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Reshuffling the pack in the Swiss hospital market
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The Lesotho Hospital PPP experience: catalyst for integrated service delivery
UNDER THE DIRECTION OF
H.H. Sheikh Mohammed Bin Rashid Al Maktoum
Vice President and Prime Minister of the United Arab Emirates and Ruler of Dubai

UNDER THE PATRONAGE OF
H.H. Sheikh Hamdan Bin Rashid Al Maktoum
Deputy Ruler of Dubai, Minister of Finance
President of Dubai Health Authority

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The hospital of today is a remarkable testimonial to the scientific advances of the 20th century and man’s ingenuity in pushing human survival and quality of life to an ever-expanding limit.

Heavy investments over the past 30 years have made the hospital sector the largest expenditure category of the health system in most developed and developing countries. Despite shifts in attention and emphasis toward primary care as a first point of contact for patients, in most countries, hospitals remain, in most countries, a critical link to health care, providing both advanced and basic care for the population. Often, hospitals are the provider “of last resort” for the poor and critically ill when other services fail and households run out of money.

In most countries – western and developing – the community hospital is a cornerstone provider of primary care and other basic services to the population, fulfilling a role similar to those of schools, social services, water, sanitation systems and electricity. And in major urban centers, even in low-income countries, the university hospital is often a pinnacle of technological splendor – unsurpassed in other sectors of the economy. It is the future come true today.

Revered as hospitals are in this context, from a different point of view, they are also one of the most reviled parts of the health system. Ministries of Finance or the Treasury consider the hospital a “black hole” in their fiscal accounts, a monster with an insatiable appetite and a chameleon with infinite ability to reinvent itself in new and costly ways. In developing countries where resources are often scarce and quality low, a referral to a hospital may be a “death sentence” – a place of no return.

Whatever the perspective, the hospital is a place that treats seriously ill patients, has dedicated staff and struggles to make ends meet in the face of unquenchable demand. They are a place of great joy at the time of birth and successful recovery from serious illness. And they are a place of great sorrow at the time of incurable illness and death.

The authors demonstrate that running a high-performing hospital is a complicated business requiring strong leadership, management skill and willingness to be innovative in a changing world.

The first article, by Denis Porignon, Reynaldo Holder, Olga Maslovskaya, Tephany Griffith, Avril Ogrodniczck, and Wim Van Lerberghe, sets the scene. Avril emphasizes the need for health systems integration and continuity of care across levels of care. It makes it clear to all that hospitals are needed as part of health systems in addition to primary care. When it is time to set up priorities, the tendency to put in opposition primary care and referral care are from another age. People will receive good health care only if the continuum of care works properly.

The article by Amer Ahmad Sharif and Iain Blair describes the changes that have taken place in the hospital sector of the United Arab Emirates during the past 40 years and the remarkable associated improvements in population health. Today their hospital sector is growing, with a strong input from private sector investments. The authors emphasize that current and future health needs of the population are complex, requiring hospitals to adapt to new and innovative approaches in the balance between inpatient and ambulatory care. Anticipating such trends and introducing the needed reforms requires a clear vision for the future and strong leadership. This story is universal and reflects the changes that have taken place in the hospital sector in many developing countries over the past few decades.

Rapid progress and change is not just in the developing world. Richard Umbdenstock, Maulik Joshi and Jill Seidman describe the core elements of the recent landmark Affordable Care Act in United States. They stress that U.S. hospitals and the health systems more broadly face unprecedented demand to change in both the near- and longer-term future, due to factors ranging from demographic changes to increasing reliance on value-based payment, and to the uncertainty surrounding governmental

In most countries – western and developing – the community hospital is a cornerstone among the basic services provided to the population, like primary care, schools, social services, water, sanitation systems and electricity.
They identify four key strategies to deal with the changes introduced through the reforms: (a) aligning hospitals, physicians, and other providers across the continuum of care; (b) using evidenced-based practices to improve quality and patient safety; (c) improving efficiency through productivity and financial management; and (d) developing integrated information systems that will allow providers to better manage both services and clinical care.

Daniel B. McLaughlin and Jack Militello continue some of these themes, looking specifically at the changes that are likely to take place following reforms in payments systems and the new emerging competitive marketplace in the USA.

Further south, Bernard F. Couttolenc and Gerard M. La Forgia also describe the important role that payment systems play in Brazil in providing incentives for improved hospital performance under a multipayer and multipayment system.

Moving to the other side of the Atlantic, Nigel Edwards describes the significant pressures confronting hospitals across Europe and how they are facing the need to change. They are not well adapted to deal with the current financial crisis and accompanying challenges. In many cases, the overarching framework is poorly adapted to deal with change. He highlights that European hospitals need strong leadership coupled with bold and imaginative solutions to deal with the challenges they face in the near future.

Patrick Bolton and Prue Power provide a vivid example of how modern information technology and modeling can be used to simulate the results of various proposed reforms in the Australia context, allowing policy makers and hospital managers to avoid costly and damaging mistakes, while identifying opportunities for positive change.

Bernard Wegmüller and Martin Bierlein echo some of these themes in the context of the reshuffling of the pack in the Swiss hospital market and complex private multipayer health insurance system.

Continuing the theme of reassessing the role of hospitals in modern healthcare systems, Oludemil M. Omololu and Rafaat O. Olatunji describe the challenges that face the Nigeria hospital sector. They emphasize the need to include the hospital sector in countries where the focus on health care reform is often dominated by vertical disease programs and agendas set by donors rather than the need for systemic health systems reform. Lagos State in Nigeria is taking a step in this direction with its new Health Service Reform Law, which includes an emphasis on improving the functioning of hospitals and new innovative approaches.

Carla Faustino Coelho and Catherine Commander O’Farrell describe one such innovative approach in Lesotho. When faced with a need to replace its main public hospital, Queen Elizabeth II, the country decided to design and construct the new 425-bed public hospital and adjacent primary care clinic through a public-private partnership (PPP) using a private operator under an 18-year contract. This included the renovation and expansion of three strategic clinics in the region and the management of all facilities, equipment and delivery of all clinical services under the health network. The creation of this PPP health network and the contracting mechanism has increased accountability for service quality, shifted the government to a more strategic leadership and policy-making role. This PPP has become a model for managing other public sector facilities and providers in Lesotho.

With this special issue, we are sure that you will be able to have a quick and comprehensive update on the key challenges facing the hospital sector in the world. In the 37 World Hospital Congress hosted by Dubai, November 8–10, 2011, the attendees will have the opportunity to enlarge their perspective on some of the key subjects presented in this issue.
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The evolving role of hospitals in health systems

The role of hospitals within the framework of the renewed Primary Health Care (PHC) strategy

DENIS PORIGNON
HEALTH POLICY EXPERT, HEALTH SYSTEM POLICY, GOVERNANCE AND SERVICE DELIVERY DEPARTMENT (HDS), WORLD HEALTH ORGANIZATION (WHO)

REYNALDO HOLDER, OLGA MASLOVSKAIA, TEPHANY GRIFFITH, AVRIL OGRODNICK AND WIM VAN LERBERGHE

ABSTRACT. This article summarizes a presentation made at the IHF Leadership Summit held in Chicago, USA in June 2010, by Denis Porignon from the World Health Organization (WHO) and Reynaldo Holder from the Pan American Health Organization (PAHO/WHO). It focuses on the role of hospitals within the framework of the renewed PHC strategy.

PHC renewal

The global commitment to Primary Health Care (PHC) was first made in 1978 with the Declaration of Alma Ata. Early attempts at PHC implementation netted key health and health-related improvements across multiple sectors. On the whole people across the world are healthier and live longer than thirty years ago. A changing world, however, commands a responsibility to adapt the way health is dealt with. Anticipating and adapting is necessary because of the transitions: the demographic transition, the epidemiological transition, but also the transition in demand, itself fuelled by an expanding middle class with rising expectations. It is equally necessary because of the evolution ion the supply side: a different workforce with new contradicts and new expectations, advancements in technology and knowledge and growing concerns about costs in a context of globalisation. All this has led the World Health Organization to revisit the PHC approach 30 years after Alma Ata, with the 2008 World Health Report - "Primary Health Care – now more than ever" (Tables 1 and 2). This report signalled a renewed commitment to health for all, suggesting key policy directions: inclusive governance of the health sector, so as to build trust and sustainable leadership; investment in public policy reforms to promote and protect the health of communities; a move towards universal coverage, to increase equity in health; and a profound reorientation of health care delivery, to make health systems people centered, building on a strong primary care infrastructure.

The conventional model of care focuses disproportionately on treating acute episodes of disease. It is neither sufficiently comprehensive nor organised to provide adequate care for vulnerable populations or persons with chronic diseases. As they should, hospitals privilege disease-centred care for acute conditions and complications of chronic disease, but they most often do this in a setup where the connection with primary care is ill-conceived or neglected. At the same time, and by default or by design, hospital outpatient and emergency departments provide a considerable part of ambulatory care. In doing so they also share the paradigmatical weakness of much conventional health care delivery (table 3).

Responding to a new health paradigm requires changes in all areas of health services, and it is important that health systems are sufficiently flexible to quickly adapt to new circumstances: the demographic and epidemiological transition, but also the transition in demand and in expectation, and the social tensions associated with globalization. Hospitals are an integral part of all health systems: as health systems evolve, so does the role of the hospital. Hospitals will remain central to how people perceive their health systems and to technical innovation. But they will have to find a new place within the health care system as the necessary back-up for primary care, and no longer as the only institution around which all the rest evolves. Hospitals will have to adapt to an organization in networks with primary care at the centre. It is thus important to define the function of hospitals in this context and elucidate the needs and challenges that hospitals are likely to face in the future.

The hospital within the health care system

In the future hospitals will no longer be the centre of the health system or stand alone. They will be part of a network that includes primary care, specialized out-patient care, and diagnostic services organized in networks. They will also be more open to the community and to the other members of the network including social services. Hospitals should then be able to contribute to improving health and reducing inequalities, as part of the wider health system, and should provide a highly valued ‘rescue’
The evolving role of hospitals in health systems

Old Paradigm     Emerging Paradigm
Responsibility for individuals    Responsibility for the health of defined populations
Emphasis on care of acute episodes of disease   Emphasis on care throughout the continuum
The service providers are essentially equal    Differentiation based on the capacity to provide added value
Success is measured by the capacity to increase hospital admissions   Success depends on increasing coverage and capacity to maintain people healthy.

The service providers are essentially equal    Differentiation based on the capacity to provide added value
Success is measured by the capacity to increase hospital admissions   Success depends on increasing coverage and capacity to maintain people healthy.

Primary care as the antithesis of the hospital   Primary care as coordinator of a comprehensive response at all levels
PNC is cheap and requires only a modest investment   PNC is not cheap: it requires considerable investment, but it provides better value for money than its alternatives


Table 1: Transformation of the health paradigm

<table>
<thead>
<tr>
<th>Old Paradigm</th>
<th>Emerging Paradigm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibility for individuals</td>
<td>Responsibility for the health of defined populations</td>
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</tr>
<tr>
<td>Success is measured by the capacity to increase hospital admissions</td>
<td>Success depends on increasing coverage and capacity to maintain people healthy.</td>
</tr>
<tr>
<td>The objective of the hospitals is to fill beds</td>
<td>The objective of the network is to provide the appropriate care at the appropriate level</td>
</tr>
<tr>
<td>Insurers, hospitals, ambulatory centers, work separately (Fragmentation)</td>
<td>Networks of Integrated Delivery Services (IDS)</td>
</tr>
<tr>
<td>Management of isolated organizations</td>
<td>Management of networks</td>
</tr>
</tbody>
</table>


Table 2: Aspects of care that distinguish conventional health care from people-centred primary care

<table>
<thead>
<tr>
<th>Conventional ambulatory medical care in clinics or outpatient departments</th>
<th>Disease control programmes</th>
<th>People-centred primary care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on illness and care</td>
<td>Focus on priority diseases</td>
<td>Focus on health needs</td>
</tr>
<tr>
<td>Relationship limited to the moment of consultation</td>
<td>Relationship limited to programme implementation</td>
<td>Enduring personal relationship</td>
</tr>
<tr>
<td>Episodic curative care</td>
<td>Programme-defined disease control interventions</td>
<td>Comprehensive, continuous and person-centred care</td>
</tr>
<tr>
<td>Responsibility limited to effective and safe advice to the patient</td>
<td>Responsibility for disease control target among the target population</td>
<td>Responsibility for the health of all in the community along the life cycle, responsibility for tackling determinants of ill-health</td>
</tr>
<tr>
<td>Users are consumers of the care they purchase</td>
<td>Population groups are targets of disease control interventions</td>
<td>People are partners in managing their own health and that of their community</td>
</tr>
</tbody>
</table>

function for life-threatening conditions, and can improve outcomes from treatment by concentrating technology/expertise where necessary.

The organization of health services within the PHC framework will then be based on three tenets:

1. Hospitals should not be the entry point - relocating the entry point to the health system from hospitals and specialists to close-to-client generalist primary-care centres and the like;
2. Instead, hospitals will function as part of health care networks to fill the availability gap of complementary referral care by giving primary-care providers the responsibility for the health of a defined population, in its entirety;
3. The role of primary-care providers’ as coordinators of the inputs of other levels of care should be strengthened by giving them administrative authority and purchasing power.

The Pan American Health Organization defines a PHC-based health system as an overarching approach to the organization and operation of health systems that makes the right to the highest attainable level of health its main goal while maximizing equity and solidarity. With the shift in focus of the PHC movement over time, and under the revised model, implementation of PHC now requires more commitment and investment, and ultimately will deliver coordinated and comprehensive care. The expected benefits of the new PHC strategy are improvements in health outcomes at the population level, efficiency, access to health services, and equity, as well as lower costs and increased user satisfaction.

Hospital costs are high compared to primary care costs. This does not mean that hospitals are inefficient; it means that primary care and hospitals have different roles and responsibilities, and one should provide care for each case at the most efficient location where this can be done effectively. This requires a clear division of labour with provisions to eliminate catastrophic health expenditure both at primary care and at hospital levels.

Improving health information systems may help hospital planning and regulation by improving information-based decision making. Improving health information systems may help hospital planning and regulation by improving information-based decision making.

The policy directions set by the renewal of PHC carry a lot of potential to produce health, reduce inequalities and tackle the wasteful fragmentation of health systems. But they will not happen spontaneously. The convergence of the equity and health systems...
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agendas are mentioned in a number of recently produced reports including the "World Health Report 2008: Primary Health Care. Now More Than Ever", "Strengthening Health Systems to Improve Health Outcomes: WHO’s Framework for Action", "Closing the Gap in a Generation: Health equity through action on the social determinants of health", and "The World Health Report 2010: Health systems financing: the path to universal coverage". These reports all emphasize the importance of linking PHC-based health systems with other determinants of health by incorporating "health in all policies" and by emphasizing equity, social protection, intersectorality, health promotion and participation, human rights and equality. While incorporating the PHC strategy, it is also important to understand what people value and want from a health system. People want to live long and healthy lives; to be treated fairly and equitably; to have reliable health authorities; and to receive efficient services "cases" in the medical system; to have a reduced risk of diseases; to have reliable health authorities; and to receive efficient services and effective medicines and technologies. This has implications to have a say in what affects their lives and the lives of their families; to be regarded as human beings and not just for the future of hospitals. As health systems continue to change and the PHC approach is implemented, the role of hospitals will evolve, but they will still remain vital to the health system15). In the future, hospital functions, healthcare network responsibilities and an effective continuum of care will be of crucial importance. "People want to live long and healthy lives; to be treated fairly and to have reliable health authorities; and to receive efficient services..." In the future, hospital functions, healthcare network responsibilities and an effective continuum of care will be of crucial importance. Instead of having a hospital-centred health system, a balance should be achieved between people-centeredness and technological requirements, between over and under spending with high risk of error repetition, between the lobby of equipment and pharmaceutical industry and between social aspects of equity and inclusiveness and participation. While there are multiple ways to provide services, the objectives in all contexts should encourage accessibility, efficiency, quality of care, responsiveness and fairness in financing.

References


Denis Porginon is a medical doctor working as a health policy expert with the Health System Policy, Governance and Service Delivery Department (HOSD) in WHO Headquarters in Geneva. He used to work as a clinician and a public health at various levels of health systems mainly in Africa and Europe. He teaches health planning and health services organization at the School of Public Health of the Université Libre de Bruxelles and the Faculty of Medicine of the Université de Liège, both in Belgium.
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The evolving role of hospitals in health systems: Dubai

ABSTRACT: In the UAE, health services have developed greatly in the past 40 years and there have been enormous improvements in population health. The hospital sector is growing strongly with private sector investment. However the current and future health needs of the population are complex and may not be properly served by the continued expansion of hospital capacity. In this paper, using the Emirate of Dubai as a case study, we examine the changes that have taken place in health services and attempt to predict their optimum configuration and capacity in the future taking into account population structure and growth and levels of morbidity and service use.

Health has improved dramatically in the UAE in the past 50 years. The under-5 mortality rate has fallen dramatically from 223 (per 1000 live births) in 1960, to 84 in 1970, 30 in 1990, 17 in 1990, 11 in 2000 and 7 in 2009. This decline in death amongst children has resulted in life expectancy increasing over the same period from 53 in 1960 to 78 in 2009.

These improvements in health have been possible because of the wise investment of oil revenues by the leadership to improve the social conditions of the population. Investment in health care provision has also been important, in particular preventative services and immunization and services for children and women. Population size, population growth, nationality and age and gender distribution are all important factors when examining health needs and health services configuration and capacity.

The last census in UAE was carried out in 2005 when the population was 4.1 million. At that time, of the seven Emirates that make up the UAE federation Abu Dhabi, Dubai and Sharjah were the most populous and overall, 20% of the population were Emirati nationals. At the end of 2009 the UAE population was 8.2 million of which only about (11%) are nationals. Currently (2010) the population of Dubai is 1,905,476 of which 173,635 (9%) are nationals whereas the population of Abu Dhabi is 2,321,003 of which 433,769 (19%) are nationals. The UAE population is growing at an annual rate of 3.3% which places it sixth in the world rankings. This growth is due both to high net migration (at 19/1000 per year UAE has the world's third highest net migration rate) and high natural growth (births minus deaths).

The three main authorities that make up the UAE health care system are the Federal Ministry of Health (MOH), Dubai Health Authority (DHA) and the Health Authority of Abu Dhabi (HAAD). Abu Dhabi is the capital of UAE and the largest of the seven Emirates. The Government of Abu Dhabi re-organized its health system in 2006 and introduced a private health insurance and private provision model. The health authority adopted a strategic and regulatory role, and a separate health services company (SEHA) was established to operate government owned health care facilities.

The Department of Health and Medical Services (DOHMS) of Dubai was established in 1970 as a local health authority and service provider for the population of Dubai emirate. DOHMS continued to be the main local health authority in Dubai even after the formation of the MoH. In 2007, Dubai Health Authority (DHA) was formed to oversee health strategy and regulation when it was separated from health service provision. Private health insurance is becoming the preferred funding source although Dubai Government is still an important provider of services. DHA has a strategic and regulatory role similar to HAAD, but it still operates its own hospitals and health centres. A free zone entity, Dubai Healthcare City, has been developed to encourage medical tourism. In Dubai and Abu Dhabi, the MoH role is now focused on developing national health strategy and policy but it still has a role in service provision in the five remaining emirates. UAE nationals have access to free public sector health care services in Dubai and the northern emirates while in Abu Dhabi they are covered by a government funded health insurance scheme. This allows them to choose from different private providers. Quality of facilities and services vary between the different emirates and providers. In the remainder of this paper we will focus mainly on the changes that have taken place in the Emirate of Dubai.

While prosperity has brought great benefits, it is now threatening population health in the UAE on a worrying scale. Changes in lifestyle have contributed to a rising prevalence of overweight and...
obesity. These effects are most marked among the national population, where, as the population has started to age there has been an explosion in the prevalence of diabetes and cardiovascular disease. The health of the expatriate population is better. Here the healthy worker and healthy migrant effect play a part and most will return to their country of origin before they can contribute to the overall burden of morbidity.

Lifestyle changes on a population scale are urgently needed to reduce obesity, CVD and diabetes and reduce the effect of these diseases on health services. Unlike most western countries, in UAE, alcohol, drugs and HIV infection are not important public health determinants but sedentary lifestyles, obesogenic diets, smoking, road crashes and mental health are all important. While these changes are underway, it will be important to maintain the quality and quantity of health services and ensure they continue to respond to the needs of the population.

How can an understanding of the population structure in Dubai and an appreciation of the levels of health help health planners to accurately specify the capacity and configuration of health services now and in the future? We need to consider two parts of the population which have different health needs. The national population and the expatriate population vary greatly in size, growth, levels of ill-health, the extent to which they will age and health service utilization. It should be noted that a third population segment are visitors who increasingly travel to Dubai for medical tourism purposes.

The national population is currently youthful but it is ageing and has high levels of morbidity and health service utilization. The larger expatriate population is also youthful but it currently has below average morbidity and low levels of health service utilization.

What changes can be expected in population size over the next decade? Natural population growth rate (the difference between births and deaths) is 29/1000 for nationals and 7.4/1000 for non-nationals. Applying these rates to the population of Dubai suggests that by 2020, if natural growth rates are maintained the population of non-nationals will have increased by 8% to 1.86 million and the population of nationals will have increased by 33% to 2.30 million. The total population has grown by 10% to 2.1 million. If in addition there is net inward migration of 10/1000 per year then the non-national population will rise by 19% to 2.06 million and the total population will be 2.3 million.

How will these changes translate into the need for health services and hospital capacity?

In the UAE over the past 40 years health services have expanded greatly. In 1970 there were seven hospitals with 700 beds but by 2005 there were 62 hospitals with 9600 beds. In general bed numbers have increased in proportion to the increase in population. Health care is a major component of the Dubai Strategic Plan 2007-2015 and a major function of DHA when it was established was to implement the government strategy for health by 2012. In any health care system hospitals play an important role, financially (accounting for half of overall health care expenditure), organizationally (they dominate the health care system) and symbolically (they are seen by the public as the main element of the health care system). Dubai is no exception. The first clinic started in Dubai in 1943 and building of the first hospital, the Al-Maktoum Hospital, started in 1981. Now, Dubai has 3 major public hospitals accredited by JCA and a new rural hospital in Hatta area. To ensure a supply of well-educated health care professionals, DHA hospitals have developed continuing education and residency programs. Specialized centres have been established including a Trauma Center and a Thalassaemia Center. The Hospital Services Sector (HSS) was created by DHA as the governing body of all government hospitals and specialty centres. Private sector hospitals, which are regulated through the DHA Health Regulation Department, have also developed and have obtained international accreditation as a means of demonstrating quality.

In Dubai in 2006 there were seven public (MOH and DOHMS) hospitals with 2021 beds and 18 private hospitals with 913 beds. At that time 31% of bed capacity in Dubai was in the private sector which accounted for 32% of inpatient activity. However 90% of clinics and health centres, 78% of physicians and 58% of outpatient attendances were provided by the private sector. By 2010/11 there will be further 1075 beds in 9 new or expanded private hospitals and 1006 beds in 12 facilities within Dubai Health Care City (DHCC). This means that at that time, of the 5000 hospital beds available in Dubai (2.6 beds/1000 population), 20% will be provided by DHCC, 40% by the rest of the private sector and 40% by the Government (8% MOH, 34% DHA). This is fully in line with Dubai Government plans to expand private sector provision, encourage private and social health insurance and improve access to services.

But will this expansion meet population health needs?

Morbidity is less amongst non-nationals and so their need for hospital services will not rise at the same rate as amongst nationals although the introduction of mandatory health insurance may lead to supply side increases in service use. Nevertheless the high levels of morbidity amongst nationals and the continued growth in medical tourism should be well catered for by these increases in hospital capacity and specialties.

International benchmarks are often used to predict the optimum number of hospital beds and physicians for a given population. Obviously these benchmarks are dependent on the levels of morbidity in the population and this usually dependent on the age distribution within the population. Also countries and jurisdictions vary in the nature of the service they offer. Those with well-developed chronic disease management services, nurse led services and availability of step-down and nursing home accommodation have reduced the numbers of beds and physicians that are needed to meet health needs. Nevertheless a benchmark or norm of two physicians and two hospital beds per 1000 population are widely accepted. Currently the ratios in Dubai are 2.6 beds and 2.8 physicians per 1000 population. These figures might suggest over-capacity of hospital beds and physicians and should prompt a critical examination of the health needs of the Dubai population, both national and expatriate and medical tourists to ensure the capacity and configuration of hospital services are accurately meeting health needs in the most cost-effective way.

Conclusion

UAE health services have developed greatly in the past 40 years and this has coincided with enormous improvements in population...
The evolving role of hospitals in health systems: Dubai

However the current and future health needs of the population are complex and may not be properly served by the continued expansion of hospital capacity. The hospital sector is growing strongly fuelled by private sector investment with business cases predicated on population growth, high levels of morbidity, universal health insurance and medical tourism. This may not be the best model of care. Rising levels of morbidity amongst nationals will require the development of chronic disease management programs that support screening, prevention and self-care. Community based generalist services will be more effective than hospital based specialist services. The expatriate population also has unique health needs. This population has low morbidity so that ambulatory care, occupational health and preventative services offer the greatest benefits. Good electronic health records will be required to avoid excessive, inappropriate use of services.

It is to be hoped that careful planning by health authorities, continued investment in health services and the growing influence of the private sector will allow the health needs of nationals, expatriates and medical tourists alike to be satisfactorily met by the development of a comprehensive range of modern, high-quality health services.

Dr Amer Ahmad Sharif is currently an Advisor on Health System Development at Dubai Health Authority (DHA). Prior to his current appointment he was the Director of the Continuing Medical Education and subsequently became the Director of Human Resources at DHA. Simultaneously with his appointment in the Dubai Health Authority, he is doing his PhD in Public Health at the Faculty of Medicine and Health Sciences (FMHS), UAE University (UAEU), and his research is mainly focusing on critically evaluating the UAE health care system. Dr Sharif obtained his Medical degree at FMHS, UAE University in 2003 and earned his Master of Science (MSc) in Healthcare Management at Royal College of Surgeons of Ireland (RCSI) in 2007. Dr Sharif has been involved in undergraduate and postgraduate teachings at the FMHS, and an invited lecturer for the MSc in Healthcare Management program at RCSI-Dubai. Dr Sharif was awarded the Best Employee award by the Dubai Health Authority and received the prestigious Sheikh Rashid Award for Excellence for Distinguished Students, for being the gold medalist at the FMHS, UAE University.

Dr Iain Blair is Associate Professor in the Department of Community Medicine, Faculty of Medicine & Health Sciences, United Arab Emirates University (UAEU). He is Director of the UAEU Master of Public Health programme, interim Director of the UAEU Global Health Institute and an external examiner for the University of Malaya in Kuala Lumpur. Having trained as a general practitioner, he worked in Canada and the Middle East before commencing training in public health in the UK in 1986. In 2003 with the establishment of the Health Protection Agency he became Director of the Black Country Health Protection Unit (HPU). In 2008 he moved to the UAE. He has published articles on surveillance and health protection and is a co-author of Communicable Disease Control Practice a major international textbook on health protection. His current research interests are the social and environmental determinants of modern lifestyle diseases in the UAE and the effect of chronic illness on the Emirati family.

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Hospitals of the future

ABSTRACT: Hospitals and health systems face unprecedented demand to change in both the near- and longer-term future, ranging from demographic changes to increasing reliance on value-based payment, and to the uncertainty surrounding governmental reform. The American Hospital Association Board Committee on Performance Improvement embarked on an initiative to identify the top ten strategies all hospitals must adopt in order to be successful care systems of the future. As a result of the committee’s survey research, four top strategies were identified: 1) Aligning hospitals, physicians, and other providers across the continuum of care; 2) Using evidenced-based practices to improve quality and patient safety; 3) Improving efficiency through productivity and financial management; and 4) Developing integrated information systems. This article summarizes ten strategies and the measures to assess the accomplishment of these strategies.

Hospitals and health systems face unprecedented demand to change, now and in the future. From radically changing demographics and payment systems to the uncertainty surrounding governmental reform legislation, these pressures combine to create substantial concerns among health care leaders.

In the current financial environment, hospitals must focus their efforts on performance initiatives that will pay dividends now and also position them for success in the long term. This reality inspired the American Hospital Association’s (AHA) Board Committee on Performance Improvement to center their initial project on the “hospital of the future.” Economic, demographic, and regulatory changes are occurring throughout the health care industry and compete for organizations’ attention. This article aims to cut through the competing messages to synthesize the best-practice strategies hospitals can adopt today to reach tomorrow’s desired care delivery models.

Approach

The strategies put forward in this article are the result of telephone and in-person interviews conducted with senior leaders from health systems, hospitals, and stakeholder organizations. These leaders represent a comprehensive cross-section of geographically diverse providers. These providers have various physician affiliation and employment models.

The AHA Committee on Performance Improvement synthesized the results of the interviews and identified the most important actionable strategies for organization-wide implementation. To prioritize the results, the strategies were voted on by members from various AHA regional board and constituency groups. The hospital leadership members were asked to vote on the most urgent of the strategies, thereby developing the list appearing on the follow pages. This list of strategies articulates a broad vision of the future of the hospital.

First Curve to Second Curve

Economic futurist Ian Morrison believes that changing payment incentives will cause hospitals to modify their business and service delivery models. He calls this a first-curve to second-curve shift. As displayed in Figure I, the first curve displays where providers have come from. It is an economic paradigm driven by the volume of clinical services, fee-for-service reimbursement, and competition between providers. The second curve is concerned with value. It is a paradigm centered on the cost and the quality of care. This paradigm shift is necessary to produce desired health outcomes.

Morrison finds that the current system has not yet left the first curve and has not arrived at the second. Instead, he refers to the current market as “the gap.” Managing during this period requires an evolving equilibrium on the role of all involved. Providers that implement second-curve economics before the market is ready may see significant revenue reduction. Conversely, those that remain in the first curve and do not organize themselves will not gain the capabilities to succeed when market transition is complete. Life in the gap is challenging on its own. As the number of pilot programs that demonstrate life in the second curve...
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Findings

By considering in tandem the shift from the first curve to the second curve as well as the findings from the interviews, the following 10 strategies were identified as critical to implement for all hospitals.

**Must-Do Strategies**

- Aligning hospitals, physicians, and other providers across the continuum of care
- Using evidenced-based practices to improve quality and patient safety
- Improving efficiency through productivity and financial management
- Developing integrated information systems
- Educating and engaging employees and physicians to create leaders

- Strengthening finances to facilitate reinvestment and innovation
- Partnering with payers
- Advancing through scenario-based strategic, financial, and operational planning
- Seeking population health improvement through pursuit of the Institute for Healthcare Improvement’s “Triple Aim” of improving the health of the population, enhancing the patient experience of care (including quality, access, and reliability), and reducing, or at least controlling, the per capita cost of care.

**First-Curve to Second-Curve Metrics for Physician Alignment**

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**First-Curve to Second-Curve Metrics for Quality and Patient Safety**

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**First-Curve to Second-Curve Metrics for Physician Alignment**

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**First-Curve and Second-Curve Metrics for Integrated Information Systems**

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These priorities represent actions that organizations should consider instituting now to manage life in “the gap” and to help propel them to the second curve. They will help providers be more successful until payment incentives like value-based payment arrive and push the entire health care system into the second curve.
Organizational culture is an essential foundation to support the execution of the must-do strategies. A culture of performance improvement, accountability, and high-performance focus is critical to the organization’s ability to implement these strategies successfully.

The strategies detailed below are non-exclusive. Organizations cannot expect to pursue just one strategy and remain successful in the second curve. However, the prioritization will not be the same for every hospital and will depend on the organization’s capabilities, potential for external collaboration, and market demographics. The metrics provide an example of how organizational thinking needs to change around each topic in order to move from the first to the second curve. Metrics are provided for only the top four priorities.

**Strategy #1: Aligning hospitals, physicians, and other providers across the continuum of care**

Market and regulatory forces are putting pressure on hospitals and physicians to pursue employment strategies and other ways to align. Hospitals are partnering with physicians to improve care coordination and thus reduce unnecessary admissions. Physicians seek hospitals as partners in the face of higher administrative costs and the threats of decreased reimbursement. Seventy-four percent (74%) of hospital leaders participating in a 2010 survey revealed that they planned to increase their number of employed physicians over the next year. However, interviewees overwhelmingly said that simply employing physicians only secures alignment of financial incentives. To succeed in the second curve, hospitals must collaborate with physicians on quality and strategic objectives in addition to those surrounding economic considerations. Alignment arrangements have the ability to create a system in which all parties are accountable for achieving high performance, reaching patient-centred goals, and eliminating unnecessary costs. A symbiotic system such as this is beneficial to all in a value-based payment world.

**Strategy #2: Using evidence-based practices to improve quality and patient safety**

Although considerable gains have been made within defined areas of quality and patient safety, moving to the second curve requires widespread expansion of these programs. In a year, Medicare (government coverage for the elderly) spends $17 billion, or 20%, of all Medicare payments on unplanned readmissions. In 2013, payment for unnecessary readmissions is scheduled to be eliminated. This demands quality at the inpatient site of care. In addition to the readmissions policy, potential new value-based models tie quality to financial reimbursement. Several methodologies have been deployed in the mission to improve quality, ranging from use of evidence-based medicine and patient-focused care delivery to bundles of care and multidisciplinary team training. Moving to the second curve requires measurement, analysis, and reducing clinical variation to improve quality.

**Strategy #3: Improving efficiency through productivity and financial management**

The demand for increased efficiency is felt on all sides of the acute-care organization. Providers fear that by 2025, the projected combination of a 20% increase in primary care workload and only 2%-7% growth in the number of primary care physicians will overstress their systems. In addition, the focus on quality-based reimbursement combined with tightening margins requires hospital leadership to eliminate duplicative efforts and standardize processes through a combination of operational improvements and redesigned care-delivery models. While some organizations have improved efficiency and cost management through a focus solely on quality and access, others are considering financial margins throughout process improvement projects.

**Strategy #4: Developing integrated information systems**

The policy arena has positioned health information technology (HIT) as a key to health system cost reduction, predicting it will decrease administrative overhead, duplicative tests, paperwork, and medication errors. The 2009 Health Information Technology for Economic and Clinical Health Act within the American Recovery and Reinvestment Act provided a financial incentive for
physicians and hospitals to adopt electronic health records. However, interviews revealed that organizations that installed HIT systems have found literacy, cultural, and workflow barriers are even more critical than cost to a successful organization-wide implementation. Despite the difficulties, well-established and utilized systems are critical to future success in the second curve, connecting providers and providing critical real-time information to actively plan, measure, and improve efficiency and quality from the bedside to the C-suite. It is not enough to possess information systems or extract “important” data. The ability of an organization to leverage technology to perform sophisticated data mining and analysis in real time is critical for long-term organizational sustainability and care improvement.

Strategy #5: Joining and growing integrated provider networks and care systems
The interviews revealed that a large majority of organizations have already extended their care reach or are in the process of doing so. These expansions come in a variety of forms: mergers; co-management agreements; acquisitions; and strategic alliances of hospitals, ambulatory facilities, physician groups, and other providers. In a challenging environment, organizations have recognized that well-chosen partnerships with joint accountability for both outcomes and cost provide the opportunity to coordinate care, improve quality, increase efficiency, leverage expensive technology, increase profitability, and achieve service excellence.

The second curve commands a dedication to the overall patient population, and these affiliations expand an organization’s ability to manage patient health across the continuum. Beyond traditional acute-care partnerships, health systems will begin to collaborate with community, public health, government, and education agencies. This will require the development of new competencies for many management teams. While interviews revealed that the same model will not be successful for every organization, thriving relationships have traditionally displayed proven benefits to all involved parties.

Strategy #6: Educating and engaging employees and physicians to create leaders
Long-term success of health care organizations is based on the culture, desire, and dedication of their employees. To thrive in a second-curve market, every clinical and administrative employee must be involved in initiatives to control expenses, improve efficiency, and increase quality. This can be accomplished with a variety of educational and involvement strategies. As physicians continue to become more aligned with the interests of acute-care facilities, it is essential to provide leadership training to clinicians who can guide the integration process.

Strategy #7: Strengthening finances to facilitate reinvestment and innovation
Hospitals must prepare for tightening margins. The future of decreased reimbursement and a severe case-mix requires organizations to cut costs and improve operating margins without sacrificing quality. Simultaneously, new technologies are available that can significantly improve patient outcomes but require a huge financial investment. Interviewees commented that without improving current operating margins, they would not have the financial resources to perform any of the other must-do strategies. To achieve the financial status desired for future innovation, organizations will have to revise their current service offerings, policies regarding capital, and management structure to reduce fixed costs throughout their budget.

Strategy #8: Partnering with payers
In the current fee-for-service reimbursement system, payers have the most potential to realize savings. This will continue unless new provider arrangements are made. As both CMS and commercial payers increasingly reward clinical integration and high-quality care, providers must assume greater accountability. For these reasons, the majority of interviewed organizations have considered or have already entered into contractual arrangements with payers to align risk and potential rewards. Accountable care organizations will probably not be the appropriate arrangement for all organizations. However, it is essential for institutions to involve their clinical staff throughout the process of considering new arrangements with payers, both to receive buy-in, and to explore together ways to make clinical quality improvements that might be able to reduce costs overall.

Strategy #9: Advancing through scenario-based strategic, financial, and operational planning
In a turbulent and unpredictable market facing economic and regulatory changes, organizations must move beyond traditional future-focused strategic planning. They must use methods that prepare their organizations for a large number of potentially new situations and incorporate financial and operational considerations into their plans. This advanced method of strategic planning requires a strong basis in financial management, risk assumption, and established core-planning capabilities. Institutions should ensure they create a flexible infrastructure that will prepare them for any scenario, health exchanges and Medicaid cuts to natural emergencies and the loss of large, local employers. Successful strategic planning is market- and organization-specific, and this process allows for the entire team to determine their future direction and success within the second-curve market.

Strategy #10: Seeking population health improvement through pursuit of the Institute for Healthcare Improvement’s “Triple Aim” of improving the health of the population, enhancing the patient experience of care (including quality, access, and reliability), and reducing, or at least controlling, the per capita cost of care
In a cooperative environment, hospitals historically were able to leave population health considerations to public health officials and organizations throughout their market area. However, the aging population and value-based payment have encouraged hospitals to take a more prominent role in disease prevention, health promotion, and other public health initiatives. The "Triple Aim" is an initiative launched by the Institute for Healthcare Improvement in 2007 to encourage hospitals to focus simultaneously on improving population health, increasing quality, and reducing health care cost per capita. The pursuit of these three goals permits organizations to identify and fix a wide range of problems, but most importantly, it allows them to redirect resources to activities that will have the greatest impact.
on overall health. For the organizations interviewed, these activities included community-wide education and wellness projects, disease screening initiatives, and chronic disease management programs.

Conclusion: Implications for the future of hospitals
This article should help motivate hospital senior leadership teams to consider the strategies they must deploy throughout their individual organizations to adapt and succeed in the future. Consensus exists that change will occur; what varies is each organization’s path to embrace the hospital and care system of the future. Despite the current uncertainty in health care, there is much that hospitals can do now that will better position them for success in the future. By implementing a set of top ten strategies, and in particular, by aligning all providers along the continuum of care, improving quality, patient safety and efficiency and integrating information systems, hospitals will be prepared to succeed in the future.

Richard J Umbdenstock is president and chief executive officer of the American Hospital Association, which represents more than 5,000 member hospitals, health systems and other health care organizations, and 40,000 individual members. He serves on the National Quality Forum Board of Directors and the National Priorities Partnership, and chairs the Hospital Quality Alliance.

Maulik S Joshi, Dr PH is President of the Health Research & Educational Trust (HRET) and Senior Vice President of Research at the American Hospital Association (AHA). Dr Joshi has a doctorate in public health and a master’s in health services administration from the University of Michigan and a bachelor of science in mathematics from Lafayette College. Dr Joshi is Editor-in-Chief for the Journal for Healthcare Quality. He also co-edited The Healthcare Quality Book: Vision, Strategy and Tools and authored Healthcare Transformation: A Guide for the Hospital Board Member.

Jill Seidman is a program manager for Hospitals in Pursuit of Excellence, AHA’s strategic platform to assist hospitals in accelerating performance to improve quality of care. She is responsible for the content behind actionable guides and other literature that supports AHA members’ strategic initiatives.

References
The evolving role of hospitals in health systems: USA

The underlying theories of health care reform in the United States – Strategy implications for hospitals

ABSTRACT: The United State Health Reform (Affordable Care Act) presents health care providers with the goals that should be achieved in the reformed health care environment and the rationale for those goals. Developing strategies to implement the act’s policies by any health care organization must take into account the underlying theories of the act:

- Managed change through payment design and funds flow
- Market place competition

To execute strategy effective internal organizational management is a must and can be facilitated through a strong alignment between mission and operating factors. The mission must relate to the organization’s markets. Markets are best addressed through a local perspective where the ACA goals can be applied within a specific community or culture. The systems approach brings as many participants in the system to define their mutual success as it relates to reform.

The Affordable Care Act (ACA) provides the United States with the national goals of healthy individuals, healthy communities, and a true system of health service delivery. It is the result of years of policy research, demonstration projects, pilot studies, and a review of the best practices of health care organizations throughout the world. The law contains ideas and theories that have been advanced by both Democratic and Republican legislators over the past twenty years. The overall outcomes are connected to universal access, cost controls, and quality improvement. However the ACA does not direct hospitals or other health care related organizations on how to implement its legislation. Implementation is the strategic challenge of all health care providers.

This article addresses a set of strategic responses hospitals might take in implementing ACA legislation. The authors have organized the ACA into two theoretical categories: funds flow and markets. Suggested strategic responses are organized in light of these two theories and in the context of a systems approach to strategic outcomes.

ACA organizing theories
Funding design can influence behaviour and the ACA has many funding policies which are based on successful demonstration projects.

A highly visible example is the Physician Group Practice demonstration which defined the Accountable Care Organization (ACO) in the ACA. ACOs provide comprehensive care for a defined population for a preset price. One of the most successful demonstration sites was the Marshfield Clinic. In three years the clinic met greater than 98% of its 32 quality measures and received a performance payment of 13.8 million, generating a $23.49 million Medicare savings in the third year.

Another demonstration was focused on bundled payments for inpatient care. In this demonstration the Baptist Health System was paid a flat bundled rate for 9 orthopedic and 28 cardiac procedures. This fee included hospital care, physicians and outpatient follow up and rehabilitation. Physician payments were increased by 25% if certain cost reduction targets and quality goals are met. The project and immediately generated gain sharing payments from Medicare that ranged from $65.00 to $6000.00 per admission.

These demonstrations supported the ACA theory that, with the proper incentives in place, cost can be contained as good service is provided. In many of its policies the ACA reform addresses the incentive system with scheduled cost containments and controlled pricing. Hospitals must now react to these Medicare initiatives.

A second underlying theory of the ACA is that a fully functioning and competitive market for health care services will achieve the goals of reform. The ACA bases this position on a demonstration
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In Massachusetts which has successfully implemented large group purchasing for individuals. It succeeded in insuring 96.1% of the Massachusetts population. However, it has not had a significant effect on restraining cost growth.

A second demonstration of controlled market competition is the Medicare drug benefit Part D. In this case, Medicare beneficiaries chose from over 30 drug benefit plans each year. The cost of the average drug plan is now 41% below what was originally forecast.

The ACA sets a direction for health care reform through the theories of funds flow and markets. Now the managers of the health care organizations need to bring together these two theories into an operational perspective. A systems approach can be the way to strategically do so. In the opinion of the authors, a systems approach, which is at the heart of the ACA, is drawn from the Clinton Health Care Reform plan of 1993. At that time over 40 topical working groups were formed containing subject matter experts from all aspects of the broader health care system. This process set the tone for defining and resolving inter-health sector conflicts and could serve a vital role in current health care reform implementation.

The strategic response

Any strategic response to funds flow and markets has to be taken in relation to the each other and in the context of the broader health care system. A discrete response to the administrative pricing directives in the ACA is quite simple: cut costs and retrench to meet pricing constraints or seek new venues to gain revenue. The former is currently undertaken through a number of initiatives accepted within the hospital industry. They include analytically based cost containment; operational improvement protocols; and employee motivational development. These initiatives are necessary but not sufficient to strategically succeed in the ACA's reformed environment. The latter demands the application of each of these tools with the addition of an engagement with competing business models; potential partnerships; community and governmental relationships; generational culture differences; and the power of the consumer. In short, it demands a systems perspective on strategy.

There are four perspectives health care providers can bring to a systems approach to reform.

One: A systems approach begins when first you see the world through the eyes of another. The health care delivery

Figure 1: Total Health System Model
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System is a conglomeration of a myriad of business models, ranging from nonprofit services through return-on-investment models for publicly traded companies. The hospital’s health care delivery system might begin from the patient provider interaction but then takes in all the suppliers of goods and services which support this core interaction. Figure 1 provides one example of a system’s model centered on the patient and provider. Hospital administrators must understand that various stakeholders bring many possible approaches to the transaction, with their own needs and constraints.

Two: A systems approach goes on to discover that every business plan is terribly restricted. The points of view of the systems stakeholders can be only known imperfectly and relationships based on objective information are impossible to create. Therefore it becomes the role of the administrators of these systems to challenge each other’s assumptions. This means engaging in a dialog that challenges each other’s thinking behind competing business models with the aim of finding a space where agreements can be reached.

Three: There are no experts in the systems approach. These who embark on a strategy to address the health care system as a whole may become frustrated in the face of sectional interests. The systems planner must address those factions with a spirit of dialog and with an understanding that the complexity of the health care system brings with its various business models and a variety of moral judgments and ethical considerations. In such a system there can be no experts, merely participants in the dialogue.

Four: The systems approach is not a bad idea. The attempt to take on the whole system remains a worthwhile ideal, even if it cannot be fully realized in practice. The complexity of health care has frustrated many good thinkers at the personal, organizational, and governmental levels. So, administrators should pick the place where they can enter the system dialog and use most effective.

Implementation of a system strategy
With the assumptions that health care reform is built on the two theories of funds flow and markets and that a systems approach to strategy is an appropriate one, the following are strategic initiatives that hospitals can take.

Align the internal system
A reference projection is the recommended way to begin a strategic process. The SWOT Analysis is probably the most familiar reference projection tool. However a systemic reference projection can also be provided through an alignment analysis. The health care organization should first determine its strategic purpose and, then, conduct an analysis to see how organizational factors such as knowing, culture, management practices, etc., align with purpose. Research has shown that organizations that align management factors with purpose realize superior financial performance over those who do not.

It ought to be noted that an organization’s purpose should express its vision, either implicitly in its goals or explicitly in a clear statement of mission. Mission statements are often high-minded but lacking in connection to actual operational management of the organization’s assets. A clear mission should state long-term goals and determine how to measure progress toward reaching them and should provide the organization with a business model that provides a distinctive competitive advantage. An alignment analysis would situate any health care provider with the insight as to how to approach its markets.

It is the ultimate alignment of the provider’s business design, market approach, and human assets that allow for a robust strategy. It is the clear statement of purpose that brings these factors together into a viable management system. The ACA does not dictate management behaviors. So, the management imperative is that health care provider’s internal alignment must be strong in order to perform in a market.

The market approach
Much of the ACA is based on the theory that strong market competition will drive improved overall provider performance. Market viability in health care has been challenged by economists because of the fact that patients are not always the direct purchasers of health care services.) This may be the case. However, contemporary technologies have created a knowledgeable consumer class that has more participation in all its purchases, including health care. This is true in both personal health and in health care itself. Awareness of healthy choices for consumers is becoming part of our everyday discourse. People are exposed, at least, to health choices and the consequence of choice. Likewise, health care providers are becoming more consumer-sensitive. Firms such as Target and Walmart, among others, are bringing health care to retail settings and further alerting people to the market choices in the field. These and other activities, such as health savings accounts, are creating markets for health care and are also enlightening people to the fact that they represent a market.

From a systems perspective, health care organizations are embedded in a social context of relationships. For many health care providers these relationships are local and are open to localized market information. A strategic market response to the ACA would be to look at local and regional organizational positioning. While national policy makers think only in terms of a national mandate for quality and costs, a valid strategic response to the ACA would be in community partnerships, health products and services that represent regional preferences, and services that can attract local constituents to programming that is social in nature.

Effective health care leaders will see how supermarkets, financial services institutions, and colleges market locally to their constituents and see what can be learned from them.

Spread the dialogue across the system
The systems theory underlying the ACA should create willingness among health care providers to engage in strategic discussions with suppliers to their organizations. Trade associations bring similar organizations together to discuss shared concerns. There are few venues where a wide array of health care systems stakeholders can participate in a similar dialogue.

All parties within the health care system need to negotiate with each other with both their own interests in mind and the overall concern for healthy people, healthy communities, and a healthy delivery system in mind. This relationship driven approach to the system can assist administrators to learn their way to desirable and feasible change. Any competitive stance between provider and supplier would have to be eased in the dialogue process but
can open up novel and elegant proposals for systems improvement.

**Conclusion**

The ACA presents health care providers with the goals that should be achieved in the reformed health care environment and the rationale for those goals. The implementation of any health care reform lies with the stakeholders in the system itself. Effective internal organization management is a must and can be facilitated through a strong alignment between mission and operating factors. The mission must relate to the organization’s markets. Markets are best addressed through a local perspective where the ACA goals can be applied within a specific community or culture. The systems approach brings as many participants into the system to define their mutual success as it relates to reform.

Dan McLaughlin is the Director of the Center for Health and Medical Affairs at the University of St Thomas in Minneapolis Minnesota. His research is focused on operations management and leadership. He is the author of Healthcare Operations Management and Responding to Healthcare Reform: A Strategy Guide for Healthcare Leaders.

Jack Militello is a Professor of Management and Director of the Health Care and Executive MBA Programs at the University of St Thomas in Minneapolis, Minnesota. His research, consulting, and teaching help leaders development and implementation sound strategies. He holds a PhD from the Wharton School of the University of Pennsylvania in Social Systems Sciences.

**References**

ABSTRACT: A variety of provider payment mechanisms (PPMs) are used in Brazil to direct funds to hospitals. This article examines their effects on hospital efficiency, costs and quality. Public hospitals funded through the traditional line-item budget are the least efficient. Those funded through global budgets and other decentralized budget modalities perform on a par with private providers funded mainly by private prepaid health plans. Private hospitals that are dependent on government payments exhibit lower levels of quality. However, the overall effects of PPMs on performance are less than expected for some groups of hospitals. Factors compromising the impact of PPMs on performance are examined.

Provider payment mechanisms (PPMs) are an essential driver of performance because health care providers respond to the incentives embedded in specific payment mechanisms. Although there is no perfect PPM, a carefully designed payment system can go a long way toward promoting efficiency, cost-consciousness, and quality.

Brazil has experimented with alternative ways of paying for hospital services, and debate on the effectiveness of PPMs used by the government has been ongoing. Nevertheless, despite modest initiatives to use PPMs to support policy priorities, payment mechanisms remain essentially an unused policy instrument in the public sector. The use of payment mechanisms to influence hospital performance is even less developed in the private sector.

This article examines PPMs used to pay for hospital services in Brazil, their embedded incentives and administrative characteristics, and the effects of both on hospital behaviors. Drawing on a series of analyses in this article we highlight the salient findings of the association between PPMs and efficiency, costs, and quality in Brazilian hospitals. In general, policies to reform payment mechanisms attempt to improve performance along one or all of these dimensions.

Payment mechanisms for hospital care in Brazil

Health service purchasers in Brazil (the public system and private insurance plans) use an array of mechanisms for paying hospitals. For this discussion, PPMs are classified along two dimensions: by their use in the public and private sectors and by their pricing method, and whether the amounts are defined before (prospective) or after (retrospective) care (Wouters, Bennett, and Leighton. 1998; Barnum, Kutzin, and Saxenian 1995; and Bitrán and Yip 1998).

Public sector: Five types of PPMs are used in Brazil’s public sector and they all are prospective:

- **Line-item budget.** In this traditional form of budget, the budget is fixed annually and allocated in advance by line-item categories. Budget formulation is generally based on historical values. Budgets are managed directly by government through its Unified Health System (SUS), and hospitals have little flexibility or managerial autonomy to reallocate resources. This is the chief public hospital model in Brazil.

- **Decentralized budget** is a variant of the line item budget and is used in less than 10 percent of public hospitals. Managers may have a modicum of financial and managerial autonomy, but usually only for buying consumables such as drugs and supplies.

- **Global budget** consists of a negotiated global payment allocated monthly or quarterly. As implemented in Brazil, global budgets are attached to a management contract with predefined performance targets (e.g., service volume, coverage, and quality). Applied in a small by increasing number of autonomous public hospitals, this model allows facility managers much more flexibility, and accountability requirements are more stringent.

- **Case-based payment.** Under this PPM, payment is based on predefined episodes of care, treatment, or disease, which include all or most of the individual services or procedures performed for that episode. Values are in theory based on...
average or expected costs, but in practice have become unaligned with costs (De Matos, 2002). Known as the AIH system, this PPM is a prospective procedure-based payment mechanism used by all levels of government to pay for inpatient care in private hospitals.

Private Sector: Two types of PPMs are used in the private sector:

- Prospective fee-for-service payment (prepayment). This is a service-based mechanism by which the cost of individual services provided is reimbursed. It is usually based on a previously agreed fee schedule. This is the main PPM used by institutional purchasers in the private sector. However, large public referral facilities also maintain contractual relationships with health insurers and derive revenue through this PPM.

- Out-of-pocket fee-for-service. For private, uninsured patients, the main form of payment is out of pocket. Payments are based on fee schedules, defined, usually prospectively, by each facility, and are generally much higher than the fees negotiated between health plans and providers.

Payment Mechanisms and Performance

As displayed in Figure 1, hospitals financed mainly by prospective prepayment and fee for service displayed higher total efficiency scores as measured through Data Envelopment Analysis (DEA), 0.456 and 0.437, respectively. All hospitals in these groups are private. In contrast, hospitals that are dependent on line-item budget – all public facilities – are the least efficient, displaying significantly lower DEA scores (0.270). Public hospitals constituting the decentralized and SUS prospective PPM groups occupy an intermediate level of efficiency, with DEA scores approaching the sample’s average (0.341). Importantly, hospitals paid through global budgets, consisting of public hospitals under autonomous management arrangements, achieve scores approximating those of the privately funded facilities.

We conducted a benchmarking analysis of efficiency indicators by PPM group and the results more or less confirm the DEA findings. Bed turnover was highest among private prepayment hospitals (60), followed by line-item (53) and global (52) budget facilities. The public prospective fee-for-service and, to a lesser extent, public global budget groups are the most productive, as measured by discharges per bed. Line-item and decentralized budget groups as well as hospitals under prospective prepayment are the least productive.

Using data from De Matos (2002) we assessed the effect of PPM on costs. The average procedure cost was computed by PPM group. However, due to dataset limitations, only four PPMs were included in the analysis. The unadjusted and case mix–adjusted findings are displayed in Table 1.

Before adjustment for case mix, the mean procedure cost was highest for public hospitals (several of them university hospitals) followed by decentralized and global budget facilities. The public prospective fee-for-service group is the least expensive, followed by line-item budget facilities. Public hospitals under prospective prepayment plans occupy an intermediate level of efficiency, with DEA scores approaching the sample’s average (0.341). Importantly, hospitals paid through global budgets, consisting of public hospitals under autonomous management arrangements, achieve scores approximating those of the privately funded facilities.

### Table 1: Average Cost of Typical Procedures, by PPM Group, 2001

<table>
<thead>
<tr>
<th>Payment mechanism</th>
<th>Mean cost unadjusted (R$)</th>
<th>Mean CMI</th>
<th>Mean cost-adjusted CMI (R$)</th>
<th>Mean cost ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional line-item budget</td>
<td>2,924.24</td>
<td>1.105</td>
<td>2,718.40</td>
<td>114.35</td>
</tr>
<tr>
<td>Decentralized budget</td>
<td>2,883.72</td>
<td>1.525</td>
<td>2,129.10</td>
<td>77.99</td>
</tr>
<tr>
<td>SUS prospective payment</td>
<td>2,037.52</td>
<td>0.851</td>
<td>2,691.25</td>
<td>102.92</td>
</tr>
<tr>
<td>Private prospective plans</td>
<td>2,011.29</td>
<td>0.851</td>
<td>2,830.29</td>
<td>100.05</td>
</tr>
</tbody>
</table>

Note: No hospital in the sample belonged to the fee-for-service group. US$ = R$ 2.35 (2001); CMI: case-mix index.

Sources: De Matos et al., 2002 and Dias, Couttolenc, and De Matos, 2004.
under traditional budget and decentralized budget PPMs, and lowest for private hospitals funded either through SUS prospective system or private PPMs. The high values observed for public hospitals, especially those under decentralized budgets, were expected, because university and teaching hospitals are classified in that group and overall treat a more severe case load than private hospitals (as shown by the CMI index, table 1, column 2). After adjusting for case-mix differences, the relative costs changed significantly. The decentralized budget group displayed the lowest procedure costs while hospitals under prospective private payment displayed the highest, followed by public hospitals under traditional line-item budgets.

To illustrate the relative costs between hospital groups, a ratio of the PPM-adjusted mean cost to the overall mean cost was constructed. This ratio appears in the last column of table 1. The traditional line-item budget group displayed the highest relative cost; the decentralized budget group, the lowest. Private hospitals, whether funded through SUS prospective payment or private prospective prepayment, showed similar relative costs around the sample mean. Taken together, results on costs and relative costs suggest that, once adjusted for case mix, facilities under traditional budget PPM are relatively costly.

Payment mechanisms must also be judged by how much they influence quality. Based on the AMS facility survey, we also examined the effect of PPM on quality. These findings should be interpreted with caution due to the limitations of the index as computed from the dataset, as well as the small number of hospitals in each category. On average, hospitals funded through traditional and decentralized budgets achieved slightly higher quality scores (around 0.5) than those in the other categories. The hospitals funded through the SUS prospective payment system and fee for service had the lowest values (around 0.4) while those under global budgets occupied an intermediate position (0.46). These results suggest an inverse relation between efficiency and quality, although this tradeoff appears weak.

Discussion

Public hospitals under traditional line-item budget payment mechanism are not only the least efficient group, but they also have higher costs after adjusting for case mix. However, in terms of structural features of quality, they score the highest. But this is probably due to higher personnel use. Public hospitals funded through some decentralized and global budgets are both more efficient and less costly (after adjustment) than traditional public hospitals. Autonomous hospitals under global budgets achieve good scores on efficiency, apparently without compromising quality. Hospitals depending on SUS prepayments or funded mostly through fee-for-service payments are efficient but may provide low-quality care. In the case of hospitals dependent on government prospective payments, low quality may be due to the severe resource constraints (because the government pays well below the cost of most procedures.).

These results are in line with the economic incentives imbedded in each PPM as described above. The rigidities of the traditional line-item budget do not encourage efficiency and cost containment, but flexible, global budgets, associated with managerial autonomy, do. However, prospective payment systems based on production (both case-based and fee-for-service), as implemented in Brazil, appear to promote only limited incentive for cost control.

As applied in Brazil, PPMs appear to weakly stimulate performance, and some may actually drive poor performance. From a policy perspective, we have identified four factors contributing to the limitations of hospital PPMs in Brazil:

**Diluted incentives and adverse behaviours**
The diversity of the Brazilian hospital sector and the large number of payers contributes to a multiplicity of PPMs. The typical private hospital, and an increasing number of public facilities, receives revenue from several public and private sources. Each funder applies one or more PPMs. This situation results in diluted and sometimes conflicting incentives that fail to improve efficiency and quality.

**Absence of cost information**
All PPMs are unaligned with underlying costs and therefore do not reflect resource use. As a result, PPMs do not provide hospitals with any incentives to use resources efficiently. PPMs are unrelated to underlying costs partly because there is almost no hard information on costs in Brazilian hospitals.

**Lack of adjustment for case severity**
None of the payment methods used for financing hospitals in Brazil makes or allows payment adjustment for case severity or case mix. As in the case of costs, adjusting for case mix is constrained by the general absence of robust patient information at facility level. This is related to poor recording in medical charts, absence of standardized medical practices, and near inexistence of systematic case review.

**Dominance of line-item budgets in public hospitals**
Budgets provide few incentives to raise productivity and quality, adapt managerial innovations, stimulate managerial flexibility, decrease excess capacity, or establish a robust information environment. Because of these limitations, most high-income countries that once used line-item budgets to pay hospitals have implemented more sophisticated PPMs such as DRGs, per diem payment, and global budgets.

Policy implications

To improve the hospital payment system in Brazil, both short-term and medium-to long-term policy changes are recommended. In the short term, given the difficulties and time lag involved in reforming information systems, emphasis should be placed on improving and upgrading systems such as eliminating inconsistencies and distortions in the prospective fee-for-service system, and expanding successful models of payment mechanisms such as the performance-based global budget payment system under implementation in the State of Sao Paulo. In the medium to long term, payment mechanisms should evolve to incorporate systematic diagnostic and cost information and migrate toward a DRG-like system, which eventually would be applied by all institutional payers.

Bernard Couttolenc is a health economist with 20 years of experience in the planning, management, and evaluation of health care systems.
experience as a hospital manager and consultant for international organizations in fifteen developing countries. His areas of research include health care reform, health finance and hospital efficiency. A former professor at the University of Sao Paulo, Dr Couttolenc is currently CEO of the Parifoma Institute, a health policy research center located in Brazil.

Gerard La Forgia is a Lead Health Specialist at the World Bank, currently working for the South Asia Region and formerly posted by the Bank for six years in Brazil. He specializes in health finance and management in developing countries. He formally was a Research Associate at the Urban Institute and a Senior Health Specialist at the Inter-American Development Bank. He has a ScD degree in Health Service Administration from the University of Pittsburgh.

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END NOTES:
1. The detailed findings are reported in La Forgia and Couttolenc, 2008.
2. DEA is a method for estimating technical efficiency - the ratio of outputs to inputs used. It involves the use of linear programming to rank organizations producing goods and services according to their relative efficiency scores.
3. A case-mix index was computed from the relative costs of individual hospitals to the mean for each procedure and used to adjust mean costs.
4. Index of nearly 150 imply costs near the sample mean.
5. Quality was measured by a quality index based on hospital mortality rate adjusted for case mix, the ratio of nursing personnel per bed, and the proportion of registered nurses in nursing personnel. This measure of quality used here, like most other available measures, can capture only part of the full range of health service quality.
6. More than 6,000 public providers (including each of the 5,500 municipalities) and 2,000 private providers are active in the health sector.
7. Such adjustment is important because the cost of care is heavily influenced by individual case severity and the size of costs imputed by a provider.


Hospitals and delivery systems: the need for change

NIGEL EDWARDS
DIRECTOR OF GLOBAL HEALTH REFORM AT KPMG AND SENIOR FELLOW OF THE KINGS FUND IN LONDON

ABSTRACT: Hospitals across Europe are facing huge pressures and need to change. They are not very well adapted to deal with these challenges and in many cases the policy frameworks are poorly adapted to help them change. Hospitals increasingly need to be seen as part of the wider system and need bold and imaginative solutions to deal with the problems they face.

There is widespread recognition that health care systems need to change to respond to long term trends in demography and epidemiology and to changes in medicine that require very different delivery models from those currently in use. In much of Europe the short term impact of the financial crisis and the long term challenge of rising costs and shaky funding sources give the need for change even greater urgency while at the same time limiting the options that are available to policy makers by rationing the funds needed for restructuring.

Hospitals are still an important part of the health care system but their role is changing and being challenged. Increasing amounts of care traditionally delivered in hospital can be provided as effectively in settings that are more convenient for patients and may be less expensive. The growth of non-communicable diseases (NCDs) and patients with multiple conditions is a challenge to hospitals that are often insufficiently co-ordinated with primary care, organised in sharply divided silos based on disease specialties and which are based on a model of providing short episodes of care rather than continuity.

The high fixed costs of hospitals mean that the economics of the hospital tend to require it to grow, and this option is increasingly unavailable, not least because of the effect of the financial crisis. In many countries there is concern about the efficiency of hospitals and a major push to reduce lengths of stay, increase day treatments, improve the use of guidelines, etc. As well as poor efficiency there are major concerns about quality and safety which has become a major area of concern over the last decade.

Hospitals can no longer provide all services and in particular a number of major surgery procedures and specialist care are now not considered to be safe when done in hospitals that perform small numbers. This has led to the centralisation of more specialist activity where there is some evidence that high volumes are associated with higher quality, this includes cancer surgery, vascular surgery, neonatal care, trauma, stroke and ST elevated myocardial infarct. Workforce shortages and restrictions on working hours are also creating pressures that make the maintenance of services in small hospitals increasingly difficult.

This is a particular issue in rural areas.

In many countries buildings and equipment are depreciating faster than the funds for their replacement are being accumulated. This is a time bomb issue and the shortage of investment capital in Europe due to the financial crisis is likely to make it worse.

In Central and Eastern Europe (CEE) and the countries of the former Soviet Union there are a number of additional challenges:

- The survival of a number of monoprofile institutions specialising in TB, infectious diseases and other areas is an obstacle to the development of high quality multidisciplinary care.
- The very poor state of hospital and other infrastructure including cases where hospitals have significant problems with basic utilities.
- Problems with the workforce migrating to other countries or the private sector.
- The objective in most systems is to develop care that is more integrated and better co-ordinated in which less care takes place in hospitals and other institutional settings and where there is a step change in efficiency and quality.

Responding to the challenge

Hospitals are not very well equipped to deal with these challenges. Partly this is due to the fact that in the west of Europe they tend to have a high proportion of fixed costs invested in buildings and...
There is difficulty in accessing investment capital in many countries and overcoming for strategies to be successfully implemented: there are major challenges that have to be developed strategies and those responsible for the strategic oversight and direction of hospitals sometimes lack the skills, vision or experience to execute this role adequately. It is still the case that despite their size and significance hospitals are still managed by individuals with little formal training in management, limited support from finance and management professionals and with appointments that are subject to political influence. Even in those countries where there is professional management the task is difficult and demanding. Costing, performance management and other information systems are generally poorly developed as is a culture of accountability. In many countries there is a very hospital-centric view of health care at a political level with a bias towards high technology and tertiary services. Hospitals remain very politically powerful both nationally and locally and have the ability to block change very effectively. In countries in CEE where local government is the owner of the hospitals there is a political dynamic that makes both efficiency improvement and major reconfiguration more difficult. Because of the political and economic importance of the hospital, owners have incentives to resist change but also a limited ability to hold the hospitals to account for improving quality and efficiency or challenging them to change their role. The owners are not sufficiently objective or powerful enough to exercise this power effectively. At the same time their conflicting responsibilities for a wide range of other local services has tended to mean that there is a pattern of chronic under investment in maintenance, buildings and equipment in a number of countries. Local government in Denmark, Finland and Sweden have done better with efficiency improvement and investment but questions about whether they have sufficient scale to manage strategic change are being asked and Denmark has already regionalised the oversight of hospitals. Even where hospitals or other actors in the system are able to develop strategies there are major challenges that have to be overcome for strategies to be successfully implemented:

- There is difficulty in accessing investment capital in many countries which has worsened recently.
- Implementation expertise is often in short supply.
- Successful change in hospitals requires high quality information on clinical and other activity, financial systems and well developed management arrangements to ensure that staff have clear objectives and that they are held to account for these. As noted above the extent to which these mechanisms are in place is very variable.
- Where major changes are to be made it is particularly important that staff are fully engaged in supporting and implementing the change. This is difficult but particularly so in countries where doctors and other staff have significant opportunities to work part time in the private system or receive a large unofficial income.

The changing nature of the demands made on hospitals means that it is particularly important for them to work closely with other health and social care services. In many countries, particularly in Central and Eastern Europe, hospitals have often been poorly integrated with primary health care and the gatekeeping function is only partially effective. In those countries where specialist ambulatory care models exist alongside hospital and primary care the challenge of care coordination is even greater. The organisation of hospitals on clinical silos defined by the disciplines of the doctors, rather than the often complex, multiple and ill-defined needs of the patient, tends to exacerbate this. The separation of mental health services from both primary and hospital care is a particular concern as increasingly patients with long term conditions and frail older people admitted to hospital are likely to have mental health co-morbidities.

While there has been significant development of the family doctor system in many countries in Central and Eastern Europe and the CIS there is still more to do to develop a really effective gatekeeping system. In many countries primary care is fragmented, has limited resources and has poor access to diagnostics and specialist opinion. This is a significant obstacle to co-ordinated care and leaves the hospital as the provider of last, and often first, resort.

**Issues with policy frameworks**

The wider policy framework is not always supportive of the changes that are required. Although many countries have now moved away from historically based and centrally set line item budgets to a variety of activity based payment methods there is still much to do. For many chronic conditions payment systems that re-enforce an episodic model of care and that incentivise additional activity are not appropriate but progress towards more bundled payment has been slow. DRG based payment methods may encourage improved efficiency but they are not particularly powerful as mechanisms to change the shape of the hospital system. This requires some decisions to be taken at a political level, by the payers or by the providers themselves. For all the reasons listed above this has proven to be difficult.

Often not enough is done to articulate the vision for the future role of the hospital or the shape of the wider delivery system. Some countries have developed hospital masterplans but these tend to focus on the distribution of facilities. Sometimes there is even a lack of acknowledgement that there are problems. There may not even be a clear focus for policy leadership on health care delivery systems. Many CIS countries have made surprisingly slow progress in developing policy that will drive significant change.

**The response to this**

It is fashionable to predict the end of the hospital and yet they have proven to be more robust than most prophets have expected. This does not mean that they do not need to change radically. Firstly, it is time to talk about the whole delivery system not just hospitals. It is now impossible to reform hospitals without also changing primary care, specialist management of chronic disease and long term and social care. Increasingly their interface with mental health services also need to be considered. It is almestone
the rigid silos between different specialisms within the hospital
are broken down to ensure that there can be multidisciplinary care
and on this basis the stand-alone infectious diseases hospital
seems to be a thing of the past. There is an emerging argument
from authorities such as Michael Porter and Clayton Christensen
that suggests that hospitals and the wider health care system are
made up of models that are grouped together more for reasons of
history than business logic. They argue that the interaction of
these very different business models – factory type elective care
and the much more uncertain and variable emergency medicine
means that the hospital is not optimised for most of the patients it
sees and creates huge inefficiency. This suggests a far more
radical change in the way hospitals are organised.

Managing these large and important parts of the health system
cannot be done from the centre and there is a trend in many
countries towards the devolution of power to local hospital
managers and owners. In some cases this has been accompanied
by changes in the legal status and ownership of the hospital and
the growth in more transparent reporting of performance. This
reflects a growing interest in ensuring organisations are well
managed and much more emphasis on transparency and a
culture of accountability which is potentially a powerful source
of change.

Improving the internal efficiency of hospitals, focusing on making
care systematic and organised along pathways that span
organisational boundaries is going to be increasingly important.
The application of redesign and production engineering
approaches such as Lean is surprisingly slow but does appear to
be an effective approach. Ensuring that the training of clinical staff,
the payment systems and the regulatory arrangements support
these changes is going to be particularly important.

Policy makers need to be clear what they want from hospitals,
understand that hospitals, the patients they serve and the
diseases they treat are very different from what has gone before
and that major change will be required. Politicians will find this
difficult and so it is now time for clinicians and managers to take a
lead, apply new ways of thinking to transforming how the hospital
operates internally, to improve co-ordination with other services and
radically change the wider system beyond the hospital’s
doors. We need a really compelling and powerful story about how
care could be different and the new role that hospitals will play in
that. There needs to be capital to allow them to change and many
people attached to old models need to be prepared to abandon
them.

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Nigel Edwards is Director of Global Health Reform at KPMG and a
Senior Fellow of the Kings Fund in London. He is an Honorary
visiting Professor at the London School of Hygiene and Tropical
Medicine. He has recently been working with the WHO Regional
Office for Europe on hospitals and delivery systems

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Box 1: UK Experience

In the UK the pressures to centralise care, financial pressures
and workforce shortages are raising questions over the
financial and clinical viability of a number of smaller hospitals.
Staffing obstetric and paediatric units, the availability of staff to
support emergency surgery and emergency units is increasingly
challenging. This is leading to mergers and proposals for
 closures and partial closures. So far it does not seem to have
led to any very radical approaches to the redesign of the
traditional hospital and the assumption appears to be that
following rationalisation the remaining services are just bigger.

Some experimentation with home care and decentralised
care has taken place but this is not usually on a scale to prevent
a significant change in the number of patients needing to
attend hospitals. For some specialties network models have
provided a solution to the problem of how to standardise care
between providers and maintain services where a standalone
staff would be unsustainable. However, few of the assertions
and evidence that is relied on in making these assertions and
drawing up plans to address them appears to be based on a
robust research literature.

Over the last 6-7 years many providers have become
autonomous Foundation Hospitals in an attempt to break the
hold of central government and encourage more entrepreneurial
behaviour. There has been some partial success in this but still
50% of hospitals have not made this transition.
ABSTRACT: A change in the national government of Australia in 2007 lead to a process of review and reform in healthcare which is now being implemented. The Australian Healthcare and Hospitals Association (AHHA) ran a simulation exercise to model the likely impact of the planned reforms. This paper describes the background to these changes, the process of consultation and implementation of the reforms, and the results of the simulation exercise. The process identified the risks inherent in the reform and the need to address long-term structural issues in the Australian health care system in order to ensure optimal patient-centred care.

Labor, a social democratic political party, was elected to power in Australia in 2007 after an 11 year rule by Liberal, a conservative party. The newly elected government was perceived to have a mandate for change which included health care and has recently negotiated a new funding model for the health system after four years of discussion and debate. The Australian Health care and Hospitals Association (AHHA) engaged leading policy makers and service providers in a simulation exercise to explore the likely results of these changes.

This paper starts by describing the Australian health care system as it has operated for the last three decades and the perceived problems with it. The history and nature of the reforms is then discussed. It then describes the application of a method of modelling by simulation to explore the possible consequences of the planned reforms.

The Australian health care system

In 2007-8 Australia spent 9.1% of GDP on health care, just over the OECD median of 8.9%. Government (Commonwealth and states) funded almost 70%, and hospitals consumed more than one-third of the total. Hospital admissions rose by 37% in the decade to 2008. A key concern for funders is the sustainability of the system in the face of this growing demand, which is the critical driver for reform.

The Commonwealth government funds Medicare, the public insurance scheme for outpatient generalist and specialist medical services, and subsidises the cost of most prescription medications. The State governments, partly subsidised through direct Commonwealth grants, fund public hospitals. Public hospital care is free, while patients contribute to the cost of a majority of outpatient medical services. This dichotomy in responsibility for service provision lead to gaps in continuity of care and encouraged cost-shifting between funders, with consequent inefficiency and inequity.

Australians enjoy good health. Their levels of health generally compare favourably with those of other OECD nations. Their life expectancy is the highest of OECD nations, although they rank 20th in infant mortality. There remain gaps in access to health services, particularly for Indigenous and rural Australians. These too provide a stimulus for reform.

The reforms

The Labor Government under Prime Minster Kevin Rudd appointed a panel of senior health practitioners, health policy analysts and former politicians to the National Health and Hospitals Reform Commission within a year of winning office in 2007. Their terms of reference focused on improved efficiency through greater integration of health services, particularly in aged care, increased disease prevention, and better chronic disease management; improved access, particularly in rural areas and for Aboriginal people; and a sustainable health workforce. The Commission tabled its final report in June 2009.

The Commission made over one hundred recommendations. These included improved access to dental care – hitherto excluded from Medicare; improved access to mental health; and greater investment in information technology in support of improved use of data. A controversial proposal, designed to end the split in responsibility for health services between the Commonwealth and States for ambulatory and hospital care respectively, was to be operationalised through compulsory, privately administered health insurance underwritten by a base level of risk adjusted public subsidy. The key recommendations for hospitals were national performance targets for timely care delivery, and a standardised "efficient price" for health services.

Better than a crystal ball? Using simulation to foresee emerging issues in the Australian Healthcare System

PATRICK BOLTON
NATIONAL VICE-PRESIDENT OF THE AUSTRALIAN HOSPITALS AND HEALTHCARE ASSOCIATION (AHHA), DIRECTOR OF CLINICAL SERVICES AT PRINCE OF WALES HOSPITAL SYDNEY

PRUE POWER
EXECUTIVE DIRECTOR OF THE AUSTRALIAN HEALTHCARE AND HOSPITALS ASSOCIATION (AHHA)
When the government was elected in 2007, its mandate for reform was strengthened by the fact that the Labor Party was in government Federally and in all six major States. By the time the Commission reported in 2009, Labor had lost office in Victoria – the second largest State, and was to lose government in New South Wales – the largest State – and Western Australia shortly thereafter. Prime Minister Rudd sought to fund greater Commonwealth control of, and responsibility for, the health system, by retaining State income raised through a national goods and service tax. The States rejected this model. Rudd’s electoral popularity fell to levels unprecedented for an Australian Prime Minister in their first term in office concurrently with this, and he was replaced by Julia Gillard.

Labor won the following election at the end of 2010 by the narrowest of margins, and was left negotiating its reform agenda as a minority government. In February 2011 the Council of Australian Governments (COAG - the peak body representing the Commonwealth and the States) published a Communiqué in which they agreed “to work in partnership on National Health Reforms to deliver a better deal for patients and secure the long-term sustainability of Australia’s health system”. The headline goal of the reforms is “a nationally unified and locally controlled health system that will ensure future generations of Australians enjoy world class, universally accessible health care”. The reforms implement many of the Commission’s recommendations, but in a less complete, and arguably less coordinated, fashion than the Commission envisaged. Critically, there is no single funder and no clear driver to integrated health services. Hospital performance targets based on the timeliness of care have been introduced. Efficiency is encouraged by the setting of a benchmarked “efficient price” for hospital services by an Independent Hospital Pricing Authority. A national episode funding mechanism is to be introduced which has the potential to become the major mechanism by which hospital service provision is influenced and coordinated at a policy level. The States continue to manage hospital services, while the Commonwealth continues to subsidise these and is responsible for community based ambulatory care. The stated objective of greater local control of health services is sought through the creation of health service boards with the usual corporate commercial responsibilities to govern both Local Hospital Networks (LHNs) and “Medicare Locales” (MLs). MLs have been established from existing geographically based Divisions of General Practice, with the intention that they should integrate all community health care, including non-medical services, and negotiate with hospitals to better integrate services between the hospital and community. There is some suggestion that they may become purchasing and commissioning agencies, but this has not been formalised.

The Simulation

The Simulation process was based on the United Kingdom’s National Health Service / Kings Fund ‘Rubber Windmill’ exercise. It was designed to reflect the system during and after implementation of the reforms and focused on the interactions between the participants in three scenarios over different time periods at 18, 36 and 60 months into the future. This method offered a safe environment where the dynamics of the new system could be explored and provided advance insight into some of the challenges and opportunities that the reforms are likely to generate. It drew directly on the experience and judgement of the participants who played their own roles as politicians, senior government officials, clinicians, managers, policy shapers, consumers and journalists. Participants benefited from the Simulation in their personal learning and understanding of how best to respond to the reforms in their professional context.

The outcomes

The Simulation generated a number of hypotheses or system descriptions in respect of the environment created by the health care reforms as COAG has developed them to date. These are set out in the following paragraphs.

Improvement in clinical services and consumer experience will depend on MLs and LHNs working together to deliver integrated services across boundaries. It remains unclear what financial or other incentives exist to facilitate this. The role of MLs and the mechanisms through which they are to achieve their objectives remain unclear. In the simulation, LHNs became increasingly focussed on managing internal functions in response to financial pressure, in preference to developing better integrated services with the MLs. Health services in poorly resourced locations, such as rural and outer metropolitan regions, struggled to engage in integration and the reforms in general.

The new Commonwealth-State financing arrangements are a central feature of the reforms. The Simulation was designed to test the Independent Hospital Pricing Authority’s role in setting the “efficient price” for services. It identified a lack of clarity about how the efficient price would be set. Traditional funding mechanisms, such as fee-for-service, are unlikely to provide adequate incentives for multi-professional team care involving a range of services. The price setting model has the potential to determine whether and what model of services are provided. It offers a mechanism for rationing hospital services which has been at best implicit in the Australian health care system hitherto. It is therefore critical to determining the future role of hospitals in Australia.

Care will be required to ensure that funding mechanisms do not simply maintain the status quo, and that new models are tested to determine which health services are best provided in what setting. The new funding model may be too rigid if it has no capacity to support the allocation of resources which allow the substitution of more efficient services for less efficient services. There is a danger that this aspect of the reforms will lock in existing inefficient practice, rather than providing an environment which fosters the development of innovation and testing of more efficient models of service delivery.

The Simulation noted the potential for competition and duplication between the various new data and regulatory authorities. These are the National Health Performance Agency,
the Australian Institute of Health and Welfare, the Australian Commission on Safety and Quality in Australia and the COAG Reform Council. Consideration was also given to the activities of the National E-Health Transition Authority (NeHTA) and its role in supporting collection of data. NeHTA will determine health data definitions and data sets in electronic patient records. These need to be coordinated with data and regulatory activities conducted by the other agencies.

The extent to which the private sector will be governed by the various regulatory and funding authorities is unclear.

Conclusion
This Simulation highlighted the good-will and potential that exists to deliver improved health care. Equally, it identified the importance of the implementation process and the creation of the right incentives. There remains a high level of uncertainty among senior health leaders about the basic implications of the government’s reform agenda and the complexity of the working arrangements. Participant observations summarise the challenges which lie ahead:

A health worker participant observed:

The Simulation’s early phases gave us all insight into how powerful is the old “State vs Commonwealth” competitive culture within the health system, and how this has the potential to derail any genuine reform initiatives. Equally, the Simulation later revealed how effectively all key elements of the system can work together when State and Commonwealth leaders and bureaucrats decide to work positively towards change with a renewed focus on consumers and providers – and not traditional internally-focused pursuits.

One of the consumer participants said:

The way events unfolded on the day were actually quite extraordinary and shone the spotlight on Consumers and Consumer Centred Care principles being key to the solutions for healthcare. The outcome of the day highlighted the need for the real world system implementation to initiate new ways to ensure a collaborative approach takes place right at the start of any process and the direction driven in partnership with Consumers at all levels of healthcare.

Patrick Bolton is National Vice-president of the Australian Hospitals and Healthcare Association (AHHA), Director of Clinical Services at Prince of Wales Hospital Sydney, and has broad experience in management and services delivery in the Australian healthcare system.

Prue Power is Executive Director of the Australian Healthcare and Hospitals Association (AHHA). Previous roles have included Director of General Practice with the Australian Medical Association and Adviser to the Commonwealth Minister for Health. Prue has served on a number of Boards, including 5 years on the ACT Health & Community Service Board.

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Reshuffling the pack in the Swiss hospital market

ABSTRACT: Swiss hospitals face two major changes: one is the introduction of DRG as the currency for payment and the other is the shortage of personnel due to demographic changes. They will do so by strengthening their accounting systems to be able to calculate costs per patient. First steps to attract new personnel are taken within the new professional educational system. A third change, the evolving landscape of social health insurance companies, is hard to predict.

Integrated care is on the top of the political agenda. However, the Swiss hospitals have other priorities these days. They have to reorganize their core business and position themselves in a national hospital market with new rules.

The social security act on health care dominates the Swiss health care system. In order to reduce costs and provide better services for patients, the parliament discusses new regulations on managed or integrated care. The legislative outcome is open, and the effects on the Swiss hospitals are even less predictable. Although some hospitals have integrated care procedures for certain illnesses, there is currently no massive trend towards integrated care models within the Swiss hospital market or the health care market as a whole.

Five tasks for Swiss hospitals

Instead, the hospitals try to adapt to and to implement legal regulations which have already been decided and will come into effect on the 1st of January 2012. In 2007, the Swiss Parliament has revised the hospital financing by demanding a national DRG system for in patient services combined with a financial benchmarking among hospitals. The aim is to bring about transparency in medical service tariffs. The partners in the health care system (health insurances, public entities and hospitals) have decided to introduce Swiss DRG, a DRG system derived from the German G-DRGs. It will take several years until we see the effects on the Swiss hospital system, i.e. which hospitals will survive and which will not. The challenges and tasks of each hospital are as a consequence manifold. Firstly, they have to introduce the necessary means of data collection, codification and billing. Secondly, they have to enable themselves to calculate the cost of the average patient per DRG and, based on that, calculate reasonable prices for their services. Thirdly, hospitals might want to make the treatment procedures more effective, especially by cutting waiting time and reducing length of stay. Fourthly, they might focus their services by reducing the number of diagnoses and treatments offered. Fifthly, small and medium hospitals in particular will tend to merge to bigger entities. Hospitals with a public ownership have undergone such processes already in the decade before. In 18 out of 26 cantons (political entities), public hospitals are a single legal entity, often situated in different locations. Private clinics are now following this path. So far, there are two nationwide private hospital groups with 14 and nine locations, respectively.

Since the prices for the DRGs have not been negotiated yet, even hospitals which are economically up to date cannot be sure if they will survive in their current form and with the range of services offered so far. This uncertainty brings a lot of unease in the hospital system, even though most other parameters within the health care system, even remain stable.

Lower priority for an overall vision

In such periods of perturbation and turmoil, attention towards the health care system as a whole is rare. The focus of the hospital management is currently turned inside, towards the functioning of the own enterprise. It seems as if visions and leadership can be mastered best with traditional business administration means such as strategy formulation and implementation, human resources or process orientation. Traditionally, Swiss hospitals are well equipped and fast in implementing new technologies. This is a good precondition for coping with the challenges of the on-going change process.

More personnel in the long run

Like most European countries, Switzerland faces an ageing work force as well as ageing patients. This leads to a paradox: getting short of employees when you need them the most. Swiss hospitals have not been forced yet to change their recruiting strategy fundamentally. There are four good reasons for this: firstly,
they limit the work task of care professionals to care and outplace non-care work to other employees, such as making beds or serving food. Secondly, hospitals and clinics offer a new professional education in care beginning directly after obligatory school, at the age of 16. Young employees generally work under the mandate of experienced nurses, rather than replacing them. Thirdly, the jobs which hospitals and clinics offer are usually more attractive compared to long term care institutions. Thus they are forced less to seek new workforce on the market. Fourthly, increasing the effectiveness of hospitals and clinics, as seen above, may lead to reducing staff, which can be reinserted for the rising number of patients in other departments or houses.

Nevertheless, it is to assume that the combination of aging workforce and aging patients will lead Swiss hospitals to take more action in recruiting personnel in the near future.

Uncertain role for insurance companies

Today there is a clear role distinction between hospitals as service providers on the one hand and insurance companies as payers on the other hand. A systematic cooperation between the two actors to the benefit of the patients is so far missing. With the introduction of managed care, the role of the insurers might be subject to change. In what direction this change will go and how strong it will be, depends on the legal framework that the Parliament is ready to give. Debates on that matter have been heavy, especially in a time of rising insurance premiums. Insurance companies up to now have shown themselves incapable to contain costs. Instead, they pass them on to the insured.

The role of insurance companies might also change when in the near future the number of insurance companies drops from today 80, leaving half a dozen or dozen nationwide insurance companies behind. The fewer they are, the more important is their role. The bigger the share of an insurance company among the patients of one hospital the greater is their potential impact on the service they are paying. When today an insurance company has a share of 10% of patients, their impact is not considerable, because they have limited means to deviate their patients to another hospital. In any case the effect would be limited, as 90% of the patients in that hospital are insured by other companies. When the share rises to 40 or 60%, the negotiation between the insurance company and a hospital will change naturally. Payment conditions are vital to hospitals.

Conclusion

By using traditional entrepreneurial means, Swiss hospitals actively adapt to the new tariff system Swiss DRG. And they will be even more active in the field of human resources in the near future, to meet the challenges of an aging society. However, it is not foreseeable whether Swiss hospitals will seek a more active and systematic role within the integrated care or the health care system as a whole. Another major change comes from the insurance companies finding their new role in the managed care and a consolidated insurance market.

Bernhard Wegmüller has been Executive Director of the Swiss Hospital Association H+ since 2004. He joined the association of the public and private hospitals and clinics in Switzerland in 2001. From 1994 to 2001, he worked for a pharmaceutical company, where he occupied various functions. Bernhard Wegmüller has PhD in Biochemistry and an MBA.

Martin Bienlein is Head of Politics of the Swiss Hospital association, H+. He has joined H+ in 2002. Martin Bienlein majored in political science in Bern, Switzerland. He graduated from High School in Hamburg, Germany, where he was born.
The evolving roles of hospitals in health systems: the Lagos – Nigeria example

ABSTRACT: With the revision of the definitions of health systems and the expectations of the public there is a need to reassess the roles of hospitals. Hospitals remain the centre of health care services and they face lots of challenges in service delivery. Lagos State in Nigeria has analyzed her peculiar circumstances and formulated a Health Service Reform law. This law seeks to restructure the State’s health system with an emphasis on improving the functioning of the hospitals. This article highlights the roles of hospitals in general with an insight into how the Health Service Reforms seek to improve Lagos hospitals and health system.

The term “health system” encompasses the personnel, institutions, commodities, information, financing and governance strategies that support the delivery of prevention and treatment services. The main objectives of a health system are to respond to people’s needs and expectations by providing services in a fair and equitable manner.

The World Health Organization defines a health system as “all the activities whose primary purpose is to promote, restore, or maintain health.” The World Bank defines health systems more broadly to include factors interrelated to health, such as poverty, education, infrastructure and the broader social and political environment.

These revisions in the definitions of health systems have also redefined the different approaches to functioning of health systems.

Hospitals have long been the centre of health care in communities worldwide. Most citizens see their community hospital as the place to visit when sick or in need of emergency care. Most do not see it as a place for ongoing health, focusing on treating disease rather than preventing disease. But that is quickly changing. With a focus on developing community-based programs, investments in continuous process improvement, and integrating the appropriate information technology into the care-delivery process, hospitals and health centres can become centres for community health. The goal is to maximize health by offering programs on wellness, prevention, early detection, and ongoing health management.

Today, hospitals and health systems are on the frontlines of this broken system. They persevere every day in the face of mounting challenges such as:

- Perpetually rising costs;
- Inability to hire enough nurses and other skilled providers;
- Perverse payment models that encourage waste and inefficiency;
- Growing demands of an aging population;
- Overcrowded emergency rooms;
- Lack of broad technology adoption and, therefore, system wide interoperability;
- Rising liability costs.

These challenges are global but more so in Africa which continues to struggle to keep up with the developed world. This was recognized at the WHO Regional Committee for Africa meeting on Strengthening the role of hospitals in national health systems in the African Region in 2003. At that meeting it was resolved that there was a conviction of the importance of fully functional hospitals as integral parts of national health systems in the attainment of health for all, including their contribution to retaining suitably qualified health personnel with a need to reorientation and restructuring of hospitals based on primary health care and develop strategies for improving quality of care in health care institutions in the African Region.

In Nigeria health care provision is a concurrent responsibility of the three tiers of government in the country. However, because Nigeria operates a mixed economy, private providers of health care have a visible role to play in health care delivery. The Federal Government’s role is mostly limited to coordinating the affairs of the University Teaching Hospitals, while the state government manages the various General Hospitals and the local government focus on dispensaries. There are numerous problems with the health system in Nigeria as evidenced in the WHO country
cooperation strategy report 2008-2013. As the major source of health care delivery, there is thus a need for a change that requires hospitals to embrace new values, visions, goals, and metrics of success.

Lagos state the commercial capital of Nigeria with a population of 18 million people was caught in this web of problems and sought to tackle them head on. This led to the signing into Law of the Health Sector Reform Bill which ushered in a new era in health care service delivery in the public owned hospitals in Lagos State in 2004. This brought about the redefinition of stewardship role of government and provided for autonomy of the hospital units which led to drastic improvement of hospital functioning thus aligning the state health care delivery system with what obtains in the 21st century and by extension provision of better service to the community. The objectives of the health sector reforms were to establish a state health system which:

- Encompasses public and private providers of health;
- Provides the population of the state with the best possible health service that available resources can afford;
- Sets out the rights and duties of health care providers, workers, establishments and users;
- Provide uniformly in respect of health service delivery across the state.

Some of the strategies of the reforms are:

- Re-organisation of the Health care system.
- Redefinition of the stewardship role of the Ministry of Health.
- Decentralization of Health management board (which was a central body responsible for all the needs of the hospitals ranging from funding to staffing to procurement etc) and the creation of a Health service commission which would focus mainly on management of Human Resource for Health.
- Revitalization of the primary health care system.
- Promoting Public-Private partnership.
- Encouraging alternative sources of financing for the health sector.
- Establishment of a regulatory agency to ensure minimum standard of health care service is provided in all health institutions.
- Enhancing the technological capacity through improvement of the HMIS.

The new arrangement entails that the Ministry of Health takes up the stewardship role with regard to policy formulation, health program derivation and implementation, and the Health Service Commission deals with HRM matters while hospitals through the granted autonomy anchors day-to-day activities. The later is carried out through the Hospitals Governing Boards and Hospitals Management Committee.

The roles of hospitals can be viewed in the following regards:

Role of hospitals to hospital staff

Often too much focus is given to patients while little attention is paid to hospital staff but studies have shown that the hospital staff plays a key role in the quality of services provided as they will need to implement any change that can help improve health care delivery. This starts from the leadership within the hospitals to the lowermost cadre of staff. The leadership of hospitals in Lagos State have always been medical doctors with very sound medical education and experience but limited leadership and management skills. Some even get to top management positions by “promotion”. Leadership and management training is very essential for hospitals to be well run and The Health Reform Law addressed this issue. In line with this the Lagos State Health Reform Law stated that hospitals must have a Hospital Management Committee comprising of all heads of departments which must meet monthly and partake in the administrative functioning of the hospital. Continuous training and re-training of all hospital staff which is very essential is undertaken by the Health Service Commission. This involves not just professional training but also administrative, equipment maintenance, attitudinal and use of protocols and guidelines as well as appropriate staffing and remuneration of workers. In all there is the need to continuously create an engaged, motivated, and passionate workforce. This requires internal changes to how hospitals organize, educate, support, and compensate their employees, from administrative staff to nurses to executives to physicians.

Role of patients

Patients come to the hospitals expecting to receive care. This used to be simply the case but now an enlightened people come hoping to receive not just care but affordable good quality care. Delivery of safe, efficient, and effective care is now essential. It is thus necessary that hospitals pay attention to the quality of care provided by the hospital staff and the support services. This also requires investing in cutting-edge technology, embracing new models and processes of delivering care, and using care guidelines based on evidence. The attitudes of hospital staff must be at its best as this alone is one of the key areas of perceived quality of health care. Supporting units must also be established where patients can be adequately counseled on their conditions and given health promotion tips which will help to prevent or limit disease. The Hospital Governing Board is expected to set up agendas towards achieving these. This has been done in Europe as seen in the proceedings of the 2nd International Conference on Health Promoting Hospitals held in Padova Italy where various health promoting activities in different pilot hospitals were discussed. In Lagos Nigeria there has been a failure of the Primary Healthcare System and Health Reform Law sought to correct this by establishing a State Primary Health Care Board and a Local Government Health Authority to deal with Primary health care issues and thus free up the secondary and tertiary hospitals to perform their specific roles.

Role of hospitals to hospital staff

There is a need for hospitals to reach out to the community it serves. Hospitals are sometimes seen as a place no one wants to visit as it is truly filled with sickness and gloom. Hospitals could help prevent this bleak picture through health promotion activities which will be another reason for people to visit hospitals. Screening programmes, well being clinics, diet clinics are examples of health promotion clinics that can put hospitals in a good light and change the way they are perceived. Hospitals must become centres of community health. This requires that they
move from an acute-based, volume-driven model to one that maximizes health, wellness, prevention, early detection, and ongoing health management. The issue of quality care cannot be over emphasized. In this regard hospitals must embrace production modes of delivery and efficiency to improve outcomes. This requires incorporating proven systems of production like LEAN Six Sigma into all aspects of clinical operations. With this hospitals can build a true consumer-focused organization with a genuine, core focus on the patient’s experience and well-being. This requires building a model that creates a culture of customer service and deploys the appropriate tools and technologies to engage their patients.

The Lagos State Health Sector Reforms sought to address these roles and functioning of the hospitals. Each State Hospital has its own Governing Board amongst whose functions are:

- Setting out targets in line with the overall objectives of setting up the hospital(s) and taking due cognisance of government policy directives as provided by the Commissioner for Health, in respect of economic, financial, operational and administrative programs;
- Measuring performance against set targets;
- Implementing broad policy measures on hospital and health care development plans;
- Supervising and monitoring management committees to ensure that targets are achieved;
- Ensuring co-ordination and integration of various hospital services within its jurisdiction;
- Approving expenditure up to a maximum amount as approved by the Governor for each hospital, and delegating as appropriate, any portion of that power to the Hospitals Management Committee;
- Considering and accommodating private sector participation in clinical and non-clinical support services in line with approved guidelines issued by the Ministry, e.g. Pharmacy, Radiology, Laboratory, Mortuary and any service(s) that may be necessary for the hospital.

Hospital Management Committees were also established. They are to manage the affairs of the hospitals on a day-to-day basis. This committee consists of all the heads of departments, clinical and non clinical in the hospital.

The functions of the Health Management Committee is to assist the Chief Medical Director in the day-to-day management of the hospital and to ensure proper medical care of patients in the hospital; to implement executive decisions of the Governing Board with regard to the overall planning, expansion, development and maintenance of the hospital or health institutions within its jurisdiction; the revenues and expenditures of the hospital and the purchase of stores, furniture and equipment within the limits approved by the Governing Board.

On their own part the Medical Directors will essentially handle the day to day management of human, financial and material resources of the hospital(s) in accordance with the objectives and targets set by the Governing Board of Hospital(s).

Considering the fact that there is a lot of clandestine and substandard medical practice in the private sector in Lagos state, the HSA also established the Health Facility Monitoring and Accreditation Agency which serves to ensure that all health facilities within the state, public or private, perform within a given standard of health care delivery.

Since the passing of the Health Sector Reform into law in 2004 there has been improvements in the roles hospitals play in health care delivery. Despite the fact that the law is somewhat in its infancy stage, its impact on the Health System in Lagos State is already obvious as it has redefined the roles and functioning of hospitals within the State. Dr Olatunji is a Consultant Haematologist with bias for Transfusion Medicine and the pioneer Permanent Secretary of the Lagos State Health Service Commission in Nigeria. She is an advocate of reform in the Health Sector and is currently at the vanguard of its implementation. Dr Omololu is a Consultant Obstetrician Gynaecologist and the Director of Clinical Services at the Lagos Island Maternity Hospital. He is also the Head of the Quality Unit of the hospital.

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The Lesotho Hospital PPP experience: catalyst for integrated service delivery

ABSTRACT: For many years, Lesotho urgently needed to replace its main public hospital, Queen Elizabeth II. The project was initially conceived as a single replacement hospital, but eventually included the design and construction of a new 425 bed public hospital and adjacent primary care clinic, the renovation and expansion of three strategically located primary care clinics in the region and the management of all facilities, equipment and delivery of all clinical services in the health network by a private operator under contract for 18 years. The project’s design was influenced by the recognition that a new facility alone would not address the underlying issues in service provision. The creation of this PPP health network and the contracting mechanism has increased accountability for service quality, shifted Government to a more strategic role and may also benefit other public facilities and providers in Lesotho. The country is considering the PPP approach for other health facilities.

Many governments have poorly functioning facilities and want to replace them but will this solve the problem? Unless the underlying causes are addressed, a new facility can become an expensive new home for many of the same problems. Lesotho is a small mountainous country in southern Africa with a population of 2 million where government has adopted a new model for the integrated management and delivery of health services. The project arose from circumstances that are familiar to many governments – failing health infrastructure, poor quality services, and resource constraints. What makes this project different is Government’s response to these circumstances, which was an examination of the underlying problems and an open approach to tailoring solutions.

The Lesotho government had struggled to improve services at the existing Queen Elizabeth II hospital for years. In less than five years, the hospital's budget had almost tripled, yet the level and quality of care had actually declined. With many services unavailable, patients would cross the border to access South African hospitals, ultimately creating more bills for government and crowding out local patients in South Africa. Lesotho has fiscal constraints, and resource constraints, and an increasing health and economic burden of HIV/AIDS and related conditions, so Government decided that this ineffective spending in such a critical sector was unsustainable.

In 2006, Lesotho requested assistance from the International Finance Corporation (IFC, part of the World Bank Group) to explore options for including the private sector in a new hospital project for the capital city of Maseru. The IFC team included PPP experts together with clinical and other technical specialists who assisted Government in designing and implementing this project. The initial concept was for a single replacement hospital, yet the final project was much broader, including the design, construction, and equipping of the new 425 bed public hospital and adjacent primary care clinic, refurbishment, expansion and upgrade of three regional primary care clinics, all facility and equipment management and all clinical services, creating a health network operated by the private partner. The new hospital functions as the nation’s referral hospital, serves as a district hospital for greater Maseru, and is the nation’s major clinical teaching site for physicians, nurses, and other allied health professionals. The competitive tender resulted in the selection of Tsepong, a consortium led by Netcare, a leading South African and U.K. health provider, together with a women-owned investment group and local and expatriate health care professionals.

There were many considerations for sustainable project design. Could the country afford new facilities and better public care? What was the appropriate mix of services, quantity, and quality of care that would be affordable? What indicators should be used for evaluating the performance of the new management, staff and facilities? To answer these questions, a detailed survey was constructed to examine the health care costs and services at Queen II and the existing primary care clinics.

The Baseline Survey
A team of doctors, nurses, health administrators, and statisticians from the Lesotho-Boston Health Alliance (LeBoHa) spent more than six months assessing the physical facilities, quality of medical
records and patient management, referrals to South Africa’s hospitals, interviewing patients, observing hospital and filter clinics’ technical capacity, and surveying personnel about existing practices, service delivery and staff morale. This baseline study included four different surveys conducted between June 2007 and June 2008.

The results revealed that the situation was far worse than anyone had expected. Queen Il had neither emergency nor life-saving equipment readily available in most departments. The hospital was not meeting the fundamentals for patient care of for the majority of very sick patients due to the lack of standard diagnostic testing, intravenous therapy and other causes, despite the availability of equipment and supplies.

The burden of illness revealed by the baseline study would challenge any government and any hospital and was especially daunting in the context of the staffing, equipment, and management challenges at the existing hospital. Infection control, whether for TB or other infections, was a serious problem. Malnourished children accounted for 25% of all pediatric medical admissions, with pneumonia in children even more common.

The study found many physicians and nurses in Queen Il to be well-intentioned, compassionate, and, in the case of several specialists, extraordinarily skilled by any standard. Yet, the low quality of services in the hospital was partially the product of management failures and lack of accountability. The hospital, for example, used an outdated, error-prone, “team” approach to patient care with jobs are divided among nurses for specific types of care so that no single nurse was accountable for a particular patient or for keeping track of a patient’s overall condition and changing needs. Doctors and nurses rarely washed their hands; there were 54 hand-washing stations in the wards, of which, 52 had running cold water, but none had soap.

Primary care clinics were similarly understaffed and poorly equipped. Patients often bypassed the clinics entirely and either went directly to Queen Il, overwhelming the hospital with patients, or crossed the border into South Africa in an attempt to access services.

All these findings confirmed one of the key arguments for using new approach to improving the health care in Lesotho. Without drastic changes in management including the introduction of adequate supervision, mentoring, training, reorganization of job profiles and content and accountability for personal performance, linked to meaningful incentives, new buildings and equipment would not be enough to make meaningful changes in the health system. New facilities must be accompanied by systematic changes in how health professionals work.

In the interim: quick fixes

The baseline study identified nearly a dozen low-cost changes that could be instituted immediately to significantly upgrade care at the existing hospital while construction was underway. Suggested changes included regular stocking of soap at all hand washing stations, overhauling laundry services, a new management system for nurses to make a single nurse accountable for several patients, and improvements to chart maintenance, particularly medication records. Simple but effective improvements were also identified in the triage system for casualty admissions and in the collection and analysis of bacteriology samples. These suggestions yielded some good interim results from rapid corrective actions by the Ministry of Health.

The clinics were rapidly expanded and upgraded and opened while the new hospital was under construction. This reduced pressure on the existing old hospital and began to change patient behavior by building trust in locally available services.

What makes this project different?

Health sector PPPs typically range from simple outsourcing of support services (such as catering or laundry) to the more complex design, build, and facilities management of hospitals. The Lesotho PPP structure is a first for Africa—and one of only a handful of similar projects worldwide. In addition to the design, construction and full operation of all facilities, the private operator has full responsibility for delivery of all clinical services, including recruitment of doctors, nurses, and other health professionals, and provision of all medical equipment and all pharmaceuticals necessary for clinical services delivery.

The baseline study revealed that volume pressures on the existing hospital came from service gaps at the primary care level. The project’s health network design covers the greater Maseru area and this structure allows for treatment of less severe cases at the clinic level, freeing up hospital capacity and working to contain costs.

Government as strategic purchaser

The Government of Lesotho has effectively become an active, strategic purchaser of health services using a contract that defines the type and number of services, annual payment for the services as well as the payment mechanism and performance indicators.

This contract, monitored independently, provides Government with a measure of certainty and accountability in terms of budget, service quality, facility and equipment maintenance and other provider obligations. The contract also provides mechanisms for service penalties, dispute resolution and the flexibility to address future needs.

Payment and performance monitoring

The private operator delivers a defined service package, agreeing to treat all patients presenting at the hospital and filter clinics, up to a maximum of 20,000 inpatients and 310,000 outpatients per annum—with very few clinical exceptions. The government provides the private operator with an annual fixed service payment, escalated only by annual inflation. Private operators in similar PPPs, reluctant to commit to a fixed cost for clinical care, have historically opted for direct-cost-plus-margin payments until patient profiles and disease patterns could be established. In this case, the baseline study provided that information.

The agreement includes typical payment and penalty mechanisms related to facilities management, equipment, and other nonclinical service outcomes. Detailed clinical and nonclinical service indicators must be met in order to receive full payment from the government. Failure to do so results a deduction of a percentage of the total service payment, with the relative importance of clinical versus facilities performance indicators is reflected in the percentages deducted. Repeated failures can eventually result in termination. The facilities must also obtain and
The evolving role of hospitals in health systems: Lesotho

maintain accreditation from the Council for Health Services Accreditation of Southern Africa.

The project has an independent monitor specifically created for this project to perform quarterly audits against the contractual performance indicators (clinical and nonclinical) and, where performance has not been achieved, determine the penalty deduction that applies. The independent monitor is a consortium of companies with specialized experience in PPPs, clinical services, hospital operation and management, medical and nonmedical equipment, information management and technology, and soft and hard facilities management.

For the flexibility required in a long term project, there is a Joint Services Committee, established by the government and the private operator, to review performance and discuss and develop improvements and to address changes in disease patterns, new technologies, or new national priorities, thereby ensuring that the project remains relevant for the country.

Outcomes

The PPP agreement for this project was signed by the government and the private operator on October 2008. The expanded and refurbished primary care clinics were opened in May 2010 and the new hospital had its official opening in October 2011.

Although the project is still in its early stages and the expectation of success is high, there will certainly be challenges and obstacles for the private operator and the government. There is a high probability that the hospital will reach maximum capacity very early in the project term, requiring the government to rapidly improve the service offering at other health facilities to relieve the pressure on the new public hospital.

Government is working with the Millennium Challenge Corporation to fund refurbishment of over 150 health facilities across the country, including 138 primary health care centres. The project is underway, with construction started and the refurbishment and expansion of all facilities expected by 2013. Once completed, the government will become responsible for ongoing facilities management. Given the experience thus far, government is considering a new PPP project that would provide these additional health facilities with ongoing facilities management, ICT and equipment maintenance services in order to ensure the long-term sustainability of the refurbishment program and continuity of services.

Carla Faustino Coelho is an Investment Officer at the International Finance Corporation, advising Governments in the identification and structuring of Public Private Partnerships for health, water and sustainable energy in the Southern Africa region. She holds an M.B.A. from the University of the Witwatersrand. Carla worked extensively on the Lesotho Hospital PPP project and continues to work with the Government on PPPs in health and other sectors.

Catherine Commander O’Farrell is a Senior Investment Officer at the International Finance Corporation, advising Governments in the identification and structuring of Public Private Partnerships for health and other public services, primarily in Africa and in other regions. She has an M.B.A. from the George Washington University. Catherine led the Lesotho Hospital PPP project and is working on a similar project in West Africa, as well as other health PPPs in Africa.
RÔLE DES HÔPITAUX DANS LE CADRE DE LA NOUVELLE STRATÉGIE DE SOINS DE SANTE PRIMAIRE (SSP)

Résumé : Cet article résume un exposé présenté au Sommet de leadership de la FH qui a eu lieu à Chicago aux États-Unis en juin 2010 par Denis Poirignon de l’Organisation mondiale de la santé (OMS) et Reynaldo Holder de l’Organisation pan-américaine de la santé (PAHO/OMS). Il examine le rôle des hôpitaux dans le cadre de la nouvelle stratégie de SSP.

RÔLE DES HÔPITAUX DANS LE PAYSAGE CHANGANT DES SOINS DE SANTE DANS LES EMIRATS : COUP D’ŒIL SUR DUBAÏ

Résumé : Dans les Emirats Arabes Unis, les services de santé ont connu un grand essor en quarante ans, et la santé de la population connaît une amélioration spectaculaire. Le secteur hospitalier est en forte croissance, avec des investissements du secteur privé. Cependant, les besoins présents et futurs de la population sont complexes et peuvent ne pas être adéquatement satisfaits par l’expansion constante de la capacité hospitalière. Dans cet article qui utilise l’Emirat de Dubaï comme cas-type, nous examinerons les changements qui sont intervenus dans les services de santé et tentons de prédire leur configuration et leur croissance, de la morbidité et de l’utilisation des services.

LES HÔPITAUX DE L’AVENIR

Résumé : Les hôpitaux et les services de santé sont confrontés à une demande de changements sans précédent et à long terme, allant de changements démographiques à une dépendance croissante en matière de financement. Les cadres de politiques ne sont guère adaptés pour leur faciliter le changement. Les hôpitaux ont de plus en plus besoin d’être considérés dans un cadre plus large, et des solutions novatrices s’imposent pour résoudre les problèmes qu’ils affrontent.

LES THÉORIES QUI SOUS-TENDENT LES RÉFORMES DE SANTE AUX ÉTATS-UNIS – IMPLICATIONS STRATÉGIQUES POUR LES HÔPITAUX

Résumé : La réforme du système de santé américain (ACA, Affordable Care Act, Loi sur les soins abordables) présente aux prestataires de santé les objectifs qu’il faut accomplir dans le cadre de la réforme des soins et les motifs de ces objectifs. Toute organisation de santé désireuse d’élaborer des stratégies visant à la mise en œuvre des politiques de cette loi doit prendre en compte ses théories sous-jacentes, à savoir :• Gestion du changement par la conception des paiements et les flux de fonds• Concurrence sur le marché

Pour exécuter cette stratégie, il est essentiel de gérer efficacement l’administration interne, qui sera facilitée par un alignement solide entre la mission et les facteurs opérationnels. La mission doit être coordonnée aux marchés de l’organisation. Il faut aborder les marchés en fonction d’une perspective locale par laquelle les objectifs ACA peuvent se définir au sein d’une communauté ou d’une culture spécifique. L’approche par systèmes implique autant de participants au système pour définir leur succès mutuel par rapport à la réforme.

EFFETS DES MODES DE PAIEMENT SUR LE COMPORTEMENT HOSPITALIER AU BRÉSIL : OBSERVATIONS D’UN SYSTÈME DE PAIEMENTS MULTIPLES ET D’UN SYSTÈME DE PAIEMENTS MULTIPLES

Résumé : On utilise au Brésil un certain nombre de systèmes de rémunération des prestataires (SRP) pour orienter les fonds vers les hôpitaux. Cet article examine leurs répercussions sur l’efficacité, les coûts et la qualité des hôpitaux. Les hôpitaux publics financés par des budgets globaux ou par d’autres systèmes de budgets décentralisés fonctionnent aussi efficacement que les prestataires privés financés par des plans de santé privés pré-payés. Les cliniques privées qui dépendent de rémunérations gouvernementales présentent des niveaux de qualité inférieurs. Toutefois, les effets globaux des SRP sur les performances sont moins importants que prévu pour certains groupes d’hôpitaux. L’article étudie les facteurs qui compromettent l’impact des SRP sur les performances.

HÔPITAUX ET SYSTÈMES DE PRESTATIONS : LE BESOIN DE CHANGEMENT

Résumé : Les hôpitaux de toute l’Europe sont confrontés à d’énormes contraintes et nécessitent de profonds changements. Ils sont mal outillés pour faire face à ces défis et dans bien des cas, les cadres de politiques ne sont guère adaptés pour leur faciliter le changement. Les hôpitaux ont de plus en plus besoin d’être considérés dans un cadre plus large, et des solutions novatrices s’imposent pour résoudre les problèmes qu’ils affrontent.

MIEUX QUE LE MARC DE CAFÉ ! LA SIMULATION PERMETTRENT DE PRÉDIRE LES FUTURS PROBLÈMES DU SYSTÈME DE SANTE AUSTRALIEN

Résumé : En 2007, le changement de gouvernement national en Australie a donné lieu à une démarche de révision et de réforme.
Le service de la santé a évolué de manière considérable au cours des dernières années. L'Association australienne de la santé publique et des hôpitaux (AHHA) a mené un exercice de simulation pour créer un modèle des répercussions probables des réformes planifiées.

Cet article décrit le cadre général de ces changements, le processus de consultation et de mise en œuvre des réformes, et les résultats de l'exercice de simulation. Cette démarche a permis de déterminer les risques inhérents à la réforme et de définir des approches pour résoudre ces problèmes. Elle met en évidence l'importance de réévaluer le rôle des hôpitaux au sein du système de santé.

L'expérience du PPP à l'hôpital du Lesotho: catalyseur des prestations de services intégrés

Résumé : Depuis de longues années, il est urgent que le Lesotho replace son principal hôpital public, le Queen Elizabeth II, initialement conçu pour le remplacement d'un seul hôpital, dans le contexte de l'évolution des systèmes de santé. Le projet a fini par inclure la conception et la construction d'un nouvel hôpital public de 425 lits, ainsi que la restructuration des services de santé dans le réseau de santé du pays. La conception du projet était influencée par la prise de conscience du fait qu'un seul établissement ne pouvait pas résoudre tous les problèmes de la santé publique.

El papel de los hospitales dentro del marco de la estrategia para una atención primaria de salud (en inglés PHC) renovada

Este artículo es un resumen de una disertación hecha conjuntamente por Denis Pognon de la Organización Mundial de la Salud (OMS) y Reynaldo Holder de la Organización Panamericana de la Salud (en inglés PAHO/WHO), durante una Conferencia de alto nivel de la FH, celebrada en Chicago, EE UU, en junio de 2010. La ponencia trata del papel de los hospitales dentro del marco de la estrategia para una atención primaria de salud renovada.

El papel de los hospitales en el entorno en proceso de cambio de la atención de la salud de los Emiratos Arabes Unidos: enfoque hacia Dubai

El servicio de la salud ha evolucionado en gran manera en los Emiratos Arabes Unidos en los últimos cuarenta años, con lo cual la salud de la población ha experimentado una mejora muy notable. El sector hospitalario está creciendo de manera muy significativa gracias a la inversión del sector privado. No obstante, las necesidades actuales y futuras de la población en materia de salud son muy complejas y es posible que la ampliación sostenida de la capacidad hospitalaria no sea suficiente para cubrir esas necesidades. En este informe, haciendo uso del Emirato de Dubai para un estudio de casos, se examinan los cambios que han experimentado los servicios de salud y se intenta predecir la configuración y capacidad óptimas en el futuro, teniendo en cuenta la estructura y el crecimiento demográfico, así como los niveles de morbimortalidad y la utilización de los servicios.
como a largo plazo, que va desde un cambio demográfico a una dependencia cada vez mayor de los pagos basados en el precio, así como a la inseguridad que implica una reforma gubernamental. El Comité de la Junta sobre la mejora del nivel de rendimiento de la Asociación Americana de Hospitales emprendió una iniciativa encaminada a identificar las diez estrategias principales que deberían poner en marcha todos los hospitales con el fin de convertirse en sistemas de atención de la salud del futuro con buenos resultados. Como consecuencia de la encuesta del comité, se identificaron las cuatro estrategias principales siguientes: 1) La armonización de los hospitales, los médicos y demás proveedores de asistencia sanitaria de una parte a otra de la esfera de los cuidados de salud; 2) El uso de prácticas basadas en los hechos con miras a mejorar la calidad de los cuidados y la seguridad de los pacientes; 3) Mejorar la eficiencia mediante la productividad y la gestión financiera; y 4) Instalando sistemas de información integrados. Este artículo ofrece un resumen de diez estrategias y las correspondientes medidas encaminadas a evaluar el logro de esos objetivos.

TEORÍAS FUNDAMENTALES DE LAS REFORMAS SANITARIAS EN LOS ESTADOS UNIDOS: REPERCUSIONES DE ESTA ESTRATEGIA PARA LOS HOSPITALES

Las reformas sanitarias de los Estados Unidos (Decreto de Ley sobre la asistencia con capacidad de pago, en inglés Affordable Care Act (ACA)) presenta a los proveedores de asistencia sanitaria los objetivos que se deberían alcanzar en el marco del servicio de salud tras la puesta en práctica de esas reformas, así como la lógica de los objetivos en cuestión. Las estrategias en vías de desarrollo encaminadas a poner en marcha las políticas del decreto por parte de cualquier organización sanitaria habrán de tener en cuenta las siguientes teorías fundamentales del Decreto de Ley.

- Reforma controlada mediante una estructura de pago y utilización de fondos
- Competencia del mercado

Con el fin de llevar a cabo esta estrategia es imperativo que haya una gestión orgánica interna eficaz, algo que se puede lograr gracias a una sólida armonización entre los objetivos y los factores de gestión. Los objetivos deberán estar relacionados con el mercado de la organización, mientras que la mejor manera de dirigirse al mercado consiste en enfocarlo desde una perspectiva local por la que los objetivos de la Ley sobre la asistencia con capacidad de pago se puedan poner en práctica en una comunidad o cultura específica. El enfoque por sistemas reúne a tantos participantes con el fin de definir el éxito de cada uno de ellos en lo que respecta a las reformas.

CONSECUENCIAS DE LOS DISTINTOS MECANISMOS DE PAGO SOBRE LA ACTUACIÓN DE LOS HOSPITALES EN BRASIL: PRUEBAS DE UN SISTEMA DE PAGOS Y FINANCIACION MÚLTIPLES

Brasil cuenta con toda una variedad de mecanismos de pago (PPMS) de los proveedores de asistencia sanitaria para destinar fondos a los hospitales. Este artículo estudia las consecuencias sobre la eficiencia, los costes y la calidad en los hospitales. Los hospitales públicos financiados mediante los presupuestos públicos tradicionales de partidas presupuestarias son los que tienen peor rendimiento, mientras que aquellos financiados a través de presupuestos globales y otras modalidades presupuestarias descentralizadas funcionan a la par con los proveedores privados financiados principalmente por seguros de enfermedad privados. Los hospitales privados que dependen de la financiación del Estado tienen un nivel inferior de calidad. No obstante, las consecuencias totales de los PPMS sobre el rendimiento son inferiores de lo que se esperaba para algunos de los hospitales. Este informe examina los factores implicados en las consecuencias de los PPMS sobre el rendimiento hospitalario.

LOS HOSPITALES Y LOS SISTEMAS DE PRESTACIÓN DE LOS SERVICIOS DE SALUD: LA NECESIDAD DE UN CAMBIO

Todos los hospitales de Europa trabajan bajo una gran presión y necesitan una cambio. Estos no están realmente en condiciones para hacer frente a semejante reto y en muchos de los casos ni siquiera su estructura normativa cuenta con los medios para ayudarles a efectuar esa reforma. Cada vez hay mayor necesidad de que los hospitales se consideren parte integrante de todo el sistema de salud y por tanto necesitan unas soluciones energéticas y muy imaginativas con el fin de hacer frente a los problemas con los que se enfrentan.

¿MEJOR QUE UNA BOLA DE CRISTAL? EL USO DE LA SIMULACION PARA PREVER LOS PROBLEMAS POTENCIALES DEL SISTEMA DE SALUD DE AUSTRALIA

Un cambio del gobierno de Australia en el 2007 ha dado lugar a un proceso de análisis y reformas del sistema de salud que se está poniendo en práctica en la actualidad. La Asociación Australiana de asistencia sanitaria y hospitales (AHHA en inglés) puso en práctica un ejercicio de simulación encaminado a estudiar las posibles repercusiones de las reformas proyectadas. Este artículo describe el trasfondo de dichas reformas, el proceso de asesoramiento y puesta en marcha de las reformas, así como los resultados del ejercicio de simulación. El proceso señala los peligros propios de las reformas y la necesidad de abordar los problemas estructurales a largo plazo del sistema de salud de Australia con el fin de evitar por unos cuidados de salud óptimos centrados en el paciente.

REORGANIZACIÓN DEL CONJUNTO DE HOSPITALES EN EL MERCADO HOSPITALARIO AUSTRALIANO

Los hospitales suizos se enfrentan con dos reformas de envergadura: la primera es la introducción de los GDR (Grupos de diagnósticos relacionados) como moneda de pago y la segunda es la escasez de personal debido a los cambios demográficos. Esto deberán hacerlo reforzando sus sistemas de contabilidad con el fin de poder calcular el coste por paciente. Se toman las primeras medidas encaminadas a atraer personal nuevo dentro del marco del nuevo sistema de enseñanza profesional. La tercera reforma, el panorama en evolución de las compañías de la seguridad social es difícil de pronosticar.

LA EVOLUCION DEL PAPEL QUE DESEMPEÑAN LOS HOSPITALES EN EL SEÑO DEL SISTEMA DE SALUD: EL ESTADO DE LAGOS, NIGERIA

Con la modificación de la definición de los sistemas de salud y las expectativas del público hay una verdadera necesidad de llevar a cabo una reevaluación del papel que desempeñan los hospitales.
Estos siguen siendo el centro de los servicios de salud y hacen frente a toda una serie de retos en la prestación de la salud. El Estado de Lagos en Nigeria ha realizado un análisis de sus circunstancias tan características tras el cual ha formulado una ley para reformar el servicio de salud de su estado. Dicha ley pretende llevar a cabo una reestructuración del sistema de salud del Estado de Lagos, poniendo énfasis en particular en la mejora del funcionamiento de los hospitales. Este artículo pone de relieve el papel de los hospitales en general y lleva a cabo un estudio más a fondo sobre la manera en la que las reformas del Servicio de salud se proponen mejorar los hospitales y el sistema de salud de Lagos.

**EL PROYECTO DEL HOSPITAL LESOTHO DENOMINADO PPP: EFECTO CATALIZADOR PARA LA PRESTACIÓN INTEGRAL DEL SERVICIO DE SALUD**

Durante años, Lesotho tuvo la necesidad urgente de sustituir su principal hospital público, el Queen Elizabeth II. Si bien en un principio se proyectó construir otro hospital para sustituir al antiguo, el proyecto definitivo comprendió la construcción de un nuevo hospital público con capacidad para 425 camas y una clínica adyacente de atención primaria de salud, la renovación y ampliación de tres clínicas de atención primaria de salud, situadas en la región de manera estratégica, y la gestión de todas las instalaciones, el material y equipamiento y la prestación de todos los servicios clínicos del sistema de salud a cargo de un organismo privado contratado por un plazo de 18 años. El proyecto se diseñó por reconocer que las nuevas instalaciones por sí solas no serían suficientes para solucionar los problemas subyacentes relativos a la prestación de los servicios. La creación de este sistema de salud denominado PPP y el mecanismo de contratación han mejorado la capacidad de respuesta de la calidad de los servicios, obligado al gobierno a desempeñar un papel más estratégico y hasta es posible que sirvan para beneficiar a otros establecimientos públicos y proveedores de asistencia sanitaria de Lesotho. Tal es así, que este país está pensando poner en marcha el proyecto PPP en otros servicios de salud.
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Conjunto E
Edificio Palacio do Radio 1
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BRAZIL

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Chicago, Illinois 60601-1595
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1 bis Rue Cabanis
75014 Paris
FRANCE

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House G40C, Road 1
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CAMARA ARGENTINA DE EMPRESAS DE SALUD (CAES)
Tucuman 1668, 2 Piso
Buenos Aires C.P. 1500
ARGENTINA

Prof HELEN LAPSLEY
Research Professor
CENTRE OF NATIONAL RESEARCH ON DISABILITY & REHABILITATION MEDICINE
University of Queensland
3 Kooyong Avenue
Mosman, Sydney NSW 2088
AUSTRALIA

Prof GUY DURANT
Administrateur général
CLINIQUES UNIVERSITAIRES SAINT-LUC
Avenue Hippocrate 10
B – 1200 Bruxelles
BELGIUM

Dr DEERS DAHM
Chief Executive
GERMAN HOSPITAL FEDERATION
Weghydras 3
10433 Berlin
GERMANY

Dr LAURENCE LAI
Senior Advisor
HONG KONG HOSPITAL AUTHORITY
Room 1003, Administration Block
Queen Mary Hospital
102 Pokfulam Road
HONG KONG (SAR)

Dr MIKI RENI/SUSIJO
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c/o Jl.H.R Rasuna Said Kav C-21 Kuningan Jakarta
Selatan 12940 INDONESIA

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13-3 Kitabashi, Chiyoda, Tokyo
JAPAN

Dr TSUNEO SAKAI
President
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13-3 Kitabashi, Chiyoda, Tokyo
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Universitetsgata 2
NO-0130 OSLO, NORWAY

Prof CARLOS PEREIRA ALVES
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ASSOCIAÇÃO PORTUGUESA PARA O DESENVOLVIMENTO HOSPITALAR
Av. António Augusto de Aguiar, 32-4º
1050-016 Lisboa
PORTUGAL

Dr THADB LEKALAKALA
Director - Hospital Management and Planning
DEPARTMENT OF HEALTH
Street Hallmark Building
231 Pros Street
001 Pretoria
SOUTH AFRICA

Ms PAULINE DE VOS BOLAY
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HUS – Hôpitaux Universitaires de Genève
Avenue de Beau-Séjour 22
1211 Genève 14
SWITZERLAND

Dr DEON WIU
President
TAIWAN HOSPITAL ASSOCIATION
25F, No29-5
Sec. 2, Jung jeng E. Road
Danshou Township, Taipei County
TAIWAN

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President
UGANDA NATIONAL ASSOCIATION OF HOSPITAL ADMINISTRATORS (UNAHA)
Mulago Hospital
PO Box 7351, Kampala
UGANDA

Mr ABDUL, SALAM AL-MADANI
President
INDEX HOLDINGS
Dubai Healthcare City
Block B, Offices 203 – 303
P.O Box 13636, Dubai
UNITED ARAB EMIRATES

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NHS CONFEDERATION
29, Bressenden Place
London SW1E 5DD
UNITED KINGDOM
2011 Events

**IHF**

**37th World Hospital Congress**
8-10 November 2011, Dubai, United Arab Emirates
Theme: “Healthcare in a Changing World: Overcoming the Challenges”
Email: Sheila@ihf-fih.org; siddarth.nanthur@index.ae Website: http://www.ihfdubai.ae

**MEMBERS**

**FRANCE**

**36ème Congrès de la FEHAP**
October 5, 6 and 7, 2011, la Cité des Congrès de Lyon, Lyon
For more information: http://congres.fehap.fr/

**SWITZERLAND**

**Congrès H+ 2011**
3 November 2011, Hôtel Bellevue Palace, Berne
For more information: http://www.hplus.ch/fr/servicenav/evenements/congres_h/

**2012**

**IHF**

**IHF Hospital and Healthcare Association Leadership Summit**
May/June 2012 - South Africa
(By invitation only)
For more information, contact sheila@ihf-fih.org

**MEMBERS**

**USA**

**Congress on Healthcare Leadership**
For more information: http://ache.org/Congress

**COLLABORATIVE**

**Geneva Health Forum – Fourth Edition**
18-20 April 2012
A Critical Shift to Chronic Conditions: Learning from the Front liners
Geneva, Switzerland

**2013**

**IHF**

**38th World Hospital Congress**
18-20 June, Oslo, Norway
Future Health Care: The Possibilities of new technology
For more information: http://oslo2013.no Email: Sheila@ihf-fih.org
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