitals) and/or on an ambulatory basis, in private practice. GPs mostly work in private practice. Because there is no referral system between these two different types of physicians, every citizen has free access to medical specialists and hospital care, even as the first point of contact with the health system.

Hospital care is provided either by private non-profit or by public hospitals. The hospital legislation and financing mechanisms are the same in both sectors. In 2005, there were 215 hospitals, of which 146 were general and 69 psychiatric. The basic feature of Belgian hospital financing is its dual remuneration structure according to the type of services provided: services of accommodation (nursing units), emergency admission (accident and emergency services), and nursing activities in the surgical department are financed via a fixed prospective budget system based on diagnosis-related groups (DRGs); while medical and medico-technical services (consultations, laboratories, medical imaging and technical procedures) and paramedical activities (physiotherapy) are predominantly remunerated via a fee-for-service system. Pharmaceuticals are exclusively distributed through community and hospital pharmacies. Only physicians, dentists and midwives can prescribe pharmaceuticals. About 2,500 pharmaceutical products are on a positive list and therefore partly or fully reimbursable. The reimbursable percentage of the cost varies depending on the therapeutic importance of the pharmaceutical.

Strengths, weaknesses and recent reforms

The overall strength of the Belgian health system is that care is highly accessible and responsive to patients. The drawbacks of the Belgian system are its cost and complexity. Although the system has not undergone any major structural reforms since the 1980s, various measures have been taken mainly to improve its performance. Reform policy included: hospital financing reform; strengthening of primary care; restriction of the supply of physicians; increase of accountability of healthcare providers and sickness funds; tariff cuts; and more emphasis on quality of care, equity, evidence-based medicine, healthcare technology, benchmarking with financial consequences and economic evaluations.

Prospects

Three recent policy initiatives are worth mentioning:
Until recently, a difference was made between a general scheme of social health insurance and a scheme for self-employed persons. The latter were only insured for major risks, which mainly coincide with hospital care. As from January 2008, this distinction will be abolished progressively. No difference will any longer be made based on the professional situation of the insured.

A second reform concerns the introduction of a so called "maximum billing". In Belgium, 5% of the patients consume 61% of the total social health insurance expenditure. The same 5% are also charged 35% of the total amount of co-payments and co-insurance. In case of a long-term or serious illness, financial burden can be high. Some years ago, the maximum billing-system was introduced as a solution to this problem. This reform aims to limit the healthcare cost of each family to a maximum amount per year that varies according to the income of the family the person belongs to. Nearly 10% of households are concerned with this reform.

A third reform area concerns the pharmaceutical policy. To advance the use of generic pharmaceuticals, a reference pricing scheme was introduced for products with generic equivalents. Furthermore, a lump-sum reimbursement system for pharmaceuticals was introduced for in-hospital patients. And finally, the gross annual budget for pharmaceuticals is now established in consultation with the industry. If the budget is exceeded, a claw-back mechanism is applied and the pharmaceutical industry has to finance part of the overspending.

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THE HOSPITAL SYSTEM IN BELGIUM

The direction of reforms

By Professor Marie-Christine Closon

The Belgian healthcare system is a mix of mandatory national insurance and private medicine, a system of collective agreements between healthcare providers and insurance companies (national healthcare funds), and regulations issued by the public authorities. The Ministry of Public Health is responsible for defining laws on hospital programmes, number of beds and major equipment.

The healthcare system is extremely fragmented and the various levels of healthcare are not well coordinated. Patients have access to hospitals and specialists without having to obtain a referral from a general practitioner. Providers are generally self-employed, both in hospitals and for outpatient treatment, and paid on a fee-per-service basis.

Description of hospital service provision

Belgium has a population of about 10 million and there are 146 general hospitals and approximately 60 psychiatric hospitals, 70% of which are private, non-profit organisations. Public and private hospitals are subject to the same financing rules.

The number of hospital beds has decreased significantly since the beginning of the 1980s, from 92,436 to 70,795. This decrease is attributable to the conversion of hospital beds into retirement and nursing home beds for the elderly, as well as incentives for hospitals to merge, a reduction in the length of stay, an increase

in hospital outpatient treatment and the development of alternatives to psychiatric hospitalisation. Since the 1980s, the length of stay has decreased (11.9 to 8.3 days) and the number of admissions has increased (13.6/100 to 17.4/100). The length of stay is higher and the number of admissions is lower than European averages.

Hospital financing system before reforms

Financing of hospital care in Belgium can be broken down into two parts. The first, medical services and medication, are included under the heading of healthcare, paid mostly on a fee-per-service basis and retrospectively (according to the rates negotiated between the national health insurance companies and professional bodies). The second segment includes days of care, covering nursing services and accommodations. Until 1995, every day was reimbursed up to a certain quota based on the number of beds and a standard occupancy rate.

This type of financing system did not take into account the usefulness of the days or that of the services provided, nor did it encourage service providers or hospitals to find the most effective way to treat their patients.

In order to ensure that resources were used more efficiently, the development of need and performance indicators concerning both the use of resources and the quality of care had become critical. Financing-related incentives based on these indicators then had to be introduced. In other words, the general tendency was to introduce prospective elements into a reimbursement system, which until then was operating almost completely on a fee-for-service and retrospective basis. Advantages associated with a prospective financing system include better management of expenses and motivation to be efficient, but risks include decreasing quality of care and the selection of higher-yielding patients based on the expected financial structure.

Principal reforms in the hospital sector

a) *Prospective financing for in-patient hospital care*
Belgian hospitals are financed for the number of justified days according to the activity measured and type of illnesses treated (taken into account by APRDRGs), age and the geriatric characteristic of the stay. Since 2007, the impact of social factors is also being taken into account. The number of justified days is determined by national averages in terms of the relevant characteristics.

In addition, the number of days covered is reduced if the hospital has a lower percentage of hospital outpatient treatment than the national average, taking into account the treatment performed.

Initial studies conducted after this reform indicate that it has been somewhat effective in reducing lengths of stay and increasing the percentage of outpatient treatment.

b) *Prospective funding for medication expenses*
Prospective funding for medication in terms of APRDRGs and four severity levels has been established since 2006. This affects approximately 50% of medications used in hospitals. Exclusions apply to vital medications from a therapeutic and social point of view, which continue to be paid per medication. For medications included in the budget, each hospital receives a sum that theoretically covers 75% of its medication expenses based on the structure of the illnesses it treats. The remaining 25% continues to be financed on a fee-per-service basis.

c) *Flat-sum billing of certain categories of fees based on "reference amounts"*
Since physicians have always been paid on a fee-per-service basis in Belgium, the flat-sum billing of medical fees encounters significant resistance in medical circles. However, an initial attempt has been made. More flat-sum financing was decided upon for 28 frequently occurring illnesses which are uniform in terms of expenses, simple in terms of procedures (cataract, tonsillectomy, appendicitis, etc.), and for which patterns of consumption that deviate significantly from the national average can be easily identified.

For each group of illnesses, a reference amount has been determined by severity class (1 and 2) and by expense item (clinical biology, med-

ical imaging and internal medicine). This amount corresponds to the national consumption average per patient increased by 20%. The hospital must reimburse expenses exceeding this amount. These 28 groups account for 22.7% of stays.

However, this reform excludes many stays, sanctioned by type of expense and by APRDRG, without allowing compensation between APRDRGs and expenses. In addition, it does not include positive incentives for hospitals.

Conclusion

In order to limit expenses and encourage efficiency, spending limits must be established for hospitals. However, it is unrealistic to think that it will be possible to take all clinical situations into account. Clinical situations are rarely specific and standardised enough to make it possible to precisely determine which services need to be provided for each patient based on guidelines. In order to take this inherent variability of medical practice into account, it must be possible to distribute risk. Efficient practices greatly reduce the probability of having expenses that exceed the expected budget, taking into account all patients, their illnesses and their severity.

Compensating for risks can then come completely into play. In conclusion, while it is useful to put a limit on expenses based on measurable needs (severity APRDRG, etc.), it is extremely important that physicians and managers realise that this limit only has meaning for an overall budget, and not per patient or group of illnesses, where the level of accuracy is too low.

Budget is a financial framework and not an indication of quality. The imposition of a budgetary framework must be accompanied by the development of quality care promotional programmes (development and evaluation of quality indicators, development of guidelines making more efficient practices possible).

To increase efficiency in the field of patient care in Belgium, it will also be crucial to increase coordination between the various levels of care (outpatient, specialised medicine, institutional, hospital), all the more so since an ageing population and increase in chronic illnesses will require more and more integrated medical services.

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THE BELGIAN HOSPITAL MANAGERS ASSOCIATION

By Professor Eric Engelbrecht

Founded in the early 1970s as a de-facto association representing Belgian hospital managers, the organisation stresses inclusion regardless of hospital status, language group or Community/Region. More specifically, the association aims to:

- Help hospital managers acquire and maintain the necessary skills to run a quality hospital.
- Promote and defend the hospital managers' status at the community, regional, federal and European levels.
- Encourage interaction between hospital managers.
- Provide its members with legal aid.
- The association may also undertake any activities that aim to fulfill its objectives, in particular by:
  - Organising meetings
  - Studying problems common to its members
  - Providing information to hospitals managers who are members of the association
  - Organising relations with various healthcare sector authorities

On 1 February 2002, the association was transformed into a non-profit association (ASBL) with articles of association drawn up in accordance with applicable law.

Further to the association's purpose, numerous trips have been organised for members to the US, Canada, the Netherlands, Germany, Luxembourg, Spain and France, among others.

Trips last between 4 and 14 days with many visits to hospitals as well as activities to gain an insight into the organisation and financing of healthcare systems in the countries visited. Every year, two or three seminars are organised that address themes associated with hospital activities. In the last two years, our seminars have covered hospital ICT, and lastly, risk management for Belgian hospital managers.

We are partners of the TYCO Award which is granted every year to a hospital that submits a hospital project with a major impact on the operation of the facility. The TYCO award is organised as a Tyco initiative with 2 partners: The KULeuven Hospital Science Centre and the Belgian association of hospital managers. The jury is made up of professors from various Belgian universities, one representative of the Belgian association of hospital managers and two members representing the business world. From all the hospitals that submit a project, five are nominated and one winner is chosen to receive a 12,500 euro prize which is presented during an official ceremony.

In the context of the legal aid mission, our association also includes legal assistance coverage in its membership dues.

Thanks to all these activities, the association can claim 160 members from all regions of Belgium.

Headquartered in Brussels, our association also actively supports the European association and is one of the founders of the European association of hospital managers. One of our members, Mr. Willy Heuschen, hospital manager in Eupen (Belgium), holds the position of Secretary General.

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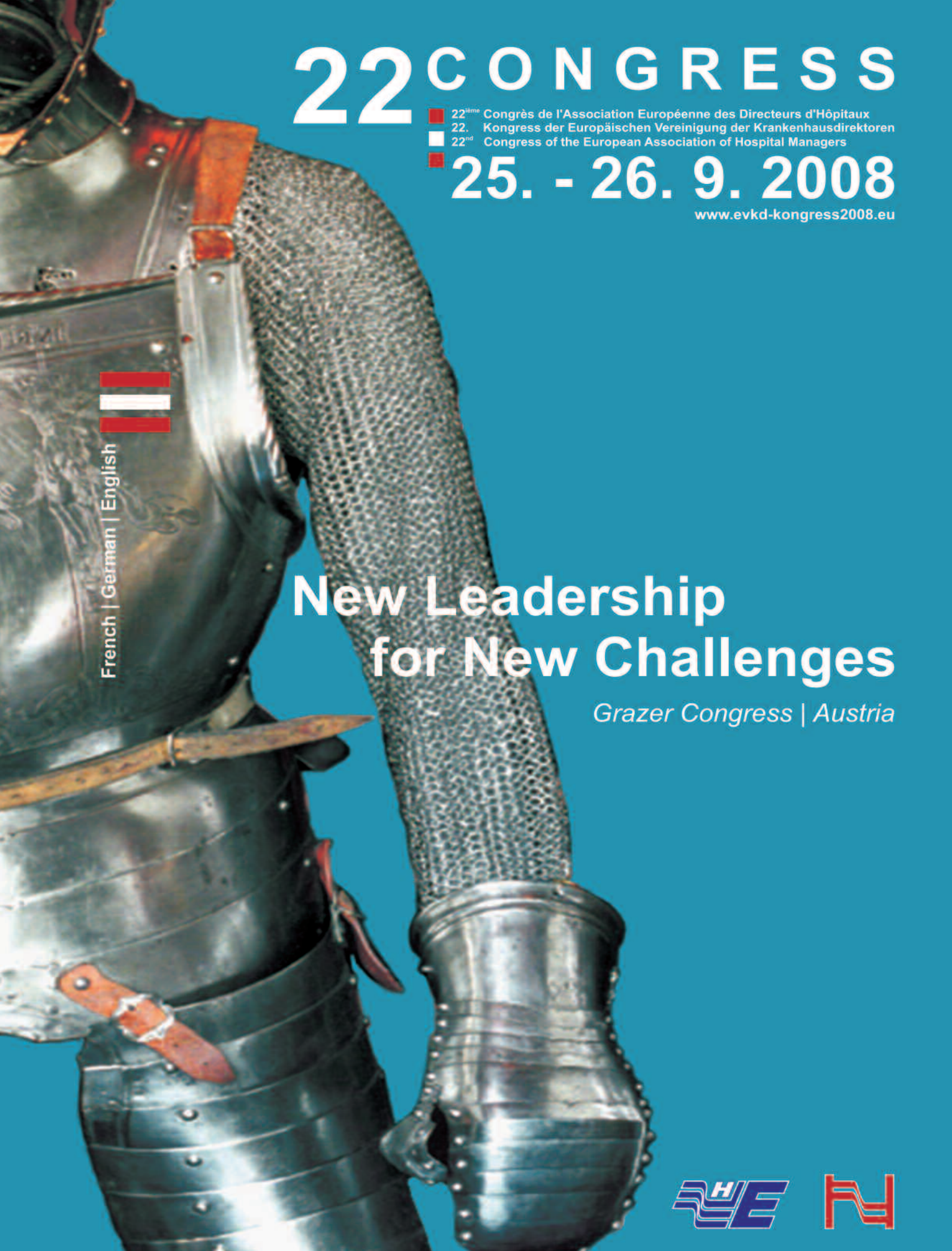

22 CONGRESS

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Les managers de la Santé et les outils d'évolution des organisations

Il est peu dire que les hôpitaux européens doivent actuellement faire face à de nombreux défis. Au-delà des particularités et des spécificités de chacun des états membres, partout des interrogations surgissent sur le rôle des hôpitaux, leur capacité à répondre aux attentes des patients, leur attractivité dans un contexte de concurrence accrue, l'évolution de leur financement… Malgré l'apparente hétérogénéité de ces problématiques, toutes ont pour point commun d'interroger les établissements sur leurs organisations et leur capacité à les faire évoluer.

Plus que toute autre institution, les hôpitaux sont en effet des matières vivantes qui doivent sans cesse s'adapter à leur environnement, sans cesse améliorer leur efficience, sans cesse revoir leur organisation pour offrir la prise en charge la plus adaptée aux besoins de leurs clients.

Cette tâche est bien entendu au cœur du métier des directeurs d'hôpitaux, qui disposent de nombreux outils pour les aider à accomplir cette mission d'optimisation des organisations hospitalières. Si ces outils et ces méthodes ont connu des déclinaisons variées et des fortunes diverses selon les périodes et les pays, l'accréditation et, plus largement, l'évaluation de la qualité est, aujourd'hui, une approche incontournable et centrale dans l'ensemble des pays membres. A ce titre, les articles présentés dans ce nouveau numéro d *(E)-Hospital* permettront à chacun de se rendre compte de la vague de fond que représentent aujourd'hui les démarches de mesure et d'évaluation externe de la qualité en Europe qui, partout, ont montré leur puissance, leur caractère positif et leur capacité à faire évoluer les organisations vers plus d'efficience.

Fidèle à sa vocation de contribution à la construction de l'Europe de la santé, l'AEDH a choisi d'aller plus avant dans la réflexion autour des systèmes d'accréditation et de dégager des éléments constitutifs de ce qui pourrait être un modèle européen d'accréditation.

Le prochain séminaire de l'association, qui se déroulera le 16 novembre à Düsseldorf, permettra à ce titre aux responsables hospitaliers européens d'échanger autour des systèmes d'accréditation et de mesure de la qualité et, in fine, de réfléchir aux conditions d'une approche européenne harmonisée en la matière qui, sans se substituer aux systèmes existants et sans nier les particularités de chaque Etat, permettrait de définir un standard qualitatif européen, accepté par tous et visible des patients.

Bien entendu, la démarche d'accréditation n'est pas le seul outil à la disposition des managers de la santé pour faire évoluer leurs organisations et les nouvelles technologies offrent en ce sens de nouvelles possibilités et des développements infinis. C'est notamment le cas de la méthode du «capacity planning», qui va sans conteste connaître des applications prometteuses au sein des hôpitaux et dont *(E)-Hospital* se fait aujourd'hui l'écho.

Paul Castel

On le voit, les défis posés aux hôpitaux sont certes nombreux, mais les réponses le sont également et les managers hospitaliers sauront faire preuve de leur capacité à aller de l'avant et à travailler de concert. En cela, l'AEDH assume plus que jamais son rôle d'agitateurs d'idées et aura à cœur de faire émerger de nouvelles visions européennes pour la santé.

Paul Castel
Président de l'AEDH

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Les contributions publiées ici ne reflètent cependant que l'opinion de leur auteur et ne représentent en aucune façon la position officielle de l'AEDH.

L'AEDH agit pour la mobilité du personnel de santé

L'étude de l'AEDH, *Mobilité des professionnels de santé of Healthcare Professionals* a répondu à des questions pertinentes concernant la migration du personnel au niveau national et hospitalier. Les questions portaient sur la façon dont le personnel migrant était considéré, comme un bienfait ou comme un fardeau; sur des sujets spécifiques concernant le pourcentage de personnel étranger dans le pays/hôpital; sur les problèmes principaux du point de vue de la gestion hospitalière.

Avantages

Des différences notables sont apparues entre pays d'Europe occidentale et orientale: alors que les pays d'Europe occidentale ont largement signalé qu'ils tiraient avantage de la mobilité (Autriche, France, Luxembourg, Pays-Bas), les pays d'Europe de l'Est n'ont pas perçu ces avantages, et certains ont dénoncé des problèmes actuels et/ou des préoccupations qui pourraient émerger à l'avenir.

En Bulgarie, par exemple, les directeurs de plusieurs hôpitaux ont noté que la plupart des médecins qui travaillent à l'étranger se spécialisent dans des domaines différents et reviennent après un an ou deux. Les fluctuations d'infirmières, de sages-femmes et d'assistants de radiologie et de laboratoire sont néanmoins plus alarmantes. Il n'y a pas un seul établissement de santé dans le pays qui n'a pas perdu au moins cinq infirmières le mois précédent. La mobilité est un concept inquiétant pour la Bulgarie, où le nombre de médecins a baissé d'un cinquième ces 16 dernières années: dans quelques années, une pénurie sérieuse de personnel médical spécialisée apparaîtra. En Croatie, on s'attend à ce que l'entrée dans l'UE provoque un problème (ou un bénéfice) de mobilité des professionnels de santé similaire. La Lituanie souffre déjà de la mobilité croissante des professionnels de santé, surtout les médecins. En Pologne, une étude de l'année dernière a révélé que pour l'instant, il n'y a pas de menace au système de prestation des soins dû à la mobilité croissante. Cette menace existe pourtant à plus long terme, parce que les professionnels qui quittent le pays sont souvent relativement jeunes, ce qui signifie que dans quelques années, un fossé de générations se fera jour. D'autres rapports polonais font écho à cette tendance, et arrivent à la conclusion que la mobilité professionnelle est ou deviendra bientôt un problème pour le système de soins polonais.

La situation du Royaume-Uni est ambivalente: accueillir du personnel étranger déstabilise et rend les relations plus difficiles, mais ce 'sang nouveau' injecte aussi de l'énergie et des idées nouvelles dans le paysage hospitalier.

Quelques chiffres

En réponse à la question concernant le pourcentage de personnel étranger dans les hôpitaux, les chiffres pour les médecins en Europe de l'Ouest se situent entre 3.56% et 7%; pour le personnel de santé en général—les chiffres vont de 3 à 30% avec une moyenne de 5% en Allemagne et de 10% aux Pays-Bas.

Aux Pays-Bas, le plus haut pourcentage de personnel étranger est représenté par les infirmières et les techniciens médicaux (jusqu'à 30%!). En ce qui concerne les professionnels non médicaux en France et en Allemagne, le pourcentage de personnel étranger est plus bas que pour les médecins (moins de 1% en France, 4% en Allemagne).

Il convient de noter qu'en Lituanie, il n'est pas possible d'engager du personnel étranger vu le manque de base juridique (ainsi qu'une différence importante de paiement).

Problèmes

La barrière linguistique a été citée comme le problème majeur pour la mobilité des professionnels de santé (Autriche, France, Luxembourg, Pays-Bas). La seconde difficulté évoquée concerne la bureaucratie (permis de travail, homologation du diplôme, enregistrement dans le registre approprié) et a été signalée en Autriche, France, Irlande et Allemagne. Ces préoccupations ont occasionné des pertes de temps et ont empêché une certaine flexibilité. Des problèmes d'intégration culturelle ont été cités aux Pays-Bas et au Royaume-Uni, mais loin derrière les autres facteurs. Les Pays-Bas ont aussi évoqué des problèmes fiscaux.

Il faut noter que le Luxembourg a affirmé que les normes éducatives sont plus hautes à l'étranger, et que donc le personnel formé au Luxembourg demande une réévaluation de la formation nationale. Les hôpitaux sont également critiqués parce qu'ils engagent des médecins étrangers qui sont souvent hautement spécialisés. La crainte est qu'une 'demande' de spécialistes soit créée, qui pourrait influencer les budgets d'assurance maladie.

Réglementation

En termes de solutions possibles ou de défauts de réglementation exis-

tants, les réponses peuvent être classées en deux catégories: créer des normes pour une formation/pratique commune; et créer des points d'information.

Certains pays ont plaidé pour des normes communes de formation (France, Irlande, Luxembourg, Allemagne), alors que d'autres privilégiaient des normes de pratique communes (Bulgarie, Irlande, Royaume-Uni, Allemagne) et que d'autres encore envisagent les deux. Le Luxembourg a aussi proposé une formation continue afin d'acquérir une connaissance des pratiques de travail, y compris des cours de langue (également la proposition principale allemande).

La France a aussi proposé la création d'un 'Conseil' en tant qu'intermédiaire entre les hôpitaux et les professionnels. Les Pays-Bas et la Bulgarie ont appelé à l'élaboration d'un point d'information où les professionnels migrants pourraient s'informer sur les normes éducatives nécessaires, les procédures à suivre, etc.
Les Pays-Bas ont insisté sur la nécessité d'une reconnaissance mutuelle des processus d'éducation et de formation (si les hôpitaux de formation veulent accepter des résidents étrangers). Un cadre de normes professionnelles est une base importante de ce processus et devrait être réglementé au niveau européen, ou au moins bilatéral.

Après examen de ces résultats, le sous-comité Affaires européennes a décidé, lors de sa réunion du 19 octobre 2007, de suggérer au Bureau et au Comité exécutif de l'AEDH de continuer à agir autour de cette question. Avec le soutien de différentes régions transnationales, des réunions exploratoires ont été proposées avec les hôpitaux impliqués (les hôpitaux universitaires de Maastricht et d'Aix-la-Chapelle dans la région Rhin-Meuse) et des représentants académiques. Les réunions proposées constitueront une opportunité pour tous les intervenants de discuter des solutions aux problèmes existants et aux insuffisances hospitalières.

Première annonce du programme du Congrès 2008 de l'AEDH à Graz (Autriche)

Lors de sa réunion du 12 octobre 2007, le sous-comité scientifique a élaboré le programme scientifique du prochain Congrès de l'AEDH qui se tiendra à Graz (Autriche) le 25 et 26 septembre 2008 (voir annonce p.41)

Les titres de séances suivants ont été définis:

Un leadership nouveau pour de nouveaux défis

- Quand la gestion hospitalière rencontre le leadership -

Jeudi 25 septembre 2008

14:00 – 15:30 Leadership et politique
16:00 – 17:30 Leadership et économie

Vendredi 27 septembre

09:00 – 10:30 Leadership et éthique
11:00 – 12:30 Leadership et patients
14:00 – 15:30 Leadership et professionnels de santé
- Mobilité
- Vieillissement du personnel

16:00 – 17:30 Leadership et dirigeants
- Accréditation
- Gouvernance hospitalière

De nombreux états membres de l'AEDH ont répondu à l'appel à contributions et ont suggéré de nombreux orateurs et modérateurs de haut niveau. Les membres du sous-comité scientifique ont été enchantés d'étudier des titres et résumés de présentations très intéressants, ce qui a rendu la sélection extrêmement difficile. Suite à des discussions approfondies et prolongées, les orateurs sélectionnés dans toute l'Europe promettent de faire de cet événement un Congrès réussi! Pour tous détails et développements, veuillez consulter régulièrement le site du Congrès:
www.evkd-kongress2008.eu

Systèmes d'évaluation de la qualité en soins de santé Une perspective européenne p. 14

Par Ewa Gojniczek

Un problème commun à tous les hôpitaux de l'UE est la nécessité d'une norme pour des soins de haute qualité ainsi que les moyens de la mesurer et de la garantir. Quatre approches externes de base coexistent pour l'évaluation de la qualité de la gestion du service: Certification industrielle — International Organisation for Standards (séries ISO 9000); European Foundation for Quality Management— EFQM; Visite d'inspection spécialisée, telle que Visitatie (version néerlandaise du programme basé sur le peer review); et l'Accréditation en soins de santé. Toutes les méthodes comportent des éléments intéressants et précieux, mais l'accréditation et la visitatie semblent être les plus adaptées aux professionnels de santé. EFQM et ISO traitent principalement de l'aspect organisationnel de la procédure.

Etudier l'accréditation p. 18

Par le Professeur Jeffrey Braithwaite et le Dr David Greenfield

L'accréditation est devenue le catalyseur central de tous les organismes de santé dans leur quête d'amélioration de la qualité et de la sécurité. Le Centre pour la Recherche en Gouvernance clinique (CCGR) de l'Université de Nouvelle Galles du Sud (Australie) poursuit une étude de l'accréditation, en utilisant EquIP comme base. Le programme CCGR de recherche sur l'accréditation poursuit deux objectifs: examiner les relations entre accréditation et performance organisationnelle (performance clinique et culture organisationnelle) ainsi que l'influence des examinateurs sur la fiabilité et les organisations dans lesquelles ils travaillent. Les résultats préliminaires soulignent les contraintes de temps associées à la conduite et à la préparation de visites de vérification sont de véritables défis. Néanmoins, il s'avère que la mise en lumière de la question de l'accréditation a été bénéfique puisqu'elle a poussé les organisations à se concentrer sur des problèmes souvent négligés.

Nouvelles normes JCI p. 20

Par Karen Timmons

La Joint Commission International (JCI) est le bras international de la Joint Commission, qui accrédite plus de 90% des hôpitaux aux Etats-Unis. La nouvelle accréditation se concentre encore plus sur la priorité numéro un de la JCI: la sécurité du patient. Nous avons incorporé au sein des 323 normes des informations mises à jour par nos hôpitaux internationaux accrédités en matière de bonne pratique. Par exemple, les hôpitaux accrédités par la JCI doivent valider les références des prestataires de soins de santé avec les institutions qui sont censées les leur avoir fournies. Pour déterminer si un hôpital remplit les 323 normes, et leurs 1193 éléments mesurables, une enquête est effectuée sur place par une équipe de trois professionnels, un médecin, une infirmière et un gestionnaire.

Risques pour le patient et frais évitables: Six Sigma réduit les variations médicales p. 22

Par Maximilian C. von Eiff

La variation est la caractéristique principale d'un processus de soins contrôlé de façon inadéquate. Six Sigma soutient la détection du phénomène de variation et offre des instruments pour la surmonter. Six Sigma est un système ciblé de pensées, méthodes et techniques pour la réalisation et le développement de la réussite commerciale. Il est caractérisé par une compréhension des vrais besoins du client, une utilisation disciplinée des données et des faits sur base de méthodes statistiques sures, une focalisation sur le business process ainsi que son amélioration permanente et une réorganisation orientée client. L'utilisation cohérente des outils Six Sigma est un prérequis, qu'il s'agisse de l'expertise des intervenants, ou de la conception du produit. En cette période de budgets flexibles et/ou fermés, le capital nécessaire à tout ceci est relativement facile à mobiliser.

Planification des capacités dans les hôpitaux allemands p. 25

Par le Professeur Ludwig Kuntz, le Dr Boris Augurzky et Roman Mennicken

En Allemagne, les hôpitaux font face à un excès de capacités suite à des incitants réglementaires inappropriés de la part de la planification hospitalière et du système de financement. En outre, depuis l'introduction des DRGs en 2004, les hôpitaux sont confrontés à un environnement plus compétitif, qui augmente la nécessité d'efficacité de la planification des capacités et de la gestion. Dans ce contexte, les alliances horizontales et verticales se révèlent souvent fructueuses et les états ont tendance à déréglementer la planification et à donner plus de liberté managériale aux hôpitaux.

Planification de la capacité hospitalière – penser l'espace p. 27

Par Knut Bergsland

La plupart des hôpitaux européens devront étendre leurs capacités d'examen et de traitement à l'avenir. Ils

devront aussi réorganiser et restructurer leurs fonctions de base. Il est rarement économiquement viable d'éluder les problèmes de capacité, quel que soit le financement des investissements de soins de santé. Vu que la capacité de chaque fonction est étroitement liée à son efficacité, l'organisation des procédures professionnelles est essentielle à son expansion.

Au niveau de l'hôpital, ceci peut déboucher sur un remaniement complet du travail. La facilité de l'administration hospitalière à encourager une meilleure utilisation des espaces existants peut entraîner une amélioration des résultats à un moment donné. Quand ce moment est atteint, une réorganisation créative du travail est peut-être la seule réponse aux problèmes internes. Les modes de travail habituels devraient être remis en question. La planification au niveau de l'hôpital ou du groupe d'hôpitaux devra toujours prendre en compte la situation existante en termes d'activité, de capacité et d'espace. Des résultats significatifs ne seront sans doute pas obtenus immédiatement, mais tous les hôpitaux devraient pouvoir contrôler leur capacité et leur utilisation de l'espace.

Gestion des lits par RFID à l'hôpital de l'Île de Bern p. 29

Par André Calame et Gregor Hotz

L'Hôpital de l'Ile a testé la viabilité de l'utilisation de la technologie RFID pour la gestion des lits à l'occasion d'un projet spécifique. Les techniciens médicaux de l'hôpital ont procédé à un certain nombre de tests pour exclure la possibilité que la technologie RFID n'affecte négativement l'équipement médico-technique et les implants. Il a été démontré que l'information nécessaire pouvait être générée automatiquement, et que la corrélation entre ces informations et les données produites en parallèle sur papier était de 99,9%. La nouveau système a parfaitement fonctionné et aucune mesure spéciale n'a été prise pour obtenir une transmission correcte des données. Comme l'hôpital est constamment informé de la localisation de tous ses lits, il est possible de satisfaire aux besoins de capacité avec 20% de lits en moins. Ceci devrait permettre de substantielles économies durant la phase actuelle de développement.

Le système belge de santé p. 31

Par Kristof Eeckloo

Le système belge de santé est principalement organisé au niveau fédéral et régional. Le gouvernement fédéral est responsable de la réglementation de l'assurance maladie obligatoire, de la détermination des critères de licence pour les établissements de soins, du financement du fonctionnement des établissements de soins, de la réglementation de la qualification des professionnels de santé, de l'enregistrement et du contrôle des prix des produits pharmaceutiques. Les gouvernements régionaux sont responsables de la prévention et de la promotion de santé, des services de maternité et de santé de l'enfant, de différents aspects des soins aux personnes âgées, de l'adoption de critère de licence des établissements de soins et du financement des infrastructures (selon des règles de base adoptées au niveau fédéral). La force du système belge de santé est que les soins sont facilement accessibles et réceptifs aux patients.

Le système hospitalier belge et l'orientation des réformes p. 33

Par le Professeur Marie-Christine Closon

Les hôpitaux belges sont financés en fonction des jours justifiés d'activités mesurées et du type de pathologie traité (pris en compte dans les APRDRGs), de l'âge et du caractère gériatrique du séjour. Depuis 2007, l'impact des facteurs sociaux est également intégré. Le financement prospectif pour la médication en termes d'APRDRGs et quatre niveaux de gravité a été établi depuis 2006. Comme les médecins sont rémunérés à l'acte en Belgique, la forfaitarisation des frais médicaux rencontre une grande résistance auprès du corps médical, qui ne veut accepter une telle situation que sur base de directives médicales. Une première tentative a été entreprise. Un financement forfaitaire accru a été décidé pour 28 maladies courantes qui sont uniformes en termes de dépenses, simples en termes de procédure et pour lesquelles les modèles de consommation qui dévient significativement de la moyenne nationale peuvent être facilement identifiés.

Association belge des directeurs d'hôpitaux p. 36

Par le Professeur Eric Engelbrecht

Fondé au début des années 70 en tant qu'association de fait visant à représenter les directeurs d'hôpitaux belges, l'organisation accepte tous les membres sans distinction de statut hospitalier, de groupe linguistique ou de communauté/région. Les buts de l'association sont d'aider les directeurs d'hôpitaux à acquérir et à maintenir les compétences nécessaires pour diriger un hôpital de qualité; de promouvoir et défendre le statut des directeurs d'hôpital aux niveaux local, régional, fédéral et européen; d'encourager l'interaction entre directeurs d'hôpitaux; et d'offrir à ses membres une aide juridique. En 2002, l'association est devenue une ASBL (association sans but lucratif). Depuis son siège de Bruxelles, l'association soutient également activement l'association européenne des directeurs d'hôpitaux, dont elle est un des membres fondateurs.

Möglichkeiten der Organisationsentwicklung für Gesundheitsmanager

Es ist allgemein bekannt, dass europäische Krankenhäuser heute zahlreichen Herausforderungen gegenüber stehen. Neben den Partikularitäten und spezifischen Gegebenheiten in jedem Mitgliedstaat, laufen überall Diskussionen über die Rolle der Krankenhäuser, deren Kapazität, den Anforderungen der Patienten zu entsprechen, ihre Attraktivität im Kontext eines harten Wettbewerbs, die Entwicklung ihrer Finanzierung usw.

Trotz der offensichtlichen Heterogenität dieser Problematiken, haben alle Fragen gemeinsam, die Einrichtungen im Hinblick auf ihre Organisation zu hinterfragen sowie ihrer Fähigkeit, diese weiter zu entwickeln.

Mehr als jede andere Einrichtung, sind Krankenhäuser lebende Materie, die sich fortwährend einer ändernden Umgebung anpassen, immer weiter ihre Effizienz steigern und jederzeit die Organisation überprüfen müssen, um den Kunden eine bestmögliche Leistung bieten zu können.

Diese Aufgabe ist das Herzstück des Krankenhausdirektors, der über vielerlei Instrumente verfügt, die ihm dabei helfen, diese Mission der Optimalisierung der Krankenhauseinrichtungen zu erfüllen. Wenn diese Instrumente und Methoden viele Varietäten kennen und mehr oder weniger erfolgreich im einen oder anderen Mitgliedstaat eingesetzt worden sind, ist doch die Akkreditierung und im allgemeinen die Entwicklung der Qualität heute ein unumgänglicher und zentraler Ansatz in allen Mitgliedstaaten.

Dementsprechend ermöglichen die in dieser Ausgabe von *(E)-Hospital* enthaltenen Artikel jedermann, sich einen Überblick zu verschaffen über die grundlegenden Ansätze der externen Qualitätsevaluierungsmethoden in Europa, die überall ihre Macht demonstriert haben, sowie ihren positiven Ansatz und ihre Fähigkeit, die Einrichtungen zu mehr Effizienz zu führen.

Ihrer Berufung treu, an der Konstruktion eines Europas der Gesundheit mitzuarbeiten, hat die EVKD sich entschlossen, in der Fragestellung rund um Akkreditierungssysteme einen Schritt weiter zu gehen und konstituierende Elemente zu definieren, die ein europäisches Akkreditierungsmodell schaffen könnten.

Das geplante EVKD-Seminar, welches am 16. November 2007 in Düsseldorf stattfindet, ermöglicht es den Verantwortlichen der Krankenhäuser in Europa, sich über die bestehenden Systeme auszutauschen, über den Wert der Qualität und darüber nachzudenken, welche Voraussetzungen ein harmonisiertes, europäisches System erfüllen müsste, welches ohne die nationalen Systeme zu verdrängen und ohne die nationalen Besonderheiten in den Hintergrund drängen zu wollen, es ermöglichen würde einen europäischen Qualitätsstandard zu definieren, welcher von allen akzeptiert werden kann und für den Patienten transparent ist.

Natürlich ist die Akkreditierung nicht der einzige Ansatz, der den Gesundheitsmanagern zur Verfügung steht, um deren Einrichtungen zu entwickeln.

Paul Castel

Die neuen Technologien bieten hierbei neue Möglichkeiten und unendliche Entwicklungen. Dies ist z.B. der Fall bei der Methode der „Kapazitätenplanung“, die zweifelsohne viel versprechende Anwendungen in den Krankenhäusern finden wird und für die *(E)-Hospital* heute ein Echo bietet.

Wir sehen, wie zahlreich die Herausforderungen für Krankenhäuser sicherlich sind, aber die Antworten sind dies ebenfalls und die Krankenhausdirektoren werden ihre Fähigkeit unter Beweis stellen können, einen Schritt voraus zu sein und zusammen zu arbeiten. Hierbei erfüllt die EVKD mehr denn je ihre Rolle des „Ideeninitiators“ und wird am Herzen haben, neue europäische Visionen für die Gesundheit hervorzubringen.

Paul Castel
Präsident der EVKD

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

EVKD agiert zum Thema „Mobilität des Gesundheitspersonals“

Die kürzlich von der EVKD ausgeführte Blitzumfrage „Mobilität des Gesundheitspersonals” beantwortete Fragen, wie z.B. ob das betroffene Land oder Krankenhaus von der Mobilität des Gesundheitspersonals profitiert oder darunter leidet, wie hoch der Prozentsatz des eingesetzten aus dem Ausland stammenden Personals im Land und in Beispielkrankenhäusern ist, welches die Hauptprobleme sind und wie diese aus Sicht des Krankenhausmanagements gelöst werden können.

Vorteile

Festgestellt werden konnten zunächst die zu erwartenden Unterschiede zwischen west- und den osteuropäischen Staaten: während westeuropäische Staaten von der Mobilität profitieren (z.B. Österreich, Frankreich, Luxemburg oder die Niederlande) ist dies für osteuropäische Staaten nicht der Fall. Teilweise leiden diese Länder bereits heute unter einer Abwanderung, teilweise werden diese Probleme in naher Zukunft erwartet.

In Bulgarien zum Beispiel erklärten Direktoren verschiedener Krankenhäuser, dass viele Ärzte ins Ausland auswandern, die meisten jedoch einer Spezialisierung nachgehen und daher in ein oder zwei Jahren wieder ins eigene Land zurückkehren. Die Fluktuation von KrankenpflegerInnen, Hebammen, Radiologieassistenten oder Laborassistenten sei weitaus alarmierender. Es gäbe keine einzige Gesundheitseinrichtung im Land, die sich nicht von mindestens fünf KrankenpflegerInnen im letzten Monat verabschiedet hat. Die wachsende Mobilität bereite Sorgen, da in den letzten 16 Jahren die Anzahl der Ärzten um ein Fünftel zurückgegangen ist, was bedeutet, dass Bulgarien in ein paar Jahren unter einem großen Ärztemangel vor allem bei spezialisierten Fachkräften leiden wird.

In Kroatien wird erwartet, dass nach EU-Beitritt das Problem (oder der Vorteil) der Mobilität genauso auftreten wird, wie in anderen sich in der Übergangsphase befindlichen Ländern.

Litauen auf der anderen Seite kämpft heute schon mit den negativen Auswirkungen der großen Abwanderung aus dem eigenen Land, vor allem was Ärzte betrifft. In Polen allerdings gab es im letzten Jahr eine regionale Untersuchung, wonach derzeit keine Gefahr für das reibungslose Funktionieren des Gesundheitssystems durch die stattfindende Abwanderung besteht. Es bestünde allerdings eine Gefahr auf lange Sicht, da die meisten Abwanderer relativ jung sind. In ein paar Jahren wird daher aufgrund des Generationswechsels unter einem Mangel an Gesundheitspersonal leiden. Unter Berücksichtigung von Stimmen aus mehreren polnischen Regionen, kann gesagt werden, dass die Freizügigkeit des Gesundheitspersonals heute oder in naher Zukunft ein Problem für das polnische Gesundheitswesen darstellen wird. Interessanterweise wird das Phänomen in Großbritannien zweischichtig beurteilt: ausländische Mitarbeiter zu empfangen bedeutet einerseits weniger Stabilität und weniger enge Beziehungsbildung aber auch, und positiv, „neues Blut” und Energie, zusammen mit neuen Ideen.

Zahlen

Ergebnisse bezüglich der Prozentsätze des beschäftigen ausländischen Personals im jeweiligen Land oder in den Krankenhäusern ergaben, dass bezüglich der Ärzte die Beschäftigung in westeuropäischen Staaten zwischen 3.56% und 7% liegt. Für Gesundheitspersonal im allgemeinen liegen die Beschäftigungszahlen zwischen 3-30%, mit einem Durchschnitt von z.B. 5% in Deutschland oder 10% in den Niederlanden.

In den Niederlanden liegt die höchste Anzahl ausländischer Mitarbeiter im Pflegeberuf und bei den medizinisch-technischen Assistenten (bis zu 30%!). Die Prozentsätze für nichtmedizinisches Personal in Frankreich oder Deutschland sind hingegen weniger hoch als für Ärzte (in Frankreich weniger als 1% und in Deutschland 4%).

Probleme

Größtes Problem sind die mangelnden Sprachkenntnisse (genannt z.B. in Österreich, Frankreich, Luxemburg, Deutschland und den Niederlanden). Die zweite Schwierigkeit betrifft die Bürokratie (Erhalten einer Arbeitserlaubnis, Anerkennung der Ausbildungsabschlüsse, Registrierung in einem geeigneten Register, usw.) – genannt in Österreich, Frankreich, Irland, Deutschland- was zu zeitlichen Problemen führt und keine Möglichkeit für Flexibilität bietet.

Schließlich werden kulturelle Integrationsschwierigkeiten von den Niederlanden und Großbritannien angeführt, aber auch hier als nicht besonders schwerwiegend eingestuft. Die Niederlande führten auch fiskalische Probleme an. Luxemburg gab an, dass aufgrund der höheren Ausbildungsstandards im Ausland, die in Luxemburg ausgebildeten Kräfte für eine Aufwertung der eigenen Ausbildung plädieren. Weiterhin werden Krankenhäuser auch für die Beschäftigung ausländischer Fachkräfte kritisiert, da diese meist hoch spezialisiert seien und daher eine „Nachfrage“ für diese Art

der medizinischen Behandlung hervorgerufen würde, was das Budget der Krankenversicherung beeinflusse.

Regulierung

Was die möglichen Problemlösungsansätze anbelangt, konnten Antworten in zweierlei Kategorien unterteilt werden: es sollen gemeinsame Standards für Ausbildung und Praxis geschaffen werden, sowie zentrale Informationspunkte für die Berufsangehörigen.

Einige Länder plädierten für gemeinsame Ausbildungsstandards (Frankreich, Irland, Luxemburg und Deutschland) und andere für gemeinsame Praxisstandards (Bulgarien, Irland, Großbritannien, Deutschland), einige sprachen sich für beide aus. Luxemburg schlug daneben eine „kontinuierliche Fortbildung" vor, welche vor allem auch die notwendigen Kenntnisse des Arbeitslandes, einschließlich der Sprache (Hauptvorschlag auch von Deutschland), vermitteln soll.
Ein Vorschlag Frankreichs war es, eine „Vermittlungsstelle" einzurichten, die als Verbindungsglied zwischen Krankenhaus und Personal fungiert. Die Niederlande und Bulgarien hingegen sprachen sich für das Einrichten einer Informationsstelle für einwandernde Mitarbeiter aus, an der Informationen zu Ausbildungsstandards, Verfahrensschritte usw. eingeholt werden können. Die Niederlande deuteten auch auf die Notwendigkeit der gegenseitigen Anerkennung von Ausbildungs- und Weiterbildungsschritten hin (um es Krankenhäusern zu ermöglichen, Ärzte im Praktikum aus dem Ausland zu beschäftigen). Das Definieren gemeinsamer Berufsstandards, die auf europäischer oder zumindest bilateraler Ebene geschaffen werden sollen, ist hierfür wichtige Voraussetzung.

Diese Ergebnisse wertend, entschied der EVKD-Beirat, dem Präsidium und Vorstand der EVKD vorzuschlagen, wie folgt zu agieren: Mit der Unterstützung mehrerer Grenzregionen sollen zunächst Treffen abgehalten werden, in denen das weitere Vorgehen diskutiert wird. Es sollen Krankenhäuser eingeladen werden (z.B. das Universitätskrankenhaus Maastricht oder das Uniklinikum Aachen in der Region Rhein-Meuse) sowie Universitätsvertreter die darüber beraten können, wie bestehende Probleme und Mängel in Krankenhäusern beseitigt werden können.

EVKD Kongress in Graz, Österreich

Anlässlich der Sitzung am 12. Oktober 2007, hat der Wissenschaftliche Beirat der EVKD das Programm des kommenden EVKD Kongresses in Graz, Österreich, am 25.-26. September 2008, festgelegt (siehe auch Ankündigung auf S.41)

Festgehalten wurden die folgenden Programmtitel:

Neue Führung für neue Herausforderungen

- Krankenhausmanagement trifft Führung -

Donnerstag, 25. September 2008

14:00 – 15:30 Führung trifft Politik
16:00 – 17:30 Führung trifft Wirtschaft

Freitag, 26. September 2008

09:00 – 10:30 Führung trifft Ethik
11:00 – 12:30 Führung trifft Patienten
14:00 – 15:30 Führung trifft Gesundheitsberufe
- Mobilität
- Alternde Mitarbeiter

16:00 – 17:30 Führung trifft Spitzenreiter
- Akkreditierung
- Krankenhausführung

Zahlreiche EVKD Mitgliedsstaaten waren dem Aufruf zur Einreichung von Vortragsthemen gefolgt und hatten herausragende Sprecher aus dem eigenen Land eingebracht. Die Mitglieder des Beirats freuten sich daher, viele exzellente Vortragstitel und –themen analysieren zu können - was die Auswahl allerdings schwierig werden ließ.
Bitte besuchen Sie regelmäßig die Kongress-Homepage, um über die fortlaufenden Entwicklungen zu erfahren: www.evkd-kongress2008.eu

Qualitätsevaluierungssysteme in der Gesundheitsversorgung Eine europäische Perspektive p. 14

Von Ewa Gojniczek

Ein gemeinsames Problem für alle Krankenhäuser in der EU ist die Notwendigkeit einer Norm für die qualitativ hochwertige Gesundheitsversorgung und die Möglichkeit diese zu messen und zu garantieren.

Vier Ansätze der externen Evaluierung der Qualität der Verwaltung des jeweiligen Dienstes bestehen derzeit nebeneinander. Alle Methoden beinhalten interessante und wertvolle Elemente. Die Akkreditierung und die *visitatie* scheinen die meist adaptierten für den Gesundheitsbereich zu sein. EFQM und ISO behandeln hauptsächlich die Organisationsaspekte des Verfahrens.

Inspektion der Akkreditierung p. 18

Von Professor Jeffrey Braithwaite und Dr. David Greenfield

Das Zentrum für Forschung in der Klinikleitung (CCGR) einer australischen Universität führt eine Akkreditierungs-Studie durch, bei der EquIP exemplarisch genutzt wird. Das Forschungsprogramm des CCGR hat zwei Ziele: die Beziehungen zwischen der Akkreditierung und der Organisationsleistung zu untersuchen sowie den Einfluss der Examinatoren auf die Verlässlichkeit und die Einrichtungen, in denen sie arbeiten. Erste Ergebnisse.

Neue Normen der JCI p. 20

Von Karen Timmons

Die Joint Commission International (JCI) ist der internationale Arm der Joint Commission, die mehr als 90% der Krankenhäuser in den USA akkreditiert. Die neue Akkreditierung JCI stellt die Nummer-Eins-Priorität der JCI noch mehr in den Vordergrund: die Sicherheit des Patienten. Um ein Krankenhaus anhand von 323 Normen und deren 1193 messbaren Elementen zu bewerten, wird eine Untersuchung vor Ort ausgeführt von einem Team von drei Spezialisten, einem Arzt, einer Pflegekraft und einem Repräsentanten der Verwaltung.

Risiken für den Patient und vermeidbare Kosten: Six Stigma reduziert medizinische Schwankungen p. 22

Von Maximilian C. von Eiff

Schwankungen sind ein Hauptcharakteristik eines Behandlungsverfahrens, das eine ungeeignete Kontrolle erfährt. Six Stigma unterstützt die Detektierung des Phänomens der Schwankungen und bietet Instrumente, diese zu beseitigen. Six Stigma ist ein System auf das vielerlei Gedanken abzielen, Methoden und Techniken zur Realisierung und Entwicklung eines wirtschaftlichen Erfolgs. Charakterisiert wird Six Stigma durch ein Verständnis der echten Bedürfnisse des Kunden, eines disziplinierten Gebrauchs der Daten und Fakten auf Basis von statistisch sicheren Methoden und einer Fokussierung auf den Geschäftsprozess sowie der permanenten Weiterentwicklung und einer Reorganisation, die sich am Kunden orientiert.

Der kohärente Gebrauch des Instruments Six Stigma in eine Grundvoraussetzung, ob es sich um die Expertise des Intervenierenden handelt oder des Konzepts des Produkts. In einer Zeit der flexiblen und/oder festen Budgets, ist es relativ einfach das notwendige Kapital für dieses Verfahren aufzubringen.

Kapazitätenplanung in deutschen Krankenhäusern p. 25

Von Prof. Ludwig Kuntz, Dr. Boris Augurzky und Roman Mennicken

Krankenhäuser in Deutschland haben zu viele Betten als Ergebnis falscher Anreize, die durch die Regulierung der Krankenhausplanung und des Finanzierungssystems geschaffen wurden. Seit der Einführung der DRGs in 2004 sind Krankenhäuser mit einem erhöhten Wettbewerb konfrontiert, der die Notwendigkeit für eine effiziente Bettenplanung und –management hervorruft. In diesem Zusammenhang erweisen sich horizontale und vertikale Allianzen oft als erfolgreich und der Trend geht hin zu weniger staatlich regulierter Kapazität und mehr Freiheit des Managements für Krankenhäuser.

Planung der Krankenhauskapazität – räumlich denken p. 27

Von Knut Bergsland

Die meisten der europäischen Krankenhäuser werden in Zukunft ihre Untersuchungs- und Behanglungskapazitäten steigern müssen. Sie werden auch ihre Basisfunktionen reorganisieren und restrukturieren müssen. Es ist jedoch fast nie wirtschaftlich lebbar, Probleme der Kapazität zu umgehen, wie immer auch die Finanzierung der Einrichtung gestaltet sein mag. Da die Kapazität jeder Funktion eng an ihre Effektivität gebunden ist, ist die Organisation der beruflichen Verfahren für deren Ausweitung essentiell. Auf Ebene des Krankenhauses kann dies zu einer tiefgreifenden

Änderung der Arbeit kommen. Die Möglichkeit des Krankenhausmanagements, einen besseren Gebrauch der existierenden Räumlichkeiten zu fördern kann eine Verbesserung der Ergebnisse zu einem bestimmten Zeitpunkt führen.

RFID-Bettenmanagement im Inselspital Bern p. 29

Von André Calame und Gregor Hotz

Das Inselspital Bern hat den Einsatz der RFID-Technologie beim Bettenmanagement geprüft. Die Medizintechniker des Inselspitals haben Abklärungen getroffen, um sicherzustellen dass keine Einflüsse der RFID-Technologie auf die medizintechnischen Geräte und auf Implantate zu erwarten sind. Der Pilot hat gezeigt, dass die notwendigen Informationen automatisch erfasst werden können und gemessen an den parallel geführten Karteidaten zu 99,9% übereinstimmen. Das eingesetzte System hat ohne Pannen funktioniert und keine besonderen Vorkehrungen für die korrekte Übermittlung der Daten erfordert. Da das Krankenhaus jederzeit weiss, wo welche Betten sind, kann die gleiche Anzahl Bettenstandplätze mit 20% weniger Betten bewirtschaften werden, Dies ist in der aktuellen Wiederbeschaffungsphase ein wichtiges Sparpotential.

Das belgische Gesundheitssystemp. 31

Von Kristof Eeckloo

Das belgische Gesundheitssystem wird prinzipiell auf nationaler und regionaler Ebene organisiert. Di föderale Regierung ist verantwortlich für die Regulierung der obligatorischen Krankenversicherung, für die Definition der Lizenzkriterien für die Versorgungseinrichtungen, für die Finanzierung und Funktionieren der Einrichtungen, für die Reglementierung der Qualifizierung der Gesundheitsprofessionalisten, und für die Zulassung und Preiskontrolle der pharmazeutischen Produkte.

Die regionalen Regierungen hingegen sind verantwortlich auf dem Gebiet der Präventionsmedizin und der Gesundheitsförderung, für die Dienste der Geburtshilfe und der Kindergesundheit, den verschiedenen Bereichen der Pflege älterer Menschen, für die Verabschiedung von Kriterien für die Lizenzverteilung der Pflegeeinrichtungen und der Finanzierung der Infrastrukturen (nach den Grundregeln, die auf nationaler Ebene bestimmt werden). Die Stärke des belgischen Gesundheitssystems ist, dass die Versorgung leicht zugänglich ist und den Patienten offen gegenüber steht. Nachteile sind die Kosten und die Komplexität.

Das belgische Krankenhaus-system und die Ausrichtung seiner Reformen p. 33

Von Professor M.C. Closon

Die Finanzierung belgischer Krankenhäuser gestaltet sich anhand eines Schlüssels von nachgewiesen Tagen, nach dem Typ der behandelten Pathologie (welcher sich in den APRDRGs widerspiegelt), dem Alter des Patienten und dem geriatrischen Charakter des Aufenthalts. Seit 2007 ist auch der Sozialfaktor ein Bestandteil.

Die Finanzierung für die Medikation in den d'APRDRGs und vier verschiedene Schweregrade sind seit 2006 erarbeitet. Da Ärzte in Belgien nach ausgeführtem Akt bezahlt werden, erfährt die Pauschalisierung der medizinischen Kosten eine große Resistenz in der Ärzteschaft in Belgien. Diese wollen eine derartige Situation nur auf Basis medizinischer Richtlinien akzeptieren. Ein erster Versuch wurde bereits unternommen. Eine pauschalisierte Finanzierung wurde für 28 gängige Krankheiten beschlossen, die in Bezug auf die Ausgaben vergleichbar sind, die bezüglich der Behandlung einfach zu handhaben sind und für die es Gebrauchsmodelle gibt, die auf nationaler Ebene einfach definiert werden konnten.

Die belgische Vereinigung der Krankenhausdirektoren p. 36

Von Professor E. Engelbrecht

Zu Beginn der 70er Jahre als faktische Arbeitsgemeinschaft gegründet, die darauf abzielt, die belgischen Krankenhausdirektoren zu vertreten, nimmt die Organisation heute Mitglieder auf, ohne Unterschied auf den Status des jeweiligen Krankenhauses, der Sprachzugehörigkeit oder der Region bzw. Gemeinde.

Ziel der Vereinigung ist es, den Krankenhausdirektoren die nötigen Kompetenz zu vermitteln und diese zu unterhalten, um ein qualitativ hochwertiges Krankenhaus leiten zu können; den Status des Krankenhausdirektors auf lokaler, regionaler föderaler oder europäischer Ebene zu fördern und zu verteidigen; und eine Interaktion zwischen den Krankenhausdirektoren zu fördern sowie den Mitgliedern eine juristische Hilfe zu bieten. In 2002 wurde die Vereinigung eine ASBL (eine Gesellschaft ohne Absicht auf Gewinnabzielung). Seit der Sitz der Vereinigung in Brüssel ist, unterstützt die Vereinigung auch aktiv die europäische Vereinigung der Krankenhausdirektoren, von der sie ein Gründungsmitglied ist.

2007

December

2 - 5
International conference 2007 – eHealth: Combining Health Telematics, Telemedicine, Biomedical Engineering and Bioinformatics to the Edge, Regensburg, Germany
www.cehr.de

10 – 11
9èmes Journées internationales de la Qualité hospitalière (JIQH), Paris, France
www.mateda.com/jiqh2007.html

11
Telehealth 2007
Brussels, Belgium
ec.europa.eu/information_society/news-room/cf/itemdetail.cfm?item_id=3684

2008

January

24 – 25
Recherche en Soins et Evaluation des Pratiques professionnelles, Courbevoie, France
www.arsi.asso.fr/fearsi.htm

February

6
Nursing in Practice,
Belfast, United Kingdom
www.nursinginpractice.com/events

16-17
Patienta,
Essen, Germany
patienta.messe-essen.de

March

10 – 12
4th Annual World Health Congress – Europe 2008,
Berlin, Germany
www.worldcongress.com

April

16 – 18
Med-e-tel,
Luxembourg
www.medetel.lu

23 – 24
4th International Forum on Quality and Safety in Healthcare, Paris, France
forum.eventsinteractive.com/bmj/em.esp?id=11032&pageid=_2540KH07D

23 – 24
Healthcare in Ireland,
Dublin, Ireland
www.healthcare-ireland.com

May

27 – 30
Hit (Health Information Technologies) 2008,
Paris, France
www.healthit.fr/docs/Plaquette_HIT_Bilan.pdf

27 – 30
Hôpital Expo,
Paris, France
www.hopitalexpo-intermedica.com

June

25
26th International EuroPACS meeting,
Barcelona, Spain
www.europacs.org

25 – 28
4th CARS Computer assisted Radiology and Surgery,
Barcelona, Spain
www.congres-medical.com/modules.php?name=Redirect_Links

September

25 – 26
EAHM Congress «New leadership for new challenges» , Graz, Austria
www.aedh.eu.org

October

19 – 23
IFHE 2002- 20th Congress of International Federation of Hospital Engineering,
Barcelona, Spain
www.aeih.org/ih/Congresos/Congreso26/Eng/2008ifhecongress.asp

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