The IHF present at the IAPO Congress

The International Hospital Federation was invited by the International Alliance of Patients Organization (IAPO) to attend their 6th Global Patients Congress, which was held 29-31 March 2014, at the Macdonald Berystede Hotel, in Ascot, United Kingdom.

Sharing the same engagement towards patients centered care, the IHF and IAPO have started to collaborate formally through a Memorandum of Understanding since 2012. In 2013 the IHF has developed a survey on “formal involvement of patients in hospitals” and this has been sent to both IHF and IAPO members.

The theme of the IAPO Congress was “Better access to better health: a patient-centered approach to Universal Health coverage”. During the two days of the conference, sessions were organized under three major streams: equity, quality and financing. IHF was also be involved in the scientific committee and was invited to be a supporting organization of the IAPO Global Patients Congress.

During the first Plenary Session, held on Sunday, 30 March, the theme of the Congress was introduced and the key note speaker, Dame Sally Davies, Chief Medical Officer at the UK Government presented the situation of access healthcare in the country and the role of patient’s engagement at both local and global level to achieve patients-centered care.

The sessions of the two days congress allowed high level exchange and raised the core problems and limitations for patient-centered care towards a universal coverage, namely economic, political, institutional, educational, financial, social and cultural obstacles.

Some 170 delegates from 48 Countries who attended the event, had the opportunity to share knowledge and best practices on patient-centered care as well to raise important questions to move forward on the need of patient involvement.

The last Plenary Session was dedicated to final considerations towards universal health coverage. Marie-Paule Kieny, Assistant Director General, Health Systems and Innovation at the World Health Organization, underlined that there is need to a multi-stakeholder to define and achieve universal health coverage.
The International Hospital Federation was invited to attend, as co-organizer, the 22nd International Conference on Health Promoting Hospitals and Health Services, held 23-25 April 2014 in Barcelona, Spain. The IHF President, Dr Kwang Tae Kim, in his opening remarks mentioned that the rise in multiple-chronic conditions is strongly related with the ageing population and therefore integration of healthcare is to be considered as a key challenge.

The theme of the Conference, “Changing hospital & health service culture to better promote health”, was organized under three sub-themes:

- Health literacy – an emerging concept for more patient-oriented healthcare
- Enhancing the health environment for health professionals – Developing a more salutogenic culture for and by healthcare staff
- Better health care responses to community needs through a culture of cooperation between organizations and settings

During the conference the IHF hosted a session on the “Institutionalization of Health Promoting Practices”. Speakers from five regions presented pictures of their respective national context. The presentations are available on the IHF Website at: http://www.ihf-fih.org/Events/Collaborative-Events/Past-Events/HPH-Conference.

This meeting was also an opportunity for the IHF to organize its Governing Council (GC) meeting. A first meeting was hosted on Tuesday, 22 April 2014 at the Unió Catalana d’Hospitals, an Associate Member of the Federation. This first meeting was also an opportunity for IHF Governors to meet with the President of the Unió – Dr Manel Jovells – and the CEO – Dr Helena Ris.

The Unió organized a press meeting with journalists from Europa Press, EFE Agency, Expansión, Ara and Catalunya Ràdio. Dr Kim and Dr Jowells were of the same opinion that there is need to strengthen relations between IHF and the Unió. Dr Erik K. Normann underlined that the two major international challenges confronting healthcare as: i) the growth in multiple-chronic conditions among the ageing population and ii) patient-centered care. High interest was shown towards IHF Special Interest Groups.

The second GC Meeting was organized in conjunction with the HPH Conference on Wednesday, 23 April 2014. On this occasion, IHF Governing Council Members met with the HPH Board in a side meeting.

During the last plenary session, the IHF CEO, Mr de Roodenbeke, highlighted five major trends in the evolving role of hospitals in health promotion:- The increased empowerment of people in relation to access to health information- The growth of patients with multi-chronic conditions- The breakthrough of predictive medicine and the identification of risk factors- The dissemination of Electronic Health Records- The universal health coverage in order to oblige healthcare to be more cost effective and sustainable.

Related articles in the newspapers

The IHF in Expansión Catalunya(español).pdf 71.79 kB
The IHF in Diari de Girona(catalan).pdf 465.69 kB


The International Hospital Federation (IHF) participated as a Thematic Partner of the 2014 Geneva Health Forum (GHF), held 15-17 April 2014 in Geneva, Switzerland.

IHF’s Chief Executive Officer, Eric de Roodenbeke was a speaker at the parallel session entitled “Accessing the Impact of Healthcare Institutional Partnerships”. Multiple inter-connected areas of institutional health care partnerships were explored against a background in which institutional health care partnerships are receiving increasing attention in the global health arena, particularly in regard to the knowledge base on how hospital-to-hospital partnerships can strengthen service delivery.

In his presentation, IHF CEO, discussed 3 valuable elements to building partnership.

No. 1: Team-building. Steps to achieve this requires that there be recognition of the hospital as a complex organization that faces many challenges and high levels of stress are experienced daily.
No. 2: **Change of management.** People should be obliged to think about [their] behaviors to bring in innovations. So that hospitals can provide even more satisfactory care delivery to patients.

No.3: **Resource constraint: Not a barrier to accomplishing much with little.** The current trend among healthcare providers is to complain of limited resources that restricts their capacity to perform efficiently and effectively. The perspective being to equate greater productivity with more resources. This would require a change of mindset, whereby healthcare providers should look for opportunities rather than concentrate on barriers.

Other speakers provided insider views on partnership, by addressing such topics and elements as:

- hospital-hospital partnerships; e.g. south-south; south-north;
- contribution of partnership to health development
- the way forward in sustaining such partnerships
- Ways to measure the impact and define partnerships;

The 3 key take home messages from this session were:

1. **Quality of Partner:** Partnerships maybe not be eternal and is time-constricted.
2. **Converting the unbelievers** to the value of partnerships: Promote and encourage others on the possibilities available through partnerships. Ensure that actual results of partnerships are evaluated.
3. **Human interaction:** The importance of engaging in a “process”, that will require human interaction and support to create a sustainable, long-lasting, meaningful programmes.

Visit IHF blog at [ihfnews.org](http://ihfnews.org) to read more about the forum


Presenters proposed potential solutions to the problem of antimicrobial resistance in populations, whilst simultaneously explaining the reasons for their persistence. The increasing prevalence of resistance, particularly in developing countries, was highlighted as well as assessment of its substantial negative impact on mortality and the economy. Also highlighted was the current phenomenon of over prescription by medical professionals. There exists a high positive correlation in all countries between use of antibiotics prescribed by doctors and levels of antimicrobial resistance in populations, thus suggesting that countries with high resistance rates may be misusing modern medical technologies, igniting long-term suffering on society despite intentions to alleviate short-term sickness of individuals.

Other arguments presented on the reasons why this preventable problem continues to impact health systems, included:

* Lack of vigilance by the health sector, not only in planning and policies by global and national institutions, but in scant attempts to properly track resistance and its patterns across the world.

* Failure to sensitisie the health sector to this development.

* Difficulties in convincing medical industries to create new medicines only to rigorously regulate their use by practitioners. Such conflicts tend to force clashes between individual and societal values in times of reforms.

* Weak leadership at governance level which results in lack of accountability within local circles. Because no one is willing to accept the risk of administering fewer antibiotics on their own, there is acceptability in health circles of overusing medications in an attempt to save as many lives as possible for the short-term. Unfortunately, this social failure cultivates a perpetual circle of long-term suffering.
There was consensus, however, that all of these frames were not only relevant, but also interconnected. A deficiency in leadership and efficiency at top governance levels has trickled down to negatively affect everyday culture and how invested common people are in antimicrobial resistance. It was agreed that comprehensive reforms that simultaneously address the multiple factors contributing to the prevalence of resistance across the world, are possible. Individual countries must utilize solidarity to initiate policies that alter outlooks and behaviours of professionals and patients.

WHO Round Up

Influenza seasonality and vaccination timing in tropical and subtropical areas of southern and south-eastern Asia
Siddhartha Saha et al., in WHO Bulletin Volume 92, May 2014

Objective
To characterize influenza seasonality and identify the best time of the year for vaccination against influenza in tropical and subtropical countries of southern and south-eastern Asia that lie north of the equator.

Methods
Weekly influenza surveillance data for 2006 to 2011 were obtained from Bangladesh, Cambodia, India, Indonesia, the Lao People's Democratic Republic, Malaysia, the Philippines, Singapore, Thailand and Viet Nam. Weekly rates of influenza activity were based on the percentage of all nasopharyngeal samples collected during the year that tested positive for influenza virus or viral nucleic acid on any given week. Monthly positivity rates were then calculated to define annual peaks of influenza activity in each country and across countries.

Findings
Influenza activity peaked between June/July and October in seven countries, three of which showed a second peak in December to February. Countries closer to the equator had year-round circulation without discrete peaks. Viral types and subtypes varied from year to year but not across countries in a given year. The cumulative proportion of specimens that tested positive from June to November was > 60% in Bangladesh, Cambodia, India, the Lao People's Democratic Republic, the Philippines, Thailand and Viet Nam. Thus, these tropical and subtropical countries exhibited earlier influenza activity peaks than temperate climate countries north of the equator.

Conclusion
Most southern and south-eastern Asian countries lying north of the equator should consider vaccinating against influenza from April to June; countries near the equator without a distinct peak in influenza activity can base vaccination timing on local factors.

Read the full article here

Community-based prevention of hepatitis-B-related liver cancer: Australian insights
Monica C Robotin et al., in WHO Bulletin, Volume 92, May 2014

Problem
Although most primary hepatocellular cancers (HCCs) are attributable to chronic viral hepatitis and largely preventable, such cancers remain a leading cause of cancer-related mortality wherever chronic hepatitis B is endemic.

Approach
Many HCCs could be prevented by increasing awareness and knowledge of hepatitis B, optimizing the monitoring of chronic hepatitis B and using antiviral treatments – but there are gaps in the implementation of such strategies.

Local setting
The “B Positive” programme, based in Sydney, Australia, is designed to improve hepatitis-B-related health outcomes among immigrants from countries with endemic hepatitis B. The programme offers information about disease screening, vaccination and treatment options, as well as optimized access to care.

Relevant changes
The B Positive programme has been informed by economic modelling. The programme offers culturally tailored education on chronic hepatitis B to target communities and their health practitioners and regular follow-up through a population-based registry of cases.

Lessons learnt
As the costs of screening for chronic hepatitis B and follow-up are relatively low and less than one in every four cases may require antiviral drugs, optimizing access to treatment seems an appropriate and cost-effective management option. The identification and accurate staging of cases and the judicious use of antiviral medications are predicated upon an informed and educated health workforce. As establishing community trust is a lengthy process, delaying the implementation of programmes against chronic hepatitis B until antiviral drugs become cheaper is unwarranted.

Read the full article here

From international Organizations

Health Spending Continues to Stagnate in Many OECD Countries
David Morgan and Roberto Astolfi, OECD Health Working Papers No 68, April 2014

The global economic crisis which began in 2008 has had a dramatic effect on health spending across OECD countries. Estimates of expenditure on health released back in 2012 showed that, for the first time, health spending had slowed markedly or fallen across many OECD countries after years of continuous growth. As a result, close to zero growth in health expenditure was recorded on average in 2010. Preliminary estimates suggested that the low or negative growth in health spending was set to continue in many OECD countries in following years.

This paper updates the previous report1 to cover the most recent trends in health spending based on the 2013 Health Accounts joint data collection. In a continuing effort to improve the timeliness of the available spending data, an increased number of countries were also able to provide preliminary estimates of more recent health spending to give an initial insight of the likely spending patterns that occurred in 2012 ahead of the 2014 collection.

Following the significant downturn in 2010, average health spending growth across OECD countries continued to stagnate in 2011, with a likely continuation in 2012. That said, there is large variability in the observed growth rates between countries. As in last year’s paper, this update provides a more detailed analysis to give a picture of which countries continue to be most affected, and across which types of financing and sectors of the health system.

Based on the analysis, the following conclusions can be made:

Preliminary spending estimates for 2012 for a sub-set of OECD countries suggest that the low growth of health spending observed in 2010 and 2011 has continued;

Almost all OECD countries have seen the growth in health spending fall since 2009, albeit to varying degrees;

Reductions in government spending have continued to drive down growth in health spending overall;

For social health insurance financing systems, there is some evidence of a reduction in the share coming from wage-based contributions;

All sectors of the healthcare system have seen significant reductions since 2009; spending on pharmaceuticals and on public health and prevention services has seen the greatest reductions, on average.

Read the full article

Improving the measurement of maternal mortality by strengthening civil registration and vital statistics systems
By Samuel MILLS, published in Blogs.Worldbank.org, Mai 2014

Today the Maternal Mortality Estimation Inter-Agency Group (MMEIG) released a report on the global and country maternal mortality estimates for 2013. Globally, maternal mortality ratio (MMR) decreased from 380 maternal deaths per 100 000 live births in 1990 to 210 in 2013. Although this 45% decline is far less than the expected 75% decrease between 1990 and 2015 in order to achieve the fifth millennium development goal (MDG 5), 19 countries were reported to have already achieved MDG 5: Belarus (96%), Maldives (93%), Bhutan (87%), Cambodia (86%), Israel (84%), Equatorial Guinea (81%), Poland (81%), Lao People's Democratic Republic (80%), Romania (80%), Bulgaria (78%), Estonia (78%), Timor-Leste (78%), Eritrea (77%), Cabo Verde (77%), Latvia (77%), Oman (77%), Lebanon (76%), Nepal (76%) and Rwanda (76%).
The report also noted that of the 183 countries and territories included in the estimation exercise, only 67 countries mostly from high income countries had MMR directly computed from civil registration data (Figure 1). The remaining countries had MMR estimated from a multilevel regression model. The range of uncertainty or confidence intervals of the MMR estimates from statistical models are so wide that they cannot be used for short term monitoring and evaluation of maternal health programs (Table 1). Neither do they produce MMR estimates at sub-national level to inform planning and implementation of programs. Considering that the MMR estimates from household surveys such as the demographic and health surveys (DHS) have limitations (such as capturing pregnancy-related deaths instead of maternal deaths, and providing estimates for several years prior to the survey instead of the reference year [Table 1]), the MMEIG includes the DHS data in a statistical model in order to obtain more robust MMR estimates. This sometimes puts countries in a quandary as to which one to use in official reports.

**Figure 1. Map with countries showing the source of data for maternal mortality estimates, 2013**

This is why it is imperative that all countries should endeavor to strengthen civil registration and vital statistics (CRVS) systems to produce routine data on maternal and child mortality rates as well as other relevant statistics for monitoring the performance of health systems or achievement of universal health coverage. Indeed, the 116 countries shown in Figure 1 are unlikely to meet the recommendation of the Commission on Information and Accountability for Women’s and Children’s Health that “by 2015, all countries have taken significant steps to establish a system for registration of births, deaths and causes of death, and have well-functioning health information systems that combine data from facilities, administrative sources and surveys”.

Measuring MMR (number of maternal deaths during a given time period per 100,000 live births during the same time period) requires universal birth and death registration as well as attribution of cause of death. For instance, birth registration coverage can be readily increased to be at par with other services with high coverage rates such as immunization and use of antenatal care. As shown in Figure 2, birth registration coverage tends to lag behind coverage of antenatal care and DPT1 immunization. Thus, existing maternal and child health services can be used as entry points to boost birth registration such as creating awareness among pregnant women during antenatal care, immediate birth registration of all institutional births, and ensuring all children who are vaccinated at 6 weeks for DTP1 vaccination are registered. Additionally, birth registration can be included in the list of incentivized indicators in results-based financing programs. Further, establishing maternal death surveillance and response systems will provide the require data on maternal deaths.

Read more

7 Things You Should Know About Universal Health Coverage
Robert Marten in Blogs.Worldbank.org, April 2014

This year’s World Bank Spring Meeting featured a blockbuster event on health entitled, **Toward Universal Health Coverage by 2030** featuring United Nations Secretary-General Ban Ki-Moon, World Bank President Jim Kim, Harvard Professor Lawrence Summers; Nigeria’s Minister of Finance, Ngozi Okonjo-Iweala; World Health Organization Director-General Margaret Chan, and former New York City Mayor Michael Bloomberg. Following this event, the French and Japanese Missions to the United Nations in New York co-hosted a panel discussion at the United Nations on national experience implementing and measuring universal health coverage citing examples from Chile, Benin, and Thailand; and presentations from both the World Health Organization and the World Bank.

There is a growing consensus that **universal health coverage should be an umbrella goal for health in the post-2015 development framework**. Given its importance for the future of global health, here are some of the best resources to better understand universal health coverage (UHC):
What is Universal Health Coverage?

Everyone is talking about universal health coverage, but what does it mean exactly, and why is it important? Joe Kutzin explains it in simple and easily understandable language.

Why Focus on Universal Health Coverage?

The recent Lancet Commission on Investing in Health chaired by Larry Summers concluded that universal health coverage is one of the most compelling investments a government can make. As a joint UNICEF-Save the Children-WHO-Rockefeller Foundation report showed, UHC also addresses equity. But UHC is not just the right economic approach or best way to address equity, it is also, as a group of leading international lawyers recently argued, the practical expression of the human right to health.

The National and Global Policy Campaign

The landmark Lancet paper, All for Universal Health Coverage, published in August 2009 by Laurie Garrett, Mushtaque Chowdhury, and Ariel Pablos-Mendez sets out the vision for a strong national and global policy advocacy campaign for universal health coverage.

Access to Health Services Without Financial Risk

The 2010 World Health Report on Health Systems and the Path to Universal Health Coverage: Led by David Evans, this report played a critical role in synthesizing and articulating a framework to understand how countries reform health systems that ensure access to health services for all without financial risk. This report later led World Health Organization Director-General Chan to declare that universal health coverage is, “the single most powerful concept that public health has to offer.” Additionally, the World Health Organization focused its 2013 World Health Report on Research for Universal Health Coverage.

Impact on Population Health

The Lancet's themed issue on Universal Health Coverage: This collection of papers and comments includes a viewpoint from Jeff Sachs looking at UHC in low and middle-income countries, and an assessment of the evidence of how UHC impacts population health. There have also been a number of papers and series assessing progress towards UHC in Mexico, Turkey, Bangladesh, Rwanda, India; in Arab uprising countries Tunisia, Egypt, Libya, and Yemen; and in Southeast Asia.

Case Studies From 22 Countries

The World Bank’s Universal Health Coverage Study Series: The World Bank compiled twenty-two country case studies of national efforts from Brazil to Vietnam to move towards UHC as part of its broader health efforts focused on universal health coverage. The analysis and work behind these studies contributed to World Bank President Jim Kim declaring at the World Health Assembly in 2014, “We must be the generation to deliver universal health coverage.”

Role in Global Health

Action for Global Health's briefings on Universal Health Coverage: Action for Global Health is a broad network of more than thirty NGOs. Their call to action and briefings on the intersections of UHC and sexual and reproductive health rights, nutrition, WASH, and tuberculosis are excellent resources. More recently, Jonathan Quick, Jonathan Jay, and Ana Langer wrote a paper on Improving Women’s Health through Universal Health Coverage.

Hospitals and Services Worldwide News

Europe

Austerity and health in Greece
Konstantinos N Fountoulakis and Pavlos N Theodorakis, in The Lancet, Volume 383, 3 May 2014
A recent report by Alexander Kentikelenis and colleagues (Feb 22, p 748) in The Lancet comments on the effect of austerity on public health in Greece. The article is subtitled “from austerity to denialism”, which we believe is overly emotive and is not supported by the data. Although it is certain that economic crises and austerity measures have an adverse effect on public health, the way this specific paper handles the issue is misleading. It uses inappropriate indices (eg, incidence of malaria cases), includes overinterpretations and unreliable reports (eg, on suicide and depression), and refers to absolute cuts in health-care expenditures without discussing the context.

For example, the incidence of tuberculosis is decreasing in indigenous Greeks while the increase of cases among immigrants continues (appendix). As for suicides, the authors fail to mention that the rates in countries that have not suffered from recession and austerity are sharply rising (eg, Germany, the Netherlands, Norway). With respect to attempted suicide, if 1.0—1.5% of the population had attempted suicide in the previous month—as a survey suggests—this would have resulted in more than 1 million attempts per year, which is impossible. We estimate that the actual number of suicide attempts is probably about 10 000—20 000, with 3000—5000 visiting emergency departments.

The incidence of HIV increased from 4.7—5.4 cases per 100 000 people for 2006—10, to 8.7 cases per 100 000 for 2011, and 10.7 cases per 100 000 for 2012. In October, 2013, the rate was 7.2 cases per 100 000 people. The increase is almost entirely due to an increase in intravenous drug misuse, according to Hellenic Center for Disease Control and Prevention (KEELPNO) data.

According to data from the Hellenic Statistics Authority, infant mortality trends have been unstable—eg, a decrease occurred in 2008, followed by an equivalent increase in 2009 and 2010, then returning to lower levels. During this period, the two most important causes of death in infants were perinatal disorders and congenital malformations. It will be important to further establish the cause of such fluctuations and other explanations of the causes of death.

As for funding, the cut in absolute percentage of funding does not reflect the actual decrease in cost because of cheaper medication and services. In an overspending and out of control system, the size of the cut is not the issue; the real question is whether treatment access and availability have deteriorated, whether morbidity and mortality rates have increased as a consequence, and whether the government has taken suitable and effective countermeasures.

From the social perspective, it is disturbing that the proportion of children at risk of poverty might have increased from 28% in 2007, to 30% in 2011. However, taking into consideration the three times increase in unemployment (from 8% to 28%) and the 30% fall in gross domestic product, this figure is rather a relief although still alarming.

**The Irish health-care system and austerity: sharing the pain**

Steve Thomas et al., published in The Lancet, Volume 383, 3 May 2014

As Ireland exits its bailout, the experience of the Irish health system provides valuable insights into the opportunities and pitfalls of managing austerity. Ireland is being held up for prudent adjustment and austerity. Yet 6 years into the crisis, Ireland’s economy is only just emerging from its second bout of recession, its debt to GDP ratio stands at about 120%, and its fiscal deficit, although falling, is still above the 3% European Union guideline. It is revealing to sift through the evidence and see how the Irish health system has adjusted to this macroeconomic environment, providing lessons for those who must embrace austerity.

The Irish health system has endured radical resource cuts. From 2009 to 2013 financing of the Health Service Executive fell by 22%, which amounted to almost €3.3 billion less in public funding. Staffing of public services has also fallen by 12 200 whole time equivalents or 10% of total staffing from its peak in 2007. A major concern at the beginning of the crisis was that the Irish health-care system would not be able to sustain cuts and maintain services and quality. Nevertheless, many indicators of performance suggest better outputs with fewer resources. There are now more day cases in the hospital sector, more attendances and admissions at emergency departments, and slightly lower average lengths of stay.

Were the only message more productivity and improved efficiency—then a mild and brief austerity programme might be the boot camp needed for a lagging health system. Nevertheless, the prolongation of austerity, coupled with other less appealing adjustment policies, has yielded increased rationing. First, despite increased efficiencies, waiting lists are rising. Whereas, there were some improvements in reducing wait times for elective public hospital care between 2011 and 2012, these were lost in the first 9 months of 2013. Designated numbers of public hospital beds fell by about 900, or around 10%, between 2008 and 2012 and not surprisingly the system is now showing strain. Also other cutbacks in services relate to home-help hours, which are projected to be 18% lower in 2013 than in 2008. This is despite a policy to care for more people in their homes in the community, keeping older and sicker people out of hospitals.
Nevertheless, Ireland has provided substantial financial protection for the worst off in the health sector through the crisis bailout period. More people than ever before have medical cards (which ensures free family doctor and hospital care and medications at low charge) due to higher unemployment rates and decreasing incomes. Yet, there has also been considerable but quiet cost-shifting by government back onto households. Ireland, despite being a tax-based system, had user charges at all levels of care even before the crisis. Now, increasingly the costs of care are being transferred onto patients (figure). Throughout the austerity period, tariffs have risen (in terms of inpatient day charges, emergency department attendance charges, and the introduction and escalation of prescription charges, even for those with medical cards) and eligibility for subsidies has been eroded (the threshold for reimbursement of drug payments has increased) or been revoked for some groups (no longer automatic free care for people older than 70 years). In 2013, such cost-shifting meant that every person in Ireland was on average paying about €100 in additional costs for accessing care and prescribed drugs. More specifically the burden is on sick and old people. All this is happening when the government's policy is to achieve universalisation by extending free access to family doctor care and introducing universal health insurance. Yet that policy, hampered by the recession, is only just beginning with the promise of free family doctor access for children younger than 5 years in 2014.

Read more

Economic recession and maternal and child health in Italy

Greece's dramatic downward trend in livebirth rates has been described as a component effect of the ongoing economic crisis. This pattern has been noted in other European countries, especially in Italy—where the recent economic recession has worsened social conditions and further increased unemployment.

Increased poverty and youth unemployment (42·3% of individuals younger than 25 years are unemployed according to the Italian statistics bureau, know as ISTAT) have been associated with reduced birth rate and increased women's age at childbirth. According to ISTAT, in 2012 there were 534 186 infants born in Italy—about 12 000 fewer than in 2011 and about 42 000 fewer than in 2008 (a 7·4% decrease between 2008 and 2012). The provisional data for 2013 show a further 4·3% decrease in birth rate. The decrease in fertility rate is more pronounced in Italian women: fertility rate in 2012 was 1·42; 1·29 for Italian women and 2·37 for foreign women. Furthermore, there has also been an increase in the age of Italian women at childbirth—the highest in the European Union, with 34·7% of women giving birth at 35 years or older.

Infant mortality rate has progressively declined in Italy, reaching 3·2 per 1000 livebirths in 2011—although there are regional disparities: infant mortality rate is about 30% higher in the poorest southern regions, according to ISTAT. Babies born to women living in disadvantaged conditions (eg, immigrants) or with little access to prenatal services during pregnancy are at increased risk of disease. Worryingly, childhood poverty is increasing dramatically. Even during this economic crisis, the government should not cut health and social subsidies to avoid further deterioration in maternal and child outcomes.

A maturity model for governance, risk management and compliance in hospitals
Ronald Batenburg et al., in Sciedu, Vol 3, No 4, 2014

In this paper we propose a preliminary model (hereafter referred to as maturity model) to assess and monitor Governance, risk and compliance (GRC) and GRC maturity in Dutch hospitals. Relevant health care literature and a comprehensive comparison of existing maturity models served as input for the developed maturity model. The maturity model was tested and evaluated by interviewing senior hospital managers, representing 12.4% of the total Dutch hospital bed capacity. The need and relevance of knowledge about GRC was repeatedly emphasized by the interviewees.

The model consists of 14 different dimensions based on the headlines of the practice in Dutch hospitals and five levels of maturity. The primary value of the model lies in the compact presentation and its practical approach which can guide hospitals to improve their GRC maturity.

Introduction

Multiple changes in health care fortify the need for a new approach towards Governance, Risk Management & Compliance (GRC) in hospitals. GRC has become highly relevant for hospitals, as they are increasingly under the magnifying glass of the public, government, supervisory bodies and insurance companies. Over the past years, governments, for several reasons, introduced many new regulations and policies in the health sector. The Netherlands is a good example to elaborate this.
Today, it is normally presumed that the underlying philosophy of risk management is quite clear for Dutch hospitals. Boards and managers have mostly recognized this vital concept, elaborated corresponding policies and plans, implemented related procedures and handbooks, and undertaken many other activities including training the personnel and developing manuals to explicitly control medical as well as associated non-medical processes (e.g. surgery and recording patient information) through which patients usually go. The main aim of this essential and just effort is to manage risks incurred by the patients within hospitals as far as possible to ideally create an event-free hospital and lastly offer a better care.

For fulfilling this crucial social task in an appropriate fashion, Dutch hospitals have also a number of possibilities and instruments at their disposal of which we concisely describe here three examples to help establish a certain image of them. The first one is the Health Care Inspectorate (locally known as IGZ which is part of the Dutch Ministry of Health, Welfare and Sport) that promotes public health through effective enforcement of the quality of health services, prevention controls and medical products. The inspectorate possesses different measures to ensure adherence to legislation, professional standards and guidelines. The second possibility is concerned with the Netherlands Institute for Accreditation in Healthcare (nationally called NIAZ) that develops quality standards. It assesses whether healthcare organizations comply with them and accordingly provides assurance and encourages improvements. The third possibility pertains to the Safety Management System (in the Netherlands referred to as “VMS Zorg”) which is the rural system that supports in mitigating risks for patients and reducing (unintended) damages to them. The basic requirements for this goal are stated in NTA 8009 which must be satisfied by Dutch hospitals and are applied for performing external audits as well. Nevertheless, events of various nature occurred at Dutch hospitals are regularly the latest hot news and headlines these days.

Africa

Physician tracking in sub-Saharan Africa: current initiatives and opportunities
Candice Chen et al., published in Human Resources for Health 2014

Background
Physician tracking systems are critical for health workforce planning as well as for activities to ensure quality health care - such as physician regulation, education, and emergency response. However, information on current systems for physician tracking in sub-Saharan Africa is limited. The objective of this study is to provide information on the current state of physician tracking systems in the region, highlighting emerging themes and innovative practices.

Methods
This study included a review of the literature, an online search for physician licensing systems, and a document review of publicly available physician registration forms for sub-Saharan African countries. Primary data on physician tracking activities was collected as part of the Medical Education Partnership Initiative (MEPI) - through two rounds over two years of annual surveys to 13 medical schools in 12 sub-Saharan countries. Two innovations were identified during two MEPI school site visits in Uganda and Ghana.

Results
Out of twelve countries, nine had existing frameworks for physician tracking through licensing requirements. Most countries collected basic demographic information: name, address, date of birth, nationality/citizenship, and training institution. Practice information was less frequently collected. The most frequently collected practice fields were specialty/degree and current title/position. Location of employment and name and sector of current employer were less frequently collected. Many medical schools are taking steps to implement graduate tracking systems. We also highlight two innovative practices: mobile technology access to physician registries in Uganda and MDNet, a public-private partnership providing free mobile-to-mobile voice and text messages to all doctors registered with the Ghana Medical Association.

Conclusion
While physician tracking systems vary widely between countries and a number of challenges remain, there appears to be increasing interest in developing these systems and many innovative developments in the area. Opportunities exist to expand these systems in a more coordinated manner that will ultimately lead to better workforce planning, implementation of the workforce, and better health.

Asia

Driving Growth and Productivity in India’s Hospitals
By Priyanka Kohli, published in Gallup Business Journal
India's private hospitals are expanding aggressively to serve the increasing number of patients who are seeking an alternative to the country's underfunded state-run medical system. As the ranks of India's middle class swell, private healthcare systems will likely see opportunities to achieve unprecedented rates of growth. But there's a catch: Because these patients and their families pay most of their medical expenses out of pocket, private healthcare companies must tightly manage their costs to keep services affordable and to compete in rapidly expanding markets.

To meet the challenge, private hospitals have adopted various strategies to enhance operational efficiency, most of them related to technology or process improvement. Though such measures have brought success in the past, these gains are unlikely to withstand rising medical inflation rates for long.

One solution that most hospitals have overlooked is engaging their untapped reserves of human capital, and this oversight could prove harmful to their long-term growth. Engaged employees are involved in, enthusiastic about, and committed to their work -- and they can play a crucial role in helping hospitals deliver cost reductions and world-class healthcare.

Engagement in India needs critical care

India's workforce suffers from a lack of engaged employees in every industry -- a condition that has gone largely undiagnosed and untreated for too long. Gallup's State of the Global workplace report reveals that only 9% of the country's workers are engaged in their jobs, while 31% are actively disengaged.

The prognosis is not much brighter in the professional workers category, which includes India's doctors and nurses. Gallup found that fewer than one in five (17%) are engaged, while about one in 10 (12%) are actively disengaged -- meaning they regularly undermine their coworkers' and companies' best efforts. And the vast majority (71%) of professional workers in India are not engaged. In other words, they are not emotionally connected to their company and committed to its success.

Read more

America

Health Promotion in Ecuador: A Solution for a Failing System

In 2008, the newly written Ecuadorian Constitution guaranteed access to healthcare for all citizens. Consequently, a vast amount of resources have been directed toward rebuilding the public healthcare system, which was in shambles due to the effects of neoliberalism. Although national healthcare studies show positive outcomes, community-based research studies from an impoverished rural barrio in southern Ecuador indicate that the public healthcare system has been unable to address a health epidemic. Based on several years of fieldwork, we argue that the failure originates from the continued functioning of the biomedical model of healthcare as the dominant health discourse in Ecuador. The ensuing result has been the construction of health system governed by an "administrative state" that enforces health policies from the top-down and delivers "episodic" emergency-style care. Accordingly, we maintain that the Ministry of Health (MOH) should create a nationwide community-based health promoter program guided by the principles of health promotion.

Since winning the presidency in 2006, President Correa and his political allies have been at the forefront of a so-called "citizens' revolution" in Ecuador. The ultimate objective of the movement is to develop a society where all citizens can live the "good life" through unimpeded access to important institutions such as the economy and healthcare. Consequently, one of the main foci of the Correa-led revolution is to create a healthcare system that will provide access to high quality services at no cost to not only Ecuadorians but anyone who steps foot in the country regardless of citizenship status. To accomplish this objective, the State Constitution was rewritten in 2008 to provide the government with the necessary legal authority to reinvent key institutions including the healthcare system. However, President Correa and his political allies have faced a monumental task as they inherited a weak and ineffective healthcare system due to the failure of the neoliberal movement in Ecuador. To correct the free-market catastrophe, the Ecuadorian government has taken control of the healthcare sphere and the Ministry of Health (MOH) is now one of the primary entities responsible for developing a universal public healthcare system.
Over the past several years, the MOH has been quite busy increasing the public health presence throughout Ecuador via the expansion of infrastructure and personnel along with developing state-led intervention programs to address serious healthcare problems. The initial results, at the national level, are nothing short of spectacular. Access to healthcare for the general population has increased considerably and intervention programs have had high levels of success even in the poorest regions of the country. Beyond these national figures few studies examine the healthcare system at other levels, particularly the community level. In order to fill that gap, the authors teamed up with the residents of Las Mercedes, which is a rural and poverty-stricken barrio located on the coast of southern Ecuador, to assess the state of health in the community in both 2009 and, once again, in May of 2013. The results revealed that the services provided by the public health system are of low quality. Furthermore, the system is unable to curtail the spread of infectious diseases such as malaria and dengue fever in Las Mercedes.

Download the full article

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**International Events**

**Germany - Quality Day of hospitals**
May 9, 2014, Berlin. **Organizer:** German Hospital Association

**Program**
- Quality initiative - implementation of the agreements of the coalition agreement for Quality in Health Care
- Quality of quality measurement - an overview
- Panel discussion on the development of quality assurance
- Limits of Objectivity - quality of quality comparisons
- Equal opportunities? Possibilities and limitations of risk adjustment
- Pay for Performance: Is quality safe enough measurable?
- Structural quality - a good alternative? Neither evidence nor financing?
- Summary and Outlook

**Location:** Scandic Berlin Potsdamer Platz, meeting room Aurora Borealis,

**Gabriele tergite-Promenade 19, 10963 Berlin**

**Information and registration**
DKG event office

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dkq-veranstaltung@adverta.de

**Hong Kong - Hospital Authority Convention 2014**
May 7-8, 2014 at the Hong Kong Convention & Exhibition Centre

Since 1993, the Hong Kong Hospital Authority has been organising the convention every year to promote sharing of experience among local and overseas healthcare professionals. The Hospital Authority Convention held in May 2013 was attended by 4,500 clinicians and healthcare professionals, including staff of the Hospital Authority and healthcare managers and executives from Mainland China, Hong Kong and overseas.

This year, we have invited over 80 local and overseas expert to participate and share their knowledge and experience on clinical advances and approaches to modern healthcare service as well as exploration and discussion of contemporary concepts among healthcare professionals and stakeholders.


**Colombia - IV Feria Internacional de la Salud, Meditech 2014**
Agosto, 12 al 15 de 2014, Bogotá, Colombia

• Conozca la visión de los hospitales del futuro

• Reunase con los representantes de la salud mas destacados

• Obtenga tarifas preferenciales por inscripción anticipada

**Lugar:** Centro Internacional de Negocios y Exposiciones, Corferias

**Información:** http://www.feriameditech.com/
Tel (57-1) 3810000 Ext. 5322

Email: msanchez@corferias.com

**Colombia - XI Congreso Colombiano de Hospitales y Clínicas**
Agosto 13 y 14 de 2014, Bogotá


Asista y conozca hacia dónde avanzan las Instituciones Prestadoras de Servicios de Salud en el mundo.

Información: [www.achc.org.co](http://www.achc.org.co)

Tel: (57-1) 3124411 Ext. 110

Email: atencionalafiliado@achc.org.co - comunicaciones@achc.org.co

**Australia - The Australian Healthcare and Hospitals Association’s 2014 Congress**
September 8-10, 2014, Sydney, Australia

“*The Quantum Leap: Innovation - Making Quality Count*”, in collaboration with the Australian Council on Healthcare Standards

This Congress will focus on quality improvement in the healthcare sector.

More information is available by contacting: swright@ahha.asn.au

We welcome the interest and participation of IHF members in this Congress

**Austria - 17th European Health Forum Gastein**
October 1-3 2014

The EHFG is the leading health policy event in the EU and takes place annually. It provides a major platform for decision-makers in various fields of public health & health care. With its wide-ranging three-day programme, the EHFG offers an unparalleled opportunity to exchange information about a broad spectrum of contemporary health issues.

[http://www.ehfg.org/home.html](http://www.ehfg.org/home.html)

**Korea - 2014 Korea Healthcare Congress at 63 Convention Center**
November 12 - 14, Seoul

Organized by The Korean Hospital Association


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